Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board - 16 September 2015

Subject: Citywide Practitioner Design Team - update

Report of: Joanne Royle, Strategic lead for Health integration, MCC

Summary

This report provides an update of the progress of the Citywide Practitioner Design Team since they were formed 4 weeks ago.

Recommendations

The Board is asked to:

1) Note the progress of the Citywide Design Practitioner Team

2) Comment on the content of the report

Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	
Educating, informing and involving the community in improving their own health and wellbeing	
Moving more health provision into the community	The Practitioner design team are developing design models that will support the movement of health provision away from hospital and residential care provision and into the community
Providing the best treatment we can to people in the right place at the right time	The services that are designed by the Practitioner Design Team will be place based and centred around the person.
Turning round the lives of troubled families	
Improving people's mental health and wellbeing	The provision of earlier provision of mental health services will be considered in the design models of the Practitioner Design Team.
Bringing people into employment and leading productive lives	
Enabling older people to keep well and	The cohorts that the Practitioner Design

live independently in their community	team will include older people and their carers with a strong focus upon building self care models and utilising community assets to support them to stay closer to home for longer.

Lead board member:

Hazel Summers, Strategic Director, Families, Health and Wellbeing, MCC

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

The Blueprint for Living Longer Living Better was set out in '*Living Longer Living Better, An Integrated Care Blueprint for Manchester*', presented to the Health and Wellbeing Board in March 2013.

This was followed by the 'Living Longer Living Better Strategic Outline Case' presented to the Health and Wellbeing Board in June 2013, which described in more detail the three main areas or 'domains' of the city's plans for integrated care.

In November 2013, the Health and Wellbeing Board received a Strategic Business Case, which described in more detail the care models, the population groups and the financial case for change.

Further progress updates on LLLB were provided to the Health and Wellbeing Board throughout 2014, including a Strategic Plan for 2020. The HWB has also received a 2020 Commissioning Specification and a Provider response in 2015, both detailed how the LLLB vision will be implemented.

Living Longer, Living Better: Citywide Practitioner Design team

Update on Progress for the Health and Wellbeing Board

1 Introduction and Context

1.1 Earlier this year, 11 provider organisations collectively responded to the Living Longer, Living Better (LLLB) Commissioners' 2020 design specification. This included all GP organisations in the city, all acute and integrated community trusts in the city, the mental health trust, Manchester City Council and NWAS.
The commitment was made to deliver integrated services for the population based upon the 12/3/1 model.

1.2 A high level integration road map was outlined in the provider response which highlighted how the collective services would come together based on the 12 hubs, 3 localities and 1 city model.

1.3 An agreement was made that the first phase of the integration roadmap would be the following Adult Social Care services integrating with community health services by April 2016:-

- Adult Social workers
- Primary Assessment Team
- Reablement
- Business support

1.4 As a result the road map in appendix one was agreed at Executive Health and Wellbeing Group which outlines how the integration of adults social care and community health would be broken down into three workstreams:-

- Reablement and Intermediate Care integration
- Neighbourhood Teams development
- Development of Single Point of Access

1.5 The timescales for these 3 workstreams were outlined to commence in April 2016. All partners have determined that this must not be just about moving the line management of existing services; the design must deliver services provided in a different way that are better able to manage demand and shift care appropriately into the community and away from acute hospitals and residential/nursing care homes.

1.6 It is acknowledged that this is the first stage of the wider integration of community mental health services and primary care; however the three initial workstreams will establish how the services in scope will deliver mental health care provision to the neighbourhood team cohort and work with primary care differently.

1.7 In order to ensure that the newly integrated teams are implemented by April 2016, it was agreed that the hospital trusts, mental health trust and Manchester City Council would commit appropriate people who were close to the services in scope for the three workstreams, with backfill, so that they were released from their 'day job' to join a Practitioner Design Team.

2 The Practitioner Design Team

2.1 It was agreed to initiate a flexible and adaptable Practitioner Design Team (PDT) that can work to the scope outlined for the initial road map but would also develop and change membership as other specific areas fall into scope in the future.

2.2 The PDT commenced at the beginning of August this year. The Lead for the team is Joanne Royle, Strategic Lead for Health Integration, MCC. The current membership is outlined below:-

Vicky Isaac – UHSM for 2 days per week
Phil Brown – UHSM commitment undetermined
Sharon Lord – PAT for 2 days per week
Emma Flynn – PAT for 2 days per week
Helen Geach – CMFT for 3 days per week
Jan Barnes – CMFT for 1 day per week
Helena Paperday – UHSM for 2 days per week
Stuart Long – MMHSCT for 1 day per week
Paul Teale – MCC for 4 days per week
Jill Thompson – MCC for 4 days per week
Kathy Weaver – MCC for 3 days per week

2.3 Each of the team have been designated to work on a specific workstream and to collaborate with a LLLB enabling group. More information about areas of responsibility is contained in appendix 2. The Practitioners are supported by a team of Project Managers from the LLLB Project Management Office, which is provided from the pooled funding source from the 8 LLLB partner organisations.

2.4 There are three GP Champions who have recently been appointed by the CCGs and they will join the PDT in their design work.

2.5 Although the PDT is new, there has already been some changes in personnel, with the Single Point of Access workstream having the least capacity left and some of the other workstreams requiring additional Practitioners from specific organisations.

2.6 The PDT are based on the 6th floor in the Town Hall Extension, which has been developed to provide a shared based with the integrated commissioning team. Members of the enabling workstreams ‘hot desk’ in the facility as well.

3 Progress to Date

3.1 It has been agreed that each of the three workstreams will build the following elements into their design work:-

- The need to undertake a Cost Benefit Analysis (CBA) for each project
- The need to clearly define which cohort of service users each project is targeting,
- The need to consider the role of the District General Hospital (DGH) in community based care,
- The need to include the General Practice sector, and the Pharmacy sector, in the design work to ensure greater integration with Primary Care,

- The need to ensure the informal health and social care workforce, carers in particular given their criticality to a functioning community care system, are recognised and included in plans to re-skill and up-skill the workforce,

- The need to design how integrated services will operate with community mental health teams, and explore the extent to which further integration can take place with these teams,

- The need to ensure the design work for the Urgent Care First Response programme is aligned with the PDT design work, particularly in terms of first contact and complex care,

- The need to co-design with staff, service users, carers and representative organisations, using the LLLB Co-production workstream to facilitate this,

- The need to consider the role of, and consult with, service providers that sit outside of the Manchester Provider Group (MPG) but have a huge impact upon the health of Manchester residents, for example, registered housing providers and voluntary sector organisations.

- The need to link design work with commissioning timelines, as managed by the Commissioning Project Team.

3.2 The PDT have worked hard to complete the scope of their design within the first 2 weeks of their formation, and high level timescales that demonstrate how they will have developed a service model by December 2015. From December the programme of implementation will commence.

3.3 The design for each workstream will outline a citywide offer which will be based upon learning from the North early implementer work and will be consistent across the city. More detail can be found in the scoping document in appendix 3. A brief outline for each workstream is provided below:-

3.3.1 Integration of reablement and intermediate care services.

The aim of this workstream is to design an integrated service model between Health and Social Care that provides step up and step down Intermediate care and reablement services in Manchester as one provider, building on the early implementer work undertaken by PAHT and MCC in the North of the city.

The project will design services across the city which have a common set of principles, so that citizens will be able to access quality and consistent service provision across the whole of Manchester based on the main principals from the North Manchester early implementer work.

3.3.2 Integration of care management and neighbourhood teams

This workstream will set out the ‘gold standard’ for the neighbourhood team for an enhanced model of assessment and place based care delivery. The design will determine which multi-disciplinary roles will be part of the place based care teams and how they will utilise other specialist and non specialist community services to support people to stay at home for longer, ensuring closer integration with community mental health services and primary care.
The reach of the workstream is wide, in that it will impact upon the way services are configured and accessed by both residents and professionals across the whole system. The depth of change related to day-to-day operations is also likely to be significant, particularly as services are currently managed, delivered and held to

account very differently and will require cultural, behavioural and structural change. The geographical reach of the project covers the city.

3.3.3 Development of single point of access/integrated access

As services across the health and social care system begin to integrate further, the service access points that people use will need to change to reflect the new configuration of services. This workstream is about ensuring the people who deliver and use services can access these services and connect and share relevant information in a safe, timely and efficient way. This workstream will look to do the following:

- Gain consensus on the outcomes, and citizen and health and care worker benefits, to be achieved through integrated access,
- Understand how many health and social care service access points are currently in operation in Manchester, and how these operate,
- Research the work that's been undertaken in other areas across the country to integrate service access points to determine the variety of different service access models available,
- Determine which of these service access point models will produce the most benefit for Manchester, if adopted,
- Recommend the adoption of a service access model which will support both planned or routine access needs, and urgent and emergency access requirements over the long term.

3.4 The detailed scope for each workstream has been approved by the LLLB citywide design and has been circulated to the three acute trusts who have committed to working to the principles that are outlined.

3.5 In addition a detailed plan has been developed which outlines how each workstream will work towards the delivery of a design by December 2015.

3.6 The PDT are currently working on the first phase of their plan which is to gain clarity and understanding of the 'as is' position across the city in order to identify, assess and analyse current service provision and learn from any current evaluation.

4 North Early Implementer

4.1 On behalf of the city the North locality agreed to commence the integration of adults social care and community health services earlier, in order to enable the city to learn from their experience of integration and to start to understand the impact of the new services prior to citywide implementation.

4.2 The first service that has been planned and will commence on 1st September 2015, is the CASS service (Community Assessment and Support service). The CASS service is an integrated intermediate tier pathway that incorporates bed based intermediate care; home based intermediate care and reablement, crisis response and accident & emergency navigators along with a network of community health and

social care services to provide a tailored response to the person receiving the service.

4.3 The CASS integrated team will comprise of and include Advanced Nurse Practitioners, Social Workers, Primary Assessment Officers, Occupational Therapists, Nurses, Physiotherapists, Pharmacists, Dementia/Mental Health Nurse, Consultant, General Practitioners with special interests, Assistant Practitioners, Reablement Team Lead, Reablement support workers, Administrative Staff and Service Manager. CASS service has a number of functions within the overall service pathway. These are

- Points of access
- Points of entry
- Assessment passport
- Crisis Response
- Bed based interventions-Henesy House and Enhanced beds –J5, NMGH
- Home based interventions

The CASS new service delivery model provides an opportunity to introduce new ways of delivering service to optimise the benefits for the person and their carers.

4.4 The service is designed to support the transition between illness and recovery by providing a short period of intervention with rehabilitation. The service is predominantly provided to the frail elderly, too:

- Support them avoid going into hospital unnecessarily
- Support them be as independent as possible after discharge from hospital
- Prevent them having to move into residential or nursing homes

Performance targets and evaluation have been agreed and the analysis of the data will be monitored by the CASS manager, Performance manager from Pennine Acute Hospital and Manchester City Councils, performance, research and intelligence service. The performance data will be collated monthly.

4.5 As the PDT progress with the development of the design, the monitoring information collected from the CASS service will continue to inform the service development. An immediate priority is to track the impact of the CASS on demand for placements to residential care and on admissions to hospital and length of stay. From this data a Cost Benefit Analysis will be completed so that the financial viability of the service can be understood. This will also ensure that those organisations that benefit contribute proportionally to the future costs.

5 PDT Capacity

5.1 Whilst developing the detailed plans, it has become apparent that there are a number of gaps in capacity and skills within the PDT. All of the core partner organisations are represented on the PDT. Members of the PDT have got up to speed with the work quickly and have made good progress over the course of their first month as a team, developing the scoping document, enabling workstream briefs

and workplans, as well as making a positive start on delivering those workplans. However, there are organisational representation gaps on specific projects:

- Need to include PAHT representation on the Reablement & Intermediate Care Project (ideally two days a week commitment needed), and CMFT time commitment needs to lift from one to two days a week.
- Gap in MMHSCT representation on Integrated Neighbourhood Teams Project (ideally two days a week commitment needed). This is to ensure the integrated neighbourhood teams are effectively linked in with mental health services.
- The resourcing of the Integrated Access Project requires more input from CMFT, PAHT and MMHSCT. One Practitioner has left which has had a significant impact upon the ability of the project team to develop the model by December and so the requirement for partners to increase the capacity to this team is urgent. In addition the development of Urgent Care First Response delivery model needs to be aligned to the PDT work. How that is undertaken will be determined by the Citywide Leadership group.

The capacity each organisational representative currently has to offer the PDT varies, from one day a week through to four days a week across the team, which makes the equitable sharing of workload challenging. This has been discussed by the LLLB Citywide Leadership Group and further commitment from partner organisations has been requested.

5.2 It has also been recognised that further technical skills and capacity is required in order to support the Practitioners in the design development. A small pool of business analyst skills will be built in order to ensure that in this next phase of design the Practitioners are able to

- Gather appropriate information to understand how services currently operate.
- Ensure the information is analysed to determine what needs to change, and why (the as-is).
- Identify whether similar services are operating elsewhere for benchmarking purposes.
- Set out all relevant options for service redesign and determine the impacts and the cost benefits.

5.3 In addition, the PDT have created an ‘ask’ of each of the existing LLLB enabling workstreams so that there is clarity and minimal duplication and these are currently being reviewed by the enabling workstreams.

5.4 Discussions have taken place with the Voluntary Sector to determine how they can work within the PDT team. The PDT will need to ensure that the design models demonstrate how we will start working in a different way with residents and local communities, and engage and empower individual and community contributions. We

need Voluntary Sector expertise to design assessments which are focused on opportunities and solutions within families and within communities. Where potential connections to “Community Assets” are identified within assessments, we need to design a proactive ways if connecting people to those assets and we need expertise to understand how these assets are developed. This principle is at the heart of the new service delivery and it is essential that this is co-produced with the voluntary sector so that the team can be supported and advised in order for them to develop models that gain maximum benefit from community assets to enable Manchester people to be more self reliant and to utilise the existing community resources in a different way.

5.5 As a result an invitation has been extended to the voluntary sector to second somebody (or 2 half time possibly) to join the PDT. The basis of the secondment would be until March 2016 to be based with the PDT in the Town Hall Extension, to initially support the three workstreams to ensure that all opportunities for building the use of community assets into the design models have been exploited. The secondee would also be able to utilise their existing network of voluntary sector providers to include them in the work of the PDT and support the team to extend lines of communication with the community providers so that they are aware of the work of the PDT.

6 Next Steps

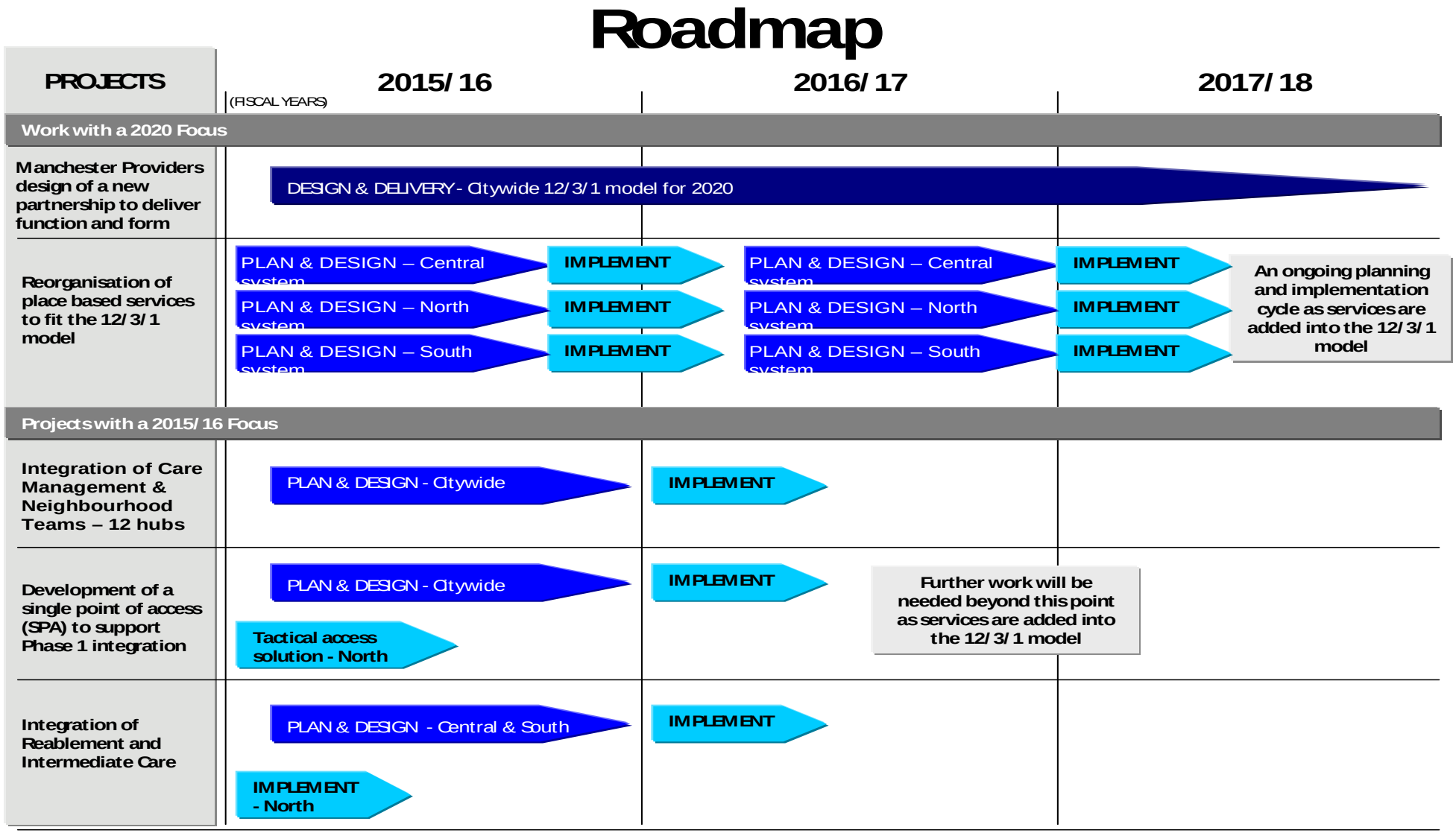
6.1 This has been an extremely busy period over the summer to initiate an integrated Practitioner Design Team. The Practitioners and the PMO team have worked at a challenging pace to produce scope and detailed plans within 4 weeks of set up. This is however, the first phase of a much larger programme of integration. The next steps to build upon this initial PDT work includes:-

- Extending the membership of the current PDT to include the Clinical Champion GPs, recently recruited to be part of LLLB One Team on a sessional basis and the Community Voluntary Sector (see item 8 on EHWG agenda 02.09.15).
- Agreeing further core integration across community mental health services and primary care. The design that is currently being developed will include elements of both, however, we need to determine whether this is to be extended to include staff and services moving into new management structures in the same way that Adults Social Care and Community Health services have.
- Identifying how the Urgent Care First Response work should be aligned to the PDT programme of work and how it may impact upon the service model design.
- To date this has been a positive and collaborative example of how Providers and Commissioners across health and social care can work more closely to ensure that collectively we deliver the right outcomes for the people of Manchester. The Integrated Commissioning team is based with PDT and commissioners join the weekly meeting that takes place. It has been agreed to identify ‘check points’ through this programme where collaboratively we can take stock of and review progress to ensure that we are still working to the same objectives and aims.
- The work of the PDT is currently governed via the LLLB Citywide Leadership Group. As the LLLB governance is reviewed this will need to be re – examined, however in the interim the PDT will report to the Place Based Care Delivery Board.

7 Recommendation

7.1 The Health and Wellbeing Board is asked to note the excellent progress of the Practitioner Design Team and the comment on next steps that are currently being developed.

Appendix 1


Roadmap
PROJECTS
(FISCAL YEARS)
2015/ 16
2016/ 17
2017/ 18
Work with a 2020 Focus
Manchester Providers design of a new partnership to deliver function and form
DESIGN & DELIVERY - Citywide 12/ 3/ 1 model for 2020
Reorganisation of place based services to fit the 12/ 3/ 1 model
PLAN & DESIGN – Central system
IMPLEMENT
PLAN & DESIGN – North system
IMPLEMENT
PLAN & DESIGN – South system
IMPLEMENT
PLAN & DESIGN – Central system
IMPLEMENT
PLAN & DESIGN – North system
IMPLEMENT
PLAN & DESIGN – South system
IMPLEMENT
An ongoing planning and implementation cycle as services are added into the 12/ 3/ 1 model
Projects with a 2015/ 16 Focus
Integration of Care Management & Neighbourhood Teams – 12 hubs
PLAN & DESIGN - Citywide
IMPLEMENT
Development of a single point of access (SPA) to support Phase 1 integration
PLAN & DESIGN - Citywide
IMPLEMENT
Tactical access solution - North
Further work will be needed beyond this point as services are added into the 12/ 3/ 1 model
Integration of Reablement and Intermediate Care
PLAN & DESIGN - Central & South
IMPLEMENT
IMPLEMENT - North

Appendix 2

Practitioner Design Team

Practitioner	Organisation	Workstream	Lead	Enabler Workstream	Locality Link
Vicky Isaac	UHSM	IC/R	Yes	Workforce	Annabel Hammond
Sharon Lord	PAHT	NT		Self Care	Deborah Lyon/Lindsey Darley
Helen Geech	CMFT	NT		Co-Prod	Chris Lamb/Kathy Hern
Helena Pembeday	UHSM	NT		Commissioning	Annabel Hammond
Stuart Long	MMHSCT	Int. Access		Performance & Evaluation	Maeve Boyle
Paul Teale	MCC	IC/R		Estates	Nicky Parker
Jill Thompson	MCC	NT	Yes	Comms	Nicky Parker
Emma Flynn	PAHT	Int. Access	Yes - strategic	Finance	Deborah Lyon/Lindsey Darley
Kathy Weaver	MCC	Int. Access	Yes - tactical	IM&T	Nicky Parker
Phil Brown	UHSM	Int. Access			Annabel Hammond
Jan Barnes	CMFT	IC/R			Chris Lamb/Kathy Hern

Appendix 3

Living Longer, Living Better

Practitioner Design Team

Scoping Document

Version Control

Author: Andrew Southworth, LLLB Programme Manager, on behalf of the PDT.

Version	Date	Summary of Changes	Changed by
1.0	20/08/15	Following on from changes made up to v0.7	Andrew Southworth

Distribution:

For distribution to CWLG representatives to take through their organisational governance structures, and to LLLB Enabling Workstreams to set the context behind the PDT workstream briefs.

Approved by:

Name	Area of Responsibility
LLLB Design Workstream Group	Design leadership for the Programme.

CONTENTS

1. Purpose of this document

The provider partners in the LLLB Programme ('the Programme') have agreed to establish a joint team to design key elements of the Programme, following the lead of the 2020 Commissioning Specification and the Provider Response. The members of this joint team – the Practitioner Design Team (PDT) – have been drawn from service delivery functions of MCC, UHSM, CMFT, PAHT and MMHSCT, with the aim of delivering the citywide design for three projects:

- Integration of Reablement and Intermediate Care Services,
- Integration of care management and neighbourhood teams,
- Development of an integrated access model.

Implementation of the three projects will take place in most instances on a locality level and will be led by locality teams. As a result, this document focuses on the delivery of project design phases by December 2015. Implementation plans will be worked up later in the year, informed by design work, and may well be written up in a further implementation scoping document nearer the time to ensure a consistent approach to implementation.

The overall purpose of this document is to define the specifics of the work the PDT will deliver, by when, along with the mechanisms in place to keep this work on track.

2. Consultation on document contents

To date, the LLLB Programme has been characterised by joint working between Providers and Commissioners, and joint decision making. The PDT is keen to continue in the same fashion and will therefore ensure the scope identified in this document is discussed and agreed with both Providers and Commissioners, thereby ensuring a fit with both the 2020 Commissioning Specification and the Provider Response.

3. Aims and objectives of the work

3.1 Primary drivers

The vision and strategic objectives of the LLLB Programme will not be included here; they can be found in to Strategic Plan. Similarly, the 2020 Commissioning Specification and the subsequent Provider Response both directly influence this scoping document, though the detail of each will not be included here.

The primary drivers behind the design work are as follows:

- To reduce demand,
- To increase the quality of services,
- To help bridge the financial gap.

3.2 Common design themes

The specific aims and objectives of the three projects are set out from section 3.3 below. However, there are a number of emerging requirements that all three projects will build into their design work. These include:

- The need to undertake a Cost Benefit Analysis (CBA) for each project – see section 5.4 for details,
- The need to clearly define which cohort of service users each project is targeting,
- The need to consider the role of the District General Hospital (DGH) in community based care,
- The need to include the General Practice sector, and the Pharmacy sector, in the design work to ensure greater integration with Primary Care,
- The need to ensure the informal health and social care workforce, carers in particular given their criticality to a functioning community care system, are recognised and included in plans to re-skill and up-skill the workforce,
- The need to design how integrated services will operate with community mental health teams, and explore the extent to which further integration can take place with these teams,
- The need to ensure the design work for the Urgent Care First Response programme is aligned with the PDT design work, particularly in terms of first contact and complex care,
- The need to co-design with staff, service users, carers and representative organisations, using the LLLB Co-production workstream to facilitate this,
- The need to consider the role of, and consult with, service providers that sit outside of the Manchester Provider Group (MPG) but have a huge impact upon the health of Manchester residents, for example, registered housing providers and voluntary sector organisations.
- The need to link design work with commissioning timelines, as managed by the Commissioning Project Team.
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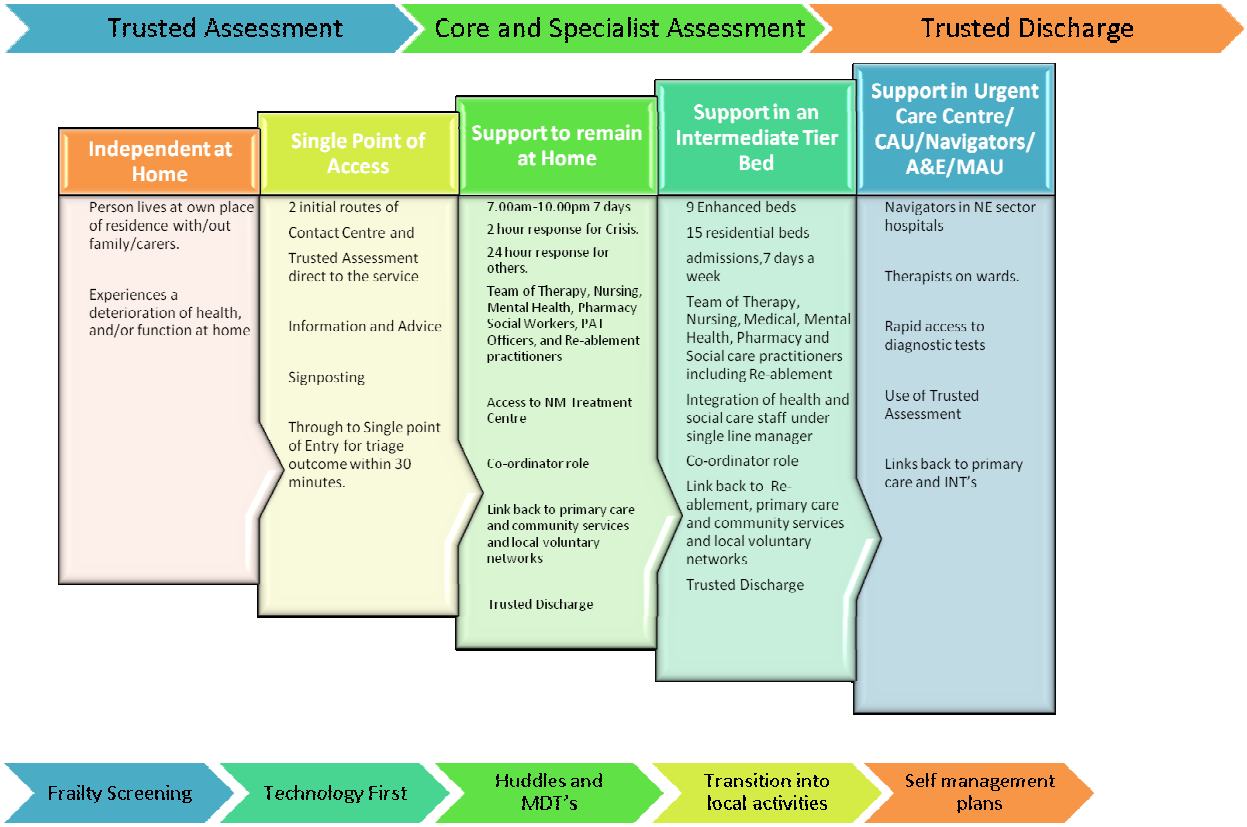
3.3 Integration of Reablement and Intermediate Care Services

3.3.2 Project description

The aim of this project is to design an integrated service model between Health and Social Care that provides step up and step down Intermediate care and reablement services in Manchester as one provider, building on the early implementer work undertaken by PAHT and MCC in the North of the city.

The project will design services across the city which have a common set of principles, so that citizens will be able to access quality and consistent service provision across the whole of Manchester as described in the below chart that sets out the main principals from the North Manchester early implementer work.



Identified Cohort

The new services will be available to adults over the age of 18 years. It is however acknowledged that the greater proportion of users of the service will be over the age of 65 years. For example, 88% of people who use the Reablement Service are over 65.

Within this cohort there will be significant numbers of frail older people requiring more complex interventions in line with the LLLB care model for frail older people.

Integration principles

- **Multi-disciplinary working**: A range of professionals from health and social care will work closely together to coordinate care for the patient/citizen ensuring the right care at the right time,
- **Co-location**: Staff will be physically located in buildings with shared office space and facilities to support this multi-disciplinary approach,
- **Information sharing**: Staff across teams will share proportionate and relevant patient and management information in order to coordinate care and reduce duplication,

- **Record keeping**: There will be a single assessment and support plan for each patient/citizen to which all relevant professionals will contribute. Information sharing permissions will allow other professionals to access the information, as needed,

- **Integrated management of staff**: A staff management structure will be put in place to support multi-disciplinary working and integrated care provision,

- **Competencies**: Generic competencies will be developed to support the provision of integrated care by a range of professionals,

- **Co-production:** the project will offer the opportunity to create a co-designed service in an integrated delivery model,

- **Terms and conditions**: Existing employer and terms and conditions will remain unchanged.

Care Pathway principles

- **Referral management**: Referrals will be triaged as urgent or non-urgent. Urgent referrals will be assessed within two hours and non urgent cases within 24 hours. An initial core assessment, or receipt of a trusted initial assessment, will determine the most appropriate professional to coordinate further care, within the service,

- **Assessment**:
- A single Core Assessment will be carried out, for each patient/citizen, with specialist assessment taking place, where required, and supplementing the original Core Assessment (creating an assessment "passport"),
- Trusted Assessments will be accepted, from identified practitioners, so that care begins quickly and duplication is avoided,
- At the end of the period of rehabilitation practitioners will be trusted to assess for ongoing care needs, equipment or adaptations i.e. Trusted Discharge,

- **Frailty:** there will be identification of suitable frailty tools to ensure effective interventions and target provision,

- **Support planning**: Enabling Self Care will underpin all support planning, with the patient/ citizen actively engaged in the creation of their support plan and their goal setting. The support plan will be asset based and encourage independence,

- **Self Care**: Practitioners will work together by enabling self care and independence and enabling transition into local services at the end of the intervention,

- **Assistive Technology**: supporting the use of assistive technology, in a 'technology first' approach, to support independence planning within the Support Plan,

- **Generic care**: staff will develop generic skills, as appropriate, to provide coordinated care for the patient/citizen,

- **Specialist care**: Practitioners will be called upon to provide specialist assessment and care as required, contributing more in-depth assessment to the original core assessment,

- **Service hours**: The service will be open seven days per week, with time range from 7.00am – 10.00pm.

This project will draw from learning gained from the early implementer work in North Manchester and will aim to create consistent service principles and provision across the city.

3.3.3 What will be delivered?

The project will look to deliver a model design that incorporates all principles for integration, providing a consistent model for intermediate rehabilitation services across Manchester.

The project will:

- Define the requirements to facilitate co-location of teams across the city following the 12/3/1 model,
- Review and agree a single citywide trusted assessment document across the project groups,
- Review and agree a clear rationale for use of such a document,
- Review IT systems with the IT business change managers to ensure streamlined access to information, and recording of care plan information,
- Develop an agreed management and professional structure to reflect integrated working,
- Define the professional reporting and accountabilities for teams,
- Design a strategic approach to communications and workshops for staff groups to understand the model alongside Organisational Development (OD) and Communications leads,
- Define the generic competencies required to support integrated working,
- Design a training programme to provide staff with the skills required to operate effectively within the new model.

Design interdependencies

The project will review and develop specific requirements that will impact on other projects as well as this project:

- Review of IT interconnectivity between and within organisations,
- Define training needs for staff around IT systems,

- Review premises and facilities to enable co-location of staff,
- Scope the Information Governance agreements to allow essential information sharing between partner organisations,
- Define Assistive Technologies available to support independence planning,
- Develop Standard Operating Procedures for integrated services,
- Conduct a cost benefit analysis based on the 'as is' and 'what will be' to identify efficiencies,
- Review a directory of services to enable the new teams to function effectively.

3.3.4 Timescales

- 30th October 2015 – Citywide quality assurance framework agreed,
- 27th November 2015 – Performance and evaluation framework agreed,
- 1st December 2015 – Citywide operating model designed,
- 31st December 2015 - Induction and training on design model roles agreed,
- 1st April 2016 – Implementation starts.

3.3.5 Scope

In scope for this project are Health and Social Care services across the three localities which equate to the following services:

- Primary Assessment Teams (PAT) for social care (MCC service),
- Reablement (MCC service),
- Intermediate Care home pathway (Trust provider service),
- Intermediate Care bed based provision (Trust provider service),
- Crisis/Rapid Response (Trust provider service).

The project will develop and manage a wide range of interdependencies which may also be addressed by other project groups – see section 3.3.

The services listed below are not within the direct scope of the project, but will be impacted upon by the changes:

- Social Work teams in the localities and hospitals,
- Contact Manchester/ Emergency Duty Service (MCC service),
- MEAP (MCC service)
- Continuing Health Care (MCC and Trust provider function),
- Funded Nursing Care (FNC),

- Palliative Care Service,
- Housing (Extra Care),
- Commissioning services – Clinical Commissioning Groups (CCG),
- NWAS Pathfinder,
- Access services, being addressed both tactically and strategically by the Integrated Access project.

As the design develops, links and interfaces with a wider range of services than those listed above will become apparent, given the relationship between the outcomes of this project and the LLLB Care Model for frail older adults. The project will identify and work with these services through the design process.

3.4 Integration of Care Management and Neighbourhood Teams

3.4.2 Project description

The Integrated Care Management and Neighbourhood Teams project will enable the delivery of the four strategic objectives of LLLB by delivering the design work to support the first phase integration of health and social care teams, as specified in the 2020 Commissioning Specification. This will involve:

- Building shared knowledge and understanding of how the existing integrated teams in the city operate to inform the wider design of integrated neighbourhood teams (INT),
- Identifying the benefits of integrated working at a neighbourhood level, both from citizen and staff perspectives. This will include undertaking a CBA for the project,
- Determining the core service offer of an INT and related service standards, to ensure consistency across the city, building on a more developed understanding of the cohort of users, including carers, that will access INTs. This will involve specifying what will be different as a result of first phase integration,
- Setting out what a ‘Gold Standard INT’ would look like leading up to 2020, setting out a potential roadmap for further phases of service integration at a neighbourhood level,
- Ensuring further integration with GP practices and community mental health services,
- Ensuring further integration with community assets across the 12 local communities served by INTs.

This activity will determine the design for an enhanced model of assessment and place based care delivery. The design will determine which multi-disciplinary roles will be part of the place based care teams and how they will utilise other specialist and non specialist community services to support people to stay at home for longer.

The aims of the INTs will be:

- To enable the delivery of place based integrated health and care services for adults aged 18 and over who are residents in Manchester. There are a small number of health services that can be accessed from 16 years of age which are also included in the scope of the project,
- To deliver safe, effective and efficient responses to the needs of citizens with an identified health and social care need,
- To have a community place based care focus, geared to delivering preventative and anticipatory care and supporting peoples rehabilitation and independence,
- To enable self care and self management for citizens, in line with Manchester's Self Care strategy.
- To support those with moderate needs where earlier intervention can reduce their complex care needs and enhance their independence and resilience,
- To support the shift by 2020 in care away from an institutional setting (hospital and care homes) towards people's homes and the communities and neighbourhoods they live in. The teams will be designed to prevent people needing hospital care and reducing their length of stay following an episode in hospital,
- To be statutorily compliant, including compliancy in the recently implemented Care Act and in respect to the statutory functions delegated by the Director of Adult Services (DASS) relating to the delivery of adult social care.
- To be integrated as fully with GP practices as is practical and desirable.

The reach of the project is wide, in that it will impact upon the way services are configured and accessed by both residents and professionals across the whole system. The depth of change related to day-to-day operations is also likely to be significant, particularly as services are currently managed, delivered and held to account very differently and will require cultural, behavioural and structural change. The geographical reach of the project covers the city.

3.4.3 What will be delivered?

The project will look to deliver the following:

- An analysis of INTs currently operating in the city, identifying the lessons learnt and impact (positive and negative), with a view to this informing the design work for the INTs,
- An analysis of the services in scope for integration, including demand, performance levels, staffing, customer feedback, budgets, and interfaces with out-of-scope services.
- An analysis of the cohort of people the teams need to work with in order to achieve the shift in demand required by the teams,
- The core service offer of an INT, and related service standards,
- The design of an INT Operating Model for citywide implementation building on the work of the early implementer in the North of the city including, for example (but not restricted to):
- Information sharing protocols,

- An integrated single support/care plan for each patient/citizen and all relevant individuals will contribute to this including carers,
- A competencies framework for generic care competencies across organisational and professional boundaries,
- Day to day management arrangements and how clinical/professional supervision will be provided,
- A referral management and allocation process,
- A single initial/trusted assessment tool,
- A set of other policies, procedures and guidance which describe where responsibility and accountability sits within the model,
- Identification of the behaviours and cultural change required,
- Information to inform training and development programmes,
- Identification of the ICT requirements to support the implementation of INTs,
- Alignment with Public Health to delver the key priorities,
- Specific citizen feedback on the INT proposals, managed by the LLLB Co-Production Workstream.

3.4.4 Timescales

- 30th September 2015 – As-is analysis including information on services in scope and lessons learned from existing INTs,
- 30th October 2015 - Definition of the minimum core service offer for each hub, along with common standards,
- 1st December 2015 - Design of the INT Operating Model.

3.4.5 Scope

In scope are the community teams across Health and Adult Social Care in the three localities as described at a high level in the Provider Response to the 2020 Commissioning Specification. There is a desire on behalf of the LLLB Programme to ensure community mental health services are also included in this stage of integration. Discussions are still ongoing at a leadership level to identify the capacity to enable this. Once these discussions are concluded the scope of this project may be amended to establish the extent to which community mental health services will be included in first phase integration.

The project has a number of dependencies, and will:

- Ensure linkages between other Programme and service redesign activities, including the other two PDT projects, MCCs Transforming Adult Social Care programme, Urgent Care First Response and developments in Primary Care commissioning arrangements,
- Identify external dependencies which may impact on delivery, for example (but not limited to) the Mental Health Improvement Programme, Healthier Together, Devolution Manchester and partnership working with the Housing sector.

- Ensure that the design work takes account of formal and informal community assets inside and outside the voluntary sector that could support the work of INTs.

The Project will not be implementing the INTs. This responsibility will shift to local implementation teams once the design work is complete.

3.5 Development of an Integrated Access Model

3.5.2 Project description

As services across the health and social care system begin to integrate further, the service access points that people use will need to change to reflect the new configuration of services. The project is about ensuring the people who deliver and use services can access these services and connect and share relevant information in a safe, timely and efficient way.

This project will look to do the following:

- Gain consensus on the outcomes, and citizen and health and care worker benefits, to be achieved through integrated access,
- Understand how many health and social care service access points are currently in operation in Manchester, and how these operate,
- Research the work that's been undertaken in other areas across the country to integrate service access points to determine the variety of different service access models available,
- Determine which of these service access point models will produce the most benefit for Manchester, if adopted,
- Recommend the adoption of a service access model which will support both planned or routine access needs, and urgent and emergency access requirements over the long term.

All the above work is geared towards the development of integrated access points that support the 2020 vision. In the shorter term, the project will also need to support the development of tactical service access solutions that underpin the implementation of the first wave of integrated services from April 16. The project will need to ensure that these tactical solutions are 'future proofed' as far as possible, that they are in line with Urgent Care First Response timelines and that they fit with a longer term vision for services access to support the 2020 vision.

The reach of the project is wide, in that it will impact upon the way services are accessed by both residents and professionals across the whole system. This includes primary care, community health services, ambulatory services, social care and links with local voluntary sector and community groups for example. The depth of change related to day-to-day operations is likely to be significant, particularly as long-standing, ingrained ways of contacting services will be replaced. The geographical reach of the project covers the city, and potentially all first contact for all services.

The objectives of the project, therefore, are to:

- Develop integrated service access points to support the delivery of the first wave of integrated services from April 16, as directed by both the Integration of Reablement and Intermediate Care Project and the Integration of Care Management and Neighbourhood Teams Project, and ensure alignment with Urgent Care First Response timescales,
- Recommend the approach Manchester should take to developing and delivering a service access model to support the new place based care system.

3.5.3 What will be delivered?

The project will deliver the following products to support the first phase of integration from April 2016:

- The design of tactical access solutions to support the delivery of integrated intermediate care and reablement services and integrated neighbourhood teams. This work will be driven by the design timescales being followed by these projects,
- Work is currently underway to scope out the work needed to align activity with the Urgent Care First Response first contact workstream. Both the PDT and the Urgent Care First Response programme leads are keen to avoid duplication of activity.

To support the development of an integrated access model for 2020, the project will deliver:

- An ‘as-is’ analysis of the health and social care service access points operating across the city, to better understand how service access currently works,
- A research document that explores the approach other areas in the country have taken to integrating service access points, setting out the range of potential options Manchester could pursue,
- An outcomes document that expresses what Manchester wants from an integrated access model, building in both staff and user feedback through a co-production process,
- An options appraisal on Manchester’s long term approach to service access, to support the delivery of the LLLB vision. This will include an analysis of any investment required (capital and revenue) to develop a strategic solution for integrated access that delivers agreed outcomes, and a high level road map or plan of the work required to deliver integrated access model options to support the 2020 vision.

3.5.4 Timeline

Tactical workstream milestones:

- 30th October 2015 - Confirmation of access requirements/tactical access solutions for P1 informed by the other two PDT projects,
- Delivery milestones TBC following on from the milestone above, with a view to design work being completed in December 2015.

2020 access model workstream milestones:

- 30th September 2015 – First phase as-is analysis on Manchester service access points completed,
- 30th October 2015 - Research on best practice in service access complete,
- 30th October 2015 – Service access outcomes document complete,
- 27th November 2015 - Second phase as-is analysis on Manchester service access points completed,
- 18th December 2015 - Options Appraisal first draft complete,
- Milestones beyond the completion of the first draft of the Options Appraisal will be mapped out in November/December 2015 as interdependencies become clearer.

3.5.5 Scope

In scope:

- All service access points for adults in the city across the health and social care system,
- Manchester GP Registered and Resident people.

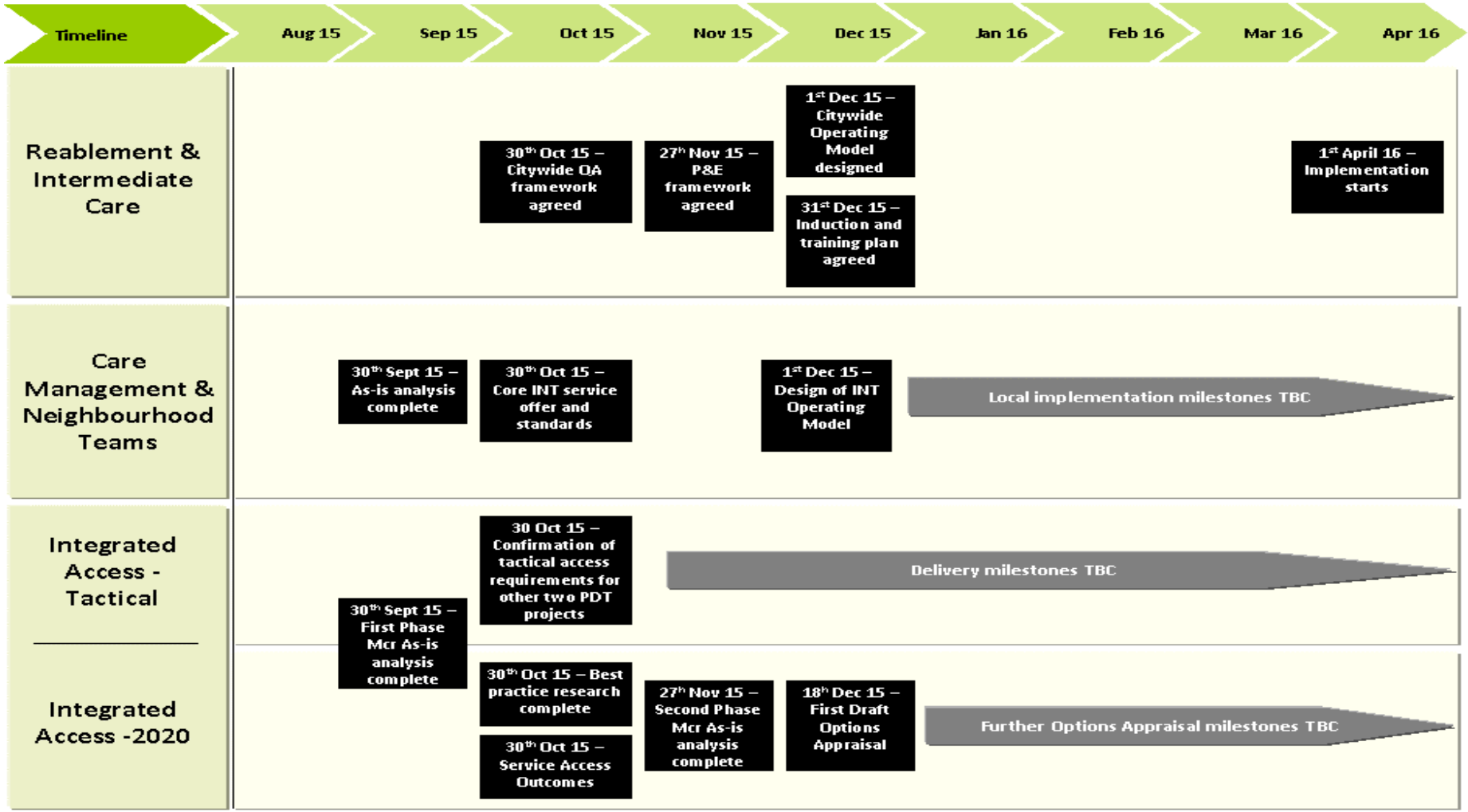
Out of scope for first phase integration:

- People either not GP registered or resident in Manchester,
- Contacts in relation to children.

The extent to which contacts relating to safeguarding, deprivation of liberty, and specialist city wide services are included in the design work will be determined by the scope set out by the other two PDT projects.

3.6 Overall timeline

Note: CBA milestones will be built into the plan as and when confirmed with CBA support team.


Timeline
Aug 15
Sep 15
Oct 15
Nov 15
Dec 15
Jan 16
Feb 16
Mar 16
Apr 16
Reablement & Intermediate Care
30th Oct 15 – Citywide QA framework agreed
27th Nov 15 – P&E framework agreed
1st Dec 15 – Citywide Operating Model designed
31st Dec 15 – Induction and training plan agreed
1st April 16 – Implementation starts
Care Management & Neighbourhood Teams
30th Sept 15 – As-is analysis complete
30th Oct 15 – Core INT service offer and standards
1st Dec 15 – Design of INT Operating Model
Local implementation milestones TBC
Integrated Access - Tactical
30th Sept 15 – First Phase Mcr As-is analysis complete
30 Oct 15 – Confirmation of tactical access requirements for other two PDT projects
Delivery milestones TBC
Integrated Access -2020
30th Oct 15 – Best practice research complete
30th Oct 15 – Service Access Outcomes
27th Nov 15 – Second Phase Mcr As-is analysis complete
18th Dec 15 – First Draft Options Appraisal
Further Options Appraisal milestones TBC

4. Key links

4.1 LLLB Workstreams

The three projects being undertaken by the PDT all require the support of the existing LLLB workstreams, namely:

- Estates,
- Workforce,
- Information Management & Technology,
- Communications,
- Performance & Evaluation,
- Self Care,
- Co-Production,
- Commissioning,
- Finance.

The PDT will produce a brief for each enabling workstream once this scoping document is agreed.

4.2 External links

All three projects will also need to manage dependencies with services, programmes and projects outside of the immediate LLLB Programme. Examples include: the national NHS111 programme for the Integrated Access project; discussions around the function of district general hospitals and the impact of Healthier Together reorganisation on the Care Management and Neighbourhood Teams project, amongst others. Each project team will look to identify and manage these dependencies as analysis work progresses.

5. Organisation

5.1 Project Team

The PDT has eleven members, listed below. The table below also indicates where the PDT member has a lead responsibility for one of the projects, and which of the LLLB workstreams they will be the key link for.

Name	Org.	Project working on	Workstream link
Vicky Isaac	UHSM	Reablement & IC *(lead)*	Workforce
Jan Barnes	CMFT	Reablement & IC	N/A
Paul Teale	MCC	Reablement & IC	Estates
Jill Thompson	MCC	Care Management/NTs (*lead)*	Comms
Sharon Lord	PAHT	Care Management/NTs	Self Care
Helen Geech	CMFT	Care Management/NTs	Co-Production
Helena Pembeday	UHSM	Care Management/NTs	Commissioning
Emma Flynn	PAHT	Integrated Access *(2020*	Finance

		lead)	
Kathy Weaver	MCC	Integrated Access (*tactical lead)*	IM&T
Stuart Long	MMHSCT	Integrated Access	Performance & Evaluation
Phil Brown	UHSM	Integrated Access	N/A

All PDT members are working part-time on the PDT, with the amount of time available per person differing from one day a week to four days a week.

Joanne Royle, Strategic Lead for Health Integration at MCC, is the Team Leader, as is ultimately responsible for the outputs of the Team.

The PDT will draw its technical project management support from the LLLB Programme Management Office, which includes the following:

- Andrew Southworth, Programme Manager,
- Joan Collins, Project Manager, specifically supporting *the Integration of Reablement and Intermediate Care Services* project,
- Angela Beacon, Project Manager, specifically supporting the *Integration of Care Management and Neighbourhood Teams* project,
- Gregg Holt, specifically supporting the *Development of an Integrated Access Model* project,
- Philip Owen, Project Manager,
- Samaira Saeed, Project Officer,
- Gemma Holt, Project Officer.

5.2 Governance

The PDT is accountable to the Design Group that leads the design workstream of the LLLB Programme. The Design Group, in turn, is accountable to the monthly Place Based Care Delivery Board (PBCDB) for reporting and monitoring purposes, and the City Wide Leadership Group (CWLG) for strategic alignment. The Place Based Care Commissioning Board (PBCCB) will also be regularly updated on progress.

The PDT will also work to define and strengthen links with integration governance structures within partner organisations.

5.3 Progress monitoring

The PDT will track progress internally on a weekly basis. A monthly highlight report will be produced for the PBCDB, following the standard template.

If a project is likely to miss a key milestone, the Project Manager allocated to the project will undertake a brief impact analysis exercise to determine the consequences of a delay. This will then be discussed by the whole PDT, with the most appropriate member(s) taking on responsibility for communicating the delay and mitigating and impacts as a result.

5.4 Costs and benefits

The costs and benefits of this approach to integration are outlined at a high level in both the 2020 Commissioning Specification and the Provider Response.

There is, however, a pressing need to understand in more detail the financial impact the three projects detailed in this document will have on the financial gap. The CWLG has agreed that a Cost Benefit Analysis (CBA) will be undertaken for each project, which in turn will feed into the CBA for the Programme as a whole. The project CBAs will also inform the design work, helping to determine which design options are likely to have the most beneficial impact.

Each of the three projects will ensure that the analysis work undertaken includes the collation and validation of the metrics needed to develop a CBA, once the PDT has been briefed on the process of developing and delivering a CBA.

5.5 Quality assurance

The Team Leader will be responsible for ensuring that all the products that the Team develops are of a high standard. All the Projects have a Project Manager allocated to them, and each Project Manager will be responsible for ensuring products are developed and delivered to time and quality standards set out by the Team Leader.

5.6 Approach

The approach the PDT takes to design will draw upon the Complex Adaptive Systems (CAS) methodology that members of both CWLG, and to a lesser extent the PDT, have been introduced to through AQuA.

Best practice project and programme management tools and techniques will be used to support the projects throughout the duration of the PDT. However, it is the stated intention of the CWLG that the PDT should not become wedded to a project methodology or approach that will potentially slow the PDT down.

6. Challenges

6.1 Initial challenges

The PDT has identified the following six challenges, which it will be working to mitigate or resolve in the near future:

- **Capacity of PDT members.** PDT members have all been freed up by their organisations to work part time in the PDT. However, team members have different time commitments, from one day a week up to four days a week. This will pose problems in terms of an equitable sharing of workload, and capacity to deliver the work.

- **Organisational representation on projects**. The table in section 5.1 which outlines which member of the PDT is working on which project shows some gaps in organisational representation. None of the project teams have representation from all five organisations on them.

- **Design capacity and capability**. The success of all three projects depends to a large extent upon the quality of analysis undertaken to determine three key things – what we deliver now (demand for services, range and quality); where improvements can be made (problem identification and resolution); and design for the future (how to meet the objectives of the 2020 Commissioning Specification). The complexity of the design environment outlined below puts an extra pressure on the need for accurate analysis, given the number and range of interdependencies. The PDT is currently short of resource with technical analyst expertise.

- **Complexity of the design environment**. The complexities of operating as a city system incorporating eight core organisations with their own sovereignty, along with a wider group of Providers, has been rehearsed and accepted elsewhere and will not be repeated here.

The design parameters have been set by 2020 Commissioning Specification and the Provider Response. Emerging discussions taking place between partners to develop the Manchester Locality Plan as part of the devolution deal are also resulting in extra design parameters, which are being built into the scope of the PDT work as far as possible.

Alongside the range of partners involved, there also sit a number of related transformation programmes, including Healthier Together, the Manchester Mental Health Improvement Programme and the McMillan Cancer Improvement Programme, amongst others. This design environment increases the complexity of dependency management.

- **Changing governance.** This document references the PBCDB as the governance body responsible for reporting and monitoring. However, the future of this group in uncertain in light of the constitution of the Manchester Provider Group (MPG). CWLG have agreed that the governance provided by the PBCDB will transfer to the MPG over time, with mechanisms currently being developed to enable this.

- **Implementation capacity.** This scoping document covers the design work for the three projects. Once design work is complete, the expectation is that locality programme/project teams will take on responsibility for local implementation. At this stage the extent of integration needed and therefore the capacity need to support it isn't known given design work is yet to complete. The assumption is that implementation can be delivered locally from April 2016. However, the accuracy of this assumption has to be kept under review given the lack of certainty at this stage over resources needed to implement.

6.2 Management of risk and issues

Risks and issues will be identified and managed within the team where possible. The escalation route for risks and issues, in the event that further help to mitigate or resolve is required, is to the PBCDB, CWLG or MPG, depending upon the specific need and the urgency required.