Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 7 September 2022

Subject: Better Outcomes, Better Lives

Report of: 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 November 2021, when the committee last had an update.

Recommendation

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 2022/23, the Better Outcomes, Better Lives programme reflects the declaration of a climate emergency. The responsive commissioning workstream in particular continues to 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 people and assets to improve outcomes for those who need support. Report specifically includes work within programme on equality impact assessment, a tool for ensuring impact of our work supports equitable access.
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	

Contact Officers:

Name: Bernie Enright
Position: Executive Director of Adult Social Services
E-mail: bernadette.enright@manchester.gov.uk

Name: Sarah Broad
Position: Deputy Director of Adult Social Services
E-mail: sarah.broad@manchester.gov.uk

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 people 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 and November 2021.
Link to the March 2021 committee reports
Link to the June 2021 committee reports
Link to the November 2021 committee reports

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

2.0 Background

2.1 Better Outcomes Better Lives is a programme of practice-led change centred on achieving better life outcomes for the people of Manchester by working in a strength-based way. The programme aims to enable less dependency on more formal care, whilst also helping us to build a more sustainable future for the people we support.

2.2 The programme began in January 2021 to an existing backdrop of rising demand for Social Care support among the adult population of Manchester, and growing pressures on Social Care funding. Since starting the programme, the unprecedented challenges of the COVID-19 health pandemic have continued to impact, and we are seeing more significant health challenges for our people, increases in unemployment, greater usage of food banks, and a rise in loneliness and mental health concerns.

2.3 In this context, the Better Outcomes Better Lives has continued to focus on embedding a strengths-based approach alongside work to develop our short-term offer, work to improve and develop our operating model, work on how and what we commission and embedding a performance approach across all of our services. Collectively these interventions have been intentionally designed to help our people achieve independence and better outcomes wherever possible, whilst preventing, reducing and delaying demand into adult social care services.

2.4 The programme has six areas of focus:

- **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
- **Early Help –** developing our Early Help offer so that people can receive the right support and guidance at the right time. Including providing a robust online information, advice and guidance offer and developing a strengths-based conversation approach with our Contact Centre staff.
- **See and Solve –** This workstream works on specific challenges that impact on staff working in a strengths-based way.

3.0 Impact

3.1 Now that we are more than 18 months into the programme we know that we are having an impact:

- The **number of Older People's residential and nursing placements** has **reduced to 740** (June 2022). This represents **a net reduction of 25 placements** since March 2022, evidencing that people's independence is being supported in less restrictive settings
- A **reduction of 6 residential Learning Disability placements** in 21/22. Exceeding the modelled reduced of 4.
- **Around 4% reduction** in the proportion of reviews resulting in an **increase to a package of care** in comparison to this time last year. Indicating a shift in focus to increasing independence.
- **10% increase in monthly TEC applications**, compared to last 12 months. Indicating greater knowledge and awareness of using TEC to support people.
- **58% of people requiring no package of care at the end of period of reablement** (June 2022), exceeding the service target of 54%
- Our all-staff survey results for 2021 have shown an improvement across a number of questions from 2020 with **92% of colleagues understanding the organisation's values and behaviours** (strongly agree or agree).
- **Over 900** survey responses in the first year of the programme, from staff saying that the programme had supported them to develop strength-based approaches in their practice.
- **Over 400** survey responses in the first year of the programme, from staff saying that their involvement in a Community of Practice had supported them to further develop their strengths-based practice, improving the impact of their work

3.2 The following feedback has been shared about what this feels like for the people that we are working with:

- **Strengths, passions and interests are part of the conversation:** "I asked Diane what she used to enjoy doing. She started to talk about knitting, her art, walking to the shops. As she spoke, her face lit-up for the first time!"

- **Focusing on supporting independence can improve wellbeing for the person and their family**: “We have seen a change in grandma. She sits outside in the sun, watching people pass by. I don’t have to worry now”
- **Listening to what matters, adapting approaches and providing choice** “I hope you know what a gem you have in Vanessa. In my time I have only come across a handful of people who can advise, and help disabled people with compassion”

3.3 The following feedback is from our staff about the impact they see day to day:

- **Practitioners are sharing really strong case studies about working in a strengths-based way to support people’s independence:** “It’s too easy to ask people what their needs are and want to fix it. Better Outcomes Better Lives makes me more aware of working with people and not doing to them. It keeps that at the forefront of your mind”
- **Awareness is increasing of using TEC to support independence.** “I don’t feel like an expert but becoming a TEC Champion has given me the confidence to try new things. We’re really seeing the impact on TEC keeping people independent”
- **Communities of Practice are supporting greater awareness of the local offer in neighbourhoods:** “The past few themed weeks have opened up and developed knowledge and relationships with 3rd party services. The impact is incredibly positive and empowering”
- **Practitioners' views are shaping priorities on the programme:** “I felt better getting it off my chest. I was then invited to a senior manager’s meeting to provide more feedback. This impact its now had – just from completing My VIEWS”.
- **Stronger relationships are being built between Commissioning and frontline Social Care.** “In my 20-year career as a social worker, it was the first time I’ve sat with a group of commissioners and been able to articulate some of the front-line challenges. It felt that people were engaged”

3.4 The impact of the work delivered so far was recently highlighted through the programme being shortlisted for an LCG award in innovation in health and social care. While this acknowledges the work delivered to date, we know there are still challenges to be tackled. The following provides an update on key work and priorities in achieving our aims and delivering better outcomes for the people of Manchester.

4.0 Maximising the independence of our people through improving our social work practice

4.1 Supporting our staff to work in a strengths-based way is fundamental to the programme. This means that Social Workers and Assessors will work with people to identify what they can do, what they love, and what makes a good life for them. This helps to support individual wellbeing and is regarded as best practice. Some people may benefit from TEC, equipment or other support and services to maintain their independence and achieve the outcomes that they want to achieve. This support is planned around being as least restrictive as

possible so that people can live as independently as possible. It's about ensuring the right support is provided, at the right time for that person.

4.2 To illustrate the difference that this approach can make for people, see the case studies below:

Maximising Independence: Case study 1
Jane Reck – Social Work Apprentice

Ken and his wife were living in private rented property. The accommodation was in his wife's name, and when she recently passed away, he was forced to move. Jane told us "Ken chose to move to a new area to make a fresh start. When I met with him, he had just moved into extra-care housing. In his new accommodation, Ken has a lovely large wet room, however he felt intimidated by the size and space, and insecure while showering. I ordered Ken a shower seat and rails, so he'd feel more secure. **As a trusted assessor, I am able to confidently identify, order equipment and return to fit the items as required**. I used their in-house fitter for the rails - to make the process faster."

Jane focused first on what Ken was able to do himself. "**We talked about the pros and cons so that he can make an informed decision**. Despite health conditions that impact his ability to do things, Ken loves his independence and is keen to not lose it." **Ken had been offered assistance with his laundry**, however because there's a lift, Jane ordered him a four-wheel walker - so he can continue to do this himself. He also bought a small plastic four-draw container so that he can organise his medication for the following week. Jane continues "**It's about giving him control and independence.** We're sometimes preoccupied with TEC and can be intrusive in offering too much." Staff helped Ken register with a GP, so in under a week, he had an equipment assessment, his needs identified, and everything ordered including his medication.

Ken enjoyed socialising throughout his life, however since lockdown has become much more apprehensive. The purpose-built extra care housing has a café, so he's not isolated now, and can socialise again once he's ready.

Jane concludes, "I really enjoyed spending time with Ken. **My strength-based toolkit has enabled me to identify that care is not always required - by being proactive with the person's abilities**. Ken has a good outlook and wants to remain independent. Low-level equipment will enable him to complete personal care independently and be in control of his day-to-day activities. I naturally take a holistic approach and I'm also a big believer in reflection. I try to make sure people have all the information they need to make an informed decision. **Better Outcomes Better Lives just reminds me to always see the person - not a situation or referral**.

And Ken? Jane saw him again this week. Reflecting on his new equipment, he said "It's very handy, just the job to keep me going so I don't need to ask for help".

Maximising Independence Case Study 2: Think Strengths, Think Community

Adele Hooper (Primary Assessment Officer) & Debbie Baxter (Direct Payments Coordinator)

Paul is a high-functioning autistic adult. He is 27, attends college and is currently living with his parents. Adele first met with Paul when his advocate from Gaddum got in touch to say that **Paul is keen to live independently**. When Adele first met with Paul, they talked about him having a **direct payment** as one of the **first steps towards his independent living**. Unfortunately, Paul previously had a bad experience with his benefits being over-paid – which he'd then had to pay back. Adele discussed these concerns and put him in touch with Debbie, so that they could discuss his options.

Debbie tells us "I always read case notes - the assessment and support plan – before contacting the person. I saw Paul is an adult with autism, so when during our first telephone conversation I found myself going over and over the same thing, I asked Paul if he'd rather we meet in person – and if so where. Paul chose Costa Coffee in Withington, so we met there, along with his advocate, Maureen**.**

Paul told me he'd like to be able to socialise more with other autistic people his age. I contacted I AM Autism (a UK charity specialising in supporting people 10yrs and above, who have a diagnosis of autistic spectrum condition). I then told Paul about their activities, and how he could manage his budget to decide which activities he'd like to attend. Following his previous experience with benefits, I was keen that Paul didn't have ongoing concerns in this area, so we discussed this together with I AM AUTISM, and they set up a process **whereby they provide Paul with a weekly invoice, and support him to pay this, so that he feels in control and knows where he's up to. It was important for Paul to manage this without the support of his parents.**

"**I asked Paul for his preferred method of communication going forward**. He advised his preference would be a telephone call, followed up by bullets in an email. Our Direct Payments information letter is six pages long, so I adapted it into an easy-read version that sets out – this is what you have, how you can top up, and that it's flexible. This is working really well!"

Adele reflects, "**In Manchester we always want the best for people and will go out of our way to achieve that**. When I first spoke to Paul, he was very anxious. I followed-up with I AM Autism to see how he is getting on and they said it's all going really well.

4.3 Working in this way isn't without challenges, however, and we know that sometimes processes, forms and policies aren't always set up in a way that supports our teams to work in this person-centred way. To really change how practice works and support a change in culture we also need to address some of these barriers and challenges that can drive different behaviours. To support this change in practice we have developed regular forums for front line teams to come together and share their experiences and reflections. Routine,

group reflection is also part of professional development for Social Workers and is recognised as supporting practice development.

Community of Practice

4.4 Community of Practice meetings provide weekly space for front line teams to come together, learn and reflect on their experiences of working in a strengths-based way. They provide peer-to-peer learning, support and challenge in a safe and constructive space. They are hosted in each Integrated Neighbourhood Team and Learning Disability Teams and are facilitated by the Senior Social Worker or Practice Supervisor.

4.5 Practitioners have routinely fed back that attending a Community of Practice has supported them to work in a strengths-based way, 96%, or, just over 400 responses recorded in Learning Logs stated that Communities of Practice had helped practitioners to develop their Strengths Based working in the first year of the programme. Feedback is also regularly sought from facilitators and attendees through our Community of Practice Self-Assessment process, this has highlighted an:

- Increase in practitioner knowledge of resources available in the local community
- Better information sharing on cases as a result of attending CoPs
- Assessments becoming more analytical as a result of CoPs
- Strengthened networking & relationship building with wider colleagues
- Impactful learning and peer reflection -particularly for newly qualified staff
- Positive impact on team building and wellbeing

4.6 As well as providing space for positive connections with colleagues and increasing knowledge, these forums also enable reflection on topics that are more challenging. This means barriers to working in a strengths-based way can be discussed, and ideas shared for how to approach these. Where there are issues that cannot be resolved by the group, these are fedback into the rest of the programme.

4.7 Providing more time for practitioners to reflect and learn is widely regarded as good practice and has been acknowledged in a visit from Lynn Romeo, Chief Social Worker for England.

4.8 To expand the reach and scale of these forums work has started to introduce other services to the approach. Introductory sessions have now been run with wider Adults Services including: Reablement, Equipment and Adaptations, Short Breaks and the Multi-Agency Adults Safeguarding Hub.

My VIEWS

4.9 To support further support individual reflection and help to ensure that the programme is tackling the barriers faced by front line staff, we have also established an engagement tool called ‘My VIEWS’, previously named Learning Logs. My VIEWS stands for ‘My Views, Ideas, Experience, Wisdom

and Skills' and is a survey completed by staff to reflect on how they have worked in a strengths-based way and to highlight what they think has worked or what might have got in the way of this. The most frequent themes highlighted in My VIEWS since March 2022 are:

- **The importance of informal care relationships** – highlighting the significant role that these relationships play, even when people are receiving formal care and support
- **Positive examples of using TEC to support people's independence** – demonstrating the growing awareness and confidence in use of TEC

4.10 Themes around barriers faced by practitioners to working in a strengths-based way have highlighted issues and concerns where there has been a lack of support or input from services. This demonstrates the need to influence and introduce more partners to the ambitions of the programme and strengths-based working.

4.11 Information, ideas and feedback is collected from survey responses and is included in programme reporting and supports key activity. A recent example of feedback from My VIEWS has been the challenges highlighted by practitioners around finding the right support for people with Autism. Following this feedback there is now a priority focus on Autism in our commissioning work.

Strengths Based, Focused Reviews

4.12 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. Strengths based tools have been developed with practitioners to support review conversations to focus on independence and choice. These tools are being used alongside a more proactive approach to reviews that have been launched. These reviews focus on opportunities that might lead to greater independence. For example, when someone might have been discharged from hospital and are getting well faster at home than initially expected.

4.13 Over a 12-month period just over a third of these focused reviews are showing a reduction in the size of the support package. This represents a higher proportion than those in annual reviews, around 17%. The impact of this work continues to be monitored to ensure it supports greater independence and improved outcomes.

Communities of Practice Case Study – Strengths Based Reviews

Albert Ndhlovu - Primary Assessment Officer

When Albert met with Diane for her Strengths-Based Review, she was struggling with her mental health. Diane was finding it hard to get motivated to leave her property or prepare food for herself. Albert tells us:

"**I asked Diane what she used to enjoy doing. She started to talk about knitting, her art, walking to the shops. As she spoke, her face lit-up for the first time! I could see these things made her happy**. I queried what was stopping her now, and she stated her friend had moved away, and since she'd become depressed, she struggled to meet with new people".

Diane's daughter stated that Diane "never listened" to her, and Diane felt her daughter was "pushing too much". Albert knew that an ongoing care package would take any independence away and would be a barrier to improving Diane's mental health. Instead, he suggested mother and daughter start afresh and just do one thing together.

Albert continued, "Next time I saw them they'd walked to the shops instead of taking the car. 20 minutes there and 20 minutes back, and they enjoyed spending time together, walking and chatting. **I introduced them to a Good Neighbours Befriending Service** and Diane started to attend a regular coffee morning! She told me afterwards "I realised some people are like me, they have the same feelings and fears." Diane also now wants to join a knitting group but is nervous meeting new people. I've suggested her daughter attends with her the first few times to introduce her to the group. They're going for the first time 1st April. I also spoke to her grandson who told me, "**We have seen a change in grandma**. **She sits outside in the sun, watching people pass by. I don't have to worry now."**

What made the difference for Albert? **"I heard about strengths-based approaches before, but sometimes due to the pressures of work we don't always see the options available. The application of a strengths-based approach in real life, has changed the teams view of assessment. We're really seeing a difference**."

5.0 Improving our short-term offer

5.1 The programme is also making significant improvements to the short term offer that people receive for temporary, intensive care and support, in order to ensure this service is as good as it can be. If we get this part of our offer right, it will mean people only go on to receive longer term care when it's right for them. Before embarking on the Better Outcomes, Better Lives programme, we knew 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)

5.2 To support our "TEC first" approach and increase the knowledge and awareness of the different TEC items predominantly used in Manchester we have been delivering TEC equipment briefing sessions to the TEC Champion Network. Our TEC Champion Network in turn receives their own briefing packs and have started to deliver briefing sessions directly to their teams, increasing and sharing their knowledge and experience across the Directorate. A

centralised Teams Channel has also been developed for the Network. This has a number of benefits: we have an improved centralised communication channel that reaches each and every team with a TEC Champion; this is directly connected with our in-house experts at Community Alarms and Technology Enabled Care Team (CATEC) who are always on hand to answer any technical questions; enables us to develop a directory of knowledge and a rich source of learning and information for our teams.

5.3 Although it is a long-term journey to truly embed the TEC first approach we have progressed significant work on the path towards achieving delivery of the agreed TEC vision to improve peoples' outcomes by enabling them to maintain their independence, dignity and quality of life at home and that their loved ones remain safe at home. A key element of this is the ongoing work with practitioners to identify, create and circulate materials, such as the MLCO Extranet web page and demonstration videos, to promote and educate to increase awareness and knowledge on TEC and the positive impact it can have upon peoples' outcomes.

5.4 As well as the progress on the development of materials to promote, educate and raise awareness on TEC both internally and externally the workstream has focused capacity upon the delivery of prototypes to test new TEC devices or kit to understand their impact and the potential for them to be included within the TEC offer. Examples of these prototypes are:

- ARMED – falls early detection system
- Just Checking – sensor system to enable improved assessment for potential ongoing care needs

5.5 The outcomes and learning from the existing and any future prototypes combined with the developing metrics will help increase our understanding of how TEC can best support people to maintain independence. With this knowledge we aspire to achieve the development of a TEC offer that is proactive in providing the right support at the right time.

5.6 Recent data demonstrates that from July 2021 to June 2022 the monthly average number of installations was 318, this is a 58% increase on the average number of installations for the previous 11 months, The Community Alarm Base Unit and Pendant, Key Safe and Falls Detector continue to be the highest issued TEC devices though the rising number of sensors being installed indicates a variation in approach from front line practitioners. Our Performance, Research & Intelligence service have provided considerable support on the development of TEC metrics which is enabling the workstream to identify targeted activity with services or localities to increase the issuing of TEC, where appropriate. The data in this report has also enabled us to identify areas of good practice and understand the reasons for this. From this analysis we have developed proposals for key roles in the system particularly around the customer journey and currently exploring opportunities with the service to deliver targeted training to support our TEC first approach. Our ambition doesn't end here either, we are exploring using our Network of TEC

Champions to share their knowledge and experience right across the Manchester Local Care Organisation so everyone thinks TEC.

Communities of Practice and TEC Case Study

Bianca Kelly, Social Worker in Ancoats, Clayton & Bradford.

Edna is a spritely older lady and loves living in the sheltered accommodation where she's been for 13 years. She is sociable, enjoys chatting to her neighbours, gets on well with her carers and has a good sense of humour! Edna has informal support from her daughter, and four daily care calls.

Edna has been diagnosed with dementia and whilst in the early stages of the disease, and still very aware of her surroundings, there have been times late in the evening when she will put on her coat and go to look for her mum**. Edna ventured outside the perimeter of her city centre Ancoats accommodation,** with train tracks nearby.

Bianca tells us, "Her daughter raised concerns and I visited Enda to reassess her support. **Following reflections in Communities of Practice, I'd seen how positive Technology Enabled Care (TEC) can be**, and as a least restrictive option, the resident and family were in agreement to give it a try.

Because Edna lives in sheltered housing, she was used to wearing a pendant but that was connected to their on-call, which didn't work outside the flat. **I worked with the Scheme Manager and Community Alarm Team** and was able to map the nearby streets to **provide a geofence and GPS tracker for the perimeter of the accommodation**. The MCC pendant is a much better option which also has an inbuilt falls detector."

Bianca continues, "This has meant that Edna can still sit in the gardens, go to her neighbours address and enjoy a cup of tea on the patio without the tracker sounding. Door sensors are also now used overnight, when she wouldn't expect visitors and shouldn't be leaving the flat**. This is working very well and has allowed Edna to remain independent and happy in the home she's familiar with and loves**."

TEC also gave Edna's daughter peace of mind, so that she knows her mother is safe.

Improvements to reablement

5.7 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 through the Better Outcomes, Better Lives programme. This will mean that it is well resourced and available when needed, and our staff are qualified and highly skilled.

5.8 Since we last reported in November, the Reablement service has been working closely with Integrated Neighbourhood Teams to increase the number of community referrals from practitioners. Following a successful pilot in North, the service is currently working with colleagues across Central INTs to increase community referrals, and this work is evident in the significant rise in new referrals between April and May.

5.9 More generally, our Reablement service has demonstrated very positive outcomes during 2021/22. This is evidenced by an average of 275 people entering into a Reablement intervention per month, this figure increased over the course of the year, peaking at 303 in October. The outcomes of people leaving the service at the end of their intervention in 2021/22 were higher than the agreed target metric of 64% leaving with either independent or with reduced ongoing care. With 58% leaving fully independent with no ongoing care and 9% leaving with reduced ongoing care needs; a total of 67%, higher than the target metric.

Testing small scale pilots

5.10 **Anywhere Care:** This pilot is testing the use of 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 tested in partnership with the South Discharge to Assess Team, to support hospital discharge and improve outcomes. 30 devices have been issues to adults discharged from hospital over summer and the evaluation of this pilot is due to start in November.

5.11 **Occupational Therapy (OT) trial:** Testing the impact at scale of using an OT to improve the quality of reablement goal setting, focus on independence and reduce demand for long-term care. Following a successful short-term, first phase of the trial, which proved the proof of concept by evidencing improved outcomes for people and demand management through the implementation of time-specific therapy led goals in a support plan a second phase of the trial was undertaken. This involved the scaling up the OT capacity to cover a whole locality for a longer time period. This second phase reinforced the outcomes from the first phase with an evaluation identifying significant impact for people who participated in the trial. These included the reduction in the average length of stay in Reablement by 5 days, from 23 to 18 and the percentage of people leaving the service after an intervention independent with no ongoing care needs increasing from 51% to 68%. Now onto its third phase, the OT capacity has been increased to three OTs with the scope extended too citywide.

6.0 Improving how and what we commission

6.1 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 and collaborative commissioning will be how we work with system-wide partners to respond to local needs. Above all, we want our commissioning to be responsive to what people need and want and much better connected to what front-line practitioners are telling us is required.

6.2 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.

6.3 There are eight priorities in the commissioning plan which will help us achieve this. Updates since November are outlined against the priorities:

- **Putting prevention into practice –** *Create an environment with more choice and control for people, with support closer to home that enhances peoples' wellbeing and independence in a way that is right for them.* Since November, we have worked with practitioners and identified requirements that will support people to have more choice and control over their support utilising low level VCSE services. A prevention strategy is being produced as a result of this. We are trialling new services at a small scale which are designed to stop people escalating into more restrictive, higher cost services at a point of crisis. Examples include outreach work with Learning Disabled people and people with an 'autism-only' diagnosis.

- **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. Quarterly Innovation labs have now been established to provide forums to collaborate with partners and providers and ensure support is efficient and outcomes focused. In addition, two specialist Innovation Labs are in the pipeline with one for the VCSE Sector early September and a Housing Innovation Lab taking place in November.

- **Citizen Commissioning –** Making sure that commissioners have the tools and knowledge to meaningfully involve residents when developing support models, and to make sure that our people's voices are heard when things aren't right. We have developed approaches led by people to make sure that our residents are part of decision-making. Using the Think Local, Act Personal Coproduction Ladder as an exemplar, we have set out our coproduction pledges to work more with residents and people who use adult social care services. Through a small 'test of change' a grant competition to the VCSE enabled Gaddum to be selected to host our

Citizen Commissioner concept. This has resulted in a dedicated Coproduction Lead working directly to the Head of Commissioning and leading the campaign citywide to recruit volunteers. So far, the small group has designed the approach they wish to take with officers of MLCO and created the 'Citizen Commissioner Committee'. These foundation steps will enable both the Better Outcomes Better Lives officers as well as Commissioners to proactively engage with the Committee and seek out their independent views.

- **Community led commissioning –** *Creating and using flexible purchasing models for community-led solutions that are more personalised, strengths-based and build resilience.* An example is work with Greater Manchester Integrated Care, Greater Manchester Mental Health Trust and VCSE partners to develop, co-design and co-produce models to shape community mental health services.

- **Flagship commissioning activities** – *Identifying the highest impact projects in adult social care to make them more than the sum of their parts.* Since November, we have been able to assess and identify the high impact projects and embed a strengths-based approach to ensure a consistent way of working. The flagships are currently being transitioned into Business as Usual activity to ensure monitoring of benefits. One example is a review of day services which has looked at our in-house and externally commissioned services. We have had input from 175 people and directly engaged day service users in a series of workshops. We are drawing together the conclusions of this work and will make firm proposals for the future shortly. A further example includes the consolidation of the Unpaid Carers pathway, with the 18 VCSE organisation in the Carers Network working together with Commissioners to help Carers early in their caring journey, offering timely interventions and support and reducing levels of carer 'crisis'.

- **Building Local Good Practice into Business as Usual** – *Taking stock of current arrangements to make sure they are the best they can be.* We have produced a data template for commissioners, PRI and finance to use as part of the commissioning process and a standard set of KPIs, both will help improve our use of data and ensure we are commissioning based on evidence. We are improving our tracking of existing contracts to make sure we have a co-ordinated approach to commissioning activity.

- **Contract management** – *Driving better outcomes for people through robust performance management of existing support delivery, evolution of measuring outcomes and better relationships with providers.* Substantial work has taken place to stabilise the contract management function, including the appointment of a dedicated Head of Contracts and more rigorous approaches to the Contracts Register, working closely with corporate colleagues to embed best practice.

- **Skills for strengths-based commissioning** – *Equipping our commissioning workforce and stakeholders with a strength- based*

approach is key. Working with our HROD colleagues, a range of commissioning training course and qualifications is being finalised; this will ensure that commissioners have the formal skills and knowledge to deliver innovative, collaborative commissioning going forward. Following engagement with staff, a range of learning opportunities were identified, including learning lunches, which is now a well-embedded approach to share information across the various commissioning teams and specialisms.

7.0 Better use of data

7.1 Improving our use of data is a priority in Better Outcomes, Better Lives. This supports us to understand the impact that we having both in terms of the programme and as a service.

Adults Strategic Performance Report (ASPR)

7.2 The Finance and Performance Framework workstream developed a strategic performance and finance report, which reflects demand, budget trajectories and cost. We recognise that is important to monitor performance so we can identify areas of improvement but also celebrate success where its due. It is produced by the Council's Performance, Research and Intelligence (PRI) service, and owned by the Adults Directorate Management Team. The purpose of the ASPR 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

7.3 The Adults Strategic Performance 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 Healthy Manchester and Social 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.

Team Level Framework (TLF)

7.4 We want teams to understand and own their own performance and how their actions, behaviours and culture have an impact on measurable outcomes. We know that understanding and owning performance is a key part of owning change at a team level.

7.5 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, have developed a Team Level Framework which is essentially a list of metrics distilled from the ASPR for Team Managers to manage their performance. The tool is adapted to provide only the data that teams need to support constructive improvement. A series of workshops were delivered to support managers to interpret data and compose a narrative that articulates levels of performance. The workstream have successfully delivered these sessions across all localities.

7.6 We recognise that 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.

Data Quality

7.7 Through the Programme and Finance and Performance Framework Workstream, the programme has developed a Data Quality Approach to ensure that our data is right. We recognise that it is important that the data we are reporting is accurate and available at the right time, at the right place. This is so our decisions are evidence based and correct.

8.0 Early Help

8.1 Providing the right advice, support and guidance to people at the right time can make a significant impact in supporting people to stay well. This workstream was launched in April and is making progress on its original aims, which were to:

- Create a cohesive initial contact
- An improved online offer which supports independence
- Maximise use of the community offer

8.2 There are four key areas that are being prioritised to support the aims outlined above.

- **The development of an online information, advice and guidance offer.** A key facet of a preventative early help offer to enable effective signposting and resolution. A framework for this has been established on Help & Support Manchester with approval recently granted for a role for 6 months to provide capacity to work with internal and external stakeholders to map, review, refresh the required content for the offer.

- **Establishing a Strengths-Based style of conversation when people contact the** Contact Centre. A 'Pioneer Group' of Contact Officers have been testing new tools and conversation prompts to support a more open, strengths-based conversation. This will be expanded across the Contact Centre supported by a Community of Practice approach for Contact Officers as well as a Team Leader Community of Practice. This activity will

start from early September led by colleagues from the Maximising Independence workstream.

- **Developing a standardised contact form to improve the quality of contacts and referrals from partners and professionals.** A first draft has been created with revision underway after the review at the workstream steering group. Engagement with internal and external partners to test the form will start in late August, before implementation and launch.

- **Testing the impact of increased professional input into duty.** A pilot site within one of the Integrated Neighbourhood Teams is being launched in September. The INT team is being supported by the new Early Help & Targeted Support team to support decision making and better triaging within their duty. A 6 week review will be completed to understand impact on support discussions and potential expansion of the prototype.

8.3 In terms of impact, there are early indications that the different strengths-based approach being taken by the Pioneer Group is having a positive impact, with fewer repeat calls being made to the Pioneers, lower numbers of duplicate records being created, and an increase in the percentage of new contacts being successfully resolved at the first call. These trends are only taken from a small sample size of the Pioneer Group and will be monitored closely as the approach expands.

8.4 To support with the development of the future front door operating model Impower have been commissioned to deliver a short-term piece of work, for 6 weeks, to support the workstream. This work will review the activity completed by the workstream to understand what's working well and identify potential future opportunities. The learning from this review will be used to develop and design a business case outlining options and requirements for a truly integrated front door operating model to support people to achieve the best possible outcomes and provide timely and effective management of demand.

9.0 See and Solve

9.1 The focus of See and Solve is to address entrenched system barriers that get in the way of practitioners taking decisions which empower people and build on their strengths. This work is practitioner focused and uses their experiences to unlock opportunities for different ways of working. This means that the outcomes are more likely to be owned by the teams and therefore embedded.

9.2 This workstream launched in April with an initial focus on the Learning Disability service. Working with teams, an opportunity was identified around how duty operates, in particular how staff could work better together and how frequent callers were handled.

9.3 Data and perspectives from the teams evidenced that if duty staff were empowered to work in a more strengths-based way, underlying issues could

be identified and resolved earlier. This could result in a better experience for the caller as well as more impactful use of staff time. This activity was prioritised by See and Solve because of the potential significant opportunity it presented to improving outcomes for people while also improving strengths-based practice for staff.

9.4 Work initially started with teams to define a collective understanding of what an integrated duty offer looks like. This was developed with teams through the Learning Disability Community of Practice exploring 'what makes a good experience of duty?'. We have captured shared learning on what the right response, at the right time looks like including collecting example case studies that evidence the impact of a more joined-up initial conversation. It has also identified opportunities to test something new and the barriers that practitioners face to working in a more joined up way.

9.5 To support a different conversation, South Learning Disability Team has tested out strengths-based tools and prompts as well as closer working between duty, health and social care. The tools have been impactful and supported duty staff to provide a more meaningful outcome for the person ringing. In addition to this, closer working across teams has provided a more holistic offer and reduced the number of referrals across services, meaning that staff time is spent more effectively, and the person receives a more joined up outcome.

9.6 Rolling out this work out further will however need to be supported by the following activity. This responds to the challenges identified by staff around what can get in the way of them working together:

- **Communicating the role of the offer to frequent referrers** – embedding the offer so providers and discharge teams are aware of the Duty Offer and promote this where possible.
- **Increase access and use of the Universal/Community Offer** – Strengthen access the universal and community offer including developing guidance and prompts. Greater access to local support and services provide an opportunity to increase independence and choice so that people can access activities that they are interested in in their community and not in specialist support that they might not be the best fit for them.
- **Route of Access** – Maximising our use of technology where possible and identifying system barriers, so that these can be resolved. Different recording systems has been frequently mentioned by staff as a barrier to working in a more joined up way. We want to explore what the opportunities are to join up systems to support staff.
- **LD Offer** – Develop an offer that supports a specialist LD services

9.7 The next steps will be to roll out this work in North and Central teams to embed across the city. Once rolled out another area of focus for See and Solve will be identified.

10.0 Equality Impact Assessment

10.1 A key priority of the Our Manchester Strategy is to ensure Manchester is an equitable city. To evidence that the Better Outcomes, Better Lives programme contributes towards this ambition, work on an Equality Impact Assessment has been progressed. This will identify any unintended, disproportionate impacts that changes the programme is implementing have on people who are part of a protected characteristic group.

10.2 The Better Outcomes, Better Lives programme is changing how front-line teams are working and this will change the conversations that our staff have with people. This focuses on firstly identifying what strengths a person has and what outcome they want from support. This does not mean removing all formal packages of care, but working with people to understand what their desired outcomes are and what different kinds of support can enable someone to achieve these outcomes.

10.3 For people, this will feel like their strengths are recognised. They might benefit from a small piece of equipment or TEC to maintain their independence. Or from accessing groups in their local neighbourhood that help them to explore their interests and support their wellbeing. Support planning will focus on choice and independence by using the least restrictive or intrusive method of support.

Equality Impact Assessment – Better Outcomes, Better Lives Programme approach

10.4 Initial work undertaken in December 2022 highlighted that focusing EqIAs onto individual workstreams did not capture the interconnectedness of work across the programme. Working with the Equalities, Inclusion and Diversity Lead, a programme-wide approach has been developed. This focuses our approach on understanding the impact of activity that will directly affect people.

10.5 The programme team with the Equality, Diversity and Inclusion Lead has identified six key areas of programme activity that will likely have the greatest direct impact on people. A combination of workstream activity might contribute towards these changes, meaning that data and insight from more than one workstream might be needed to understand the impact of the work on people. However, one lead workstream has been identified for each to support the development of the EqIA for each area of focus:

Area of focus / impact	**Lead Workstream**	**Anticipated impact on people**
Strengths based practices; including Community of Practice approach; and the Pioneer Group Community of Practice in Contact Centre	Maximising Independence and Early Help	Direct impact for people, in terms of how practitioners and staff interact with them – greater focus on independence and what the person can do, what their strengths might be and what the appropriate type of support might be available that enables them to live as independently as possible.

Focused Reviews	Maximising Independence	Direct impact on people currently receiving a package of care who might have their annual review earlier than statutory timescales with a focus on maximising independence and using the least restrictive option.
Increasing use of TEC	Short Term Offer	Direct impact – seen on the kinds of support that people might be offered as part of their support plan with more people being offered and accessing TEC to stay well and independent for as long as possible.
Increasing use of reablement	Short Term Offer	Direct impact – seen on the kinds of support that people might be offered as part of their support plan, with more people accessing reablement support to improve their independence at home.
Improving the online offer and promoting self-help	Early Help and Responsive Commissioning	Direct impact on how people find out about groups and support that might be available
Increasing professional capacity tested by a pilot INT team and the new Early Help & Targeted Support team	Early Help	Direct impact - as greater professional input will be available for contacts providing increased knowledge and support with decision making around advice, guidance, offer.

10.6 In addition to workstream activity listed above, the programme has also been using approaches to test, on a small scale, services and interventions that might address gaps identified in provision. Testing in this way with a small-scale prototype helps to provide learning and evidence for what might needed on a greater scale. Additional EqIAs may also need to be undertaken to the above six areas, to understand the impact of individual protypes and to support their evaluation.

Progress to date

10.7 A workshop facilitated by the Equalities, Diversity and Inclusion Lead has been delivered and relevant data has been identified to support the work. Within the Early Help workstream, work has started to build upon the information provided within an earlier EqIA developed by the Customer Service Organisation to support changes to the service made during covid.

10.8 This work has included working with the Performance, Research & Intelligence Service to develop a deeper understanding of the demographics of people who are either contacting or being referred into the Contact Centre. The data will provide the workstream with an improved understanding of the

characteristics of these adults to enable the identification of gaps, challenges or opportunities to be included within an EqIA on increasing professional capacity.

10.9 Within the Maximising Independence workstream relevant data and appropriate actions that might be needed to mitigate any unintended consequences of Focused Review activity are being identified.

10.10 Once actions within each of the six EqIA focus areas have been identified these will be included within programme governance for reporting and accountability.

11.0 Conclusion

11.1 Embedding real, sustainable change in how we work across the whole service takes a lot of time. This report sets out the amount of work that has been completed since we last provided a report and there remains a lot to do over the course of the rest of the programme. The Better Outcomes, Better Lives is an ambitious transformation programme, however we are committed to delivering on our ambitions for the people of Manchester.

12.0 Recommendations

12.1 The Committee is asked to consider and make comments on the content of this report.