Health and Social Care in Bury

Background and context

Health and social care reform across Greater Manchester aims to deliver a substantial reduction in avoidable admissions to hospital and other care institutions, mainly in the over-65 population thereby significantly improving the experience of individuals within the care system. This means the development of 'integrated care services' - care that is based around the needs of people and carers that put them in control, are joined up, and deliver better outcomes. Our delivery plan will be implemented through a phased approach guided by our shared principles.

Local evidence for change

Bury's population is 185,100 (Census 2011), with a 65+ population of 29,500 which accounts for 16% of the Bury population. This is below the national average, but slightly higher than the Greater Manchester average.

The population group will be aimed at all ages, but with an initial emphasis to focus on this particular cohort group of frail and older people over 65 including dementia; people with long-term conditions risk stratified and people with complex needs.

The new delivery model comprises:

- **Support for self-care and independence:** Patients, individuals and their carers will be supported and empowered to take ownership of their care and well-being so that they are able to live independently and so that health and social care resources are targeted on the most vulnerable. This will be delivered through patient education programmes, expert patient programmes, systematic use of direct payments, personal budgets, carers support and assistive technology.
- **Planned pathways of care:** Agreed care pathways and protocols will be in place to ensure that patients receive standardised care with reduced variability and unnecessary attendances.
- **Providers working together:** Health and social care teams will work in an integrated way, particularly for the frail elderly and people with long-term conditions. Patients and their carers will experience care provided in a seamless way, with unnecessary duplication avoided, as a result of effective collaboration between those involved in the planning and delivery of care. This will be delivered through integrated case management across health and social care, a single assessment process, with elements of co-ordination across Greater Manchester.
- **Accessible and Responsive care services**: will be easily accessible and responsive. Primary Care and GPs should usually act as 'first port of call' particularly for people with long term conditions. This will be delivered through enhancing the range of services within primary care.
- **Quick response to urgent needs:** There will be rapid access and response to urgent care needs to minimise the reliance on Accident and Emergency services and to ensure that the most appropriate care is provided. This will be delivered through rapid response/ intermediate care teams, aligned to Reablement Urgent Care Centres. Joint

urgent response services across health and social care will be available 24 hours a day, every day.

- **Appropriate specialist and hospital care only when required:** Patients will receive appropriate specialist input in a timely manner, when required, and will only spend the appropriate time in hospital with planned discharge in the community as early as possible. This will be delivered through an early supported discharge service and 'hospital at home' teams, including reablement and integrated end-of-life care.

Characteristics of new delivery models of integrated care

The local model will need to demonstrate that it has:

- Cross-agency leadership commitment and governance including local authority (political and managerial), clinical commissioning groups (clinical and managerial) and acute trust (managerial and clinical) to new service models focused on substantially reducing avoidable admission to hospital and other care institutions.
- An understanding of the costs and benefits across all partners of the new service models being proposed, and the contracting and reimbursement models that would allow decommissioning and new commissioning to occur at scale.
- A focus on scale – for example the need to target new interventions at cohorts of the risk stratified of those aged over-65.
- A focus on outcomes – to deploy analysis such as the Aqua/Association of the Director of Adult Social Services benchmarking tools to understand the baseline and test the effect of the operation of the local system.
- A recognition of how interventions planned and delivered at a GM level (e.g. North-West Ambulance Service, 111, reconfiguration of some hospital services) will inform the development of the local model.
- A demonstration of the extent to which patient and carer experience is captured and used to inform future development of the model.
- A credible plan to address some key enabling functions, particularly;
- **Data sharing agreements** across partners that actually work at service level to support single entry and single access points for different agencies.
- **Workforce development strategy** that promotes genuinely integrated working, including joint training and development opportunities.
- **A "total place" consideration** of estate utilisation to effect the necessary shift of activity from hospital and care institution.

Shared Vision and Commitment:

Our vision of integrated health and social care in Bury is one that is person-centred with co-ordinated care and support delivered through a model:

Figure 3: The vision for integrated health and social care in Bury.

Developing, implementing and investing in a new delivery model in Bury

We are currently finalising our new delivery model as shown in Figure 3, for this area of work, as this work progresses we will finalise whether this will be tested in a specific geographical area, and the teams listed are examples and not an exhaustive list, or with a specific cohort to test the model further. Alongside the development of the new delivery model we will also be gathering the relevant information to develop and draw together our investment proposition in anticipation of the September deadline from AGMA.

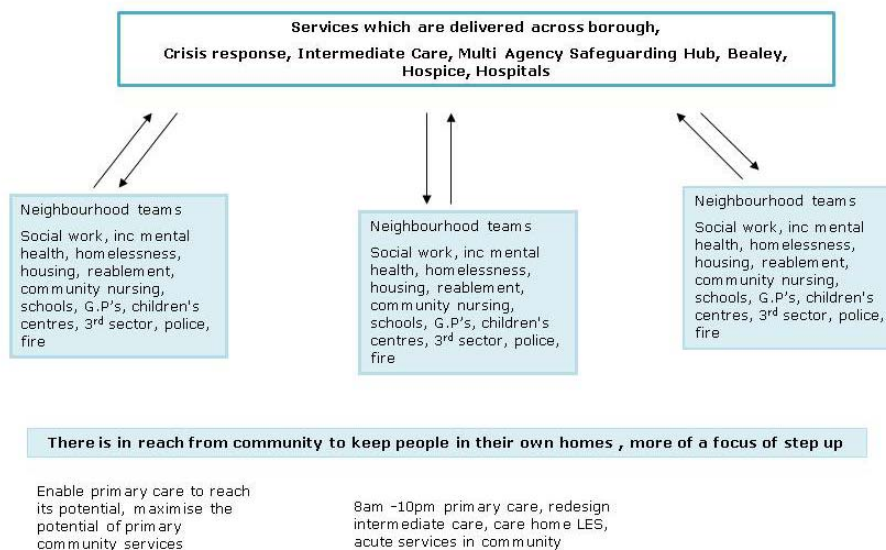

Figure 4: The New Delivery Model

The analysis referred to in (b) above will enable us to demonstrate where the costs and benefits of a new delivery model will fall, across CCGs, local authorities, acute trusts and others. Partners need to work together to develop contracting and reimbursement mechanisms that effect the shift to targeted and planned interventions and away from the reactive spend associated with avoidable admissions.

The current investment proposition/ money flow for the over 65 spend within community health services is currently under review and will be extracted from the block contract arrangement and current reporting requirements will follow in due course.

What are our engine room requirements for the new delivery model?

Within the project pathways there is a specific stream which will consider workforce development issues to ensure that Team Bury organisations can effectively deliver new integrated care services. This is currently being scoped and developed.

Who is supporting the delivery of the new delivery model in Bury?

- Cabinet Member for Adult Care, Health and Wellbeing
- Executive Director Adult Care Services
- Bury Clinical Commissioning Group
- Bury Health and Wellbeing Board
- Bury Integrated Health and Social Care Partnership Board
- Pennine Care NHS Foundation Trust
- Pennine Acute Hospitals NHS Trust
- Third Sector (to include Hospice)
- Department of Works and Pension (DWP)
- Mental Health services
- Housing services and providers
- Education services and providers
- Healthwatch
- North West Ambulance Service (NWAS)

Governance

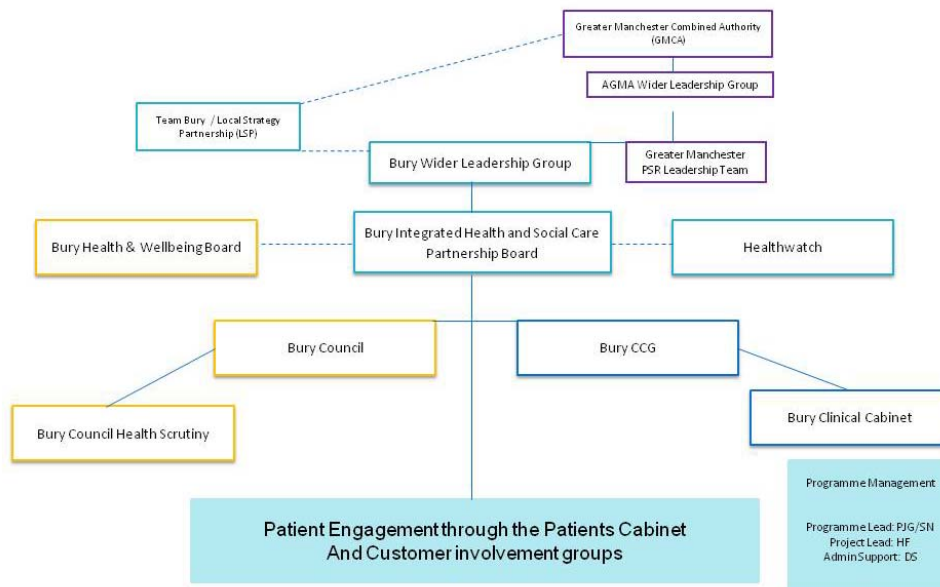

Figure 5: Local Governance arrangements for delivering Integrated Health and Social Care in Bury.

What are the milestones for implementation of the new delivery model in Bury?

Integration between health and social care is at an early stage, but local authority leaders have asked to receive an overview of the integrated care plans in development across Greater Manchester in June 2013. A framework for this submission will be created largely based on the characteristics identified above. Scoping work is currently under way and a detailed timetable will be developed from June which will agree key milestones with key partners to support the submission of the investment proposition in September 2013.

What does this implementation plan commit Team Bury partners to?

Work collaboratively in partnership to implement a joint integrated health and social care programme of work for all ages.

Outcomes and how will we know we have succeeded?

A number of local outcomes are currently being developed in line with the project implementation in Bury at a local level.

We will know we have succeeded by:

- Demonstrating significant cost reductions required by all partners;
- Setting challenging targets to reduce inappropriate admissions to residential and nursing care;
- Improved health and wellbeing outcomes for all;
- A demonstrable reduction in emergency admission;
- Increase in patient participation and involvement;
- Increase in number of people dying at their place of choice/usual place of residence;

- Fewer A&E attendances and admissions
- Support the delivery of the Supporting Communities, Improving Lives programme
- Increased preventative services

Evaluation

The Integrated Health and Social Care Partnership Board members are committed to evaluating the effectiveness of the project and delivering effective outcomes to the identified cohorts. The process of evaluation will utilise evidence of improved performance and the patient/service user experience. The detail will be developed throughout the whole stages of the project.

Key projects:

- Joint commissioning
- Complex care
- Early years/early help
- Special Educational Needs (SEN) and Disability
- Multi-Agency Safeguarding Hub (MASH)
- Long-Term Condition (LTC) and Radcliffe Pilot (HINc), Urgent Care Intermediate Team (this includes falls)

Challenges ahead:

- Integrated records, integration of systems
- Quality assurance built into the design processes
- Ability to maintain stable Acute services whilst investment in community services
- Changing the various cultures of a number of partners and professionals into one
- Resources /capacity
- Setting performance targets that measure what matters to the community rather than national targets
- Changing national picture/ political environment
- People's expectations increasing, need to change public attitude to take ownership of their own health and wellbeing
- Overlap and interdependencies of Healthier Together, Primary Care and Integrated Teams
- Current contracting arrangements make it difficult to breakdown spend
- Registered v Resident

Case Study: The new delivery model in action

NOW: Mrs Peel is 83 years old and she lives alone in a 4-bedroom house. She has no immediate family, but attentive good neighbours. Recently she has been noticed to be forgetful and wandering. Team Bury partners are alerted to the fact that she is very confused and appears unwell. A member of staff from a Team Bury agency visits and finds she is dehydrated and has a chest infection; she cannot cope on her own. Under current arrangements a doctor completes a capacity assessment and makes a clinical decision on the patient's best interest. No support can be found for her in the community so she is admitted alone in an ambulance to Accident and Emergency. She receives treatment in hospital and is discharged; reablement support and a memory assessment takes place. But, the GP only receives information about issues relating to her chest infection.

THE VISION for the new integrated health and social care system means that Mrs Peel is already living in supported accommodation; she has telehealth equipment in the house so her illness is picked up at an early stage and she receives a consultation via Skype. A support worker visits the house and undertakes more tests and administers antibiotics via a drip. A worker from a third sector partner monitors Mrs Peel for the next 72 hours. Mrs Peel's health records are updated and available for all agencies to see via a web portal.

Action Number	Health and social care delivery plan	Lead Officer	Part of GM Action?	April 2013	May 2013	June 2013	July 2013	August 2013	Sept 2013	Oct-Nov 2013	Jan- Mar 2014	April- Jun 2014	July – Dec 2014	2015
1	Health and Social Care Partnership													
a	Establish the Bury Integrated Health and Social Care Partnership Board & Project Manager	SN/ PJG												
2	Vision													
a	Define the Integrated Health and Social Care Vision for Bury linked to Healthier Together	All												
3	Joint programme of work Implement joint programme of work around five domain areas: • Reforming Systems; • Developing People; • Improving Systems; • Policy Alignment & Evaluation; • Finance - (Affordability and Contractual implications)													
	Joint Commissioning	JG/RW/SM												
	Complex Care	LJ/KW/MG												
	Early Years and Early Help	SR/KW/CF												
	Special Educational Needs (SEN) and Disability	IC/SM/JG/LJ/CF												
	Multi-Agency Safeguarding Hub (MASH)	MG/JG/CF												
	Urgent Care Intermediate Team (including Falls)	FM/LJ/PT/JT/ST/SM/CP/SB												

		/KW												
	Finance - (Affordability and Contractual implications)	JG/SK/CP /PL												
	Equality Assessment	CK/HF												
Key to personnel:														
SN	Stuart North	Chief Operating Officer, Bury Clinical Commissioning Group												
PJG	Pat Jones-Greenhalgh	Executive Director – Adult Care Services, Bury Council.												
KP	Kiran Patel	Chair Bury Clinical Commissioning Group												
SM	Sharon Martin	Head of Commissioning, Bury Clinical Commissioning Group												
HF	Hemlata Fletcher	Project Lead, Bury Council												
LJ	Linda Jackson	Assistant Director – Operations, Bury Council												
KW	Karen Whitehead	Strategic Lead Health/Families, Children's Services, Bury Council												
JG	Julie Gonda	Assistant Director – Commissioning & Procurement, Bury Council												
SB	Stan Bowler	Pennine Care NHS Foundation Trust, Mental Health												
JT	Jackie Taylor	Service Director and Operational Senior Management Team, Productive Borough Link, Pennine Care NHS Foundation Trust												
ST	Steve Taylor	Pennine Acute NHS Foundation Trust												
PT	Dr P Thomas	Urgent Care Lead, Bury Clinical Commissioning Group												
IC	Ian Chambers	Assistant Director, Learning, Children's Services												
CP	Claire Postlethwaite	Deputy Chief Finance Officer, Bury CCG												
PL	Peter Lowe	Head of Finance, Children's Services												
MG	Mark Gibbon	CHC and Complex Care Commissioner Bury CCG												

CF	Cathy Finnes	GP Lead Children's and Maternity CCG Safeguarding Lead
FM	Fin McCaul	Clinical Work stream Lead Long Term Conditions
CK	Catherine King	People Strategy / Equalities Advisor