Manchester City Council
Report for Information

Report to: Health and Wellbeing Board – 3 July 2013

Subject: Manchester's Public Service Reform Local Implementation Plan

Report of: Deputy Chief Executive (Performance)

Recommendations

The Board is invited to endorse the contents of the Manchester Local Implementation Plan.

Wards Affected:

All

Contact Officers:

Name: Carol Culley
Position: Assistant Chief Executive (Finance and Performance)
Telephone: 0161 234 3406
E-mail: carol.culley@manchester.gov.uk

Background documents (available for public inspection):

Local Implementation Plan (Full document)

1.0 Information

1.1 This cover report introduces Manchester's Public Service Reform (PSR) Local Implementation Plan (LIP). This is the implementation plan for the first phase of the PSR programme in Manchester. It sets out which agencies, partnerships and individuals will undertake tasks as part of the programme, and what this is designed to achieve. This will support local agencies to align activity set out in the plan with their organisational transformation and savings programmes.

1.2 Each of the 10 Greater Manchester Local Authorities is producing a Local Implementation Plan. This will support strategic planning to achieve the objectives for PSR at a Greater Manchester level and facilitate progress monitoring.

1.3 The LIP has been submitted to the Manchester Investment Board and is due to go to the Manchester Board on 9 July. The sections of the Local Implementation Plan most relevant to the Health and Wellbeing Board are

included as an appendix to this report. This includes the introduction to the LIP and the sections on Health and Social Care (pages 11 - 18) and Early Years (pages 19 - 24). The Health and Social Care section has been endorsed by the Health and Wellbeing Board Executive Group and the Chairs of the three Clinical Commissioning Groups. The full version of the LIP is available as a background document to this report. Copies of the full Local Implementation Plan can be requested from the committee officer.

1.4 Key Stakeholders in Manchester's PSR programme are asked to sign the Local Implementation Plan to indicate their endorsement. At the meeting of the Health and Wellbeing Board members of the Board will be invited to sign the LIP.

2.0 Next Steps

2.1 The Board is invited to endorse the contents of the Manchester Local Implementation Plan. The Plan will then to go to the Manchester Board to be adopted as the formal plan for PSR implementation in Manchester.

Manchester Public Service Reform – First Phase Implementation Plan

Introduction

Responding to the reducing levels of public spending, the Manchester Partnership has agreed a new Strategic Narrative for the Community Strategy. The Narrative describes how the members of the Partnership will achieve their objectives in three interconnected priority areas: growing the local economy, supporting leadership of place and reducing residents' dependency on high cost public services. These objectives support the priorities in the Greater Manchester Strategy of economic growth and reducing dependency as well as the principles of Public Service Reform (PSR) work across Greater Manchester.

PSR work within Manchester is focused on increasing independence and reducing dependency on high cost public services, thereby reducing demand. Key to this are the design and implementation of new service delivery models supporting our early intervention and prevention programmes, taking commissioning and decommissioning decisions based on a solid evidence base and developing investment agreements. Investment agreements between the Council and Job Centre Plus, Work Programme primes, the Manchester College and the Greater Manchester Probation Trust have been developed setting out how public services will co-invest in delivery models and how they will share the benefits of reducing demand. This will support the city to invest in increasing the scale of PSR to support independence and reduce expenditure and allow investment in universal and preventative services critical to the economy and the city's neighbourhoods.

The Manchester Partnership has put in place a Manchester Investment Fund which enables continued investment in interventions that reduce dependency. Focus on securing investment agreements and implementing new delivery models will be necessary to achieve improved outcomes, reduce mainstream targeted spend and allow reinvestment in the Fund. Heads of Terms agreements are already in place for the Troubled families workstream, and further agreements are being developed.

The Local Implementation Plan

This document is the implementation plan for the first phase of the PSR programme in Manchester; it may in future incorporate additional reforms. It sets out which agencies, partnerships and individuals will undertake tasks as part of the programme, and what success will look like. Local agencies will wish to align activity set out in this Plan with their organisational transformation and savings programmes.

To track progress towards PSR objectives a number of performance measures have been established. These are detailed in the sections on each of the workstreams. Work is underway to track progress towards all our PSR objectives through a comprehensive performance management framework.

In five detailed thematic plans and one cross-cutting plan, it also sets out how Manchester will develop:

- new integrated services that reduce demand on public agencies in the city

- new investment models that can sustainably fund these services by capturing and reallocating the resources released by this reduced demand; and
- new approaches to evaluating our integrated services to show where they are more effective than existing practice, and where possible to create an evidence base that can attract future investment.

Working together across Greater Manchester

Public Service Reform is a key strategic objective of the Greater Manchester Strategy and the Manchester PSR programme forms part of the wider Greater Manchester (GM) PSR programme.

Both Manchester and GM level programmes have been significantly informed by the work of the GM Whole-Place Community Budget pilot, which was undertaken in 2012. Outcomes from this work can be found at www.agma.gov.uk/gmca/community-budgets/index.html.

Public Service Reform in Manchester

Central to the success of this programme is to ensure a clear focus on the reform of public services as a whole in Manchester.

The governance diagram and the thematic structure of the work set out on the adjacent page should not be read as requiring or endorsing the development of parallel thematic or silo reforms.

PSR in Manchester is based on four principles:

- Family focused assessment and intervention
- Coordinated and sequenced support to families
- Commissioning and delivery of evidence based interventions
- Persistent work with families until at least one family member is back at work

One of the key principles of PSR in Manchester is the commitment to the development of robust evidence to inform decision making. New delivery models are designed based on assumptions, and then tested based on data from pilots as this becomes available. This evidence and the learning from it is relied upon to focus on those interventions which evidence shows have the greatest chance of success allowing safe decommissioning to reduce expenditure.

It should be noted that there are significant synergies between the different workstreams. The benefits of many of these synergies will be captured by ensuring the whole-family way of working, identified and developed first through the Troubled families workstream, sits at the heart of our new integrated delivery models. This is particularly the case for the Early Years, Transforming Justice and Work and Skills workstreams. This is shown on the Local Implementation Plan structure diagram.

Understanding how thematic PSR workstreams align and coalesce into a programme of PSR across Manchester will be crucial.

Governance

The Greater Manchester PSR programme reports into the Greater Manchester (GM) Public Service Reform Executive, led by lead GM Chief Executives and Chief Officers for each of the themes. The PSR Executive in turn reports in to the AGMA Wider Leadership Team and the GM Combined Authority. Thematic Strategic Groups and operational groups drive progress on particular themes and a network of GM PSR Champions lead implementation in individual organisations and districts.

Within Manchester, the Manchester Board has appointed the Manchester Investment Board to lead on the local PSR programme. To ensure democratic accountability of the programme, proposals are reported to the Thematic Partnerships making up the Manchester Partnership and to Manchester's overview and scrutiny function exercising democratic oversight of the work of the Council and the Partnership. Other partnership groups secure broader engagement on workstreams, for example Integrated Care Boards have been set up for the health economies in the north, central and south areas bringing together providers, Clinical Commissioning Groups and the local authority.

Proposals requiring the Council to make significant Executive decisions are reported to the Council's Executive, and to Council as appropriate. Proposals and new delivery models are developed by lead officers across the organisations working with local executive members.

Governance structures at a neighbourhood level are being developed and strengthened. For example, within the Troubled families workstream, Local Integration Teams (LITs) are being established to review performance and direct activity around Troubled families at a neighbourhood level. They include a wide range of partner organisations with a role to play in addressing the needs of Troubled families. The Local Integration Teams feed directly into the Troubled Families Board, which reports progress to the Manchester Investment Board.

Leadership of the PSR Programme is provided by the Leader of the Council as Chair of the Manchester Board and as a member of the GMCA. This creates an important link between the PSR work in Manchester and the Greater Manchester PSR programme.

Who has endorsed this Plan?

This Implementation Plan will be submitted to the following people to ask them to sign off and endorse the contents:

- Members of the Manchester Board
- Members of the Manchester Investment Board which takes direct oversight of the Manchester Investment Fund
- Members of the Health and Wellbeing Board
- Chairs of Thematic Partnerships
- Lead Officers, tasked with delivering key projects (where otherwise not represented)

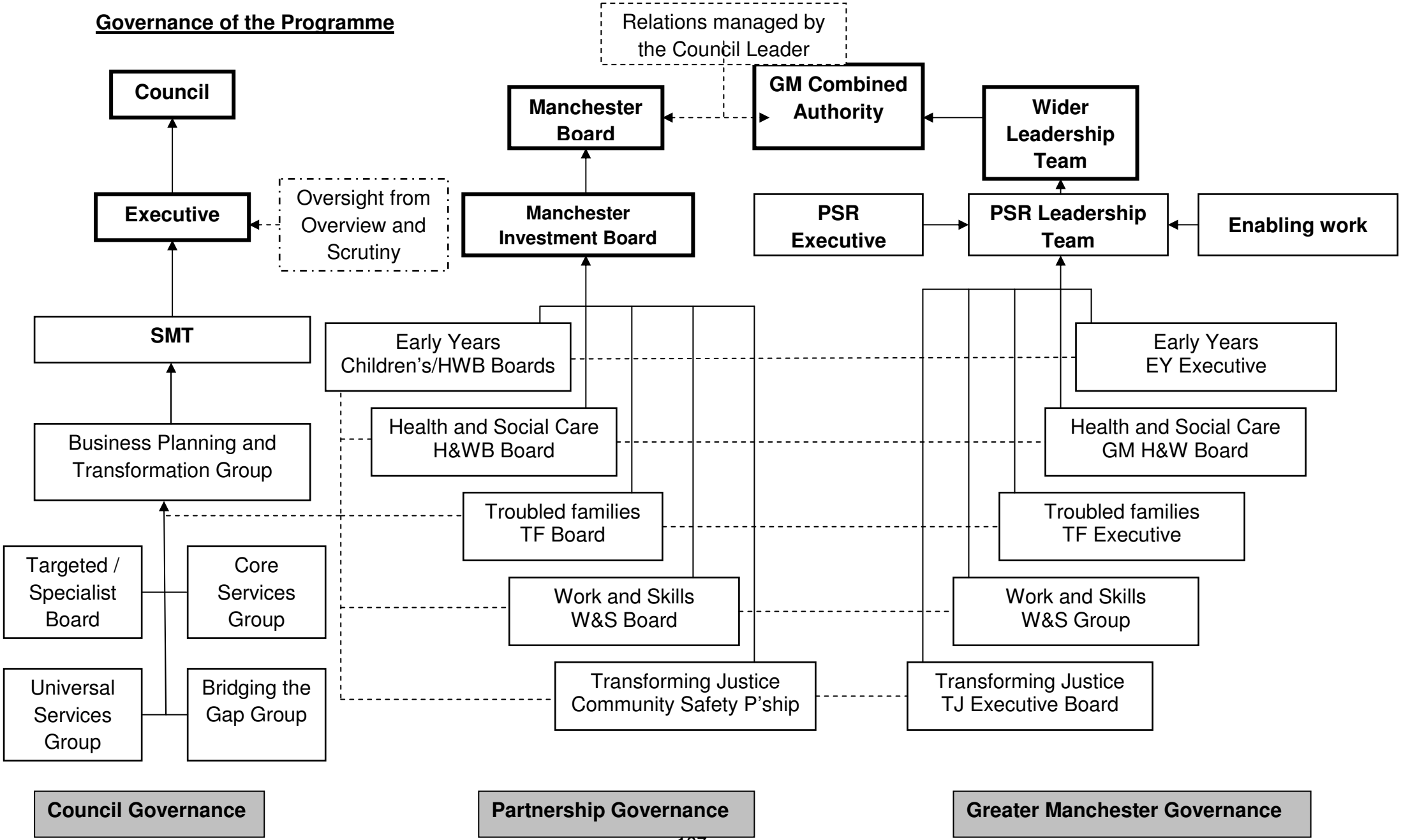
Name	Role	Signature
The Manchester Board		
Cllr Richard Leese	Leader, Manchester City Council; Chair, Manchester Board; Chair, Health and Wellbeing Board	
Councillor Andrew Fender	Transport for Greater Manchester Committee	
Phil Korbel	Radio Regen	
Lorraine Gradwell	Breakthrough UK Ltd	
Sue Woodward	Director of the Sharp Project	
Atiha Chaudry	Equalities and Third Sector	
Scott Fletcher	Chairman and Founder of ANS Group	
Chairs of Thematic Partnerships		
Mike Livingstone	Strategic Director, Children and Commissioning Services, Manchester City Council, Chair, The Children's Board (Also member of the Manchester Investment Board).	
Vicky Rosin	Deputy Chief Executive (Neighbourhoods), Manchester City Council Chair, Community Safety Partnership	
Sara Todd	Assistant Chief Executive (Regeneration), Manchester City Council Chair, Work and Skills Board	
Manchester Investment Board		

Geoff Little	Deputy Chief Executive (Performance), and PSR Champion, Manchester City Council	
Sue Hart	Vice Principal, The Manchester College	
Bill Tamkin	Chair of South GP Commissioning Consortium and South Integrated Care Board	
Chris Edwards	Assistant Chief Executive, GM Probation Trust	
Carol Culley	Assistant Chief Executive (Finance and Performance)	
David Regan	Director of Public Health, Manchester City Council	
Liz Bruce	Strategic Director, Families, Health and Wellbeing, Manchester City Council	
Paul Beardmore	Director of Housing, Manchester City Council	
Phil Lowthian	District Manager, JobCentre Plus	
Richard Paver	City Treasurer, Manchester City Council	
Russ Jackson	Divisional Commander (North), GM Police	
Health and Wellbeing Board members (not otherwise listed)		
Michelle Moran	Chief Executive, Manchester Mental Health Social Care Trust	
Mike Deegan	Chief Executive, Central Manchester Foundation Trust	
Councillor Paul Andrews	Executive Member for Adults, Manchester City Council	
Warren Heppolette,	Director of Operations & Delivery, NHS England (Greater Manchester)	
Karen James	Acting Chief Executive, University Hospital South Manchester	
Ian Rush	Chair of the Manchester Safeguarding Boards, Adults and Children	
John Saxby	Chief Executive, Pennine Acute Hospital Trust	
Vicky Szulist	HealthWatch	

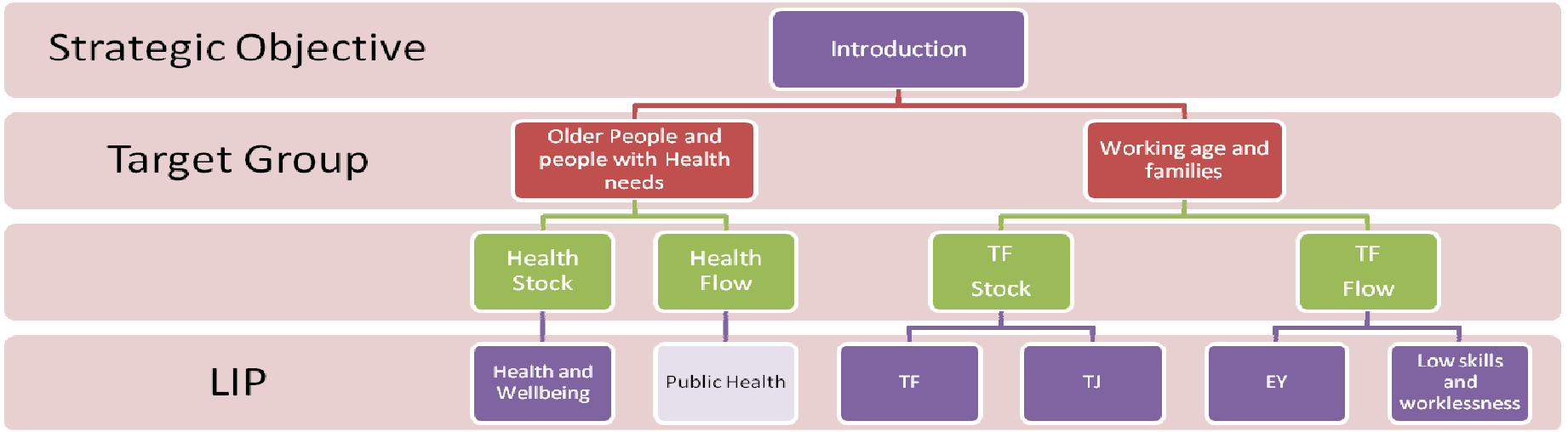
Mike Wild	Director, Manchester Alliance for Community Care (Macc)	
Martin Whiting	Chair, North Manchester Clinical Commissioning Group	
Mike Eeckelaers	Chair, Central Manchester Clinical Commissioning Group	
PSR Thematic Leads,		
Councillor Bernard Priest	Executive Member for Neighbourhoods, Chair of the Neighbourhoods Board	
Councillor Afzal Khan	Executive Member for Children's Services	
Richard Barnes	Greater Manchester Probation Trust	
Alison Connelly	Office of the Greater Manchester Police & Crime Commissioner	
John Edwards	Director of Education and Skills	
Angela Harrington	Work & Skills Lead Officer	
Emma Gilbey	Health & Social Care Lead Officer	
Fiona Worrall	Strategic Business Partner, Place, People and Strategy	
Karen Dolton	Troubled families Lead Officers	
Jacob Botham	Troubled families Lead Officers	
James Binks	PSR Lead	
Kath Smythe	Strategic Business Partner, Children and Commissioning Services	
Jenny Andrews	Deputy Director, Children's Services and Early Years Lead Officer	
Karen Jarmany	Senior Quality Assurance Officer	
Nasreen King	Early Years Senior Operational Manager	
Nicky Parker	Head of Transformation and Strategic Business Partner, Families, Health and Wellbeing	

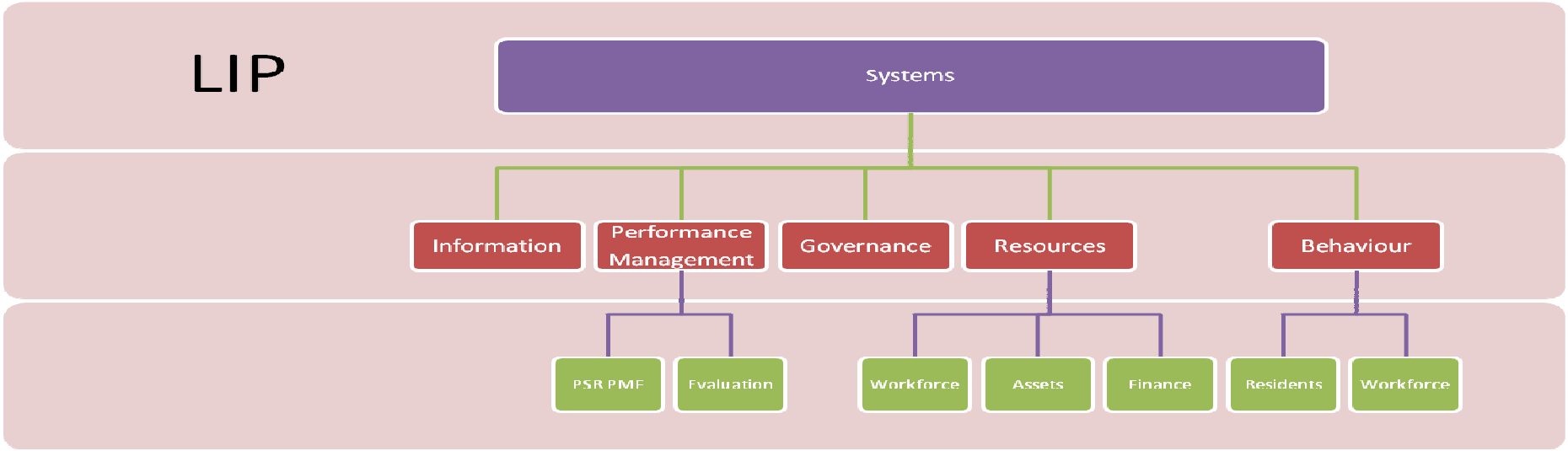
Sarah Henry	System Reform Lead Officer	
Vicky Charles	Transforming Justice Lead Officer	

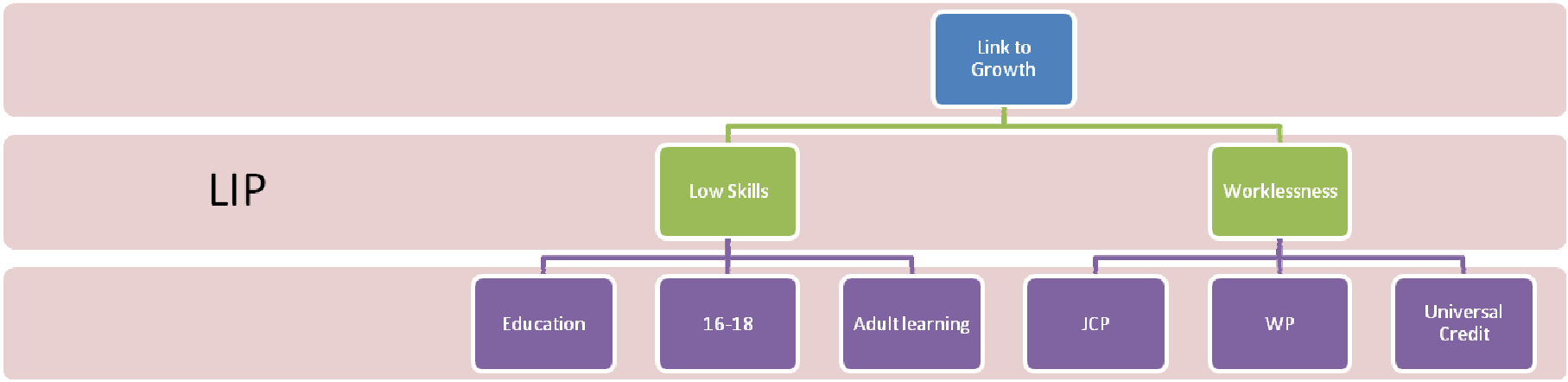
Governance of the Programme



Manchester – Local Implementation Plan structure




LIP
Systems
Information
Performance Management
Governance
Resources
Behaviour
PSR PMF
Evaluation
Workforce
Assets
Finance
Residents
Workforce


LIP
Link to Growth
Low Skills
Worklessness
Education
16-18
Adult learning
JCP
WP
Universal Credit

Health & Social Care

Background

i) Our goal in Manchester is for our population to be **living longer and living better** – and this is the name of our health and care programme. We want our focus as a health and social care economy to be on people, pride and place.

ii) Integration is a means by which we want our care to be centred on the individual.

> National Voices definition of Integrated Care:
>
> "My care is planned with people who work together to understand me and my carers, put me in control, co-ordinate and deliver services to achieve my best outcomes."

iii) Current service models within health and social care are not fit for the coming financial and quality challenge. Manchester needs to achieve a transformational reduction in demand, not just for individual service providers, but across the whole health and social care system. More people will live longer with multiple long term conditions and yet a further tightening of the fiscal environment, with both NHS and Local Authority budgets reducing in real terms, will mean continuing with the 'as is' model is unsustainable financially, or able to deliver the quality of care expected by local residents.

iii) Integrated care has been led by the three health and social care systems in North, Central and South Manchester with joint programmes of work that have crossed the CCGs, acute and community sector, primary care, mental health, social care and other agencies. Each of the three health economies has begun the development of integrated services under their own local governance structures.

iv) The New Delivery Models in Manchester have been designed with the following long term aims:

- Demand shift across the health and social care system in Manchester, to enable real and cashable savings to be made and re-invested in evidence based early interventions.
- Better health and social care outcomes, including improved management of long term conditions.
- Improved experience for patients / services users and carers – a more coordinated, coherent customer journey; better social connectivity; improved self reported well being; and improved social independence.
- Targeted reductions in health and social care costs – particularly the highest costs (e. g. reduced non-elective hospital admissions, admissions to residential care and bed days attributed to people with multiple long term conditions) but also greater efficiencies and de-duplication of services in the community.

v) In its initial work each locality has adopted a different approach to its target cohort to reflect the different health needs of the population. For example, in South Manchester, the New Delivery Model is piloting community based provision targeting people with Respiratory, Diabetes and Stroke care needs through a step down model from Hospital. In Central Manchester, new community based models are being implemented to support those who fall, patients with COPD (Chronic Obstructive Pulmonary Disease) and to support people at the end of life to remain in their home of choice. In all three localities in the City, the Combined Predictive Model risk tool is being used to identify patients at risk of hospital admission. Multi-disciplinary care teams are starting to work together with identified patients, carers and families to implement shared care plans to support people to remain healthy safe and well at home and in their communities. The integrated care team models are primarily targeting those at Very High and High risk of hospital admission. This equates to approximately 1.5% of patients registered with GP practices in Manchester (or c9,000 people).

vi) Local agreements have already seen the investment of significant funds across health and social care providers to support delivery of the proof of concept new delivery models.

City Wide Blueprint

vii) A study into Health and Social Care in Manchester was commissioned by the then Shadow Health and Wellbeing Board in 2012. Key messages from the report highlighted the relatively poor health outcomes for our population, the quality and access to services is variable, and the use of the acute sector for the delivery of services is high relative to the national average. Their proposal was for a far more ambitious programme for integration to be developed.

viii) In January 2013 the Manchester Health and Wellbeing Board asked for a high level city wide framework for integration, a Blueprint, to be developed.

ix) Our Manchester Blueprint has been co-authored and supported by the following eight organisations in the City:

- Manchester City Council
- North Manchester Clinical Commissioning Group
- Central Manchester Clinical Commissioning Group
- South Manchester Clinical Commissioning Group
- Manchester Mental Health and Social Care Trust
- Pennine Acute NHS Trust
- Central Manchester Foundation Trust
- University Hospitals South Manchester

x) The document details our shared strategic intent for the future health and social care system in Manchester. It addresses the areas of our population, service model, overall system, workforce, infrastructure, resources and engaging people in change.

xi) We have chosen Mrs Pankhurst as a symbol of our change. It is in recognition of our reforming past as a city, and a signal to our future, which aims for our citizens to have personal power and independence.

Population

xii) In Manchester we are targeting the priority groups in Manchester (both Adults and Children) needing care. They are people who are likely to be living with limiting long term conditions, growing older with a burden of disease, or living chaotic lives and likely to be living with high levels of deprivation. We have mapped where people live who are in the target groups and we know how many days these people will spend in hospital and the cost of this care to the health system.
Blueprint statement: We will identify those people most at risk of hospital admissions, who would benefit from a co-ordinated community response to enable them to live longer and live better.

Model of Care

xiii) We recognise how important it is that people continue to receive excellent care when they need to go into hospital. However, we believe that by providing a properly co-ordinated and better resourced range of services, in their homes and close to where they live, we can improve their quality of life and reduce their need for hospital, nursing and residential care. We have described a shared model of need for our population most likely to require care, which describes what the outcomes should be for these people and what care we should offer.
Blueprint statement: We will develop a model of care which co –ordinates out of hospital services across the city based on a consistent offer to achieve outcomes which will enable people to live longer and live better.

Different Health and Social Care System

xiv) If we are to provide a different model of care which enables people to have co-ordinated care as near to their homes as possible and reduce their risk of being admitted to hospital we will need to change our health and social care system. If people do not need to go into hospital as much, as they are living longer and better at home, then the function of our hospital and community system will need to change. There is a wealth of services which already support care in the community, all of which need to be considered in scope as part of the redesign. All these community services need to wrap around our hospitals and they need to be seen as an integral part of a changing system of care.
Blueprint statement: We will develop a health and social care system which commissions and provides more co-ordinated care in the community to enable them to live longer and live better.

Our Workforce

xv) Our population is living with increased levels of illness and we know that we have a complexity of care that we haven't seen before in the community. If we achieve our goal of people living longer and better then the workforce has to change to support this. We need exceptional practitioners across our systems who view the care of people in the community as a prestigious speciality in its own right, e.g. doctors,

nurses, therapists, social care professionals and support staff. We believe that these people are only part of the workforce which should include carers, friends and neighbours. We need to put carers and patients themselves at the centre of how we build and co ordinate teams around Mrs Pankhurst.

Blueprint statement: A workforce which is skilled to deliver co-ordinated care in the community to enable people to live longer and live better.

Buildings

xvi) Knowing our needs, changing our service models will not be enough to enable change to be embedded. We need to shape the infrastructure so it works for Mrs Pankhurst and not against her. We need to have facilities in our community be they on existing hospital sites, in buildings around the city or redesigned to co ordinate care in one place. Mrs Pankhurst's time is as important as anyone else's and she should be able to have coordinated, efficient and effective care as near to her home as possible. She should not have an army of people and appointments on different days across the city which could be co-ordinated better around her and near to her.

Blueprint Statement: To have quality buildings providing multi agency co-ordinated care to support people to live longer and live better.

Information

xvii) We need to have mobile solutions supporting information needs with information systems that are shaped across the different agencies, so that Mrs Pankhurst can be assured that she is having the most effective and co-ordinated care, based on her needs. Information is up to date and can be shared with her, and between the practitioners that care for her, as she wishes.

Blueprint statement: To connect systems and people with up to date information, and support co-ordinated care for people to enable them to live longer and live better.

Money

xviii) Our resources need to follow Mrs Pankhurst. If she doesn't need hospital but community care then we should be able to shift the resources to where she needs them. We need to have a resource cycle that is long enough to be able to assess that the services we put in place are embedded and having an impact. We need to be able to collaborate together across the organisations to ensure that we work together to provide the best services for Mrs. Pankhurst not compete against each other causing fragmentation.

Blueprint statement: For resources to be aligned to the person and their needs to support co-ordinated care for people to live longer and live better.

Engagement for Better Health and Well-Being

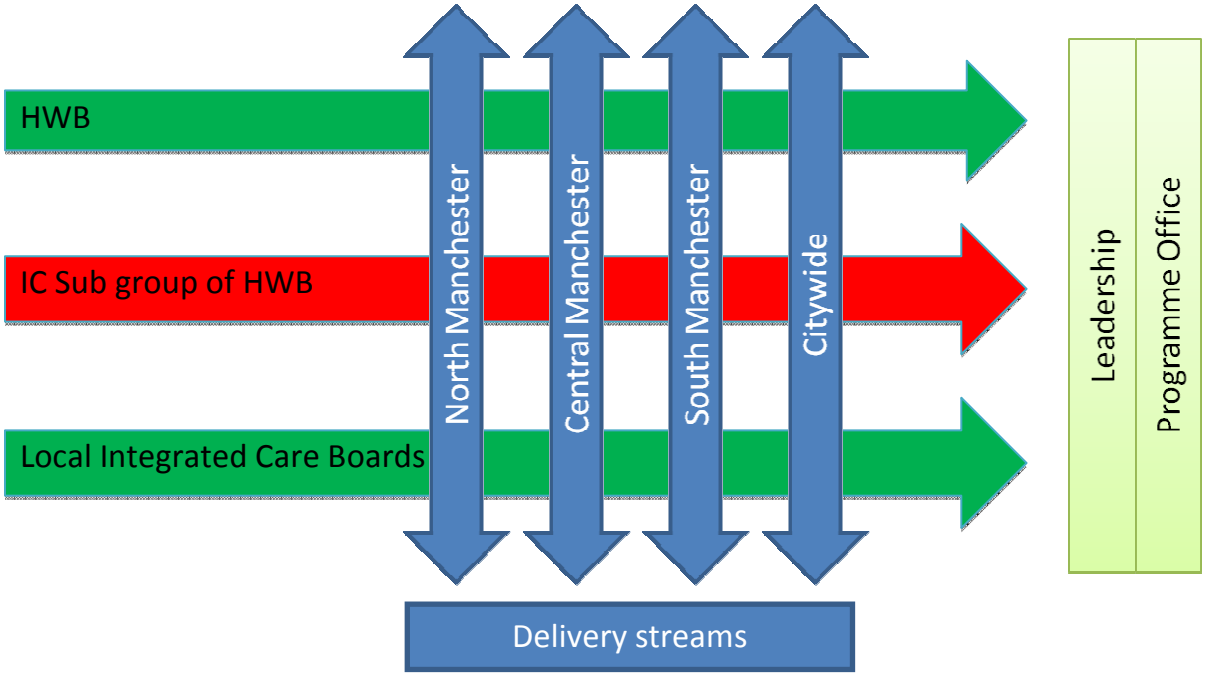
xix) We believe that to change the perception of what care is in Manchester and to enable people to Live Longer and Live Better is the biggest change programme we will have entered into as a health and social care economy. To do this we need an engagement programme that is not just about informing but involving. We need to move from traditional ways in which we have communicated separately to a

programme of engagement which is a single story of our city and how we have a movement for social change.

Blueprint statement: To create a movement for social change to provide a new paradigm for how people view their health and this programme of change to live longer and live better.

Who is leading this work in Manchester?

We will govern, redesign and deliver our new health and social care system through city wide governance of the Health and Wellbeing Board and the three Integrated Care governance arrangements in North, Central and South Manchester.



What does success look like?

The overall aim of the Manchester integrated health and social care programme is for citizens to live longer and live better, with sustained improvements in life expectancy, reductions in the disease burden and increasing wellbeing and economic activity for citizens.

Key performance measures will include:

- Reductions in Hospital admissions
- Reductions in Hospital readmissions
- Reductions in Hospital length of stay
- Reductions in Care home admissions, particularly straight from hospital.

Strategic Outline Case (SOC)

Subsequent to the LLLB Blueprint, the Health and Wellbeing Board tasked the city wide leadership group with developing a **Strategic Outline Case** for its July 2013 board. The strategic outline case is based on the same domains as the blueprint for Living longer, living better, with the addition of domains for Leadership and Evaluation. The SOC accords major priority to the following three areas:

Understanding the target population. Further analysis of Manchester's population has identified 10 target population groups who sit within and across the risk stratified cohorts:

Very High and High Risk Sub Groups

- Adults and children that are at the end of their lives
- Adults and children living with long term conditions, illness, disease or disability and are unwell
- Older people living with dementia and /or are frail elderly
- Adults with chaotic lifestyles such as the homeless, people with addictions or those in troubled families and people with long term mental health problems.

Moderate Risk Sub Groups

- Children and adults with long-term chronic conditions, illness or significant disabilities but who are generally functioning well.

Low Risk Sub Groups

- Adults and children who are carers
- Older people over 75 who are well
- Children in their early years 0-4
- School and college children who need promotion, information and support to prevent accident and illness
- Adults in work within our organisations who need to change lifestyles, and our perception of how we care, in order to actively deliver and promote living longer living better

This approach has led us to re-focus the symbol of our change from Mrs Pankhurst to the Pankhurst family, with members in each of the 10 sub groups.

The 'stock' and 'flow' concept used within other public sector reform themes (particularly Troubled Families in Manchester) has been considered in the context of health and social care. 'Stock' being those people with existing conditions and 'Flow' those at future risk. Analysis of characteristics or triggers for increasing risk of hospital admission will support the development of distinct care models to support both the highest risk and lower risk groups across the whole Manchester population.

Understanding the care model. We will design care models based on this population approach that focuses on the individual, family and community. Our commissioning care model(s) will be for a 100% of our population and within that approach we will segment and prioritise the population into groups and communities. This will mean we can focus care models on outcomes for individuals and their families. We will aim to have a universal as

well as a targeted approach to treatment, prevention and promotion in the city. By effectively prioritising our resources together on those most in need we will aim to get the best value for money for the services we deliver. New delivery models will be developed and delivered to meet local priorities and needs but partner organisations in the new delivery models will need to work to the same explicit shared goals and be measured against the same outcome based criteria.

Exploring the contractual model. Based on the recognition that an agreed contract model will be essential both to maintain the sustainability of the integrated care system and to help stimulate appropriate organisational behaviour, further consideration of both contracting and funding approaches has been made with a short list of options proposed. These options will be matched against the needs of the target care models for best fit, alongside agreed sources of funding. It is also proposed that some high level strategic principles by which organisations will work together, be adopted to facilitate organisational behaviour change.

Next Steps

- Further development of the strategic outline case by September 2013
- Establishment of roles and funding for Strategic Lead and city wide Programme Team by September 2013
- Commissioning of external review and appraisal of gaps and issues, and support for some aspects of data analysis not available locally by September 2013
- Commence design and delivery of scale up plans from November 2013

Action Number	Health and Social Care local delivery plan	Part of GM Action?	April 2013	May 2013	June 2013	July 2013	August 2013	September 2013	Oct – Dec 2013	Jan – Mar 2014	April – June 2014	July – Dec 2014	2015
HSC1	**Implementation of integrated care teams for at risk patients**												
HSC1.1	North Neighbourhood 1												
HSC1.2	North Neighbourhood 2												
HSC1.3	North Neighbourhood 3 & 4												
HSC1.5	Central Wave 1 & 2												
HSC1.6	Central Wave 3 & 4												
HSC1.8	South Neighbourhoods 1 & 2												
HSC2	**Prepare Strategic Outline Case (SoC) for Living Longer Living Better**												
HSC2.1	Agree SoC development plan												
HSC2.2	SoC drafted and reviewed Exec. H&WB Group												
HSC2.3	SoC first version issued												
HSC2.4	H&WB Board												
HSC2.5	SoC updated and second version issued												
HSC3	**Implement New Care Models**												
HSC3.1	NDMs drafted and agreed												
HSC3.2	Locality implementation plans for NDMs agreed and commenced												
HSC3.3	Measurement, Improvement & Shift cycle in place and operational												

Early Years New Delivery Model

Summary

The Manchester Early Years New Delivery Model (EYNDM) will provide integrated service delivery between Health and Local Authority services for 0-4 year olds. The model is based on an integrated care pathway with five key stages (pre-birth, new birth visit and follow-up, three months, 9 month health and development review and the 2 year health and development review). The Greater Manchester model includes additional three stages: parent-led check at eighteen months (targeted) and checks at thirty six months and forty eight months which, it is envisaged, will be led by Children's Centres, Early Years providers and/or schools. The Manchester five stage model and approach is supported by the regional NHS Commissioning Team and has been approved by the Clinical Integrated Commissioning Board (CICB) and the three Manchester Clinical Commissioning Groups (CCGs). Work will now take place to introduce the additional stages into Manchester's model following approval from the Health and Wellbeing Board.

Further work is being done to develop the financial model for the eight stage model and to understand the consequential impacts of implementing the model, for example, increase in speech and language referrals, earlier identification of CiN and the associated cost benefit analysis. The development of the financial model and cost benefit analysis will be informed by the early adoption areas.

In delivering the integrated service, Health Visitors and Early Years Outreach Workers will work together to ensure that children and families are engaged, that assessments take place at the key points and that when children and families are identified for further support, they receive the right evidence based interventions which are delivered as part of an integrated package of public services, that are properly sequenced and bespoke to the needs of the family as a whole. A catalogue of evidence based interventions has been developed for use across Greater Manchester and interventions used in Manchester for targeted support will be taken from this list.

It was agreed that the EYNDM would be implemented in Manchester from 1 April 2013 in three areas initially: Rusholme, Old Moat and Charlestown, one in each of Manchester's Clinical Commissioning Group Areas and covering 1,000 (0-4s) in each area.

The implementation started in Rusholme on 1 April operating across the Rusholme Sure Start Children's Centre and the neighbouring Robert Derbyshire GP practice. The Team based at the Robert Derbyshire Practice consists of: Team Leader, five Health Visitors, one staff nurse and two student Health Visitors. Two Early Years Outreach Workers were recruited to Rusholme SSCC and a joint induction and training programme has been developed and implemented taking, where appropriate, a multi disciplinary approach across agencies.

The model will be implemented in Old Moat and Charlestown from September 2013. Data is being collected in the three areas on a set of agreed outcome measures and performance indicators. These include: number of referrals to speech and language

therapy, type of referral, numbers referred to parenting courses/completing parenting courses and numbers referred to early years outreach services. Qualitative measures will also be collected including life story examples and the views of larger number of parents and key stakeholders on the new approach. Health colleagues have also identified three areas of the city where outcomes from implementing the new delivery model can be compared to outcomes from the business as usual model.

This information will inform commissioning decisions as the model is fully rolled out as well as testing out some of the assumptions behind the model.

A number of 'work arounds' have been agreed in order for the roll out in Rusholme to start; further work is being done to ensure electronic systems (health and the local authority) can support the integrated approach as it is scales up.

A Recruitment and Retention Strategy is in place to ensure there are sufficient health visitors in post to roll out the model; this includes increasing the number of 'practice teacher health visitors' so that more student health visitors can be taken on, an advertising campaign and the development of a system of incentives to encourage more health visitors to come and stay in the City.

Government is currently consulting on proposals for a changed role for Local Authorities in the delivery of funded early education for two, three and four year olds. As with schools the Government's stated aim is to maximise the funding that is passed to early years providers alongside increased autonomy complemented by rigorous inspection arrangements. Ofsted is seen as the sole arbiter of quality in the early years and will have the role in identifying under performance. Providers can choose to get advice and support from local authorities or from provider chains or through the childminder agencies which will be established. In the context of the new delivery model for Early Years local authorities will need to provide leadership, and use influence working with all partners to develop a systems leadership approach with the range of Early Years providers. In Manchester the model of working with schools through the development of the Strategic Education Partnership and Manchester Schools Alliance will be applied to the Early Years sector.

Who is leading this work in Manchester?

- Councillor Afzal Khan, Executive Member for Children's Services;
- Mike Livingstone, Strategic Director, Children and Commissioning Services, Manchester City Council and Children's Board Chair;
- Jenny Andrews, Deputy Director is the Early Years Lead Officer and is supported by Nasreen King, Early Years Senior Operational Manager and Karen Jarmany, Senior Quality Assurance Officer;
- The Young People and Children's Scrutiny Committee and the Health and Well-Being Board receive regular reports on this work on an on-going basis.

What does success look like?

September 2013

- Draft Local Implementation Plan (attached), timescales agreed and in place leading to full roll out of the EYNDM across Manchester by 1 April 2015;
- Early Years Outreach Service fully recruited to (and externally commissioned where appropriate) by the end of September 2013 enabling the NDM to be scaled up incrementally across the City as health visitors are appointed leading to City-wide implementation by 1 April 2015;
- Outcomes being monitored by the early implementation areas tracked; systems for feeding in to overall evaluation process to inform the development of the model agreed;
- All disadvantaged 2 year olds in early implementation areas identified by September 2013 and have a targeted offer and are accessing 15 hours day-care ;
- Analysis of current commissioned interventions completed and decisions about future intentions made in the context of principles of the EYNDM;
- Eight stage model and interventions to be used rolled out in Old Moat and Charlestown;

Longer Term

- There is a defined MCC offer for 0-4 year olds that brings together: the EYNDM based on partnership working with Health colleagues, the new Sure Start Core Purpose, day care providers including childminders and schools to provide a locality based offer to families.
- Increase in the number (%) of children achieving a good level of development as measured by the Early Years Foundation Stage profile assessment (school readiness);
- Systems for storing and sharing information securely have been developed and are in place and a more integrated system has been developed;
- There is a reduction in CiN referrals related to neglect;
- All disadvantaged 2 year olds identified (by 18 months or sooner), have a targeted offer and are accessing 15 hours day-care;
- All Manchester parents apply on time for a reception class place;
- Schools identified as key beneficiaries of the EYNDM in terms of outcomes and costs as more children arrive at school who are 'school ready'; fewer children with SEN associated with delayed language development or social, emotional and behavioural needs - schools prepared to contribute to the investment model;
- Development in Manchester of Early Years Alliance based on providers wanting to work with the Local Authority as partners, strong focus on self-evaluation and improvement similar to the school model.

What does the implementation plan commit partners in Manchester to?

- The ongoing design and development of the eight stage model so that it operates effectively across the City';
- Delivering the programme at a local level including the engagement with all relevant health partners and education partners: GPs, Midwives, Health Visitors, School Nurses, Early Years providers, Schools;

- At a strategic level willingness to tackle the implications for the diverse health economy in terms of governance for the delivery and commissioning of midwifery services, GPs, Health Visitors etc
- Delivery of the Health Visitor 'Recruitment and Retention Strategy' supported by partners;
- Establishing and agreeing a standardized set of assessment tools from pre-birth to starting school, used by all the EY workforce across Manchester and Greater Manchester;
- Developing a more integrated IT system (data hub) to support data sharing across partners; this includes agreement on what data is shared at each stage of the process and the method by which it is shared and has implications for investment in IT infrastructure;
- Resources are invested by partners as laid out in the investable proposition; these could be looked at over a five year period profiling costs and benefits to inform the type of budget models and investment required.

Local Implementation Timescales

PHASE	Apr-13				May-13				Jun-13				Jul-13				Aug-13				Sep-13				Oct-13			
	Wk 1	Wk 2	Wk 3	Wk 4	Wk 1	Wk 2	Wk 3	Wk 4	Wk 1	Wk 2	Wk 3	Wk 4	Wk 1	Wk 2	Wk 3	Wk 4	Wk 1	Wk 2	Wk 3	Wk 4	Wk 1	Wk 2	Wk 3	Wk 4	Wk 1	Wk 2	Wk 3	Wk 4
Early Implementation Sites	Rusholme - Full MCC model Charlestown - Initial ways of working Old Moat - Initial ways of working																								Charlestown & Old Moat - Full MCC model			
Early Implementation Evaluation	Agree short term & long term measures Agree collection methods											Perf. Report				Perf. Report				Perf. Report	Analyse & recommend modifications (incl induction pack and training plan)							
Final Model Development	Review GM Model vs MCC Model Establish gaps Understand impacts of gaps and additional elements																Options following model review (including evaluation of early sites)								Final model approval for Manchester			
City Wide Roll Out	Agree phasing of sites in line with HV staffing To include accommodation requirements								Recruitment strategy required Review outcomes framework & review timetable (in line with GM work)																			
Financial Model					Cost Benefit Analysis & Financial Evaluation																Build Financial Model based on review of GM and Early Implementation Sites							
Dependencies																												
CMFT Health Visitor Staffing																					Additional Health Visitors qualify							
GM Milestones (as at May 2013)	EY3: Parental Contract & Universal Credit				EY5: Shared Outcomes Framework								EY8: Investment Agreement - Costs and Resources agreed								EY1: Stages 7/8 assessment in place EY4: Common Ts&Cs for free entitlement EY9: Common Suite of Interventions							
																									EY7: Longitudinal Study (to 2016)			

PHASE	Nov-13				Dec-13				Jan-14	Feb-14	Mar-14	Apr-14				May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15			
	1	2	3	4	1	2	3	4				1	2	3	4												1	2	3	4
Early Implementation Sites																														
Early Implementation Evaluation																														
Final Model Development																														
City Wide Roll Out	Agree and source accommodation Establish implementation plan by site											Manchester Phase 2 Roll Out (dependent on HV staffing numbers)																Manchester Phase 3 Roll Out (dependent on HV staffing numbers)			
Financial Model									Final Investment Agreement Preparation			Final Investment Agreement in place (in line with GM)																		
Dependencies																														
CMFT Health Visitor Staffing											Additional Health Visitors qualify									Additional Health Visitors qualify						Additional Health Visitors qualify			
GM Milestones (as at May 2013)												EY6: Systems in place to enable data and intelligence sharing EY8: Investment Agreement in place EY10: GM wide workforce agreement							EY1: Stage 6 assessment in place							EY1: Stage 1-5 assessment in place			
	EY7: Longitudinal Study (to 2016)																													