Report to:	**CARE TOGETHER SINGLE COMMISSIONING BOARD**
Date:	6 September 2016
Reporting Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**INTEGRATED NEIGHBOURHOOD BUSINESS PROPOSITION**
Report Summary:	The Neighbourhood Development workstream leads the design and delivery of an innovative, ambitious, high quality and financially sustainable locally based integrated health and social care system. This system will work to improve health and social care outcomes, increase healthy life expectancy, reduce duplication, improve patient/service user satisfaction and reduce dependency on the acute sector. This report is the Care Together Business Proposition for our Integrated Neighbourhood model. There will be five Integrated Neighbourhoods across the Tameside and Glossop CCG footprint. Four of the Neighbourhoods are co-terminous with the Tameside Metropolitan Borough Council Neighbourhoods. Glossopdale will be supported by Derbyshire County Council from a social care perspective. The development of INs will build upon the recent development of place based hubs in Tameside, and the public sector prevention agenda which went live in May 2016. These hubs bring together front line providers from across a range of agencies to focus resource where it is needed most and responding to issues in a holistic rather than single agency way. Agencies currently include social services, police, housing, mental health, fire and the voluntary and community sector.
Recommendations:	SCB are asked to approve the attached report to proceed to the implementation stage as part of the Care Together programme.
Financial Implications: (Authorised by the statutory Section 151 Officer & Chief Finance Officer)	Funding to implement this model has been requested as part of our £23.2m bid from GM Health & Social Care Partnership. An extraordinary TFOG (Transformation Fund Outcomes Group) has been arranged for 23 August to consider our bid again. Over the long term this project will deliver significant financial savings (on-going savings of £10.1m p.a.) and is congruent to the Care Together strategy. Approval of this business case needs to be made conditional pending the outcome of the GM funding decision. The GM funding will be contingent on meeting agreed performance metrics. Failure to deliver these targets would result in future funding being withdrawn, therefore the PRG decision also has to be linked to delivery against targets.
Legal Implications: (Authorised by the Borough Solicitor)	This report outlines at a strategic level a model for future service delivery. Once funding is approved there will need to be clear governance to spend the funding to ensure delivery of outcomes, vfm and a clear project plan to ensure delivered expediently and

	a clear understanding of risks that will need to be managed and how. It will be necessary before there are any specific service delivery changes that there is clear consultation and engagement with the public about those proposals to meet necessary legal requirements.
How do proposals align with Health & Wellbeing Strategy?	Improved care and outcomes, a focus on early intervention and prevention for all patients are priorities of the Health & Wellbeing Strategy, and are priorities for the Integrated Neighbourhood model
How do proposals align with Locality Plan?	The development and implementation of the Integrated Neighbourhood model is a key part of our Locality Plan. The vision to move quickly to a fully person-centred and integrated model of care, with a much heavier emphasis on prevention, supporting self-care and care closer to home is in line with the vision for Integrated Neighbourhoods.
How do proposals align with the Commissioning Strategy?	Integrated Neighbourhoods are key to the delivery of our commissioning strategy. The strategic commissioning priorities of a focus on the ***wider determinants*** of health and wellbeing, early intervention and prevention across the life course to encourage ***healthy lifestyles*** and promote, improve and sustain population health, creating a care model so that people with ***long term conditions*** are better supported and equipped with the right skills to manage their conditions more effectively, and supporting positive ***mental health*** in all that we do are clearly delivered by the model outlined in this paper.
Recommendations / views of the Professional Reference Group:	The paper was accepted by PRG with the following recommendations: • That the work is aligned with that of the Healthy Lives workstream • Joint work with our public (including a focus on carer engagement) must be an integral part of the Integrated Neighbourhoods' further development and implementation • That the outcome measures are reviewed to include 2 additional 'I' statements: – I am confident that my experiences of the services I have used will help inform the improvement of the services offered in my neighbourhood – I know that I am actively able to contribute to the development of health and social care services in my neighbourhood.
Public and Patient Implications:	The model outlined in this paper has been developed with the engagement of patients / public. We will continue to engage with our patients in the implementation phase. The model outlined will deliver improvements to our public / patients by achieving the following objectives: • Proactively identify people at high risk of requiring access to services, through early intervention and prevention • Help people live as independently as possible whilst managing one or more long term conditions

- Co-ordinate delivery of services from all providers, with teams of multi skilled professionals based in each of the Neighbourhoods
- Optimise self-care and family/carers support to enable people to stay at home for as long as possible, independently and safely
- Focus on improved condition management to avoid admissions
- Help prevent people from having to move to a residential or nursing home (24 hour care) until they really need to.

Quality Implications:

The delivery of this model will improve the quality of life of our population, improve the quality of interactions with health & social care professionals, and deliver improvements in our population's ability to be resilient and self-manage, on an individual and community basis.

How do the proposals help to reduce health inequalities?

Delivering a model of care around the needs of our 5 neighbourhoods, with a core offer and neighbourhood specific priorities (based on robust risk stratification data and local intelligence) will enable us to target the delivery of interventions in a way that will reduce health inequalities.

What are the Equality and Diversity implications?

Equality and Diversity implications have been addressed in the development of this model, and will continue to be in the implementation and ongoing design and delivery.

What are the safeguarding implications?

All providers included in the Integrated Neighbourhood model are bound by safeguarding standards and policies. Will ensure through the implementation of this model that these are in place and that any new providers / partners understand their responsibilities.

What are the Information Governance implications? Has a privacy impact assessment been conducted?

Information governance is included as an element of the core offer for Integrated Neighbourhoods, and will be addressed via the Care Together IG and data sharing agreement work. All partners in the neighbourhood work will be bound by the necessary guidelines.

Risk Management:

Risks related to the INs will be managed and reported through the Care Together governance.

Access to Information :

The background papers relating to this report can be inspected by contacting Clare Watson, Director of Transformation.

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TAMESIDE AND GLOSSOP
Caretogether

Neighbourhood Development

Business Proposition

1. STRATEGIC CONTEXT – CARE TOGETHER

1.1 The Care Together programme has the ambition to significantly raise healthy life expectancy (HLE) in Tameside and Glossop, through the adoption of a place based approach to better prosperity, health and, wellbeing. The Tameside and Glossop Locality Plan sets the bold ambition of raising healthy life expectancy to the North-west average by 2020. For both men and women, this means an increase in healthy life expectancy of 3.3 years over the next five years. Our vision to achieve this ambition is to move quickly to a fully person-centred and integrated model of care, with a much heavier emphasis on prevention, supporting self-care and care closer to home. The Tameside & Glossop Commissioning for Reform Strategy sets out the strategic commissioning priorities for improving population health over the next 5 years, and these are:

- A focus on the ***wider determinants*** of health and wellbeing, in particular giving children the best start in life and helping people to stay in and return to work, thereby improving their own prosperity.
- Early intervention and prevention across the life course to encourage ***healthy lifestyles*** and promote, improve and sustain population health.
- Creating the right care model so that people with ***long term conditions*** are better supported and equipped with the right skills to look after themselves and manage their conditions more effectively, reducing dependency on the health and social care system by promoting independence.
- Supporting positive ***mental health*** in all that we do.

2. GM PERSPECTIVE TO NEIGHBOURHOOD DEVELOPMENT AND PLACE BASED CARE

2.1 Tameside and Glossop Care Together partners are part of a wider Greater Manchester health and social care system. In February 2015, the 37 NHS organisations and local authorities in Greater Manchester (GM) signed a landmark agreement with the government to take charge of health and social care spending and decisions in the Greater Manchester area; Tameside and Glossop Clinical Commissioning Group and Tameside Council are two of the 37 organisations.

2.2 Greater Manchester Health & Social Care Devolution have outlined what they see are the key features and characteristics of 'Locality Care Organisations'. Scaled, population health and wellbeing management is core to the GM strategy to transform community based care and support. Our Tameside & Glossop models closely reflect the key characteristics set out at a GM level.

2.3 Greater Manchester Public Service Reform (PSR) principles have been agreed, which are to promote:

- A **new relationship** between public services and citizens, communities and businesses that enables shared decision making, democratic accountability and voice, genuine co-production and joint delivery of services. Do with, not to.
- An **asset based approach** that recognises and builds on the strengths of individuals, families and our communities rather than focusing on the deficits.
- **Behaviour change** in our communities that builds independence and supports residents to be in control
- A **place-based approach that redefines services** and places individuals, families, communities at the heart
- Stronger prioritisation of **well-being, prevention and early intervention**
- An **evidence led** understanding of risk and impact to ensure the right intervention at the right time

2.4 In May 2015, Combined Authority members at a GM level agreed to the principles of adopting Place Based Integrated Working as a Public Service Reform workstream. The development of place-based integrated working is an essential feature of the GM whole-system approach to the creation of new Public Service delivery models and is central to the GM Health and Social Care reforms. These new delivery models have been designed to focus on reduction and prevention and building on community capacity. It is intended that these new models will maximise operational effectiveness within the context of reduced budgets and are essential to the sustainability of the neighbourhood policing function and other fundamental neighbourhood services.

2.5 To begin addressing these issues a GM-led project was carried out throughout the latter half of 2015 that delivered 'proof-of-concept' integrated working in a Neighbourhood in Wigan and another in Tameside. The purpose of the proof-of-concept working was to build evidence to demonstrate the benefits that can be realised through working in this way, increase understanding of the extent to which frontline roles can be redesigned and recognise the competencies and powers required to deliver these new roles effectively. The work has also begun to identify blockages created by current system conditions that by being addressed would lead to enhanced effectiveness and future demand reduction. The work in Wigan and Tameside has highlighted the high level of support required locally in terms of leadership and coordination, the importance of a dedicated local Strategic Lead and relevant dedicated project management support.

2.6 Our neighbourhood approach to the design and delivery of a model to deliver scaled population health and wellbeing management is in line with the Greater Manchester Devolution strategy to transform community based care and support. This paper sets out the Neighbourhood Development and Place Based Care elements of the Tameside & Glossop approach to "Neighbourhood Care Organisations" and is consistent with the GM proposed scope and features of such a model.

3. TAMESIDE & GLOSSOP NEIGHBOURHOOD DEVELOPMENT

3.1 The following vision statement was developed in Tameside and Glossop for the Care Together Programme:

"Our vision is to significantly raise healthy life expectancy in Tameside and Glossop through a place-based approach to better prosperity, health and wellbeing and to deliver a clinically and financially sustainable health and social care economy within 5 years"

3.2 To support the delivery of the Care Together programme, four key Workstreams have been established, with senior Executive, Professional and Clinical leadership. The Neighbourhood Development Workstream will act as a significant enabler to the realisation of this strategic ambition. The model represents a fundamental shift in thinking, blending evidence based approaches and interventions, robust workforce development, and place-based community approaches.

3.3 The Neighbourhood Development workstream will design and deliver an innovative, ambitious, high quality and financially sustainable locally based integrated health and social care system. This system will work to improve health and social care outcomes, increase healthy life expectancy, reduce duplication, improve patient/service user satisfaction and reduce dependency on the acute sector. This system will be developed over the next 3 -5 years and in full partnership with patients, staff, voluntary sector, residents and regulators to ensure the model achieves its aims, is well understood and meets the needs of the population. Key objectives for the workstream are to:

- Define ambitious outcomes which will demonstrate delivery of the workstream's aims

- Design the models of care for each of the 5 Neighbourhoods to deliver these outcomes
- Agree how each Neighbourhood can incorporate additional services also required to meet the specific needs of their population
- Determine the scope and cost envelope for the Neighbourhood model
- Lead the transformation of Primary Care services, and deliver closer alignment and joint working of general practices within the Neighbourhood model
- Determine if new categories of staff are required to support the new ways of working and if so, to liaise with the Human Resource Enabling workstream to ensure these can be created/sourced
- Agree and prioritise a work programme to deliver these objectives
- Challenge and drive the progress of the work programmes
- Clarify interdependencies with the other workstreams, agreeing where each starts and ends
- Consider emerging Greater Manchester Devolution programmes and incorporate relevant work within the overall Neighbourhood Development programme
- Lead the commissioning/decommissioning of services to deliver the new model of care, turning it into 'business as usual' by 2018/19
- Harness opportunities for innovation and new ways of working to improve the health and well-being of people in Tameside and Glossop.

3.4 We have aligned our Neighbourhood Development work with the Health Lives workstream to ensure the neighbourhood model is a robust delivery vehicle for our system wide self-care, social prescribing and 3rd sector offer.

4. INTEGRATED NEIGHBOURHOODS

4.1. **The Neighbourhoods**
There will be five INs across the Tameside and Glossop CCG footprint. Four of the Neighbourhoods are co-terminus with the Tameside Metropolitan Borough Council Neighbourhoods. Glossopdale will be supported by Derbyshire County Council from a social care perspective.

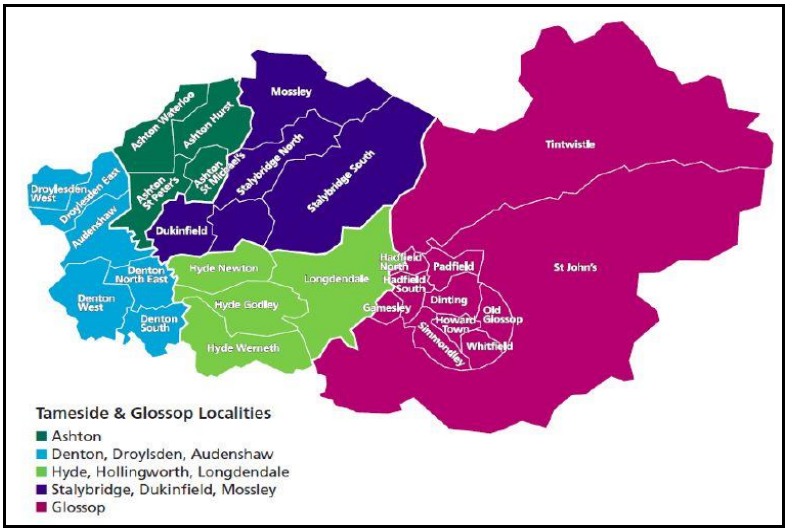
4.2 The development of INs will build upon the recent development of place based hubs in Tameside, and the public sector prevention agenda which went live in May 2016. These hubs bring together front line providers from across a range of agencies to focus resource where it is needed most and responding to issues in a holistic rather than single agency way. Agencies currently include social services, police, housing, mental health, fire and the voluntary and community sector.

4.3 We are working with colleagues in the Glossopdale neighbourhood to ensure we build on the existing links with Derbyshire Constabulary, NWAS and Derbyshire Fire & Rescue Service when implementing our model. Examples of good practice in relation to joint working in Glossopdale include the MAPs forum (a Glossop forum consisting of Police safer neighbourhood team, housing and Adult Care to manage anti-social behaviour, protect vulnerable citizens and reduce offending in the community), and the DCC work with Police Community Support Officers and Persons Susceptible to Harm Officers (with regular face to face contact and hot-desking agreements). DCC are also involved in the Vulnerable Adult Risk Management approach (VARM).

4.4 As a single commission we will continue to work with Derbyshire County Council on issues relating to the commissioning of services for the Glossopdale neighbourhood.

4.5 INs will bring wider health and social care teams into these place based hubs to deliver a wide range of services that not only treat illness but promote wellness and behaviour change. This will involve a comprehensive response from community services, social and primary

care, outreach from hospital specialists, mental health and support from public health and preventative services. Input from the voluntary and community sector will be central to the success of this approach.



	GP Practices	Registered Population
North Neighbourhood: Ashton –U-Lyne	10	56,596
South Neighbourhood: Hyde / Hattersley / Hollingworth / Longdendale	8	62,662
East Neighbourhood: Stalybridge/Dukinfield/Mossley	10	43,817
West Neighbourhood: Denton/Droylsden/Audenshaw	7	49,696
Glossopdale Neighbourhood	6	32,000

The Integrated Neighbourhood Principles and Objectives

4.6 Integrated Neighbourhoods will facilitate provision of / access to bespoke person centred solutions, working to the following principles of place based care:

- Integrated local services responsive to local need
- Services that build on assets of the community & intervene early in an emerging problem
- One team, knowing their area & each other
- Person centred approach within the context of family & community
- Services delivered within the community, close to home from a flexible asset base

4.7 The Integrated Neighbourhood vision is to support neighbourhoods to deliver asset rich, high quality and connected services which look after the whole neighbourhood population to support all to have improved outcomes, prosperity and wellbeing.

The key objectives are to:

- Proactively identify people at high risk of requiring access to services, through early intervention and prevention
- Help people live as independently as possible whilst managing one or more long term conditions
- Co-ordinate delivery of services from all providers, with teams of multi skilled professionals based in each of the Neighbourhoods
- Optimise self-care and family/carers support to enable people to stay at home for as long as possible, independently and safely

- Focus on improved condition management to avoid admissions
- Help prevent people from having to move to a residential or nursing home (24 hour care) until they really need to

4.8 The INs will achieve the aims and objectives outlined above as follows:

- Focus on wellbeing, wellness and preventing illness and longer term health improvement and proactive self-care
- Provide high quality safe and sustainable services centred around the individual
- Provide short term interventions to maximise independence and self-management of illness/condition
- Work closely with partners to ensure smooth and seamless support during periods of crisis and the transition to / from hospital based care
- Use a Multi-Disciplinary case management approach to co-ordinated consistent care and support in the person's own home
- Provide high quality, holistic person centred care and support – to ensure individual choice and control
- Where appropriate, conduct Multi-Disciplinary Team meetings to review people at high risk of admission to longer term care
- Provide long term Care-Coordination to maintain stability of illness/condition
- Identifying people who may benefit from care co-ordination by a lead professional to improve individual outcomes, reduce repetition, duplication and 'hand offs' between services
- Ensuring people receive the right level of care and support at the right time and in the right place, therefore reducing the need for crisis interventions
- Support individuals and their families towards self-reliance and away from being dependent on services
- Enable carers to have a life outside of their caring role
- Consider how accessing employment and skills provision could support the patients continual health condition management and refer to specialist services and co-case manage as appropriate.

4.9 The fundamental principle of the IN proactive approach to care is that individuals are assessed for the level of care they require. Depending on the level of risk an individual has at any given point, they would be managed/signposted within the relevant framework of the model. The model takes a proactive approach to the management of individuals across the whole risk spectrum and not just those at the higher end of need.

Integrated Neighbourhood Outcomes

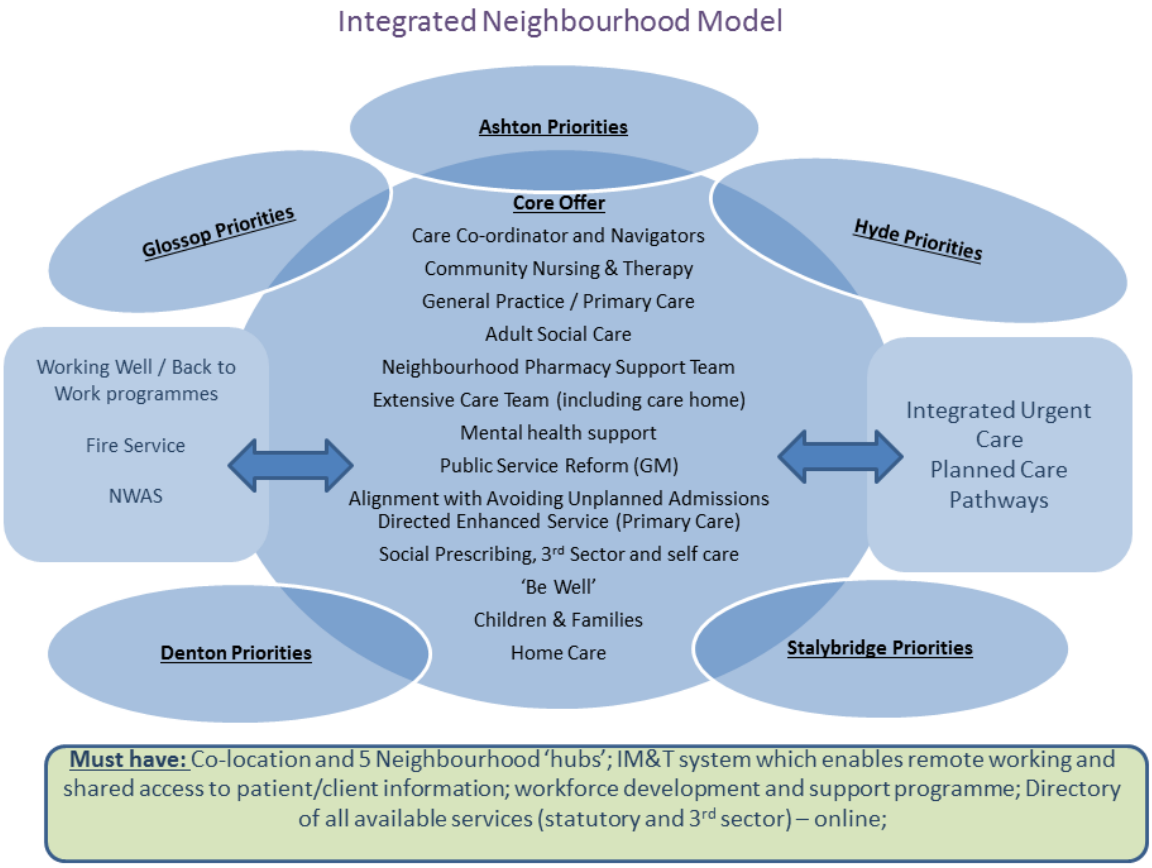
4.10 During the development of the IN model we have produced proposed metrics and outcomes in the form of 'I statements'. These have been presented to the Care Together Programme team to ensure they are included in the overall Care Together metrics, and are refined if required to ensure they are in line with the programme approach. The latest version is attached at **appendix 1**. We will continue to work with the programme team on the refinement and development of these to ensure we have robust outcome measures to take into the implementation phase of INs. We are working with Tameside Hospital NHS Foundation Trust as the shadow ICO on a set of contractual outcome measures to support delivery of our IN model.

The Model for INs in Tameside & Glossop

4.11 Our model for Integrated Neighbourhoods has been developed over a number of months, building on the previous 'Local Community Care Team' proposals, and taking into account the local progress made through the 'Public Service Reform' agenda. This is the model which all 5 neighbourhoods will work towards delivering through the implementation processes outlined in section 6 of this paper.

4.12 Through consultation with stakeholders and detailed engagement with our 5 neighbourhoods, using the vision and objectives outlined above, we have developed a model which includes a 'core offer' – an offer which is available to all 5 neighbourhoods – and local priorities which are specific to meet the needs of neighbourhood populations. Each of the five INs will look different and will eventually be staffed according to the local needs and demands, though they will share the same objectives, goals and outcomes.

4.13 The initial work has been focused on the population aged 18 years and over, but the Integrated Neighbourhood model is an 'all age' model, and as illustrated below will increasingly include the delivery of support for our children and families.



The Core Offer

4.14 As already cited in this proposal, each Neighbourhood will have a 'core offer' – an offer which is available to all 5 neighbourhoods – and local priorities which are specific to meet the needs of neighbourhood populations. The level of intervention delivered by the INT will be determined by the need of the individual. Needs will be met by a range of people with the appropriate skills from community health and social care providers, 3rd sector, General Practice (and wider primary care, e.g. pharmacy), and wider public sector teams (e.g. fire service, police service, council provided support). The core offer has been developed through consultation with stakeholders and members of the developing integrated neighbourhoods, and currently includes the functions outlined below.

4.15 The proposal is that the transformation funding requested from GM will be used to support any developments in the core offer which require additional funding. These are highlighted below *

4.16 Lists of existing staff and teams have been produced at a neighbourhood level to facilitate the development and redesign of the IN model.

4.17 **Care Co-ordinator and Navigators** The Integrated Neighbourhood Model is based upon the principle of care co-ordination and navigation. The initial proposed staffing structure includes 'care navigator' roles to support people to access the support they require, encouraging and enabling self-care and supported self-management. Key to the success of the INs will be the delivery of effective care co-ordination and key worker roles from within the existing multi-disciplinary teams, delivering the clarity and support required across what can at times be a complex system.

4.18 **Community Nursing & Therapy** The community nursing services provided by Tameside NHS Foundation Trust have been aligned/allocated to the 5 neighbourhoods to ensure delivery of core community nursing services as part of this model. The District Nursing teams have been allocated to neighbourhoods, with named members of other teams (e.g. the Macmillan palliative care team, and Long Term Conditions team) allocated to neighbourhoods whilst continuing to work as part of a CCG-wide team.

4.19 **General Practice / Primary Care** The Integrated Neighbourhood model is based on the inclusion of our member practices as part of the multi-disciplinary team / offer to our residents. Primary Care is at the heart of integrated care and our GPs have a unique opportunity to contribute to and lead the development of the ICFT. The evolving agenda requires leadership and engagement to ensure that the pathways, models of care, quality and performance are designed with primary care at the centre, working as a fully integrated partner in the new delivery models/provider.

4.20 The recently published NHSE 'General Practice Forward View' gives legitimacy and credibility to the work already underway in Tameside & Glossop to work with our practices in a new way: offering support to improve quality of care, recognising the pressures some of our practices are under and working with them to alleviate this, and working increasingly at a Neighbourhood (place) based level.

4.21 **Adult Social Care** Both Tameside Metropolitan Borough Council and Derbyshire County Council have confirmed the inclusion of their Adult Social Care teams in the Integrated Care model for the 5 neighbourhoods. The INs will therefore be responsible for the delivery of the assessment and delivery models for core adult social care. Tameside MBC have also included their Health & Wellbeing Advisors in the INs.

4.22 **Neighbourhood Pharmacy Support Team *** All 5 neighbourhoods have cited primary care based pharmacy as a priority for their neighbourhood model therefore the proposal is that this is included in the core offer for all neighbourhoods. The 'offer' from a neighbourhood pharmacy support team could include:

- Discharge facilitation: In-reach to liaise with ward based pharmacist teams
- Clinical medication reviews with patients with LTC and polypharmacy issues (including care home and domiciliary / house-bound patients)
- Support for a case load of patients from the upper two strata of the Risk Profile, intervening pro-actively to reduce likelihood of crisis, in effect conducting a community based ward round.
- Deliver training programmes to other members of the IN team.
- Pharmacist support to GP practices: Working across a neighbourhood the practice pharmacist team would help relieve some of the pressure on General Practice as indicated in the five year forward view and 'The future of primary care ; creating teams for tomorrow'
- Repeat Systems: Produce and implement a practice repeat prescribing policy.
- Undertake changes to medicines (switches) designed to save on medicine costs where a medicine or product with lower acquisition cost is now available.

- Medicines Information: Answers all medicine related enquiries from GPs, other practice staff, integrated neighbourhood members and patients, suggesting and recommending solutions and providing follow up for patients to monitor the effect of any changes
- Medicines Quality improvement: Undertake audits of prescribing in areas directed by the GPs and INs, feedback the results and implement changes
- Implement changes to medicines that result from MHRA alerts, product withdrawal and other local and national guidance.
- GMMMG: Monitor T&G community prescribing against the GMMMG formulary

4.23 **Extensive Care Team ***All neighbourhoods have highlighted the need for improved support for the 'at risk', frail, elderly, care home residents, and people with complex needs and / or multiple long term conditions. Requests were also made for improved communication and links with the elderly care physicians currently working in the acute sector, with some proposing an 'outreach' model for the care of the elderly.

4.24 Models of extensive care exist in other areas of the country and have already been considered as an approach for Tameside & Glossop. The INs will include a proposed model for extensive care / extensivists which will be designed and developed under the auspices of the Neighbourhood Development workstream and the Model of Care Steering Group. This piece of work will encompass the existing care homes work, will be aligned with the 'home first' model and proposals for intermediate care, and will take into account the existing Better Care Fund 'over 75s' resource and schemes. The work which has already commenced on proposals for an internal hospital model for the assessment and management of frailty will be aligned with this work in the community.

4.25 **Mental Health Support *** One of the commissioning priorities included in the Tameside & Glossop Commissioning for Reform Strategy is 'Supporting positive mental health in all that we do'. The IN model will include support for the mental health needs of our population. Our existing mental health services are aligned with our neighbourhood model, which means from an operational perspective each neighbourhood will know the resource available, who the people are, and how services can be accessed. Going forward we will work with our neighbourhoods, mental health commissioners and providers to address any gaps or areas for development, including support for people with dementia, and access to psychological support for people with long term conditions. This has been identified as a priority for ALL neighbourhoods through our consultation, therefore will be taken forward through the implementation phase, with proposals being developed for additional resource from across all 5 neighbourhoods' allocation of any GM transformation funding.

4.26 **Public Service Reform (Tameside Neighbourhoods)**
From 9 May 2016 the Public Service Reform model in Tameside has been rolled out across all 4 neighbourhoods. Through the implementation phase for our IN model we will ensure we align the functions and processes to bring these approaches together.

4.27 Within the Public Service Reform offer wider determinants of health such as work will be considered when supporting a patient. Referrals into specialist employment and skills services (such as Working Well) or closer integration with Jobcentre Plus services will ensure that residents who are unemployed or in work with low pay with a health condition can access support to access further opportunities into work. The core offer will provide a mechanism to further integrate health and employment and skills services centred around the resident.

4.28 The Glossopdale approach to working with the wider public sector, as it sits outside the Tameside footprint, is included in the local priorities section below.

Alignment of the Avoiding Unplanned Admissions Directed Enhanced Service

4.29 The Commissioning Team will work with primary care and the IN implementation team to ensure the DES criteria and specification is aligned with the IN approach. A proposal has

been prepared for the Professional Reference Group (reporting to the Single Commissioning Board) which recommends that we continue with the AUA as it stands but implement the IN alignment recommendations as soon as possible, latest by Autumn 2016. The national service specification is in line with our approach to Integrated Neighbourhoods therefore does not need to be reviewed or amended. However, practices have not to date been supported with the delivery or to engage with partner organisations in its delivery. This can be remedied within the current specification by aligning with our IN model.

Social Prescribing, 3rd Sector and Self Care *

4.30 The involvement of the 3rd sector is key to the success of integrated neighbourhoods, as are the use of 'social prescribing' and the development of a non-medical model. The alignment of our IN model with the Healthy Lives workstream will ensure we have the pathways and services available to deliver our social prescribing and 3rd sector access effectively across all 5 neighbourhoods. The 'Healthy Lives' GM transformation funding proposal will support this element of the IN model.

4.31 One of the key approaches to creating a sustainable economy will be supporting the population to manage their health more effectively, adopt healthier behaviours and choose appropriately when accessing support from health and social care. We will adopt a system wide approach to self-care and supported self-management, where self-care becomes our default and something promoted by all parts of the health system.

4.32 Underpinned by a proactive risk stratification approach and the use of the Patient Activation Measure, we will identify people who are at greatest risk of poor health and high levels of unplanned activity. We will focus on the development of social prescribing at scale and combine it with an asset based community development approach seeking to unlock the potential of communities and individuals.

4.33 **'Be Well' Service (Tameside Neighbourhoods only)** This team provides support for multiple lifestyle issues, e.g. improving the quality of diet and nutrition, stopping smoking, reducing alcohol intake, increasing physical activity etc. The service welcomes anyone over the age of 16 and the advisors also offer all clients a holistic 'wellbeing' assessment. The assessment will include asking about: clients overall health, feeling connected to other people, affordable warmth concerns, money, emotional health and work/training. Clients will then be supported to achieve their goals and to navigate the system and access appropriate services. The 'Community Liaison' approach will be to work with residents, groups and organisations to promote Health and Wellbeing and encourage greater access to Be Well Tameside services. Be Well Tameside offers a health and wellbeing a training programme to enhance and develop the competencies and skills of the wider public health workforce across organisations and the community.

4.34 **Children & Families** The Integrated Neighbourhoods will provide support to the whole population of Tameside & Glossop. Initial work has focused on a model for adults (18yrs+) but the existing programme of work relating to children & families is now being aligned with our neighbourhood model, to ensure seamless delivery of support to our population. Further detail of the services deemed 'in scope' for neighbourhood level delivery will be identified from July 2016 onwards and included in the implementation of the IN model. This work will include alignment with the Public Service Reform agenda and the GM children & families reform agenda.

4.35 **Home Care** Using a holistic approach to service delivery, we will redesign the current homecare model to ensure it is focused on individual strengths and capabilities. Homecare workers and providers will form an integral part of the INs. We will place an emphasis on moving away from time and task, to high quality contact with people that utilises a wide range of community assets, technology and the range of community and primary health available to remain safe, secure and independent at home. The new service will deliver a sustainable

care home market with significant more capacity and which pays its staff at levels commensurate with the expected role.

4.36 **Accessing the Integrated Neighbourhoods** Through the implementation phase a detailed process and pathway will be developed to ensure the access to support from our Integrated Neighbourhoods is clear to all – professionals and public. This will need to align with the Integrated Urgent Care Team pathways, assessments and points of entry. It has been agreed, through the development of the draft Operational Procedures for INs (see section 4.7 below) that there will be three main points/routes of access to the IN:

i. New and urgent presentation

This will be made via the single point of contact, where an assessment / triage will be undertaken, based on the information provided by the "referrer". This will ensure the first assessment is responsive, holistic and multi-professional

ii. Known cases / clients requiring review of existing intervention / package of care

These cases will be picked up via the internal INT communication channels and relationships developed by working as a neighbourhood team and/or via the statutory trigger points for review where applicable. No new referral will be required, but the new need will be highlighted via internal messaging and communication.

iii. Case finding (including from risk stratification data – see below)

Appropriately nominated members of the INT will be responsible for the analysis of the risk stratification data, including the identification of individuals who would benefit from intervention and/or case management. New / Known client routes of access (see points i and ii above) would be applied to cases identified via risk stratification

Work has commenced on the development of clear access points, including the assessment and triage processes, to enact the approach outlined above. This work will ensure alignment with the urgent care pathways and processes.

4.37 **Expanding the Neighbourhood Model** The Neighbourhood Development workstream will work across the Care Together programme to identify the priority pathways for redesign and delivery via / in support of the Integrated Neighbourhoods during 2016-17 and beyond. Services currently delivered at a CCG level will also align themselves to our Neighbourhood model, to ensure that whether via electronic referral, "advice and guidance" or face to face presence in the Neighbourhoods, our INs have access to the specialist input and support needed. Initial priorities identified include pathways for people with respiratory disease, diabetes, cardiovascular disease, support for people with a learning disability, and those in need of palliative / end of life care. This will also ensure the necessary links are made with the Planned Care and Urgent Care workstreams.

4.38 **Enabling Projects and Priorities** The Integrated Neighbourhood Project Steering Group have identified 12 key enablers to the development and implementation of the Integrated Neighbourhood model, and are working across the Care Together programme to facilitate the achievement of these tasks:

Agreed outcome measures and "I statements" for the Integrated Neighbourhoods: The IN Project Steering Group defined a set of metrics in the early stages of the project, and expanded these to the level of detail seen the draft document at appendix 1 of this document. The Care Together Programme are now developing metrics which will cover all elements of the programme, including INs. The IN project steering group will continue to engage in this piece of work to ensure the workstream's priorities are included.
Clear points of entry into the INs defined and communicated: As described in section 4.5 of this document, the IN steering group are leading a project to determine the detail of the access points for the INs.

A co-ordinated offer for prevention, health and wellbeing support in the 5 localities: The work of the IN and Healthy Lives workstreams is aligned to ensure the healthy lives 'offer' is included in the IN model, and that INs are established to deliver and support people into the defined offer.
Ensure information on the wellness offer is accessible and clear with in the localities: The IN Project Steering Group through the Care Together Programme Office are taking this work forward to ensure delivery of the information and support requested and specified through our programme of engagement.
Clear plan in place for the co-location of core LCCT staff: The development of the IN model has informed our Strategic Estates planning, in particular the development of the proposal for 5 neighbourhood 'hubs'. Input to this planning will continue.
IM&T plan in place to support LCCT project, to reflect the work to date with Liquid Logic and EMIS, and to include plans for community nursing and mental health systems: The IN project steering group work closely with the IM&T enabling workstream to ensure the IM&T requirements of the IN model are addressed by the wider IM&T plans. We are working with the IM&T team on the re-procurement of a community system, and work to develop and implement a system which enables viewing of records across health and social care.
Development of a clear HR/OD/Workforce plan: A 'People Task & Finish Group' has been established, led by the HR/OD leads from the ICO and TMBC, to support the development of a workforce plan for the IN model.
Clear plan for information sharing (Long term strategy and ensure safe and secure working in the interim): Working with the wider Care Together programme to ensure safe practice in relation to information sharing.
Full Standard Operating Procedure developed and agreed: A draft 'operating model' has been developed which will be picked up and developed further as required in the implementation phase of the IN work.
Review of the Admissions Avoidance Directed Enhanced Service to be completed, to ensure alignment with the Integrated Neighbourhood model: A proposal for the alignment of the AUA DES and the IN model has been developed for consideration by the Professional Reference Group and Single Commissioning Board, as described in section 4.4.9 above.
Clear plan in place for support for Carers: Through the single commission, an approach for the support for carers as part of the IN model is in development
Confirmation of the dedicated resource for each IN: A summary of the resource allocated to each IN from the existing service providers has been developed (general practice, THFT community services, adult social care DCC and TMBC) to inform the implementation phase of this project.

4.39 **Neighbourhood Priorities** During the development of our initial Local Community Care Team model, which developed into the Integrated Neighbourhood proposal, we have engaged extensively with a wide range of local stakeholders, including patients and public representatives. This engagement has provided the detail of the model described in this paper, and the detail of our core offer. This engagement has included numerous workshops, regular discussions at the existing neighbourhood meetings, presentation to and discussions with Patient Participation Groups, and the formation of a multi-agency Integrated Neighbourhood Steering Group.

4.40 To ensure we gained consensus on our proposals for the IN model and the 'core offer', and to ensure we captured the local priorities, the 5 Neighbourhoods have held workshops during June and July 2016 to identify their key priorities for delivery. The IN workshops, or 'lock-ins' were each attended by between 40-60 (varied between neighbourhoods) representatives from a range of statutory and public sector services / teams (including general practice), 3rd sector organisations and Patient Participation Groups. The sessions were facilitated by members of the Single Commission and shadow Integrated Care Organisation, and gave all stakeholders the opportunity to participate in the design process. The write up of the

sessions has been shared widely to ensure those attending and those unable to attend could confirm their support for the model and their agreement with the declared local priorities.

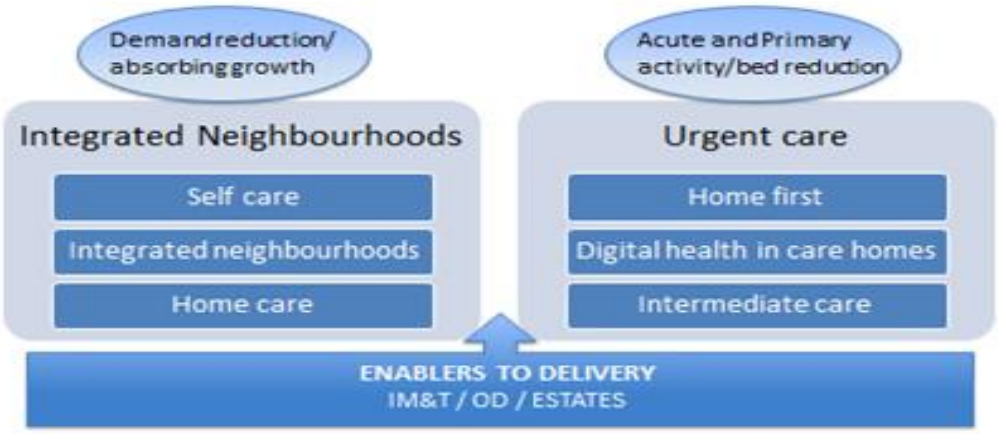
4.41 Some priorities arising from the workshops were identified in more than one neighbourhood, and have therefore been included in the 'core offer' as developments to take forward across the locality. The Neighbourhood specific priorities, for consideration and development over and above the core offer, currently stand as:

North Neighbourhood (Ashton)	Campus approach to delivery of services and support Upskill volunteers in the community Consistency in primary care offer Increased resources in IAPT
West Neighbourhood (Denton)	Telecare/medicine - expand use of assistive technology in the community Community patient transport Additional / enhanced support for care homes Community paramedic
Glossopdale Neighbourhood	Retain community paramedic role in Glossop Access to work / employment schemes Build on / develop further the strong links with the voluntary sector in Glossop Childhood mental health and 'school readiness'
South Neighbourhood (Hyde)	Care Navigation & 'Alice' role - Community resilience and development Improvements in early intervention and proactive support / case finding Improved links between health and education / school age children and their families Improved dementia care
East Neighbourhood (Stalybridge)	Support and action groups for young families Support to care home sector Proactive multi-agency case finding – neighbourhood 'case conference'

4.42 There will be further work within the neighbourhoods during July and August to refine and confirm these priorities, taking us into the implementation phase which will commence from August 2016 onwards.

5. COST BENEFIT ANALYSIS & GM TRANSFORMATION FUNDING

5.1 The Care Together investment case to GM comprises a series of interdependent transformation schemes that together help Tameside & Glossop deliver a financially and clinically sustainable health and care economy and improve the healthy life expectancy of the local population. The schemes are broadly split into two groups focusing on demand reduction/absorbing growth and reducing acute and primary activity as illustrated by Diagram 1 below.



5.2 An effective integrated neighbourhood model will impact on the demand on our urgent care system, non-elective pathways, and traditional models of elective care (including hospital based outpatient services). In order to deliver this model, we have proposed investment in the neighbourhood infrastructure and have submitted plans to GM for transformation funding to this effect. The funding model below is an extract from the GM submission, but further work will be required prior to allocation once the Care Together programme receive feedback and a decision from GM.

Neighbourhood Development

36 month non recurrent support required from start date. Assumed funding granted on 30 June with 2/3 months mobilisation. Therefore funding required September/October

Neighbourhood Specific Offer	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	2016/17 Total	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	2017/18 Total	2018/19 Total	2019/20 Total	2020/21 Total	Total £000's
Ashton	0	0	100	100	200	100	100	100	100	400	400	200	0	1,200
Denton	0	0	100	100	200	100	100	100	100	400	400	200	0	1,200
Hyde	0	0	100	100	200	100	100	100	100	400	400	200	0	1,200
Stalybridge	0	0	100	100	200	100	100	100	100	400	400	200	0	1,200
Glossop	0	0	100	100	200	100	100	100	100	400	400	200	0	1,200
Total	0	0	500	500	1,000	500	500	500	500	2,000	2,000	1,000	0	6,000

Staffing of new structures	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	2016/17 Total	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	2017/18 Total	2018/19 Total	2019/20 Total	2020/21 Total	Total £000's
Ashton	0	0	38	38	75	38	38	38	38	150	150	75	0	450
Denton	0	0	38	38	75	38	38	38	38	150	150	75	0	450
Hyde	0	0	38	38	75	38	38	38	38	150	150	75	0	450
Stalybridge	0	0	38	38	75	38	38	38	38	150	150	75	0	450
Glossop	0	0	38	38	75	38	38	38	38	150	150	75	0	450
Total	0	0	188	188	375	188	188	188	188	750	750	375	0	2,250

Total Neighbourhood Development	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	2016/17 Total	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	2017/18 Total	2018/19 Total	2019/20 Total	2020/21 Total	Total £000's
	0	0	688	688	1,375	688	688	688	688	2,750	2,750	1,375	0	8,250

5.3 The neighbourhood costs above cover £750k additional pay costs in relation to the creation of neighbourhood managers and care co-ordinators who will ensure that all services are wrapped around the person. In addition to this a further £2m per annum has been identified to ensure that services appropriate to the neighbourhood's needs are developed to ensure that growth is stemmed.

5.4 In order to support this it will be necessary to improve home care services within the area to upskill staff to provide a broader range of support for individuals than is currently offered and to ensure that that support is integrated into the neighbourhood and forms part of the wrap around services offered. The details of the financial investment proposals to support this are outlined below.

Home Care

	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	2016/17 Total	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	2017/18 Total	2018/19 Total	2019/20 Total	2020/21 Total	Total £000's
Training	0	0	0	20	20	0	24	36	26	86	0	0	0	105
Supervision & Support	0	0	21	62	83	62	62	62	62	248	0	0	0	331
Increased Pay costs	0	0	0	56	56	56	125	227	302	710	1,210	605	0	2,581
Total	**0**	**0**	**21**	**138**	**158**	**118**	**211**	**325**	**390**	**1,044**	**1,210**	**605**	**0**	**3,017**

5.5 The proposed investment in the 'Living Well / Healthy Lives' initiatives – summarised below – will also support the delivery of an effective IN model in T&G and support our work to reduce demand and stem growth.

Living Well

	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	2016/17 Total	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	2017/18 Total	2018/19 Total	2019/20 Total	2020/21 Total	Total £000's
Community Navigators	0	0	88	88	175	88	88	88	88	350	350	175	0	1,050
Stimulate Voluntary Sector	0	0	188	188	375	188	188	188	188	750	750	375	0	2,250
Social Prescribing IT	0	0	0	50	50	5	0	0	0	5	5	0	0	60
Primary Care Volunteers Netwo	0	0	0	125	125	0	500	0	0	500	400	200	0	1,225
Social Marketing & Comms	0	0	25	25	50	25	25	25	25	100	100	50	0	300
GP/patient facing dynamic hea	0	0	0	1	1	0	0	0	2	2	4	0	0	7
Total	**0**	**0**	**300**	**476**	**776**	**305**	**800**	**300**	**302**	**1,707**	**1,609**	**800**	**0**	**4,892**

5.6 The table below identifies the benefits associated with the implementation of and investment in Integrated Neighbourhoods. The basis of this model is that we will prevent all growth from Q2 2017-18 as outlined below:

Benefits Realisation

Integrated Neighbourhoods

£000's	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	2016/17 Total	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	2017/18 Total	2018/19 Total	2019/20 Total	2020/21 Total	Total £000's
A&E	0	0	0	0	0	0	17	35	52	105	390	575	862	1,932
Non Elective	0	0	0	0	0	0	91	181	272	544	2,031	2,990	4,481	10,045
Non Elective XBD	0	0	0	0	0	0	8	17	25	51	190	279	419	939
Elective	0	0	0	0	0	0	29	58	87	173	648	953	1,429	3,204
Outpatients	0	0	0	0	0	0	59	118	176	353	1,317	1,939	2,907	6,516
Total	**0**	**0**	**0**	**0**	**0**	**0**	**204**	**408**	**613**	**1,225**	**4,576**	**6,737**	**10,098**	**22,636**

Activity	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	2016/17 Total	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	2017/18 Total	2018/19 Total	2019/20 Total	2020/21 Total	Total
A&E	0	0	0	0	0	0	147	293	440	880	3,287	4,840	7,191	16,198
Non Elective	0	0	0	0	0	0	55	110	165	331	1,235	1,818	2,701	6,084
Non Elective XBD	0	0	0	0	0	0	38	77	115	231	863	1,270	1,887	4,250
Elective	0	0	0	0	0	0	27	53	80	159	594	874	1,299	2,926
Outpatients	0	0	0	0	0	0	513	1,026	1,539	3,078	11,493	16,921	25,141	56,633

5.7 The information above uses our planned budgets for 2016-17 as a baseline. The plan is to maintain activity over the next 5 years at our 2016-17 planned levels for A&E attendances,

non-elective admissions, emergency excess bed days and outpatients, and to reduce growth in elective and daycase admissions by 50%. In the implementation phase we will develop detailed neighbourhood-level subsets of the plans outlined above. In summary, the INDICATIVE 'split' based on registered population is as follows:

Required saving split by neighbourhood (£000)		**2016-17**	**2017-18**	**2018-19**	**2019-20**	**2020-21**
Ashton	24.77%	-	607	1,133	1,669	2,501
Denton	19.90%	-	488	911	1,341	2,009
Glossop	11.37%	-	279	520	766	1,148
Hyde	26.40%	-	647	1,208	1,778	2,666
Stalybridge	17.56%	-	430	803	1,183	1,773
Total	**100%**	**-**	**2,451**	**45,76**	**6,737**	**10,098**

6. IMPLEMENTATION OF THE INTEGRATED NEIGHBOURHOOD MODEL

6.1. **Neighbourhood Implementation Teams** The Neighbourhood Development workstream will support and lead the establishment of 5 Neighbourhood Management Teams to lead the implementation of the model. The Model of Care workstream will provide oversight to a robust governance structure, including the development and approval of 'memoranda of understanding' between the Neighbourhoods and the Care Together Programme and Single Commission.

6.2 To support the implementation of the IN model in each neighbourhood, and to ensure the detailed local requirements are addressed, a full write-up of the sessions held in June 2016 has been produced and will be available to the commissioning and operational teams to enable them to support the neighbourhood in an ongoing programme of development and implementation.

6.3 **Risk Stratification** The Single Commission will ensure the production and distribution of risk stratification data to support the implementation of the IN model, and the identification of 'at risk' patients. The GPs will be the custodians of this data, and through application of the Risk Stratification Policy we will ensure safe use of this information. The Single Commission will work with the INs on the ongoing refinement, analysis and presentation of risk stratification data.

6.4 **Operational Management** Each IN will be led by a senior IN Operational Manager, managed via the shadow Integrated Care Organisation. The post holder will work closely with partners within the neighbourhood, and cultivate and develop close working relationships. Acting as an ambassador for best practice within care planning and problem solving, the post holder will also work closely with external partners. They will assist in ensuring that the Neighbourhood delivers its financial, activity, user experience and clinical and quality outcomes. The post holder will be responsible for the continuing development of the IN to meet the needs of the local population, using and developing the resources available to enable this. Dynamic individuals will need to be recruited to these posts to ensure the IN model reaches its full potential. Recruitment to key posts to support the operational implementation of the Integrated Neighbourhoods is due to commence in July 2016.

6.5 **Commissioning Support**
Each of our neighbourhoods already have dedicated commissioning support from the single commission, including members of our finance team. This resource will support the ongoing implementation and development of our IN model, working closely with the operational managers and team, and our member practices, to lead the effective implementation of our plans as key members of the Neighbourhood Management Teams.

APPENDIX 1

INT Objectives					
Proactively identify people at high risk of needing access to services	**Help prevent people from having to move to a residential or nursing home until they really need to**	**Coordinate delivery of services from all providers, with teams of multi-skilled professionals based in each of the localities**	**Help people to live as independently as possible whilst managing one or more long-term conditions**	**Focus on improved condition management to avoid admissions**	**Optimise self-care and family/carers support to enable people to stay at home for as long as possible, independently and safely**
Client Outcomes – possible Outcomes for each INT Objective					
I get help at an early stage to avoid a crisis	I feel safe and supported in my own home	I do not have to speak to lots of different people to get the support I need or There is a single point of contact available to me where there is knowledge and skills to help me	I have the information and support I need in order to remain as independent as possible*	I have considerate support delivered by competent people*	I have access to a range of support that helps me live the life I want and remain a contributing member of my community*
It is recognised that I may need support to help me to keep well and at home	I have the equipment I need to be supported in my own home	I can speak to people who know something about care and support and can make things happen*	I want to feel that services are shaped around my needs and not the other way round**	I can plan ahead and keep control in a crisis*	I have a network of people who support me - carers, family, friends, community and if needed paid support*
The people who know me communicate with each other and let each other know if I have any extra needs that I may need their support with	I know what to do and who to contact in a crisis	I have access to easy to understand information about care and support which is consistent, accurate, accessible and up to date	I am supported to maintain my independence for as long as possible***	I feel safe, I can live the life I want and I am supported to manage any risks	I have opportunities to train, study, work or engage in activities that match my interests, skills, abilities*
I want to get the right type of help, when things	I am supported with both my physical and	I have a clear line of communication, action and	I am happy with the quality of my care and support and I	I have systems in place so that I can get help at	I am in control of planning my care and support *

first start to be a problem, at the right time in the right place and without having to wait until things get worse**	mental health needs so that I can stay in my home	follow-up* or The goals of my rehab are clear, meaningful and measured and there is recognition that my goals may change throughout my life.	know that the person giving me care and support will treat me with dignity and respect ***	an early stage to avoid a crisis*	
I can refer myself to services easily when I need to and as my needs change		I have knowledge of, and access to, joined up rehabilitation services that are reliable, personalised and consistent.	My rehabilitation supports me and gives me confidence to self-care and self-manage, making the best use of available technologies and stops me from being admitted to hospital unnecessarily		I have care and support that is directed by me and responsive to my needs
					I am supported by people who help me make links into the community*
Possible Performance Measures for each INT Objective					
Proactively identify people at high risk of needing access to services	**Help prevent people from having to move to a residential or nursing home until they really need to**	**Coordinate delivery of services from all providers, with teams of multi-skilled professionals based in each of the localities**	**Help people to live as independentl y as possible whilst managing one or more long-term conditions**	**Focus on improved condition management to avoid admissions**	**Optimise self-care and family/carers support to enable people to stay at home for as long as possible, independentl y and safely**
Number of people identified at risk of needing access to services (include LD and MH)	No and % people remaining at home 90 days after discharge from hospital (including mental health	No and % people with single, holistic and personalised INT care plan in place	% people advising they have the information and support they need	% people reporting they feel more confident in managing their care at home	% of clients with a personalised and holistic support plan

	and LD)				
No. and % of A&E attendances for INT cohort (baseline vs. 1 year into targeted support	% people in 50% cohort (needs more help; needs a lot of help) being supported in their own home	% of staff completed mandatory training	% people feeling informed of their conditions and able to manage independently with the support provided	No. and % of INT cohort admitted to hospital	% of clients reporting that they are supported by their network - via patient experience measure
Delayed Transfers of Care attributable to INT	Proportion of adults with a learning disability who live in their own home or with their family	% people reporting their care is coordinated	% people feeling their psychological health and well-being is supported	SI Reporting Evidence of triangulation of learning from incidents; complaints, compliments, and other Patient Experience measures - you said, we did approach	% of clients whose care plan is monitored and reviewed regularly (appropriate timings to be agreed and will need to personalised dependent on need level)
? measure re Safeguarding	Proportion of adults in contact with secondary mental health services living independently, with or without support	% Staff FFT			
% clients reporting they know who to contact in a crisis	% people in 50% cohort with named case worker	% Staff feeling valued in their role (may need to complete staff-survey bi-annual; as will not be able to disaggregate INT staff from overall staff group)	% of people reporting improvement in individual Goals	% staff training completed (need to agree any key areas beyond mandatory)	
% of medical outpatient appointments	% people reporting feeling safe and supported in own home	% People knowing who to contact for support	% of people reporting positive impact based on the Session Rating Scale	Case studies – analysis of 10 randomly selected cases per INT of people with a Care Plan to	

				measure impact against a range of indicators including change in admission rate	
% cohort reporting increased well-being	% people admitted to care homes or care homes with nursing in year	Evidence of open and safe reporting culture (STEIS; patient safety incidents; safeguarding)		Outcomes on discharge/case closure	