Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 10 November 2021

Subject: Better Outcomes Better Lives

Report of: The Executive Director of Adult Social Services

Summary

Better Outcomes, Better Lives is the adult social care transformation programme. It is a long-term programme of practice-led change, which aims to enable the people of Manchester to achieve better outcomes with the result of less dependence on formal care.

The report provides an update on progress and the impact of the programme since June 2021, when the committee last had an update.

Recommendations

To note the report.

Wards Affected: All

Environmental Impact Assessment - the impact of the issues addressed in this report on achieving the zero-carbon target for the city
As a key contributor to delivering the ASC and overall Manchester City Council budget in 2021/22, the Better Outcomes, Better Lives programme reflects the declaration of a climate emergency. The responsive commissioning workstream in particular will explore options to ensure the programme makes a contribution through action taken working with our external care market.

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	
A highly skilled city: world class and home grown talent sustaining the city's economic success	
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	Our work to tackle health inequalities and deliver Better Outcomes Better Lives are designed in particular to make a contribution to creating a progressive and equitable city – through working with our communities, our residents and assets

	to improve outcomes for those who need support.
A liveable and low carbon city: a destination of choice to live, visit, work	
A connected city: world class infrastructure and connectivity to drive growth	

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Background documents (available for public inspection): None

1.0 Introduction

1.1 Better Outcomes Better Lives is the Manchester Local Care Organisation's programme to transform the way that we deliver adult social care so that it meets the needs of our most vulnerable residents and makes best use of the resources that we have.

1.2 The Committee previously received a report in March 2021 giving an overview of the whole programme, and a further update report in June 2021.
Link to the March 2021 committee reports
Link to the June 2021 committee reports

1.3 This report provides an overview of the programme and an update since June 2021.

2.0 Background

2.1 In 2020, we worked with a consultancy (IMPOWER) to carry out an in-depth analysis of Manchester's adult social care. We reviewed our current practices and how our demand was expected to change over the next few years. We identified significant opportunities to improve practices in order to reduce, prevent and delay demand on services, while also improving outcomes for people in Manchester.

2.2 This review of our practices identified that, if we act now to support people to maximise their independence, by 2024 we can improve outcomes for adults:

- 700 fewer people than currently projected in nursing care
- over 1,400 fewer people in residential care than if we don't act
- avoiding 45 people more than currently projected from going into supported accommodation, which is estimated to be close to 800 in 2024
- almost 3,000 fewer people needing home care support.

2.3 The Manchester LCO have commissioned IMPOWER to support us to deliver Better Outcomes, Better Lives. The programme builds on IMPOWER's expertise and experience with other local authorities, tailored to the specific strengths and challenges that we have in Manchester.

2.4 The programme is structured around six key workstreams. Four of the workstreams started in January 2021.

- **Maximising independence** – practice led work with teams across the city, embedding strength-based approaches to assessment and review including via 'Communities of Practice' being rolled out across teams
- **Short-term offer to support independence** – building reablement capacity, embedding technology and digitally enabled care and ensuring opportunities to maximise independence through hospital discharge
- **Responsive Commissioning** – ensuring that our commissioning approaches are responsive to need and demand

- **Performance Framework** – embedding a learning and performance approach across the service at all levels

2.5 The programme is key to delivering the savings set out in the 2021/2022 budget agreed by the Council in March 2021. The Better Outcomes Better Lives trajectory model, agreed in October 2020, has net savings of £6.1m in 2021/2022.

2.6 The aim of the programme is to build a social care system that starts from people's strengths and puts in place support earlier, so that people can lead more independent lives for longer. Doing this right means that Manchester citizens receive the right support at the right time, based on individual needs, delivered at neighbourhood level by integrated teams.

2.7 The programme will ensure that Adult Social Care in Manchester can be delivered sustainably. It operates alongside other system-wide strategies, like the Manchester Housing Strategy, to make sure that all services across Manchester are working in sync as enablers to support people's independence.

3.0 What will feel different for residents who receive our adult social care services in the future?

3.1 These are our aspirations for what social care will feel like after the Better Outcomes Better Lives programme is complete in 2024:

- Discussions with health and social care staff will be consistent, person-centred and focus on how people would like to live their lives, enabling them to explore different, creative options to do this, including using assistive technology.
- There will be better early help by making the most of all points of contact that people have with health and care, including a better online presence so that people are empowered to help themselves, when appropriate
- More people will be able to do things for themselves and remain in their own homes, or have care closer to home so that they can be connected to their communities in a way that is right for them. If leaving hospital, or in need of a step-up of support, an excellent reablement service with technology enabled support throughout it, will be there. This will mean that people will be more likely to be supported at home or in their local neighbourhood in 2024, rather than in residential care.

What will feel different for families and carers?

3.2 The lives of carers and families will be as important as a person in direct receipt of care when discussing support. Carers will be supported to have fulfilling caring experiences in a way that is right for them for as long as possible.

3.3 Through the new Carers Manchester Contact Point (CMCP), carers can expect proactive and flexible support. The CMCP has begun extensive

proactive work to identify more carers, including those who need a Carer's Assessment. Strong referral pathways will ensure that Social Workers and the Carers Team work will closely with CMCP to deliver improved outcomes to carers such as personalised support and contingency planning, access to a Carer's Personal Budget, and an improved respite offer to allow Carers regular breaks, with the wider aims of reducing Carer crisis and breakdown.

3.4 Community teams will be supported so that users can access specialist support services, including for learning disability, mental health and autism. Health and care staff will be part of integrated neighbourhood teams across Manchester, so that local support is provided that understands the strengths and needs of local people.

What will feel different for staff?

3.5 Teams will have more freed up capacity to focus on delivering the right support to the right people. Teams will have more confidence in having a conversation with citizens, families and their carers focused on their strengths and practical opportunities, like technology ana, to living more independent lives.

3.6 Teams will have increased awareness and confidence in community resources in the areas they work, through training and new information links.

3.7 NHS, hospital and social care teams will work more closely together through MLCO. They will also work more closely with colleagues in their neighbourhood, such as district nursing, and with health and care commissioners.

3.8 Practitioners and commissioning will work closer together to ensure that commissioning enables practitioners to identify the most suitable support for people.

3.9 Staff will have more confidence to use and trust data to understand how change is happening. This will support them to be empowered to have the biggest positive impact that they can, as important changes can be prioritised

4.0 Key activities

4.1 The following sections set out the main activities and changes that are taking place within the programme, which will enable us to achieve these aspirations. We have also included some short case studies to illustrate what these changes mean in practice.

5.0 Maximising the independence of residents through improving our social work practice

Strengths-Based Approaches

5.1 We know that there is more we can do in Manchester to support and empower our residents to lead as full and independent lives as possible. In the past, the culture and practices in social work in Manchester have sometimes been risk averse and disempowering for residents. The best practice in social work starts by looking at what a person can do, what they love, and what makes their life good. It then looks at what additional things a person needs putting in place, to build on that person's strengths. This is called a Strengths-Based Approach.

5.2 It has long been recognised that this approach is a better way to practice social work. When social workers and social care assessors work in a strengths based way, the people they work with are happier, healthier, feel more in control and able to make choices. It leads to better outcomes. This way of working is the approach for the future of adult social care assessment and social work in Manchester. Analysis of Manchester's care packages shows that on average, we put in place more care than people really need or want, which costs us more money than necessary. This means that if we improve social work practices we should see packages of care reducing, on average. This should reduce the increases in demand that we would otherwise expect to see. But cost does not drive the decisions the social workers make.

5.3 In Manchester, we first introduced strengths-based practices in 2018, with a focus on training the workforce. This was a really successful training programme, but it revealed that there were things that got in the way of practitioners taking a strength-based approach with residents. Things such as not being able to access the right commissioned provision, not having enough capacity and not knowing what impact the approaches had. So strengths based practices found a home in Better Outcomes, Better Lives, a much larger transformation programme that is, in part, designed to address those barriers that practitioners find get in the way of taking a strengths-based approach.

Case Study – taking a strengths-based approach to a safeguarding concern, to support someone to stay at home

Joint working enabled a man to be safely discharged from hospital back to home when he previously had been unable to manage in his home environment.

Focus on strengths: Prior to his hospital admission, the man had been sofa-sleeping and unable to manage his home environment. While he was in hospital he was referred to safeguarding. The duty safeguarding professionals (a social worker and a physiotherapist) undertook a joint visit to his home and family. The professionals applied a strengths-based approach to the visit. The visit looked beyond the immediate safeguarding concerns and considered his mobility in the home and assessed the wider home environment.

Outcomes: Without an integrated and strengths-based approach by the professionals involved, the citizen would likely have ended up in a placement. Without the joint working the citizen's support would have been caught between health and social care decision making processes.

However, because of the strengths-based approach the citizen was safely discharged to his home environment. The physiotherapist continues to provide support and feedback on safeguarding concerns via the physiotherapy care plan

Communities of Practice

5.4 One of the barriers that was identified was a lack of professional support for practitioners to help them implement the improvements they learned about in training. In order to support professional development and reflective practice, we have established Communities of Practice (CoPs). These are weekly meetings, held in teams, which give practitioners a space to learn, reflect, share experiences as well as enable peer support and challenge.

5.5 CoPs started in the south locality, then were rolled out in North and now have been set up in Central. The CoPs that take place in the south are very well established and the facilitators who run them have taken complete ownership. In North they are heading in that direction, and in Central there is more work to do to establish them. The next steps in developing them further is to bring in wider input from health colleagues and the wider system.

Communities of Practice Case Study – Reflections and new ways of working

Dave Bradley, Health Development Coordinator and CoP Co-Facilitator

Our Community of Practice meetings started like many others across the city, with the Maximising Independence team being key to setting the tone of these initial meetings. I think both myself and Winifred may have felt a little worried about taking responsibility for them.

During these early days the engagement of the Social Work Team was a little less than enthusiastic, and it was often hard work to get good conversations flowing. Reflecting on this, this scenario was completely normal! Bringing tricky case studies, we are often exposing our potential weaknesses to others.

I decided to ask the Team what would work best for them? Do people find the meetings useful? How would you like to see the meetings develop? This generated some useful conversations and the group decided that we would start to invite partners into the meeting. Initially these were Health focused - Be Well Social Prescribing Team and 93 Wellbeing Centre. Both of these participants added so much value to the meetings and it was at this point the meetings started to become more interactive.

As a further development, Winifred and I decided that the meetings would now become themed. This was discussed with the Team and the focused sessions have been put together based on the predominant themes/ challenges that the team face on a day-to-day basis. Our first session was around finance, debt management and support accessible in the community. We invited Gateway M40 and North Manchester Community Partnership to the meeting to share what they do and how they support people, whilst also informing the team how they can support them to support the people they work with.

Other focused sessions planned for the future include: alcohol and substance abuse: dementia and neuro conditions: work and skills and housing.

Our CoPs still have a focus on strengths-based and reflective conversations; however this now also includes strengthening the knowledge of the team to what support networks and community assets are available to them and Manchester's residents.

Since starting the CoPs I believe that referrals to other agencies have increased, this is predominantly via Be Well but as we bring more agencies in referrals will widen across all partners.

Winifred Laryea, Senior Social Worker and CoP Facilitator continues...

“Team members initially thought CoPs were an addition to their workload. However, over the weeks we have begun to see the benefits. We always engaged in reflective conversations soon after each CoP, and gradually after meeting Dave in person, most team members have lit up with confidence to fully participate! The past few themed weeks have opened a minefield of developing knowledge and relationships with 3rd party services. **The impact is incredibly positive and empowering.**

It's great working with Dave who is very knowledge about services within our community and has links with them. This has contributed hugely to our CoPs.”

What do the Team say?

“Overall CoPs have improved my strength-based conversations and assessments, improved outcomes for service users; and boost my confidence working with complex cases. Thank you so much to the facilitators!”

"They have increased my knowledge on resources in the community to sign-post people to”

“The CoPs sessions have increased my awareness of services available to work with collaboratively to promote strength-bases working. Some interventions are now moving on quicker than before.”

“The community of practice sessions have been beneficial to my strength-based practice in various way. For example, listening to case studies from other professionals has been used as a learning tool on how to improve my own practice.”

Strengths Based Reviews

5.6 Strengths-based reviews help to identify if a person's needs have changed and if the support being provided might need to be altered as a result. In the original evidence base for Better Outcomes Better Lives, Manchester was identified as having significantly more reviews that result in 'no change' than

other local authorities who are our statistical neighbours. This presents an opportunity to use strengths-based approaches to undertake reviews to make sure that people have the right support in place. The programme has also worked with practitioners to develop strengths-based tools to support planning and preparation for review activity, an approach to prioritisation of activity and is monitoring the impact of this work to ensure it supports greater independence and improved outcomes.

Case Study – Person-centred integrated working to prevent an emergency placement of a young adult

A young adult was at risk of admission to a mental health or specialist hospital. Their family unit was at risk of breakdown. The young adult was assaulting mum. The family were receiving separate service offers from health and social care; and the focus of support was on managing the young person's behavioural challenges.

Focus on strengths: The young adult was identified as being at risk of emergency placement or being arrested because of assaults on mum. Community Learning Disability and mental health professionals from Greater Manchester Mental Health (GMMH) and the Clinical Commissioning Group (CCG) discussed the case in a newly established multi-disciplinary meeting.

The multi-disciplinary discussion focused on identifying the least restrictive support option for the young adult. As a result of this discussion, a positive placement search was undertaken. The placement search was centred on identifying a provider who could work positively with the young adult's family and their college. The search was also based on identifying a provider who could support the young adult to achieve SMART targets to improve their wellbeing and reduce behavioural challenges.

Outcomes: A suitable placement was identified and a co-designed plan was put in place, which all parties agreed to (including the family, the provider, and the service professionals). As a result of this the family remain intact and functioning as a unit. The multi-disciplinary team remains active in supporting the young adult. The young adult and the family are moving forward in a positive direction.

6.0 Improving our short term offer

6.1 Another part of the service that the programme focuses on is the short term offer that people receive for temporary, intensive care and support. Some people receive support and then don't need anything further, and some people go on to longer term care. At the moment, we know that too many of the people who receive the short term support go onto longer term care, or larger care packages than needed. An important part of ensuring that people have the right type and level of care for them is ensuring that when they're in crisis, the support they get helps them and makes things better. There are two main ways in which we are improving this.

Better use of Technology Enabled Care (TEC)

6.2 TEC can enhance someone's experience, give them greater control over their lives and help them keep in touch with loved ones, their community and professionals. It's a crucial part of supporting people to be as independent as possible. But it needs to be the right kit, for the right person, and people need to know how to use it.

6.3 In Better Outcomes, Better Lives we are investing in making sure we have the right technology for what people need. We are testing different types of technology, so that we have an offer that suits what people need and want.

6.4 We are also supporting the workforce to take a "TEC first" approach. This means that TEC should always be considered when practitioners are making assessments about what support needs to be put in place for a person. We have made a lot of improvements to how we communicate about TEC, to help practitioners think of it in the first instance. We are also improving the process for making requests for TEC to ensure there are no barriers to accessing it for residents.

6.5 The data for September demonstrates an upward trend of TEC devices being used as enablers to support individuals to live more independent, and healthier lives, building on their strengths and improving outcomes.

Case Study – Applying an integrated and strengths-based response to manage complex needs

An Occupational Therapist and a Social Worker adopted a strengths-based approach to respond quickly and effectively to a safeguarding concern.

Focus on strengths: The person was identified as being a safeguarding concern because they were living with someone who was a severe hoarder. They have a learning disability and were identified as being vulnerable to abuse and exploitation. They lead a chaotic lifestyle and have previously been in contact with the criminal justice system.

Prior to Better Outcomes Better Lives there would have been separate service responses to the challenges this person was facing. The Learning Disability teams would have only assessed them individually and their health needs would have been managed separately to their social care needs. The issues relating to hoarding would have been managed via a totally separate referral to the Integrated Neighbourhood Team.

However, because of Better Outcomes, Better Lives an occupational therapist (OT) and a social worker undertook a joint visit to identify the best least restrictive option to support the person.

Outcome: As a result of the joint working, a single co-ordinated response was developed. The response involved using TEC to manage the risks the person was

facing whilst allowing them to stay in their own home. They continue to receive input from the OT so that they are able to manage the home environment.

Improvements to reablement

6.6 Reablement is way of helping a person remain independent, by giving them the opportunity to relearn or regain some of the skills for daily living that may have been lost as a result of illness, accident or disability. A reablement service may be offered for a limited period in a person's own home and can include personal care, help with activities of daily living, and practical tasks around the home. When reablement goes well for someone, it can help them get back to normal quickly, or adjust to changes in their circumstances. It can also mean that someone doesn't need to have longer term care or will need a less intensive care package than they otherwise would. This is why we have invested more into our reablement service. This will mean that it is well resourced and available when needed, and our staff are qualified and highly skilled.

6.7 As a result of the improvements we have made, the Reablement service has seen a 78% increase in community referrals from the Integrated Neighourhood Teams since the programme began. For the September period, the service also supported 309 citizens which is significantly above the target of 260 citizens. In the same period, 61% of citizens were able to leave the service with no further care requirement.

Testing small scale pilots

6.8 In order to work out the best way of enhancing our use of TEC and maximising our reablement offer, we are testing different ways of working using small scale pilots. If these pilots demonstrate strong evidence that they make a positive difference, we will scale them up, either geographically or with a wider group of people. If they don't demonstrate evidence we will discontinue them. We have a number of small scale pilots in progress or in planning. Three of our key pilots are:

6.9 **Reablement criteria:** To increase the number of people who access Reablement, build relationships and encourage staff to consider people's potential for reablement, we are trialling a new approach through a one-page criteria document. We're currently testing this with Victoria Mill INT.

6.10 **Anywhere Care:** The Anywhere Care device brings together a number of technologies (including falls sensor, GPS monitoring and YourMeds alerts), into one monitoring device which alerts families/carers when triggered. The device is being testing in partnership with the South Discharge to Assess Team, to understand whether it can enable people to be more independent at home post discharge.

6.11 **Occupational Therapy trial:** In Central Locality, Reablement Discharge to Assess (D2A) assessors are identifying people with mobility / personal care /

kitchen related needs and delivering joint goal setting with Occupational Therapists from Central Manchester Community Response Team.

Case Study – Joint working between occupational therapy and reablement

The person was discharged on 20/07. At discharge they were assessed as have reduced confidence in relation to mobility, needed full support to wash and dress, and needed support to prepare meals and drinks.

Focusing on strengths: The reablement review officer identified that this person could benefit from occupational therapy input to develop goals which would enable them to be more independent. At a home visit on 22/07 the occupational therapist identified that what mattered to the person was being able to go to bingo in the community three times per week, like they had done before admission.

The reablement review officer devised progressive strengths-based goals which would work towards this main goal. The first set of goals were that after two weeks, the person would be:

- independent and confident with mobility when using the kitchen trolley
- independent with using the shower
- independent with preparing hot drinks and snacks
- independent with ordering shopping online

The reablement review officer and occupational therapist set out tasks for the reablement support workers to enable these outcomes, including to:

- supervise the person when they were using the shower, and only assist if needed
- use a perching stool to enable them to wash and dry independently
- supervise when they prepare a meal and hot drink and only assist if needed, use a kitchen trolley to transport items between kitchen and living room.

Outcomes: When their progress was reviewed on 28/07, they were assessed to be:

- independent with drink/meal preparation.
- independent mobility using walking stick and accessing community.
- still needed support to wash and dry because of having a temporary orthopedic boot

The outcome of the review: care package reduced from 3 calls to once daily. A further review will be needed when the orthopedic boot is removed.

7.0 Improving how and what we commission

7.1 Historically, 'commissioning' has been how we work to arrange and buy services for people who need adult social care in Manchester. In the MLCO, we want commissioning to be much more than that. Effective, strategic, compassionate commissioning will be how we work with system-wide partners to respond to local needs in a truly place-based way.

7.2 Within Better Outcomes, Better Lives, we have developed a Commissioning Plan which sets out how our approach to commissioning will support integration between health and social care services in the coming year. The plan sets out how we will innovate with providers and shape local markets to respond to the short, medium and long-term challenges that we collectively face as we recover from the Covid-19 pandemic. Our approach will help us grapple with an ever complex landscape, where we increasingly recognise that social determinants of health will be crucial not just to social care, but also to health services.

7.3 We have set out eight priorities in the commissioning plan which will help us achieve this:

Putting prevention into practice – Create an environment with more citizen choice and control, with support closer to home that enhances peoples' wellbeing and independence in a way that is right for them.

Market development – Plan to support the adults social care market to be innovative, improve outcomes, align to LCO's strategic objectives & ensuring adequate supply of future support.

Citizen commissioning – Making sure that commissioners have the tools and knowledge to meaningfully involve residents when developing support models, and to make sure that citizens' voices are heard when things aren't right.

Community led commissioning – Creating and using flexible purchasing models for community-led solutions that are more personalised, strengths-based and build resilience.

Flagship commissioning activities – Identifying the highest impact projects in adult social care to make them more than the sum of their parts.

Building Local Good Practice into Business as Usual – Taking stock of current arrangements to make sure they are the best they can be.

Contract management – Driving better outcomes for citizens through robust performance management of existing support delivery, evolution of measuring outcomes and better relationships with providers.

Skills for strengths based commissioning – Equipping the commissioning workforce and stakeholders in the widest sense with the knowledge and skills to deliver the commissioning plan priorities.

8.0 Better use of data

8.1 Making better use of data is a key part of how Better Outcomes Better Lives is enabling people to work differently. There are two closely linked, but distinct, sides to improving how we use data. The first is how we use data within the programme. We are collecting specific information about what impact the programme is having, what's working and what could work better. The second

part is supporting service and teams use data to make better decisions. There are three key tools to enable this, which are currently in varying stages of development.

Learning Logs

8.2 Learning Logs are completed by practitioners when they have carried out an assessment or review. The information they capture includes how the programme has supported them and whether there are gaps in provision. They provide a rich source of information, both quantitative and qualitative, to inform what we need to focus on to support improvement.

Top Level Report

8.3 The workstream has also developed a high level performance and finance report, which reflects demand, budget trajectories and cost. It is produced by the Council's Performance, Research and Intelligence service, and owned by the Adults Directorate Management Team. The purpose of the Top Level Report is to give an overarching view of performance across the directorate, to:

- Provide assurance and visibility.
- Enable senior leaders to set priorities and actions.
- Understand the impact of performance and demand measures on spend.
- Show what impact Better Outcomes, Better Lives interventions are having on business as usual.

8.4 The Top Level Report is now in regular monthly production, and has received very positive feedback from senior leaders in the LCO and Council. It is reviewed on a monthly basis by the MLCO Executive, contributes to the Council's integrated monitoring report and is reported into the MLCO Accountability Board, co-chaired by the Executive Member for Health and Care. The report will evolve over time to ensure that it remains a useful tool which enables taking decisions and actions that lead to improvement. A number of the metrics included in the report are referred to above.

Team Level Framework

8.5 We want teams to understand and own their own performance and how their actions, behaviours and culture have an impact on measurable outcomes. As set out earlier in the report, there are new approaches, structures and practices being put in place for practitioners and teams. Teams need to be able to understand what tangible difference these practices make. This will reinforce good practice, but also enable managers to tackle poor practice. With this goal in mind, the programme, led by PRI, are working with teams to develop a tool to support this. The tool is being co-designed and adapted to provide only the data that teams need to support constructive improvement. Following extensive engagement to understand needs, a pilot version of the tool has been developed with a team in south locality.

8.6 We recognise that this using data effectively requires skills and knowledge that are new to some staff, so we will be undertaking a review of skills and providing support and development for those who need it. Our guiding principle is that performance shouldn't be punitive, but constructively support improvement.

9.0 Next Steps

9.1 Better Outcomes, Better Lives began in January and we are 10 months into a three year programme. We are currently in the process of taking stock within the programme to set out our plans for phase two, which will take us to March 2022. Two of the six workstreams in the original plan were intentionally not started in order to concentrate resources on where we could have the most impact. We have now agreed in the programme it is the right time to commence the most pressing of this work. These workstreams are key to tackling significant barriers within the service and systems, and therefore they are essential to enabling all of our ambitions in the programme to be achieved.

9.2 **Early Help** – we have agreed to commence scoping this workstream in detail. The overarching aims of this workstream will be to have:

- A cohesive initial contact
- An improved online offer which supports independence
- Maximising the community offer

9.3 The number of new contacts that we receive through the contact centre is much higher than we would normally expect to see at this time of year and are consistently above the three year average. This is likely driven by the Covid-19 pandemic and is putting considerable pressure on our services. The purpose of the Early Help workstream is to ease some of these pressures.

9.4 **See and Solve (Transforming Community Teams)** – The purpose of see and solve will be to address entrenched system barriers that get in the way of practitioners taking decisions which empower residents and build on their strengths. We are currently in the process of assessing what to prioritise in order to have the most effective impact.

10.0 Conclusion

10.1 In the first ten months of the programme we have progressed at significant pace and achieved a huge amount. Embedding real, sustainable change in how we work across the whole service takes a lot of time. It's an incredibly ambitious transformation programme and there remains a lot to do over the course of the rest of the programme, to deliver what we need to and our staff and residents deserve.