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MANCHESTER CITY COUNCIL

Health Scrutiny Committee

Date: Tuesday, 5 February 2019
Time: 10.00 am
Venue: Council Antechamber, Level 2, Town Hall Extension

Everyone is welcome to attend this committee meeting.

There will be a private meeting for Members only at 9.30am in Committee Room 6 (Room 2006), 2nd Floor of Town Hall Extension

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Membership of the Health Scrutiny Committee

Councillors - Farrell (Chair), Battle, Clay, Curley, Holt, Lynch, Mary Monaghan, O'Neil, Paul, Reeves, Riasat, Smitheman, Wills and Wilson

Agenda

1. Urgent Business
To consider any items which the Chair has agreed to have submitted as urgent.

2. Appeals
To consider any appeals from the public against refusal to allow inspection of background documents and/or the inclusion of items in the confidential part of the agenda.

3. Interests
To allow Members an opportunity to [a] declare any personal, prejudicial or disclosable pecuniary interests they might have in any items which appear on this agenda; and [b] record any items from which they are precluded from voting as a result of Council Tax/Council rent arrears; [c] the existence and nature of party whipping arrangements in respect of any item to be considered at this meeting. Members with a personal interest should declare that at the start of the item under consideration. If Members also have a prejudicial or disclosable pecuniary interest they must withdraw from the meeting during the consideration of the item.

4. Minutes 5 - 12
To approve as a correct record the minutes of the meeting held on 8 January 2019 .

5. Single Hospital Service Progress Report 13 - 68
Report of the Director, Single Hospital Service

This report provides an update on the City of Manchester Single Hospital Service Programme. It sets out the work that has taken place since the creation of Manchester University NHS Foundation Trust (MFT) on 1st October 2017 and describes the approach used within MFT to track the anticipated benefits of the merger. It also outlines the part MFT is playing in the work being led by Greater Manchester Health and Social Care Partnership to transfer North Manchester General Hospital (NMGH) into MFT.

6. Manchester Local Care Organisation 69 - 96
Report of the Chief Executive, Manchester Local Care Organisation

Further to the establishment of the Manchester Local Care Organisation (MLCO) as a public sector partnership on April 1st 2018 through the agreement and signing of a Partnering Agreement, this paper provides Scrutiny Committee with a further update of progress made across core business areas of MLCO. Scrutiny Committee are advised that this paper builds on the update provided in October 2018.

7. Updated Financial Strategy and Directorate Business Plans 2019-20 - To follow

8. Manchester Health and Care Commissioning Pooled Budget 2019/20, including Adult Social Care - To follow

9. Overview Report 97 - 108

Report of the Governance and Scrutiny Support Unit

The monthly report includes the recommendations monitor, relevant key decisions, the Committee's work programme and items for information. The report also contains additional information including details of those organisations that have been inspected by the Care Quality Commission (CQC) within Manchester since the Health Scrutiny Committee last met.

Information about the Committee

Scrutiny Committees represent the interests of local people about important issues that affect them. They look at how the decisions, policies and services of the Council and other key public agencies impact on the city and its residents. Scrutiny Committees do not take decisions but can make recommendations to decision-makers about how they are delivering the Manchester Strategy, an agreed vision for a better Manchester that is shared by public agencies across the city.

The Health Scrutiny Committee has responsibility for reviewing how the Council and its partners in the NHS deliver health and social care services to improve the health and wellbeing of Manchester residents.

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This agenda was issued on **Monday, 28 January 2019** by the Governance and Scrutiny Support Unit, Manchester City Council, Level 3, Town Hall Extension (Mount Street Elevation), Manchester M60 2LA

Health Scrutiny Committee

Minutes of the meeting held on 8 January 2019

Present:
Councillor Farrell – in the Chair
Councillors Battle, Clay, Curley, Holt, Lynch, O'Neil, Paul, Reeves, Riasat, Wills and Wilson

Councillor Craig, Executive Member for Adults, Health and Wellbeing
Councillor Midgley, Assistant Executive Member for Adults, Health and Wellbeing
Nick Gomm, Director of Corporate Affairs, Manchester Health and Care Commissioning (MHCC)
Dr Manisha Kumar, Clinical Director MHCC
Dr Amjad Ahmed, Clinical Lead Diabetes MHCC
Dr Naresh Kanumilli, Clinical Champion Diabetes UK, Clinical Network Lead for Diabetes, Greater Manchester & East Cheshire Strategic Clinical Networks
Dr Vish Mehra, Manchester Primary Care Partnership
Professor Steve Ball, Consultant & Hon. Professor of Medicine & Endocrinology, Manchester University Foundation Trust
Dr Martin Rutter, Consultant Physician & Lecturer Medicine and Endocrinology, Manchester University Foundation Trusts
Nicola Milne, Community Diabetes Specialist Nurse, Chair Diabetes UK Professional Organising Committee
Sara Fletcher, Head of Commissioning MHCC
Tony Ullman, Deputy Director, Primary Care and Population Health MHCC
Caroline Bradley, Head of Primary Care Commissioning MHCC

Apologies: Councillor Mary Monaghan

HSC/19/01 Minutes

The minutes of the meeting held on 4 December 2018 were submitted for approval. Cllr Holt requested that her attendance be recorded.

Decision

To approve the minutes of the meeting held on 4 December 2018 as a correct record subject to the above amendment.

HSC/19/02 Adult Diabetes

The Committee considered a report of the Clinical Director, Manchester Health and Care Commissioning (MHCC) that provided an update on the diabetes work programme that had been designed to reduce inequalities in diabetes care and outcomes for the people of Manchester. The main aim was to improve the health outcomes and quality of life for all those at risk of, or living with diabetes in

Manchester, through supported self-management, personalisation and early optimal interventions.

The Clinical Director MHCC referred to the main points of the report which were: -

- Providing a description of the different types of diabetes and the implications of this condition;
- Describing the prevalence of diabetes in Manchester, providing comparisons against Greater Manchester and England figures;
- Projected figures for the number of cases of diabetes, noting that Manchester's expected diabetes prevalence rates were set to increase;
- Information on The National Diabetes Prevention Programme, an ongoing national programme which began in 2016 and was rolled out in Manchester in August 2017;
- Data on the diagnosis of diabetes, with particular reference to NHS Health Checks that helped to identify people with diabetes, particularly as the service was able to provide outreach in hard to engage with populations;
- The role of Primary Care in the prevention of diabetes, including adoption of the Manchester Standards with its eight processes of care to standardise care for patients;
- Data on how the Manchester Standards had reduced the number of emergency hospital admissions;
- Information on the Community Diabetes Service, the Community Diabetes Education and Support Team, Secondary Care Services, Inpatient Support Services and transition to Adult Services;
- The work undertaken to deliver Health Care Professional Education;
- Activities to educate people living with diabetes; and
- The work to reduce the number of lower limb amputations.

Members sought clarification on the information that had been provided in the graphs and tables throughout the report and an explanation was provided as to the various data sets and recording periods.

In response to concerns expressed by Members regarding the numbers of reported medical errors Prof Ball described what constituted a medical error, and provided examples of what would be categorised as severe to minor errors. He stated that all errors had a negative impact on patients and their experience of care. He said that all incidents are recorded and reported and practitioners are held to account.

Prof Ball explained that the report presented to the Committee reported processes rather than clinical outcomes. He said that this was the beginning of a new approach to the management of diabetes and clinical benefits were understood, however the clinical outcomes would be reported in future years.

Dr Rutter responded to questions from Members regarding flash glucose monitoring to improve self-care for patients. He said that this would be provided for those patients with the highest clinical need and funding had been awarded for this.

Members commented that the impact of austerity, wage freezes and welfare reform had a significant detrimental impact on people's health and their ability to make healthy lifestyle choices. Members further commented that diabetes was a serious

illness with serious outcomes for patients if not managed correctly and more needed to be done to raise people's awareness of this condition.

Members also discussed the importance of improving the experience for patients when transitioning from young people's services to adult services. Prof Ball agreed with the view of the Committee, commenting that it would be beneficial to establish age appropriate and lifelong care pathways and work was underway with commissioners to consider this approach, further stating that often barriers are self-engineered by systems. The Chair noted that consideration needed to be given as to how topics that cross the remit of more than one Scrutiny Committee were reported appropriately.

Ms Milne responded to a comment from a Member who suggested that the Care Processes described were in fact diagnostic tests by advising that these prompted Health Professionals to engage in conversations with patients to identify the correct care pathways so as to manage their condition appropriately. Dr Rutter stated that the correct management of diabetes had reduced the number of admissions to hospital. Prof Ball said appropriate conversations were needed between health professional and patients to establish a relationship and motivate people to take self-care of their condition.

Dr Rutter explained that Manchester, in recognition of the diverse makeup of the population had attracted funding to pioneer this new approach to diabetes management. He said that appropriate education programmes would be devised and delivered to reach all members of the community, using appropriate language and materials, in addition Community Champions would be identified to support this activity. Funding had also been secured to deliver an online resource that patients could access to obtain information and advice on their health care and people would be supported to access this resource.

Dr Kumar stressed the importance of education in relation to diabetes awareness and informed the Committee that activities were focused on preventative measures that promoted healthy living as a system wide message. Ms Milne commented that NHS Health Checks were also being promoted amongst the general population that included screening for diabetes. In response to a question regarding routing retina screening the Committee were informed that this service was administered nationally.

Decision

The Committee;

1. Note the report;

2. Recommends that a progress report is submitted for consideration at an appropriate time; and

3. Recommends that the Chair considers how topics that cross the remit of more than one Scrutiny Committee are reported.

HSC/19/03 Primary Medical Care in Manchester

The Committee considered a report of the Clinical Director, Manchester Health and Care Commissioning (MHCC) which provided information on how quality in Primary Medical Care in Manchester was assessed and improved.

The Clinical Director MHCC referred to the main points of the report which were: -

- Describing the Quality Assurance and Improvement Framework for General Practice;
- The Early Warning System (EWS) that brought together a range of available data sources to identify a practice being in need of support;
- Current Care Quality Commission (CQC) ratings for GP Practices across Manchester;
- Information on the 9 Primary Care Standards based on the Greater Manchester Primary Care Standards, designed to deliver long term improved health outcomes across the City, building on the prevention work and based on Our Manchester; and
- Information on GP access, including the enhanced 7 Day Access service and Digital Access.

Members discussed the issue of non-attenders at GP appointments, both in the core hours offer and the out of hours' service, noting that the number of non-attendees for the out of hours' service was currently 20%. Dr Mehra said that the issue of non-attenders for out of hours appointments was being addressed. He advised that previously patients did not have the facility to cancel an appointment out of hours, say on a weekend if their own practice was closed. He said that to address this a dedicated telephone number, operating 24/7 had been established so patients could cancel an appointment if their own practice was closed. He further informed Members that a text message reminder service had also been implemented that provided an option to cancel the appointment if required. He also advised that the ability of the 111 service to book out of hours' appointments for callers was also being discussed.

Members questioned if the availability of out of hours' appointments was widely known by patients and asked how this offer had been promoted. Dr Mehra advised that training for reception staff had been delivered, advertising campaigns had been delivered and local radio campaigns. He also advised that literature should be available in surgeries, in different languages to inform people of this offer. Mr Ullman advised that they had worked closely with Healthwatch and the Patient and Public Advisory Group to address the promotion of the out of hours' service and that they also use mystery shoppers to monitor the information given to patients.

Members commented that the rationale for the introduction of the extended GP service was to reduce the number of non-emergency attendees presenting at A&E departments. Members asked if analysis of this had been undertaken and requested that this information was included in any future update report. Dr Kumar responded that the service had reduced the number of non-emergency attendees at A&E and assisted with the management of the increased demand on services during the

period of winter pressures. The Chair recommended that a report on Winter Pressures and how this was managed is provided for the March meeting.

In regard to access Dr Kumar commented that surgeries also offered an online booking system that allowed patients to book appointments for themselves, stating that patients would need to register for this service in the first instance. She further noted that more needed to be done to educate patients in relation to selfcare and social prescribing, and to the range of health professionals that work in surgeries and the care that they could provide, stating that a GP appointment was not always necessary.

Mr Ullman informed the Committee that it was recognised that people may wish to access primary care using online methods and the options to support and deliver this were being explored. A Member commented that it was important to recognise that not all patients would choose to use a digital system and expressed caution that this could create inequalities in terms of access. Mr Ullman reassured the Committee that this would only be offered as one of a range of options.

Members discussed the popularity of Walk In Centres with residents and asked what consideration was being given to maintaining the current provision or extending this offer. Mr Ullman responded that there was currently no intention to change any of the current provision, however stated that there was mixed opinion amongst health professionals as to the role of Walk In Centres. He said one limitation that had been identified was that these Centres did not have access to patient records. He said that the ambition was to deliver a better service that provided an integrated and consistent offer for patients.

Members then discussed the issue of Care Quality Commission (CQC) ratings following inspection and enquired as to what the ‘not yet rated’ entry signified and was there any link between a CQC rating and the deprivation experienced in the local area. Dr Kumar informed the Members that traditionally primary care had historically been underfunded and options for addressing this were being considered. She said that a resilience fund had been agreed to support any practice that was experiencing difficulties and the establishment of Neighbourhoods Teams would help strengthen the local offer and improve local arrangements.

Mr Ullman advised that the establishment of Neighbourhood Teams allowed for the much needed work to modernise the local estate by working in partnership with other providers. The Executive Member for Adults, Health and Well Being said an investment plan looking at the whole estate had commenced and local ward Members would be consulted. She further commented that a significant amount of work had been done around the issue the workforce and resilience and a full report on this activity would be submitted to the Committee at an appropriate time. Dr Kumar described that a lot of work was being done with local school and colleges to develop careers pathways into health and social care careers.

Ms Bradley explained that a practice would be awarded a ‘not yet rated’ rating during the period of time when a practice was awaiting formal registration with the CQC, and stressed that this was at no detriment to patients.

Decision

The Committee:-

1. Note the report;

2. Recommend that a report on Winter Pressures be submitted to the Committee for consideration at an appropriate time; and

3. Recommend that a report on Workforce activities and neighbourhood teams be submitted to the Committee for consideration at an appropriate time.

HSC/19/04 Delivering the Our Manchester Strategy

The Committee considered the report of the Executive Member for Adults, Health and Well Being, which provided an overview of work undertaken and progress towards the delivery of the Council's priorities, as set out in the Our Manchester strategy, for those areas within her portfolio.

Members welcomed the information provided regarding the funding that had been secured for Smoking Services. The Executive Member for Adults, Health and Well Being said that she acknowledged the work of the recent Task and Finish Group and commented that as smoking contributed to many poor health outcomes for Manchester residents it was important to establish a service that would support people to quit tobacco. She informed Members that a more detailed report would be submitted to the Committee for consideration at an appropriate time on this area of activity.

The Executive Member for Adults, Health and Well Being commented that the ambition of the Local Care Organisation was to deliver services, including prevention services, such as smoking cessation programmes in neighbourhood teams. She said the intention was also to bring together other public services, such as the police into the local teams. She advised that a lot of work had been undertaken around the issue of workforce and that a more detailed report would be submitted to the Committee for consideration at an appropriate time.

Members noted the work undertaken to improve Mental Health Services across the city. The Executive Member for Adults, Health and Well Being commented that the journey had been one of improvement and thanked the Committee for their continued challenge in this important area of work. She further informed the Members that work was ongoing at a Greater Manchester level to look at the funding inequalities between children's mental health services and adult services.

The Executive Member for Adults, Health and Well Being stated that she was passionate about challenging the myths that are perpetuated in certain sections of the media regarding asylum seekers in the city. She said she was working to improve services available to support asylum seekers and improve how information was shared with the Local Authority regarding where asylum seekers are housed so that appropriate support could be offered. A Member commented upon the often poor

condition of the properties that were offered to asylum seekers by providers, noting that currently there appeared to be no political will from central government to improve this situation.

Decision

To note the report.

HSC/19/05 Overview Report

A report of the Governance and Scrutiny Support Unit which contained key decisions within the Committee's remit and responses to previous recommendations was submitted for comment. Members were also invited to agree the Committee's future work programme.

Decision

To note the report and approve the work programme.

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Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 5 February 2019

Subject: Single Hospital Service (SHS) Progress Report

Report of: Director, Single Hospital Service

Summary

This report provides an update on the City of Manchester Single Hospital Service Programme. It sets out the work that has taken place since the creation of Manchester University NHS Foundation Trust (MFT) on 1st October 2017 and describes the approach used within MFT to track the anticipated benefits of the merger. It also outlines the part MFT is playing in the work being led by Greater Manchester Health and Social Care Partnership to transfer North Manchester General Hospital (NMGH) into MFT.

Recommendations

To note the information provided in the report.

Wards Affected: All

Alignment to the Our Manchester Strategy Outcomes (if applicable):

Manchester Strategy outcomes	Summary of how this report aligns to the OMS
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	MFT is the largest employer in the City. North Manchester General Hospital is the largest employer in its local area. Both have significant supply chain which brings opportunity. MFT already has links to local schools and business which adds added value to local communities.
A highly skilled city: world class and home grown talent sustaining the city's economic success	MFT and NMGH both have roles in education of health professionals as well as significant research portfolios.
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	The Manchester Single Hospital Service and the wider strategy regarding North Manchester will improve the health of the population and create greater benefits in the surrounding communities.

A liveable and low carbon city: a destination of choice to live, visit, work	High quality healthcare provision can support Manchester being an attractive place to live. Modernisation of estate and digital can have a significant impact upon the carbon footprint of the City.
A connected city: world class infrastructure and connectivity to drive growth	The strong research and educational status have a global reputation for the City. Research has great potential for further economic growth.

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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.

- Manchester Locality Plan 2015 – 'A Healthier Manchester'
- Manchester Locality Plan (refresh) 2018 'Our Healthier Manchester'
- Sir Jonathan Michael Single Hospital Service Reviews
- Taking Charge – Greater Manchester Health and Social Care Partnership
- Single Hospital Service progress report October 2018 – Manchester Health Scrutiny Committee
- MFT One Year Post-Merger Report

1.0 Purpose

1.1 The purpose of this paper is to provide an update for the Health Scrutiny Committee on the City of Manchester Single Hospital Service (SHS) Programme. It includes an overview of the work in place to ensure post-merger integration activities are happening as planned. It also explains the current position of MFT with regards to the proposal made by NHS Improvement that MFT should acquire North Manchester General Hospital (NMGH).

2.0 Background

2.1 The proposal to establish a Single Hospital Service for Manchester, Trafford and surrounding areas was built on the work of the independent Single Hospital Service Review, led by Sir Jonathan Michael. The Single Hospital Service Programme has been operational since August 2016.

2.2 The Programme is being delivered through two linked projects. Project One, the creation of MFT through the merger of Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM), was completed on 1st October 2017.

2.3 'Project Two' is the proposal for North Manchester General Hospital (NMGH) to transfer from Pennine Acute Hospital NHS Trust (PAHT) to MFT.

3.0 Progress to Date

3.1 Integration Governance

3.1.1 As intended at this stage of the merger, year two integration plans are being developed with direct contributions from corporate, operational and clinical teams. This includes attention to the implementation of complex programmes of work aimed at harmonising care pathways. In effect capitalising on the success of the first year post-merger by applying MFT-wide resources to reduce variability of treatment i.e. achieve the same standard of care wherever a patient is treated in MFT. Group Executive Directors and Hospital / Managed Clinical Services Chief Executives are working closely with the Director for the Single Hospital Service to ensure the pace of delivery is both ambitious and achievable.

3.1.2 In this context, the Integration Steering Group (ISG), chaired by the Director for the Single Hospital Service, continues to oversee delivery of all integration work streams, providing resource and support to help work stream leads deliver their objectives.

3.1.3 As part of the on-going scrutiny of post-merger deliverables the ISG recently organised 'Confirm and Challenge' review meetings of work streams which are supported by GM Transformation Funding. The meetings focussed on the 2018/19 expenditure and forecast spend for 2019/20.

3.1.4 In conjunction with the above governance processes, the fifth iteration of the Post Transaction Integration Plan (PTIP) has been developed. The PTIP refreshes and reinforces the integration plans to ensure MFT tracks delivery of, and realises, merger benefits. This will be the final iteration of the PTIP relating to the merger since work streams will increasingly continue to the deliver their integration benefits though business as usual processes overseen by the relevant Group Executive Director or Hospital /MCS Chief Executive.

3.2 Integration Deliverables

3.2.1 Good progress continues with the Integration Programme, details of which are provided in the attached Year One Post-Merger Report (Appendix A).

3.2.2 The Report explains the scale and breadth of achievements made and sets out a high-level account of lessons learnt. As a consequence of the efforts made by all staff, MFT has an even firmer platform to begin to operationalise large, complex schemes to promote significant patient and organisational benefits. The report also outlines the new organisational structure including the scope and scale of services MFT provides, before setting out the vision and values that have been collaboratively developed with staff.

3.2.3 The Report is a public document which has been shared with a wide range of stakeholders. To date it has been well received with positive feedback from colleagues across multiple organisations.

3.2.4 The following extracts from the report illustrate the type of patient and staff benefits MFT has achieved in the first year of the merger.

3.3 Urology

3.3.1 Patients in need of kidney stone removal now have quicker access to non-invasive lithotripsy treatment following the introduction of a combined lithotripsy service between the Manchester Royal Infirmary and Wythenshawe Hospital. Patients needing kidney stone removal wait no longer than 4 weeks. Before the merger, some patients waited 6 weeks or more.

3.4 Fractured Neck of Femur Services

3.4.1 An improved rehabilitation pathway has been developed by Therapy and Nursing Teams for Trafford residents. Patients receiving Fractured Neck of Femur surgery at Wythenshawe Hospital, who meet set criteria, are now able to be transferred to Trafford General Hospital to receive rehabilitation as well as the medical care they need. Patients can recover in a specialist environment closer to home and this enables better outcomes, shorter lengths of stay and improved patient experience.

3.5 Urgent Gynaecology Surgery

3.5.1 An additional dedicated urgent gynaecological list has been introduced at Wythenshawe Hospital. Before the merger, patients who needed surgery for

an urgent gynaecological condition were added to a general theatre list with the possibility their operation could be delayed due to emergency cases taking priority. Women who need surgery after a miscarriage are getting faster treatment in less than 2.5 days on average instead of 4 days before the merger.

3.6 Imaging and Nuclear Medicine

3.6.1 Since the merger, Imaging and Nuclear Medicine colleagues across sites have been working together to combine protocols and procedures to ensure consistent standards are being met across all areas of work. A new process has been introduced to manage turnaround times for scan reports across all MFT Hospitals, reducing the time that patients are waiting to receive their results.

3.7 Stroke Services

3.7.1 Staff from across all MFT sites have collaborated to create a single point of access to stroke services to improve the stroke pathway for patients being transferred from a hyper-acute stroke unit to a district stroke centre in MFT. The aim was to improve timely access to stroke treatment and rehabilitation.

3.7.2 A single point of access pilot in June 2018 analysed the potential to prevent delays in patient transfers by deploying the entire stroke bed base across three sites – Wythenshawe, Trafford and Manchester Royal Infirmary. The model was launched on 1st October 2018 and witnessed a dramatic fall in the number of delays from ten in June to one in October. As a result of the initiative, the MFT Stroke Team won an award for Quality Improvement from the Sentinel Stoke National Audit Programme (SSNAP).

3.8 MFT Vision and Values

3.8.1 MFT has developed a Leadership and Culture Strategy with a significant focus on organisational development including a major work stream on vision and values. This is linked to the integration work required to bed in the new leadership structures across Hospitals and Managed Clinical Services. A video summary of the Trust's Vision and Values is available here: https://vimeo.com/289424367/99d0749724.

3.9 The Manchester Investment Agreement Metrics

3.9.1 The delivery of the Manchester Investment Agreement patient benefits is reported to Manchester Health and Care Commissioners (MHCC) on a quarterly basis. MFT is held to account by MHCC on the delivery of specific, measurable patient benefits such as shorter wait times to surgery and improved clinical outcomes. It is anticipated that a further cohort of metrics will be included in the agreement as part of a process to review and re-baseline deliverables that MFT will seek to realise over the coming two years.

3.9.2 MFT colleagues will attend a meeting with MHCC and Greater Manchester Health and Social Care Partnership (GMH&SCP) in February 2019 to update on the delivery of the Manchester Investment Agreement metrics. Clinicians, Service Managers and colleagues from the SHS and Transformation Teams will present updates on the improvements they have been able to realise as a result of the merger.

4.0 Proposed Acquisition of North Manchester General Hospital

4.1 The second stage in the creation of a Single Hospital Service is to transfer NMGH, currently part of Pennine Acute Hospitals NHS Trust (PAHT), into MFT.

4.2 NHS Improvement (NHS I) has set out a proposal for MFT to acquire NMGH as part of an overall plan to dissolve PAHT and transfer the remaining hospital sites (Bury, Oldham and Rochdale) to Salford Royal NHS Foundation Trust (SRFT) – this is referred to in general terms as the 'two-lots' proposal.

4.3 The transaction process is being managed under the auspices of the national NHS I Transaction Guidance with oversight provided by a Transaction Board established at the end of November 2017. The Board is chaired by Jon Rouse, Chief Officer Greater Manchester Health & Social Care Partnership (GMH&SCP).

4.4 The current timetable for the dissolution of PAHT expects strategic cases from both SRFT and MFT to be suitably aligned in Q4 of 2018/19. The strategic case will outline MFT's financial plan for NMGH, in addition to the benefits, risks and any required mitigations associated with the transaction.

4.5 One of the challenges in completing this work is the need to ensure the strategic cases submitted by SRFT and MFT are complementary i.e. not contradictory or in any way inconsistent with the 'two-lots' proposal. In this context, MFT continues to work collaboratively with MHCC, PAHT, SRFT, and NHS I and colleagues at GMH&SCP to ensure the two transactions associated with the dissolution of PAHT are progressed as efficiently as possible.

4.6 In anticipation of the proposed transaction, MFT and MHCC continue to connect with colleagues at NMGH through a staff engagement programme. Colleagues are able to attend and provide updates for NMGH staff and answer any queries they may have with regards to the transaction.

4.7 Furthermore, the SHS Team also met MFT Council of Governors on 28th January 2019 to provide key updates on the progress of the proposed acquisition. The session served as an opportunity for the Council of Governors to learn more about the services at NMGH and the transaction process.

5.0 Conclusion

5.1 Integration work is progressing well aimed at realising patient benefits and creating new efficiencies. The Year One Post-Merger Report provides a good account of this work and illustrates the criticality of the Post Transaction Integration Plan to ensuring integration objectives stayed on track.

5.2 The importance of integration notwithstanding, MFT remains committed to fully establishing the Manchester Single Hospital Service by transferring NMGH to MFT at the earliest practicable opportunity. On this basis, MFT will continue to engage with all key stakeholders and in particular, work with Greater Manchester Health and Social Care Partnership in its role to oversee the plan to dissolve Pennine Acute Hospitals NHS Trust.

6.0 Recommendation

6.1 The Health Scrutiny Committee is asked to receive the report.

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NHS
Manchester University
NHS Foundation Trust

One Year Post-Merger Report
November 2018

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Foreword

Manchester University NHS Foundation Trust (MFT) was launched on 1st October 2017. The new organisation brought together a group of nine hospitals plus community services, providing a once in a lifetime opportunity to deliver even better services for the people of Manchester, Trafford and beyond.

Our first priority was to keep services running safely and smoothly. On day one, patients saw little change apart from the new name and new lanyards for staff. We wanted to minimise disruption to maintain stability for staff and ensure patient safety.

We quickly started detailed planning to maximise the opportunities to improve services for patients and address the health inequalities that exist in the City of Manchester, Trafford and the wider communities we serve. We started to deliver changes steadily and we are pleased to see some major improvements for patients being delivered already. Behind the scenes significant work has also taken place to consolidate the systems, policies and processes that support the day-to-day operation of a major organisation.

Designing and embedding new governance and leadership structures was a key component of our early work. It took a great deal of effort and support from staff and, as a result, we now have an organisational structure that is fit for purpose. This means we can press on to finalise the service strategy which will support more fundamental transformation over the coming years. This is exciting work which will continue to involve staff from across our nine hospitals and community services, along with partner organisations.

All this work has taken place against a challenging backdrop. Like other NHS Trusts, we face increasing demand on our services, workforce challenges and financial pressures. Despite this headwind our staff have continued to deliver outstanding care whilst also developing single services and delivering early transformation. We would like to thank them for their unrelenting efforts and support in establishing MFT, and for the steps they have taken to maintain and improve services for patients.

We look forward to continuing the development of MFT, and remain excited about the potential for us to reduce variation in care so that all patients can get the same standard of service no matter where they are in MFT. Together we can achieve an international reputation and exceed all expectations across care provision, education and training, and research and innovation for the benefit of patients.

Kathy Cowell OBE DL
Chairman

Sir Michael Deegan CBE
Chief Executive

Executive Summary

Manchester University NHS Foundation Trust was created through the merger of Central Manchester NHS Foundation (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM) on 1st October 2017.

This One Year Post-Merger Report provides an overview of the Trust's establishment and first year of operation. It outlines the new organisational structure including the scope and scale of services it provides before setting out the vision and values that have been collaboratively developed with staff. It explains the initial priorities of the organisation, including the primary objectives of maintaining stability and continuing to deliver core activities safely.

The Report explains that a new organisation structure has been established comprising both traditional hierarchies and new networks that run across the breadth of the organisation. It outlines how the Trust's formal governance arrangements have been set up and how the Hospital, Managed Clinical Services and Clinical Standards Groups function and interact. It also confirms that despite the significant levels of change staff engagement to date has remained strong.

The Report confirms that the main driver for the creation of MFT was the opportunity to deliver significant patient benefits across the full range of services offered. These span improvements in patient safety, clinical quality and outcomes, to improvements in the experience of patients, carers and their families. It explains how the Trust is developing its overarching service strategy, setting out a long term vision that will shape how services are provided in the future. This service strategy work will inform the delivery of significant service transformation over the coming years.

"The overriding reason for the merger was to create single hospital services for the people in Manchester and Trafford and, to make sure every person using our hospitals and community services receives the same excellent experience and quality of care, no matter where they live or where they access care. During our first year we have seen many examples of staff working together to improve standards of care for patients and their families."

Professor Cheryl Lenney, Chief Nurse

The Report outlines that delivery of patient benefits has commenced with major improvements already evidenced in services ranging from lithotripsy and urgent gynaecology services to the better management of patients suffering a fractured neck of femur. Across the organisation staff have been working to develop single services that build on the strengths of the predecessor organisations. This work has been underpinned by efforts to consolidate systems, processes and policies in support services, such as IT, finance, HR and workforce.

The creation of MFT and subsequent work to fully establish the organisation has been a significant undertaking. The Trust has learnt useful lessons during this process and these are set out in the Report. This learning will go on to inform MFT's future work, including the proposed acquisition of North Manchester General Hospital. It is hoped that other NHS organisations will also be able to benefit from this learning.

Key Messages

The value of having a credible, robust and adaptable Post-Transaction Integration Plan (PTIP) cannot be overstated. The PTIP provided the Group Board of Directors and external scrutineers with a framework to assess progress and gain assurance about the merger. More importantly it afforded staff, clinical leaders, managers and transformation teams a framework against which to operate from day one of the merger.

Having a dedicated Single Hospital Service/ Integration Team avoided the deployment of external consultancy and enabled delivery of the PTIP as a local product recognised and owned by staff. It also provided a resource to coordinate post-merger work including the transition from merger change processes to business as usual linked to portfolios of individual Group Executive Directors and Hospital and Managed Clinical Services Chief Executives.

Communicating and engaging with staff was crucial throughout the merger. Staff were central to the planning and delivery of the merger work and the subsequent development of the Vision and Values of the new Trust. Despite the significant level of change that has taken place staff engagement remains strong.

The establishment of an Integration Steering Group with active involvement of Group Executive Directors has been critical in driving change, tracking patient benefits and planning for Year Two of the merger.

The new organisational structure and governance arrangements were well planned pre-merger and established relatively quickly. Combining hierarchy and certain reporting arrangements with defined structures offered clear lines of accountability without stifling innovation, agility and flexibility. Matrix working has, and continues to be, encouraged.

A key element of post-merger work has been the consolidation of systems, processes and policies on a priority basis to ensure MFT operates as a single entity. This work is complex and will continue to receive attention as part of the PTIP work stream.

As planned, the development of the Trust's long term service strategy is well underway with strong engagement from across the organisation and with relevant partners.

The focus for the first year was on ensuring as much stability for staff as possible as well as protecting patient safety during a time of significant change. In essence it was a deliberate policy to maintain business continuity and avoid any unnecessary disruption to pre-merger working practices.

During the establishment of MFT and in its first year of operation important lessons have been learnt. These will be carefully considered to optimise future work.

"The creation of the new Trust was always going to be a fantastic opportunity to bring together the clinical strengths of our two predecessor organisations, and build on them to provide even better care to our patients. Both in the lead up to the merger and since, clinical engagement has been at the heart of the work to bring about benefits for patients; and I'm sure that's a major factor in achieving the successes we've already delivered."

Miss Toli Onon, Joint Medical Director

1 Introduction to Manchester University NHS Foundation Trust

MFT was created on the 1st October 2017 following the merger of CMFT and UHSM. It is one of the largest acute Trusts in England, employing over 20,000 staff. The Trust is responsible for running a group of nine hospitals across six distinct geographical locations and for hosting the Manchester Local Care Organisation:

Manchester Royal Infirmary

Saint Mary's Hospital

Royal Manchester Children's Hospital

Manchester Royal Eye Hospital

University Dental Hospital of Manchester

Wythenshawe Hospital

Trafford General Hospital

Withington Community Hospital

Altrincham Hospital

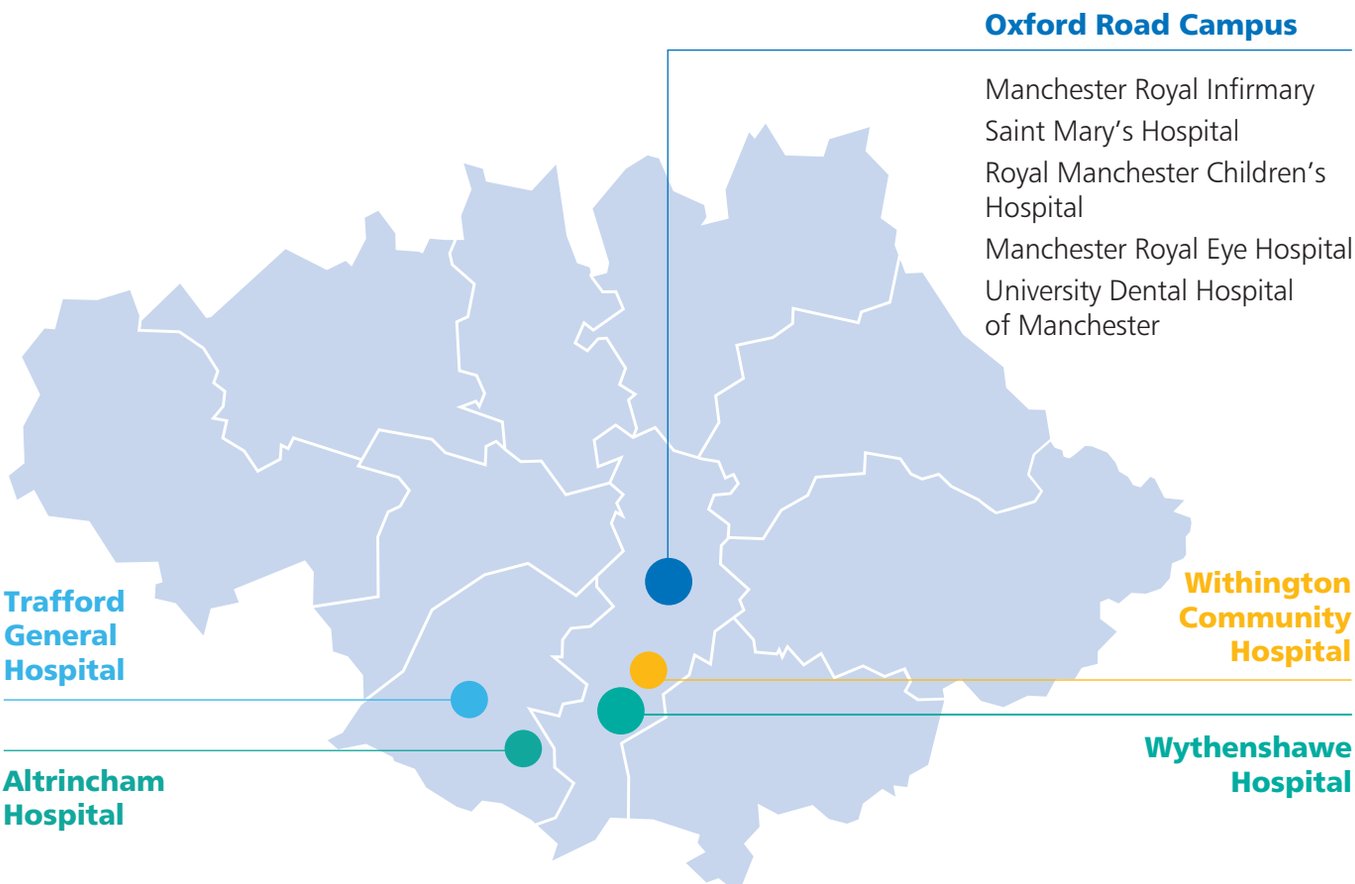
In **Manchester City Centre** on the Oxford Road Campus care is delivered from the Manchester Royal Infirmary and four specialist hospitals: Saint Mary's Hospital, Royal Manchester Children's Hospital; Manchester Royal Eye Hospital; the University Dental Hospital of Manchester.

In **South Manchester** care is provided from Wythenshawe Hospital and Withington Community Hospital.

In **Trafford** services are delivered from Trafford General Hospital and from Altrincham Hospital.

MFT hosts the Manchester Local Care Organisation which is responsible for delivering integrated **out-of-hospital care** across the City of Manchester.

Figure 1: Manchester University NHS Foundation Trust



Whilst they operate as distinct hospitals, Saint Mary's Hospital, the Royal Manchester Children's Hospital, the Manchester Royal Eye Hospital, and the University Dental Hospital of Manchester have also been established as Managed Clinical Services. The hospital services use their in depth expertise to deliver and manage specific clinical services across the Trust. In addition, a dedicated Managed Clinical Service for Clinical and Scientific Support Services has been established and operates across the Trust. This arrangement ensures consistency of clinical standards, guidelines and pathways across the breadth of the organisation.

The Trust is the largest and one of the most diverse acute and community hospital groups in the country, which despite its size is strongly rooted in the local communities it serves. It provides district general hospital services to a population of approximately 750,000 local people. It is also a major provider of tertiary and quaternary services across Greater Manchester and the wider North West region in areas including Vascular, Cardiac, Respiratory, Urology, Renal, Burns/Plastic Surgery, Cancer, Paediatrics, Women's Services, Ophthalmology, Breast Surgery and Genomic Medicine. The Trust is also the largest provider of specialised services in the country, providing 88 specialised services and 9 highly specialised services.

The Trust employs over **20,000** staff

The Trust attends to more than **1,725,000** out-patients per year

The Trust has an annual turnover of almost **£1.6 billion**

The Trust delivers over **13,000** babies and carries out in excess of **189,000** operations/ procedures per year

The Trust sees around **405,000** patients in its Accident & Emergency Departments per year

The Trust has approximately **2,500** inpatient beds

The Trust's research portfolio is the largest in the North West

The Trust has the largest number of undergraduates and clinical staff in training in the North West

MFT is a major academic research centre and education provider. This clustering of clinical services with life sciences and academia enables the Trust to deliver cutting edge care to patients.

Manchester Local Care Organisation

Leading local care, improving lives in Manchester, with you

Whilst the creation of MFT was progressing, the Manchester Local Care Organisation (MLCO) was also being established. The Manchester LCO is a partnership between the City Council, Commissioners and providers, including MFT, with responsibility for the delivery of out-of-hospital care and improved community-based health services aimed at preventing illness and caring for people closer to home.

In March 2017, Manchester Health and Care Commissioning (MHCC) invited bids for the award of a single contract for the provision of health and care services across the neighbourhoods and communities of Manchester, through a Local Care Organisation (LCO). The prospectus stipulated that a single provider would be awarded a single contract by commissioners. A range of possible organisational models were reviewed, to establish which model could deliver the objectives and ambition of the LCO. Although a single contract for the delivery of the LCO services was not possible, partners including MFT agreed to develop a legally binding ten-year Partnering Agreement, which commits all parties (MFT, MHCC, Manchester City Council, Manchester Primary Care Partnership and Greater Manchester Mental Health NHS Foundation Trust) to the delivery of the LCO agenda and the transformation of out of hospital services.

The Partnering Agreement was formally signed by all Partners in March 2018, coming into effect on 1st April 2018, and in doing so establishing MLCO. MLCO is a virtual organisation responsible for the delivery of a range of services including community health services, and adult social care. As the organisation develops over an agreed three year phased approach, the range of services that will be delivered through MLCO will grow to include Mental Health and Primary Care.

MLCO continues to develop the Integrated Neighbourhood Team hubs, and the creation of a co-designed and all-encompassing approach to the MLCO. Key deliverables for 2018/19 and beyond will ensure that it is best placed to meet the needs of communities and neighbourhoods of Manchester in regards to integrated health and social care.

The benefits delivered through the Manchester LCO include improved health outcomes, improving people's experience of care, local people being independent and able to self-care, better integrated care, better use of resources, fewer permanent admissions into residential/nursing care and fewer people needing hospital-based care. Alongside progressing integration of the two predecessor Trusts, MFT is also working hard to support the establishment of MLCO.

This large and complex organisation has been in operation for just over twelve months. Although still in its infancy, MFT has already achieved a great deal. This report has been produced to explain some of these achievements and to celebrate the progress that has been made during its first year, including the improvements that have been delivered for patients and staff.

2 The Creation of Manchester University NHS Foundation Trust

Single Hospital Service Review

The principle of significantly changing the way that hospital and community services are provided in Manchester was first established late in 2015, in the Manchester Locality Plan.

This work was led by MHCC in collaboration with the Manchester Health and Wellbeing Board. It commenced in response to the challenges faced by health and social care providers, and set out an ambitious programme of work made up of three 'pillars' and called the Manchester Locality Plan:

- A Single Hospital Service for Manchester;
- A local care organisation that delivers integrated, accessible, out-of-hospital health and care services across Manchester; and
- A single commissioning system for health and social care services across the citywide footprint.

The Manchester Locality Plan was endorsed by all local stakeholders across the city and supported by Trafford Council.

"The creation of a Single Hospital Service is a key strand of the Manchester Locality Plan, along with the Single Commissioning Function and Local Care Organisation, and was a complex undertaking. The two Trusts achieved this within a year, working in partnership with organisations in the locality. This was a vital step towards ending health inequalities in our city to make sure everyone gets the same quality of care, no matter where they live."

Ian Williamson, Chief Responsible Officer, Manchester Health and Care Commissioning

To commence the Single Hospital Service element of this work the 'Single Hospital Service Review' was commissioned in 2016. This work, independently led by Sir Jonathan Michael, sought to consider the benefits that might be accrued by hospital services in Manchester working more closely together and to identify the optimal organisational form required to deliver these improvements. At the time of the Review there were three hospital service providers in Manchester: CMFT, UHSM, and North Manchester

General Hospital (NMGH) – part of Pennine Acute NHS Hospitals Trust (PAHT). All three were included in the review process.

The first stage of the review acknowledged the significant challenges that were facing health and social care providers in Manchester. The review found that hospital care was fragmented and that there was an unacceptable variation across the City in the provision and quality of care provided. The review also identified that although duplication, and even triplication, existed across the city in some clinical services, in other specialties patients were struggling to access healthcare appropriate to their needs. Workforce challenges facing hospital providers, exacerbated by the imperative to move to more even service provision across the seven days of the week, were also highlighted as a key issue. In line with NHS services nationally, increasing financial and operational difficulties were also acknowledged.

The development of a Single Hospital Service was identified as a key mechanism to address these issues. To identify the potential benefits of a Single Hospital Service the review focussed its attention on eight specialty areas and engaged clinicians to identify specific improvements that could be delivered by closer co-operation of clinical teams. This work was extrapolated and expanded to include contributions from colleagues working in research, training, finance and back office support services.

The process resulted in the identification of a series of high level benefits that cover a range of areas including quality of care, patient experience and financial/operational efficiency. The full list of potential benefits that were identified is shown in Table 1.

Table 1: High level benefits identified in the Sir Jonathan Michael Review[1]

Category	Benefits
Quality of Care	• Reduce variation in the effectiveness of care • Reduce variation in the safety of care • Develop appropriately specialised clinicians and reduce variation in the access to specialist care, equipment and technologies
Patient Experience	• Provide more co-ordinated care across the city (and reduce fragmentation) • Enhance the work of the Local Care Organisation to transfer care closer to home • Improve patient access and choice • Improve access to services and reduce duplication (and thus unnecessary trips to hospital)
Workforce	• Improve the recruitment and retention of a high quality and appropriately skilled workforce • Support the requirement to provide a seven day service • Reduce the reliance on bank and locum/agency staff • Support teams to meet the needs of current and future demand for services
Financial and Operational Efficiency	• Reduce costs in supplies and services (including drug costs) • Reduce staff costs through improvement in productivity and changes in skill mix • Limit future capital outlay and ongoing fixed costs assets • Improve operational performance
Research and Innovation	• Increase research activity and income • Create a single point of entry to all clinical trials thereby improving access • Ensure new research and best practice guidelines are implemented consistently to improve services
Education and Training	• Optimise curriculum delivery, clinical exposure and reduce the variability in the student and trainee experience • Widen student and trainee exposure to different clinical environments • Enhance the reputation of Manchester as a place to come to be trained and to work

[1]City of Manchester Single Hospital Service Review Stage One Report; April 2016.

Given the scale of the potential benefits, the second stage of the review considered the options for changing the governance and leadership arrangements for hospital services in Manchester to achieve the identified benefits as rapidly and effectively as possible. This process recommended that the most effective organisational approach to delivering benefits would be through the creation of a single new hospital provider, encompassing the existing hospitals (CMFT, UHSM and NMGH) located within the City of Manchester.

The findings of the review were fully supported by all local stakeholders including the three acute Trusts, local commissioners, civic leaders across the city, civic leaders at Trafford Council and Manchester's Health and Wellbeing Board.

"The creation of Manchester Foundation Trust was a crucial step in the development of a Single Hospital Service for the City of Manchester and our devolved health and care model for Greater Manchester. By UHSM and CMFT bringing together their assets, skills and specialisms, we now have an organisation which is greater than the sum of its parts, of national and global significance. Already we are seeing the impact in terms of improvements to clinical services, enhanced career opportunities and a richer research and development offer."

Jon Rouse, Chief Officer, Greater Manchester Health and Social Care Partnership

Creating MFT

To fulfil the recommendations of the Single Hospital Service Review it was decided to first merge the two Foundation Trusts in the expectation that the resulting single Foundation Trust would later acquire NMGH from Pennine Acute NHS Hospitals Trust.

Work started in the Autumn of 2016 to merge CMFT and UHSM. A programme team was established and appropriate governance mechanisms were arranged to ensure elements of process, including Competition and Markets Authority (CMA) submissions, the development of a Business Case, Due Diligence and legal mechanisms were completed.

This work was undertaken in twelve months and obtained clearance from both NHS Improvement (NHS I) and the CMA. A key component of this work was the development of a PTIP which set out the tasks required to successfully merge CMFT and UHSM, and start to deliver the Single Hospital Service patient benefits, by Day One, Day 100, Year One and Years 2-5.

MFT remains committed to the principal of a Single Hospital Service in the City of Manchester and has started work to enable NMGH to join the Trust. This work is expected to conclude between 1st October 2019 and 1st April 2020 and is being overseen by the Greater Manchester Health and Social Care Partnership. The transfer of NMGH into MFT will truly allow the full range of benefits, outlined in the Single Hospital Service Review, to be delivered to all residents across the City of Manchester, and beyond.

CMA Competition & Markets Authority

NHS Improvement

3 First Priorities Post-Merger

Although merging two large acute NHS Foundation Trusts to create MFT was a relatively unique undertaking, there have been a number of examples of hospitals integrating. These integrations have achieved varying success, and MFT has sought to learn lessons from elsewhere to avoid the problems that similar projects have experienced. Some of the key issues that NHS I advises merging Trusts to consider are:

- Setting a realistic timeframe for delivering change.
- Engaging with stakeholders.
- Balancing merger implementation and maintaining core activities.
- Embedding a common culture.
- Establishing effective management across multiple sites.

Taking these issues into account, MFT deliberately placed an emphasis on the need to maintain stability throughout the process of merger and immediately after. The PTIP, developed in advance of the merger, intentionally minimised the number of changes that would take place on Day One of the new organisation. This allowed a focus on the basics of constantly and consistently delivering patient safety, patient experience and high quality care. MFT delivered this against the challenging backdrop of unprecedented winter pressure nationally which resulted in considerable demand on urgent and emergency services.

"The important thing to achieve was to ensure patients and staff felt safe on day one of the merger. Having an integration plan meant we could do that. We deliberately did not plan for major changes in the first year but we did deliver some early benefits."

Julia Bridgewater, Group Chief Operating Officer

Throughout the merger and integration UHSM and CMFT, and subsequently MFT, ensured that existing staff, including those at NMGH, were central to the planning and delivery of the merger work. There was a conscious decision to limit reliance on external management consultants. This has ensured that knowledge has been retained and embedded within the organisation, and that work was undertaken with an in depth understanding and appreciation of the predecessor organisations, including their underlying cultures, strengths and weaknesses.

This measured and steady approach ensured that the new organisation maintained its focus on the delivery of safe and high quality services for patients, whilst also undertaking the significant work required to create a new organisation. The focus on stability and delivering core activities, while steadily implementing the integration required when two organisations come together, has persisted.

In preparation for Day One, significant work was undertaken by support services to provide the essentials to create a new MFT identity. All staff were sent a welcome letter and provided with a new lanyard and badge holder. Although CMFT and UHSM email addresses continued to work, each staff member was provided with a new MFT email address. This helped to promote the sense that staff from both predecessor organisations were now part of a single entity and working together.

Alongside these more visible changes, critical work was undertaken to enable the organisation to operate successfully as a single entity. The majority of this work was overseen by a Corporate Integration Steering Group, chaired by the Deputy Chief Executive, and a Clinical Risk and Governance Steering Group, chaired by the Chief Nurse.

The integration plans for the first 100 days largely focussed on the need to put in place firm and robust organisational structures, including a new Council of Governors, a substantive Group Board of Directors and Hospital/Managed Clinical Service leadership teams. In addition work commenced to consolidate systems, processes and policies and to implement a small number of clinical improvement schemes. Preparation was also undertaken to support the Trust's first Care Quality Commission (CQC) inspection.

The work to consolidate systems, processes and policies has been significant. Immediate work was undertaken to enable cross site working and to support effective management and reporting across the Trust. This included merging the Electronic Staff Records, implementing a single ledger, integration of the Annual Planning Process and development of a single risk management system.

Alongside delivering this change, corporate services began to consolidate into single teams working across MFT, bringing together the teams from the two predecessor organisations. This has involved over 1000 members of staff. Due to the scope and scale of the services, and the pressure to simultaneously support wider changes within the organisation, this work has been carefully paced. The restructures that have been completed to date have delivered financial savings of five percent. It is planned that similar savings will be delivered across the services that remain to be consolidated.

Collectively these early changes began to give the new organisation a sense of identity that staff could relate to and feel part of. To promote this further one of the first priorities was the development of MFT's vision and values as part of a major organisational development programme with staff. Developing these early with staff, patients and partners was essential to supporting the development of the organisation's culture and setting the direction of travel on which the foundations of success would be built. These are set out in Figure 2.

Figure 2: MFT's Vision and Values

Our Vision

Our vision is to improve the health and quality of life of our diverse population by building an organisation that:

- **Excels in quality, safety, patient experience, research, innovation and teaching**
- **Attracts, develops and retains great people**
- **Is recognised internationally as a leading healthcare provider**

Our Values

Together Care Matters
Everyone Matters
Working Together
Dignity and Care
Open and Honest

https://mft.nhs.uk/the-trust/our-vision-and-values/

Staff quickly engaged in this work and related strongly to the vision and values. This has been clearly demonstrated through the regular staff surveys undertaken by the Trust. For example, in Quarter 2 of 2018/19, 89% of MFT staff reported that they were aware of the Trust values.

This significant change work has been delivered carefully without distracting MFT from its core purpose; to excel in quality, safety and patient experience. MFT recognises the valuable contribution that all staff have made following the merger. Whilst the organisation has been committed to ensuring all employees are kept informed and engaged regarding the integration process, much of the success of MFT's first year is because of the hard work, commitment and dedication of MFT staff. Teams have seized the opportunity that the merger provided and have been working to ensure that the benefits of a Single Hospital Service are delivered. Some examples of the excellent work that has been undertaken following the creation of MFT are outlined in Chapter 8.

The creation of MFT was a ground breaking process that has yet to be repeated elsewhere in the country. The remainder of this document sets out some of the key achievements that have been delivered by MFT during its first year.

4 Establishment of Leadership and Organisational Structure

In order to deliver services safely and effectively, MFT prioritised the establishment of a robust organisational structure and new leadership teams. Given the scale of the organisation this was critical to ensuring a strong and continued focus on delivering safe care for patients. In addition to being a new organisation, MFT was formally and legally constituted as a 'Group'. This required a new design of Executive oversight and leadership.

Trust Membership Base

As a new NHS Foundation Trust, MFT required a new membership base. In order to establish the membership in a timely manner it was formed from the existing CMFT and UHSM membership base. Members were contacted and advised that they would automatically become members of the new Trust unless they actively opted-out. A small number of staff chose to opt-out. The remaining 42,000 members formed the initial membership of the new Trust. Work has since been undertaken to recruit more participants and to refine the involvement, ensuring that it is representative of the population served by MFT.

Council of Governors

As a new NHS Foundation Trust, MFT also had to meet a statutory requirement to have a new Council of Governors. Immediately after authorisation of the new Trust on 1st October 2017, the MFT Public and Staff Governor election process was instigated. The elections concluded in November 2017 and the results were announced at a Special Members Meeting in December 2017. A new Lead Governor was elected and this appointment was confirmed at the inaugural meeting of the MFT Council of Governors on 20th December 2017. Since then significant work has been undertaken to plan and deliver training and development for the new Council of Governors.

Group Board of Directors

Prior to the merger of UHSM and CMFT an Interim Group Board of Directors was established in line with the requirements set out in the NHS I Transaction Guidance. This Interim Board remained in operation after the merger to provide stability and continuity. The substantive Group Board of Directors was confirmed and became operational on 20th December 2017 following a robust selection process which included external assessment.

Design of the Organisational Structure

Alongside the establishment of the high level organisational leadership, implementation of the new organisational structure commenced. To ensure that every member of staff was clear about their own accountability the default position was that pre-merger accountability arrangements would stand and no overnight changes were made for Day One of the new organisation except in exceptional circumstances.

The leadership team carefully designed the new structure, taking into consideration learning from other hospital groups, both nationally and internationally. Some of the organisations reviewed favoured a vertical structure, where hospitals and accountability were the focus, ensuring operational grip. Contrastingly, other organisations favoured a horizontal structure where clinical synergies and pathways were the main focus. Notably, each organisation stated they would have focussed on the opposite approach if they went through the process again.

Considering this learning, MFT designed a structure that starts with the delivery of clear, vertical operational grip to ensure patient safety and maintain clear accountability. This is achieved through the management of the Hospital Sites and Managed Clinical Services as operational units, each with their own Chief Executive and leadership team. These operational units are overseen by the Group Chief Operating Officer with Chief Executives reporting to the Group Chief Executive.

The achievement of clinical synergies is being delivered through the establishment of Managed Clinical Services and Clinical Standards Group functions. The Clinical Standards Groups bring

together a multi-disciplinary group of subject experts and supporting professionals to enable clinical staff to apply best practice and standardisation across the Trust. In addition, Education and Research runs through the whole structure.

Through this comprehensive approach, the new organisational structure facilitates clinical service delivery against evidence-based standards of practice, combining site specific management with the management and ongoing development and change of clinical services across sites. This dual approach is beginning to give the organisation flexibility and agility despite its size. As the horizontal functions and networks mature it is envisaged that they will provide challenge and will enable the organisation to continually adapt and change.

Detailed Organisational Structure

Breaking down the structure in greater detail, MFT has eight operational units; five of these are described as Managed Clinical Services, two are hospitals and one is the hosted Manchester Local Care Organisation. Of the five Managed Clinical Services, four are associated with a distinct physical site, whilst one manages services across multiple sites. The five Managed Clinical Services are accountable for the delivery and management of a defined group of clinical services taking place on any site within MFT. Their role includes the operation of Clinical Standards Groups for their areas of specialty, setting clinical standards and developing evidence-based guidelines and pathways across the Trust. This arrangement is described in Table 2.

Table 2: Managed Clinical Services

Managed Clinical Service	Services	Clinical standards development function
Clinical & Scientific Services (CSS)	Anaesthesia, Critical Care, Pathology, Radiology et al	Yes
Manchester Royal Eye Hospital (MREH)	Adult & Paediatric Ophthalmology	Yes
Royal Manchester Children's Hospital (RMCH)	Children's Services	Yes
Saint Mary's Hospital (SMH)	Women's Services & Neonatology	Yes
University Dental Hospital of Manchester (UDH)	Dental Surgery & Oral Medicine	Yes

The other two operational units are the hospital sites of Manchester Royal Infirmary (MRI) on the Oxford Road campus, and the multiple hospital sites of Wythenshawe, Trafford General, Withington and Altrincham Hospitals (WTWA) managed by the senior leadership team based out of Wythenshawe Hospital. The two operational units of MRI and WTWA each deliver many clinical services to adults which they share in common, such as Emergency Medicine, Urology and Cardiac Surgery, but which are operationally managed independently by each site. This arrangement is described in Table 3.

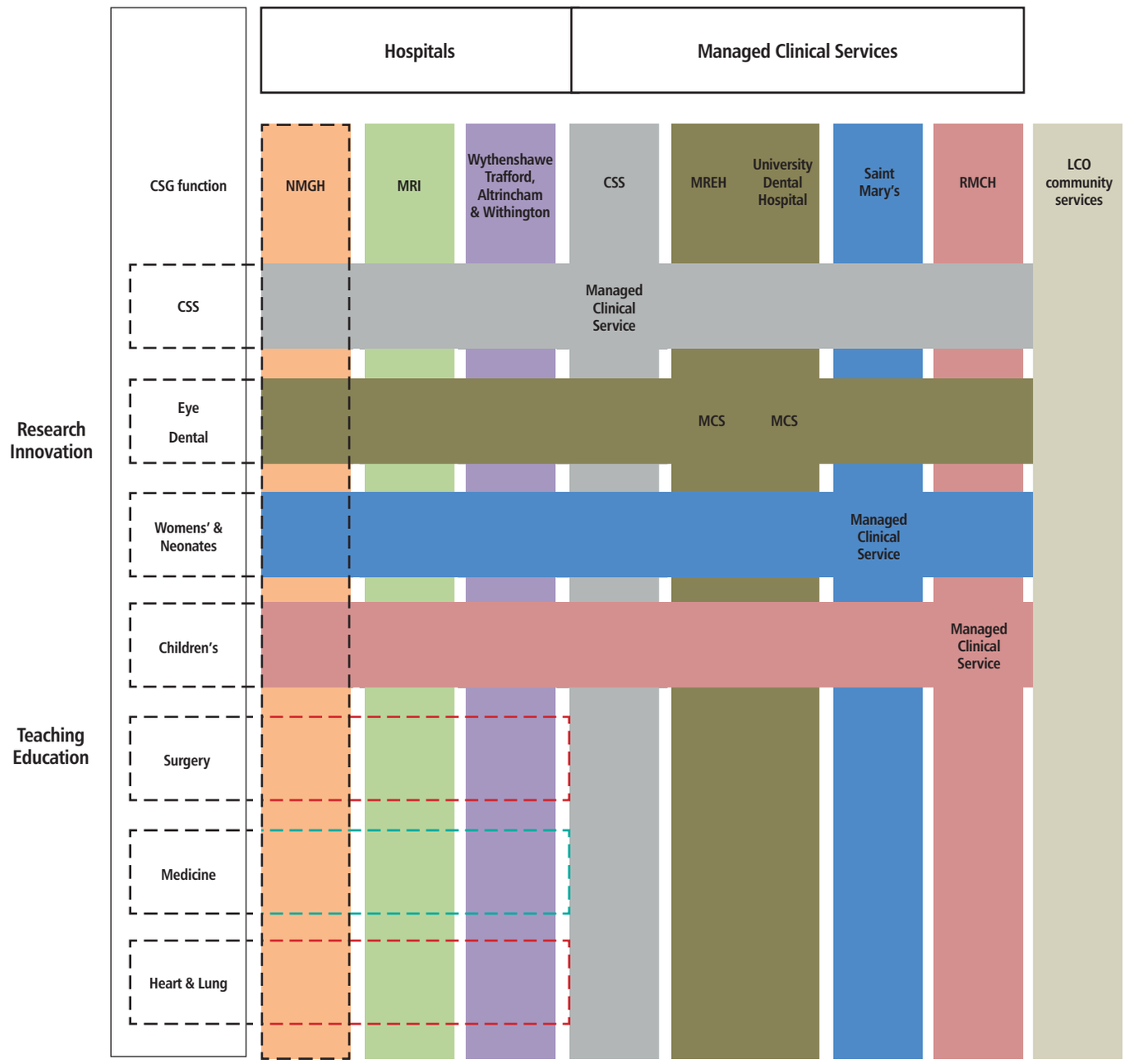
Table 3: Hospital Sites

Hospital Site	Services include:	Clinical standards development function within hospital site
Manchester Royal Infirmary (MRI)	**Adult Medical & Surgical Services including Cardiac & Respiratory**	**No**
Wythenshawe, Trafford, Withington & Altrincham (WTWA)	**Adult Medical & Surgical Services including Cardiac & Respiratory**	**No**

The organisation structure also takes into account the Manchester Local Care Organisation (LCO) and provision of community services. MFT is a key partner in the LCO that is providing integrated out-of-hospital care in the city of Manchester. Services provided incorporate community nursing, community therapy services, intermediate care and enablement, and some community-facing general hospital services.

The overall organisational structure of MFT is illustrated in Figure 3, including NMGH which is planned to join the Trust in the near future.

Figure 3: Diagram of MFT Organisational Structure



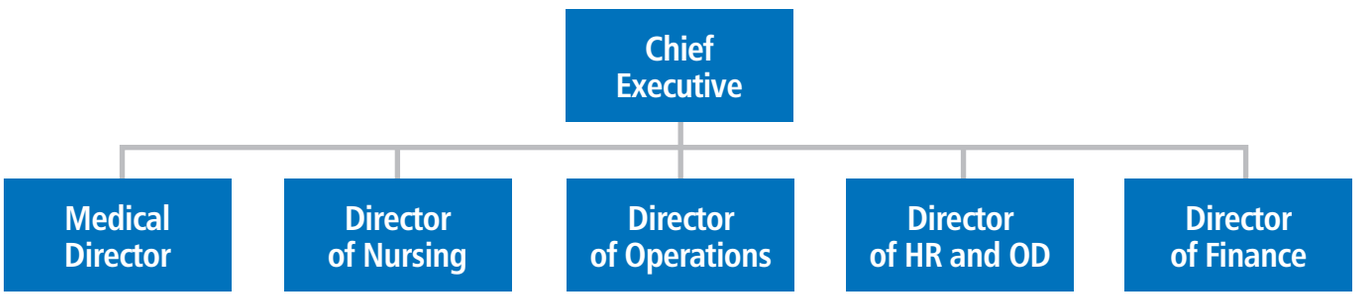
NMGH is planned to join the Trust in the near future.

Organisational Leadership

Based on the new organisational structure, implementation of the senior leadership arrangements started immediately after the Trust was established. This was undertaken in a planned, staged approach to limit disruption to services, but at sufficient pace to ensure that the structure was in place by April 2018.

The Hospital and Managed Clinical Service leadership teams are central to maintaining patient safety and clear accountability. It was therefore decided that they would be recruited as early as possible through rigorous internal and external recruitment processes. Each Hospital and Managed Clinical Service has its own Medical Director, Director of Nursing, Director of Operations, Director of Finance and Director of HR and Organisational Development. These senior leadership teams are each led by a Chief Executive.

Figure 4: MFT Hospital and Managed Clinical Service Organisational Structure



The appointment of leaders in the Group Corporate functions followed the establishment of the substantive Group Board of Directors. Each Group Executive Director developed the structures for their own directorates, and formal consultation on these changes started in January 2018. The review and alignment of Group Corporate functions has been undertaken in a phased approach, based on an assessment of priority to minimise disruption, reduce risk and ensure business continuity.

Throughout the recruitment of the organisational leadership there was a strong focus on consistency in both the design of structures, roles and pay, and also in the approach to the process of managing change and recruitment. This ensured transparency and equity of access for all individuals. The process was overseen by the Group Executive Director Team.

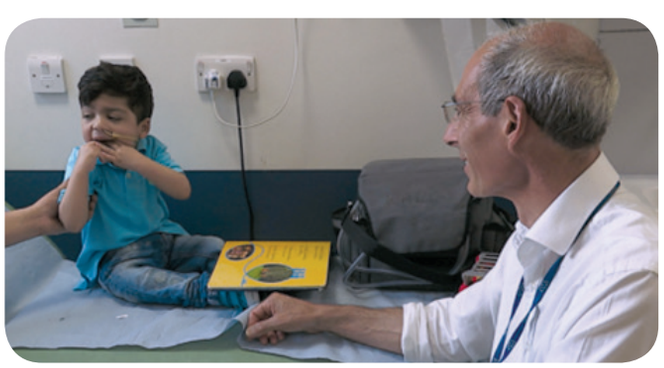
"We made a conscious decision to maintain a clear focus on continuing to deliver stable services during Year 1, while also starting the work required to integrate our hospitals and community services. I'm so proud of what we have achieved so far. Now we will build on this, sharing our many strengths to deliver consistent, high quality care for all."

Sir Michael Deegan CBE, Group Chief Executive

In addition to the establishment of the Hospital and Managed Clinical Service leadership teams, the leadership of the three standalone Clinical Standards Groups was appointed to during March 2018.

The Clinical Standards Group leads are medically-qualified consultants who provide clinical leadership and expertise to oversee a set of clinical standards. For example, the Surgery Clinical Standards Group Lead sets standards relating to Adult Surgery including General Surgery, Oral and Maxillofacial Surgery, Otolaryngology, Burns and Plastics, Trauma and Orthopaedics, Urology and Vascular Surgery; but excluding Cardiothoracic and Heart/Lung Transplant Surgery (which would fall under the Heart and Lung CSG), and excluding Paediatric Surgical specialties (whose standards will be monitored and developed by the RMCH Managed Clinical Service).

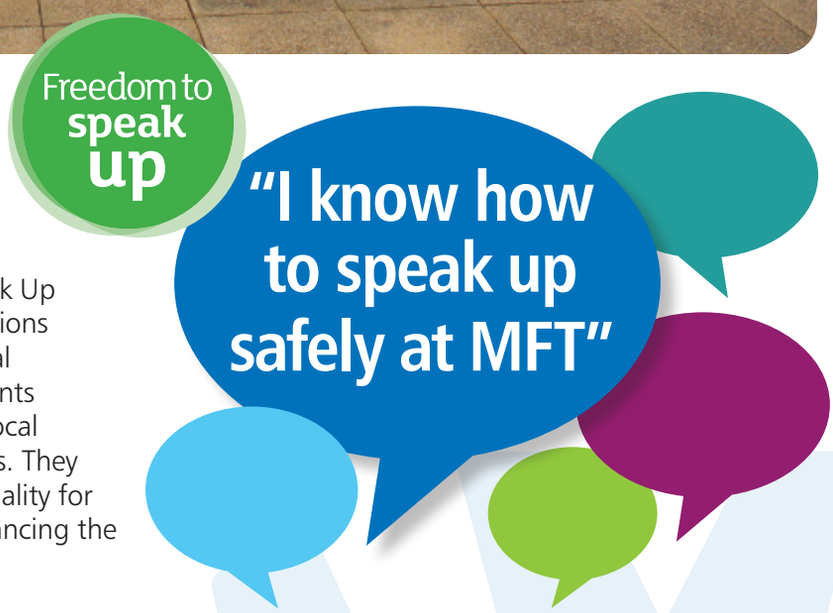
In undertaking their roles the Clinical Standards Group Leads are expected to foster high levels of clinical involvement and joint working, underpinned by a culture of integrity to reach the best outcomes for patients.



Freedom to Speak Up Guardian and Champions

The Trust also appointed a Freedom to Speak Up Guardian and Freedom to Speak Up Champions across all hospital sites and Managed Clinical Services to support staff, students and patients to raise concerns. The Champions act as a local resource to support staff who raise concerns. They work continuously to improve safety and quality for patients, carers and families, as well as enhancing the work experience for staff.

MFT Freedom to Speak Up Guardian David Cain



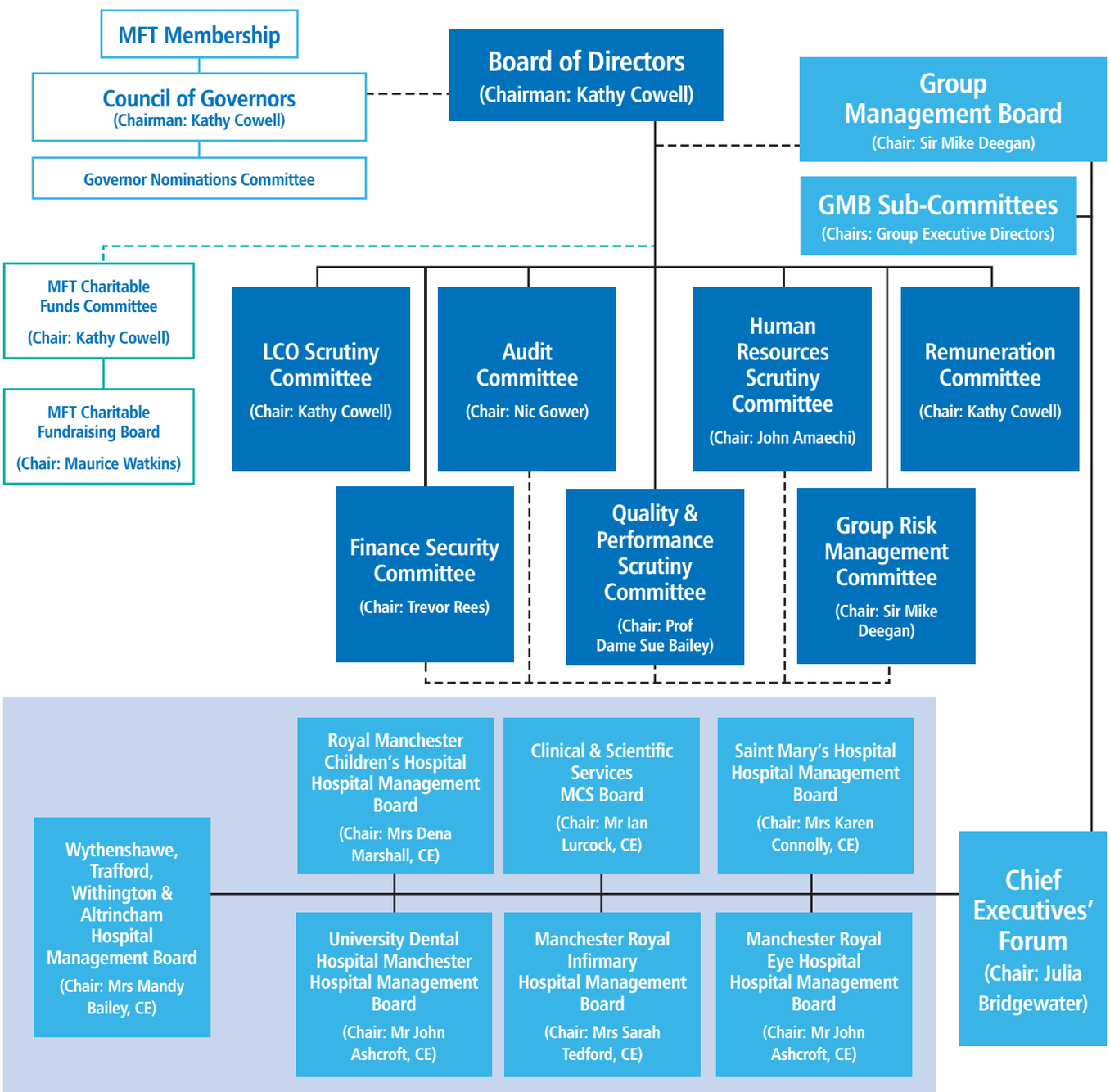
5 Establishing Robust Governance and Assurance Arrangements

As a new NHS Foundation Trust, MFT needed to establish its Board Sub-Committee structure and a new design of Executive Director oversight and leadership appropriate to its constitution as a Group. The governance structure and assurance arrangements to support the Board of Directors have been established over the course of the Trust's first year.

Board Sub-Committees

Board Sub-Committees chaired by the Non-Executive Directors and the Group Chief Executive were established in October 2017, providing oversight of the full breadth of MFT's clinical and non-clinical activities. The Board Sub-Committee structure is illustrated in Figure 5.

Figure 5: Board Sub-Committee Structure



Accountability Oversight Framework

The Accountability Oversight Framework (AOF) underpins how the Hospitals and Managed Clinical Services function and interact with the Group Executive Directors. The AOF contributes to the overarching Board Governance Framework. The key purposes of the AOF are to:

- Provide a fair and transparent means of understanding performance across the Group;
- Identify areas of good and poor performance; and
- Enable Group Executives to direct Group resources to support improvement in areas of greatest need.

The AOF records monthly performance across a wide range of metrics. This provides visibility to the Group Executives on performance trends, providing early warning signs where performance is off track. Focussed discussions are held with Hospitals and Managed Clinical Services to agree remedial actions.

Single Operating Model

Each Hospital and Managed Clinical Service leadership team is responsible for establishing effective governance and accountability to ensure successful operational delivery and achievement of the metrics set out in the AOF. To support this the Trust introduced a Single Operating Model.

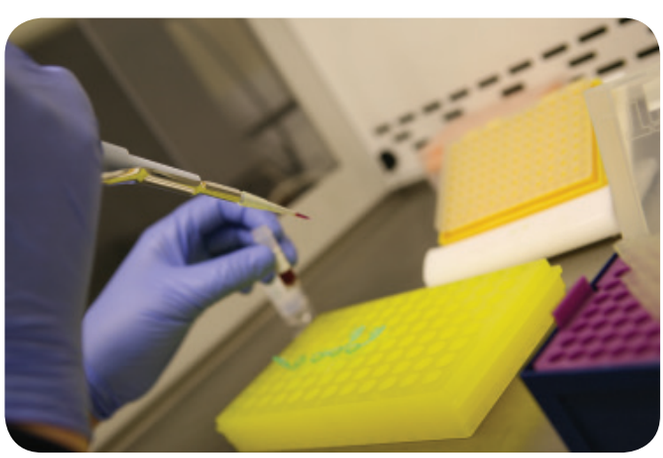
The Hospital and Managed Clinical Service Management Boards have established governance structures that mirror the corporate governance structure. The Management Boards are responsible for the oversight and delivery of performance. They are underpinned by a number of sub-groups focussed on the day-to-day management of performance against key business areas. To gain assurance a performance review process is undertaken with individual service lines to ensure consistency from 'Ward to Board' with input from the Clinical Standards Groups, where appropriate.

Clinical Standards Groups

To ensure that the Clinical Standards Groups are embedded across the Trust, the Clinical Standards Group Leads and Managed Clinical Service Medical Directors are members of the Group Management Board, Clinical Advisory Committee and Quality & Safety Committee. They also share corporate responsibility for the implementation of agreed Board decisions.

The Clinical Advisory Committee, chaired by the Group Joint Medical Directors, provides oversight and assurance of the Clinical Standards Groups' work programmes. This ensures that all hospital and Managed Clinical Service Chief Executives are sighted on their priorities and activities, and that any changes instigated are planned and delivered without unintended consequences on day-to-day operations.

The output of the Clinical Standards Groups is scrutinised by the Quality and Performance Scrutiny Committee and any risks identified are reported to the Group Risk Management Committee; both are sub-committees of the Group Board of Directors.



Hospital and Managed Clinical Service Reviews

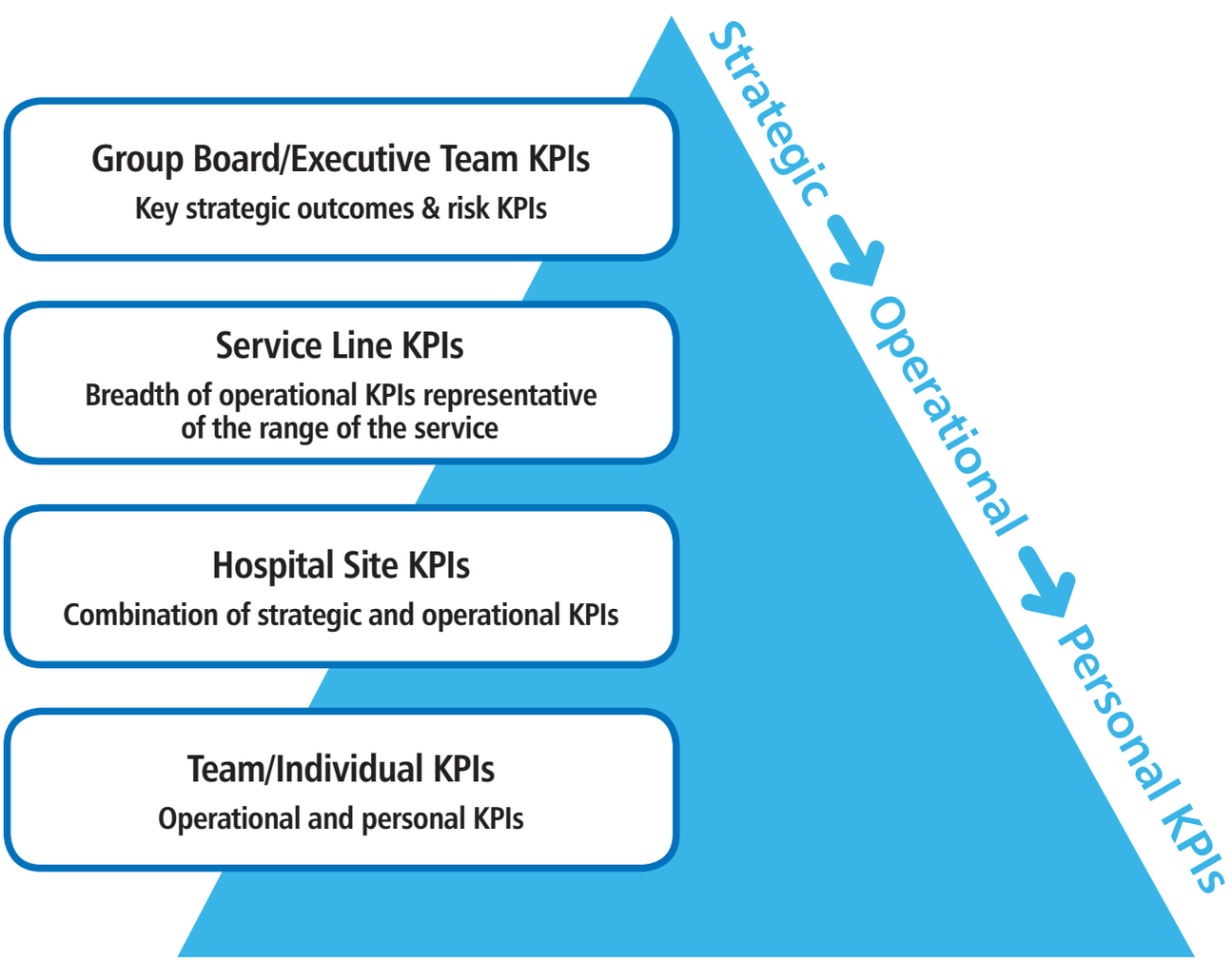
Each Hospital and Managed Clinical Service has regular reviews every six months, chaired by the Group Chief Executive. These reviews focus on the operational unit's strategic vision, and the key issues and challenges being faced in achieving this. They provide an opportunity for a broad and in-depth discussion about issues such as:

- Leadership and governance, including objectives, priorities and risks
- Strategy and business planning
- Quality, safety and patient experience
- Workforce
- Finance
- Communications and Engagement

Group Executive Directors' Appraisals and Mid-Year Reviews

The formal governance mechanisms and clear lines of accountability and assurance are underpinned by regular staff appraisals. Annual appraisals and mid-year reviews are used to set and review clear, measurable objectives for Group Executive Directors which are then cascaded through the organisation, ensuring that all staff have clarity of purpose and accountability. The connection between Group Executive Director and Executive Team objectives is illustrated in Figure 6.

Figure 6: Cascade of Group Executive Director Objectives



External Governance

The establishment of MFT is supported by funding from the Greater Manchester Transformation Fund. The funding was secured through a composite bid that encompassed the full spectrum of health and care transformation activities in the Manchester Locality Plan.

The overarching governance arrangement for this funding is through an Investment Agreement between the Greater Manchester Health and Social Care Partnership and the Manchester system. Within Manchester a more detailed Investment Agreement has been established to manage the partnership working arrangements and the flow of resources.

The Investment Agreement with the Greater Manchester Health and Social Care Partnership required the agreement of a set of high-level indicators to allow the progress and success of integration activities to be assessed. These indicators were agreed in early 2018 and include financial and non-financial metrics. Ongoing monitoring of these metrics is undertaken and they are reported to the Manchester Health and Care Commissioning performance team on a quarterly basis and then through to the Greater Manchester Health and Social Care Partnership. In addition to the reporting of metrics, MFT has met Manchester Health and Care Commissioning and the Greater Manchester Health and Social Care Partnership to provide a broader overview of the integration and transformation work being undertaken.

Each month the Greater Manchester Health and Social Care Partnership arranges a Performance and Delivery meeting to hold commissioners to account for delivery against the Greater Manchester transformation schemes and key performance metrics. MFT's Group Chief Operating Officer is one of the two provider representatives on this Board.

NHS I is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. They continue to hold MFT to account for delivery of the merger integration through their normal assurance processes.

Greater Manchester Health and Social Care Partnership

NHS Improvement

6 Developing MFT's Service Strategy

On the establishment of MFT, there was no overarching service strategy that provided a comprehensive overview of the Trust's services and how they would be developed in the future. The Trust's Strategy Team has therefore been working closely with clinical leaders and stakeholders to develop a full service strategy.

The Trust's strategy is being developed at two levels:

- **Group Service Strategy: Outlining MFT's long term vision for existing clinical areas, setting out potential new clinical areas to develop, and, outlining linkages across people, research, education and service strategies.**
- **Clinical Service Strategies: Service level plans covering configuration of services across the Hospital Sites, vision for how the service will operate and develop over the next 5-10 years, potential new service provision to develop and recommendations to address specific long standing issues.**

The work is supported by clinical leads and overseen by the Group Service Strategy Committee.

The Group Service Strategy has been developed internally through wide engagement across the Trust and externally with key stakeholders. Executive and Corporate Directors, Hospital leadership teams and Clinical Standards Group Leads have informed the starting position. It has been further developed through discussion with external stakeholders including commissioners, Health Innovation Manchester and those involved in the Greater Manchester transformation work. Wider engagement with the Trust's workforce, the Council of Governors and other key groups within the Trust has then further shaped its development.

The content of the Clinical Service Strategies is being developed by Clinical Working Groups, and, due to the scale of the work it has been split into three waves. Each Clinical Working Group includes a Clinical Lead, representatives from all of the constituent specialties, sub-specialties and co-dependent services and representatives from external organisations, principally commissioners and Local Care Organisations. Staff from across the organisation, including over 150 doctors, nurses and allied healthcare professionals, have been engaged in the process.

"The two Trusts that joined to form Manchester University NHS Foundation Trust had many excellent services. The merger has given us the opportunity to bring clinical teams together to develop service strategies that best serve the city of Manchester and beyond. In this way, the merger will continue to deliver benefits for many years to come. "

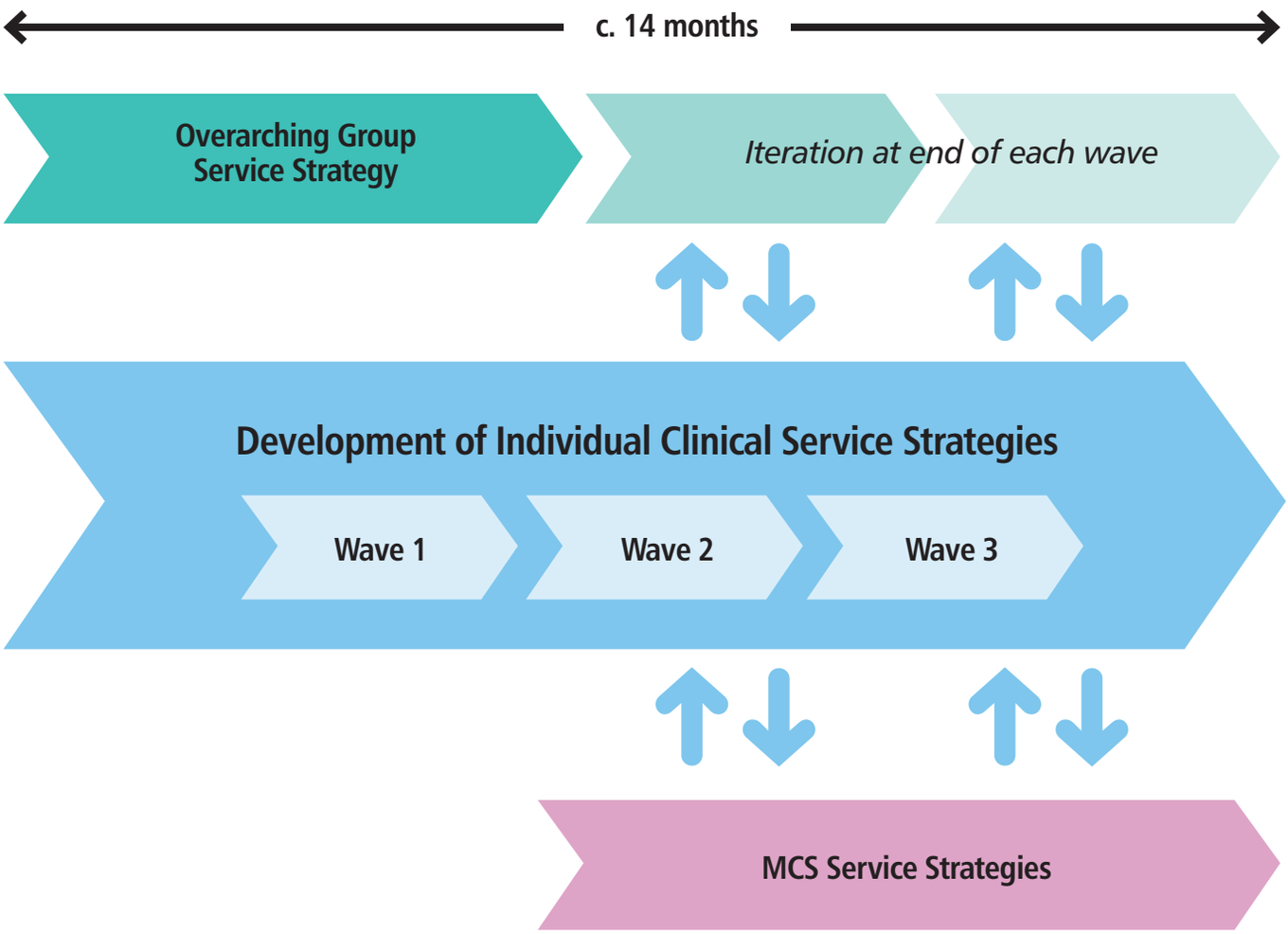
Darren Banks, Group Director of Strategy

The Strategy Team has ensured that the strategy development aligns with wider work in the health and social care economy. The aims of the Manchester Locality Plan and those of Trafford have been reflected in a set of principles that have been used to frame the work. Decisions that have already been taken, for example by NHS England or within Greater Manchester, have been considered 'fixed points' and Manchester and Trafford commissioners have been engaged on an on-going basis.

The Service Strategy work is also accounting for NMGH as a future member of the Trust. Each Clinical Lead has considered how their vision for the service would change if NMGH joined the Trust. This has been informed by meetings with groups of NMGH clinicians.

The development of the Service Strategy has proven to be a large and complex task and will take approximately fourteen months to complete (illustrated in Figure 7). Development will continue until April/May 2019 with drafts being iterated during this time.

Figure 7: MFT Service Strategy Development Process



Any significant service changes that are proposed will be taken to commissioners and the public for consultation. Once completed, the maintenance and development of the clinical service strategies will be the responsibility of the Clinical Standards Groups and Managed Clinical Services. Alignment across clinical service strategies as they develop will be maintained through the Group Service Strategy Committee which includes all three Clinical Standards Group leads and the Medical Directors and Chief Executives of the Hospitals and Managed Clinical Services.

7 Planning for Major Clinical Transformation

The primary driver for the establishment of MFT was the delivery of significant benefits for patients. These benefits were set out in the Sir Jonathan Michael Review and in documentation required prior to the merger, such as the Patient Benefits Case submitted to the CMA.

To support effective and timely delivery of these benefits, MFT's Transformation Team established an Operations and Transformation Steering Group. This Group leads the planning and delivery of the programme of clinical integration, including the twenty seven work streams representing the clinical services that have developed integration plans to deliver the patient benefits described in the Patient Benefits Case and the Full Business Case.

Prior to the merger, the Operations and Transformation Steering Group developed a high level project timeline, work stream integration plans and quality impact assessments. It also identified benefits and developed non-financial KPIs. The project plans were uploaded on to a programme monitoring system called Wave to enable regular highlight reporting and robust assurance of project delivery.

The integration projects and work streams differ in scale, scope and complexity and this was taken into account in the planning and delivery. Following the establishment of the new MFT operating model it was necessary to adapt the approach to integration to ensure it worked effectively.

The senior team responsible for the delivery of the integration portfolio mapped the work streams onto a matrix which assessed whether each work stream was strategic or tactical, and, complex or simple. This approach determined whether changes were led and delivered by the clinical directorates themselves, the Hospitals or Managed Clinical Services (with or without Group support) or whether the changes must be led by the Group (complex, strategic projects).

Where an integration work stream was classified as 'complex, strategic' a Programme Board was established. Meeting monthly, chaired by a Group Executive Director and attended by senior clinicians and managers from each site, the Programme Boards are the vehicles driving the integration work across these areas. Programme Boards are now in place for general surgery, urology, cardiac and trauma and orthopaedics.

The Transformation Team has supported the delivery of patient benefits across all of the integration areas. Opportunities for improvement have come from clinical teams from each site working together to understand each other's services. This has been enhanced through use of comparable information and national benchmarks such as 'Getting It Right First Time' and 'the Model Hospital'.

Although improvements for patients are already being delivered, a number of the major clinical benefits that were outlined during the merger process will be facilitated by structural changes that are being decided through the development of Clinical Service Strategies. An Integration Steering Group, chaired by the Director – Single Hospital Service, has maintained oversight of the two areas of work to ensure that any adverse impact of each area of work upon the other is mitigated as far as possible and that the delivery of patient benefits can progress as quickly as possible. Alongside this, both work streams acknowledge the operational pressures across the Trust and aim to ensure that any service plans seek to improve operational efficiency where possible.

Organisational Development tools and techniques have been used to support the teams going through the integration work. Prior to the merger both predecessor organisations engaged in, and collaborated on, a significant programme of work to build on the best of what both Trusts did, and to align and further develop the culture and capabilities of people to lead and manage change.

In November 2017 the Interim Board of Directors approved a Leadership and Culture Strategy for the newly formed Trust. The strategy describes the kind of leadership and culture MFT needs to further build and sustain high quality care and high performance. It is a key enabler for implementing the integration plans and outlines the guidance and plans for developing the cultural conditions needed for a compassionate, inclusive and continuously improving culture.

As part of this strategy there are three core organisation development interventions in place to support teams to successfully integrate:

High Performing Team Development

Team Leaders are supported by a coach and guided through the foundations of effective team working using an online tool called the 'Affina Team Journey' in order to increase effectiveness, improve the team's ability to manage change and continuously improve. The programme aims to embed positive structures, processes and interpersonal behaviours into team working. The programme includes nine stages of evidence-based assessment tools, with automated on-line reporting, and briefings for development activities, taking between 4-6 months for a team leader to implement. The Team Journey approach is being used for teams leading strategic and system challenges as part of integration and transformation, and bespoke Organisational Development support continues to be offered for teams without a defined team leader or with complex issues.

Leadership Development

To successfully implement the Group model and integration, MFT leadership must have the right balance of technical knowledge, skills and backgrounds and be appropriately qualified to discharge their roles effectively. This includes setting strategy, monitoring and managing performance and nurturing continuous quality improvement.

Leaders must also demonstrate a commitment to our values, building positive relationships and trust at all levels, and have opportunities to access a range of leadership and management development opportunities.

Leadership programmes to support those managing change have been refreshed and further developed, including the continued delivery of a Newly Appointed Consultant programme and a new Clinical Leadership Programme. The latter is aimed at experienced Consultants leading key Clinical areas. The programmes support participants to deliver a change or transformation project or team development work during the ten month programme.

In addition, bespoke development has been delivered for the Group Board, Governors and Hospital and Managed Clinical Service leadership teams.

MFT Ward Accreditation Assessment winners

Improvement Skills

Staff at all levels of the organisation have access to a range of development programmes aimed at accelerating change and developing a culture of continuous improvement. With programmes available at Foundation, Champion, Practitioner and Expert levels, the Organisational Development and Transformation programmes aim to build confidence and capability to deliver change across the organisation and target areas that are leading integration and key enabling change programmes such as the development of an Electronic Patient Record Services. Teams have had the opportunity to learn from each other where one site is doing something well or in an innovative way or to collaborate and pool resources to provide more responsive care.

8 Delivering Benefits in Year One Post-Merger

The Single Hospital Service review identified a range of high level benefits that would be delivered from the creation of a Single Hospital Service for the City of Manchester (see Table 1). During the Trust's first year, clinical and corporate teams have started to implement changes to processes and services with the aim of delivering the best care possible for patients. The benefits realised so far have been categorised under the key themes identified in the review. Many of the benefits envisaged by Sir Jonathan Michael will be delivered over an extended timeframe and long term plans are in place to ensure that these programmes of work will be realised.

Quality of Care

Quality is defined as having three dimensions: safety, clinical effectiveness and patient experience. These must be present to provide a high quality service.

The Trust's Quality and Safety Strategy 2018-2021 was agreed by the Group Board of Directors in July 2018 and sets out a commitment to provide quality of care that matters to patients and their families as well as caring for the wellbeing of staff. As teams start to work together the Trust has been able to capitalise on the sharing of experience and knowledge allowing new and different ways of working. Early examples of improvements to reduce variation across hospitals, enhance clinical effectiveness and strengthen services are starting to become a reality. This includes opportunities for sharing specialist equipment and technologies and ensuring patients have access to the most appropriate clinicians for their care. The Transformation Strategy was approved by the Interim Board pre-merger to enable the delivery of patient benefits to start immediately.

Lithotripsy Service

Patients needing kidney stone removal wait no longer than 4 weeks. Before the merger, some patients waited 6 weeks or more.

Patients in need of Kidney stone removal now have quicker access to non-invasive lithotripsy treatment following the introduction of a combined lithotripsy service between the MRI and Wythenshawe Hospital. Lithotripsy uses ultrasound to shatter kidney stones, avoiding the need for potentially more invasive treatments. Following the merger, MRI patients in need of kidney stone removal now have the choice of elective treatment at Wythenshawe Hospital if an earlier appointment becomes available or the location is more convenient. For many patients this means faster and more convenient care and reduced waiting times. It also ensures that the Lithotripsy service at Wythenshawe is better utilised.

Imaging

Since the merger, Imaging and Nuclear Medicine colleagues across sites are working together to combine protocols and procedures to ensure consistent standards are being met across all areas of work. An accountability and oversight framework has been introduced to manage turnaround times for scan reports across hospitals, reducing the time that patients are waiting to receive their results. Plans are now being developed to offer patients' access to scans at a different site if one hospital has reached capacity or if this is closer to their home or workplace. A shared on-call rota to deliver increased staff coverage throughout the week is also being put into place. The service is also working towards Imaging Services Accreditation Standard (ISAS).

"When a hospital gains this accreditation, patients can be assured of a first class imaging service and staff benefit from working in a service that meets the gold standard."

Catherine Walsh, Divisional Director of Imaging

Patient Experience

Providing high quality, safe and compassionate care to patients and their families is the heart of what we do every day. Patient experience means putting the patient at the heart of everything, delivering timely access to services, and offering treatment and care that is compassionate, dignified and respectful wherever it is provided.

Improving the experience for patients, carers and their families is one of the Trust's strategic aims. This will be delivered by enhancing access to services, providing patient choice and ensuring a consistency in the quality and delivery of care across hospitals. One of the first service improvements aimed at reducing variation and improving access and choice for patients involved the Trust's Urgent Gynaecology Surgery service.

Urgent Gynaecology Surgery

Women who need surgery after a miscarriage are getting faster treatment in less than 2.5 days on average instead of 4 before the merger.

An additional dedicated urgent gynaecological list has been introduced at Wythenshawe Hospital as a result of the merger to create MFT. Before the merger patients who needed surgery for an urgent gynaecological condition were added to a general theatre list with the possibility that their operation could be delayed due to emergency cases. Women initially treated at Wythenshawe can now choose to join the surgical list at St Mary's and women treated at St Mary's have the choice of going to Wythenshawe to have their pre-op appointment and surgery. This will ensure that surgery is not delayed; there is a reduced risk of any condition worsening and quicker and more convenient treatment for patients. This has been made possible by dedicated teams at both sites working together to reorganise surgical waiting lists, allowing access to quicker and more convenient care for patients.

"By introducing a dedicated list at Wythenshawe, we have been able to offer greater choice for patients and reduce the chance of surgery being posponded. I'm proud that our teams have worked together across sites to introduce this extra list as they know it will be better for our patients."

Mr Theo Manias, Consultant Obstetrician and Gynaecologist at Wythenshawe Hospital

Fractured Neck of Femur Service

An improved rehabilitation pathway has been developed by Therapy and Nursing teams for Trafford residents following the recent merger. Patients receiving Fractured Neck of Femur surgery at Wythenshawe hospital sites, who meet set criteria, are now able to be transferred to Trafford General Hospital to receive rehabilitation as well as the medical care they need. Patients can recover in a specialist environment closer to home and this enables better outcomes, shorter lengths of stay in hospital and improved patient experience. Staff are able to prioritise patients and provide personalised care. The teams are continuing to work together to review the pathway with the aim of increasing the number of patients accessing the rehabilitation service at Trafford General Hospital. This pathway change was an early product of the merger.

Workforce

Securing the workforce required to deliver high quality services remains an ongoing challenge across the NHS and there continues to be a focus on reducing reliance of locum and agency staff. The retention of the Trust's hard working and skilled employees, and the attraction of new employees, is vital to ensure the delivery of excellent patient-focussed quality care across the new organisation. The merger presents significant opportunities for the recruitment and retention of a range of staff including medical, nursing and specialist clinical staff, and is a key focus for the new organisation. The creation of MFT enables revised patient pathways to be developed leading to:

- The creation of new roles.
- The integration of teams.
- The ability to provide enhanced cover out of hours.
- The creation of single integrated staff rotas.
- The opportunity for staff to sub-specialise.

"It is a real credit to our staff that they engaged so positively with the merger process at a time when for many their own future was uncertain. I'm extremely proud that our staff continued to put patients first during this time of change and are now working hard to realise the benefits of the merger for patients. Our staff are our greatest asset and we want to make MFT an even better place to work, with opportunities for people to develop to their full potential and become the best at what they do."

Margot Johnson, Group Director of Workforce and Organisational Development

"I am pleased to say the Trade Unions were encouraged at the outset to be involved with the merger plans. We had a group which met regularly and the Single Hospital Service Team worked with the Staff Side Committee to ensure we were involved and kept informed. During the first year of the organisation, I am very proud of the hard work our staff have accomplished during a period of change, which has been really exemplary."

Peggy Byrom, Legacy CMFT Staffside Chair

"We've worked hard on a partnership Management of Change document as a process to assist people to move through the change. This has irrefutably been a difficult, complex and sometimes anxiety invoking experience for staff. This being recognised, we have put in place supportive mechanisms within this process. Credit should go to everyone involved for pulling together to make this work and improve services for patients."

Kate Sobczak, Legacy UHSM Staffside Chair

Joint Recruitment Programme

Following the merger, MFT is currently leading a programme of work across all Manchester hospitals to develop a single attraction strategy for consultant medical staff that will support service development and integration plans. This is illustrated by the recent recruitment of eleven new Consultant Obstetricians and Gynaecologists who recently joined the Saint Mary's Hospital clinical team. These new posts will be based across Saint Mary's Hospital, Wythenshawe Hospital and North Manchester General Hospital. The posts were advertised jointly with North Manchester General Hospital to support recruitment issues. The eleven consultant posts will enable some specialist services to be extended across all three hospitals, ensuring equity of access to these services for women across Manchester; providing specialist care 'closer to home' and streamlining the referral pathways. The recruitment programme is now being extended to other roles and services across MFT.

"Candidates were attracted by the breath of roles available, the professional development opportunities on offer at such a large Trust, and our popular Consultant Development Programme."

Dr Sarah Vause, Medical Director, St Marys Hospital

Supporting Staff – Employee Assistance Programme

In order to retain the Trust's dedicated staff, it is vital for them to feel supported in every area of their lives. Following the creation of MFT, a 24/7 assistance programme has been rolled out across all nine hospitals, offering support with any issues MFT's employees are facing. Services were developed to provide staff with improved and enhanced support for work related or personal issues following a review of employee health and wellbeing services that took place prior to the creation of the new Trust. The Employee Assistance Programme (EAP) is available to everyone and offers a 24-hour support service that includes confidential advice, counselling services and access to an online information portal. There has been positive feedback throughout the Trust with staff actively seeking support for a wide range of personal and work related issues during the first year of operation. These issues include family problems, financial information, personal health and bereavement.

"Staff members who have used the confidential service have found it really helpful. Knowing that my staff can get immediate advice and support is a real comfort to me as a manager."

Michelle Hampson, Clinical Coordinator, Manchester Centre for Genomic Medicine

Financial and Operational Efficiency

The national focus on improving efficiency and productivity across the NHS requires taking local action to deliver financial and operational efficiency and this remains a priority for all NHS organisations. MFT continues to work hard to deliver savings through the delivery of a Cost Improvement Programme with the aim of improving efficiency, reducing waste and at the same time improving quality and safety. The formation of a new organisation provides an opportunity for increased focus for reducing unwarranted variations in every area of the hospital – reducing costs in supplies, reducing staff costs through a reduction in agency spend and by improving operational performance.

Integration Savings

Bringing together the two legacy Trusts has provided additional opportunities for efficiency benefits through the integration of clinical and corporate teams and services. In the first 12 months of operation, five focus areas have been identified based on the opportunity for financial savings from economies of scale and synergies and from using more efficient processes and working methods.

Clinical Support Service Integration schemes: The integration of Clinical Support Service across hospital sites, providing opportunities for combined contracts, cost reductions and service efficiencies. For example, work to change the Medical Equipment Service will deliver significant savings in 2018/19.

Pay harmonisation schemes: The harmonisation of pay and benefits structure for ensuring equitable remuneration and conditions across sites.

Corporate savings: The integration of the Corporate Services division including the review of team structures and removal of service duplication will deliver a 5% cost reduction on a recurrent basis.

Pharmacy Carter Plans: Cost savings identified through medicine management; reducing the cost of medicines, electronic prescribing and improved administration as identified in Lord Carter Review.

Workforce transformation: Working with third party suppliers to reduce agency and locum costs; improving the efficiency of internal systems and processes; on-going work across sites with rota harmonisation and cross site working.

The merger also provides an opportunity for a more cohesive approach to the procurement process. The joint procurement of services across hospital sites are reducing costs and increasing value for money through better negotiation power and identification of single suppliers. As an example, the Trauma and Orthopaedic Programme Board has reported significant savings from joint procurement projects across a number of sub-specialities. Forecast cost savings have already been agreed during the first year of operation across the Trauma and Orthopaedic service amounting to approximately £200,000.

Informatics Systems and Processes

Since the merger and establishment of MFT, work has commenced to improve quality and efficiency in the hospitals through the establishment of coordinated Informatics systems and processes and the use of digital technology to reduce variation across hospital sites. The informatics team at MFT has implemented a number of systems to create a suite of tools enabling teams to work collaboratively across sites, assist with clinical decision-making and improve operational efficiencies. Examples include:

- The Hive, providing web-based access to operational reports with its repository underpinned by the new MFT data warehouse.
- Lync, a set of desktop tools including WiFi access, video calling service, and instant messaging supporting cross-site collaboration, remote working and reduced travel time between hospital sites.
- A single transition network, enabling corporate and clinical services to run efficiently and safety since the establishment of MFT.

The Informatics Team have also concluded a review of the EPR Systems that are currently in use across the new Trust. It was important to agree early the way forward for the future EPR. In January 2018, it was approved that the new Trust would procure an EPR / PAS through an open Procurement process.

"This is an exciting time as we help the trust realise the clinical benefits identified as part of becoming a Single Hospital Service by harmonising clinical systems across the new organistion. The EPR decision was a significant step forward on our digital journey which will support us achieving the vision of becoming "A world class academic teaching organisation."

Alison Dailly, Group Chief Informatics Officer

Medical Workforce Improvements

One of the workforce benefits highlighted by the recent merger was an opportunity to reduce reliance on agency and locum staff. Since the merger, MFT has committed to reduce expenditure on this element of the workforce budget, not only to save the Trust money but also to improve the opportunities for employees. Two new systems have been implemented that are improving the way the Trust manages its agency spend:

TempRE: An online system providing locums with an online user friendly system covering all elements of their assignments and a centralised repository of contracts, payslips and timesheets. The system allows medical workforce to liaise with locums directly, reducing spend on agency fees.

Medic online: An e-rostering phone app is helping Junior Doctors and Consultants at Wythenshawe Hospital to manage shift cover and annual leave more easily. The system allows potential gaps in shifts to be identified and managed. As a result of the merger this system is being rolled out across all MFT hospital sites, supporting a better work-life balance for Junior Doctors and Consultants and improved recruitment and retention across the Trust.

"Making sure we have enough doctors to cover rotas through the week can be challenging and time consuming. The app means managers and rota coordinators can see potential gaps and book agency staff in advance meaning a more competitive rate, knowledge of shift coverage and the delivery of patient care."

Christine Tudor, Medical Staffing Manager

Research and Innovation

Research and Innovation allows MFT to improve the health and quality of life of patients. By combining the research and clinical strengths of the legacy Trust's, MFT will be able to develop and evaluate new treatments and technologies to achieve this ambition. Research and innovation programmes influence advances in medical care on regional, national and international levels, working collaboratively with academic partners and industry to deliver the next generation of treatments and technologies.

The merger to create MFT provides a number of exciting opportunities:

- Improved access to research, leading to better participant recruitment and improved patient outcomes;
- Accelerated adoption of research and innovation into routine clinical practice;
- A driver to leverage additional research income; and
- A more effective and efficient service for companies wanting to trial new tests, medicines and devices.

The opportunities for expanding and improving research and utilising innovation are starting to be realised as a direct response to the formation of MFT.

Life Sciences Industrial Strategy

The Government's Life Sciences Industrial Strategy brings the NHS together with government and industry to create new jobs and economic growth across the UK as well as aiming to improve care for patients.

Citylabs and Medipark, joint ventures between industry and the legacy organisations, provided an opportunity for health and medical technology business to grow and co-create new health products in collaboration with the NHS and academia. The creation of MFT has enabled these ventures to come together creating a ground breaking community of industry, clinicians and academic partners to nurture commercial success and provide new products and services for patients. It is attracting major international biotech companies to locate at the Oxford Road campus, creating a world-leading 'precision medicine campus'.

The integration of Medipark and Citylabs ensures that investment into future developments is supported by strong business demand, creating compelling and sustainable economic opportunities, and a more efficient and effective service for companies wanting to trial new tests, medicines and devices.

"The scale of the new organisation, our links to local universities, and the potential to improve the health of the populations that we serve, creates a unique opportunity. As the largest Trust in the UK, we now have huge potential to dramatically increase the amount of funding we introduce into the system for research and innovation to improve the health of patients across Manchester, Greater Manchester and the North West."

Professor Bob Pearson, Former Joint Medical Director MFT, Strategic Clinical Adviser on Academic Health Science, Honorary MAHSC Clinical Professor, University of Manchester

Single Unified Approach to Research Studies

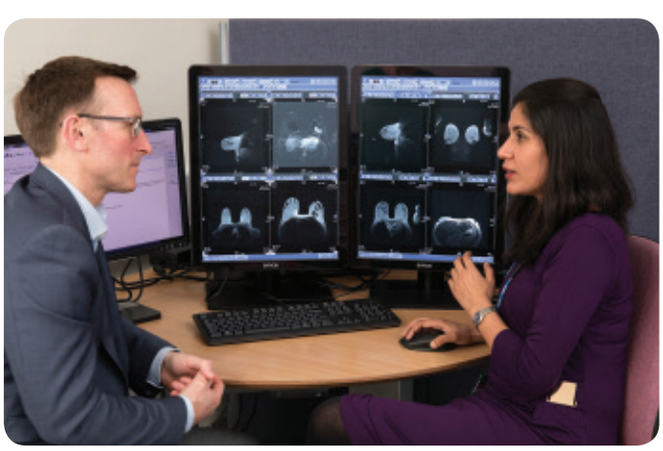
The Research and Innovation Division is creating a single unified process for the set-up of new research studies and trials across the organisation. The first part of this process was to adopt R-Peak as a common research project management system. This has played a vital role in streamlining and unifying the management of research studies across the various research centres within the Trust. Information is securely held on a central server allowing better communication and reduced duplication and ensuring that data is input, captured and coded in the same way. This has dramatically improved performance reporting to NIHR, the NHS research governing body. During Q4 2017/18, MFT initiated 94.9% of all studies to time and target, a dramatic increase from the legacy Trusts.

Intensive Care Unit (ICU) Research Trial

Patients participating in clinical trials are starting to benefit from sharing resources across sites following the creation of MFT. In one example, a patient was recruited to a complex ICU trial at MRI, assessing the use of a respiratory dialysis machine to remove partial CO_2 whilst on a ventilator. Due to the nature of ICU, there are often multiple patients recruited to a research study that require a new dialysis kit for each patient and this is not always available if multiple patients are recruited at the same time. Working together, the MRI and Wythenshawe ICU research teams and sponsor of the study looked into how they could share kit and transport across sites. This meant the patient had access to the latest treatment pathway as soon as possible and the study did not encounter any delay.

"This process was made much easier because of the merger, which has enhanced our relationship with Wythenshawe. The patient was subsequently transferred to Wythenshawe for long term ventilation needs, where colleagues were able to continue to collect data and obtain the patient's regained capacity consent, ensuring safety and high quality data."

Richard Clarke, Senior Clinical Research Nurse



Education and Training

Education and training are regarded as an essential part of the NHS not only to deliver excellence but to ensure that the NHS is responsive to changes in patient needs across healthcare. The Trust's vision is to widen access and exposure to education and training for staff and students, with the aim of delivering high quality care for all patients. The formation of MFT has provided an opportunity to improve career development opportunities, offer a choice of work locations and provide rotations to gain skills and experience thereby promoting a positive staff experience.

Educators' Development Programme

Traditionally, a number of courses had been developed to support educators within medical education by the education teams at the Wythenshawe and Oxford road sites. An educator's conference had also been developed on the Oxford Road site.

Following the merger, irrespective of location within the Trust, medical staff are now able to access an increasing number of educational sessions at either site, offering a greater choice of sessions. Regular updates are issued as new courses become available.

Neonatal Rotation Initiative

As a result of the merger a neonatal nursing rotation initiative has been established, giving nursing staffing from Wythenshawe Hospital and St Mary's Hospital an opportunity to work across the different services within MFT. The Neonatal service at the Oxford Road Campus is a level 3 service, looking after acutely ill and preterm babies that need the highest levels of intensive care. Conditions are often life-threatening with babies requiring constant close monitoring and support. The unit at Wythenshawe Hospital is a level 2 service providing short term intensive care and high dependency care. The service has a community focus and excels in patient experience feedback. Following the merger, rotations between the newborn services provided at both hospitals were offered to staff. Offering rotations allows staff to experience different working environments and opportunities to advance their learning and training. Staff at Wythenshawe Hospital are able to increase intensive care skills and gain exposure

to surgical care. Staff from St Mary's are able to understand how other neonatal units function and increase their managerial skills.

"This initiative has increased opportunities and choices for staff, which in turn makes them feel valued. A joint competency package was developed to identify individual needs and ensure that staff realised what they wanted to achieve."

Kath Eaton, Lead Nurse for Newborn Services

Mary Seacole Programme

MFT has been approved as a host organisation for the Mary Seacole Programme following the merger. The Trust was selected due to its increased size, capacity and commitment to providing excellent health leadership development. The programme is designed for first-time leaders in healthcare or those aspiring to their first formal leadership role, and is developed and run by the NHS Leadership Academy. Being part of the programme enhances the reputation of the Trust a as place to train and work in Greater Manchester and offers employees access to a nationally recognised qualification. The programme is locally-tailored to offer training across all partnership organisations in Greater Manchester. 70 participants have completed the course since the merger with another 47 registered until December 2018.

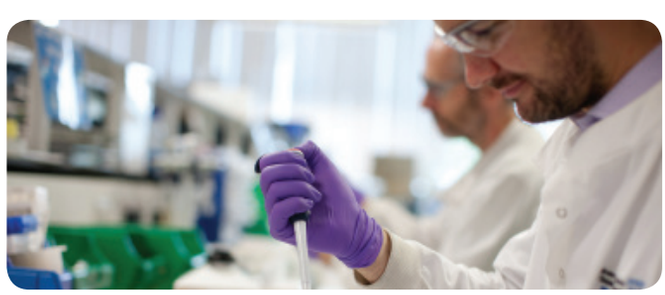
Libraries Service

Following the recent merger, MFT staff and students now have extended access to books, online journals and study areas. Access to online resources has expanded and new facilities have been provided at Trafford Hospital, the Oxford Road campus and Wythenshawe Hospital. This includes work pods with integrated device chargers, access to new PCs and new furniture to enhance the learning environment for students.

Emergent Benefits

There have been a number of emergent benefits that have also been realised as a result of the merger. These are benefits that were not identified in the original benefit plans for the merger, and have emerged during the design and implementation of new ways of working across the Trust. Opportunities for these types of benefits are continually being explored and demonstrate additional value to the creation of MFT. Early examples include:

- **Fellowship programme:** The combined Trauma and Orthopaedic service is leveraging its size and scope to create a fellowship programme.
- **MFT Frailty Standards:** A set of standards for the care of frail patients have been agreed that cross all MFT sites and services.
- **Shared capacity for trauma surgery:** At times of high demand for trauma surgery and longer waiting times at MRI, some patients have been transferred to Wythenshawe Hospital for their surgery.
- **Gynaecology Multi-Disciplinary Teams:** Cross site endometriosis and urogynaecology Multi-Disciplinary Teams have been established, improving patient access to specialists and increased capacity across MFT.
- **Gynaecology shared elective capacity:** Over 100 elective patients have chosen to transfer their care from St Mary's to Wythenshawe where they will be seen more quickly.
- **Fractured neck of femur improvements:** The implementation of a shared approach to fractured neck of femur governance has led to improvements in key metrics at Wythenshawe Hospital and MRI.
- **Urgent care recruitment:** A joint recruitment programme to fill specialist urgent care roles is being carried out across the Trust.
- **Microbiology centralisation:** The Microbiology lab will be centralised from Wythenshawe into a new, state of the art, facility at Oxford Road with associated benefits.



9 Lessons Learned

A number of important lessons have been learnt through the merger process and during the new Trust's first year of operation. It is important to appraise both the strengths and the challenges although, inevitably, it is more useful to reflect on areas where the process could be improved. Lessons learnt will continue to be used to inform programme decisions and to improve the arrangements put in place for any future transactions.

Areas of Strength

Some of the key strengths of how the merger was undertaken, and how the new Trust has operated in its first year are as follows:

Strategic issues

The Single Hospital Service Review and the reports produced by Sir Jonathan Michael provided a very firm strategic basis for the merger programme, with a clear vision that was widely understood and accepted. The key messages from the original review have been sustained throughout the process and are still relevant now.

The Single Hospital Service Programme arose out of the requirements of the Manchester Commissioners and the Manchester Locality Plan, but the overall approach is also completely consistent with the GM "Taking Charge" strategy, including the emphasis on collaborative working within and across health and social care systems. The merger (and the planned acquisition of NMGH) are creating an organisation which will be a more effective vehicle for delivering key aspects of the GM strategy, particularly in Themes 3 and 4.

Engagement and involvement

A significant amount of time and effort was expended on involving and engaging key constituencies in the process, most importantly the engagement with senior clinical staff throughout the two Trusts. In particular, clinicians with dedicated Clinical Lead roles were identified and a standing Clinical Advisory Group was put in place. These arrangements proved to be invaluable in the run in to the merger and the early period post-merger, and have been a strong influence on how the "business as usual" operation of the new organisation has been developed.

Importantly time was also committed to engaging with staff side. A local partnership forum was established specifically to engage with staff representative colleagues and Full Time Officers in a proactive way on Single Hospital Service matters. This forum took a partnership approach to agree processes in relation to consultation, management of change and integration, and development of terms and conditions for new starters from day one of MFT. These arrangements continued until December 2017 when the new Joint Negotiating and Consultative Committee was established.

The clarity of the strategic approach has also facilitated effective stakeholder engagement, and the new organisation has been fortunate to benefit from positive relationships with its main Commissioners and other partners throughout Greater Manchester. Detailed stakeholder mapping from the early stages of the programme was an essential part of optimising relationships, understanding, and support for the merger.

"The Chair and Chief Officer of Healthwatch Manchester were interviewed as part of the CMA review of the merger between CMFT and UHSM and we have maintained a constructive dialogue with the SHS leads from an early stage. The move to a Single Hospital Service is welcomed by Healthwatch Manchester. We are monitoring the impact of this initiative closely on local people with particular regard to those patients with protected characteristics."

Neil Walbran, Chief Officer, Healthwatch Manchester

The programme team included five clinical leads from UHSM and CMFT

Neil Davidson

SHS Clinical Lead Medical Consultant

Cardiologist/Deputy Medical Director, UHSM

Ngozi Edi-Osagi

SHS Clinical Lead Medical Consultant

Neonatalologist/Associate Medical Director, CMFT

Debra Armstrong

SHS Clinical Lead Nursing

Deputy Director of Nursing (Quality), CMFT

Caron Crumbleholme

SHS Clinical Lead Nursing

Head of Nursing (Scheduled Care), UHSM

Lesley Coates

SHS Clinical Lead AHP

Head of Nutrition and Dietetics, UHSM

Leadership and Organisational Development

The new organisation prioritised the establishment of experienced and effective senior leadership teams for each of the Hospitals and Managed Clinical Services. The new leadership teams included experienced individuals from the two predecessor organisations, along with key appointments of senior leaders from elsewhere.

The relationship between the Group management and the Hospital leadership teams was given very careful consideration prior to the transaction date, but it has continued to be a subject for active consideration throughout the first year of operation. In particular, the Accountability Oversight Framework (AOF) and the associated review processes have been evolved and iterated in this time, and it is likely that they will continue to be developed and refined. This is an entirely health process that is helping the Trust to ensure that the Group and each of its constituent elements can operate as effectively as possible.

There has been a clear and sustained emphasis on cultural work and organisational development. This commenced from the audits of organisational culture that were undertaken prior to the merger and has been maintained through the organisational change processes, the development of the new statement of behaviours and values, and other key OD activities. Cultural differences are known to be a key risk issue in organisational mergers, and the time and effort put into developing a positive approach has been beneficial.

Planning and review

NHS I now places much greater emphasis on PTIP in its assurance processes, and this perhaps creates a risk that PTIP will be seen simply as something that is required to negotiate an external process, rather than being of primary importance in managing the organisational merger. The two Trusts always took the development of the PTIP very seriously, and invested a lot of time and effort in developing multiple iterations, so that the document remains relevant and up to date. Three iterations were developed in the run in to the merger, and a fourth version following the first 100 days. The fifth iteration is being developed following completion of the first year of operation. Board members have been closely involved in the development of PTIP, and there have been regular progress reports at Board level throughout the merger process. This has meant that PTIP has continued to be the central function in guiding MFT's management of its integration agenda.

The merger process has been subject to a number of external audit processes, from the original Reporting Accountant Reports, through to follow-ups on PTIP and on how the new organisation performs against the Well Led framework. These processes have helped to maintain the standard of the integration work in the merger, from planning through to implementation, and although the audit outcomes have always been positive there has also been something to learn from each exercise.

Programme management and resourcing

In the process of preparing for the merger, the SHS programme team was set up to have a semi-independent role, working between the two merging Trusts. In particular, the SHS Director was clearly understood to be independent, and had sufficient seniority to join the Executive Team and Board meetings at both Trusts. This was of great benefit in fostering confidence in the two Trusts as to the fairness of the process, and allowed more rapid progress to be made.

The use of external support, for example from the major consultancies, was deliberately kept to an absolute minimum, and was focused on areas where specialist skills were required, rather than just additional capacity. This approach means that there is far better ownership, and buy-in to the integration process, and that continuity and organisational memory are maintained. In essence, the people involved in diagnosing the challenges and developing the integration plans are the same people who then take responsibility for implementation. This has been balanced with sufficient external due diligence and audit work to provide adequate assurance on the information being reported at Group Board-level.

The dedicated resourcing that the programme was able to access from the GM Transformation Fund to support the transaction process and the integration and transformation activities over the first twelve months of operation has been essential to the delivery of the planned benefits.

Areas for Improvement

Programme management

The programme management arrangements for the merger have generally been successful. The two Trusts were fortunate to be able to benefit from resourcing from the GM Transformation Funds, and this allowed for the establishment of a dedicated programme team, with a very experienced and independent senior leader. The team also able to second in key players from within the two Trusts, and this produced a positive blend of local knowledge, established relationships and balanced involvement. The governance processes operated by the programme team were also well organised and effective, as were the communication and engagement activities. The merged Trust has been able to keep together a programme team including many of the key individuals form the merger process, and this group is now managing the process to acquire North Manchester General Hospital. It is expected that the Trust will continue to be able to fund this function from GM Transformation Fund monies. If the Trust were to become involved in a further transaction after the completion of the Manchester Single Hospital Service programme, careful thought would need to be given to how to fund and establish a programme team with the relevant capacity and capabilities.

The scale and complexity of the programme made it inherently difficult to manage, and this was particularly true of the Post Transaction Integration Plan, where there were a very significant number of different activities that had to be monitored and managed, and a changing programme of work that was updated with each iteration of PTIP. To support the management of this process, the Trusts agreed to deploy a programme management tool (Wave). The functionality of Wave has proved to be very useful, and it is now used to support all of the new Trust's integration and transformation activities. There was a problem, however, with the initial implementation process. The need for a structured programme management tool was not recognised until the PTIP was quite well developed, and many of the Day One plans were being implemented. As such, the Single Hospital Service Programme Team and IM&T had to support the implementation of the package at a time when the planning and implementation agenda was already very busy, and sometimes plans that had already been recorded in other formats had to be re-keyed.

Wave has been used extensively and actively in managing the integration process, and over the long term, there is no doubt that it has been beneficial to have a structured programme management tool in place. However, it is likely that the benefits would have been greater, and the disadvantages reduced, if there had been an earlier realisation that a system of this sort would be required.

Working with external agencies

The merger process required the two Trusts to work in close collaboration with a number of external

Working with the Councils of Governors

The level of work required with the two Councils of Governors (CoGs) exceeded the original plans and expectations. The process started positively, but as the merger programme developed it became apparent that the interests and needs of the two CoGs were quite different i.e. "one size" did not fit all. There would have been a benefit in preparing a more detailed plan from an earlier stage, including more analysis and testing of the different requirements of the two groups.

At some points there was significant challenging back from the Governors and, while this is not a problem in itself, it did demonstrate that more preparation and support was needed. The intensity of the engagement with the CoGs was stepped-up in the middle of the process, in recognition of the scale of the task, and the fact that not all of the Governors were in the same place. Working closely with the two Board Secretaries was very beneficial, and it was helpful that the Programme Team had its own governance lead to facilitate these processes. The position reached with the CoGs at the end of the process was very positive, but more preparation at an earlier stage would have been advantageous.

"Governors were actively listened to and every effort was made to help us understand the formal transaction processes. The Single Hospital Team arranged independent legal advice so that we fully understood our role at the point a vote on the merger was taken."

Geraldine Thompson, MFT Lead Governor

agencies, but particularly the CMA and NHS I. Much of the interaction with the CMA was facilitated through the Economic Advisors (Aldwych Partners) and the Trust was fortunate to have such effective and expert support. The relationship and interactions with the CMA proved to be unproblematic throughout the process. The CMA's working arrangements were clear and easy to understand, and the CMA team seemed to be highly responsive, and gave meaningful feedback in a timely manner. As such, although there was no pre-existing relationship, the Trusts quickly developed a high degree of confidence that the CMA team would operate effectively and efficiently in line with their guidance.

Engagement with NHS I proved to be more problematic. Throughout the merger process, the NHS I Transaction Guidance was in a state of flux, with revisions to the guidance repeatedly being promised, but not delivered. The role of the competition team was not always as clear as it could have been. The process for critiquing the Patient Benefits Case was slow and cumbersome. The issues raised by the competition team did not always seem well informed, and there were often lengthy delays in getting responses.

The two Trusts invested a significant amount of time and energy in managing relationships with external agencies, and this proved to be essential in making sure the merger progressed on the planned timescale.

Working in a novel transaction environment

The transaction was a true merger between two existing acute Foundation Trusts. There had only been one previous merger in the NHS, with all the other transactions being acquisitions, so the two Trusts

were exploring new territory in pursuing a merger. The significant additional challenge that comes with a merger is that both of the predecessor organisations cease to exist, and so there is no constitution, senior leadership, governance arrangements or operational processes that can automatically be carried forward to the new organisation.

To address this situation, the two Trusts had to agree ways to work collaboratively in the run in to the merger, including the creation of the Interim Board, and the integration plans had to set some very rapid timescales for putting in place the new governance arrangements. There also had to be some careful judgements made about how legacy operational process could be maintained until such time as new integrated arrangements could be implemented.

All of the experience of the transaction and the first year of operation indicates that a merger was the only way to create an effective new organisation: the merged Trust is significantly different in size, scope and culture from either of its predecessor, and entirely governance arrangements and organisational structure would always have been necessary to make it function properly.

Further transactions that the Trust may be involved in are likely to be acquisitions rather than mergers, so the risk of encountering this problem again is limited. Having said that, the learning from this experience is that:

- Mergers are intrinsically more complex than acquisitions, requiring expert legal and economic advice.
- Undertaking novel processes inevitably takes more time, effort and care than following a "well-trodden path".
- The right transaction mechanism is the one that produces the right sort of post-transaction organisation.
- The engagement of Governors is critical to the smooth management of a merger of two NHS Foundation Trusts.

Describing merger benefits

The process that the two Trusts went through to deliver the merger included extended and detailed engagement with the CMA. To ensure clearance from the CMA to proceed with the merger, there was a requirement to develop a Patient Benefits Case, and this attempted to quantify what the CMA would recognise as "Relevant Customer Benefits" (RCBs). In large part, NHS I accepted that it could depend on the CMA's assessment of patient benefits, so the Patient Benefit Case became the principal description of the merger benefits, and a lot of time and resource was put into evidencing these benefits robustly.

In many ways, this was beneficial, in that it ensured that a high priority was attached to patient benefits, and some of these were described in considerable detail. However, there may have been an effect whereby the focus on this benefit area was at the expense of detailed work on other areas, such as finance. It was always recognised that there would be financial benefits associated with the merger. These were not deemed to involve the delivery of productivity improvements beyond the scope of what the two Trusts would have been seeking to achieve absent the merger, but it was argued that the merged organisation would have greater confidence about delivering the productivity improvement objectives determined through the normal NHS processes, for example, tariff deflation, particularly over the longer term.

The fact that there was less emphasis on describing the detail of financial benefits in the pre-merger phase has meant that in tracking the delivery of integration plans in the first year of operation it has been difficult to link these back to business as usual financial planning processes.

Strategy development

The predecessor organisations had strategic intentions of one sort or another that predated the merger, but during the period running up to the merger it was no longer appropriate to update or develop these. It was always clear that, when the new organisation commenced operation, there would be some elements of strategic thinking that could be continued from the previous organisations. Similarly, there would be some themes that arose out of the objectives of merger itself, for example, developing single services, minimising variation, and learning from the best services in the Trust. However, there was also an explicit understanding that there would be a need to develop a comprehensive new strategy for the new organisation, and this has been a consistent feature in all of the iterations of PTIP.

The initial intention was that the new strategy should be developed by March 2018 i.e. within six months of the creation of MFT, but in practice the process has

taken longer to deliver. Prior to the commencement of the Service Strategy Programme it was determined that:

- the strategy development work should be focused on a long-term time frame i.e. five to ten years
- in order to expedite the delivery of the quality and financial benefits the strategy development work should be supported by specialist external resources which involved a procurement process to identify and secure the correct support
- the scope of the strategy development work was too extensive to undertake it as one exercise, and so it was broken down into three "waves", with some services being considered earlier and others later.

In combination, these effects have meant that the timeframe for the completion of the new strategy will be circa 12 months following commencement in May 2018. Work to realise the merger benefits has continued to be progressed through the Trust's Transformation Programme, and those services where reconfiguration was likely to be required were planned in to the early waves of the strategy programme. For services where a major reconfiguration is envisaged, the strategic planning process may be followed by a lengthy implementation timescale, and this may mean that some merger benefits take longer to deliver than would originally have been expected.

It was recognised that the service strategy should, as far as possible, take account of the incorporation of North Manchester General in to MFT. This is being achieved by asking the clinical leads to consider scenarios with and without NMGH for any significant service change. It must be recognised that this has introduced further uncertainty into the process.

Any further transactions that the Trust is involved in are unlikely to require a wholesale redevelopment of strategic thinking on this scale, so the risks of encountering this problem again are limited. Having said that, the learning from this experience is as follows:

- to begin to consider how the long term strategy work can be effected at as early a stage as possible
- to give careful consideration to the lead time and resource requirements for an exercise of this scale and scope
- to identify any benefits that rely on the completion of the development of a long-term strategy at an early stage and plan accordingly.

This would minimise the risk of tensions between the pressure for rapid implementation of transformational change, and the need for all service change proposals to be developed in the context of a clear and comprehensive long-term strategy.

In Summary

Many elements of the merger programme have progressed well and, overall, the merger process has managed the key risks effectively, and has delivered the planned benefits for the first year of operation. However, there are always lessons to be learnt in major projects of this sort, and the issues identified above should be used to improve the arrangements put in place for any similar future exercise.

10 Conclusion

MFT was established as a new organisation on 1st October 2017. Since then significant work has been undertaken to transition and integrate the two predecessor organisations, slowly and carefully evolving the new organisation to one that has the right culture from the start, and that maintains a focus on patient safety, patient experience and high quality care.

The Trust intends to build one of the best healthcare systems in the world, underpinned by a clear understanding of the needs of the people it serves and a commitment to the skilled and dedicated people that work within it. Significant transformation will be carefully delivered over the coming years as MFT fully implements its developing service strategy and NMGH is integrated into the organisation.

The work undertaken to date, and future plans that have been made, have been achieved with the continued support of organisations in the City of Manchester and Greater Manchester, including the Greater Manchester Health and Social Care Partnership, Manchester City Council, Trafford Council and commissioners.

"I have been very impressed by our teams' enthusiasm and receptiveness to new ways of doing things during our first year as Manchester University NHS Foundation Trust – and would like to thank everyone for their contribution. I look forward to continuing to work with staff and partner organisations to further develop our world class staff and services to benefit patients."

Kathy Cowell OBE DL, Chairman

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Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 5 February 2019

Subject: Manchester Local Care Organisation

Report of: Michael McCourt, Chief Executive, Manchester Local Care Organisation

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Summary

Further to the establishment of the Manchester Local Care Organisation (MLCO) as a public sector partnership on April 1st 2018 through the agreement and signing of a Partnering Agreement, this paper provides Scrutiny Committee with a further update of progress made across core business areas of MLCO. Scrutiny Committee are advised that this paper builds on the update provided in October 2018.

The paper provides an overview of the following:

- MLCO Delivery Priorities in 2018/19;
- High Impact Primary Care;
- Integrated Neighbourhood Working;
- Manchester Community Response;
- Adult Social Care Improvement;
- Engagement;
- MRI priority; and
- MLCO Business Plan and Phase 2.

Recommendations

Scrutiny Committee are asked to note the contents of this report.

Wards Affected: All

Alignment to the Our Manchester Strategy Outcomes (if applicable):

Manchester Strategy outcomes	Summary of how this report aligns to the OMS
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	Support Manchester residents to improve their health and wellbeing so they can benefit more from jobs created in the city

A highly skilled city: world class and home grown talent sustaining the city's economic success	Improve health and wellbeing so Manchester residents are better able to access the skills and learning they need to find and sustain jobs. Improve career pathways in health and social care and support residents to access these opportunities.
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	Radically improve health outcomes and reduce health inequalities across the city. Integrate health and social care, and support people to make healthier choices, so that people have the right care at the right place at the right time.
A liveable and low carbon city: a destination of choice to live, visit, work	Better connect health and social care services to local people. Communities playing a stronger part in looking after residents in their neighbourhood, including those who are unwell, vulnerable, socially isolated and lonely.
A connected city: world class infrastructure and connectivity to drive growth	N/A

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Background documents (available for public inspection): None

1. Introduction

1.1 Further to the establishment of the Manchester Local Care Organisation (MLCO) as a public sector partnership on April 1st 2018 through the agreement and signing of a Partnering Agreement, this paper provides Scrutiny Committee with a further update of progress made across core business areas of MLCO. Scrutiny Committee are advised that this paper builds on the update provided in June 2018.

1.2 The paper provides an overview of the following:

- MLCO Delivery Priorities in 2018/19;
- High Impact Primary Care;
- Integrated Neighbourhood Working;
- Manchester Community Response;
- Adult Social Care Improvement;
- Engagement;
- MRI priority discharges and escalation; and
- MLCO Business Plan and Phase 2.

2. Background

2.1 A key priority of the Our Manchester Strategy is to radically improve health and care outcomes, through public services coming together in new ways to transform and integrate services. This involves putting people at the heart of these joined-up services, a greater focus on preventing illness, helping older people to stay independent for longer, and recognising the importance of work as a health outcome and health as a work outcome. The Locality Plan, "Our Healthier Manchester", represents the first five years of transformational change needed to deliver this vision.

2.2 Manchester has some of the poorest health outcomes in the country, and there are very significant health inequalities within the city. The Locality Plan was produced with the express intention of addressing these inequalities and to provide the framework through which the Manchester system aims to overcome the significant financial and capacity challenges facing health and social care in doing so.

2.3 The plan sets out the complex, ambitious set of reforms that are needed to integrate services for residents. This included developing a Local Care Organisation for integrating out-of-hospital care, a single hospital service for integrating in-hospital care, and a single commissioning function for health and social care.

2.4 Previous updates to Scrutiny Committee have noted that it would not be possible to establish MLCO as single legal entity owing to legal and financial issues, including implications for VAT costs to the Council, all of which are national constraints outside of the control of partners locally.

2.5 As Scrutiny Committee has been previously advised to maintain progress, in March 2018 each partner organisation of the MLCO: Manchester City Council

(MCC); Manchester University NHS Foundation Trust (MFT); Manchester Primary Care Partnership (MPCP); Greater Manchester Mental Health NHS Foundation Trust (GMMH); and, Manchester Clinical Commissioning Group (CCG part of MHCC) signed the Partnering Agreement which established the MLCO from 1st April 2018.

2.6 Scrutiny Committee are reminded that under arrangements of the Agreement existing health and social care contracts will remain with the current providers, however in scope services will be managed through MLCO.

2.7 Scrutiny Committee are further reminded that as part of the Partnering Agreement a specific schedule was included which outlines the Service Level Agreement (SLA) for MCC. The SLA confirms those functions and services that will be delivered through MLCO, and confirms those functions that will not be delegated into it. The Agreement also makes provision for those decisions which would not be delegated to MLCO, including decision making that would still reside with the Council (or officers of).

2.8 This update builds on reports brought for consideration by the Committee in June and October 2018.

3. MLCO Delivery Priorities in 2018/19

3.1 The delivery priorities for MLCO in 2018/19 were defined by its business plan which was approved by Partners at the MLCO Partnership Board in March 2018. The plan set out six key objectives for the organisation; three service objectives; and, three corporate objectives.

Service objectives:
1. Safe transition and a safe start
2. Improving lives through population health and primary care
3. Redesigning core services

Corporate objectives:
1. Financial sustainability
2. Organisational strategy for the MLCO
3. Preparing the MLCO for 19/20 and beyond

3.2 The activity of MLCO was further defined through joint work between MLCO and MHCC that identified what a range of key deliverables in relation to the business plan. The delivery of these has been overseen through MLCO's Programme Board.

3.3 Out of these deliverables four overarching service priorities were identified and this paper offers a detailed update in respect of:
- High Impact Primary Care
- Integrated Neighbourhood teams
- Manchester Community Response
- System resilience and escalation

4. High Impact Primary Care

4.1 High Impact Primary Care is one of MLCO's key new care models. It was established as a response to the small percentage of the Manchester population that are very vulnerable and have such complex health and social care needs that they find it difficult to navigate and access the standard services offered across General Practice, community nursing and social care. People who have multiple long term conditions that they are struggling to manage, together with mental health problems and / or other social issues sometimes end up using hospital based services, such as A&E, more frequently than expected as they find it difficult to keep themselves healthy, safe and well at home. The High Impact Primary Care (HIPC) service is currently targeting approximately 2% of Manchester's population who are thought to be the most vulnerable in terms of their health and care needs, and who we expect to benefit from a highly targeted proactive, flexible and integrated service.

4.2 The HIPC teams are clinically led by a GP, working alongside a nurse, social worker, support worker and pharmacist, managed operationally by a team manager and a service co-ordinator. Each team builds links with the local community and works in partnership with core primary care services, the integrated neighbourhood team, mental health services and other local voluntary services and community groups. The service offer is tailored to the goals and aspirations of each individual person, joining up care and support to best meet their needs. HIPC is based on international and local good practice. The evidence suggests this intensive and flexible approach will reduce hospital demands for this patient group and improve the lives of people living with complex health and care needs.

4.3 High Impact Primary Care is currently operating as three teams in three neighbourhoods in Manchester:

- Cheetham Hill and Crumpsall;
- Gorton and Levenshulme; and,
- Wythenshawe.

4.4 Each team has a shared office space where the team meet for daily huddles to review new patients and discuss urgent issues, and weekly full MDT meetings to conduct case reviews and patient care discussions.

4.5 Each team works with the local GP Practices to proactively case find people on the GP registers who are high users of acute care services. The Service Co-ordinators in each team have been granted access to each of the local GP EMIS and RAIDR (risk stratification) systems which means they can directly run searches for people who are at high risk or rising risk of hospital attendance and admission.

4.6 People identified through the searches are contacted with information about the HIPC Service and brought onto the caseload once consent is given for a referral.

4.7 Referrals can also be made directly into the HIPC Teams by GP practices and other community services. More recently work has started between the MLCO and the MRI to identify regular admitters from the hospital data which is being shared with the HIPC teams where identified patients are registered with local GP services.

4.8 Each person brought into the HIPC service will have an initial appointment of at least 30 minutes, although typically this can extend up to an hour for the most complex cases. A key worker is assigned as the lead contact for the person, and a holistic care plan is developed focussed on what is important and what matters to the person and their families / carer. Care co-ordination, proactive support and regular follow up is continued on at least a monthly basis until the person is able to sustain their health and wellbeing through usual primary care and community services support. Care and support will typically cover the full range of clinical, psychological and social care needs of an individual. All the teams have clinical space in which to see patients for appointments, and people are actively encouraged to come out to the service. Many people, however, require home visits due to their psychological and social difficulties although they would not be considered traditionally house bound.

4.9 The following summary of outcomes and benefits achieved to date is based on data collated by the MHCC Business Intelligence team in October 2018 when the HIPC patient case load was 379 people.

4.10 Patient activity in the 12 months prior to being referred to the HIPC service:

- 1681 A&E attendances, of which 896 were via NWAS call outs.
- 5138 bed days
- £2,660,000 cost to secondary care.

4.11 A like for like comparison for their time while with the HIPC service:

- 5.7% reduction in A&E attendances
- 25.6% reduction in bed days
- 4.5% reduction in cost.

4.12 In November the HIPC Service met the case load target of 463 which was set by commissioners. This is a significant achievement, considering the small team sizes, the continuing issue with staff vacancies and staff sickness absences.

4.13 The end of December target case load of 540 for HIPC has also been met. The expected impact of the Christmas holidays both in terms of staff leave and newly identified patients not engaging with the service at the end of the month, was offset by a significant number of new patients being brought into the service at the beginning of the month.

4.14 There is limited data available for patients discharged from the service with an average of 60 days activity available. This does show some promising results with a 65% reduction in activity and approximately 75% of patients having no emergency activity post discharge.

4.15 HIPC will be subject to a further interim investment review by the MHCC business case committee in February 2019 to determine if the development requirements have been met and to agree future commissioning plans.

4.16 Whilst these plans have not been finalised the MLCO Executive are committed to mainstreaming the HIPC service and embedding the approach across all neighbourhoods within the overall integrated care system, alongside Integrated Neighbourhood Teams and Manchester Community Response.

5. Integrated Neighbourhood Working

5.1 The principle of neighbourhood working is the foundation of MLCO delivery. The Committee have previously received updates in regards to progress to recruit 12 Integrated Neighbourhood Team (INT) leads and to mobilise 12 INT hubs.

5.2 Historically all community services (adult social care, and community health) have been largely commissioned and delivered on either a city-wide or locality level (across north, central and south); however, the Target Operating Model (TOM) for the INTs describes all services being delivered on a neighbourhood basis. Work has commenced to establish the TOM for the neighbourhoods describing revised service footprints and new operational and neighbourhood governance.

5.3 Therefore, the development of the TOM will be an iterative piece of work as the delivery of service footprints changes and because this work will take a significant amount of time and resource to achieve. As the TOM and MLCO develops in 2019 further services will move into the neighbourhood footprint but it should be noted that it is likely that ultimately some services will continue to be delivered on a city-wide or locality basis either for reasons of safety, quality or efficiency.

5.4 INTs were aligned with the ward areas of Manchester in 2017/18 (although recent changes to the ward boundaries have caused some discrepancies and there is an ongoing piece of work to align this). From 2019, each INT will provide adult community health and care services to the population within its geographical boundary and broadly speaking the population in each INT is between 30,000 and 50,000 people. All 89 GP practices are within one of the 12 Neighbourhood Teams, which are further grouped together as ‘localities’ of North, Central and South – four Neighbourhoods to each locality.

5.5 Further work is ongoing to align differing boundaries and this is part of the much broader public sector Bringing Services Together piece of work, which is aim to have all public bodies operating on complementary footprints.

INT Hubs

5.6 The hubs for the INTs across Manchester continue to be mobilised - this will ensure that staff from across health and social care are physically co-located.

5.7 To date estates and IMT work has been completed in seven of the hubs (Chorlton, Gorton District Office, Vallance Centre, Burnage, Moss Side Health Centre, Etrop Court and Withington Community Hospital) with health staff operating out of six of these.

5.8 Further progress has been made at the Cornerstones site with the IMT work being complete, tested and signed off by the local services. This is now expected to be installed by the end of January.

5.9 Etrop Court has completed partial IM&T installation and once dependencies have been resolved will progress in due course.

5.10 Progress has also been made at Parkway Green House, where initial discussions have been held with Wythenshawe Community Housing Group to agree operational arrangements for the Heads of Terms agreement, which will be subject to the relevant legal process that has to be followed when occupying third party owned estate.

5.11 In regards to the remaining hubs, progress has been made in terms of completing lease arrangements with partners. The process to create the INT hubs is a relatively complex one with a range of inter-dependencies that have to be considered and mitigation identified where required. A number of the outstanding sites will require existing occupants to decant elsewhere (much like a chain process in a residential property transaction) and there remains both IM&T and estate issues to resolve. Partners from across the system are working to ensure that all works relating to other are completed as soon as possible. A consolidated overview can be found at Appendix One.

5.12 Withington Community Hospital (WCH) – Early Adopter. This site went live at the end of October 2018 with the aim of testing integrated systems before rolling out to the rest of the city. This enabled the Neighbourhood Project to test the IT, printing, electronic faxing and integrated working. Staff based at WCH had the opportunity to share their feedback on the ‘journey wall’ and have reported some challenges and benefits of integrated working. The project has received some valuable learning from this initiative that will be used to support the roll out of the remaining sites.

<u>INT Leadership Team</u>

5.13 Effective delivery of services within each of the 12 INTs will be facilitated by the leadership team – or quintet – each of which will be led by a Neighbourhood Lead (team leader).

5.14 The quintet consists of:

- Lead GP
- Neighbourhood Lead
- Community Nursing Lead
- Social Work Lead
- Mental Health lead

5.15 Twelve Primary Care GP Leads are in place – one for each of the 12 neighbourhoods - and they have (with effect from December 18) increased their time commitment to 2 sessions per week – a session is half a day. To support the GPs in their enhanced roles each lead has taken part in a developmental centre at the end of November and the leads meet regularly with the Medical Director of MLCO to support the delivery of the INTs.

5.16 Development and delivery of the 12 Neighbourhood Lead roles has been particularly challenging as this new role, which will provide systems leadership across a range of organisations, is pivotal to the successful delivery of the INT new model of care. These roles will lead the implementation of the health and care service delivery model that is reflective of the needs of the populations that they serve for the first time at scale, and will ensure that services from all sectors can be better connected at a local level.

5.17 Following the internal recruitment (conducted after the consultation on the new structure) and the external recruitment (completed in December 18) there are two Neighbourhood Leads already in post, with a further three internal appointees who will be released as soon as cover arrangements for their current roles have been agreed, and a further four external appointees (who have now had final offer letters issued) due to start. These highly experienced individuals from a diverse range of professional backgrounds will commence in post between January and March 2019.

5.18 The three outstanding vacancies will be advertised early January 2019 which should enable all 12 Neighbourhoods to have a lead in post before the end of Quarter One (at the latest) 2019/20.

5.19 Greater Manchester Mental Health Trust has also identified six mental health leads that will support two Neighbourhoods each. All Neighbourhoods also have a lead nurse arrangement although further work to align these structures across individual Neighbourhoods is still required.

5.20 The Social Worker Team Manager role has been developed and MCC have recruited to the vacancies within the structure although they are currently working through the timing of plans to release these individuals into the Neighbourhood roles, which is dependent on workload pressures.

<u>Workforce development at Neighbourhood level</u>

5.21 Given the critical nature of the role of each quintet within the 12 Neighbourhoods, the MLCO has put extensive work into developing an effective, evidenced based development programme for the leadership team which will support them to develop their knowledge and skills in relation to this new model of care.

5.22 The programme focuses on providing the new neighbourhood leads with the opportunity to develop personal insight into what a collaborative place based leader in Manchester looks and feels like. It is an individually tailored experiential programme of learning that is focused around four key development opportunities:

- Self-assessment (at the beginning) and 360 feed- back (at the end);
- Masterclasses/development sessions;
- A peer support network for Neighbourhood; and
- Nesta 100 day challenge in each neighbourhood.

5.23 The work that is being support by Nesta is crucial in regards to development at a neighbourhood level as MLCO is focussed on supporting the development of Integrated Neighbourhood Teams and collaborative system wide working across the 12 neighbourhoods in Manchester.

5.24 There will be three waves to the roll-out of the challenge - with four neighbourhoods starting in April 2019, four in September 2019 with the final four starting in January 2020. Each neighbourhood will choose the area of improvement and transformation that they want to focus on. Each challenge will have up to twelve individuals from across the neighbourhood system participating in the challenge and this will include, but not be limited to, people with lived experience, the private and voluntary sector, health and social care staff and primary care including GPs. In order to ensure sustainability of this improvement methodology in Manchester we will also develop a cohort of individuals, again from across the system, in team coaching and enabling change skills that will be utilised in each neighbourhood as part of the challenge.

Coordinated Care Pathway

5.25 Whilst Neighbourhoods will be working collaboratively to shift service delivery towards a prevention focus, a key element of the INT core offer will be the provision of a co-ordinated care pathway for people with multiple long term health needs which will include those people in the top 15% of the risk profile (using the established risk stratification tool).

5.26 A Coordinated Care Pathway has been developed collaboratively with primary, community and social care colleagues. This will provide a consistent system wide approach helping those people who have pre-existing health needs and complex health issues to stay as well as possible in their homes. This will ensure community based care helps people to avoid unnecessary hospital admissions, and readmissions, reduce permanent admissions to long term care. The care pathway will interface effectively with Manchester Community Response to avoid admission and facilitate rapid discharge.

5.27 Pathway mobilisation is at different stages across each of the three localities and progress in delivery in each neighbourhood is dependent upon project management support, care navigation and neighbourhood leads roles to accelerate the delivery of the coordinated care pathway by 31st March 2019.

5.28 In response to the need to accelerate delivery of the pathway, dedicated project management resource has been allocated to central and north localities and is working with the operational teams and locality boards to undertake a baseline assessment of current provision and clarify plans for delivery and formulate a roll-out plan across each neighbourhood.

Neighbourhood Governance

5.29 The MLCO is implementing governance arrangements which both guarantees a minimum service offer and provides flexibility for Neighbourhoods to respond to key issues as identified in their place of operation. The MLCO is now moving from strategy and partial implementation of partnership working in Neighbourhoods across the city, to consistent implementation, for all Neighbourhoods.

5.30 Building on the Neighbourhood Partnership Approach work which commenced in 2018, further activity has now commenced on design work to mobilise the governance structure and develop a plan for implementation.

5.31 Further work in relation to the governance structure for the delivery and performance management for 'business as usual' is also required which will support the provision of assurance in relation to the quality, safety and effectiveness of services at Neighbourhood level and integrate this into the existing operational governance of the MLCO. This work is being led by the MLCO Director of Corporate Affairs and the Chief Nurse and will follow the principles that underpinned the mobilisation of MLCO governance arrangements, which were that MLCO governance is there to:

- Keep residents and service users safe;
- Support our staff to deliver services;
- Keep the organisation safe and regulatory/legally compliant;
- Support integration;
- Support effective decision making; and
- Promote effective dissemination of information.

Neighbourhood plans

5.32 To support the MLCO Business Plan for 19/20, the LCO has set off a process to compile 12 Neighbourhood plans. The plans will be built within the strategic framework for the MLCO and describe the key activities that will be delivered during 19/20 to deliver the 4 ways of working in the LCO (i.e. promoting healthy living) and the 10 outcomes described within the Outcomes Framework.

5.33 The plans will outline:

- How the plan was developed and agreed;
- What was delivered by the neighbourhood in 18/19;
- The priorities for delivery in the neighbourhood in 19/20; and
- Any support that is required to enable the neighbourhood to deliver its priorities.

5.34 The plans will complement and not replace the existing ward planning process that is used across the neighbourhood footprints in Manchester. They will include the activities that are needed across neighbourhoods to implement the standard operating procedure, such as establishment of MDTs, but they are likely to focus on the service improvement and transformation work that our neighbourhoods will collaborate on through the neighbourhood partnerships.

5.35 The INT leadership teams will be accountable for the development and delivery of the plans and will work through the existing neighbourhood infrastructure to develop and agree the plan content.

5.36 These plans by their very nature will be iterant and will be revised to reflect the change in need of residents with neighbourhoods. The approach to developing and refining these plans will be heavily reliant on active engagement with stakeholders within neighbours including elected members, communities and their residents, and the voluntary community enterprise sector. Ongoing oversight of the plans and further iterations will be through the neighbourhood governance that is being mobilised.

Development of a Standard Operating Policy

5.37 To further support the mobilisation of the INTs a Standard Operating Policy (SOP) is under development which will serve to provide a more detailed framework to capture key information regarding service delivery and service arrangements for the INTs. It outlines the context of the INT service/offer, explains the service philosophy of care and gives clear referral and assessment procedures. The Policy will provide staff, people, carers and other stakeholders with clear guidance and understanding of the INT's role, function and objectives.

5.38 The Policy describes: -

- The INTs main aim and purpose of operation;
- How the teams will deliver care;
- Clear information about the composition and roles within the team;
- Key principles involved in delivery of care; and
- Will serve as a guidance document for new and existing staff members.

5.39 The Policy also describes the cohort of people who will be cared for by the INTs and describes the process by which people will be identified for neighbourhood case management via risk stratification and/or frailty assessment tools. The INT will focus on delivering care models for individuals with complex needs - who are not yet severely ill – to avoid them becoming high risk. The INT will need to identify high risk individuals and ensure comprehensive care plans are in place to meet their needs.

5.40 For low risk individuals – which includes those facing health inequalities and may well include people engaging in high risk activities – the INT will ensure services are provided which support people to better manage their own health and to live healthy lifestyles.

5.41 As with all business areas of MLCO, the development of INT will have a clear road map in place to take into the end 2018/19 and also in 2019/20. This road map will identify the next steps in INT development.

6. Manchester Community Response

6.1 Manchester Community Response (MCR) is a seven-day service that provides community based intermediate care, reablement and rehabilitation services to patients, often older people, after leaving hospital or when they are at risk of being sent to hospital. These services offer an interface between hospitals and where people live, and between different areas of the health and social care system – community services, hospitals, GPs and social care.

6.2 The three main aims of MCR are to:

- Help people avoid going into hospital unnecessarily.
- Help people be as independent as possible on discharge from hospital.
- Prevent people from having to move into a residential home until they really need to.

6.3 It is an evolution of the highly-effective North Manchester Community Assessment and Support Service (CASS), and the different elements and services of MCR are described below.

6.4 MCR therefore brings together the following six services into a common city-wide offer operated out of each of the three localities:

- Crisis response
- Discharge to assess
- Intermediate care (Bed based)
- Intermediate Care (Home pathway)
- Reablement
- Community IV (Intravenous Therapy)

More detail on these is provided below.

6.5 The crisis response team works collaboratively to provide rapid response to a patient in urgent need of health and social care at home. It provides a short term assessment and intervention for patients in their own homes, usually for up to 72 hours. This allows them to remain safely at home and avoid an unnecessary A&E admission. The model enables referrals to the team directly from NWAS for Amber category calls (where the paramedics would usually take the patient to hospital) and those Red category calls when a patient refuses to go to hospital. The NWAS paramedics assess the patient and then contact the crisis response team if they feel it is a suitable referral. The crisis response team wrap an immediate package of care around the patient to support them at home. The service will also allow referral from hospital emergency departments and the community - including GPs.

6.6 Discharge to Assess (D2A) helps people home from hospital, quickly and safely. The essence of the approach is that the person, once medically optimised, goes home and is assessed for their ongoing needs in their home or other place of residence rather than remaining in hospital for these assessments. The aim is to reduce unnecessary delays in discharge when they

could be back at home or in a more appropriate place to receive ongoing assessment, short term interventions and support from community teams.

6.7 Short term bed based rehabilitation offers the patient a chance to work with a multi-disciplinary team to gain as much independence as possible and help them return home. Many patients, particularly the elderly, suffer with loss of function after a major physical illness or following a hospital admission and this can make it difficult for them to cope in their usual environment.

6.8 The home pathway team supports people in receiving or completing their rehabilitation in their own homes. Short term care and therapy are provided by the community and reablement teams to support the person's recovery to independence.

6.9 Reablement service is another evidence based approach to maximise people's ability to return to their optimum level of independence with the lowest appropriate level of ongoing support. The service focuses on restoring independent functioning and helping people to do things for themselves rather than the traditional approach of doing things for people.

6.10 Community IV therapy services provide intravenous drug therapies that have traditionally had to be provided in hospital in a community setting. They have recently been incorporated into the MCR offer with the intent of providing a consistent offer to residents of Manchester wherever they live. Its inclusion reflects the common aims of MCR and Community IV Therapy services to either help prevent people going into hospital wherever possible and to support people's return to the community as soon as they are medically fit to do so.

6.11 The MCR service comprises of an integrated team of community health and social care staff at various grades including community nurses, advanced practitioners in various disciplines, physiotherapists, occupational therapists, assistant practitioners, pharmacists, social workers, primary assessment officers, reablement managers and reablement staff.

6.12 Although there are discreet teams and pathways within MCR, staff may flex and work across the different teams and pathways when required. This helps to ensure the service delivers a truly integrated health and care offer for the people that it supports.

<u>Establishment and rollout of MCR</u>

6.13 To effectively establish Manchester Community Response across the city, a number of team and model of care investments are taking place.

6.14 MCR Lead roles have been created in North, Central and South Manchester reporting into the Locality Assistant Directors who have also recently been appointed. These MCR Lead roles are responsible for the effective design, implementation and operation of the MCR offer within their locality and delivering effective working across boundaries with the other localities. If any future enhancements or additions are agreed for MCR, the MCR Leads will again be responsible for the safe integration of these consistent enhancements into the service offer.

6.15 Two of the three MCR Lead posts have now been appointed to. The Central role is still being recruited to and in the interim the role is being discharged through the Crisis Lead for North Manchester, the Complex Discharge Manager from the Manchester Royal Infirmary and the Locality Assistant Director.

Progress with implementation

6.16 To ensure a consistent city-wide MCR offer, Greater Manchester Transformation Fund monies have been made available for the rollout of a number of the services within MCR across the City:

- **Crisis Response**: This service is currently provided in North Manchester and funding has been provided to roll-out the service to Central and South Manchester
- **Discharge to Assess (D2A)**: D2A is a new service offer for Manchester. Funding has been provided to design, implement and roll-out D2A across the entire city.
- **Reablement**: Reablement is a service that is already offered across the city although it is recognised that the city would benefit from additional capacity within this service. Funding has therefore been provided to increase the size of the workforce to help ensure more people have access to this service.

6.17 Difficulties have been experienced with the recruitment of suitability qualified staff and this has challenged the implementation of the service within the originally identified timescales. Particular issues have been around Advanced Clinical Practitioners (ACPs), Physiotherapists and Occupational Therapists. Despite this, we have managed to safely launch MCR services, albeit sometimes with restricted operational parameters.

6.18 Crisis response in Central Manchester went live as planned for the NWAS Amber Pathway (where paramedics attending 999 calls can refer to the crisis team rather than taking the patient to hospital) in November 2018. The team are performing to target. Referrals from other services (primarily GPs and the community are scheduled to be live by end-March 2019.

6.19 In South, the community referral aspect of the Crisis service launched in December 2019. The issue with the availability of suitably trained & capable ACPs has meant that we have had to delay go-live for the NWAS Amber pathway part of the service until the new year. We are continually reviewing the target date for the safe launch of the NWAS Amber Pathway referral route in South Manchester and are focussed on trying to launch before the end of 2018/19.

6.20 The success of the Discharge to Assess service is predicated on seamless working between hospital and community staff to manage the safe discharge of patients from hospital as soon as they are medically fit, continuing the assessments in their home environment. This requires a significant change in culture and working practice across the full hospital estate as traditionally all of these assessments are carried out whilst the patient is still an inpatient, extending their length of stay. Ideally it also needs to be fully embedded within

hospital processes and systems as discharge planning should begin at the point of attendance/admission.

6.21 Discharge to Assess for Pathway 1 discharges commenced in North in May 2018 and South Manchester in September 2018. Recruitment challenges have governed the rate at which the service capacity can be increased and whilst the majority of posts are now filled, staff continue to be recruited into the teams to deliver the required capacity as quickly as possible.

6.22 In North Manchester, the rollout of the service is complete. It is currently supporting around 25 patients per month through Pathway 1. In South Manchester, the service is ramping up. The service is supporting similar numbers to North Manchester through Pathway 1 although in November there was a single month increase to 40 accepted referrals although this returned to lower levels in December.

6.23 In Central Manchester the rollout of Discharge to Assess has been delayed to allow the team to:

(i) support the hospital staff in discharging the high number of ED attendances and admissions to ACU and AMU over summer and winter pressures; and,
(ii) concentrate on the implementation of Crisis Response which will help decompress the front end of the hospital by deflecting NWAS Amber pathway conveyances to the Crisis Response team.

6.24 In addition, staffing shortages in other critical services such as intermediate care – both bed based and home based – has resulted in some staff being re-deployed to service them.

6.25 Given the above, we are replanning the delivery of Discharge to Assess in Central and are working closely with the Manchester Royal Infirmary to ensure it is woven into the discharge process from the point of attendance/admittance.

6.26 The reablement service offers those individuals that are considered would benefit from a period of reablement up-to 6 weeks of specialist community support to help improve and/or regain their independence.

6.27 Funding for 62 additional reablement staff has been made available and recruitment into these posts continues as quickly as possible. At the time of writing all of the 62 posts have been recruited to and 47 of the individuals have started in role. Recruiting 62 new employees is a significant task and the process is being progressed as quickly as possible. However, a combination of finding the right candidates and delays in DBS checks has introduced challenges. To mitigate this, the team are actively using agencies to provide interim resources until the full-time staff start in post.

7. Adult Social Care Improvement Programme

7.1 As advised at previous Scrutiny Committee meetings there are a range of Adult Social Care services delivered through MLCO. Whilst integration at neighbourhood level is progressing at pace, there is still significant work to do in order to fully assimilate existing governance arrangements that support ASC into MLCO governance. This is in part due to the interim Director of Adult Social Services arrangements that have been put in place following the departure of the previous DASS in 2018.

7.2 One of the key priorities for MLCO in Quarter Four through 2019/20 will be the delivery of the ASC Improvement Programme. This work will ensure that we are getting the basics right in adult social care and will enabling us to successfully deliver health and social care reform and integration.

7.3 A programme plan for this work is now in place, based on the outcomes of a diagnostic piece of work and will enable the Acting Director of Adult Social Services (DASS) to address performance challenges through the targeted improvement work which will tackle challenges including:

- increase in demand across all services;
- increase in safeguarding enquiries;
- increase in Deprivation of Liberty Safeguards referrals;
- ensuring waiting lists for assessments, reassessments and reviews are kept low; and
- ensuring that temporary funding doesn't hamper ongoing delivery.

7.4 The plan focuses across the service on the core themes of process, practice, workforce and resources, acknowledging that they are interdependent and if considered together will ensure that the right foundations are in place for the service to deliver its statutory duties.

8. Engagement

8.1 Public engagement work has been a core element of the first year of MLCO. This started with the Future Search programme where over 300 staff, partners and residents were involved in 2017 work to shape design of MLCO.

8.2 In year one, the focus has been on partnership working with Manchester Health and Care Commissioning based on engagement around the Manchester Locality Plan. This has been carried out since summer 2018 to boost health engagement capacity in the city, promote MLCO and seek public views on key elements of the plan that will influence future service design and commissioning. MLCO has been directly involved in over 60 events, reaching over 1,000 residents and gaining 520 locality plan survey responses.

8.3 The reports from the survey work are due to be published in February 2019. Other MLCO linked events - such as Health Development Coordinator engagement events in the North of the city in November have taken place and reached around 400 residents and partners. MLCO is an active member of the

Bringing Services Together programme led by Manchester City Council that aims to coordinate resident engagement work across the city.

8.4 MLCO have also led an ongoing programme of staff engagement and communications. Our Freedom to Lead event in September 2018 brought together over 200 of our service leaders and team members from across the city and plans are in place to stage a second event in April 2019. The quarterly MFT pulse check survey shows good engagement performance amongst our (MFT deployed) health staff with an overall engagement score of 3.88 (good), 86% of staff understanding the benefits of MLCO to local people and 83% of staff satisfied with the quality of care they provide to local people.

8.5 The results of Manchester City Council's 'Be Heard' annual survey which covers our adult social care deployed staff has recently been published and shows improvements in engagement and other metrics across the board, although more work is required in this area.

8.6 Work is currently underway to develop a MLCO-wide pulse check system to better measure staff views on a regular basis across the integrated team and discussions are underway with MFT on how to progress this.

8.7 A series of drop in sessions are planned in February for elected members to meet with the MLCO Executive, understand the progress of MLCO to date and priorities for the coming year.

8.8 As the full Integrated Neighbourhood Team leadership team come together, individual ward meetings will be arranged in March and April for elected members with the relevant INT Leadership Team, and MCC Neighbourhood Manager. The purpose of these meetings will be to: -

- Provide an introduction to the team;
- For Elected Members to outline their priorities in relation to Health and Wellbeing for the ward they represent;
- Outline the ward health profile using data and evidence
- Outline the 19/20 INT Neighbourhood Plans as produced by the INTs and consider opportunities for alignment and joint working between wards and the Neighbourhoods; and,
- Consider the approach to date to develop Neighbourhood Insight and agree how members can input into the content.

9. MRI Priority discharges

9.1 In addition to mobilising new care models and working to integrate health and care across the city, MLCO is working with MFT to support local people by working to prevent the need for admission to hospital wherever possible, and getting people home from hospital in a timely and safe manner when they do need hospital care. With support from partners including the Council and Greater Manchester Mental Health NHS Foundation Trust, there has been a period of focussed activity to support people who have faced a long length of stay in hospital.

9.2 To date this work has focussed predominantly on the pressures at the Manchester Royal Infirmary with the MLCO senior leadership working closely with colleagues to expedite the movement and discharge of patients from an acute provider to the most appropriate community setting. As at 19th January 2019, this programme of work led by the MLCO has supported the discharge of 103 patients with an accumulated length of stay of circa 10,800 days. This programme of work, which has been operational for around 5 months, has helped reduce the average length of stay at the MRI by circa 5 days, indicating the impact this is having on acute flow, as well as ensuring that patients are treated in appropriate community settings and home where possible.

9.3 Work on this initiative continues and we are now actively working to target design the business as usual escalation process that this will transition to as well as broadening the target cohort of patients being prioritised. Active consideration of how this is also implemented to be common Manchester city-wide approach is underway.

10. MLCO Business Plan and Phase 2

10.1 The activity of MLCO in 2018/19 was defined by its Business Plan and the work which was undertaken in collaboration with MHCC that defined a core set of deliverables. Both these documents remain valid and provide the framework for all MLCO activity, although it should be recognised that additional programmes of work and priorities have emerged throughout the course of year, notably the work to support an expedition of the transfer of care for patients with significant lengths of stay in MRI.

10.2 To support the development of MLCO into 2019/20 including the business planning process, a series of 'road maps' (agreed by the MLC Partnership Board) are in the process of being developed to support further integration including:

- Operationalising INT and locality structures
- Approach to service re-design
- Population Health
- Primary Care
- Adult Social Care
- Mental Health
- Children's
- Commissioning
- MLCO Procurement (Phase 2)
- Enablers
- Resourcing
- OD
- Governance

10.3 The road maps and programmes of work are at different stages of development and by their very nature will have differing mobilisation and development timescales.

10.4 As identified above it is via these road maps that MLCO will be producing an integrated business plan and deliver the services that fall within its ambit on an ongoing basis.

10.5 As Committee will be aware the MLCO will realise its full potential in a three year phased approach as set out in the Partnering Agreement. The majority of services that were transferred in year one were community health services (including North Manchester Community Health Services) and directly provided Adult Social Care.

10.6 Year Two will see a range of other services move under the management of MLCO including a host of commissioned services such as Home Care and Residential and Nursing Care. Work is ongoing, led by Manchester Health and Care Commissioning, to define the approach to be taken to support the further development of MLCO.

11. Recommendations

11.1 Scrutiny Committee are asked to note the contents of this report.

Appendix One - INT Hub Mobilisation

Locality	Site	INT Space identified	Estates work complete	IM&T works complete	Health staff moved in	Social Care staff moved in
Central	Chorlton	✓	✓	✓	✓	
	Gorton District Office	✓	✓	✓	✓	✓
	Vallance Centre	✓	✓	✓	✓	
	Moss Side Health Centre	✓	✓	✓	✓	
North	Victoria Mill	New space identified. Lease discussions underway.				
	Cheetham Hill PCC	Space plans reviewed and agreed. Delivery dependent on other North Hubs.				
	Cornerstones	IT being installed and tested. (Small room signed off)				
	Harpurhey 1st Floor	Space plans reviewed and agreed. Delivery dependent on other North Hubs.				
South	Etrop Court	✓	✓	✓	Due Feb 2019	✓
	Burnage	✓	✓	✓	✓	
	Parkway Green House	New space identified. Lease discussions underway.				
	Withington Community Hospital	✓	✓	✓	✓	✓

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Appendix Two – MLCO New Care Models case studies

Examples and case studies of work taking place across Manchester Local Care Organisation services - February 2019

1. Joint working through Integrated Neighbourhood Teams is better coordinating services

Manchester Local Care Organisation's Didsbury East and West, Burnage and Chorlton Park Integrated Neighbourhood Team (INT) has been an early implementer of our new model of neighbourhood working across the city.

The neighbourhood's social work and district nursing teams have been working together from their hub at Withington Community Hospital in West Didsbury since November 2018. It will be one of the 12 hubs across the city.

The biggest single difference staff are reporting is the better exchange of information on a daily basis. Teams now work together and can immediately share information and take action. A great example was the district nurses going out to elderly service user who had a high level of dementia and mobility issues. They sadly found that their main carer and spouse, also elderly, had been diagnosed with cancer with a poor prognosis. The carer couldn't provide the care they previously had done and 24-hour care was going to be needed.

When a nursing needs assessment is requested by a social worker that process can traditionally take days, or even weeks. In this case, because the teams are now co-located, the nurses let the social work team know straight away of their concerns. The case was discussed in the district nurse huddle that day and the INT team was able to get the social care and nursing needs assessments completed in a day and the right care in place a couple of days later.

It's a simple example of an outcome of the teams being able to talk to each other on the spot about cases, but one that made a massive difference to the service user.

2. High Impact Primary Care wrapping care around the most vulnerable service users

High Impact Primary Care High Impact Primary Care (HIPC) is a service that provides care and support to people with complex health and care needs. The HIPC teams are led by a GP, working alongside a nurse, social worker, wellbeing adviser and pharmacist.

Mrs H is a service user with multiple issues including alcohol dependency, hearing and sight impairment, anxiety, depression and multiple long-term health conditions. She had started detox several times but not completed the courses and had cancelled multiple social care packages – putting herself at risk of harm and self-neglect. She attended A&E almost every day and her alcoholism had created a strained relationship with her children so she had no contact with her grandchildren.

The High Impact Primary Care (HIPC) team provided weekly support and developed a plan with Mrs H. They accompanied her to hearing and eye tests, arranged counselling and alcohol service support and organised attendance at social interaction groups to pursue her interest in drawing.

With the support of the team, Mrs H's drinking has significantly reduced and she has agreed to go to residential detox. She now has a hearing aid that has greatly improved her communication and has had support from pharmacy to improve how she uses her inhaler to control breathlessness; and the HIPC GP to prescribe a nebuliser to reduce anxiety.

Mrs H is now much more willing to work with agencies and her attendance at A&E has reduced from once every day to around once every three weeks. Family relationships have improved greatly and her children and grandchildren now come to visit.

Manchester Community Response stories

3. South Crisis Response - preventing hospital admission

The South Manchester Crisis Response team launched in December 2019 and provide a crisis service to hospital (A&E and other urgent care units such as the clinical decisions unit), GPs and social care - allowing them to refer to the team and prevent people from needing to be admitted or sent to hospital.

Instead of going to A&E, Mr B was seen at home by one of our physiotherapists as part of the service. Up to 72 hours of care can be provided by the team who then refer on to other services.

Mr B's wife was very complimentary of the service they received, which prevented a possible hospital admission, and stated 'the crisis response service has done more for Mr B in 72 hours than any other service has done in 3 years'.

4. Central Crisis Response - taking cases from paramedics and providing care at home

The Central Manchester Crisis Response team launched in November 2018 and provide a service where NWAS paramedics attending 'amber pathway' 999 calls can call the crisis team in to see the patient rather than take them to A&E. The crisis team attend suitable calls and provide up to 72 hours of care.

Feedback collected from one of the service users said: "My experience with the crisis team has been outstanding. The team has been utterly professional, compassionate and helpful throughout my interaction with them. I appreciated being able to undertake various health checks in my home, blood tests and various physical examinations without having to go to A&E. They also contacted my GP surgery so I could collect my prescriptions sooner rather than later.

"I'd recommend the service. It's put my mind at rest and given me a clearer diagnosis of what the problem has been. The assessments have been done promptly and the team's engagement with my GP has been invaluable. I feel I have been extremely fortunate to be cared for by the team and I am extremely grateful for it."

5. Discharge to Assess - taking assessments into the community

Discharge to Assess provides a service that allows community teams to carry out assessments in the community rather than delay hospital discharge.

Mrs W was discharged home and was assessed by the Discharge to Assess team on day of discharge with the family present on assessment. During assessment Mrs W was identified as a high falls risk. She had a pendant alarm but has not pressed the alarm when she has fallen previously and has had six hospital admissions in the last year. The team arranged for a falls sensor which was delivered the same day.

Following the family leaving, Mrs W fell and the falls sensor alerted the alarm company and the family so the right care could be provided immediately. The family thanked the team for their support and also for arranging the sensor so promptly.

Case studies collected from Manchester Local Care Organisation service users and anonymised. For further information or to use these elsewhere please contact chris.horner1@nhs.net

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Appendix Three – MLCO performance and updates at a glance

MLCO peformance and updates at a glance

January 2019

Manchester Local Care Organisation

Leading local care, improving lives in Manchester, with you

High Impact Primary Care (HIPC)

Three pilot HIPC programmes across the city providing GP led, integrated community care to most vulnerable residents who are high users of other services.

- User targets for November met with 463 residents accessing HIPC
- User targets for December met with 540 residents accessing HIPC
- Signifiant reductions in use of other services by users
- 75% of clients have had no emergency activity post discharge
- Pilots extended to March 2020.

Up to **60%** reduction in

- GP contacts
- Hospital admissions
- calls to NHS 111
- A&E attendances
- Ambulance calls

amongst HIPC cohort of patients

Escalation and patient flow support

Joint work with team at Manchester Royal Infirmary to support discharge of super stranded patients medically fit for discharge back to community settings with right support.

- Programme of work since August 2018
- Ongoing identification of super stranded patients and coordination work to expedite discharge
- Joint health and social care approach through MLCO team
- Over 100 patients successfully discharged with combined length of stay of almost 11,000 bed days
- Contributed to average MRI length of stay reducing by five days.

103 stranded patients discharged

with a combined length of stay in hospital of

10,870 days

Contributing to a reduction in average inpatient length of stay at MRI.

Manchester Community Response (MCR)

Umbrella for six programmes of work including Community Crisis Response, Discharge to Assess, Reablement and others that provide short term care to help prevent hospital admission/expedite discharge.

- Central Manchester crisis response team launched Nov 2018 to take NWAS amber pathway referrals
- South Manchester crisis response team launched Dec 2018 to provide community referrals from A&E, AMU, CDU, GPs and social
- Discharge to Assess programmes running in North and South Manchester.

Central Community Crisis Response team since Nov

135 accepted amber referrals from NWAS

116 patients treated in community and avoided A&E/admission

South Community Crisis Response team since Dec

65 referrals accepted from GPs/urgent care and treated in community

Integrated Neighbourhood Teams (INTs)

12 neighbourhood teams, co-locating health and social care services around populations of 30k to 50k residents. Each team has leadership including overall lead and GP, nursing, social care and mental health leads.

- Recruitment to 9 of the 12 overall leads complete
- All 12 GP leads in place as well as nurse and mental health leads
- Estates work to complete hub bases for each INT progressing with 6 complete and others underway/in negotiation
- Didsbury East and West, Burnage and Chorlton Park INT has been an early implementer at Withington Community Hospital since November 2018.

Early work from **Didsbury East & West, Burnage and Chorlton Park INT** early implementer has found:

\+ improved communication between health and social care teams

\+ better understanding of roles, speeding up of assessments and more joint visits

= **better coordinated care for local residents**

Powered by:

NHS Manchester University NHS Foundation Trust

NHS Greater Manchester Mental Health NHS Foundation Trust

Manchester City Council

Manchester Health & Care Commissioning
A partnership between Manchester City Council and NHS Manchester CCG

The Manchester Primary Care Partnership

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Manchester City Council
Report for Resolution

Report to: Health Scrutiny Committee – 5 February 2019

Subject: Overview Report

Report of: Governance and Scrutiny Support Unit

Summary

This report provides the following information:

- Recommendations Monitor
- Key Decisions
- Items for Information
- Work Programme

Recommendation

The Committee is invited to discuss the information provided and agree any changes to the work programme that are necessary.

Wards Affected: All

Contact Officers:

Name: Lee Walker
Position: Scrutiny Support Officer
Telephone: 0161 234 3376
E-mail: l.walker@manchester.gov.uk

Background document (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.

None

1. Monitoring Previous Recommendations

This section of the report contains recommendations made by the Committee and responses to them indicating whether the recommendation will be implemented, and if it will be, how this will be done.

Date	Item	Recommendation	Response	Contact Officer
4 September 2018	HSC/18/36 Manchester Public Health Annual Report 2018	The Chair discuss with the Chair of the Neighbourhoods and Environment Scrutiny Committee and the Executive Member for Executive Member for the Environment, Planning and Transport how best to report to the Committee that activities that are undertaken as part of her portfolio to improve air quality.	The Chair will update the Committee with how this is to be progressed.	Lee Walker Scrutiny Support Officer

2. Key Decisions

The Council is required to publish details of key decisions that will be taken at least 28 days before the decision is due to be taken. Details of key decisions that are due to be taken are published on a monthly basis in the Register of Key Decisions.

A key decision, as defined in the Council's Constitution is an executive decision, which is likely:

- To result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates, or
- To be significant in terms of its effects on communities living or working in an area comprising two or more wards in the area of the city.

The Council Constitution defines 'significant' as being expenditure or savings (including the loss of income or capital receipts) in excess of £500k, providing that is not more than 10% of the gross operating expenditure for any budget heading in the in the Council's Revenue Budget Book, and subject to other defined exceptions.

An extract of the most recent Register of Key Decisions, published on **16 January 2019**, containing details of the decisions under the Committee's remit is included below. This is to keep members informed of what decisions are being taken and, where appropriate, include in the work programme of the Committee.

Decisions that were taken before the publication of this report are marked *

Decision title	**What is the decision?**	**Decision maker**	**Planned date of decision**	**Documents to be considered**	**Contact officer details**
Cornish Close Scheme Ref: 2017/05/31B	Appointment of a support provider for the Cornish Close Scheme which includes 14 supported accommodation units over 5 properties, 6 short break beds.	Strategic Director of Adult Social Services	March 2018 or later	Report and Recommendation	Lesley Hilton-Duncan 0161 234 4419 lesley.hilton-duncan@manchester.gov.uk
Adult Social Care – Provider National Living Wage 2017/18 Fee Increase for Care Homes, Extra Care, Learning Disabilities and Mental Health services Ref: 2017/07/18E	Proposed increases are • 5% Care Homes • 3% Extra Care, LD and MH The increases proposed above when added to the previously agreed Homecare increases would be within the £4.26m allocated through the budget process.	City Treasurer	October 2018 or later	National Living Wage Briefing Note.	Michael Salmon 0161 234 4557 m.salmon@manchester.gov.uk

Framework Agreement / Contract for the Provision of Homecare Services Ref: 2018/07/02B	The appointment of Providers to deliver Homecare Services	Executive Director Strategic Commissioning and Director of Adult Social Services	December 2018	Report and Recommendation	Mike Worsley Procurement Manager mike.worsley@manchester.gov.uk 0161 234 3080
Contract for the Provision of Advice Services 2018/08/16A	The appointment of a Provider to deliver Advice Services	Executive Director Strategic Commissioning and Director of Adult Social Services	December 2018	Report and Recommendation	Mike Worsley Procurement Manager mike.worsley@manchester.gov.uk 0161 234 3080
Contract for the Provision of Housing Related Support for Young People, Homelessness and Drug and Alcohol Services 2018/08/16B	The appointment of Provider to deliver	Executive Director Strategic Commissioning and Director of Adult Social Services	December 2018	Report & Recommendation	Mike Worsley Procurement Manager mike.worsley@manchester.gov.uk 0161 234 3080

Subject **Care Quality Commission (CQC) Reports**

Contact Officers Lee Walker, Scrutiny Support Unit
Tel: 0161 234 3376
Email: l.walker@manchester.gov.uk

Please find below reports provided by the CQC listing those organisations that have been inspected within Manchester since the Health Scrutiny Committee last met:

Provider	Address	Link to CQC report	Date	Types of Services	Rating
HG Care Services Limited	HG Care Services Limited 987 Stockport Road Manchester M19 2SY	https://www.cqc.org.uk/location/1-122818088	1 January 2019	Homecare agency	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Requires Improvement
Mediline Supported Living Ltd	Mediline Supported Living Bacup 11 Bacup Street Moston Manchester M40 9HF	https://www.cqc.org.uk/location/1-191191182	5 January 2019	Residential Home	**Overall: Good** Safe: Requires Improvement Effective: Good Caring: Good Responsive: Good Well-led: Good
Standwalk Ltd	Rowsley House 3 Rowsley Avenue Didsbury Manchester M20 2XD	https://www.cqc.org.uk/location/1-284567608	9 January 2019	Residential Home	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Good

Maureen Philomena and Anne Catherine Smith	Lindenwood Residential Care Home 208 Nuthurst Road New Moston Manchester M40 3PP	https://www.cqc.org.uk/location/1-119780623	12 January 2019	Residential Home	**Overall: Inadequate** Safe: Inadequate Effective: Inadequate Caring: Requires Improvement Responsive: Requires Improvement Well-led: Inadequate
GTD Primary Care Ltd	Brookdale Surgery 202 Droylsden Road, Manchester, Lancashire, M40 1NZ	https://www.cqc.org.uk/location/1-5237676013	9 January 2019	Dr / GP Practice	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Good
Dr Serena Rochford	Poundswick Lane Dental Practice 18 Poundswick Lane Wythenshawe Manchester M22 9TD	http://www.cqc.org.uk/location/1-188001553	7 January 2019	Dentist	**No Action Required**
Sure Care (UK) Ltd	Brocklehurst Nursing Home 65 Cavendish Road Withington Manchester M20 1JG	https://www.cqc.org.uk/location/1-1333072984	16 January 2019	Nursing Home	**Overall: Good** Safe: Requires Improvement Effective: Good Caring: Good Responsive: Good Well-led: Good

Mr Bradley Scott Jones and Mr Russell Scott Jones	Brownlow House 142 North Road Clayton Manchester M11 4LE	https://www.cqc.org.uk/location/1-131420845	15 January 2019	Residential Home	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Requires Improvement Caring: Good Responsive: Requires Improvement Well-led: Inadequate
Standwalk Ltd	St James House Danes Road Manchester M14 5LB	https://www.cqc.org.uk/location/1-121992613	16 January 2019	Residential Home	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Requires Improvement Caring: Requires Improvement Responsive: Requires Improvement Well-led: Requires Improvement

Health Scrutiny Committee
Work Programme – February 2019

Tuesday 5 February 2019, 10am (Report deadline Thursday 24 January 2019)				
Item	Purpose	Lead Executive Member	Strategic Director/ Lead Officer	Comments
Single Hospital Service – Progress report	To receive a progress report on the implementation of the Single Hospital Service. This report will provide an update on the benefits realised through the delivery of this programme.	Cllr Craig	Peter Blythin, Director, Single Hospital Service Programme	This item was previously considered 17 July 2018.
Detailed budget and business plans	The Committee will consider the refreshed budget and business plans for the Directorate of Adult Services, following consideration of original proposals at its December 2018 meeting.	Cllr Ollerhead Cllr Craig	Carol Culley, Dave Regan Bernadette Enright	
Manchester Local Care Organisation	To receive a progress report on the delivery of the Local Care Organisation. This will include specific information on the establishment of the Integrated Neighbourhood Teams.	Cllr Craig	Professor Michael McCourt	
Overview Report	The monthly report includes the recommendations monitor, relevant key decisions, the Committee's work programme and items for information. The report also contains additional information including details of those organisations that have been inspected by the Care Quality Commission (CQC) within Manchester since the Health Scrutiny Committee last met.		Lee Walker	

Tuesday 5 March 2019, 10am (Report deadline Thursday 21 February 2019)				
Item	Purpose	Lead Executive Member	Strategic Director/ Lead Officer	Comments
Supporting People Housing Strategy	Scope of this report is to be agreed.	Cllr Craig Cllr Richards	Jon Sawyer	Executive Item
Winter Pressures	The Committee will receive a report that describes the pressures experienced by acute services across the city during the winter period and what is done to manage this.	Cllr Craig	Nick Gomm	
Overview Report			Lee Walker	

Items to be Scheduled				
Item	Purpose	Executive Member	Strategic Director/ Lead Officer	Comments
Autism Developments across Children and Adults	To receive an update report on Autism Developments across Children and Adults. This item was considered by the Health Scrutiny Committee at their January 2015 meeting.	Cllr Craig	The Executive Director of Commissioning & DASS	
Update on the work of the Health and Social Care staff in the Neighbourhood Teams	To receive an update report describing the work of the Health and Social Care staff in the Neighbourhood Teams.	Cllr Craig	The Executive Director of Commissioning & DASS	

Manchester Health and Care Commissioning Strategy	To receive a report on the Commissioning Strategy for Health and Care in Manchester. The Committee had considered this item at their July 2017 meeting.	Cllr Craig	The Executive Director of Commissioning & DASS	See minutes of July 2017. Ref: HSC/17/31
Public Health and health outcomes	To receive a report that describes the role of Public Health and the wider determents of health outcomes.	Cllr Craig	David Regan	
Manchester Macmillan Local Authority Partnership	To receive a report on the Manchester Macmillan Local Authority Partnership. The scope of this report is to be agreed.	Cllr Craig	David Regan	See Health and Wellbeing Update report September 2017. Ref: HSC/17/40
Mental Health Grants Scheme – Evaluation	To receive a report on the evaluation of the Mental Health Grants Scheme. This grants programme is administered by MACC, Manchester's local voluntary and community sector support organisation, and has resulted in 13 (out of a total of 35) community and third sector organisations receiving investment to deliver projects which link with the Improving Access to Psychological Therapies (IAPT) services in the city.	Cllr Craig	Nick Gomm Professor Craig Harris	To be considered at the March 2019 meeting. See minutes of October 2017. Ref: HSC/17/47
Care Homes	To receive a report that provides information on the provision of care homes in the city. The report will further describe the actions taken to respond to any findings of Inadequate or Requires Improvement following an inspection by the Care Quality Commission (CQC).	Cllr Craig	The Executive Director of Commissioning & DASS	See minutes of 17 July 2018. Ref: HSC/18/33
The Our Manchester Carers Strategy	To receive an update report on the delivery of the Our Manchester Carers Strategy.	Cllr Craig	The Executive Director of Commissioning & DASS	See minutes of 17 July 2018. Ref: HSC/18/31

Single Hospital Service progress report	To receive a bi-monthly update report on the delivery of the Single Hospital Service.	Cllr Craig	Peter Blythin, Director, Single Hospital Service Programme	See minutes of 17 July 2018. Ref: HSC/18/32
Assistive Technology and Adult Social Care	To receive a report on how assistive technology will be used to support people receiving adult social in their home.	Cllr Craig	The Executive Director of Commissioning & DASS	
Recommendations of the Public Health Task and Finish Group	To receive a report on how the recommendations of the Public Health Task and Finish Group are being implemented.	Cllr Craig	David Regan	See minutes of December 2018
Workforce Strategy	To receive a report on the Workforce Strategy.	Cllr Craig	The Executive Director of Commissioning & DASS	

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