Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 5 February 2019

Subject: Manchester Local Care Organisation

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

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Summary

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

The paper provides an overview of the following:

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

Recommendations

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

Wards Affected: All

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

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

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

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Background documents (available for public inspection): None

1. Introduction

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

1.2 The paper provides an overview of the following:

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

2. Background

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

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

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

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

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

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

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

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

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

3. MLCO Delivery Priorities in 2018/19

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

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

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

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

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

4. High Impact Primary Care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Integrated Neighbourhood Working

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

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

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

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

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

<u>INT Hubs</u>

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

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

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

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

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

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

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

<u>INT Leadership Team</u>

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

5.14 The quintet consists of:

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

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

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

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

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

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

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

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

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

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

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

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

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

Coordinated Care Pathway

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

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

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

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

Neighbourhood Governance

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

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

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

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

Neighbourhood plans

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

5.33 The plans will outline:

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

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

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

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

Development of a Standard Operating Policy

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

5.38 The Policy describes: -

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

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

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

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

6. Manchester Community Response

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

6.2 The three main aims of MCR are to:

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

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

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

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

More detail on these is provided below.

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

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

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

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

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

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

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

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

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

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

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

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

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

Progress with implementation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Adult Social Care Improvement Programme

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

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

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

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

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

8. Engagement

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

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

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

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

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

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

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

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

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

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

9. MRI Priority discharges

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

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

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

10. MLCO Business Plan and Phase 2

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

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

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

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

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

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

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

11. Recommendations

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