Mike Kelly FCIOB MCIM
Chief Executive

Our Ref JG
Your Ref HSC/JG
Date 19 January 2015
Please ask for Julie Gallagher
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Legal & Democratic Services Division

Jayne Hammond LLB (Hons)
Solicitor
Assistant Director of Legal & Democratic Services

TO: All Members of Health Scrutiny Committee

Councillors : P Adams, P Bury (Chair), E Fitzgerald, L Fitzwalter, J Grimshaw, S Haroon, K Hussain, S Kerrison, J Mallon, T Pickstone, S Smith and R Walker

Dear Member/Colleague

Health Scrutiny Committee

You are invited to attend a meeting of the Health Scrutiny Committee which will be held as follows:-

Date:	Tuesday, 27 January 2015
Place:	Peel Room (Elizabethan Suite), Town Hall, Knowsley Street, Bury
Time:	7.00 pm
Briefing Facilities:	If Opposition Members and Co-opted Members require briefing on any particular item on the Agenda, the appropriate Director/Senior Officer originating the related report should be contacted.
Notes:	**Please note there will be a pre-meeting briefing for Elected Members only commencing at 6pm in the Lancashire Fusiliers Room**

AGENDA

The Agenda for the meeting is attached.

Reports are enclosed only for those attending the meeting and for those without access to the Council's Intranet or Website.

The Agenda and Reports are available on the Council's Intranet for Councillors and Officers and also on the Council's Website at www.bury.gov.uk – click on **Agendas, Minutes and Forward Plan**.

Copies of printed reports can also be obtained on request by contacting the Democratic Services Officer named above.

Yours sincerely

Chief Executive

AGENDA

1 **APOLOGIES FOR ABSENCE**

2 **DECLARATIONS OF INTEREST**

Members of Health Scrutiny Committee are asked to consider whether they have an interest in any of the matters on the agenda and if so, to formally declare that interest.

3 **PUBLIC QUESTION TIME**

Questions are invited from members of the public present at the meeting on any matters for which this Committee is responsible.

4 **MINUTES OF THE LAST MEETING** (Pages 1 - 6)

The minutes of the last meeting held on 8th October 2014 are attached.

5 **MATTERS ARISING**

6 **ADULT SAFEGUARDING PEER REVIEW RESULTS** (Pages 7 - 26)

Julie Gonda, Assistant Director Commissioning & Procurement will report at the meeting. Presentation attached.

7 **INTEGRATED DIABETES TEAM UPDATE**

Representatives from the Clinical Commissioning Group will report at the meeting. Papers to follow.

8 **BETTER CARE FUND SUBMISSION** (Pages 27 - 200)

The Clinical Commissioning Group Chief Officer will report at the meeting. Report attached.

9 **URGENT BUSINESS**

Any other business which by reason of special circumstances the Chair agrees may be considered as a matter of urgency.

10 **HEALTH AND WELLBEING BOARD MINUTES * FOR INFORMATION*** (Pages 201 - 206)

Minutes from the meeting of the Health and Wellbeing Board held on the 29 October are attached for information.

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Agenda Item 4

Minutes of: **HEALTH SCRUTINY COMMITTEE**

Date of Meeting: 8 October 2014

Present: Councillor P Bury (in the Chair)
Councillors P Adams, E FitzGerald, L Fitzwalter, S Haroon, S Kerrison, J Mallon, S Smith and R Walker

Also in attendance: Linda Jackson - Assistant Director - Strategic Support Services.
Jimmy Cheung – Senior Medicines Optimisation Pharmacist, North west Commissioning Support Unit.
Lesley Jones, Director of Public Health, Bury Council
Sharon Martin – Deputy Chief Executive, Bury Clinical Commissioning Group.
Catherine Jackson – Executive Nurse Bury CCG/Nurse Clinician
Julie Gallagher – Democratic Services

Public Attendance: There were no members of the public present at the meeting.

Apologies for Absence:
Councillor T Pickstone
Councillor K Hussain
Councillor J Grimshaw

HSC.363 DECLARATIONS OF INTEREST

There were no declarations of interest made at the meeting.

HSC.364 PUBLIC QUESTION TIME

There were no questions asked by the members of public present at the meeting.

HSC.365 MINUTES OF THE LAST MEETING

It was agreed:

That the Minutes of the last meeting held on 11th September 2014 be approved as a correct record and signed by the Chair.

HSC.366 MATTERS ARISING

The Chair reported that he had attended a meeting of the Greater Manchester Health Scrutiny Committee to discuss the Healthier Together consultation. The Chair reported that more than 10,000 people had attended consultation events and 12,000 responses had been received, the last date for submission is 24th October 2014.

The Deputy Chief Officer responded to concerns raised by Members in relation to the proposals recently submitted by the hospital Trust's in Bolton, Salford and Wigan; the Deputy Chief Executive reported that the recent developments would not alter the consultation proposals.

In response to a question from Councillor Walker; the Director of Public Health confirmed that a report in relation to Intra-health, will be considered at a future meeting of the Health Scrutiny Committee.

It was agreed:

That the Director of Public Health will produce a briefing note for consideration by members of the Health Scrutiny Committee that provides them with information on public health funding and the intra health contract

HSC.367 PUBLIC QUESTION TIME

There were no questions from members of the public.

HSC.368 PHARMACEUTICAL NEEDS ASSESSMENT

Jimmy Cheung, Senior Medicines Optimisation Pharmacist, North West Commissioning Support Unit gave a presentation providing an overview of the PNA consultation document. An accompanying report had been submitted to the Committee providing an evaluation of the pharmaceutical need across the Borough and included information relating to:

- Context of the PNA
- Public Health services
- Population Demography
- Local Identified health need
- Current pharmacy provision and services
- Future matters

Those present were given the opportunity to ask questions and make comments and the following points were raised:-

In response to a Member's question, in relation to the need for a pharmacy in Besses ward; the Senior Medicines Optimisation Pharmacist reported that the PNA is of particular importance to NHS England, the PNA is a key document when making decisions with regards to pharmacy applications.

The Senior Medicines Optimisation Pharmacist reported that pharmacy services would be monitored firstly by NHS England via the pharmacy contract and secondly by the General Pharmaceutical Council (GPH), the GPH will register and visit all pharmacies.

Members discussed the need to ensure that pharmacies collaborate with each other and with other healthcare professionals, to develop models of care which enable commissioners to deliver integrated patient pathways, and ensure patients have consistent access to support.

Members of the Committee expressed concern that members of the public are not always aware of the additional services available in each pharmacy and it may necessary for a piece of work to be undertaken to re-educate and inform the public.

In response to a Member's question the Senior Medicines Optimisation Pharmacist reported that it is the pharmacists' responsibility to self-declare their level of competence when providing enhanced pharmacy services. The Pharmacist is supported by training and education from the GPC on an ongoing basis.

It was agreed:

That the Chair on behalf of the Health Scrutiny Committee will collate a response to the Pharmaceutical Needs Assessment consultation taking in to account the points raised in the discussion. The response will be submitted prior to the consultation deadline on 31st October 2014.

HSC.369 CLINICAL COMMISSIONING GROUP – QUALITY STRATEGY

Catherine Jackson; Executive Nurse Bury CCG/Nurse Clinician Unit gave a presentation providing an overview of Bury's Clinical Commissioning Group (CCG) quality compliance and quality strategy. The presentation contained the following information:

The Executive Nurse reported that the CCG wanted to provide members of the committee with assurance that they are meeting the statutory obligations to ensure that services for local people are of a good quality. This is done via a variety of means:

- NHS Constitution (2011) – Outcomes framework
- Quality Domains of the NHS England Assurance Framework
- Local assurance – Monitor, CQC, Healthwatch, Patient Cabinet, review patient experience, visits and performance data.
- North east sector assurance – NES Commissioning Board, Serious incidents panel, dedicated Continuing Health Team.

The Executive nurse reported that the CCG have developed a quality strategy that includes five priority areas:

- Patients will receive quality health care because all commissioning decisions will be quality assessed and approved
- The quality and safety of care will be improved by *consistent* scrutiny and challenge of *all* health care providers by the CCG and by working collaboratively with all stakeholders
- Health outcomes will improve though quality improvement measures and monitoring of outcomes
- Patients will have a better experience of healthcare by ensuring providers are compliant with national recommendations
- 'No decision about me without me'. Patient experience will meet expectations by improved engagement with patients, partners and stakeholders

Those present were given the opportunity to ask questions and make comments and the following points were raised:-

In response to a Member's question, the Executive nurse reported that some visits to Care Homes may be conducted jointly with the adult safeguarding nurse and or representatives from the Local Authority.

The Executive Nurse reported that the complaints system can be very difficult to navigate; the CCG provides a complaints helpline to assist members of the public. The Executive Nurse reported that she attends regular meetings to discuss complaints within the Pennine Acute and Pennine Care NHS footprint to identify trends/share information.

In response to a Member's question, the Executive Nurse reported that the CCG do not collate complaints in relation to nursing homes. However, some nursing homes do produce an annual complaints report.

Members of the Committee expressed concerns in relation to changes within the health service this has resulted in members of the public struggling to navigate patient pathways in respect of their care.

The Executive Nurse reported that staff in the NHS are highly motivated, fully support the quality agenda and sickness absence levels are low.

In response to a Member's question, the Executive Nurse reported that, the Quality Strategy is not a document that sits alone but will sit alongside the CCG's Strategic Development Plan and would form part of any contract negotiations.

It was agreed:

Catherine Jackson; Executive Nurse Bury CCG/Nurse Clinician Unit be thanked for her attendance.

HSC.370 BETTER CARE FUND

Members of the Board considered a verbal presentation from the Deputy Chief Officer, Sharon Martin in relation to the Better Care Fund.

The Better Care fund is a joint pooled budget for health & social care implemented from April 2015 which will have to be agreed between Local Authorities and CCG's and then signed off by Health & Wellbeing Boards.

The Better Care Fund will develop a sustainable health and social care system

The CCG Deputy Chief Officer reported that it will be necessary to organise services around people to enable them to receive care & support in their own homes.

The total Better Care Fund resource is £12.97 million and will be categorized as follows; Social care spend, £5.8 million; Performance care element £3.43million, new investment £2.5 million; Local Authority capital allocations 1.24 million.

The CCG Deputy Chief Officer reported that there are national supporting metrics underpinning delivery these are not linked to payment & performance but still need to set ambition & measure:

- Permanent admissions of older people to care homes
- Proportion of older people- still at home 91 days after discharge to reablement & rehabilitation services
- Delayed transfers of care
- Local metric – emergency hospital admissions for injuries due to falls
- Patient /service user experience – local or national metric

The CCG Deputy Chief Officer reported that the Fund was signed off by the Health and Wellbeing Board on Thursday 18th September, some initial feedback has been received.

Those present were given the opportunity to ask questions and make comments and the following points were raised:-

Members discussed the financial risks associated with the Better Care Fund. The Deputy Chief Officer reported that the performance element of the Fund which equates to 3.4 million pounds in monetary terms, is a financial risk for the Local Authority and the CCG. To secure this money the CCG will need to ensure that there is a 5% reduction in activity within the acute sector. The Pennine Acute Trust will need to be assured that if they take capacity out of the acute system as a result of a predicated drop in the level of funding, that there is an increased capacity within primary care..

In response to a Member's question, the Deputy Chief Officer reported that in order for the integration of services to be successful, all partners need to develop effective data sharing. The Healthier Radcliffe pilot has developed a system for data sharing across the six GP practices and representatives from the CCG within the north east sector have compiled a bid to develop a system to integrate patients health and social care data.

The Deputy Chief Officer reported that the Better Care Fund is money that is being top sliced from the CCG budgets and equates to 4.8% of the CCGs total budget.

In response to a members' question, the Deputy Chief Officer reported that it will be necessary for Pennine Acute NHS Trust to reconfigure services as a result of changes within the health service. Accident and Emergency departments are costly, a number of elderly patients end up there because there is nowhere else safe within the community. The Better Care Fund will ensure money is directed in to community services to prevent unwanted and un-necessary hospital admissions.

Linda Jackson, Assistant Director; Operations, reported that the Better Care Fund will result in partners within the acute sector, primary care and the local authority having to work differently and this will result in the reconfiguration and re-modelling of some services.

In response to a member's question, the Assistant Director reported that the reablement monies identified within the fund is a funded by the Local Authority.

The Assistant Director reported in the recently published quality and efficient scorecard for frail and elderly locality benchmarking standards, Bury were the highest performing CCG/Local Authority. This is an excellent achievement, despite the CCGs underfunding and funding constraints place on the Local Authority.

It was agreed:

The Deputy Chief Officer be thanked for her attendance.

HSC.371 URGENT BUSINESS

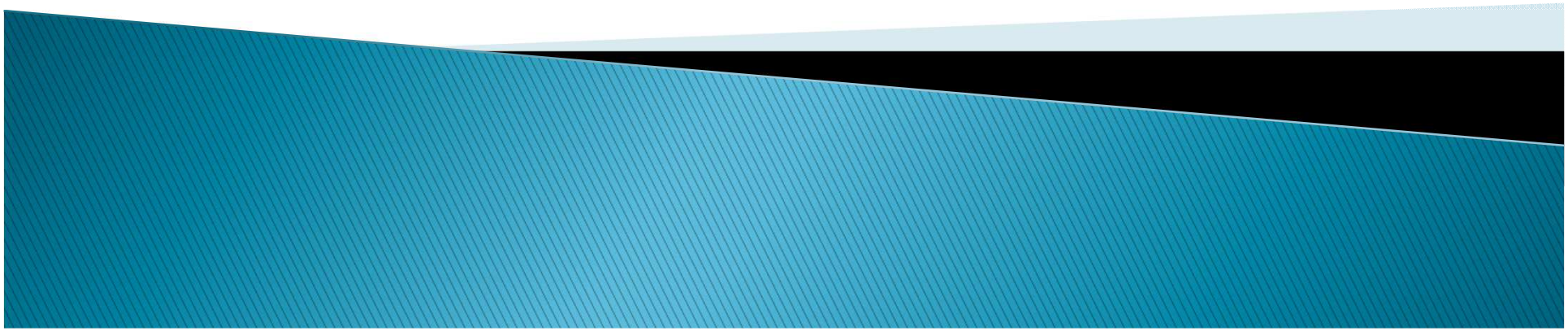
There was no urgent business reported.

COUNCILLOR PETER BURY
Chair

(Note: The meeting started at 7.00 pm and ended at 9.10 pm)

Adult Safeguarding Peer Review Results

Amanda Symes– Bury Council
Communities and Wellbeing Directorate
Strategic Adult Safeguarding Manager



Aim of the Presentation

To give assurance that Bury Council is providing a quality services to those adults who are in need of a safeguarding service.

Peer Challenge Framework

- Towards Excellence in Adult Social Care (TEASC)
- NW Regional Group have agreed 4 aims:
  - Galvanising adult social care services to achieve the best possible outcomes for people.
  - Build on existing capability in adult social care services.
  - Systematically share knowledge.
  - Develop and implement policies designed to improve the lives of service users, their families and carers.
- Peer Review

Peer Challenge Process – Bury

- Benchmarked against a modified version of the Local Government Association (LGA) model for Standards in Adult Social Care.

- Objectives Centred on the key themes below:

1. Outcomes for people who use services
2. Participation
3. Vision, Strategy & Leadership
4. Working together
5. Resource and Workforce Management
6. Service Delivery and Effective Practice
7. Commissioning
8. Improvement and Innovation

Peer Challenge Process – Bury

cont

- 3 aspects of safeguarding practice were considered:

1. Strategic approach – to consider direction and policy setting, work with partners and the working of strategic bodies – such as the Safeguarding Board.
2. Commissioned services –to consider how the Council ensures effective safeguarding practice in commissioned services – particularly consistency of approach and outcomes.
3. Frontline social work practice – in particular the consistency of approach, impact and quality of decision-making

Summary of Key Findings –Strengths and Best Practice

1. Outcomes for people who use services

- Identified excellent outcomes for service user.
- Commended on positive risk taking and ensuring individuals had choice and control.
- Noted – respectful decision making.
- Identified that there is a clear support planning process which is standard for all customers.

Summary of Key Findings –Strengths and Best Practice

2. Participation (choice, control, advocacy)

- Clear evidence of how service users, families and carers can influence adult safeguarding arrangements.
- Advocacy services also offer additional support i.e. RPR services for Deprivation of Liberty cases.
- Clear focus on ensuring services users are active participants in the safeguarding process.
- Adult Social Care Outcomes Framework results advised 95% of service users felt in control and safe.
- Feedback from service providers evidenced that a positive culture re: personalisation, choice and control is promoted.

Summary of Key Findings –Strengths and Best Practice

3. Vision Strategy and Leadership

- Passion, enthusiasm and drive from senior leadership.
- Clear and ambitious strategy for health and wellbeing.
- Good practice re: the Ambassador initiative.
- Management have encouraged and supported wider Council and partner awareness.
- Impressed by Lead Member's grasp of adult safeguarding agenda and wider health and wellbeing agenda.
- Positive impact of the Prevention Strategy

Summary of Key Findings –Strengths and Best Practice

4. Working Together (partnerships and integration)

- Care providers very positive responses and feel supported.
- Providers reported Bury had a favourable approach when compared with neighbouring authorities.
- Documentation and process “very clear”.
- Effective training provided.
- Good relationship with procurement team.
- Good working practice noted with other internal departments.

Summary of Key Findings –Strengths and Best Practice

5. Resource and Workforce Management

- Very positive comments from staff re: change in culture – culture of openness, sharing and learning.
- Comprehensive programme of training courses.
- Clear self assessment and response to the Social Work Task force recommendations.
- Detailed work and analysis re: change in law and impact on resources regarding the Deprivation of Liberty Safeguards.

Summary of Key Findings –Strengths and Best Practice

6. Service Delivery and Effective Practice

- "Threshold" document commended – empowers submission of appropriate referrals.
- Contract /Quality Assurance Team commended.
- Quality Assurance document "excellent".
- Innovative approach and use of peer assessment, and utilisation of peer approach to develop quality standards.

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Summary of Key Findings –Strengths and Best Practice

7. Commissioning (integration, consistency, quality of provision)

- Clear process for producing market position statements, commission strategy and commissioning plans.
- Market position statements send out clear message "safeguarding is everyone's business".
- Clear multi-agency policy which supports and directs adult safeguarding work in Bury.

Summary of Key Findings –Strengths and Best Practice

8. Improvement and Innovation

- Culture of openness and transparency.
- Impressive wider strategy around health and wellbeing.
- Innovative approach to peer assessment/inspection of LD services.
- Noted for Organisational Audit approach to safeguarding.
- Use of staff surveys to test safeguarding awareness and training needs.

Summary of Key Findings – Development Areas

1. Outcomes for people who use services

- Continue to develop systematic process for capturing, recording and reporting on outcomes.
- Need to continue to review "level of signup" to the Making Safeguarding Personal initiative.
- Consider how service user experience feedback is used to inform strategy and policy.

2. Participation

- Opportunity to access wider intelligence from partner agencies, and 3rd sector groups.

Summary of Key Findings – Development Areas

3. Vision, Strategy and Leadership

- Develop partner engagement strategy
- Further develop shared marketing and branding.
- Consider safeguarding adults as a priority theme in key strategic documents (i.e Annual Local Account)
- Embed Prevention Strategy delivery plan.
- Further develop the Safeguarding Board particularly around ability to challenge, consider wider membership.
- Challenge health partners re: lack of available intelligence.
- Develop roles and expectations document for Board members

Summary of Key Findings – Development Areas

4. Working Together (partnerships and integration)

- Consider how CAD (Connect And Direct) strengthen links with the children's MASH (Multi Agency Safeguarding Hubs)
- Utilise the service integration movement to focus interest and resources on adult safeguarding.

- **5. Resource and Workface Management**
- Communicate the new role of "principle social worker" across the partnership.

Summary of Key Findings – Development Areas

6.Service Delivery and Effective Practice

- Further analysis from alert to investigation.
- Develop independent audit of case files
- Develop staff compliance monitor for new ICT system
- Develop more robust process for tracking "Health" lead safeguarding cases.

- **7. Commissioning** **(integration, consistency, quality of provision)**
- Develop "intelligence input" into commissioning strategies and plans.
- Jointly owned Market Position Statements.

Summary of Key Findings – Development Areas

8. Improvement and Innovation

- Develop clear plan using results of organisational audit for each key partner.
- Develop clear Prevention Strategy implementation plan.
- Ensure effective implementation of new IT system.

- Questions

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Better Care Fund Planning template – Part 1

Bury CCG
Bury Council

October 2014

Resubmission of revised version January 2015

CONTENTS PAGE

Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

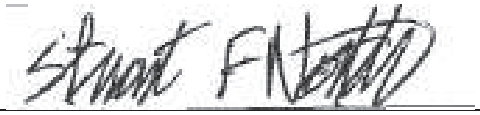
To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

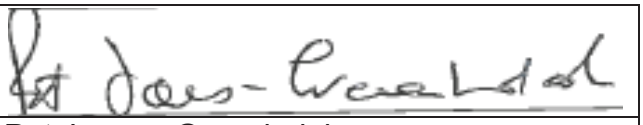
a) Summary of Plan

Local Authority	**Bury Council**
Clinical Commissioning Groups	**Bury Clinical Commissioning Group (CCG)**
Boundary Differences	**Co -terminus**
Date agreed at Health and Well-Being Board:	**18/12/2014**
Date submitted:	**09/01/2015**
Minimum required value of BCF pooled budget: 2014/15	**£681k**
2015/16	**£12,967k**
Total agreed value of pooled budget: 2014/15	**£681k**
2015/16	**£12,967k**

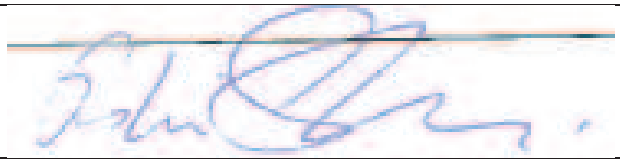
b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Stuart North
Position	Chief Officer
Date	08/01/2015

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	
By	Pat Jones - Greenhalgh
Position	Executive Director for Communities & Wellbeing
Date	08/01/2015

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Rishi Shori
Date	08/01/2015

<Insert extra rows for additional Health and Wellbeing Boards as required>

c) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	**Synopsis and links**
Bury Joint Strategic Needs Assessment (JSNA)	See link below http://www.bury.gov.uk/CHttpHandler.ashx?id=9203&p=0
Bury Joint Health and Wellbeing Strategy (HWBS) Living Well in Bury: making it happen together	The HWBS has had final approval and we are now working to pull together a delivery plan http://www.bury.gov.uk/CHttpHandler.ashx?id=11597&p=0
Developing a new model of Integrated Care and Support for People in Bury 2013 - 2018	Report detailing the proposals for integrating health and social care in Bury submitted to Greater Manchester for the purposes of Healthier Together consultation See separate zip folder
Bury Mental Health Strategy 2013 - 2018	Bury Council and Bury NHS Clinical Commissioning Group are committed to improving the mental health and emotional wellbeing of all adults in Bury. The Bury Mental

	Health Strategy 2013 - 18 sets out how we will achieve this over the next five years. The strategy has been jointly developed by the Local Authority and CCG and co-produced with service users and other stakeholders. Its main aims are to reinforce prevention and recovery based approach to mental health, including the further development and support of community and 3rd sector services. http://www.bury.gov.uk/index.aspx?articleid=3228
Bury Public Service Reform (PSR) first phase implementation plan	Local Implementation plan for Public Service Reform
Bury Dementia Strategy	The joint local dementia strategy supports the creation of an environment where we can enhance existing services to improve the quality of life for people with dementia and their carers in Bury. Working in partnership will ensure that people receive early and timely diagnosis so they continue to live and function well with dementia. http://www.bury.gov.uk/index.aspx?articleid=3313
Carers strategy	The aim of the strategy is to recognise, enable and support carers of all ages from the whole community to have a quality life of their own. It was developed in partnership with the Local Authority, CCG, voluntary sector and carers themselves, and it recognises the valuable role that carers play in supporting their loved ones http://www.bury.gov.uk/index.aspx?articleid=4903
A Healthier Radcliffe Demonstrator Community 2013	Bid documents submitted to NHS England See separate zip folder
National Voices	We have used the National Voices principles for person centred coordinated care along with the "I " statements See separate zip folder
AQUA ADASS Locality scorecard June	See separate zip folder
One Council. One Plan. Our Corporate Plan: 2014-15 Update	See separate zip folder
NHS Bury Clinical Commissioning Group Strategic Plan 2014-2019 and Delivery Plan 2014-2016	See separate zip folder
Our Place development strategy	See separate zip folder
Operational Resilience Plan	See separate zip folder
Information Governance	See separate zip folder

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

The Local Vision for health and social care services for Bury for 2019/20

Bury is committed to transforming the whole health and social care system over the next five years to further promote self-care and personal accountability of people for their own health needs in order to support people appropriately and enable them to live in their own homes and communities.

The vision is that:-

- people will live well, stay well, remain active and have better outcomes and experiences
- there will be a focus on citizenship, prevention, self-care and independence with the aim of reducing the demand for services and making efficient and effective use of both health and social care resources
- our Better Care Fund Schemes focus on integrated care delivery for the frail elderly and children with complex needs
- we will provide better support for people at home with the provision of coordinated services in their own communities to prevent people needing emergency care in hospital or being inappropriately admitted to care homes
- in order to achieve the cultural shift that will be necessary we will have to utilise our workforce more effectively, considering skill mix, reorientation and training opportunities for staff

To lay the foundations for a much more integrated system of health and social care we have worked with our partners to achieve an agreed definition of integration, aims and shared design principles. We do understand that collaborating with all of our partners in the health, social care, housing and voluntary sector is vital in developing more innovative solutions to the challenges that we face.

Joint Strategic Need Assessment

Our Joint Strategic Needs Assessment (JSNA) tells us Bury currently has around 31,000 residents aged 65+ (17% of total population) of these 3,700 are aged 85+ (2% of the total population). The numbers of older people and the proportion of the total population aged 65+ is expected to increase over the coming years. It is expected that Bury's older population will increase by over 14,000 by 2035 (43% up on 2014 figure) to nearly 47,000 people. While the total population will increase during that time, the proportion of older people will also increase – from 17% in 2014 to 21% in 2035. People aged 85 and over will more than double over the same period (3,900 to 8,900).

Men aged 65 in Bury can expect to live for an additional 16.4 years, and women an additional 19.1 years. This is significantly lower than the national average (17.7 and 20.3) and slightly lower than for the North West as a region. There are also inequalities between areas of Bury. The difference in life expectancy between the most and least deprived areas is almost 6 years.

The JSNA also highlights that the likelihood of disease and disability increases with age. Disability prevalence increases from 6% in children to 16% in the working population and 45% in those of retirement age. We estimate that there are now likely to be 2000 people aged over 65 suffering with dementia which will rise as the 65 plus population increases. Fulfilling a caring role has a higher impact on older residents with the majority of carers in Bury aged 55 and over.

Premature mortality is higher than would be expected given the levels of deprivation in Bury suggesting the health and social care system, particularly primary care could have a significant impact on improving health.

Social isolation is known to be a significant risk to health. Older people are particularly vulnerable to isolation. Sixty one per cent of over 65's in Bury live alone.

Recurrent themes from our patient and service user engagement on health priorities and service provision include a desire to see a strong emphasis on prevention, support to maintain independence, better access to primary care and joined up care; accessibility of services; good and reliable patient transport; better integration of voluntary and community services; meeting the faith needs of people in adult residential care and the need to keep the health and social workforce on board with changes through good communication and workforce development.

There is a strong local commitment by Bury Council and Bury CCG to ensure that local people are included in decisions, not only about the care being given, but also on the commissioning and delivery options for service provision. All plans are therefore developed taking into account the views of the public, patients and stakeholders . Our evidence of the approach to this and public engagement in Bury is described in more detail in section 8.

Health and Wellbeing Strategy

Our Health & Wellbeing Strategy is underpinned by the following principles that are at the core of all we do:

- Promoting prevention, early intervention and self care
- Reducing inequalities in health and wellbeing
- Developing person-centred services
- Planning for future demands

The strategy focuses on five priorities:

- Ensuring a positive start to life
- Encouraging healthy lifestyle and behaviours in all actions and activities
- Helping to build strong communities, wellbeing and mental health
- Promoting independence of people with long term conditions and their carers
- Supporting older people to be safe, independent and well

Our plans for health and social care integration are the health and social care system response to the Health & Wellbeing Strategy. Focusing initially on the over 65 population, our plans not only cover service integration for those with existing health and social care need and their carers but also feature a strong health improvement and prevention element to prevent people needing services in the first place. We are also mindful of the next generation of older people and our prevention work extends to primary and secondary prevention of long term conditions within the working age

population. We aim to connect the health and social system into local communities and to develop a relationship of co-production for health.

The wider Greater Manchester vision for integrated health and social care

Bury's Integrated Care Programme is being developed within the context of a wider review of Health and Social Care in Greater Manchester aimed at improving outcomes, at a lower cost. Specifically this involves Greater Manchester major strategic change programmes:

1. Greater Manchester Integrated Care (Community based) Programme - the development and implementation of 10 to 12 new locally derived models of integrated care and more accessible services
2. Healthier Together Programme - the review and reform of secondary care services, which are safe and sustainable
3. Staying Well, Living Well - a 5 year strategy for improving primary care within Greater Manchester which links to the national agenda for widening access to Primary Care

Bury is playing an active role in these major programmes, all of which are vital in order to develop services for the future.

Shared design principles

The following agreed shared design principles underpin the development of integrated care in Bury:

- Self care, early intervention and prevention.
- Person centred coordinated care when needed.
- Empowering and enabling people to become experts in their own condition and to access services appropriately.
- A partnership approach with people who use services and their carers to ensure their engagement and involvement in designing services.
- Fully inclusive of all communities
- Access to services 7 days per week from 8.00am to 8.00pm, currently being delivered as part of Healthier Radcliffe.
- Integrated multi-disciplinary teams based in defined localities wrapping around an identified primary health care and social care hub.
- Reconfiguration of social care assessment and care management services by June 2014; domiciliary care tender to deliver locality based support to be completed by April 2015; community health services to be reconfigured across localities during 2014.
- GP practices will be at the centre of the primary care delivery model coordinating care, providing core services and supporting the person to be accountable for their own health.
- Access for all ages with a specific focus on people at a higher risk such as people with long term conditions and over 65's risk stratified.
- Access to and availability of screening and prevention services which promotes wellbeing.
- Sharing resources, records, risks, decision-making and benefits.
- Single care record is being piloted through Healthier Radcliffe. Across the North East sector, Bury is working in partnership to develop a true integrated care system across community, acute, primary and social care. It is expected that this will be implemented by April 2016.

- Jointly defined outcomes framework.
- Joint commissioning of services to meet needs. Consideration is being given to creating a single complex care team, with an accompanying pooled budget, to cover the whole age population.

Integration programmes to deliver the vision

We have agreed three key deliverables in Bury that deliver the vision and shared outcomes of integrated health and social care. These deliverables are the main themes and infrastructure of our joint work programme as follows:

1. Ageing well
2. Enhanced access to primary care and integrated community care
3. Reablement and Intermediate Care

The Better Care Fund Schemes are listed below and explained in more detail in Part 1 Annex 1. The relationship of each of the BCF schemes to Bury's key integration themes identified above are shown below:

Ref	BCF Schemes	Bury integration theme
Bury BCF 01	Staying Well	Ageing well
Bury BCF 02	Extended Access to Primary Care	Enhanced access to primary care and integrated community care
Bury BCF 03	Integrated Health and Social Care Team	
Bury BCF 04	Care of vulnerable adults	
Bury BCF 05	Review Programme - Integrated Intermediate Care, Reablement and other related services	Reablement and Intermediate Care

As previously outlined, our vision for the future has a focus on prevention and public health, which is addressed by our Ageing Well workstream shown in the above table. Clearly it will take some time to realise the benefits of the Ageing Well approach however as this underpins our work on integration we have provided brief details on aspects of this workstream in the section below

Ageing Well

Better Together

To ensure systematic implementation of primary and secondary prevention and chronic disease management in primary care. Through benchmarking, targeted incentive schemes and engagement with primary care colleagues, we will identify the 'missing thousands' from disease registers and ensure all patients receive best care. Initial focus in 2014 -15 will be on cardio-vascular diseases and respiratory conditions as the biggest contributors to premature mortality.

Integrated Wellness Services

To commission a holistic lifestyle service that addresses the health improvement needs of the people who live, work and study in Bury. To provide support to help people live a healthier lifestyle and be better able to manage their own health and care. We will appropriately scale and better integrate these services with primary care to ensure contribution to population level health outcomes.

Staying Well

To establish a new service, systematically targeting older people who have a high potential for developing a social care and higher level health need in the future. The service will take an assets based and empowerment approach to helping people maintain their health, wellbeing and independence and encouraging people to think about and plan for their futures. This will include consideration of available social support and networks, social participation, housing and financial issues as well as health and daily living considerations.

Self Care Programme

To expand the 'Helping yourself to Health' programme which builds confidence, motivation and health literacy to enable people to self care. To date there are over 50 trained and active 'tutors' delivering the programme within Bury with profound and life-changing outcomes for many participants e.g. recovery from dependence on alcohol, gaining employment following period of worklessness, reduced social isolation. The programme is targeted towards those who experience the greatest health inequalities. So far 600 people have completed the programme.

Research evidence (www.dh.gov.uk/selfcare and www.kingsfund.org.uk) shows that supporting self care leads to improved health and quality of life, a rise in patient satisfaction and a significant impact on the use of services, including;

- Visits to the GP can reduce by up to 69%
- Outpatient visits can reduce by up to 76%
- A&E attendances can reduce by up to 54%
- Hospital admissions and number of days in hospital may be halved
- Medicines utilisation and compliance is improved
- Days off work can reduce by up to 50%

Active Ageing

Building on Bury's Sport England funded 'I Will if you Will' campaign; develop a comprehensive programme aimed at supporting older people to make regular physical activity as part of their everyday life. Latest data in the Public Health Outcomes Framework shows that only 52.3% of Bury's adult population are active enough to benefit their health and 27.9% are defined as inactive. The 'I Will if You Will' programme is designed to increase participation in sport and physical activity by women and girls with the aim of engaging 10,000 more women & girls in activity over the next 12 months.

Bone Health & Falls Prevention

To review and re-design the whole falls pathway from prevention, to early identification and treatment of osteoporosis through to management, treatment and rehabilitation of fall related injuries.

Affordable Warmth

In Bury there were 20.6% more winter deaths than expected in 2010/11. This figure is higher than for England and Wales and Greater Manchester. Based on the evidence, some of these will be as a result of cold homes. In 2011, around 16.4% of Bury households (12,882) were classified as fuel poor.

A number of schemes have been undertaken to support residents to achieve a warm home such as insulation measures for 1400 residents, efficient heating measures installed for 60 residents and fuel switching campaigns generating a total saving of £45,833 (an average of £126 a year per participant) off annual energy bills. In addition there have been two winter warmth schemes funded by the Warm Homes Healthy People Fund. These schemes paid for 285 home visits for the installation of winter warmth measures and provided over 1000 winter warmth packs for residents who were over the age of 75 or families with children under the age of 5.

The beneficiaries of these schemes have to date been identified in an ad hoc manner. We will undertake analysis and develop a fuel poverty assessment tool to enable systematic identification of households in or at risk of fuel poverty and target support to help people keep warm and well through winter.

Seasonal Flu Jab Uptake

To drive a step change in the uptake of the seasonal flu vaccine by front line staff and high risk clinical groups:

- Healthcare workers from 67.2% to 75%
- Carers from 39.7% to 55%
- Over 65's from 72.8% to 75%
- Under 65's high risk clinical groups from 52.6% to 75%

Dementia Awareness

- To encourage and enable the early identification of dementia and early presentation
- To increase awareness of the lifestyle risks associated with some forms of dementia
- To raise public awareness of dementia

Disabled Facilities Grant (DFG's)

Disabled facilities grants (DFGs) are used as part of the preventative suite of services to support people with complex needs. In many cases they have provided effective support to enable people, particularly with mobility issues, to remain in their own home and maintain good health and well-being.

A grant can be used for essential adaptions to give people better freedom of movement into and around their home and/or to provide essential facilities within it. Good quality housing makes a significant and positive contribution towards improving the overall health and well-being of residents and ensuring this is in place contributes significantly

towards the prevention agenda. In Bury, the DFG process for individual applications is overseen by the Communities & Wellbeing Department, aligning it with social care health needs assessments and ensuring that a holistic approach is adopted.

We have already done significant work to improve our processes and pathways to DFGs, including flexible options for people to use DFGs in a similar way to personal budgets, which were initially developed through Bury's participation in Right to Control. Oversight of DFG allocations is undertaken by senior managers within Adult Care Services who have a much wider remit around social care, to ensure that they are used effectively and seen as part of a person's care package.

We see DFGs as continuing to be a pivotal tool to maintaining people's health and wellbeing and in acting as a preventative method of supporting people with long term conditions to remain at home and as independent as possible. Further work is planned to ensuring that any new developments in the borough meet the 'Lifetime home' standards. Work is ongoing to measure the impact of DFGs in terms of financial efficiencies for social care.

b) What difference will this make to patient and service user outcomes?

Person Centred Coordinated Care

We will only make a difference to outcomes for people of we delivery person centred care. Person centre coordinated care will therefore be central to all of our developments and we are determined to involve people in the design of our services – consulting with them at every stage. We also want to support and empower people to take more control over their health and wellbeing. The definition of integration in Bury is:

"I can plan my care with people who work together to understand me and my carers, allow me control and bring together services to achieve the outcomes important to me"

We have used the National Voices "I" statements (reference 1c) in a proactive way to inform our integrated care developments in Bury and what matters most to people has been summarised under the following headings:

- Goals and outcomes
- Information
- Communication
- Decision making
- Transitions
- Care planning

Some specific examples of how this has influenced our approach are demonstrated in our community service specifications as part of the community service procurement process and in our pilot of locality multi disciplinary team working in Healthier Radcliffe.

The difference to outcomes for Bury citizens from the delivery of integrated care

In order to ensure that our plans drive us towards improved outcomes for our local population in terms of health, wellbeing and independence, we have developed an agreed set of population outcome measures by which to assess the overall impact of changes.

Healthy

Healthy life expectancy at birth	PHOF (0.1i)
Life Expectancy at Birth	PHOF (0.1ii)
Slope Index of Inequality in Life Expectancy at birth	PHOF (0.2iii)
Potential Years of Life Lost from causes considered amenable to healthcare	NHSOF (1a)
Happy Self-reported wellbeing	
people with a low satisfaction score	PHOF (2.23i)
people with a low worthwhile score	PHOF (2.23ii)
people with a low happiness score	PHOF (2.23iii)
people with a high anxiety score	PHOF (2.23iv)
Independent Disability-free life expectancy at 65	ONS
Social care related quality of life	ASCOF (1A)
Permanent admissions to residential and nursing care homes (65+)	ASCOF (2A)

To support this we are building a dashboard of performance indicators for each element of our plan. Initial work has prioritised reporting against the Better Care Fund Metrics, The Greater Manchester Public Service Reform metrics and 'A Healthier Radcliffe, NHS Demonstrator project metrics.

Delivery against the Better Care Fund Metrics

The table below identifies the six metrics which BCF schemes will be evaluated against and outlines Bury's planned delivery against these outcomes.

Table 1

	Level today	Target range 1 – 5 yrs	% change 1 – 5 years	Rationale for change
Non-elective Admissions	19713		20%	
Patient Experience			No baseline established	
Admissions to Residential homes	720.7	Yr 1: 666.3 Yr 2: 630.7	Yr 1: -3.1% Yr 2: -3.2%	1 year target – to achieve the current England average, based on the 13/14 figures from the ASCOF. 2 year target – to achieve the same % reduction as year 1.
91 days post discharge	81.4%	Yr 1: 82.4% Yr 2: 83.6%	Yr 1: 1% Yr 2: 1.3%	1 year target – to achieve the current average for the North West, based on the 13/14 figures from the ASCOF. 2 year target – to achieve the same % reduction as year 1.
Delayed Transfers of Care	639.4	Yr 1: 2402.0 Yr 2: 1472.7	Yr 1: -5% Yr 2: -5%	1 year target - to reduce the average number of delays days each quarter over the past 3 years by 5% 2 year target - to reduce the average number of delays days each quarter over the past 4 years by 5%
Local Metric falls	2056	Yr 1: 1871 Yr 2: 1703	Yr 1: -9% Yr 2: -9%	

It is appropriate to make reference to three of the above metrics due to specific work that has been undertaken in these areas, as described below:

- Patient Experience
- Falls
- Delayed Transfers of Care

Patient/service user experience

Outcome sought

- To take steps to begin to understand patient experience in relation to the delivery of integrated care.
- To develop a system which measures patient experience of integration over time,

allowing any improvements to be demonstrated.

Use of an existing national metric

The Better Care Fund – technical guidance v2, states that 'Analysis of potential existing measures has identified a number of shortcomings in these measures, particularly in their ability to reflect experience across entire journeys of care and sectors.' Since there is no existing national metric that adequately captures the experience of integrated care new metrics needed to be developed.

Newly Developed Local Metrics

The Department of Health commissioned the Picker Institute and the University of Oxford to develop new questions to measure people's experiences of integrated care. The aim of the project was to provide recommendations for a limited set of new questions to be included in up to seven existing national surveys:

- GP Patient Survey
- NHS Inpatients Survey
- VOICES national bereavement survey
- Community Mental Health survey
- National Cancer survey
- Personal social services carers survey
- Personal social services adult social care survey.

Eighteen new questions were developed and ideally the addition of a few of these questions in national surveys will help providers and commissioners to identify, explore and challenge poorly integrated care locally.

Consultation on Newly Developed Local Metrics

The thirteen most relevant questions from the eighteen developed by the Picker Institute and the University of Oxford were filtered out and presented to the Patient Cabinet and The Health & Wellbeing Board.

The Cabinet and the Board were both asked to rank the questions in order of importance and relevance to the outcomes desired by the Better Care Fund. After the consultation the top five questions in order of preference were:

1. Were you involved as much as you wanted to be in decisions about your care and support/treatment?
2. Do all the different people treating and caring for you work well together to give you the best possible care and support?
3. When health and care staff plan care or treatment for you, does it happen?
4. Do you have a named health and social care professional who co-ordinates your care and support.
5. Do you feel the person you contact understands about you and your condition?

Selection of the Patient User Experience Metric

The question ranked the highest by the Patient Cabinet and The Health & Wellbeing Board was selected as an appropriate measure because there is an equivalent existing question on the CQC Inpatients survey, GP Patient survey, Cancer Patient Experience survey and VOICE.

There was no equivalent on the Personal Social Services carers survey or the Personal social services adult social care survey, however the council is able to add additional questions to these surveys. The question is therefore as follows:

Were you involved as much as you wanted to be in decisions about your care and support/treatment?

Implementation of inclusion of additional questions

The additional question will be added to the Personal Social Services Carers' Survey which is to be conducted in October and the personal social services adult social care survey which will be conducted in February.

The GP Patient survey will be used to provide baseline data for the surveys and monitor the impact of the better care fund on patient experience. The CQC Inpatients survey, The Cancer Patient Experience survey and VOICE will not be used because the better care fund schemes will not have a direct effect on these patient cohorts.

Baselines and Milestones

Baseline data will be provided from the GP Patient survey. No baseline data is available for these questions from the data collated for the Personal Social Services Carers Survey and the Personal social services adult social care survey. Improvement will be measures bi-annually for carers and annually for adult social care users as the surveys are conducted.

The baseline was calculated from two questions in the GP survey:

- Q21d. Last time you saw or spoke to a GP from your GP surgery, how good was that GP at each of the following? Involving you in decisions about you care.
- Q23d. Last time you saw or spoke to a nurse from your GP surgery, how good was that nurse at each of the following? Involving you in decisions about you care.

The answers to the questions are:

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Doesn't apply

Combining the questions together provides a baseline line for those patients that thought their GP and/or nurse was very good at involving them in decisions about their care of 49% (not including those patients who answer that it doesn't apply).

The target for 2015/16 is to increase this by 5% to 54%, the target for 2016/17 is to increase this by a further 5% to 59%.

The baseline and targets have been added to Part 2 – BCF Plan, Tab 6 HWB Supporting Metrics, however the numerators and denominators have not been completed. The baseline was calculated from the data available from the GP Survey, 2014-15 will include the results from the Personal Social Services carers survey and the Personal Social

Services Adult Social Care Survey and 2015-16 will include the results from the Personal social services adult social care survey. The numerators and denominators will therefore fluctuate over the next two years and only the increase in the percentage of responders who thought that their GP/nurse/social worker was very good at involving them in decisions about their care will be relevant.

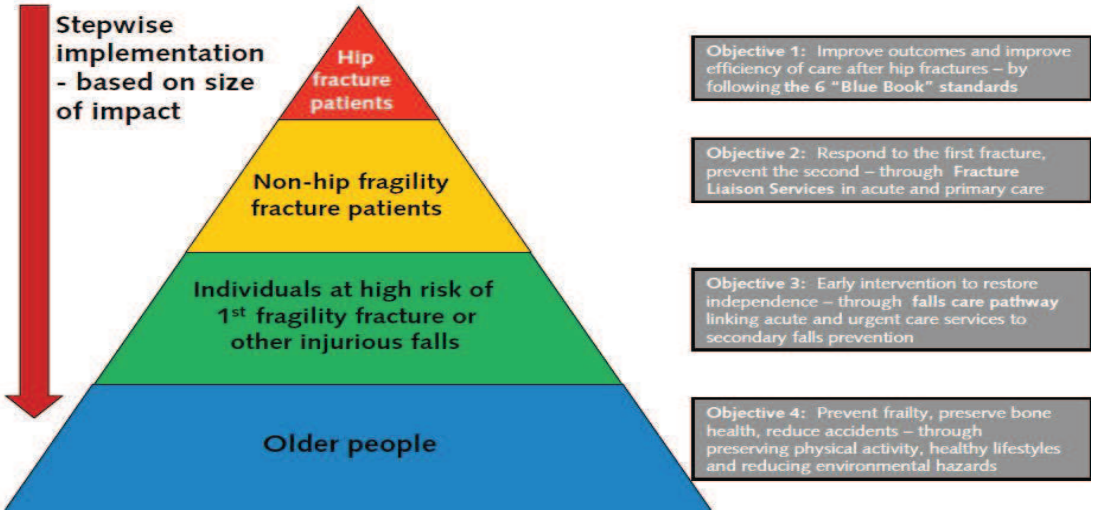
Falls

As can be seen from the above table our local chosen metric relates to a reduction in emergency admissions to hospital due to falls. We have therefore defined a workstream to drive this and the associated milestone plan can be found in the attached milestone plan document.

We will take a whole system approach to reducing the incidence of falls, reducing the severity of injuries caused by falls and ensuring effective treatment and rehabilitation for those who have fallen.

The Department of Health (DH) guidance document **Falls and Fractures: Effective interventions in health and social care**[1], suggests that efforts to reduce falls and fractures, based on the available evidence, take a systematic approach and focus on four key objectives:

Figure 1 A systematic approach to falls and fracture prevention - four key objectives



We will focus a comprehensive programme of work around these four objectives as follows:

1. **To improve patient outcomes and efficiency of care after hip fractures – through compliance with core standards**

   Working with Pennine Acute Hospital Trust, we will utilise the results of the Royal College of Physician's Falls and Fragility Fractures Audit to drive forward recognised standards of care (e.g. NICECG123, QS16) and cost effectiveness of treatment, along with achievement of the Best Practice Tariff for hip fracture

[1] DH, 2009, Falls and fractures – effective interventions in health and social care, London, DH

management.

2. **To respond to a first fracture and prevent the second – through fracture liaison services in acute and primary care settings**

   Fragility fractures are often the consequence of falls in older people that have decreased bone strength mainly due to osteoporosis. Unfortunately, these 'herald factures' are often the first sign of undiagnosed and untreated osteoporosis but many are missed for fracture risk assessment and treatment for secondary prevention (Royal College of Physicians, National Audit of the Organisation of Service for Falls and Bone Health of Oldler People 2010). We will therefore aim to address osteoporosis as a long term condition systematically maximising opportunities for identification, risk assessment, intervention and management right across the system. A Fracture Liaison Service (FLS) in an acute settings offers a systematic approach to secondary fracture prevention. It offers the potential to assess around 613 older people with fragility fratctures each year and offer osteoporosis treatment in around 75% of cases. The evidence base suggests this type of service has the potential to intervene in 50% of future hip fractures[2]. We will work with Pennine Acute Hospital Trust and its Orthogeriatrician to maximise this potential locally.

   Evidence suggests that an FLS in primary care can increase compliance with national guidelines on the secondary prevention of osteoporotic fractures (NICE TA161) from 9% to 64%[3]. In primary care, we will explore options to systematically case find patients with undiagnosed osteoporosis or unassessed fragility fracture utilizing primary care records and the FRAX™ or QFRACTURE™ fracture risk assessment tool. This will also support General Practice in delivery against relevant osteoporosis QOF indicators. In particular, we consider the potential to introduce this element into a revised community falls service.

3. **To intervene early to restore independence – through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries**

   There is a sound evidence base for a falls care pathway jointly commissioned by health and social care and delivered on a multi-agency basis. We will review the whole falls care pathway and its inter-dependencies to maximise its effectiveness and efficiency and ensure it is fit for purpose in relation to current and future needs. This will include ensuring supported discharge, reviewing care in intermediate care, and reablement within the community with input from a range of therapy services.

   The most effective component of multi-factorial interventions is therapeutic exercise, particularly those aimed at improving postural stability. It is estimated that this intervention alone can help prevent 44% of falls[4]. A meta-analysis showed that the use of the OTAGO exercise programme (OEP) for falls prevention which focuses on strength and balance retraining significantly reduces the risk of

[2] DH, 2009, Prevention Package for Older People Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh_103146

[3] DH, 2009, Impact Assessment of fracture prevention interventions, London, DH.

[4] DH, 2009, Impact Assessment of fracture prevention interventions, London, DH.

death and incidence of falling in older (65+) community dwelling adults by 45% and 68% respectively[5]. We will therefore develop a sustainable, evidence-based programme of therapeutic exercise focusing on improving strength and balance, including OTAGO, that harnesses the existing assets within our communities and the skill mix within existing therapy resources.

4. **4.To prevent frailty, promote bone health and reduce accidents – through encouraging physical activity and healthy lifestyles and reducing unnecessary environmental hazards**

   Delivery of this objective will be supported by the implementation of a range of public health strategies and work programmes. In particular, an Active Ageing programme has already commenced under our Sport England funded I Will If You Will (IWIYW) Programme, which seeks to increase participation in physical activity, particularly by women. All physical activity opportunities are currently being mapped and details will be available on Bury Council's new Bury Directory system which will house details of a range of community assets. We are also reviewing are GP Exercise Referral Scheme (BEATS) and we will include new referral criteria around falls and osteoporosis within the scheme redesign.

   We will maximise all opportunities across the system to ensure implementation of NICE Guidance CG161 on Falls, such that older people in contact with healthcare professionals are routinely asked whether they have fallen in the past year and the circumstances and where indicate offered a multifactorial assessment and appropriate intervention.

   The rate of falls in care homes is almost three times that of older people living in the community and 30% of hip fracture hospital admissions are from a care home. Bury's Community Falls Service is commissioned to support care homes in preventing falls and related injuries. We will ensure the service targets care homes with the highest incidence of falls and promotes the Good Practice Self Asessment Resource 'Managing Falls and Fractures in Care Homes for Older People' (Social Care and Social Work Improvement Scotland 2011 and NHS Scotland 2011)

Delayed Transfers of Care

A review of the metrics relating to delayed transfers of care identified that the numbers of patients delayed had increased and a further investigation was launched into the reported figures. This further highlighted the sudden increase in reported delayed transfers of care but indicated that a similar pattern was being seen elsewhere. As is often the case the information produced to support the deep dive, when reviewed, opened up further questions. A task and finish group was therefore set up to progress this further with representation from Bury CCG, Pennine Acute Trust, Bury Local Authority, Pennine Care, Bury Discharge Champion and the CCG Urgent Care Clinical Lead.

The group reviewed the data to discuss trends, identify possible reporting system issues, and develop ideas to address the situation. It was clear from this that there were system

[5] Thomas S et al, 2010, Does the 'Otago exercise programme' reduce mortality and falls in older adults?: a systematic review and meta-analysis in Age Ageing, 2010, Nov, 39 (6): 681-7

reporting issues that have now since been modified. The impact of these changes can be seen via a reduction in reportable numbers for November as shown in the table below. Further work is being undertaken on the figures so the impact can be assessed.

A further review is underway to consider specific case examples and develop practical timely responses to address delayed transfers

Reduction in reportable DTOC

Total of delayed discharge days by responsible organisation for Bury	2013/2014												2014/2015							
Responsible Organisation	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
NHS	55	59	77	48	77	131	55	95	153	147	150	241	207	250	252	373	305	340	336	124
Social Care	60	67	56	3	5	25	17	34	45	42	42	49	96	43	72	100	31	36	48	12
Both	12	0	0	0	0	0	0	3	0	0	0	0	0	0	9	0	0	0	0	0
Total	**127**	**126**	**133**	**51**	**82**	**156**	**72**	**132**	**198**	**189**	**192**	**290**	**303**	**293**	**333**	**473**	**336**	**376**	**384**	**136**

Patient snapshot by responsible organisation for Bury	2013/2014												2014/2015							
Responsible Organisation	Apr	May	Jun	Jul	Aug	Se	Oct	Nov	De	Jan	Feb	Ma	A	M	Ju	J	A	S	O	Nov
NHS	3	0	5	3	5	5	3	3	6	5	8	10	9	11	16	11	11	23	12	7
Social Care	3	1	2	0	1	0	1	4	0	3	2	8	5	0	8	4	1	2	6	0
Both	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**6**	**1**	**7**	**3**	**6**	**5**	**4**	**7**	**6**	**8**	**10**	**18**	**14**	**11**	**24**	**15**	**12**	**25**	**18**	**7**

Metrics Mapping – Impact of Schemes

An exercise was undertaken to calculate the benefits on a scheme by scheme basis and to apportion the benefits to the different BCF schemes. This is detailed in the Appendix 1.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

The vision to redirected care delivery over the coming five years in Bury is outlined in Figure 1.

Figure 1

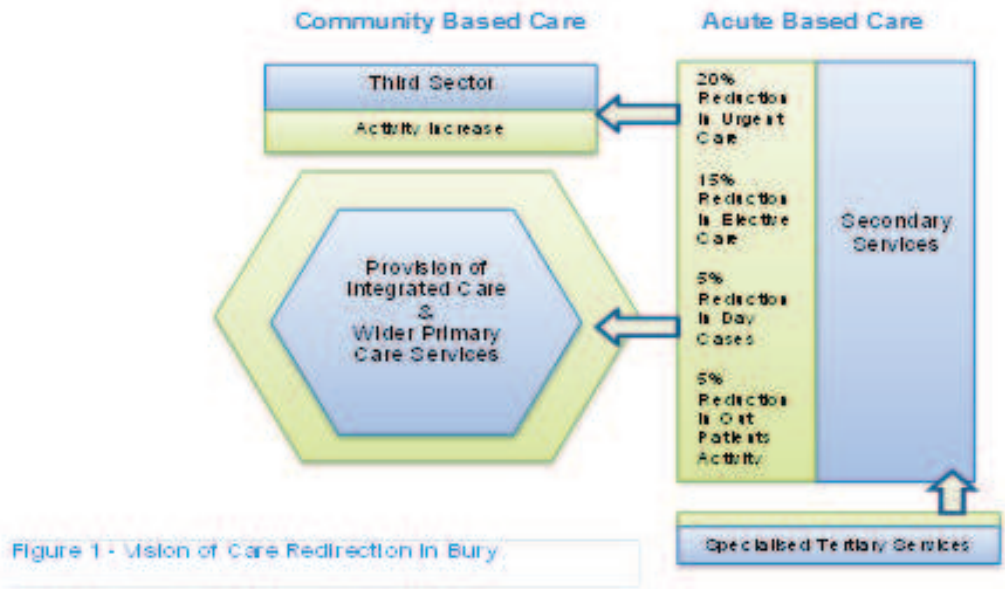


Figure 1 - Vision of Care Redirection in Bury

How will the vision change and what will the health economy look like in 5 years time?

In line with the strategic vision and the priorities arising from the needs assessment, the Bury health and social care economy in 5 years time will have the following characteristics:

- Improved outcomes and performance
- Improved safety and quality
- Greater integration of care across pathways which break down traditional barriers in primary, community, secondary and social care
- Clinical leadership at all levels
- Financial stability for all organisations
- Individuals supported to take responsibility for their own health care
- Meaningful engagement of patients and communities in decision making and active use of patient experience to improve care
- Greater innovation and use of technology to drive improved outcomes and transformation
- Earlier intervention through better identification of patients at risk and targeted support
- Innovative forms of contracting which incentivise integration and joint delivery of better outcomes and quality

Given the context we are operating within Bury, not only do we believe that it makes sense to provide care as close to our patients as possible, it is also what they have told us they would like, although safety and the availability of the right clinical expertise may

inevitably require trade-offs.

Our communities

In 5 years time we will have seen a measurable improvement in health outcomes, particularly in relation to cancer, cardiovascular disease and long term condition management, together with a reduction in health inequalities across our communities. We will have a higher level of engaged patients and engaged communities, with more patients taking responsibility for their own health and wellbeing. In particular, there will be better education for patients to help them co-produce their care plan and manage their long term conditions; there will also be greater support through decision aid tools to allow patients to take informed decisions on secondary care procedures, such as orthopaedic operations. Patients will have access to their care records and summary information will be available to all clinicians to provide better care. There will be integrated work with the local authority public health team, to help improve lifestyles and stay healthier for longer, actively mobilising our many community assets.

Primary Care

Primary care will continue to be the gatekeeper for patients' care over 7 days. There will be a higher level of quality and consistency of delivery. There will also be an expansion of capacity across Bury and changes in workforce skill mix and deployment, to attract, retain and up skill primary care, and to support the integration and sustainability of pathway models (particularly around emergency flow). There will be greater management of long term conditions and frail older people to improve quality of life, keep people healthier for longer and reduce unnecessary admissions. More straightforward elective procedures will be undertaken in primary settings closer to patients, freeing up acute capacity for more specialist work. Practices will collaborate more effectively together in a more federated way, with ICT (Vision 360) leading to greater integration and efficiency.

Community and Mental Health

The CCG commissions Mental Health and Community services from Pennine Care Foundation Trust (PCFT) and values mental health equally with physical health (parity of esteem). Bury CCGs Strategic Plan 2014-2019 and Delivery Plan 2014-2016 states that more investment will be needed in these services to deliver integrated care in the community. Executive meetings take place with Pennine Care Foundation Trust, around the longer term strategy and impact of integration on a monthly basis and PCFT are members of the North East Sector Integrated Care Board and local Bury Provider Partnership. PCFT have agreed to redesign their services to support the Integrated Care Model and already work in partnership with Pennine Acute Hospitals Trust to deliver more integrated models of care in Sexual health and Diabetes pathways (which includes traditional secondary care services being delivered in the community).

Community and mental health services will expand and work in a more integrated way to support long term condition management and ensure parity of esteem. There will also be an improved interface with acute trusts to ensure appropriate admission and discharge supported by integrated health and social care teams. We will have a focus on excellent elderly care including Dementia services, which will be integrated with social care. Care planning, through multidisciplinary teams will become the norm for older people and people with Long Term Conditions. There will be an increased move to more community mental health services, rather than inpatient care to promote and sustain mental wellbeing and a focus on early intervention for drug and alcohol dependency.

Secondary care

Over the next 5 years we will see a continued move to higher quality acute units, with outcomes, particularly mortality rates, in line with national averages. Reconfiguration work in Greater Manchester will have led to the provision of safe, sustainable obstetrics, paediatrics and A&E services. It is proposed services will be shared across a number of defined hospital sites, with clinicians working across those sites to provide seamless care, with the teams delivering the "once-in-a-lifetime" specialist care on a designated site. These "single services" are shared across the geographical footprint, and the clinical teams benefit from being part of a wider, sustainable and better supervised team, raising standards in the "routine" work within the District General Hospital, as well as meeting the clinical standards at the specialist site, a "win-win" for patients. This should also significantly improve efficiency at all the sites (as routine activity would no longer be interrupted by emergencies), and it is expected that that the Trusts would share the financial risk to avoid the perception of "winners and losers". The proposals to change hospital services will be subject to statutory public consultation, and must pass the requirements of the NHS Assurance process. The general focus on acute delivery will be on services which cannot be provided at a local level within primary/community settings, with more effective networking with other out of county hospitals and tertiary centres to improve skills and improve the patient flow to and from specialist services in areas where clinical skills cannot be sustained within the County. There will be improved integration with primary care to ensure clinical sustainability, especially around the emergency floor model and for consultant support for better long term condition management and care for frail older people in community settings. Non elective admission rates per 1,000 population will be reduced, through the delivery of integrated and long term condition pathways. We will also have reduced the relatively high rates of paediatric emergency admissions through the implementation of the new community paediatric model. We will continue to make reductions in elective procedures of limited clinical value and greater support for patient decision making (e.g. on orthopaedics).

Social Care

The role of social care in delivering health outcomes is recognised and embraced, supported by appropriate integration and collaborative commissioning of services, both for children and older people. This approach will clearly focus on priority areas associated with the ageing population (such as dementia and frail older people) and children and young people in line with locally agreed priorities. . There will be a greater focus on more integrated community health and social care support and the wider integration of the community in neighbourhood models (e.g. short term intervention services, reablement and general domiciliary care) to facilitate discharge from hospital and we will have significantly reduced delayed transfers of care, building on already existing good practice as demonstrated by AQuA data. We will be jointly commissioning more services together (eg nursing and residential homes), to ensure better value for money. Proactive market management techniques and engagement with providers will ensure sustainability of services for the future. Innovative use of assistive technology will support people to better self care and prevent escalation of need, including more joint deployment of technology (e.g. for telehealth/telecare) These initiatives will be developed within a culture of outcomes based accountability across health, social care and the wider community.

How will the Better Care Fund plan deliver this vision

The BCF will contribute to this vision by delivering against six key metrics which evidence good integrated care systems. **Table 2** below outlines where the Better Care Fund

schemes and the protection of social care contribute to these outcomes.

Table 2

Schemes BCFMetrics	BCF01 Staying Well	BCF02 Enhanced Access to Primary Care	BCF03 Integrated Health & Social Care Team	BCF04 Care of Vulnerable Adults	BCF05 Reablement and Intermediate Care	Protecting Social Care
NELadmissions	x	x	x	x	x	x
Patient Experience	x	x	x	x	x	x
Admissions to Residential homes	x			x	x	x
91 days post discharge					x	x
Delayed Transfers of Care		x	x	x	x	x
Local Metric falls	x	x	x	x	x	x

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

In the Case for Change section we demonstrate:

- The population projections for Bury
- Financial Context for health & Social Care in Bury
- Life Expectancy in Bury
- Our populations lifestyle
- Where we have efficiency opportunities
- Why Bury has decided Integrated Services will deliver improvement and the evidence base for this;
- Our populations utilisation of acute services
- How the BCF schemes have been selected to deliver improvement

Population Projections for Bury

In the 2011 Census, the population of Bury was estimated to be 185,100. This is expected to rise to 199,300 by 2021. It is expected there will be 6,700 (23%) more people aged over 65 by 2021. This means our total 65 and over population will be around 36,200 which will be 18.2% of the 2021 population.

It is also anticipated that the proportion of aged 85 and over will increase by 36% to about 4,900. By 2030 the number of people aged 85 and over is expected to rise by 3700, a staggering 97% increase as indicated within the Bury JSNA.

The ageing population will mean an increasing burden of poor health in later years and a significant increase in demand for health and social care. For example, as the population ages, the level of late onset dementia is expected to rise by about 5% over the next 10 years, which will result in a higher dependency on hospitals, carers and specialist care services. Services will need to be shaped according to these changes. We need to support people to remain safe and independent for as long as possible.

Financial Context for Health and Social Care in Bury

Bury CCG, and its predecessor, Bury PCT, have experienced significant financial challenges over the last 5 years and were in formal financial turnaround until 2012/13. Bury CCG's revenue allocations in 2014/15 are £17m behind the calculated target for the size and need of its resident population and whilst it is on a gradual trajectory to target in accordance with the NHS England pace of change allocations policy, it is expected to be significantly behind target for the foreseeable future.

For the CCG, investment in the Better Care Fund will require corresponding reductions in expenditure elsewhere e.g. non elective admissions.

The local authority is equally challenged, with council wide savings of £16m required for the financial year 2015/16, of which adult social care's share is £4.6m, some 9% of net budget. This scale of saving may well be similar in coming years, although future

financial settlements are currently unknown.

The implication of such constrained funding regimes in both social care and health is the lack of resources available to pump prime new, innovative schemes to provide local evidence towards improved outcomes. This is a significant risk for the Bury locality, both in terms of achieving NEL targets identified in the CCG plans and BCF documents, but also in terms of capacity within both organisations to review, reshape or decommission existing services.

Life Expectancy in Bury

NHS Bury CCG is in the worst quartile for potential years of life lost to causes amenable to healthcare for both men and women. Life expectancy in the borough is below the England average and this gap is widening.

For males life expectancy is around 77.5 years, just over 1 year less than the England average at 78.6 years. For women life expectancy in Bury is 81.2 years, which is 1.4 years less than the England average of 82.6 years.

Across the borough there are big differences in life expectancy. For men there is a gap of 10.8 years and 12 years for women, between the most and least deprived areas across the borough.

Bury has just under 1,800 deaths a year, with the main causes being cancer and circulatory disease, with respiratory disease also a main contributor. Early death rates from heart disease and stroke have fallen but are still worse than the England average. Deaths from liver disease are increasing.

Table 3 shows that for females, mental and behavioural disorders cause the greatest number of excess deaths (111), followed by respiratory diseases (106) then circulatory diseases (63). For males circulatory diseases cause the greatest number of excess deaths (83) followed by cancer (45), then respiratory diseases (37). Lifestyle factors such as smoking, levels of physical activity, and healthy eating, greatly affect the risk of developing all of these conditions.

Table 3

Disease Area	Excess Deaths		
	Male	Female	Combined
Mental Health	(18)	**111**	129
Respiratory Diseases	**37**	**106**	143
Circulatory Diseases	**83**	**63**	146
Cancer	**45**	(34)	79
Total	**183**	**314**	**497**

Numbers in () indicate no concerns for that gender

The sections below highlight the impact of an aging population on services.

Falls

With old age and frailty comes an increased risk of trips, falls and fractures. A study estimated that just over 12,000 people in Bury aged 60 and over fall every year: the economic and social care cost of this is in the region of £10.5 million per annum.[6]

This burden will continue to soar in line with the ageing population in the absence of effective intervention. Moreover, the effects for the individual of a fall are potentially devastating. Approximately 15% of those experiencing hip fracture in Bury (a common fall related injury) die within a month of suffering the injury, rising to 24% after four months. The corresponding national figures are lower at 10% and 20% respectively[7]. This is also borne out by the admissions rate for fractured proximal femur which reached a six year high in 2010 at 121.71 per 100,000 population, and is well in excess of all the comparator areas.

Around half of all people aged over 65 suffer from some form of arthritis. Osteoarthritis is the most common form, and can progress from stiffness of the joints through to severe pain and disability. Knees and hips are particularly at risk, as they are primary weight bearing joints within the body, and onset can have a detrimental impact upon quality of life.

Dementia

According to estimates in the Bury Mental Health Strategy, there will be in excess of 3500 adults over 65 suffering from depression or severe depression, equating to more than 10% of the population fraction. It is suggested that this figure will be far higher for those with disabilities, physical illness or living in care settings (40%).[8]

Dementia is also a key mental health concern, with current estimates suggesting that there are 800,000 people in the UK living with dementia at an economic cost of £23 billion. Projections indicate that these numbers could double by 2040. [9] In Bury, approximately 7% of the population aged over 65 has dementia. Currently an estimated 2253 people have dementia, of whom 1415 or 62.3% have been diagnosed. The numbers are increasing year on year and it is expected that an additional 5% will have dementia in 10 years' time.

Adult Care Services currently funds 568 individuals in residential and nursing care, whilst there will be self-funders above this number, 810 may thus be an over-estimate.

Diagnosis is key to helping individuals and families cope with its symptoms, but the rate is notoriously low (around 45% nationally). According to QOF statistics there are 1147 registered patients with dementia, which, encouragingly, is above this estimate (53.6%). Further national dementia estimates have been produced by the Alzheimer's Society, applying a varying rate by age bracket.

[6] Bury Falls Prevention and Bone Health Strategy (2011-15)
[7] A further 13.8% indicated that they offered care for between 20-49 hours per week.
[8] http://www.mentalhealth.org.uk/help-information/mental-health-a-z/O/older-people/
[9] https://www.gov.uk/government/policies/improving-care-for-people-with-dementia

Table 4 translates these proportions to the Bury population by age.

Table 4

Age	Prevalence
30-34yrs	0.01%
35-39yrs	0.01%
40-44yrs	0.01%
45-49yrs	0.03%
50-54yrs	0.06%
55-59yrs	0.14%
60-64yrs	0.16%
65-69yrs	1.30%
70-74yrs	2.90%
75-79yrs	5.90%
80-84yrs	12.20%
85-89yrs	20.30%
90-94yrs	28.60%
95yrs+	32.50%

Each year an increasing number of dementia sufferers are ending up in a crisis, which results in hospital admission. In 2011 Bury's rate of non-elective admissions for those with a dementia diagnosis was the joint highest across Greater Manchester (5.3% of admissions (1089), compared to an average of 4.2%). This statistic is notable because in hospital the average length of stay for those with a dementia diagnosis (10.2 days) is more than twice as long as other admissions (4.9 days). This increased stay can lead to deterioration in their overall condition and possible discharge to residential care. [10]

Vaccinations

Vaccinations are also crucial to reducing adverse health outcomes in the elderly who are more vulnerable to illnesses such as bronchitis and pneumonia. Flu vaccinations can limit infection and minimise the possibility of such complications occurring. Statistics for September – November 2012 show a 67.3% uptake, average against comparator areas.

Alcohol Misuse

There is also a growing recognition concerning alcohol misuse in the older generation. There is the concern that it is less likely to be diagnosed amongst the older generation as it can be masked by other health problems or remain hidden simply due to social isolation. Depression and dementia are fundamental mental health issues associated with excessive alcohol consumption.

[10] Greater Manchester Business Intelligence Service: GM Cluster Dementia Analysis Overview 2011 (2012)

Social Isolation

Older people are particularly vulnerable to social isolation as a consequence of the loss of family and friends over time. Research has shown that isolation can have a detrimental impact upon physical and mental health including high blood pressure and depression[11] The implications of this are highlighted by the fact that, in Bury, over half of all pensioner households have just one person resident in them.

Poverty

Poverty is the final aspect faced by older people which is linked to adverse health outcomes, and indeed social isolation. A further impact of the changing population profile is the ever increasing number of pensioners in Bury society, rendering income deprivation faced by older people, a growing challenge for the Local Authority and partner agencies. Whilst income levels have flat-lined in the current economic climate, the cost of food and fuel has continued to exceed inflation.

Excess Winter Deaths

The number of excess winter deaths is linked to the previous sections, with fuel poverty, social isolation and old age clear risk factors. The Office for National Statistics standard method defines the winter period as December to March, and compares the number of deaths that occurred in this winter period with the average number of deaths occurring in the preceding August to November and the following April to July. In Bury there were 20.6% more winter deaths than expected in 2010/11. This figure is higher than for England and Wales and Greater Manchester along with all tier 1 comparator areas except Sefton. It is, however, a lower figure than for each of the 3 preceding winters.

Housing

Housing is inextricably linked to health outcomes. Inadequate housing conditions such as overcrowding, lack of central heating and indeed fuel poverty can lead to ill health and ultimately premature mortality. The extreme of homelessness is also associated with poor mental health (including depression, self-harm and suicide), as well as the direct physical impacts of rough sleeping, inadequate diet and substance misuse.

Carers

In recent years there has been a growing recognition that issues faced by carers form an integral element of the wider social care agenda. This group is particularly vulnerable due to the demands which a caring role necessitates. Research has shown that the impact on health can be massive, particularly for older carers. 65% of those over 60 have long-term health conditions or disabilities with 68.8% citing that caring had a negative impact on their mental health.[12] They are also likely to be unaware of the support available or, in fact, that they are actually providing a caring role. Accessing support services may also be problematic due to the 24/7 nature of caring for an individual with physical or mental health needs. Under identification and unmet need are thus key components of the carer agenda.

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[11] N.Mead et al: 'Effects of befriending on depressive symptoms and distress: systematic review and meta-analysis' *British Journal of Psychiatry* (2010)196 pp 96–100

[12] Princes Royal Trust: Always On Call, Always Concerned (2011)

The 2011 Census indicates that there are 19,954 individuals providing unpaid care in the Borough, an increase of 723 since the last Census. This amounts to a sizeable 10.8% of the total population. In excess of 4,700 carers provide support for more than 50 hours a week (23.7%), and are therefore engaged far in excess of the demands of full time employment, which enhances the likelihood of social isolation and adverse health outcomes[13]. Indeed those providing 50 hours a week of care are far more likely to cite being in bad or very bad health (13.4%) than those caring for 1-19 (4.1%) or 20-49 hours (8.4%). The proportion in bad or very bad health is also slightly higher for male (14.6%) than female carers (12.5%). The proportion of carers varies between wards from 9.2% in Redvales to 12.1% in Radcliffe North. This relatively low level of variation aptly demonstrates that caring needs transcend geography and patterns of deprivation. Wide scale under identification is highlighted by the fact that, compared to the figures described above; only 3320 carers are registered with the Carers Services Team and the Carers Centre in Bury.

Ultimately service provision needs to recognise the fact that (i) the supportive needs or requirements of a carer will be radically different from the person cared for; and (ii) that there is no uniform 'carer' persona and each will have their own demands based on their ability and propensity to cope with the caring role. Effective service provision must therefore be appropriate to local circumstances and suitable to embrace the diverse plethora of needs which will arise.

Safeguarding

Ensuring there are appropriate multi-agency protection practices in place is essential to enable at risk adults and children to live free from violence, abuse, fear and exploitation. Since 2006 the number of safeguarding alerts received in Bury has risen annually to reach 754 in 2012/13. It should be noted that in only 15% of these cases were full safeguarding investigations carried out, the rest being predominantly incidents where abuse had not occurred (e.g. accidents), which could be dealt with via referral to implement appropriate prevention measures. The overall increase in numbers therefore should not necessarily be seen as indicative of higher levels of abuse, but rather of greater partner awareness to raise reports in the first instance. Three quarters of reports were created by social care (57%) and health care staff (18%), but the increase in the proportion of reports from members of the public (6%) and other sources (15%) in 2012/13 demonstrates increased awareness and social responsibility.

Acute Services Utilisation

Use of services by the over 65 population

The aging population and increase in Long Term Conditions is having an impact on the use of acute services. The majority of secondary care activity in Bury (77%) is undertaken by the Pennine Acute Hospitals NHS Trust, which is based across four sites at; Fairfield General Hospital, Oldham, North Manchester and Rochdale.

In Pennine Acute Hospital Trust (2013/14), there were 15,916 Non Elective spells of leading to 62,354 bed days, of which 4,880 were excess bed days. Figure 2 shows 5435 of these days were attributed to patients were aged 70 and over, this represented 34%.The average length of stay for those 70 + was 6.5 days, the under 10's 0.73 days

and for the remaining age bands was 2.55 days.

Figure 2

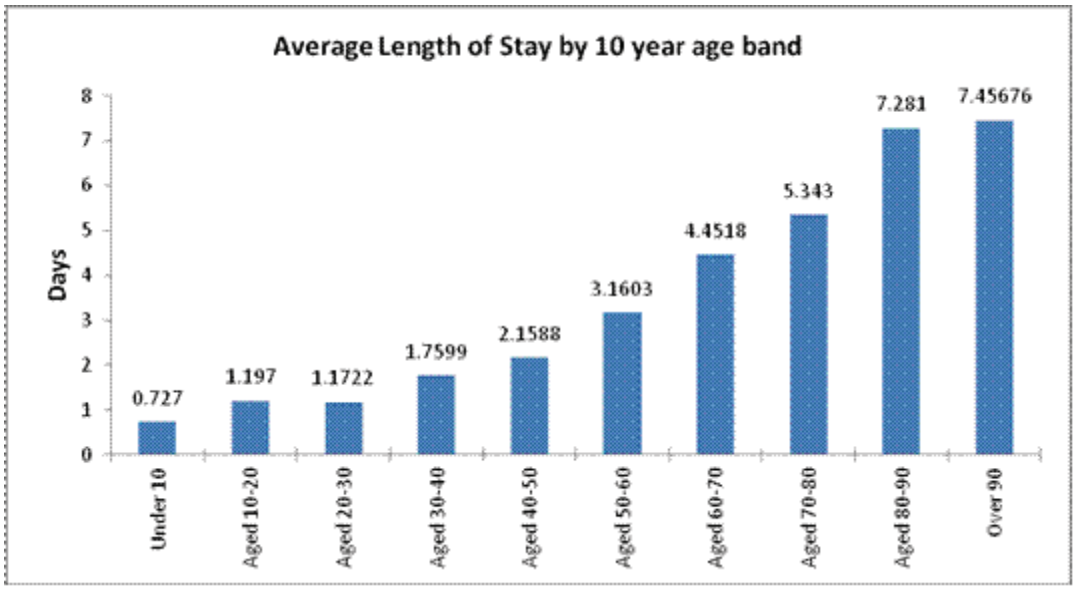


Figure 3 shows, there were 2,500 readmissions which equates to 16% of all admissions. Of these 45% were over the age of 70.

Figure 3

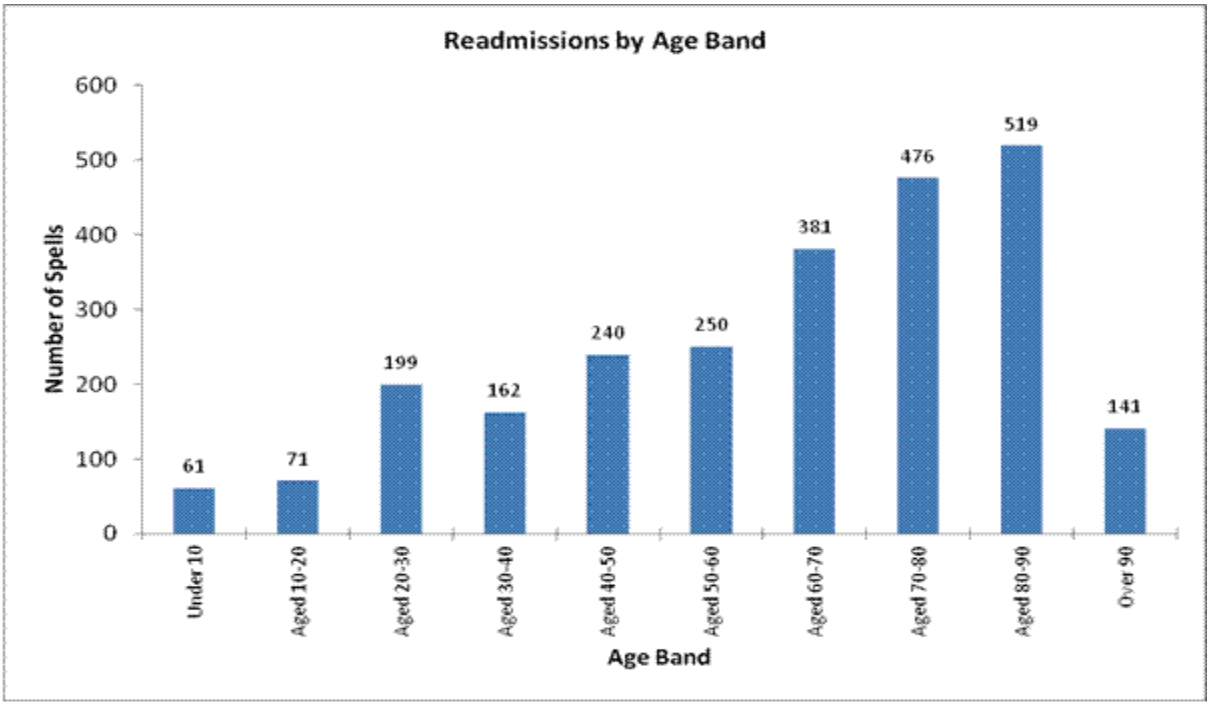
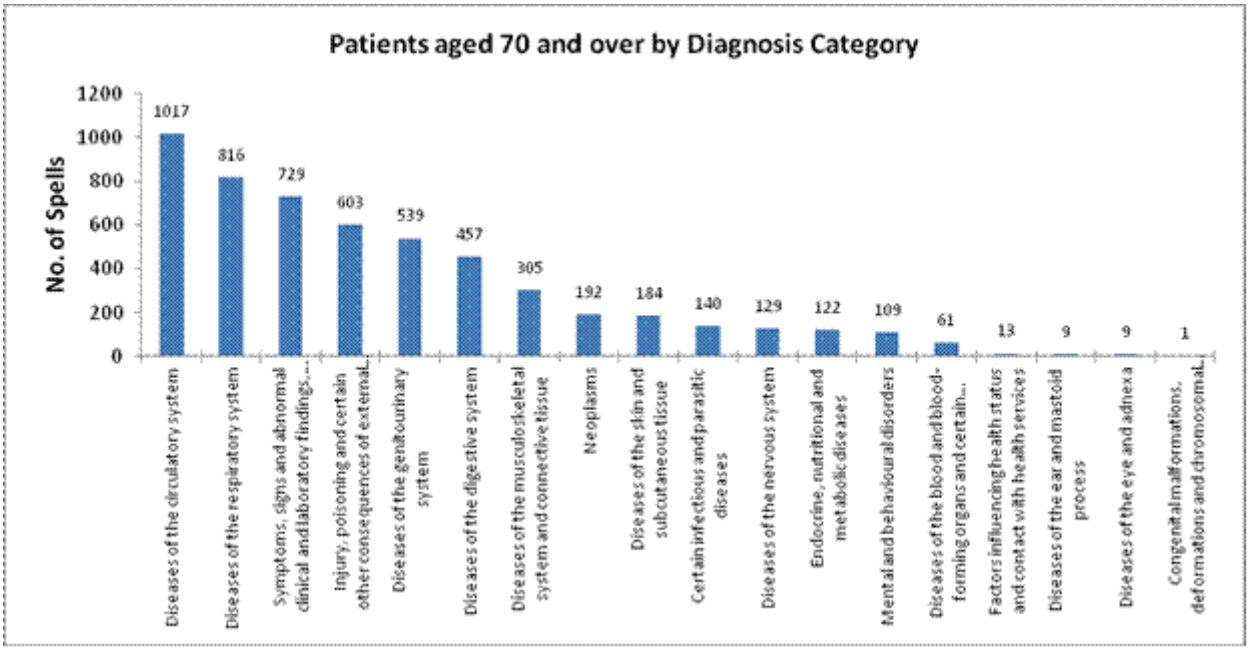


Figure 4 below shows that for patients aged 70, over 19% of these admissions are for diseases of the circulatory system and 15% for respiratory disease.

Figure 4



This information indicates that support the over 70 population and those with Long Term Conditions will support the reduction of Non Elective Activity.

Admissions below 12 hours

Of the admissions to hospital many are admitted for less than 12 hours (Figure 5). There are significant numbers of people admitted for under 12 hours and 1 hour in Bury. In a 7 month period we saw 3912 admissions under 12 hours and of these 650 were for under 1 hour (17%).

Figure 5

All Ages

Nov-13 to Jun-14 Data

Data source: BI Tools - Urgent Care - (emergency admissions only)

12 hours or less		Less than 1 hour	
Specialty	**Activity**	**Specialty**	**Activity**
300: General Medicine	1,866	420: Paediatrics	252
420: Paediatrics	1,036	502: Gynaecology	174
502: Gynaecology	389	300: General Medicine	120
100: General Surgery	262	180: Accident & Emergency	34
180: Accident & Emergency	130	100: General Surgery	27
101: Urology	98	101: Urology	11
110: Trauma & Orthopaedics	38	110: Trauma & Orthopaedics	6
350: Infectious Diseases	24	501: Obstetrics: Patients Use Hos Bed or Del Facilities	5
120: ENT	19	350: Infectious Diseases	5
140: Oral Surgery	13	130: Ophthalmology	4
501: Obstetrics: Patients Use Hos Bed or Del Facilities	8	214: Paediatric Trauma and Orthopaedics	3
340: Respiratory Medicine	7	140: Oral Surgery	3
107: Vascular Surgery	7	120: ENT	2
130: Ophthalmology	5	219: Paediatric Plastic Surgery	2
214: Paediatric Trauma and Orthopaedics	3	340: Respiratory Medicine	1
219: Paediatric Plastic Surgery	2	171: Paediatric Surgery	1
104: Colorectal Surgery	1	**Grand Total**	**650**
430: Geriatric Medicine	1		
105: Hepatobiliary & Pancreatic Surgery	1		
142: Paediatric Dentistry	1		
171: Paediatric Surgery	1		
Grand Total	**3,912**		

Over 65

Nov-13 to Jun-14 Data

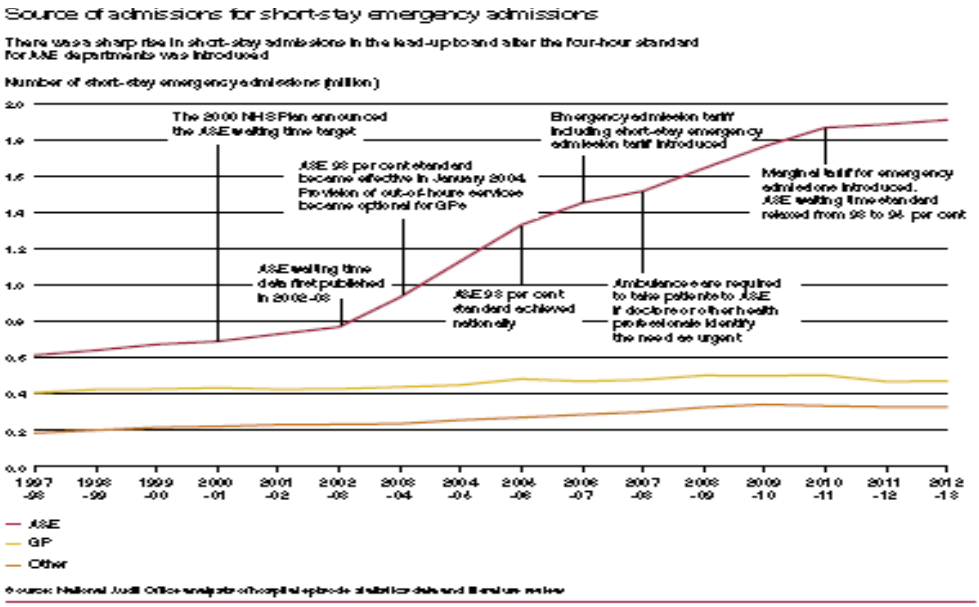
Data source: BI Tools - Urgent Care - (emergency admissions only)

24 hours or less		12 hours or less		Less than 1 hour	
Specialty	**Activity**	**Specialty**	**Activity**	**Specialty**	**Activity**
300: General Medicine	1330	300: General Medicine	801	300: General Medicine	40
180: Accident & Emergency	73	180: Accident & Emergency	47	180: Accident & Emergency	11
100: General Surgery	67	100: General Surgery	44	100: General Surgery	3
101: Urology	44	101: Urology	31	110: Trauma & Orthopaedics	2
340: Respiratory Medicine	16	350: Infectious Diseases	7	101: Urology	2
120: ENT	12	110: Trauma & Orthopaedics	6	350: Infectious Diseases	2
110: Trauma & Orthopaedics	11	340: Respiratory Medicine	6	340: Respiratory Medicine	1
350: Infectious Diseases	8	502: Gynaecology	6	120: ENT	1
502: Gynaecology	6	120: ENT	6	140: Oral Surgery	1
107: Vascular Surgery	5	107: Vascular Surgery	2	130: Ophthalmology	1
320: Cardiology	4	104: Colorectal Surgery	1	**Grand Total**	**64**
104: Colorectal Surgery	1	140: Oral Surgery	1		
303: Clinical Haematology	1	130: Ophthalmology	1		
130: Ophthalmology	1	**Grand Total**	**959**		
140: Oral Surgery	1				
Grand Total	**1580**				

Of the over 65s, there were 1580 patients admitted for less than 24 hours, 959 less than 12 hours and 64 for less than 1 hour. The majority of these admissions were coded as General Medicine.

This is consistent with a report by the National Audit Office (2013) which found short stay admissions were rising and cited the 4 hour A&E standard and the rise in assessment units (Figure 6).

Figure 6



The Integrated Care Services will target a reduction in NEL admissions under 24 hours.

Benchmarking

We have benchmarked ourselves against other CCG areas to assess the reasonableness of the outcome assumptions made in the BCF plan. Avoidable admissions have been benchmarked (Figure 7) across the regional and national average and against the Better Outcomes Maximum. Bury's Non-Elective activity is based on 19,713 admissions of which 1,848 are estimated to be avoidable. If we were to reduce avoidable admissions to be in-line with the regional average, we would have to reduce total Non-Elective activity by 2% (n = 337). To be in-line with the National Average, we would have to reduce Non-Elective activity by 3% (n = 630). To be in-line with the Better Outcomes MAX we would have to reduce our Non-Elective activity by 83% (n = 1011).

Figure 7

Emergency admissions for acute conditions that should not usually require hospital admission per 100k CCG Outcomes Tool						
Baseline used is Provcomm Q4 1314, and Q123 1415 with BCF						
http://ccgtools.england.nhs.uk/ccgoutcomes/flash/atlas.html						
		Total NEL Activity	Avoidable	Avoidable % diff	(n) reduction of Avoidable Ad	% reduction of Bury Total NEL
Benchmark	Bury	19713	1848		0	0
	Region Avg		1511	22%	337	2%
	National Avg		1218	52%	630	3%
	Better Outcomes MAX		1011	83%	837	4%
13/14 total NEL Actvity	19713					
% of Avoidable based on 1213 Baselin	9%					

Emergency admissions have been benchmarked across 10 similar CCGs, Best 5 CCGs, the national average and the England Minimum, Figure 8**.** This has been taken from the Commissioning for Value Atlas using 11/12 baseline. If we were to reduce Non-Elective admissions to be in-line with the 10 Similar CCGs, we would have to reduce activity by 3% (n= 360). Similarly, to be in line with the Best 5 CCGs, the reduction would have to be 11% (n= 1380) and 13% (n= 1580) to be in line with the National average.

Elective and Day Case admissions have been benchmarked, Figure 8. If we were to reduce EL/DC to be in-line with the 10 Similar CCGs, we would save 1,200 admissions, 2,390 admissions based on the Best 5 CCGs and 1,650 admissions based on the National averages. To be in-line with the England Minimum we would have to reduce our activity by 52% (n = 7290)

Figure 8

Emergency admissions per 100k for 11/12 Commissioning For Value				
http://ccgtools.england.nhs.uk/cfv/flash/atlas.html				
Non Elective Activity		Total NEL Activity 11/12	(n) reduction of NELs	% reduction of Bury Total NEL
Benchmark	Bury	12500	0	0
	Similar 10 CCGs	12140	360	3%
	Best 5 CCGs	11120	1380	11%
	National Avg	10920	1580	13%
	England MIN	5810	6690	54%
13/14 total NEL Actvity	19713			

It is clear from the evidence provided that Bury is above national and local averages in all areas.

Population segmentation

To understand this more and identify how we appropriately target our integrated care we have reviewed our population through segmentation, Figure 9.

Figure 9

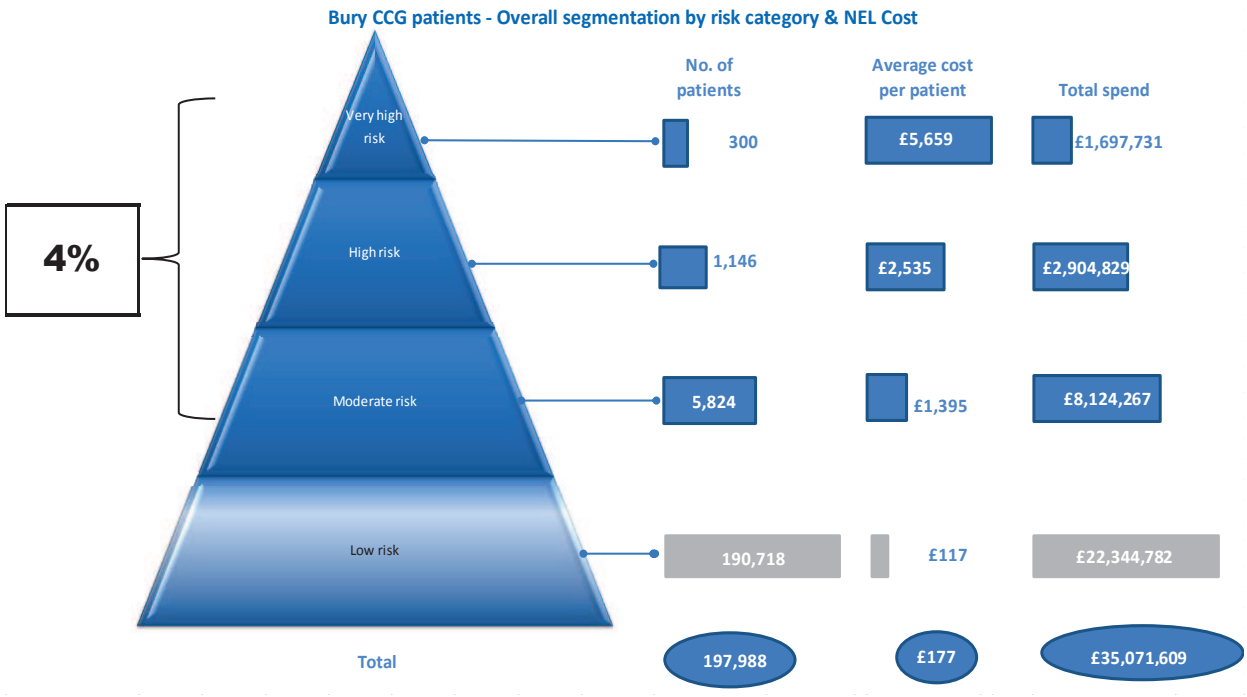


Figure 9 illustrates the population of Bury segmented across the different risk categories. The average cost and total spend per patient is profiled across the segmentation areas and is calculated based on the diagnosis and procedure tariffs for A&E visits, Outpatient Appointments and Non Elective Inpatient activity from Bury GP registered patients from the previous 12 months.

- 4% of Bury's population are in the moderate to very high category with an average cost of £5,659.00.
- Non elective activity for patients in the moderate risk category cost the CCG £8.1m with an average of £1,395.00 per patient. It is estimated there are 5,824 people in this category.
- The high risk category has an estimated cost of £2.9m with an average of £2,535.00 per patient. It is estimated there are 1,146 people from Bury within this segment.

The CCG and Local Authority will be predominantly targeting the moderate and high risk patients through the Better Care Fund Schemes outlined in Annex 1.

Conclusions

From the information presented in the case for change the following assumptions have been made:

- The consequences of the growth and profile of our population will increase demand for services particularly for older people
- The effect of social deprivation on poorer health outcomes, for some of our

population is higher compared to other areas

- Social exclusion is both a cause and consequence of poor health outcomes and often results from limited rights, resources and opportunities
- The impact of lifestyle choices, which are increasing Long term Conditions the demand on services and inequalities, will result in higher levels of ill-health and lower levels of wellbeing
- Over 45% of excess bed days are patients who are over 70
- Bury has a high number of NEL admissions under 12 hour (3912) and of these 17% are below 1 hours. 1580 patients admitted for less than 12 hours are over 65
- If the CCG reduce avoidable admissions to be in line with national average we would reduce them by 3%
- If the CCG could reduce all NEL activity to be in line with national average we have a 13% efficiency opportunity

The case for change outlined above has allowed the CCG and LA to review existing and BCF schemes to target interventions to the very high, high and moderate risk patients to effect NEL admissions reduction.

Figure 10 illustrates the proportionate breakdown of risk stratified patient population and spend that the BCF schemes are aimed at. The CCG and LA have also displayed schemes which are not funded from the BCF pooled budget but will have an effect on the NEL care pathway over the next 2 years. The diagram clearly illustrates that all segments are addressed by one or more schemes.

In totality, the Better Care Fund proposals target a reduction of 986 FFCEs in 2015/16 which equates to a total financial saving of £1,468,619 and reflects a target reduction in activity of 5%. Detailed scheme level work continues to identify and summarise this target at a scheme level.

Figure 10

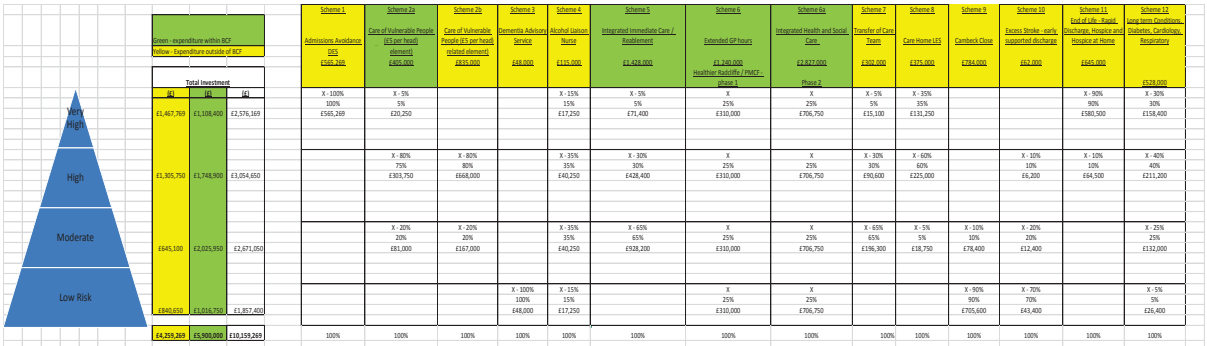
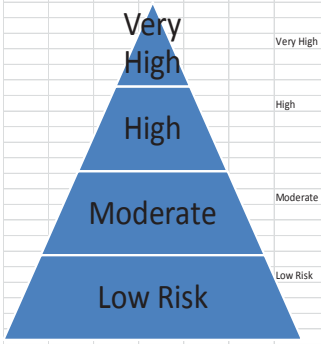


Figure 11 illustrates the risk stratification category breakdown for non-elective admissions for our population and the average cost for each of the segments. It is estimated that 300 people with Long Term Conditions are at a very high risk of a readmission, costing on average £5,649.00 each and 1146 people are estimated to be at high risk, costing on average £2535.00 each.

Figure 11



	Current Cost		Impact		Investment Cost of Scheme	Total Saved			Total Saved per Head of Population
	Per Capita NEL admissions	Per Capita Cost	Reduction Activity (%)	£					
			5%	1,848,000					
					£2,555,919				
Very High	300	£ 5,649.00	15	£ 84,735.00					
High									
					£3,074,900				
	1146	£ 2,535.00	57	£ 145,255.50					
Moderate					£2,671,050				
	5824	£ 1,395.00	291	£ 406,224.00					
Low Risk									
					£1,857,400				
	190718	£ 117.00	9536	£ 1,115,700.30					
				£ 1,751,914.80					

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Key milestones

The key milestones related to the Better Care Schemes are attached in a separate document.

The plans are all interdependent and the Better Care Fund metrics will only be delivered by all the scheme leads working together and delivering a seamless approach to ensure necessary alignments and benefits realisation.

b) Please articulate the overarching governance arrangements for integrated care locally

Governance arrangements

In order to deliver our priorities we are committed to developing new ways of working, to establish a joint approach to commissioning care and services, working in collaboration with the public and provider organisations. We aim to maximise participation in the NHS and care system, to develop a system that will truly put the public and patients at the heart of both service planning and delivery and also put them in greater control of their own care.

Integrated Health & Social Care Partnership Board

We aim to have agreed standards, formulated using a joined up approach, ensuring joint understanding, from which we will commission care and services with pooled budgets in the future. We recognise that in order to do this we will need to align our objectives, agree a prioritisation process and formulate integrated work plans. There has been significant progress made already in Bury, as our integrated care plan has been developed via a collaborative approach from the CCG, Local Authority and Public Health, through the Integrated Partnership Board and Health and Wellbeing Board.

Bury has strong integrated leadership and has further developed the overarching governance arrangements since the previous submission of the BCF in September to ensure that they are robust and fit for purpose in supporting joint accountability.

The Integrated Health and Social Care Partnership Board, oversees the progress and outcomes relating to the integration of health and social care in Bury. This board is jointly chaired by the Executive Director for Communities and Wellbeing at Bury Council and the Chief Officer at Bury NHS Clinical Commissioning Group. Constructive working relationships have been developed over a number of years.

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The Partnership Board strategically leads the strategic commissioning direction of health and social care integration and performance manages all activity. The Board is accountable to the Bury Public Service Reform (PSR) Programme Board, providing regular updates on the development, progress and outcomes in the delivery of the programme of work and this is then reported to the Bury Wider Leadership Group and Team Bury Partners

The Board provides regular progress and outcome reports to the Bury Council Health Scrutiny, the Health and Wellbeing Board and Healthwatch, Bury CCG Governing Body, Clinical Cabinet and Patient Cabinet.

Joint Commissioning Group

A Joint Commissioning Group forms part of the overarching governance arrangements. The purpose of this group is to develop a joint commissioning approach and ensure robust financial modelling is undertaken to support the development and delivery of the integration model across health and social care in Bury. Director level finance and commissioning managers from Bury CCG and Bury Council attend this meeting and the group makes recommendations for decision to the Bury Integrated Health & Social Care Partnership Board. The Joint Commissioning Group provides direction to and has oversight of the key integration work streams. The Bury Integrated Health and Social Care Governance structure is shown in Appendix 2.

There terms of reference for the Board are currently being reviewed. In particular the representation at the Board is being re considered as it is proposed that the key strategic provider leaders be invited to join this Board also.

Integration Programme Office

In order to commit to further supporting and driving the development of integrated care in Bury the economy established a joint Integration Programme Office from April 2014. The programme office is comprised of a Joint Integration Programme Manager and administrative support. The manager has a joint report directly to the Director of Public Health at Bury Council and the Deputy Chief Officer/Head of Commissioning at the CCG.

A more recent development has been the appointment of the Assistant Director (Commissioning and Procurement) at the local authority to a joint post working across both the CCG and the local authority, as Associate Director of Joint Commissioning . This is a very positive step and provides further evidence of the commitment to further develop the integration of health and social care in Bury. This post will be key in driving the integration agenda.

Co-ordinated Community Based Care Group

We recognise the importance of working with our providers in partnership and have therefore involved providers in all elements of our planning. The CCG and Local Authority have developed a Co-ordinated Community Based Care Group, with the specific purpose

of developing and coordinating our community based care developments, to include all providers. This group meets monthly and reports to our Integrated Partnership Board. The Co-ordinated Community Based Care Group has provider representatives as well as other key stakeholders, including; Social Care, GPs and a Patient Cabinet representative. There is an absolute recognition of the need for providers to be partners in developing the integrated plan from all parties. We have had a series of integration workshops involving our partners as well as a recent multi-agency seminar on developing high quality care for frail older people.

Bury Provider Partnership
The role of the aforementioned Coordinated Community Based Care group has recently been reviewed and has developed into a Bury Provider Partnership. The terms of reference for this group are currently being developed in discussion with providers and will be focused on further strengthening collaborative working to deliver the integration agenda in Bury. The group has representation from he following:

- Pennine Acute
- Pennine Care
- NWAS
- Bury GP Federation
- BARDOC
- Bury Council
- Bury CCG

The Local Authority Health Scrutiny Committee and Health & Wellbeing Board
The Local Authority Health Scrutiny Committee and Health & Wellbeing Board are the two key forums at which the review of both health and care strategic direction takes place with Elected Members. These include recent initiatives and plans such as:

- Healthier Together
- Integrated Health & Social Care
- Better Care Fund

as well as on-going plans and developments from both the CCG and the Local Authority. Examples include: CCG operating plan, Local Authority strategies, joint commissioning strategies and supporting documents.

The Lead Member for Health & Wellbeing chairs the Health & Wellbeing Board, and takes a proactive role in the political leadership around integrated health and social care. He champions the role of carers, customers and raises the profile of health and social for adults across the borough.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

The Joint Commissioning Group

The Joint Commissioning Group undertakes the management and oversight of the delivery of the Better Care Fund plan and wider collaborative commissioning activity as agreed and directed by the Integrated Health & Social Care Board. The role of the group is further described in section 4B and the structure is shown in Appendix 2. The Joint Commissioning Group is chaired by the Assistant Director Commissioning and Procurement from Bury Council and the deputy chair is the Deputy Chief Officer/ Head of Commissioning at the CCG. The Director of Public Health is also a member of this group which meets on a monthly basis.

Implementation of the Better Care Fund plan will be managed by the Joint Commissioning Group reporting directly to the Integrated Health and Social Care Partnership Board. The Joint Commissioning Group will therefore:

- Programme manage the Better Care Fund schemes and aligned projects
- Engage with senior staff in other organisations should remedial action plans be required
- Sign off modelling assumptions from the work-streams and monitor the financial delivery of the Better Care Fund in Bury
- Assess project performance through highlight and exception reports and take mitigating actions on any risks
- Direct and oversee the 3 integration programmes which will deliver the BCF
- Ensure that appropriate contractual arrangements between all partners are developed for consideration and adoption by the Bury Integrated Health & Social Care Partnership Board
- Own the risk log and escalate risks to the Board as may be necessary
- Ensure that appropriate data sharing takes place for the purposes of developing joint commissioning and finance approaches
- Manage delivery by exception
- Produce a report for the Integrated Health and Social Care Partnership Board on status, immediate challenges and accountable actions with recommendation around any slippage in timescales and delivery of outcomes.

Management of any remedial actions should plans go off track

Remedial actions will be taken by the Joint Commissioning Group as necessary should plans go off track. Issues and risks that may affect integration and the delivery of the Better Care Fund will be escalated to the Integrated Health & Social Care Partnership Board as may be necessary and reported into the Health and Wellbeing Board.
The programme leads will provide an exception report, confirming the reason for under-performance, how they will address this, and their revised forecasted trajectory, which will be discussed with the members of the Board, who will agree and support remedial action. A monthly highlight report will be produced to track delivery including:

BCF metrics

- Emergency admissions to hospital
- Permanent admissions of older people to residential and nursing care
- Effectiveness of reablement for people 65 and over
- Delayed transfers of care
- Patient/service user experience
- Falls

Quality Indicators

- Process Measures - following coordinated care processes to meet the health
- and social care needs of the patients is likely to improve their overall health and
- wellbeing.
- PROMS - patients who report improvement in their health status are likely to
- have improved their overall health outcomes measured by morbidity indicators such as emergency admissions to hospital.
- Staff Experience – professionals satisfied with their work are likely to deliver
- high-quality care which subsequently affects the patients' health outcomes.

Financial

- Anticipated shifts in spending patterns. It is expected that the costs of community and social care will increase while the costs of acute hospital
- care will reduce. The extent of shifts in spending patterns indicates the degree of the success.
- Improved health outcomes should lead to reduction in costs of health and
- social care; healthier population requires less input from professional health
- and social care services.

Risks

- Quality in terms of impacts on the population and the proposed mitigating
- actions to remedy or reduce the risk.
- Delivery of Projects due to delays or dependencies and the proposed
- mitigations with impact analysis

Bury Health & Wellbeing Board

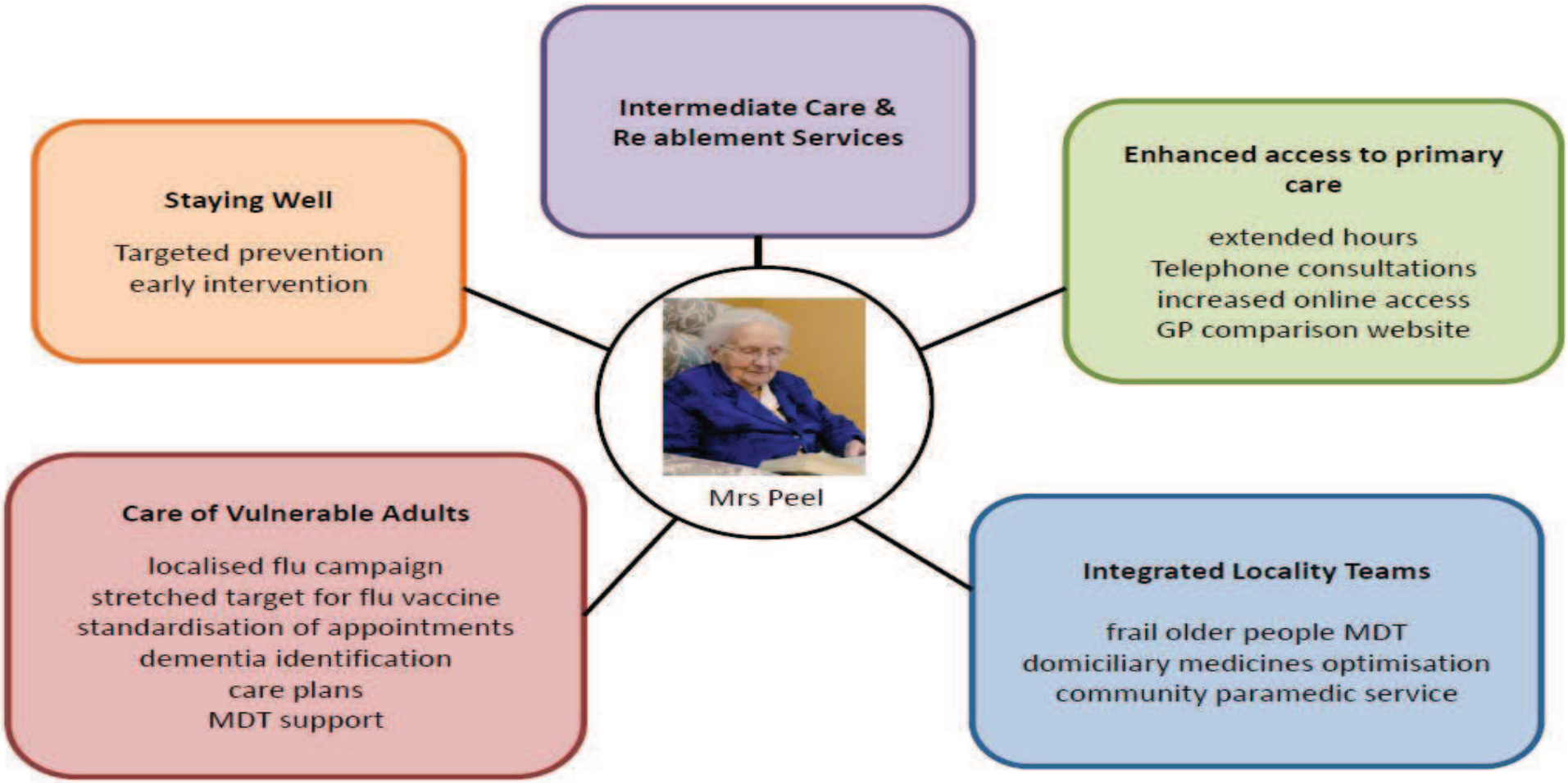
The importance of the Health & Wellbeing Board in overseeing the Better Care Fund is acknowledged. A Policy Lead has been identified from Bury Council to work in partnership with Democratic Services, the Chair and members of the board to support the development and work of the Bury Health & Wellbeing Board for the next municipal year. An initial review of the Bury Health & Wellbeing Board one year on has been undertaken by the Policy Lead. Research into 'best practice' for Health & Wellbeing boards nationally and across AGMA in addition to discussions with the Chair, Vice Chair, Democratic Services and members of the board have led to a number of proposals being developed to support the smooth running and effectiveness of the Bury Health & Wellbeing Board. A development day for the Board has recently been undertaken with the Better Care Fund as a key item on the agenda for this day.

d) List of planned BCF schemes

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref	Schemes
Bury BCF 01	Staying Well
Bury BCF 02	Extended Access to Primary Care
Bury BCF 03	Integrated Health and Social Care Team
Bury BCF 04	Care of vulnerable adults
Bury BCF 05	Review Programme - Integrated Intermediate Care , Reablement and other related services

Model of Integrated Care in Bury & Better Care Fund Schemes



5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

Risk log in appendix 3.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The financial model underpinning the BCF plan is an assumption that non-elective activity will fall by 20% over 5 years, of which 5% will be achieved within the first year. Our analysis set out within the Case for Change demonstrates that this level of ambition is achievable but it is an ambitious target and thus has a significant risk associated with it.

This submission is modelled on the basis of the baseline being actual Q4 2013/14 outturn, and planned Q1, Q2, Q3 2014/15 outturn but we understand that for the purposes of assessing performance in 2015/16 we will be assessed on our percentage reduction in non-elective activity on the actual activity in 2014/15 Q1, Q2 and Q3.

The CCG has significant over-performance on its 2014/5 non-elective activity plan which will be a cost pressure to the CCG in 2015/16. However, this is being accounted for with the CCGs financial plan for 2015/16 and should not create an additional risk to the BCF plan beyond the assumed 5% BCF deflection.

The current plan includes a planned reduction in non-elective admissions of 5% in 2015/16. Using 2014/15 plan as a baseline, this equates to 986 admissions at an estimated cost of £1.739m which is identified as being the pay for the performance element of the scheme. It is noted that if activity does not fall in line with the target, then £1.739m will be held back by the CCG in order to cover the costs of the non-elective activity still being incurred.

The local authority and CCG are working together to explore ways of mitigating the financial risk and building the resilience of the pooled budget by having schemes that incorporate payment mechanisms with providers which align incentives to the metrics within the plan. This will be explored further during the 2015/16 contracting round and as new contracts are let during 2015/16 following service review.

A recent example of where this has been successful is within the development of the CCGs £5 per head enhanced scheme for Primary Care. Within the scheme, £600k (of a total £1.2m) is set as a performance payment and will only be paid on achievement of

reductions in non-elective admissions. It is expected that this principle will be built into any funded extensions to GP access and into the development of the intermediate tier.

In the event that the Pay for Performance element of the scheme is enacted, the CCG and LA have identified a series of mitigations to manage the risk of the pool overspending. E.g.

- Through slippage
- Performance related payments to providers
- Additional income (e.g. interest receivable)
- Other savings/contingencies

The CCG and the LA have agreed to jointly manage the risks of the BCF overspending and take any and all necessary mitigating actions required to deliver a balanced financial position on the pool. It has been agreed in principle that any residual liabilities remaining after mitigations will be shared equally by the CCG and Local Authority. Agreement will be finally signed off at the Intermediate Health & Social Care Partnership Board on the 29th January 2015.

The CCG are also having early conversations with its acute provider to develop local tariff arrangements for some elements of emergency activity and are exploring risk share models where the fixed costs of planned capacity are funded separately to marginal costs for individual units of activity.

The section 75 agreement is now being developed for sign off prior to the 31st March 2015.

The risks and mechanism for the pay for performance element of the fund have been explained and are understood by the Health and Wellbeing Board.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Alignment with other care and support initiatives including self care, early intervention and prevention

In line with other Health and Social Care economies Bury has a range of challenges to address over the next couple of years. Not least additional pressures currently felt within the acute provider, the level of budget reductions across health and social care, growth in demands from both demographic changes and also the complex nature of people now surviving with a number of co- morbidities. In response to this challenge, the council and the CCG have developed or are developing a number of initiatives.

As has been previously described we have three key thematic integrated care themes and associated workstreams relating to:

- Ageing Well
- Reablement and Intermediate Care
- Enhances access to Primary Care and Integrated Care

We have a Demonstrator Community – "A Healthier Radcliffe in one part of Bury and The Prime Ministers Challenge Fund – Easy GP project, across the whole of Bury. Our development of the Better Care Fund encompasses services associated with the above. There are other initiatives in Bury that are aligned to and will support the delivery of the integration agenda and the development of the Better Care Fund and some of these are described below.

The alignment of all the initiatives across the economy is challenging however it is recognised that this has to be achieved. Plans are in place to address this by progressing a further mapping exercise, with our partners, to ensure that we are aware of all initiatives in Bury related to the provision of care and support. This exercise will assist us in further identifying the interdependencies, along with opportunities to share resources and achieve greater efficiencies. This economy intelligence will be fed to the Joint Commissioning Group and Integrated Health and Social Care Partnership Board.

It is a further challenge to ensure that these initiatives are well communicated across the whole health and social care economy and we do have a communications and engagement subgroup addressing this currently.

Other initiatives underway are as follows:

Provision of information advice and guidance - The Bury Directory

The Bury Directory is a new e-directory that includes advice and guidance which meets the requirements of both the Care Bill and the Children and Families Act 2014. It combines all existing information, advice, directories and resources (strategies/policies/documents) into one place that can be accessed by the public, customers, patients, health and social care professionals and the community and

voluntary sector.

The system has:

- A variety of search options such as search by postcode, category, keyword and by clicking on ward within a map of the borough
- A 'route planner' and 'map your journey' facility
- A shortlist functionality so that information can be pulled into a shortlist which can then be e-mailed or texted to the customer or printed
- A 'log in' function that can save searches
- A 'rate it' function for people to rate services
- A 'product catalogue' that enables product comparison
- The ability to be used on all IT platforms including PC, Tablet, smart phone
- An auto update facility which means that every entry in the system receives a regular e-mail asking them to update their details. They can do this by logging in and updating any information themselves, reducing administrative support required to keep the information valid
- An auto feed in from other websites such as NHS Choices and CQC so that this data is pulled automatically into the Bury Directory. This ensures accurate and up to date information and means information is not stored in more than one place
- Entries to the directory can be added via self service functionality that are then verified.

The Bury Directory will go live on a soft roll out from September 2014 to December 2014. This will include implementing the training and communication and marketing plan.

Following soft go-live and roll out, next steps for between September and December 2014 are to:

- Go live with a 'log in' for Personal budget customers to view their personal budget information

- Go live with a 'PA finder' module which will be a matching service for customers and Personal Assistant's, volunteers and volunteering opportunities etc

- Develop the Bury Directory Phase 2- data sharing (demo) system between health and social care professionals. This will be an innovative system that will enable the sharing of social care information with other professionals including health professionals via a secure site. It is anticipated that this will support the integration agenda by enabling data sharing to best support the customer ie, sharing of care plans, next of kin/carer details, whether a case is open to a social worker etc. This could reduce unnecessary hospital admissions, support the discharge process and support professional whom all use different IT systems to share relevant information on customers to support their care.

- Work with a third sector community consortium Bury Community Advice Network (BCAN) to offer a 'widget' functionality from the Bury Directory into their website. This will avoid duplication or errors as there will be only one set of data, stored in one place and then accessed via a link to their website. This could take until March 2015.

Links with Housing

A Housing Strategy for the Borough was approved in early 2014 that set out our ambitions to improve the suitability and sufficiency of housing across all six townships. There are strong links between health and housing at all levels and this is clearly referenced in our strategy and delivery plans. In particular:

- We have, and plan to continue, expanding the quality and choice of housing for older people – through modernising and upgrading sheltered accommodation, building more extra care facilities (Redbank, Redbank2) and increasing the number of older people's bungalows – more people are able to live in the community for longer. As a consequence, residential care admissions (and the length of time people stay in residential care) have reduced significantly. This programme will continue as the Council and its partners have received £5 million from the Homes and Communities Agency to deliver another 200 affordable units over the next three years.

- The Council has a well-established process for adapting properties via Disabled Facilities Grants with Government allocating around £700,000+ per annum in recent years for this work. It has meant approvals are being limited to mandatory grants that meet higher priority needs. Additional money would enable more cases to be processed and expand provision for minor works – works which often delay patients from returning home.

- We run a number of projects for other vulnerable people including children leaving care, people with learning disabilities, physically disabled adults and people with mental health issues. This accommodation, coupled with other such schemes such as Supported Living, is helping to keep more individuals in the community.

- Working with Public Health colleagues and other professionals, we are heavily engaged in affordable warmth initiatives including Green Deal, energy switching and related energy conservation measures to keep homes warm and minimise fuel poverty. Using thermal imaging and other property data, we are targeting 'hot spots' to raise awareness and seek to reduce excess winter deaths.

- Work across partners including the Fire Service has improved the quality and safety of properties. There is however potential to do more, particularly in older properties, in relation to falls and other trip hazards.

The Council and its partners have strengthened support to homeless people. In addition to meeting our statutory duties, innovative projects for single homeless people, cold weather provision for rough sleepers and health screening for persons entering services is making a difference by reducing their risk factors and linking a traditionally hard to reach group with mainstream health services such as GPs and dentists.

Pooled budget arrangements for complex care for children and adults

We are progressing initiatives such as pooled budget arrangement for complex care for children and adults. In addition to this we are developing a complex care team which will work with individuals and their families to put in place personal Health and Social care budgets as one element of the support.

We have a emphasis on self care and co-production, so the teams across the borough will look for prevention and early intervention services that can support people and their carers to self care, drawing on community assets to allow people to receive support within their own community.

We already have a complex care panel which meets weekly and aims to do a number of things:

- Quality assurance of support packages for children and adults with complex needs.
- Challenge Multi Disciplinary Teams on their approaches to the provision of Health and Social care budgets, ensuring alternatives have been sought and provision of service is both person centred but also cost effective.

Operational Resilience plans for Bury

The local health and social care economy have worked closely together throughout summer 2014 to review the requirements for enhanced and 7 day working in order to respond to seasonal pressures. An operational resilience plan has been developed jointly across Primary Care, Secondary Care, Community Care, Out of Hours, the Local Authority and the CCG. This plan identifies areas where additional funding and extended service provision will support operational resilience.
Examples include:

- plans to see the seasonal expansion of Extended Nurse Practitioners Services to 7/7 12 hours a day
- an integrated discharge team operating 7 days a week
- increases in consultant/OT/PT/SW provision to facilitate 7 day working
- expansion of Ambulatory Assessment Unit to allow 24/7 model of assessment for ambulatory care sensitive conditions

The development of this year's resilience plans for Bury has been achieved through a alliance model of working and we see this as being our preferred approach to future working. This has improved communication and promoted team working as well as allowing for planning and conflicting priorities to be identified and addressed as they arise.

Primary Co commissioning

Primary care development is at the heart of the CCG's integration strategy and Bury CCG is expressing interest to jointly commission Primary Cre Services with NHS England. (as described in section c)

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

The Strategic Plan submitted by NHS Bury CCG contained all elements of the Better Care Fund progressed to June 2014. It outlined five transformational schemes to collectively achieve the proposals within the Better Care Fund Submission in Bury:

- Collaborative Prevention, Wellness and Life Support Programmes

- Integrated Community Based Care Programme
- Streamline and Enhance Elective Care
- Future proofing Urgent Care
- Commissioning for Quality & Enhancing Corporate Functionality

Schemes to deliver enhanced community based care are planned and in progress which have taken into consideration the views of the public and patients in addition to member practices. The plans have been linked to the JSNA and Health & Wellbeing Board priorities, aligning all work programmes to deliver against the same local priorities.

Secondary care activity reductions have been planned and communicated to providers. Work stream prioritisation processes have been identified, to deliver against the CCG Strategy & Better Care Fund Submission. A Joint Commissioning Group and Partnership Board are in place to collaborate on the work programmes required, to achieve the outputs identified within the Better Care Fund going forward.

The BCF plan of action also aligns with the Bury Council Health & Wellbeing Strategy and the Corporate Plan. The focus of social care over the past few years has been around personalisation, recovery, self care and prevention; with the BCF this is now expanding into health care needs.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- **For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.**

Primary Care Development is at the heart of the CCG's integration strategy. Bury CCG is expressing interest to Jointly Commission Primary Care Services with NHS England. The bid includes:

- Strategic planning and design of primary care locally and design new models of service delivery that work across whole pathways of care, including primary care. It is anticipated this will be funded in the long term through the Better Care Fund.

- Ensuring the quality, capacity and capability of local GP primary care services and working with local practices to remove variation and make sure that local services meet required standards by a clear agreement with the Area Team about communication of concerns and clear escalation processes.

- Strategic planning of local estates and workforce required to deliver those plans (recognising that there would also be a GM element to the planning of local estate and workforce).

- Design and capture of associated local workforce planning data that would enable the CCG to ensure that robust workforce plans would be in place to support the development of primary care.

The CCG has involved the following stakeholders in the decision:

- Patients Cabinet
- GP Members
- Health and Wellbeing Board

We will transform Primary Care through Co Commissioning and have had a number of workshops with the CCGs sectors to work up the new model and each of the four sectors in Bury has been developing their vision for integrated care. There is an active GP Federation and 30 of the 33 General Practices in Bury, are members of the federation. The work the CCG members did through the sectors and the establishment of the GP Federation, culminated in the West sector being ready to bid to become one of the Greater Manchester Demonstrator Communities, delivering a programme called 'A Healthier Radcliffe'. This is a provider led system reform programme involving six GP practices covering 3 wards of Bury, from which learning can be rapidly rolled out across the rest of the Borough. Each of the four sector clinical leads has a seat on the Bury Co-ordinated Community Based Care Group to ensure Primary Care is represented.

The Bury GP Federation also has been successful in its bid for the Prime Ministers Challenge Fund, to roll out the above programme across Bury. The programme will cover four main areas:

- **Extended hours- longer opening hours including:**
  - Weekday opening (8am to 8pm), and
  - Saturdays and Sundays (8am to 6pm)
- **Tele consultations**
  - To ensure that all patients who request an appointment are offered the option of a telephone consultation
- **Increased Online Access**
  - To increase use of online services from the current 4% of patients to 60%+
- **Development of a "GP-Comparison" website**
  - To enable patients to make better choices about GP services

As part of the BCF the CCG has commissioned Primary Care to provide enhanced services to vulnerable older people. This explicitly links to the wider integrated care plans and will enable delivery of the outcomes agreed through the Better Care Fund.

The CCG is finalising the submission of the Expression of Interest and supporting governance architecture for submission on 30th January 2015.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Protecting social care services in Bury means that it is recognised that effective social care and targeted third sector support can contribute significantly to meeting the health care needs of people within the borough, and indeed, have been doing so for a number of years.

The Care Act requires us to ensure that people will be able to access timely information and advice and receive the support they need to meet their assessed needs in a time of growing demand and budgetary pressures. This means maintaining local Fair Access to Care (FACS) eligibility to include substantial. By maintaining a focus on self-care, prevention and early intervention, it is anticipated that the demand on long term health and social care support will be prevented or delayed in a number of cases. The development of a community asset based approach is a key factor in enabling this to happen.

In addition, the development of this community asset approach means that where long term support is required people will be empowered to self -direct this support, with a focus on community and informal support so that formal care services are available for those with the highest need.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Funding allocated under the NHS transfer to Social Care has been used to meet the demand pressures within social care, in light of significant budget pressures, and to continue to fund services where the budgets would have otherwise been cut. Examples include funding elements of reablement services, early intervention and prevention services including provision of equipment reablement and short stay for older people. Continued commissioning of domiciliary care for older people services and residential care at a slightly reduced level, mean that we have been able to maintain the appropriate level of services to meet demand. It is expected that directing NHS funding to these services will facilitate market management to ensure future sustainability as identified in key strategies and Market Position Statement documents.

In addition, the NHS transfer to Social Care funding has been used to enable the local authority to sustain the FACS eligibility criteria at critical and substantial. To do this required assessment and care management services to assess and review the care needs of clients who are FACS eligible and without this funding there is a significant risk that the Council may have to consider a move of the FACS criteria to Critical only, to meet the growing demands on the services and the ever constrained and limited budgets.

Within the Care Act, there is additional responsibility to provide information and advice to people who do not meet FACS. These services will be required to be further enhanced as result of the requirements of the Care Act and 7 day working. Any potential change to eligibility criteria outlined in the Care Act will put greater pressure on services. Funding will be used to support these services such as transitions planning, carers assessments and breaks. The assessment of self-funders will place additional burdens, which is why we are looking at investment into assessment services.

Agreement has been reached that the use of the Better Care Fund monies will be used within the high level themes of reablement, assessment and care management services and domiciliary care services. These services will enable us to manage the demand better in the community resulting in reductions of admissions to residential care and non –elective admissions.

The provision of information and support to enable people to self-care as well as investment in prevention and early intervention will aim to reduce the impact on health and social care services.

Support by funding from the BCF will maintain and potentially upscale both the volume and scale of current health benefits including fewer people being admitted to hospital on an emergency basis. The specific services to be funded by the pooled budget on an ongoing basis will be signed off once a number of reviews have been undertaken and decisions taken to either:

- Re-commission as is;
- De-commission services totally where there is not continued benefit in line with integration and BCG priorities or
- Re-design services to ensure that there is continued benefit in line with integration and BCF priorities.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

£5.883m has been identified to protect social care services from 2015/16 onwards, including an element to offset savings requirements of social care services. However, it is recognised that the amount ear-marked against social care specifically may increase depending on the outcomes of service reviews in line with the 3 requirements above.

These budgets will be finalised (from a combination of existing resources and BCF) once the reviews have been completed and the re-shaped service commissioned.
The Local Authority confirms that it will use its share of the £135m to implement the requirements of the Care Act in 2015 which equates to approximately £460,000 for Bury.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Many of the requirements of the Care Act are already being delivered in Bury as good practice, including a well established deferred payments scheme, good information and advice services, and a personalised approach to assessment and social care support.

An implementation plan is currently being developed to ensure that all requirements can be met by 1 April 2015. In particular we are working closely with our IT systems providers to ensure that public access to systems, particularly in respect of both care needs assessment and financial assessment, will be possible, as we see self- and supported- assessment as a key development to manage the anticipated volume of new customers.

The development of the Care Act requirements are being embedded using existing managers to lead on their particular areas rather than a project based approach. However, we are still working through the financial models requested nationally to understand the potential impact on demand; national estimates in terms of additional future funding requirements seem high, and locally work continues to understand and model more accurate costs.

v) Please specify the level of resource that will be dedicated to carer-specific support

Resources for Carer Specific Support

In terms of NHS Bury CCG and Local Authority funding, the existing levels of resource for carers are set to continue, at least for the present. The Bury Carers Strategy, 2013 - 2018 signed of in September 2013 identified financial support for the carers issues as, circa £7m LA and £1.25m from the CCG. For the Local Authority this detail can be found in the Carers Strategy, on page 36, Figure 12 and for Bury CCG, Figure 13, page 38 http://www.bury.gov.uk/CHttpHandler.ashx?id=12023&p=0

Carers strategy and implementation

The Carers Strategy, signed off September 2013, recognises the value of carers in supporting both the health and social care agenda, and also recognises the particular stress that carers face. In particular, the Carers Centre commissioned by the LA and funded in partnership with the CCG will continue to play a significant role in supporting carers. Carers Personal Budgets are well established in Bury and are well used for a variety of personalised support to facilitate Carer Breaks. Carers' assessments are offered routinely as part of the social care needs assessment process. The CCG has identified in the carers strategy and supporting action plan key areas for development in primary care. The CCG recognises the impact on health outcomes that effective services for carers can have. This is also explored in the Carers Strategy document and was a theme of the strategy consultation exercise. This includes identification of carers, referral of carers to the Carers Centre and other appropriate 3rd sector agencies, to support carers in their caring role and to improve carer's physical and emotional health & wellbeing. The development of care plans in primary care, to ensure carers and the cared for are involved in care planning, with a particular focus on emergency planning and managing crisis is also a key element of the strategy. As well as working directly at practice level the CCG support the wider carers agenda in a number ways. The CCG also commissions, Cambeck Close, a service which primarily provides short breaks and support to learning disabled children and adults with additional healthcare needs, assessed as having a severe or profound learning disability. There are many different ways that carers can get a break from caring, including accessing community groups, planned short breaks and time away whilst the cared for is in respite. The CCG invest annually into training and education across stakeholders and providers on EOL and Carers issues. The CCG also provide a grant to Bury Hospice partly in recognition of the support services offered to carers and family members.

Bury CCG commissions a range of services, in order to support positive outcomes for carers CCG commissioning or procurement exercises are required to ensure the needs of carers are suitable addressed. Service Specification and procurement exercises have certain checks to ensure that they cannot progress to approval if carers considerations are not addressed.

A pilot project commenced on the 1st September to further develop the necessary systems and processes that can be rolled out across the borough to support carers and the cared for. The Carers pilot forms one element of the Healthier Radcliffe overarching action plan. Representatives from the 6 practices in Radcliffe have agreed a way forward to pilot developments to improve identification, referral, awareness raising and signposting of carers from General Practices to the Bury Carers Centre and other

appropriate support services in Bury. This pilot commences on the 1st September for a 3 month period. Agreed actions associated with the pilot are:

- Practices to run a search prior to the 1st September to obtain baseline data on the number of carers currently on the carers register
- Practices to run a one-off search to identify patients over 75 - list of patients to be shared with the senior GPs to review and identify if the patients listed have a carer(s) that is known to them, and if so, ensure their caring status is coded
- Bury Carers Centre to provide each practice with awareness raising material and signposting materials to support the identification of carers - including posters and leaflets, for distribution by reception staff and GPs/clinical staff during consultations with patients
- Practices to ensure patients are read code when a practitioner provides a carer with information on Bury Carers Centre during a consultation Bury Carers Centre will provide (via fax) the practices with a monthly list of the patients registered at the practice that have referred themselves to the Carers Centre
- Practices to set up an internal system to ensure that where the carers section of the Unplanned Admissions DES form is completed, the carers record is read coded so they are added to the register
- Bury Carers Centre to liaise with each practice to run a short awareness session in September for staff to support the identification of carers and signposting to Bury Carers Centre
- Practices to review the 60 second guide to the identification of carers to support work in the practice to identify patients who may have a carer

The numbers of carers on the practice register will be monitored on a monthly basis along with the numbers of carers referred to the Carers Centre and the number of carers assessments undertaken. It is planned that the learning from the pilot can be rolled out cross the rest of Bury.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

The local authority's budget within the Better Care Fund remains at a minimum of the previously identified £5.828m revenue funding, plus £1.240 capital funding. However social care related savings for 2015/16 now been identified as £4.5m (part of £6.6m for Department of Communities & Wellbeing overall). Therefore the on-going transfer of funding from BCF to protect social care is paramount and is recognised by our CCG partner.

In addition, some of the additional BCF schemes contain elements of social care support, which has attracted additional allocation from within the BCF; should the schemes be up-scaled across Bury in the same proportion as the Radcliffe pilot, this means that social care funding, including capital, is currently planned to be around £7.887m.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

The Bury Health and Social Care economy is well advanced having already started to put in place operational services to maximise the opportunities of 7 day working. These arrangements are currently operational and are being tested through the Healthier Radcliffe pilot. There is agreement across providers and stakeholders that 7 day working is not just to facilitate hospital discharge and does not focus purely on hospital services.

Bury CCG is building a community infrastructure that will provide responsive services linked with GP practices. GP practices will be extending their core hours over 7 days and it is important that they are supported by specialist services for advice about patient care and community services (both health and social care). They will provide information to patients, practical care and support and an urgent care response to maintain people in their own home. This is the main focus of the Healthier Radcliffe pilot. Stage 2 of Healthier Radcliffe will facilitate a shift to this model and the locality team will have availability over seven days from October 2014.

The CCG and LA as joint commissioners recognise the risk to 7 day working particularly around availability of staff. The GPs in Bury have embraced the concept of 7 day working through a federated model. This allows shared accountability and control of quality whilst ensuring there is an organisation that can secure additional capacity to support 7 day working. Following patient, professional and carer evaluation as part of the Healthier Radcliffe pilot the CCG will establish the best approach to rolling this out across Bury. The key risk to 7 day working is the enhanced cost. This resource needs to come from a reduction in activity in secondary care and the essential success of the roll out will be evaluated jointly at each stage to ensure delivery.

Those with Long Term Conditions will have a community care plan in place that is developed through a Multi-Disciplinary Team (MDT) approach, which is centred upon the person. This will describe individual professionals who are available to support the person should their condition deteriorate; however the emphasis will always be on self-care as the primary response.

Should patients require hospital admission there will be a multi-disciplinary team pod based at the hospital. This team will undertake joint assessments involving the person and their carer, in relation to safe and effective discharge to a place appropriate to meet their needs.

Pennine Care NHS Foundation Trust and the Local Authority are working together with joint commissioners to jointly develop a delivery plan that will underpin the integrated services, which will be wrapped around individuals within each locality. This will cover mental and physical health and social care needs.

In addition Pennine Care NHS Foundation Trust as the provider of mental health services has worked in the local leadership team to ensure that they are able to engage with the system over the 7 day week. They have already implemented a 7 day Rapid Assessment Interface and Discharge Team (RAID) service into the General Hospital to

ensure those with co-morbid mental health problems are assisted to move through both A&E and hospital beds to discharge. Home Treatment services for older people with mental health problems are also being enhanced to offer more robust cover at weekends.

The existing services that work over seven days co-ordinates support to facilitate discharges and are used as a step up facility to avoid hospital admissions. In the last twelve months 387 referrals have be accepted by the crisis response service who were identified as a avoidance to hospital, 307 remained at home.

The hospital services are moving together to work as integrated services on the hospital site to further facilitate hospital discharges over seven days.

The Healthier Radcliffe is piloting a seven day co-ordination team, which will work closely with crisis response, RAID, EDT, seven day community nursing team, reablement and IMC to ensure that patients avoid hospital admission or attendance at A&E, and support is available to provide timely discharge from hospital.

Mental Health

There are already a number of mental health teams/services that provide a 7 day service within the PCNHSFT (Mental Health) contract. The Service Development & Improvement Plan does not currently include clinical standards for these however the 2014/2015 contract will be "refreshed" for 2015/2016 so this will be the opportunity to develop them. As these are clinical standards, the CCG Clinical Quality Team will be involved and this work be overseen by the PCNHSFT Quality Group (for Mental Health).

The services, which currently provide 7 day Services include acute inpatient & PICU wards, Crisis Home Treatment Teams (adults & Older people), & A&E Psychiatric Liaison, however, Community Mental Health Teams & Primary Care Psychological services do not currently operate 7 days. Older Peoples Community Mental health services are currently going through a redesign process to facilitate 7 day working which will be operational within the 2014 calendar year; this will include access to Home treatment, community mental health and memory services.

As part of the operational resilience and capacity planning work undertaken for the borough of Bury this year mental health services have been allocated in principle additional support to enhance services that work over 7 days throughout the winter months at times of increased demand.

The incidence of unnecessary admissions does not happen frequently in mental health services as weekend admissions are usually emergencies for people deemed "at risk of self-harm or harm to others" having come through the A&E route. The key issue is of people who have been admitted to an inpatient setting in order for their risk to be assessed and the numbers that are discharged within 72 hours. A more integrated approach with appropriate third sector services, and the development of a more robust crisis service together with robust discharge planning (health, social care & third sector) for people who have been admitted for assessment or respite should be considered as a commissioning intention. Services for people with personality disorders and wider access to Psychological therapies that include CBT and behaviour modelling should also be considered.

The expansion of services from whom 7 day provision is not contracted will incur a

significant culture change amongst staff, change of staff terms & conditions, a level of clinical risk (to be scoped) and substantial increases in costs to commissioners at the front end of the system. Service re-design needs to be scoped to allow for 7-day provision for these services.

Pennine Acute Trust

Pennine Acute Trust is currently working on the development of a strategy that will include an action plan to deliver the clinical standard requirements to support 7 day working. The strategy will be in two parts commencing with elective pathways first then non-elective pathways. As agreed with commissioners at the North East Sector Unscheduled Care Board, primary, community and social care partners will need to develop plans at the same pace as in acute services. The pace at which plans have been scheduled within Pennine Acute Trust, are detailed below:

- Year 1 (2014/15) - the contract will/does include agreement to develop a strategy and action plan to deliver the clinical standards.

- Year 2 (2015/16) –the clinical standards which will have the greatest impact will move into the national quality requirements section of the NHS Standard Contract. National Quality Indicators are mandated therefore would provide commissioners with formal levers to hold providers to account.

- Year 3 (2016/17) – all clinical standards will be incorporated into the national quality requirements section of the NHS Standard Contract

Pennine Care NHS Foundation Trust

PCNHSFT currently operate a range of 7 day services as detailed below:

- Bury Urgent Treatment Centre 07:00-22:00 Monday-Friday and 09:00-22:00 Saturday, Sunday and Bank Holidays
- Prestwich Walk in Centre 08:00-20:00
- Crisis Response Service 09:00-22:00
- Children Community Nursing Team 08:00-20:00
- Community Nursing currently 24/7
- Bealey Community Hospital 24/7

Service offering 6 day working:

- Integrated Community Diabetes Service 08:00-20:00 Monday-Saturday

There is a rolling programme of procurement with services currently out to tender. The service specifications state that services are expected to support primary care opening of hours of 08:00-20:00 and weekends from 01.04.15:

- Audiology – specification says majority of activity will be 09:00-16:45
- Podiatry
- Treatment Room
- Tissue Viability
- Community Eye Service – low vision aid and glaucoma specification states that this is not an urgent care service and therefore there is not an expectation it will be open 08:00-20:00

Pharmacy Services

There are 41 pharmacies in Bury; five pharmacies have 100 hour contracts in the Bury

area. They are centrally located and accessible by public transport, walking or own transportation providing good access during evening and weekends. In addition there are some supermarket pharmacies that also open extended hours. On Saturdays, access to pharmaceutical services is provided from a pharmacy can be found between the hours of 6am to midnight within Bury. The opening hours across Bury on a Sunday range from midnight until 6pm. Over 70% of the pharmacy contractors in Bury are open on a Saturday.

Operational Resilience

The local health and social care economy have worked closely together throughout summer 2014 to review the requirements for enhanced and 7 day working in order to respond to seasonal pressures. An operational resilience plan has been developed jointly across Primary Care, Secondary Care, Community Care, Out of Hours, the Local Authority and the CCG. This plan identifies areas where additional funding and extended service provision will support operational resilience. Examples include:

- plans to see the seasonal expansion of extended nurse practitioner services to 7/7 12 hours a day
- an integrated discharge team operating 7 days a week
- increases in consultant/OT/PT/SW provision to facilitate 7 day working
- expansion of Ambulatory Assessment Unit to allow 24/7 model of assessment for ambulatory care sensitive conditions

A full review of the impact of Operational Resilience will help to determine future full year commissioning intentions.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

The NHS number is used ubiquitously in all NHS organisations and its use is now a contractual requirement for GPs. It is used in all primary care environments including out of hours services based on real time retrieval via PDS tracing The tracing and recording of NHS Number in the Acute sector is already in place via PDS tracing in real time or via batch processing.

The NHS number will be used by Social Care from April 2015. Plans are being made to migrate the NHS numbers into the Protocol social care system as follows:

Action	Deadline	Comments	Next Steps
Identify a partner organisation to work with Bury	January 2015	Currently looking at making an agreement with Pennine Care, as they have experience of this type of collaborative work with Rochdale council	LJ and IL to further explore the partnership with Pennine Care
Agree a data	January 2015	Once Pennine (or	Dependent on

sharing agreement with partner agency		alternative agency) are in agreement, draw up and sign on both sides a data sharing agreement to allow this piece of work to progress	above step. Once partnership agreed, draw up data sharing agreement
Provide a full data extract from Bury's Protocol system	February 2015	This can be done in one of 2 ways within Bury and both of these ways have been explored and found to be accurate	Bury are in a position to provide this data whenever required
Matching exercise takes place	February 2015	As Bury do not have a local N3 connection, a partnership with a health organisation is vital to ensure that the data from Bury can be passed through the Demographics Batch Service to the NHS spine where the matching exercise will take place.	Dependent on all of the above steps being completed
Receive matched records and use NHS number loader tool provided by Liquidlogic to push this data into Protocol	March 2015	NHS tool provided by Liquidlogic will enable us to upload the data overnight to minimise the impact on the Live system. This can be used as often as required depending on the number of matching iterations we have to run, which will be determined by the results of the initial data match and the subsequent manual trawl through those records without a match	Bury are almost in a position to run this software. This will be fully available before the matching exercise has taken place once it has been tested
Manual look at	March 2015	This will look at	A manual correction

clients not matched to determine reason and perform corrections to the data where relevant		resolving data quality issue with the data held locally in Bury in order to run the matching process again to clear up those records that aren't matched initially	of the data followed by another run through DBS
Agree ongoing matching process and implement	March 2015	Look at how well the initial matching exercise has gone and develop proposals to run a similar (amend process if required) matching exercise on Protocol clients in Bury on a regular and agreed basis to ensure consistent data and record keeping protocols are adhered to	Review above steps and agree ongoing process

Discussions have taken place through the Healthier Radcliffe pilot about how providers can work together to use the NHS number as the primary identification for patients, this includes the sharing of electronic data and patient held records within patients own homes. The opportunities for honorary contracts are also being explored to overcome any potential governance barriers. Electronic information is also shared through the patient flow systems to facilitate discharges at FGH, this also uses the NHS number as the unique identifier.

From 2015/16 we are confident that the NHS number will be used as the primary identifier within the local health economy across health and social care records.

The information architecture of the Greater Manchester NE Sector clinical portal is predicated on the NHS Number being central to the patient record.

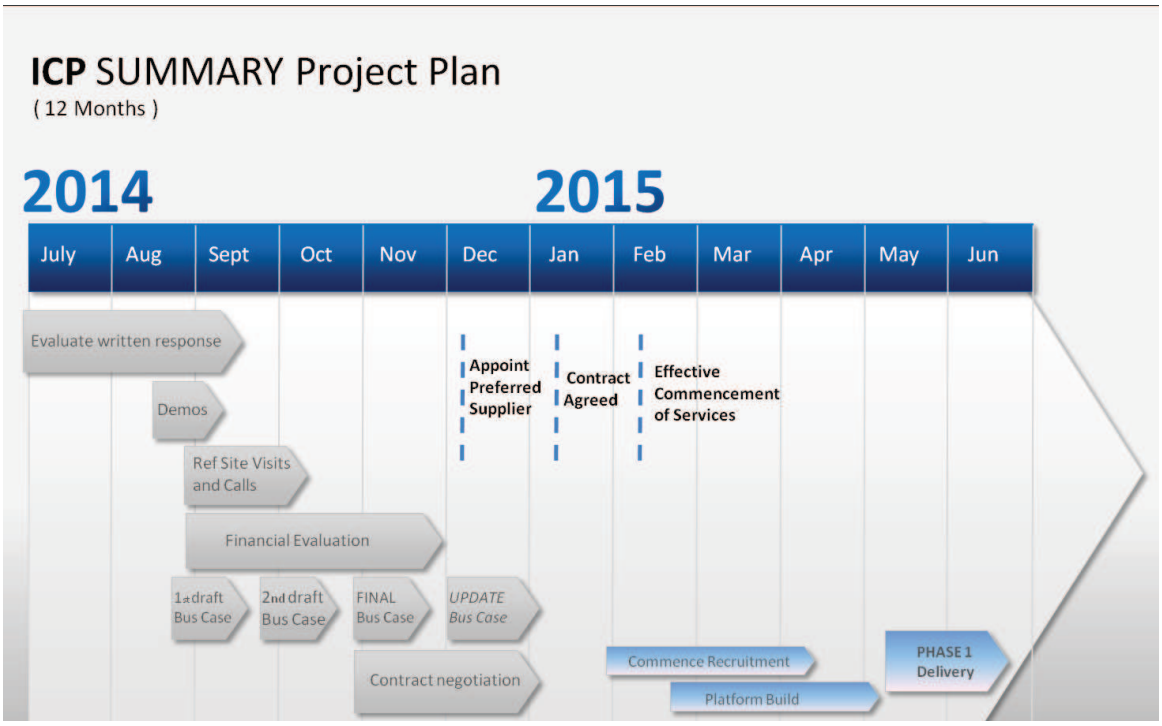
ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

It is proposed that a clinical portal is implemented in order to support an integrated care programme in the North East Sector:

The Clinical Portal will provide a single, integrated point of care system covering the entire continuum of care available whenever and wherever it is required. A clinical portal would allow information from multiple systems to be viewed and updated in a single view and would integrate with organisations' own source systems. The Portal would comprise

information from social services, local government activities, primary, secondary and out of hours care.

It is envisaged that a clinical portal solution could be procured through a government framework over a period of four to six months; the project is still in procurement. Likely milestones are shown below:



The NE Sector Portal (above) will have at its core, an integration engine which will make available a defined minimum data set. The integration is based on mandatory open APIs to ensure interoperability. The suppliers of core applications will use HL7 compliant interfaces. It's not clear currently at what level the Bury LA system can integrate with this at present but the Local Authority will have access to a web-based view. GP systems will provide much of the data and Pennine Acute, Pennine Care and BARDOC out of hours provider) will have a degree of interoperability.

iii) Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

The CCG has a dedicated Information Governance (IG) function and annual IG work programme that incorporates actions to ensure continued compliance with the Information Governance Toolkit to at least the minimum level 2 requirement. This is monitored by an Information Governance Operational Group chaired by a local GP which reports to the Quality and Risk Committee under delegated authority from the Governing Body. The CCG maintains an Information Governance Framework that highlights the governance behind the CCGs approach to IG. The CCG maintains an Information Asset Register and Data flow register, both of which are reviewed quarterly. Information incidents are investigated and reported in line with the HSCIC guidance on SIRI incident management. The CCG has performed a review against the Caldicott 2 requirements,

and will monitor continued compliance on a quarterly basis. An action plan is in place to ensure the CCG reaches and maintains compliance against the Caldicott 2 requirements.

The CCG IG Team is currently supporting the procurement process for the Integrated Care Record Programme for the Borough of Bury and advising the programme on the IG requirements for information sharing to meet the Caldicott 2 recommendations. This programme includes the development of system wide best practice information policies and protocols around interagency data sharing and the legitimate and lawful use of citizen information, and consideration to an appropriate consent model. Upon completion of the integrated care model, training and supporting guidance – including core IG elements – will be provided to all individuals involved in a patient care pathway.

There is recognition of the scale of the task, primarily around ensuring the fluid operability between the agency partner information systems, and suitable I.T. solutions are being procured which will manage and control access via legitimate relationships; sophisticated consent / dissent models and new ways for inter-agency electronic communication. All will be fully auditable and a Privacy Officer function will regularly review use for appropriateness.

There is an Integrated Care Record Information Governance Sub-committee of the North East Sector Integrated Carew programme Board, that advises and guides the programme on all the IG issues associated with a shared record.

The Bury CCG IG Framework is detailed in 1c) related documentation.

The Local Authority has established IG governance structures, which is led by members of the Strategic Leadership team which ensures compliance with both data protection and Caldicott, this also ensure compliance and where necessary developments are actioned to ensure compliance with the information governance toolkit to level 2.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

The Risk Stratification tool that Bury CCG uses is based on the Combined Predictive Model (CPM). From the end of April 2014, the CCG moved to a new version of the tool developed by NHS Northwest. The new version moved to a HRG4 grouped episode, which outperforms the previous model in terms of prediction.

To improve the level of prediction further, Bury CCG has invested in Apollo software to extract data from GP systems. This means that their risk stratification tool has the ability to look at two years of historic data for both primary care and secondary care. The secondary care data includes A&E admissions, outpatient appointments and inpatient episodes. Using the combined data, the CPM algorithm predicts the risk of admission in the 365 days following the 'run'.

A risk stratification pack is sent to each GP Practice on a monthly basis. This data is then reviewed by the GP Practices and a number of patients on the list will be reviewed by a Multi-Disciplinary Team (MDT). This team will review whether a patient would benefit

from, for example, being managed within the community to reduce admissions, the possibilities of using Telehealth or whether a patient with a long term condition would benefit from a referral to psychological therapies. The data also helps to flag patients who might otherwise be missed or to pick cohorts of patients for other more specific interventions.

An example of a specific intervention would be to review patients who are attending A&E with a long term condition of Asthma. These patients may benefit from a review of their inhaler technique or a review of their medication.

All of the above improves the quality of patient care. It also allows Bury CCG to target specific cohorts of patients or to identify opportunities for service re-design.

As part of the submission for the Better Care Fund, an analysis was undertaken to obtain a more detailed overview of Bury's risk profile. The analysis included a segmentation of the risk profile (case management, disease management, supported self-care etc.) a review of long term conditions and review of the risk profile by age group. The analysis showed where further work could be done to deflect admissions. For example: -

- 69 patients with COPD with a very high risk of admission
- 40 patients under the age of 18 at high risk of admission
- 141 patients over the age of 75 at very high risk of admission
- 365 diabetic patients with a high or very high risk of admission

The data also highlights the cohort of patients who would benefit from information on self-care. Further analysis on the risk stratification profile can be found in the Case for Change Section of this document.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Plans for health and social care teams to use a joint process to assess risk and plan care

The local healthcare economy has been working closely to ensure co-ordinated processes for the assessment of risk and care planning. In 2012/13 the key stakeholders, Bury PCT/PAHT/PCNHSFT/BARDOC and the Local Authority joined together to participate in the national Advancing Quality Alliance (AQuA) Long Term Conditions programme. Participation on this program allowed for managers, clinicians and patients to work closely to breakdown historical blockages to system wide care planning. The team developed and implemented plans for patient risk stratification, MDTs and care plans and strategies to promote self care and self management incorporating system wide training on share decision making and motivational interviewing. The relationships, commitment to joint working and progress attained through the above has been the platform to develop further joint processes to assess risk and plan care.

At a system wide level, an analysis was undertaken to obtain a more detailed overview of Bury's risk profile. The analysis included a segmentation of the risk profile (case management, disease management, supported self-care etc.) a review of long term conditions and review of the risk profile by age group. The analysis showed where further work could be done to deflect admissions. For example: -

- 80 patients with COPD with a very high risk of admission
- 138 patients under the age of 20 with a diagnosis of COPD

21 children at high risk of admissions due to asthma

The data also highlights the cohort of patients who would benefit from information on self-care. At a practice level the Risk Stratification tool that Bury CCG uses is based on the Combined Predictive Model (CPM). From the end of April 2014, the CCG moved to a new version of the tool, developed by NHS Northwest. The new version moved to HRG4 grouped episode data whereas the previous model used HRG35. The new model outperforms the original in terms of prediction.

The tool uses 2 years of historic data, both primary care & secondary care (A&E admissions, outpatient appointments and inpatient episodes). The CPM algorithm predicts the risk of admission in the 365 days following the 'run'. Using the above data, a report pack is sent to each GP Practice on a monthly basis. This data is then reviewed by the GP Practices and a number of patients on the list will be reviewed by a Multi-Disciplinary Team.

This team will review whether a patient would benefit from being managed within the community, to help reduce admissions, whether self care strategies such as telehealth could be utilised or whether a patient with a long term condition would benefit from a referral to psychological therapies.

The data also helps to flag patients who might otherwise be missed or to pick cohorts of patients for other more specific interventions. All of the above improves the quality of patient care. It also allows Bury health and social care colleagues to target specific cohorts of patients or to identify if there are any health or social care issues with a specific care pathway.

Across agencies the Bury Health and social care economy have agreed and have started to use the NWAS care plan as the primary care plan for people with LTC and pediatrics, this is currently being rolled out through Healthier Radcliffe demonstrator site. We have established targets to reduce unavoidable admission and attendance at A&E through the use of these plans. Other professional's plans from with specialist or joint MDTs will sit below these.

Under the remit of Vulnerable Adults LES, which is aimed at supporting GPs in their role as accountable GP in improving quality of care for older people; practices will be required to demonstrate the implementation and use of care plans.

Action being taken to remove barriers to joint assessments and planning

Bury CCG has identified Clinical Leads across a number of clinical areas. These clinical act as champions for the CCG and often take a lead in multi-stakeholder discussion aimed at reaching a system wide consensus. The Clinical Lead for Long Term

Conditions has been and continues to be directly involved in discussions about joint assessment and care planning helping to identify and remove barriers as required.

The CCG Clinical Lead for Long Term Conditions also chairs the Bury wide Chronic Disease Management Group, organised by Bury Public Health Department. This group considers direct operational issues preventing progress across a number of areas. Should barriers to joint assessments and care planning be identified this group would help to identify solutions across stakeholders.

As part of the Better Care Fund governance infrastructure there are also a number of multi-stakeholder forums to facilitate discussions should barriers be identified.

The role of accountable lead professional as it is envisaged, such that the patient knows who to contact when they need to and can get timely decisions about their care

Under the remit of Vulnerable Adults LES, GPs are identified as accountable in improving quality of care for older people; practices will be required to demonstrate the implementation and use of care plans. Patient will have an identified named lead in care plans. Whilst we acknowledge a key role of the GP to be part of the co-ordination of peoples care, we are taking a pragmatic approach in that it should be the person who is in the best position to support, either health, social care or other agency such as housing, third sector. Wherever possible we will always support individuals to co-ordinate their own care, providing a true self directed approach.

How GPs will be supported in being accountable for co- ordinating patient centred care for older people and those with complex needs

Under the remit of Vulnerable Adults LES, which is aimed at supporting GPs in their role as accountable GP in improving quality of care for older people; practices will be required to:

- Undertake a local flu campaign
- Stretched targets for Flu for patients aged 65 and over
- Stretched targets for dementia prevalence to 68%
- Review of appointment capacity within Primary Care with a view to benchmarking and setting an average threshold per 1000 patients
- Complete standardised care plans for:
    - all registered patients within Nursing and Residential establishments (including rest bite and mental health facilities)
    - all patients on the practices dementia register
    - any other relevant patients using local intelligence
- Support the coordination/administration of MDT meetings for all patient groups where needed

Care plans will ensure that a coordinated approach to care is taken for the vulnerable including those with dementia and mental health problems. They will ensure that the patient and those involved in the patients care know who to contact in an emergency or to get timely decisions about their care.

MDTs should be designed to support integrated working with all professionals that would

be in contact with patients, with the key aim of supporting patients to have better outcomes through sharing off knowledge and challenges that the individual may have. A key individual should then take responsibility for a patient going forward.

We are piloting the use of a frailty index approach in Radcliffe which will see a MDT including secondary care wrap around individuals. Whilst in other localities this may be used just with older people we appreciate that younger people may also become frail early. Therefore the teams will be working with anyone with a LTC who screens in using the index.

The CCG is committed to developing it services for patient at the End of Life. Improving end of life care is a key priority for Bury CCG, linked to our growing aging population and ensuring people and their families are able to access the care they need, as well as die with dignity in their preferred setting of care.

According to the 2012 ONS data 46.4% of deaths were in the usual place of residence in Bury in 2011/12. This is slightly above the expected England average of 43%, which indicates a satisfactory performance. Bury CCG is continuing to work toward improving eol and palliative care services to ensure that more treatment and deaths are in the preferred place of care (PPC).

Bury CCG working to ensure that the drivers for increasing deaths in the PPC are clearly understood to assure consistent and continuous improvement of end of life care.

In order to achieve this Bury CCG is working to:

- Reducing hospital deaths (end of life) and increasing deaths in the usual place of residence (North West Model and continued implementation of the EoLC tools)
- Increasing GP sign up to the National “Find your 1% campaign”
- All GP Practices to be implementing Gold Standards Framework at level 4 of adoption
- Improving EoLC in Acute Hospitals
- Implementation of the Six Steps to Success in Care Homes Programme.
- Implementation of the Social Care Framework

Consideration of the impact of these systems for people with Dementia and mental health problems

The CCG is developing expertise to deliver a primary care based cognitive impairment service where people with dementia are looked after by the services they are familiar with within their own community setting, which will ensure continuity of care. Currently the Memory Assessment Service (MAS) is responsible for diagnosing patients with dementia. The current service will be re-organised to use its expertise to support more complex patients and to provide consultation and support for primary care clinicians to diagnose, assess and manage non-complex patients and provide more holistic, care in the community.

The Dementia Adviser Service (DAS) works alongside the MAS with the vast majority of its referrals coming from the MAS. The DAS and MAS will work more closely to achieve its aims of providing information, promoting independent living, reducing service users’ sense of isolation and helping reduce A & E attendances.

A wide multi-agency stakeholder group with clinical and managerial representation from

primary and specialist care, consultant and third sector is developing the re-designed pathway. As part of the CCG £5 per head of population funding incentive, practices will be required to demonstrate care plans on all patients with dementia, ensure achievement of 68% prevalence rates for dementia diagnosis and ensure the re-designed is adopted and that a skilled workforce is in place to deliver the pathway. An MDT approach will also be adopted for this patient group.

Closer links as a result of the new pathway between general practices, the Dementia Adviser Service and A & E will help identify patients with dementia and their carers for whom additional support, advice and signposting is required and ensure coordinated care planning, which could help to prevent unnecessary A & E attendances.

Within the risk stratification work being undertaken in General Practices there will be a focus on people with Dementia. A priority will be to improve the diagnosis rate for people with dementia. The work underway includes:

- Working with the Data Quality Team and GPs to search GP systems to identify patients with Dementia who may not have a formal diagnosis.
- Working with the MAS and GPs to ensure sharing of information where a diagnosis has been made to ensure patient records are updated. .
- Programme of work to monitor prevalence at practices and through the Clinical Lead offer support to those practices with low prevalence rate.
- Identification of a named prescribing clinician to be the practice's dementia lead
- Training for dementia leads in order to develop a skilled workforce within primary care with the competencies to detect, investigate and manage patients with non-complex dementia, mirroring the way practices manage other long-term conditions
- Every patient in a nursing home will have a named GP and care plan which includes a Dementia Screen
- Support implementation of the National Dementia CQUIN.

Once a person has a diagnosis of Dementia they will be placed on risk register and offered a key worker.

We are building into the Domiciliary contracts a specific clause about training on dementia awareness and minimum standards. This training will be made available through the Local Authority Training Partnership, as part of the domiciliary care tender in the first instance.

In the Community Services Specifications there is an expectation that providers will create a Dementia and ASD 'friendly' environment and ensure staff have generic mental health skills to recognise and manage common mental health problems found frequently amongst patients with long-term conditions and dementia (and its concomitant impact on readmissions). All staff will need to be fully aware and up to date on where and how to access mental health services on behalf of their patients.

We plan to increase our support options through the review of reablement and intermediate care services ensuring that people with dementia are offered equal access to the support and advice available to all.

The Radcliffe Demonstrator Community is providing us with an opportunity to particularly focus on testing out aspects our multi-disciplinary working within one locality in Bury along with our partners.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

- Last years DES (Risk Stratification Process 229 patients were discussed as part of the MDT process and where applicable a joint plan was created)
- Unplanned admissions DES (2% of high risk of admission adults will receive a joint care plan, the numbers of which have been completed to date are not available)
- Accountable professional LES (Under the remit of £5 per head it is envisaged a further 2970 plans are likely to be put in place)
- Nursing home LES (Since the LESs implementation in April 2013 542 Care Plans have been created (482 in 2013/14 and 60 from April 2014 to date)
- A pilot is commencing on 1st September in Radcliffe to implement community care plans for 50 people in Radcliffe as part of a Healthier Radcliffe. The people who will be involved in the pilot are deemed to be of high risk of a hospital admission. There will be a multi-disciplinary approach to the development of the pilot and implementation of the care plans. The team will involve District nurses, GPs, North West Ambulance Service, Bardoc, Social Care staff and out of hours District Nurses.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

NHS Bury CCG and Bury Local Authority continues to work with other key partners on the development of a strategy for communication and engagement linked to their wider integrated care plans. Our vision is that:

Local people can improve their own health and wellbeing and that of those around them and are continually involved in improving health and care services.

Our objectives are:

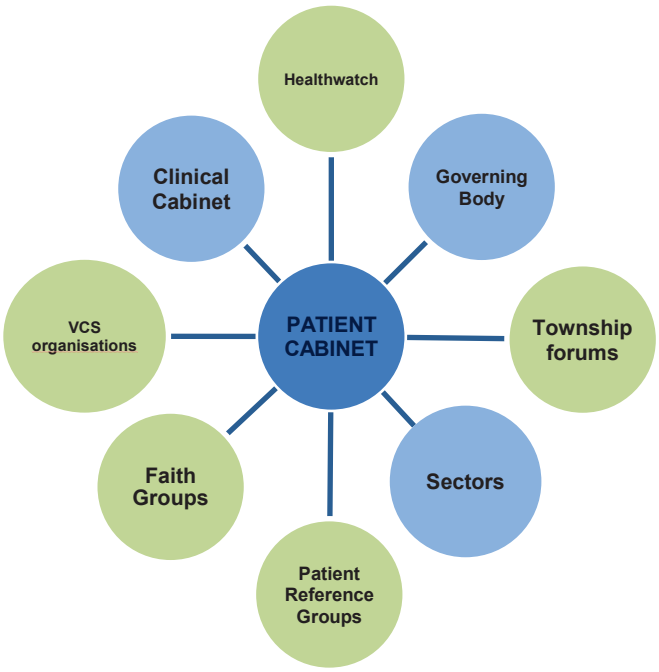
- Local people understand the need for change and own the plans to transform local health and care services
- Community Champions harness the views of local people to shape strategies and plans
- Services are designed with local people
- Local people can manage their own health on a day to day basis
- Local people can get involved in delivering services to improve health and quality of life
- Local people make informed and appropriate choices to meet their needs
- Local people are treated as partners in their own health and care - no decision about me without me

This strategy builds on an established commitment to patient, service user and public engagement that also underpins the Better Care Fund proposals described. A number of existing mechanisms have been deployed to engage patients, service users and members of the public in the development of the Health and Wellbeing Strategy, the Joint Strategic Needs Assessment and local health and social care integration plans as well as redesign and development of specific services for example, the CCG's Patient Cabinet, Adult Social Care Task Force and Township Forums. These on-going conversations have all informed the development of the Better Care Fund plan.

CCG Patient Cabinet

NHS Bury CCG has sought to develop an integrated approach to Patient and Public Involvement. This has happened by hard-wiring patient and public voice into the structure of the CCG with the development of a Patient Cabinet. The Patient Cabinet is a group of local people from a range of backgrounds who themselves use local health services. The Patient Cabinet has a key role in ensuring meaningful involvement and engagement with local people and communities - gathering views and feedback and making sure that people have a chance to feed into and actively participate in the CCG's consultations and service planning. Through the Patient Cabinet the CCG aims to ensure that services it commissions are geared around the people who use them and that decisions take into account local views.

Figure 13



Members of the Patient Cabinet have grass roots connections within their local communities and the Cabinet is developing a work plan, which dovetails with the work of the wider CCG. As a formal sub-committee of the CCG's Governing Body (Board) it meets on a monthly basis, and issues raised through the Patient Cabinet have a direct route into the Clinical Cabinet and the Governing Body via its Chair, who is a non-executive director.

In turn there has been a process of building links and strengthening relationships between the Patient Cabinet with a network of organisations and community groups including GP practice based patient forums.

Bury's integration plans reflect the much of the feedback given by patients in a small scale patient survey designed and delivered by Patient Cabinet members in February 2013. Thematic content analysis showed that immediate priorities for patients included:

- Better access to primary care
- More GP appointments
- Shorter waiting times

In the longer term respondents identified priorities including:

- Having access to a wider range of treatment and care services in GP surgeries
- 7 day and evening access to local GP services
- Better services for chronic and long term conditions
- Better access to services for disabled people
- Improved mental health services
- Improved cancer and palliative care

Respondents were critical about:

- Current access to primary care
- Having to go to multiple (hospital) sites for treatment
- Disjointed NHS services

In October 2013 the Patient Cabinet provided feedback on the vision and high level plans for the delivery of integrated care in Bury and in November 2013 the Patient Cabinet had the opportunity to comment on the draft commissioning intentions for 2014-15. Further sessions with the Patient Cabinet on the Bury model and plans have been shared in February, March and latterly September 2014.

NHS Bury CCG has implemented an approach to service redesign which involves members of the Patient Cabinet working closely with clinical leads to develop and implement plans and many of these are integral to the overall delivery of integrated care.

The Cabinet and its members have been involved in a number of projects including:

- The development of proposals for new glaucoma and minor eye conditions pathways
- Workshops with local clinicians to identify innovative ways of reducing unnecessary A&E attendances
- Providing early feedback on emerging models for the re organisation of acute hospital care in Greater Manchester – Healthier Together; and from July 2014, the Healthier Together public consultation
- The development of public health plans to improve prevention and self-care
- Several work streams relating to the improvement and better integration of services for people with long term conditions including asthma, diabetes and mental health
- Input into the development of community health service specifications and planned involvement in the tender evaluation process.

We consulted with the Patients Cabinet on 4th September 2014 on the progression of the patient /service user metric and sought their views on the approach that should be taken to this.

Adult Social Care Customer Task Force

The Adult Care Customer Task Force (previously the Service User Panel) is a group of volunteers made up of customers and carers who receive services from Adult Care and/or Six Town Housing. The group meets three or four times a year but can be contacted via post or telephone up to six times a year.

The aim of the group is to involve customers in developing and shaping future care services, so we can make sure our services meet the needs of our customers.

A number of different interactive workshops are run at each meeting, designed to make the topics easy to understand and interesting to all parties. These will be consultations or changes to services which are being planned at that time.

Examples include:

- **Self Directed Support** – members designed collages of what is important to them to help them understand personal budgets and support planning, as well as informing the team on the requirements of customers

- **Adult Care Connect and Direct** – members were involved in the design of the reception including choosing the furniture for the Assessment Room, telling us which services they would like to invite for drop in sessions in the Green Room and whether Customer Advisors should wear uniforms
- **Website** – members tested our website and told us whether it was easy to use. They also made suggestions on how it could be improved

From the events 'You said, We did' documents are produced which shows what has been done from their suggestions. This has proved a valuable tool in showing the members that they are at the centre of our services and they have really made a difference.

On Wednesday 3rd September 2014 we asked the customer task force to get involved and find out about how we are joining up Health and Social Care services in Bury and the role of the Better Care Fund in this.

Township Forum

There are six Township Forums covering the Borough of Bury. Each Township Forum consists of all the councillors representing the area and a co-opted advisory group of local representatives from the business community, voluntary organisations or community groups within the area. Each area forum meets every two months at local venues, in places such as schools and community centres. All area forum discussions are fed back to the council for appropriate action. Presentations on health and social care reform have been undertaken with all Township Forums.

Healthier Radcliffe Demonstrator Community

This project is the test bed for approaches to the provision of 7 day a week access to primary care and integration of community based services from which lessons are being learnt for wider roll out across the Borough of Bury. Patient, Service User and Public Involvement is fundamental to the design and delivery of this project.

A member of the Patient Cabinet played a key role in the development of the bid and the subsequent implementation of the Healthier Radcliffe Demonstrator site working alongside officers from the CCG, the local GP Federation and local GPs. Involvement was in both the implementation and operational groups which are driving the project It was also in the development of a communications and engagement strategy to support the development of a 'super Patient Representative Group' which will bring local patient groups together as part of the programme of practice and wider health and social care integration.

Information about the Radcliffe Demonstrator pilot and the wider vision for integrated care has been shared with patients and the wider public via the Bury CCG Patient Cabinet (Oct 2013); the Radcliffe Township Forum (Nov 2013); at a public launch of the Patient Cabinet (Oct 2013) and with Healthwatch Bury (Feb 2013) and the Jewish Care Forum (Jan 2014). In addition, information about the enhanced services has been shared amongst the patients affected by the investment (within the 6 GP practices taking part in the pilot), some 34,000 patients in total, and with the wider community through the press and media, attracting national media attention. Lessons learnt from these approaches will be applied to patient; service user and public engagement work in the rest of the borough.

Health & Wellbeing Strategy Consultation

The consultation highlighted that the priorities for patients, service users and the public are on prevention, early intervention and self care, informal support to stay well and maintain independence, joined up working between partners and professionals and asset based community development. Our Health and Wellbeing Strategy and subsequent Health and Social Care Integration plan have been built on and strongly reflect these themes.

Healthier Together Consultation Events

Reconfiguration of hospital-based services is being led at a Greater Manchester level by NHS England through a programme called 'Healthier Together'. The public discussions began in August 2012 and involved a series of patient groups, members of the public and representatives from the community and voluntary sector. The aim was to recruit patients to a series of patient panels to support the public discussions leading up to the anticipated public consultation in Spring 2013.

The first phase of the discussions branded as 'The Conversation' commenced in August and continued until October 2012. The discussions with our patients/public for the first phase were focussed on the broad rational for change. The remainder of the 'The Conversation' will be separated into Phases Two and Three and will focus on the models of care and option development. By adopting a phased approach, we will be able to tailor messages and materials that dovetail with each of the programme steps; it will also allow us to obtain specific feedback and outcomes.

An event was held in Bury in October 2013, and involved in a range of interactive discussions. A range of presentations and question and answer sessions were delivered by clinicians leading the Healthier Together Programme, clearly demonstrating the clinical leadership and strong commitment for delivering the programme in partnership with clinicians, patients and key partners.

The majority of participants understood and agreed with the proposed changes emphasising the need for more emphasis on prevention and self care, easy and quick access to primary care and access to senior medical opinion. However there were some caveats that we are also taking into consideration in our plans such as the need for better discharge planning and access to information about sources of support.

During spring 2014 a round of engagement discussions took place to secure feedback on the proposed model for hospital reconfiguration. 120 local people and in addition 80 carers participated in discussions. From July 2014, Healthier Together entered its formal public consultation phase, and an extensive engagement programme has been prepared to gather views and feedback from patients and the public about the proposed changes and what is important to them, this will run until 30th September 2014.

CCG Engagement on its 5 year strategy

During the Spring, the CCG supported by Bury Council held three engagement events: two for members of the public and patients and one with the voluntary community sector with a focus on the CCG's five year strategy including plans for better integration of health and social care moving forward. Feedback generated key themes and intelligence about what works well, what could work better and what is missing. The feedback was analysed and a "you said, we did" report was prepared and included within the summer issue of the CCG's public newsletter, Health Matters. 50 patients attending the events,

and 22 voluntary community sector organisations were represented. Recurrent themes in consultations on health priorities and service provision include an emphasis on prevention, support to maintain independence, better access to primary care and joined up care; accessibility of services; good and reliable patient transport; better integration of voluntary and community services; meeting the faith needs of people in adult residential care and the need to keep the health and social workforce on board with changes through good communication and workforce development. Concerns were also been expressed about the capacity of community-based care to manage shifts in activity from the acute sector. There are also worries about quality of care with for example people being worried about being left isolated at home, being put to bed early and not having access to support overnight. Bury's Third Sector assembly have been briefed about integration developments to date along with seeking views on the BCF plan on 8th September 2014.

Our Place

We have recently been successful in the '**Our Place initiative'** – which aims to give people more power over local services and budgets in their neighbourhoods, transforming public services by making sure they are focussed on the user, not the organisation. As a result of our successful bid we will receive a grant from the Department of Communities and Local Government as well as support over a 2 year period. The funding and support will be directed at the community engagement and empowerment element of the Healthier Radcliffe Demonstrator project.

Our **vision** for this initiative is as follows:

Local people can improve their own health and well-being and that of those around them and are continually involved in improving heath and care services.

Our **objectives** are that local people:

1. Understand the need for change and own plans to transform health and social care services
2. Community Champions harness views to shape strategies and plans
3. Services are designed with local people
4. Manage their own health and wellbeing on a day to day basis
5. Are involved in delivering services to improve health & wellbeing
6. Make informed and appropriate choices
7. Are treated as partners in their own health & care

A community event took place in May 2014 as part of this development and was well attended by people who live and work in Radcliffe. The focus of the event was to undertake a visioning exercise for Our Place in Radcliffe. The meting began the process of understanding what is already available in Radcliffe that we can harness to improve health and wellbeing. We started to identify where resources are already being used across the statutory, voluntary and community sectors in Radcliffe. Our ambition is to build on this work as part of our operational plan including further community engagement work and events in Radcliffe. A storyboard was completed at the event to capture our discussions, which will be used to underpin future work, and this can be found in Appendix 4. We have designated the Radcliffe Township Co-ordinator to drive this initiative in conjunction with local people and organisations. The actual development strategy can be found in 1c) related documentation.

Future Developments

We are planning to expand on the work to date by working with the newly formed local Healthwatch for example to engage more with 'protected' and harder to reach groups and with Bury's Third Sector Development Agency to enhance volunteering and community group involvement in the design and delivery of our plans. The CCG is planning to undertake regular engagement events throughout the year to ensure that engagement and involvement in its work is maintained. The CCG is also investing time and resources into a tool known as My NHS. This is an online engagement tool which will enable people interested in being involved in the work of the CCG to sign up to a virtual *community of interest*. This will help the CCG to target it's engagement in a more bespoke way moving forward. We have established a 'Community Engagement for Health' work-stream within our governance structure led by the Director of Public Health focused specifically on further developing our work around patient, service user and community engagement. This will focus on widening participation in consultation and planning work and strengthening engagement in self care and service delivery though embedding of the Greater Manchester Community Based Care Standards, patient education, co-production and asset based community development approaches. The following table shows the approach being taken:

Table 6

Planning	• Co – produced branding • Extend reach of 'The Conversation' • Develop and extend effective service user groups • Establish mechanisms to link into strategic planning
Delivery	• Making every contact count • All together Better – 'Right Conversations' • Living well academy • Helping yourself to Health • 'Eyes Wide Open'
Community wellbeing & resilience	• Asset Based Community Development • Community Champions Network • Community Learning Partnership • Community & Vol sector – U3A, Age UK, Contact the elderly, Silverline, Dementia friends. • Five ways to Wellbeing • Bury Directory

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Pennine Acute Hospitals NHS Trust (PAHT) is the main provider of acute healthcare services to the population of the North-East sector of Greater Manchester. Bury is one of the Trusts four main commissioners of the Trust's services, the others being Heywood, Middleton and Rochdale CCG, NHS Oldham CCG and NHS North Manchester CCG. Bury CCG acts as the lead commissioner on behalf of the other three CCGs.

Commissioner Better Care Fund plans are set in the context of a wider programme for reform across acute, primary and integrated care across the North East Sector which includes the 'Healthier Together' acute configuration across Greater Manchester and the aggregate impact of its commissioner Better Care Fund plans. PAHT is embarking on a comprehensive clinical services transformation programme which will enable it to develop a sustainable clinical and financial model, in the light of this wider reform.

Bury CCG issued commissioning intentions around integrated care, to Pennine Acute Health Trust (PAHT) in October 2013, which highlighted the level of activity shift that would be required from the acute to the community sector. The CCG has identified a 20% reduction in non-elective activity by 2018/19. Plans for year one have been built into the contract for 2014/15 and the trust has reduced its capacity accordingly, plans for year 2 will be built into commissioning intentions for the 2015/16 contracting round.

A Pennine Acute Transformation steering group has been established to oversee the transformation programme at the Trust. The steering group meets fortnightly and comprises of executive level membership across all commissioners and the provider. CCG and PAHT Financial Analysts are working on an integrated finance plan at a Greater Manchester and North East Sector level to ensure that that financial and activity modelling across provider and commissioners is aligned.

The CCG and PAHT are developing a programme of shared monitoring to ensure any risk to delivering activity reductions is identified immediately and can be acted upon. PAHT is developing its five year Business Plan to move to Foundation Trust Status. Across the North East Sector of Manchester, the CCGs are working together with PAHT to ensure all activity assumptions around integrated care are reflected in this plan. The reduction in activity PAHT will expect to see across the North East Sector of Greater Manchester is significant and will not be realised without a significant change in the way their services are delivered. Options for change are currently being considered by PAHT and the CCGs, which deliver the activity reductions whilst ensuring PAHT is economically stable. The Trust Development agency and NHS England are partners in the planning.

The CCG commissions Mental Health and Community services from Pennine Care Foundation Trust (PCFT). It is clear more investment will be needed in these services to deliver integrated care in the community. Executive meetings take place with Pennine Care Foundation Trust around the longer term strategy and impact of integration on a monthly basis and PCFT are members of the North East Sector Integrated Care Board

and local Co-ordinated Community Based Care Group. PCFT have agreed to redesign their services to support the Integrated Care Model and already work in partnership with PAHT to deliver more integrated models of care in Sexual health and Diabetes pathways (which includes traditional secondary care services being delivered in the community).

Provider Partnership

A workshop has recently taken place with providers to further explore partnership working and the sharing of the Better Care Fund plans.

Representatives from the following organizations were invited/attended the workshop:

- Pennine Acute
- Pennine Care
- CCG
- Local Authority
- Bardoc
- Bury GP Federation
- NWAS

The purpose of the workshop was to focus on how we can work together to deliver integrated care in Bury with a specific emphasis on the Better Care Fund plan. The programme for the session was constructed around the desired workshop outcomes relating to how:

1. we can better engage across all partners
2. partners can work together to support delivery
3. the whole system can give the assurance required that integration will deliver efficiencies
4. partners will have a shared approach to delivering on the specific Better Care Fund schemes
5. we establish a shared methodology of monitoring success
6. we can agree a shared approach to the assessment of current and future capacity and workforce issues
7. we can enable provider readiness at scale and pace
8. we can reach a shared understanding and ownership of the risks and mitigation involved

The discussion at the workshop then considered:

- The key challenges facing providers;
- Thoughts around how providers can develop a shared approach to engagement, assessment of current and future capacity, delivery of Better Care Fund (BCF) Schemes, and working together;
- Agreement on how providers can envisage an assurance framework operating, how BCF schemes can be monitored, how can achieve state of readiness required and key risks involved to the above; and
- Key actions ahead of a future meeting

A follow up meeting has recently taken place with actions arising from this meeting relating to:

- Future arrangements for setting up the Provider Partnership
- Securing an independent chair
- Progressing a media campaign and education sessions for patients
- Approach to whole system leadership
- Alliance contracting
- Establishing an integrated workforce subgroup

The outputs and action plan relating to the above are embedded below


Bury Provider Partnership Worksho


Bury Provider Partnership Worksho


Action Plan.doc

The Pennine Acute Hospital Trust have completed the Annex 2- Provider Commentary to indicate that they have been meaningfully engaged in discussions in regards to the Better Care Fund Schemes.

Pennine Care NHS Foundation Trust has also written to confirm their support of the Bury Plan and acknowledge that they have taken part in a number of Bury Partnership meetings held over the last few months in order to discuss the plan.

ii) primary care providers

As previously stated providers' are working together on the Radcliffe demonstrator site and are testing a number of initiatives for wider roll out subject to successful evaluation. These support the BCF objectives and the delivery of the targets we have set.

The development of Primary Care is central to our reform of services to deliver integrated care and we have had a number of workshops with the CCGs sectors to share this model. Each of the four sectors in Bury has been developing their vision for integrated care. There is an active GP Federation and 30 of the 33 General Practices in Bury, are members of the federation. The work the CCG members did through the sectors and the establishment of the GP Federation, culminated in the West sector being ready to bid to become one of the Greater Manchester Demonstrator Communities, delivering a programme called 'A Healthier Radcliffe'. This is a provider led system reform programme involving six GP practices covering 3 wards of Bury, from which learning can be rapidly rolled out across the rest of the Borough. Each of the four sector clinical leads has a seat on the Bury Co-ordinated Community Based Care Group to ensure Primary Care is represented.

The Bury GP Federation also has been successful in its bid for the Prime Ministers Challenge Fund, to roll out the above programme across Bury. The programme will cover four main areas:

Extended hours - longer opening hours including:

- - Weekday opening (8am to 8pm), and
- - Saturdays and Sundays (8am to 6pm)

Tele consultations

- To ensure that all patients who request an appointment are offered the option of a telephone consultation

Increased Online Access

- To increase use of online services from the current 4% of patients to 60%+

Development of a "GP-Comparison" website

- To enable patients to make better choices about GP services

The CCG is in the process of a series of workshops with all GPs to work up the mobilisation of the named GP for the over 75 year old population and investment to provide enhanced services to vulnerable older people. This explicitly links to the wider integrated care plans and will enable delivery of the outcomes agreed through the Better Care Fund.

iii) social care and providers from the voluntary and community sector

The CCG and Local Authority are committed to maximising the use of the Third Sector within the integrated care plan. The Strategic Commissioning Group will be developing the shape of the community model by the end of September, to inform commissioning plans for year beginning 1 April 2015.

Third Sector Development workshop took place in September 2013 where we outlined Bury CCG's priorities and approach to integration as well as highlighting opportunities for the Third Sector.

The CCG has undertaken an open market development day where we are introducing the third sector to larger health care providers. We hope this stimulates larger providers to work with our third sector when developing their services or tendering for new business.

Hospice care is developing within Bury and plans are in place for provision of a children's hospice called 'Graces Place'. The CCG will ensure that services offered by Graces Place are integrated into local pathways.

High-level consultation with social care and housing providers has taken place to date around the specific integrated health and social care agenda and the expected changes resulting from it as part of the Radcliffe pilot. The initial outcomes from the Healthier Radcliffe pilot are awaited before designing a wider model with the understanding of which types of providers would be needed as part of borough-wide integrated services. It is for this reason that the engagement of social care and housing providers has been high level, until we can be clear exactly what we want from them in terms of longer term support. We are already working with domiciliary care providers around locality based delivery as part of the ongoing tender process.

The providers of both assessment and Reablement services have been heavily involved in the development of our integration plans and are leading the stage 2 implementation of Healthier Radcliffe Social Care. It is recognised that these elements of social care have a direct impact on reducing hospital admissions, and to this end they have been working with both.

Adult Care Services engages with social care and housing providers on a regular basis, through provider forums, specific events and workshops regarding the co-production of strategies and other strategic documents, and there is ample opportunity to engage with providers in a meaningful way to work with us on the specifics of a new model. A number of events to engage social care, housing and 3rd sector providers specifically will be planned to support the design of models of care that will meet the future care needs of the people of Bury.

We are planning a provider event later in the year to look at the implications of the Care Act, Five Year Strategy and the BCF. We have started discussions through a number of avenues e.g. community based care group, resilience planning and urgent care network board about the creation of alliance models for the future. This would also allow for greater risk sharing across providers.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- **What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?**
- **Are local providers' plans for 2015/16 consistent with the BCF plan set out here?**

Health and social care services are under unprecedented financial pressure and it is known that this will increase in coming years. This is one of the key drivers for change in order to avoid services becoming steadily less sustainable.

The strategy adopted by the Bury economy is to reduce the reliance on hospital based services and support people in their local community to maintain their independence for as long as possible. It is therefore envisaged that there will be a reduction in the use of acute hospital care, in particular for those people with complex needs and multiple long terms conditions. The shift away from hospital based care and the development of primary, community and social care will inevitably lead to a reduction in bed utilisation by avoided admissions and by reduced length of stay (activity will decrease but length of stay will possibly increase as the acute sector deals with a more complex patient spectrum) and will therefore lead to bed reconfiguration and a related reduction in income and expenditure for the acute trusts.
Bury CCG has issued commissioning intentions around Integrated Care to Pennine Acute Health Trust in October 2013 which highlighted the level of financial resource transfer that would be required from the acute to the community sector.

The CCG and Council have identified a 20% reduction in non elective activity by 2018/19. Plans for year one reduction have been built into the contract for 2014/15 and the trust has plans to reduce its capacity accordingly. The CCG and PAHT are developing a

programme of shared monitoring to ensure any risk to delivering activity reductions is identified immediately and can be acted upon.

The financial plan and business case for the integrated care models have to be developed in the context of the anticipated financial position for the Council and the Clinical Commissioning Group over the next five years. The health and care sector challenge has been widely communicated across the Manchester health economies. The significant task of reducing and managing the CCGs and Councils financial pressures together with delivery of Pennine Acute Cost Improvement Programme, is being addressed through a variety of inter-dependent programmes:

- Healthier Together
- Integration of Health and Social care
- Primary Care Strategy
- Other 'Quality, Innovation, Prevention and Productivity' (QIPP) schemes

The development of the business case for integrated care in Bury sits within the context of the above. These programmes are being managed effectively in a coordinated way. Recognising the range of initiatives running in parallel and the on-going modelling work for each, the precise implications for the acute (and other) sectors are not fully developed or quantified at this stage. Work has been undertaken however to ensure that assumptions remain consistent between the various aspects of planning. The final financial models will include the recurrent cost of delivery, implementation costs and anticipated transitional support. They will also set out the efficiencies expected to be achieved and other benefits realisation plans.

A series of strategic financial planning assumptions have been agreed with key partners. These reflect the activity shift assumptions expected to be delivered through the above programmes over the planning period, as well as acknowledgement that reinvestment will be required in the community and other services to secure reductions in hospital capacity. Mitigation for non-achievement will be identified and agreed as part of this.

Partners recognise that prior to implementation of the new ways of working outlined in the Integration plan; business plans and supporting cost benefit analysis will be carried out to assess the feasibility of models, in terms of quality and outcomes, patient experience, and cost effectiveness. It is also acknowledged that a range of transitional costs will be incurred as the health and social care systems respond to the new approaches.

The timing and level of investments required (recurrent, non-recurrent and transition costs) will be driven by the pace of development of the Greater Manchester and Borough wide programmes.

Pennine Acute Hospital Trust is developing its 5 year Business Plan to move to Foundation Trust Status. Across the North East Sector of Manchester the CCGs are working together with PAHT to ensure all known activity assumptions around the Healthier Together, Integrated Care, Primary Care and QIPP schemes are reflected in this plan. The reduction in activity PAHT will expect to see across the North East Sector of Greater Manchester is significant and will not be realised without a significant change in the way their services are delivered. Options for change are currently being considered by PAHT and the CCGs that deliver the activity reductions, whilst ensuring PAHT is economically viable. The Trust Development Agency and NHS England are partners in

the planning and final decisions will be informed by the Greater Manchester Programmes. Due to the complexities referenced above it will be necessary to undertake much more detailed work with the Acute Trust over the next 2-3 months to understand the impact over 5 years. This commitment has been included in the Memorandum of Understanding that has been agreed for the 2014/15 contract.

There will be a significant financial risk to the Commissioners and Health Economy if the ring-fenced resources in the fund cannot deliver change on the scale expected.

The significant risks are:

Risk	Mitigation
If activity does not reduce in line with projections, the Trust will not be able to reduce activity quickly enough to deliver the sustainability model required for their Integrated Business Plan. This will result in CCGs paying for the activity commissioned in the community and the activity delivered within PAHT	The CCG will be looking for innovative funding models to support money following the patients, with some shared risk mitigation strategies with all providers The CCG and the council have set some short term contingency in the Better Care fund to mitigate this in year one but this is a long term strategic risk which will be better known once the detailed financial planning has been finalised
PAHT remove the capacity that the CCG and Council say will be deflected into the community and the activity continued to go to the Trust. This will result in significant service risks	The CCG and Council will adopt a turnaround mentality in monitoring success of these schemes. Monthly cross-organisational monitoring sessions will be established and risks to non-delivery will be identified early and contingencies put in place. Schemes will be piloted first and if they are not delivering they will be stopped and the resource used to fund the over performance in the acute trust
A&E target 95% of people seen within 4 hours The delivery of a reduction in A&E activity will result in patients with low level need being seen in Primary Care. This will impact on the Trusts ability to deliver the 4 hour target as they will have to reduce staffing, but the more complex cases will take longer to process through the department	The CCG and Council will review ways to deliver services in an integrated way with A & E that continue to support delivery of the standard

Finally, it is clear that all parties are committed to developing and implementing an end to end pathway redesign across the health system with the Trust having already invested in some resource to facilitate this. We will explore the opportunities that this agenda presents to consider the role of the acute sector as part of a truly integrated health system.

Bury Health & Social Care Workforce

The consequences of the Health & Social Care reform will, inevitably, not only affect the current workforce but will have huge implications for future workforce. The Five Year Forward View makes it clear that 'New Models of Care' won't become a reality without the people to deliver them. Health Education England's (HEE) Workforce Plan for England-Investing in People 2015/16 requests that partners work with HEE through the national Workforce Advisory Board and encourages employers to provide robust workforce forecasts to Local Education and Training Boards (LETBs).

Bury Provider Partnership comprising representation from all organisations across the health and social care system has agreed to work collaboratively to develop a system-wide workforce with the skills, knowledge and experience essential to support the new service delivery models of care required.

A whole systems approach has been adopted through a multi-organisational, multidisciplinary workforce group.

The Bury workforce group is working in partnership with Health Education North West (HENW) and has representation on the Greater Manchester Integrated Care Workforce Collaboration Group.

The workforce group aim to:

- Engage service users and ensure that the service user is central to workforce transformation
- Involve key stakeholders at all stages
- Ensure that plans are aligned to the wider workforce strategies including Healthier Together
- Assess current and future workforce required
- Retrain existing in addition to training new staff
- Retain and appropriately reskill the valuable human resource within the Borough
- Clarify and support new roles and responsibilities
- Consider new cross boundary roles
- Deliver the benefits of team work

The Bury workforce group recognise the need for data to be shared with all sectors to enable analysis and identification of issues across the whole system. To contribute to a 'complete picture', all providers are currently in the process of providing workforce data for inclusion in the Workforce Repository and Planning Tool (WRaPT) which has been recently commissioned by HENW. The provider partnership recently received a presentation of functionality of the tool and appreciates its potential to inform current and future system-wide workforce planning.

Many primary care providers in Bury responded to a survey of primary care workforce undertaken by Health Education North West, the Bury analysis report is embedded below. This information will be further augmented when other provider workforce data has been uploaded to WRaPT.

Primary Care Workforce report Bur

Whilst the responsibility to commission education and training places to secure the supply of the future workforce rests with HEE, it is apparent that at the same time, skilled staff are being lost from the system in some areas. Bury workforce group acknowledges that the most effective approach is to retain the current workforce; therefore, partners will ensure they focus on retaining skilled staff. Analysis of current and future workforce will include retention data and issues, findings will inform the development of strategic and cost-effective approaches to staff retention.

The partnership is currently developing a collaborative bid for submission to HENW to become an 'Integrated Care Workforce Demonstrator site' to contribute to the learning and evidence base of the workforce implications of integrated care and associated workforce initiatives. Success in achieving demonstrator site status will enable dedicated resource in Bury to maintain focus on developing an appropriate workforce to make the clear service vision provided in the Five Year Forward View a reality.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

Appendix 1 - Impact of schemes Metrics Mapping

		Metric 1 - Residential Admissions		Metric 2 -Reablement		Metric 3 -Delaged Transfers of Care		Metric 4 -Avoidable Emergency Admissions		Metric 5 - Patient experience	Metric 6 - Local metric - Falls	
Scheme	**Scheme Description**	%	Nos of people	%	Nos of people	%	Nos of people	%	Nos of people	%	%	Nos of people
BCF01	Staying Well	10%	1	0%	0	0%	0	5%	49	20%	5%	2
BCF02	Extended access to Primary Care	10%	1	25%	2	5%	13	30%	296	20%	5%	2
BCF03	Integrated Health & Social Care	35%	2	30%	2	15%	39	30%	296	20%	20%	8
BCF04	Care of Vulnerable Adults	35%	2	5%	1	15%	39	30%	296	20%	20%	8
BCF05	Integrated Intermediate Care, Reablement and other related services	10%	1	40%	2	65%	167	5%	49	20%	50%	21
Total		100%	7	100%	7	100%	258	100%	986	100%	100%	41

Annual change in admissions -7
Annual change in admission % -3.2

Annual change in proportion 1.3 (equate to 7 people)
Annual change in proportion % 1.5%

Annual change in admissions -258
Annual change in admission % -10.7%

P4P annual change in admissions -986 P4P annual change in admissions % -5%

Annual change in emergency hospital admissions for injuries due to falls (65+) -41 Annual change in emergency hospital admissions for injuries due to falls (65+) -6.7%

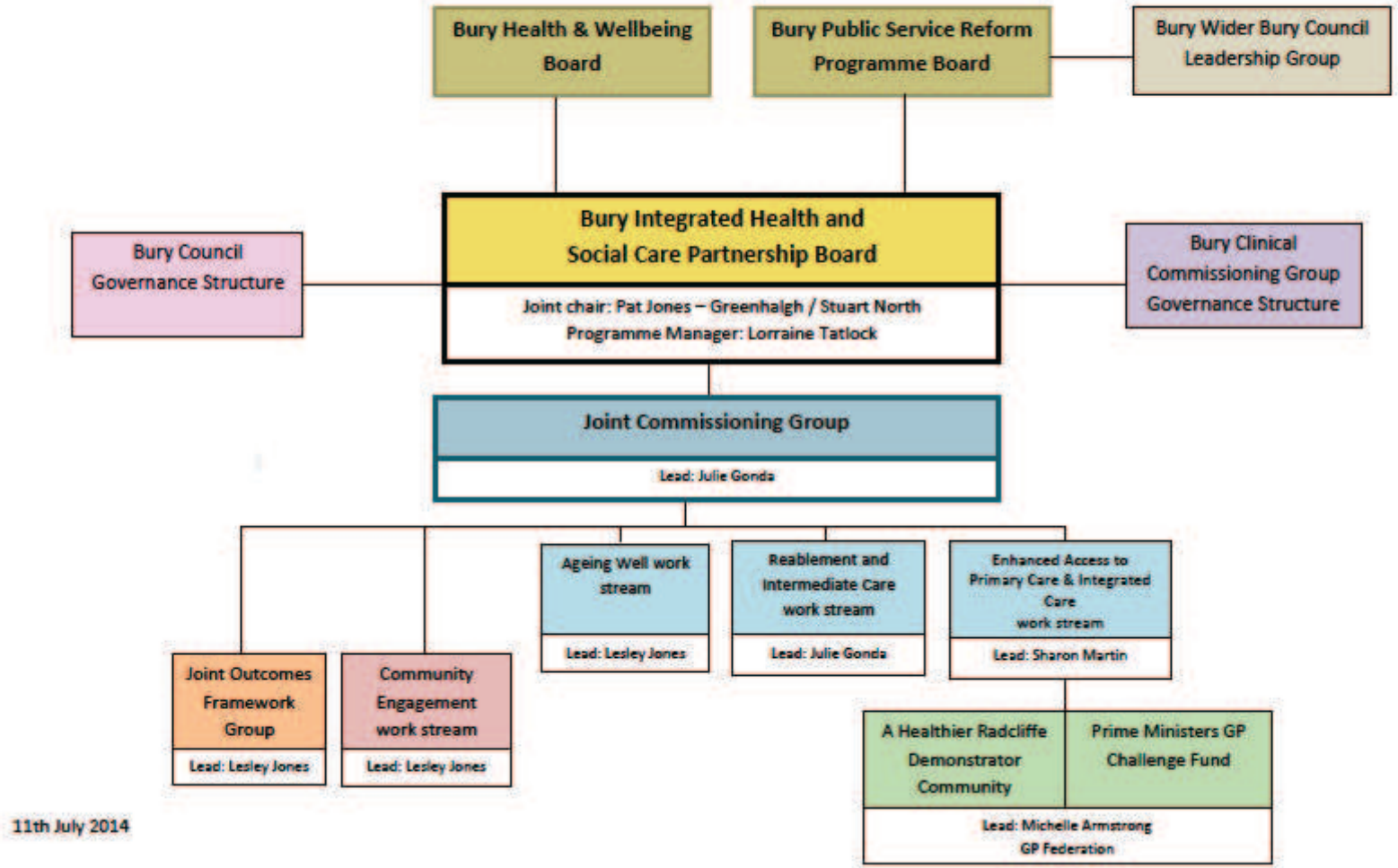
2015-16 change (from 2014-15)

Low = up to and including 10%

Moderate = 11-20%

Significant = greater than 20%

Appendix 2 - Bury Integrated Health & Social Care Governance Structure



11th July 2014

Appendix 3 – Risk Log

No	RiskThere is a risk that:	How likely is the risk to materialise? *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	Potential impact (*Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact and if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	Overall risk factor *(likelihood *potential impact)*	Mitigating Actions	Owner	Timeline
1	If resources are redirected to fund new joint interventions and schemes it may destabilise current service providers, particularly in the acute sector	2	3	6 Med	Our current plans are based on the agreed strategy for Bury The development of our plans for 2014/15 and 2015/16 will be conducted within the framework of Healthier Together Programme, which includes hospital reform, Primary Care Transformation and Integrated Care. This allows for a holistic view of impact across the provider landscape and putting co-design of the end point and transition at the heart of this process An executive level 'Transformation Steering Group' has been established between commissioners and the local acute provider (Pennine Acute Trust) which will oversee the Trusts transformation programme. The transformation programme is intended (within the context of all system reform - including BCF) to ensure a Transformation programme is in place to ensure the sustainability of the Trust. The CCG and LA have invited providers to be part of the Integrated health and Social Care Partnership Board. Progress against delivering the NEL reduction will be tracked and this will be monitored against impact on the acute sector. Triangulation of planning assumptions and provider engagement in development of BCF plans. Ongoing partnership working and provider engagement	Director of Finance (CCG)	Monthly review at Integrated Health & Social Care Partnership Board

2	The shift of activity from acute to community would result in Council over-spending on social care as a greater number of care packages are required. Proactive care planning may increase costs of other services including social care	2	4	8 Med	Financial transparency between the CCG and the LA in budget setting and development of financial plans to ensure that any assumptions and changes made and the potential impact is assessed across both organisations £5 million of the BCF has been aligned to ensure the sustainability of Social Care Services which support health. This has been calculated to ensure the sustainability of services within the context of the shift of activity from secondary care to the community A new governance arrangement for the integrated commissioning between the CCG and the LA has been established to monitor the Better Care Fund	Assistant Director - Commissioning & Procurement (Local Authority)	31-Mar-15
3	Data issues and relying on current assumptions could mean that our financial and performance targets for 2015/16 onwards are unachievable. Particular risk associated with non-elective activity growth during 2014/15 and the impact that this will have on 2015/16 targets.	3	4	12 High	The Whole Systems Integrated Care programme is undertaking a detailed mapping and consolidation of opportunities and costs that will be used to validate our plans CCG and LA have agreed a risk share to mitigate against the risk associated with non elective growth. This is detailed in the financial section of the plan We are investing specifically in areas such as customer satisfaction surveying and data management to ensure that we have up-to-date information around which we will adapt and tailor our plans throughout the next 2 years	Director of Finance (CCG) & Assistant Director (Local Authority)	Monthly review at Integrated Health & Social Care Partnership Board
4	If operational pressures are not managed this will restrict the ability of our workforce to deliver the required investment and associated projects to make the vision of care outlined in our BCF submission a reality	3	4	12 High	Our 2014/15 schemes include specific non-recurrent investments in the infrastructure and capacity to support overall organisational development Agreement for dedicated programme support to assist providers to implement the schemes has been agreed. System resilience funding has been made available to providers to reduce the impact.	Assistant Director Operations Social Care (Local Authority) & Head of Commissioning (CCG)	31-Mar-15
5	The current provider workforce lacks the capacity skills and attitudes to deliver partnership and new ways of working	3	3	9 Med	Training and development sessions, engaging with workforce, defining new roles and encouraging collaboration.	Assistant Director Operations Social Care (Local Authority) & Head of Commissioning (CCG)	31-Mar-15
6	If there is insufficient clinical	3	3	9 Med	Clinical leads for each work stream	Head of	Monthly

	engagement in the models they will not be robust or sustainable.				Provider partnership group established to ensure robust clinical and provider engagement. Clinician will be involved within the provider partnership.	Commissioning (CCG)	review at Integrated Health & Social Care Partnership Board
7	If IT systems and infrastructure are is not available due to technical issues, delays and/or financial issues will impact on the CCG and councils aspiration to share data	3	2	6 Med	IM&T lead to be integral to the development of the model and the technology solution to be developed alongside Clear plan in place for LA to implement NHS number IM&T plan in place to part implementation of shared records. We already have shared records across General Practice. The NES of Manchester have a plan developed which gives the technological solution to share patient information through a patient and clinical portal.	Assistant Director Operational Social Care / Assistant Director - Commissioning & Procurement (Local Authority) & Director of Finance (CCG)	30-Sep-15
8	If Information Governance, processes and policies are not in place we will be unable to share data.	2	4	8 Med	Policies already in place in each organisation. Information governance lead and Caldecott guardians to be involved in project from start and to develop integrated policies to support the service models.	Assistant Director (Local Authority) & Head of Commissioning (CCG)	Monthly review at Integrated Health & Social Care Partnership Board
9	If we fail to achieve the right level of patient, customer and community engagement in planning new models of integrated care they will not be robust or sustainable.	2	4	8 Med	Proactive focus on development of range and effectiveness of service user, equality and wider public reference groups Patients included on the Healthier Radcliffe steering group to ensure robust engagement Development of mechanisms to connect these to the strategic planning process	Director of Public Health (Local Authority) & Head of Commissioning (CCG)	Sep-15
10	Failure of non-elective activity to fall in line with the agreed target will limit the ability of the CCG to invest in the BCF pool in line with the performance element of the scheme. This could result in delays to scheme investment or BCF pool overspends. If activity does not reduce in line with projection the Trust will not be able to reduce activity quickly enough to	3	3	9 Med	The CCG will be looking for innovative funding models to support money following the patients, with some shared risk mitigation strategies with all providers. The CCG and the council are working together on the governance and risk share arrangements associated with the BCF pool. The CCG and local authority will be looking for innovative funding models to support money following the patients, with some shared risk mitigation strategies with providers.	Assistant Director - Commissioning & Procurement (Local Authority) & Director of Finance (CCG)	31-Mar-15

	deliver the sustainability model required for their Integrated Business Plan. This will result in CCGs paying for the activity commissioned in the community and the activity delivered within PAHT.				In the event that the Pay for Performance element of the scheme is enacted, the CCG and LA have identified a series of mitigations to manage the risk of the pool overspending. E.g. o Through slippage, o Performance related payments to providers o Additional income (e.g. interest receivable) o Other savings/contingencies The CCG and the LA have agreed to jointly manage the risks of the BCF overspending and take any and all necessary mitigating actions required to deliver a balanced financial position on the pool. It has been agreed in principle that any residual liabilities remaining after mitigations will be shared equally by the CCG and LA. Agreement will be finally signed off at the Intermediate Care Programme Board at the end of January 2015.		
11	Radical changes to patient services through shifting of resources and service redesign creates a risk to patients in disruption of services, loss of services or continuity of care. Other service redesigns and integration initiatives create confusion for integration.	3	3	9 Med	Current plans are aligned with Bury's strategic plans Current plans are agreed with stakeholders including the Local Authority's Health and Wellbeing Board Current plans are led by clinical workstream leads Risk assessment methodology will be applied consistently to service redesign	Assistant Director - Commissioning & Procurement (Local Authority) & Head of Commissioning (CCG)	31 June 2015
12	If the system does not work together to ensure a workforce strategy is in place to negate impact of relocation of services providers could end up with a risk around workforce sustainability and redundancy costs	4	4	16 High	Workforce workstream has been established System wide Alliance group to be set up for all providers to work through workforce issues. System wide workforce strategy to be developed	Assistant Director Operations Social Care (Local Authority) & Head of Commissioning (CCG)	Monthly review at Integrated Health & Social Care Partnership Board
13	The implementation of integration is likely to find additional patients' needs that were not addressed before. The cost of meeting these newly identified needs could mount on top of the overall costs of addressing the needs already identified in the population.	4	2	8 Med	The focus of the H&WB Board in Bury is to address unmet needs and the CCG, LA, Public Health and BCF strategies are aligned with the H&WB strategy and include strategies for managing the expected growth in Health and Social Care demands over the next five years.	All, includes providers too	Monthly review at Integrated Health & Social Care Partnership Board
14	**Schemes identified do not deliver expected results**	**5**	**3**	15 High	**A clear performance framework with KPIs is in development to be monitored regularly and to track if there are issues proactively.**	Assistant Director - Commissioning & Procurement (Local	Monthly review at Integrated

					Operational &delivery and financial governance mechanisms are in place to ensure total management of the programmes and to ensure that there is adequate control	Authority) & Head of Commissioning (CCG)	Health & Social Care Partnership Board
15	**Primary care contracts not in place for GP for "7 day working" by the 1 April 2015. Contracts in place for timescales that don't fit with widerimplementation of whole system whole week working**	3	3	9 HIgh	**Initial dialogue underway with primary care commissioners and GP colleagues to solidify delivery planning from April 2015.**	Assistant Director - Commissioning & Procurement (Local Authority) & Head of Commissioning (CCG)	Monthly review at Integrated Health & Social Care Partnership Board
16	**The schemes are delayed by delays in recruiting staff and so benefits are not realised. Additionally risks of GP and health and social professionals to allow full seven day working.**	**4**	**2**	8 Medium	**All plans factor in a XX month recruitment window. Review of skill mix to ensure the most appropriate grade of staff provides care and advice.**	Assistant Director - Commissioning & Procurement (Local Authority) & Head of Commissioning (CCG)	Monthly review at Integrated Health & Social Care Partnership Board
17	**Patients and the public are not adequately engaged with the BCF schemes and as a result there is dissatisfaction around the changes to services**	4	2	8 Medium	Continue to engage patients and the public, and local health watch on the Better Care Fund via existing forums	Director of Public Health (Local Authority) & Head of Commissioning (CCG)	Monthly review at Integrated Health & Social Care Partnership Board
18	PAHT remove the capacity that the CCG and Council say will be deflected into the community and the activity continues to go to the Trust. This will result in significant service risk	4	4	16 High	Our current plans are based on the agreed strategy for Bury	Director of Finance (CCG) & Assistant Director (Local Authority)	Monthly review at Integrated Health & Social Care Partnership Board
					The development of our plans for 2014/15 and 2015/16 will be conducted within the framework of Healthier Together Programme, which includes hospital reform, Primary Care Transformation and Integrated Care. This allows for a holistic view of impact across the provider landscape and putting co-design of the end point and transition at the heart of this process		
					An executive level 'Transformation Steering Group' has been established between commissioners and the local acute provider (Pennine Acute Trust) which will oversee the Trusts transformation programme.		
					Triangulation of planning assumptions and provider engagement in development of BCF plans.		
					Ongoing partnership working and provider engagement		

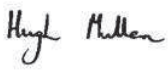
Appendix 4 – 'Our Place' Visioning Event, 28 May 2014

ANNEX 1 – Detailed Scheme Description

See separate attachment.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Bury
Name of Provider organisation	Pennine Acute Hospital Trust
Name of Provider CEO	Dr Gillian Fairfield
Signature (electronic or typed)	Hugh Mullen, Director of Operations signed on behalf of the CEO 

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	20,200
	2014/15 Plan	19,713
	2015/16 Plan	18,727
	14/15 Change compared to 13/14 outturn	487
	15/16 Change compared to planned 14/15 outturn	**5% reduction on plan** 986 FFCEs
	How many non-elective admissions is the BCF planned to prevent in 14-15?	487
	How many non-elective admissions is the BCF planned to prevent in 15-16?	986

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	The Pennine Acute trust has a good working relationship with the CCG and has been meaningfully engaged in discussions with regards to the Better Care Fund schemes. Detailed scheme descriptions with risk logs and a milestone plan have been shared and discussed with the trust. The Trust acknowledges the CCGs commissioning intentions for targeting a planned reduction in non-elective admissions to deliver a 5% overall reduction. The Trust also notes however that the 5% reduction excludes any natural NEL growth with the assumption being that such growth will flat-line during 15/16.

2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	The trust has considered the implications of the schemes in the BCF on the services it provides. At this point in time, the trust has been unable to evaluate fully the impact of these schemes due to the timing of implementation, as the implementation of a number of these schemes have been part way through the year or have not been implemented yet. It has therefore been too early to fully understand their impact on admission avoidance. Based on the current plans shared with the trust, there is some material risk that the quantity of activity within the agreed assumptions will not be completely delivered. Although we recognise the risks, we are actively engaged as a partner, which has a focus on improving outcomes and delivering the intended deflection schemes.

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Better Care Fund
ANNEX 1 – Detailed Scheme Description

Ref	Schemes
Bury BCF 01	Staying Well
Bury BCF 02	Extended Access to Primary Care
Bury BCF 03	Integrated Health and Social Care Team
Bury BCF 04	Care of Vulnerable Adults
Bury BCF 05	Review Programme - Integrated Intermediate Care , Reablement and other related services

Appendix 1	Impact of schemes - Metrics Mapping An exercise was undertaken to calculate the benefits on a scheme by scheme basis and to apportion the benefits to the different schemes. This is detailed in the table.

ANNEX 1 – Detailed Scheme Description

SCHEME 1

Scheme ref no.
Bury BCF 01
Scheme name
Staying Well
What is the strategic objective of this scheme?
The Staying Well Scheme is an early intervention scheme which aims to improve health, wellbeing and quality of life for older people, reducing the risk of future health and social care need and preventing future crisis. The scheme has the following key objectives: • To develop a systematic method of identifying those at high risk of developing future health and social care needs • To support those identified to take action to reduce their future risk e.g. by planning for their futures, helping people access relevant support and making the most of their personal and community assets • To reduce dependency on secondary health care and specialist social services in the medium to long term • To support a cultural shift towards a prevention focused system based on a social model of health • Support implementation of the Care Act 2014 Staying Well supports Bury's overall vision of enabling people to live well and remain independent for as long as possible. It is a key prevention service for older people that promotes citizenship, self-care, independence and wellbeing.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Staying Well is a targeted prevention and early intervention offer to older people that will increase their opportunities to enjoy long healthy lives, feeling safe at home and connected to their community. Far too many older people only come to the attention of health and social care services when they reach crisis point and then begin a downward spiral of decline and dependency. There is also a wide range of 'preventative' support available within Bury but this offer often fails to reach and connect with everyone who could benefit most. This scheme will adopt a systematic and proactive approach to identifying those at high risk of future care need and supporting

people to maintain their health, wellbeing and independence.

A review of the literature and consultation with older people, their carers and front line professionals suggest that the following are key risk factors for future health and social care need:

- Social isolation and loneliness
- Common conditions of older age that limit independence (e.g. mobility problems, foot health, chronic pain, visual or hearing impairment, incontinence, malnutrition, oral health)
- Housing and fuel poverty (affordability, changing housing needs)
- Practical support needs (e.g. minor household repairs, cooking, transport)

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The Staying Well scheme seeks to intervene as early as possible to minimise the need for more complex and costly interventions later on by its preventative, proactive, person-centred and community orientated approach.

Many minor needs can often be met by existing services and support commonly available in the community but awareness and access is low in the very group that needs them. Therefore, the key principles underlying the proposed model are:

- Proactive, systematic identification of those at high future risk utilising the Combined Predictive Model (CPM) and GP Practice Registers
- An asset based approach, promoting maximum independence and self-determination of older people
- Holistic approach considering the wide range of factors that contribute to health, wellbeing and independence
- A place based approach to use and develop community assets/resources
- Integration within a whole system of care, community and place
- Encouraging people to self-care and consider, plan & prepare for their futures

The cohort for this intervention will be all those aged 65 and over deemed moderate to low risk after application of the CPM Stratification to that population. It will exclude those in receipt of formal social care and those under the care of the Multi-disciplinary Locality Team. The prime basis for proactive systematic targeting of this intervention will be through GP practice registers. Further criteria for prioritising within this cohort are being considered e.g. having one or more long term condition, living alone. The intervention will also be offered opportunistically e.g. by the social care team if assessed as in-eligible for formal social care. It is expected around **2,444** people aged 65 and over will receive a Staying Well offer in Year 1 (see impact of scheme section for further details).

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The Staying Well intervention comprises the following elements:

- A person-centred conversation about needs and assets using an holistic, evidence based Staying Well Conversation Checklist Tool
- Individual goal orientated action planning to ensure patient/service user activation
- Facilitation, beyond sign-posting, to help people build the confidence, knowledge, skills and trust to enable them to make the most of the support available and take steps to improve their current and future circumstances

- Identifying, building on and making the connections between the assets & strengths of individuals and their communities
- Support, information or advice to encourage self-care and self-management
- Provision of a feedback loop to support service improvement in the wider system

The intervention will be delivered by 'Health and Wellbeing Co-ordinators' recruited and trained to deliver the holistic Staying Well intervention described below. Co-ordinators will use a range of knowledge and skills to support these steps and encourage a self-help approach. The service will also maximise the opportunities for self-management, peer support and support from local community, voluntary and faith sector groups. Our recently launched, web-based Bury Directory will support this function.

The Staying Well Conversation takes place in the client's home or another venue if they prefer. This provides the opportunity to have in depth face to face discussion and to take account of observations to ascertain the underlying and important issues that people may face now or in the future.

The Staying Well Conversation is supported by a number of tools, as an aid to identify client risk & protective factors for future health and social care need. The tools are centred around the core principles of a client centred holistic intervention. They promote an integrated approach to working and supporting individuals to live and stay well.

The Staying Well Check Tool consists of:

- Client consent form
- Quality of Life Wheel, covering 12 key dimensions of health and wellbeing
  1. Health (i.e. memory, healthy eating, screening)
  2. Carer Support (i.e. break from role, emotional well-being)
  3. Emotional Wellbeing (i.e. thinking clearly, making decisions, feeling sad)
  4. Getting Out and About (i.e. driving, managing stairs, shopping, going to the bank)
  5. Personal Care and Daily Tasks (i.e. feeding, dressing, cleaning home)
  6. House and Home (i.e. home repairs, minor and major adaptions, moving home)
  7. Managing Medication (i.e. taking the right dose at the right time, reading labels)
  8. Managing Money (i.e. debt advice, heating costs, benefits advice)
  9. Friends, Family and People (i.e. trust, relationships, loneliness)
  10. Communication (i.e. hearing, seeing, reading)
  11. Volunteering and Work (i.e. skills, training, working hours)
  12. Hobbies and Interests (i.e. shopping, puzzles, eating out)
- Visual communication cards
- Trigger questions
- Algorithms to guide referral/ signposting opportunities

The service will offer a co-ordinated response to identified needs, utilising key assets within people's communities. Our enabling workstream around community engagement seeks to stimulate and develop community capacity to support older people's health and well-being and is integral to the development and delivery of the Staying Well scheme.

Our local 'Bury Directory' provides an online hub of community assets within the Borough to support a range of potentially identified needs.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

There are two potential models for delivery:

- A commissioned model, where Bury Council will initiate a procurement exercise to identify an appropriate provider
- A directly provision model, with the Staying Well Service located within Adult Social Care within Bury Council,

A Business Case is in progress, which will present an options appraisal of both models of delivery, for consideration and decision by the Joint Commissioning Group.

Either option will require the recruitment of Health and Wellbeing Co-ordinators' who will be trained to identify those patients within GP practices and deliver the holistic Staying Well intervention described above to all eligible clients. The Health & Wellbeing Coordinators will be part of the emerging locality based health and social care teams.

GP practices will also form a key part of the delivery chain as GP practice registers will form the basis of cohort identification. We will also be exploring how GP practice read codes can be used to record social as well as clinical circumstances and interventions to help refine the identification of the target group over time, support monitoring and evaluation and help support the wider integration agenda.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Within the NHS Forward View is a clear articulation of the need to radically ramp up the focus on prevention and public health. Adopting healthier lifestyles in old age and learning how to self-care is shown to yield significant benefits and it is estimated that over half of the burden of disease among people aged over 60 is avoidable through changes in lifestyle such as regular exercise, not smoking, reducing alcohol consumption and healthy eating.

Whilst public services are challenged with meeting the needs of a growing and more dependent older population, many services struggle to provide support to people's lower or 'minor' needs. In addition, there are many older people who are not known to health and social care services who have lower level needs. Needs classed as minor can have significant effects on independence, well-being, social engagement and loneliness, social isolation and social exclusion and are known to be important risk factors for ill health and mortality in older people (Kings Fund, 2014, Making ouR health and care systems fit for an ageing population).

A significant proportion of activity within adult health and social care services can be described as 'failure demand' which is demand caused by a failure to do something or do something right for the customer at the right time and in the right place. It has been estimated that this can account for up to 80% of demand into health and social care services. Failure demand includes re-presentation with the same problem, re-screening and reassessment, all creating high volumes of work for health and social care services.

As social care eligibility alters, an increasing number will fall below defined thresholds. This can result in service users presenting in crisis where an earlier intervention may have averted the situation (Year of Care Programme, NHS IQ, 2014). Staying Well presents an alternative for these clients and addresses this gap. The scheme aims to 'shift the curve' from high cost reactive care to an approach that is preventative, proactive, based close to people and their homes and optimises self-care.

We know that maintaining independence is a key priority for older people. The ability to remain in one's own home which is clean, warm and affordable;

- to remain socially engaged; to continue with activities that give their life meaning
- to contribute to their family or community
- to feel safe and to maintain independence, choice, control, personal appearance and dignity
- to be free from discrimination
- to not feel a 'burden' and continue as a caregiver where appropriate are all important to older people

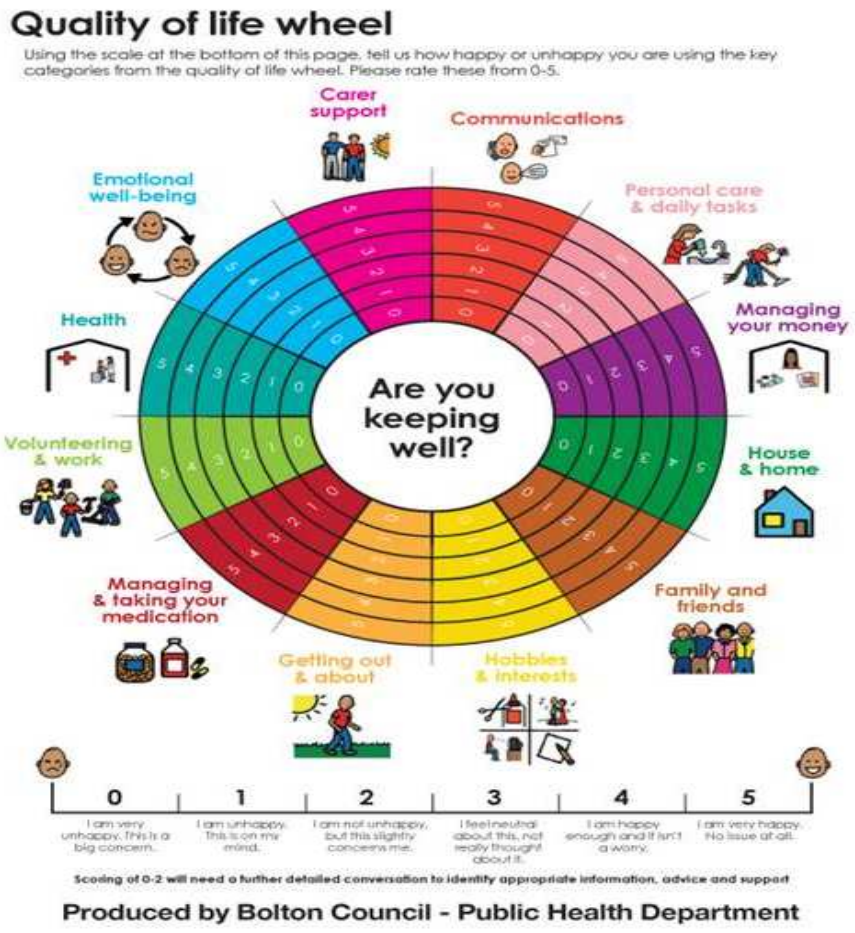
This scheme focuses on wellness and the factors that our residents value.

The service model has been shaped by evidence, national policy direction, learning from practice and evaluation from a pilot Staying Well project delivered in a neighbouring economy Bolton, an Older People's Health Screening Pilot Project in Bury, and a Health and Wellbeing Check for older people delivered in Stockport. The Bury Staying Well Project combines elements of all these and builds upon them to develop a model and approach that fits with the Bury context.

The model will adopt a range of tools in its implementation. For example, it will utilise an evidence-based Staying Well Quality of Life Wheel (see overleaf). This was developed following a comprehensive literature review which sought to identify modifiable factors that were associated with an increased risk of entering residential or nursing care. The Wheel was also informed via a stakeholder consultation which sought the views of older people and professionals working with older people on the most important themes. It is designed in a visually appealing way to provide a tool to enable the client and Wellbeing Coordinator to engage in a holistic conversation about the client's current quality of life, with the view of preparing the client to think about their potential future needs. The Wheel is currently being piloted as part of a 'social prescribing' offer for older people in our early demonstrator site at Radcliffe.

Evaluation of a pilot in our a neighbouring area of Bolton showed the take up rate for the service was 69%, which suggests significant customer demand. The greatest level of unmet need was around health-mainly pain, multiple physical health needs, sleep, breathing, physical activity and skin issues. The most positive impacts in terms of outcomes were around

improving confidence and feeling better able to cope with life. 98% of clients rated Staying Well as either good or very good. A total of 67% of clients said the project had helped them to maintain their independence. Through review of actions around goals set, 38% related to health or healthcare including referral to GP, long term conditions team, IAPTs, audiology and dental services. Contacting voluntary groups was involved in 16% of actions such as CAB, Age UK, and Carers Support thus demonstrating the utilisation of community assets rather than statutory services. A previous Older People's Health Screening (OPHS) Project in Bury showed merits in screening for hearing, foot problems, visual impairment and depression. Whilst the cost benefit analysis of the Bolton Pilot has yet to be published, the emerging evidence suggests this form of early intervention will have a significant impact on Adult Social Care and Health Service demand in the medium to long term. This scheme seeks to build the local evidence base around impact and outcomes and a model for identification and implementation that is locally focused.



Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Borough wide costs estimated at £374k for targeted Early Intervention Scheme - Staying Well.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Given the medium term nature of this scheme, its impact is assumed to be low in relation to BCF metrics for 2015/16 and is identified below.

This scheme has potential to impact on reductions in residential care admissions, avoidable emergency admissions, injurious falls, support reablement and improve patient experience as detailed in the table below. The metrics mapping exercise that relates to all of the schemes is available in part 1, appendix 1.

		Metric 1 - Residential Admissions		Metric 2 - Reablement		Metric 3 - Delayed Transfers of Care		Metric 4 - Avoidable Emergency Admissions		Metric 5 - Patient experience	Metric 6 - Local metric - Falls	
Scheme ID	Scheme Description	%	Nos of people	%	Nos of people	%	Nos of people	%	Nos of people	%	%	Nos of people
BCF01	Staying Well	10%	1	0%	0	0%	0	5%	49	20%	5%	2

At a population level, this scheme will support a range of measures variously across the NHS, Adult Social Care and Public Health Outcomes Frameworks. These include:

- Health related and social care related quality of life (NHSOF/ASCOF)
- Proportion of people feeling supported to manage their own condition (NHSOF)
- Proportion of people still at home 91 days after discharge from hospital into reablement/intermediate care (NHSOF/ASCOF)
- Improving people's experiences of integrated care (NHSOF/ASCOF)
- Proportion of people who use services who report they had as much social contact as they would like (ASCOF/PHOF)
- Permanent admissions to residential and nursing care (ASCOF)
- Fuel Poverty (PHOF)
- Perceptions of safety (PHOF)
- Falls and falls injuries in over 65s (PHOF)
- Flu Vaccination coverage (PHOF)
- Excess winder deaths (PHOF)
- Dementia and its impacts (PHOF)

Previous research from meta−analysis has demonstrated that Comprehensive Geriatric Assessment applied to the general older population followed by multi-factorial intervention leads to a mean 14% reduction in nursing and residential care home admissions (Beswick et al, 2008). It is expected that Bury's Staying Well Scheme will prevent avoidable emergency admissions and subsequent episodes of social care and reablement, including permanent

admissions of older people to residential and nursing care. Prevention of falls is integral to the Staying Well Check utilising an evidence based Falls Risk Assessment Tool (FRAT) which assesses risk of falls in the next 12 months on the basis of the FRAT score.
This will further support delivery against our local metric of a reduction in injurious falls in our 65+ population.

In Bury, there are 31,602 people aged 65 and over registered with a Bury GP practice. Our approach to population segmentation using the CPM applied to the 65+ population shows that 93% sit within the low or moderate risk categories. This scheme seeks to reach this cohort. In year 1 it will target 9 GP practices where >20% of their list are aged 65 and over - a total 65+ population of 13,141. Around 7% of Bury's over 65 population, falls within the high to very high CPM risk categories and would be excluded from this scheme. Applying this exclusion criteria to the registered 65+ population of those GP practices, would result in a sample frame of 12,221, prior to the application of further exclusion criteria. Based on capacity, we estimate that in Year 1 a Staying Well offer will be made to 20% of this eligible cohort - a total of **2,444.**

As a preventative scheme, Staying Well will impact on the projected 3.5% reduction in non-elective admissions. Although this is difficult to quantify, the likely impact across all metrics is articulated on page 8.

Further likely impacts include:

- More uptake of screening
- More pharmacy reviews for new medicines
- More people losing weight, stopping smoking and reducing alcohol intake
- Fewer people admitted to hospital due to alcohol
- Increased percentage of eligible people being vaccinated
- Better availability and access to psychological therapies
- Less loneliness & social isolation among older people
- More carers who are able to maintain their quality of life
- More homes meeting the decent homes standards in each borough
- Increased knowledge and awareness about keeping healthy and maintaining good wellbeing Increased personal responsibility and independence
- People will experience improved physical and mental health and wellbeing
- Increased utilisation of community assets as appropriate

Evidence from the Bolton pilot of Staying Well showed that the greatest level of unmet need was health-related. In addition, 67% of clients stated the programme had helped them to maintain their independence.

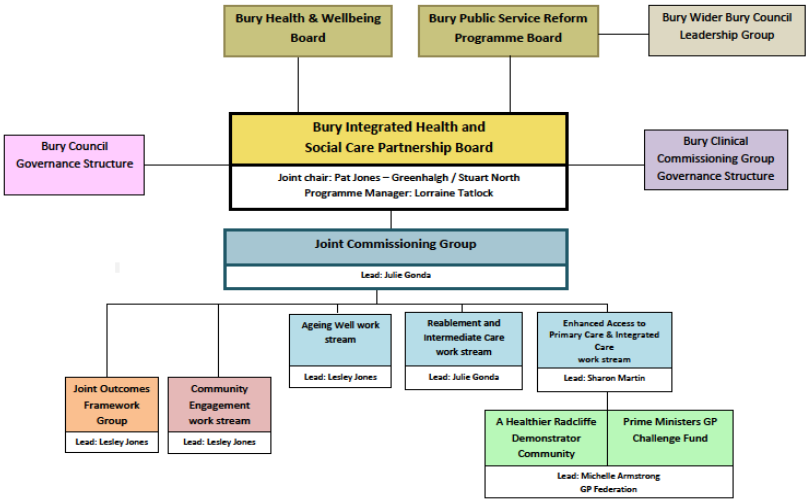
Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Governance Structure

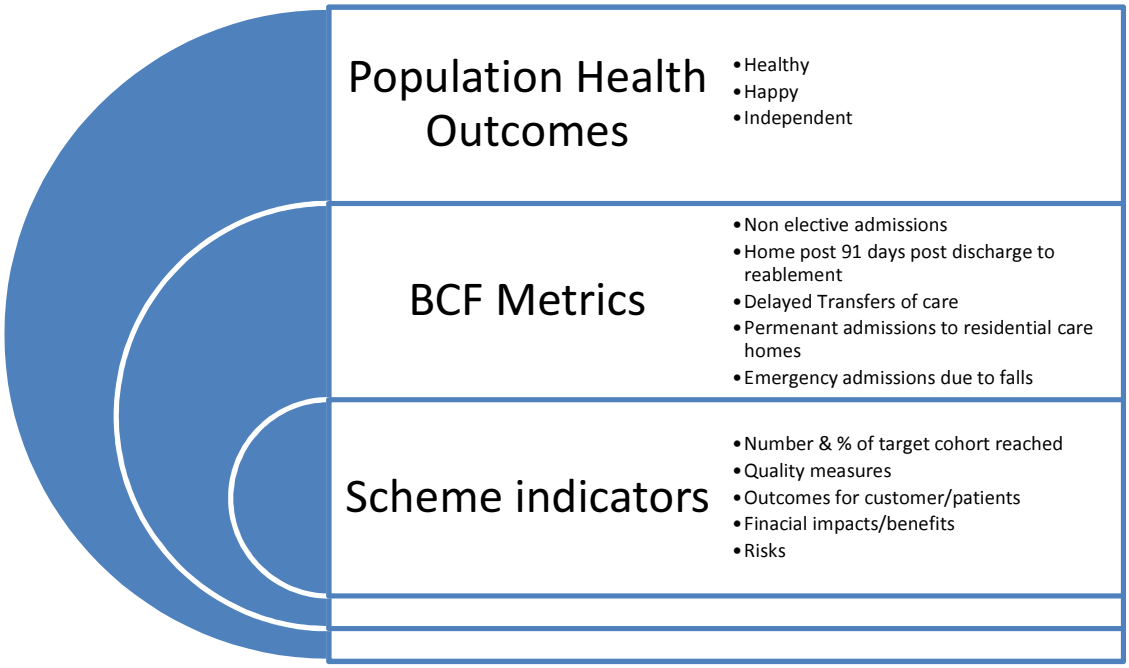
This Better Care Fund scheme is project managed by a scheme lead who reports to the Joint Commissioning Group via the ageing well workstream. The Joint Commissioning Group reports to the Integrated Health and Social Care Partnership Board and subsequently to the Health and Wellbeing Board as shown in the structure below.

Bury Integrated Health & Social Care Governance Structure



Bury Health & Social Care Partnership Board are in the process of developing a Joint Outcomes Framework through which to monitor the impact of work-streams including the Better Care Fund Schemes on the health and social care system and ultimately on the health of our population. This work is being taken forward by the Joint Outcome Framework Group comprising performance and intelligence specialists from Public Health and Adult Social Care within the Local Authority and the CSU on behalf of the CCG.

The Outcomes Framework



Population Outcome measures

We are clear that health and social care integration is a means to an end and not an end in itself and that whilst there is an immediate focus around creating a financially sustainable system, this can only be achieved in the longer term if we create a system which improves the health and wellbeing of our local population and reduces the need for treatment services.

We have therefore agreed a set of indicators through which we can determine whether our work has a positive impact on people's health, wellbeing and independence.

The embedded document outlines the measures agreed and associated data sources and gives the current picture for Bury against each indicator.

JOF overarching indicators June 14 v2

Better Care Fund Metrics

The Better care Fund metrics provide us with more immediate feedback on whether the work we are doing is driving the system changes that we are aspiring towards. We are building on work undertaken by Greater Manchester CSU on developing a performance dashboard for the Healthier Radcliffe Demonstrator and the Non Elective Story Board (see embedded document) to develop a single whole Borough , whole system dashboard incorporating the BCF metrics using software recently purchased by the Local Authority.

As an interim whilst the dashboard is developed, we will be collating current performance reports on the different metrics to create a single monthly report provided to the Joint Commissioning Group, Provider Partnership Group and Health & Social Care Integration Partnership Board.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Scheme indicators
The indicators for this scheme are set out below. The key indicators on progress will be incorporated into the above dashboard in time. Meanwhile monthly progress reports will be collated and provided to the Joint Commissioning Group and Provider Partnership with exception reporting to the Health & Social Care Integration Partnership Board. This robust governance structure is described in part 1 section 4b.

A service database will capture a range of data for a monitoring and evaluation framework. Monthly results in terms of activity and outcomes will be presented to a Project Steering Group which will oversee the progress of the scheme and consider its effectiveness. Specific components to support monitoring and evaluation will be:

- **Uptake of the scheme will be monitored, including demographics**

- **Results from the Health and Wellbeing Check Questionnaire**

- **Outcomes: Quality of life Wheel Scores**
  - The Wellbeing Coordinator helps the client to identify areas of concern for them, and they jointly agree and set actions intended to improve these areas of concern. The Staying Well Check tools, including the Quality of Life Wheel, are used to inform this discussion. The Quality of Life Wheel is then repeated on client sign off to check for changes, together with an evaluation questionnaire asking about changes that have happened to clients since they have been involved with Staying Well.

  - To focus on the clients who were in need of further support, the initial and sign off Wheel Scores of those clients who rated at least one theme as 0-2 (indicating a potential cause for concern) will be examined to determine a positive improvement across all the categories in which they initially had concerns or otherwise.

- **Outcomes: Exit questionnaire**
  - On sign off, clients will be asked to complete a questionnaire asking about the impact they feel that Staying Well has made on their lives across a range of potential outcomes, as relevant to individual clients

- **Outcomes: Client Actions**
  - The co-ordinators and clients set goals together. Reviewing their completions or otherwise will also enable assessment of outcomes. Referrals to voluntary and community sector services can also be monitored through this method.

Risks

Risk associated with the delivery of the Better Care Fund Plan and associated schemes have been identified in the Risk Log in Part 1 Appendix 3.

Any risks that may affect the delivery of this and other Better Care Fund Schemes will be raised with the Joint Commissioning Group as part of the regular reporting of the performance of the schemes. Mitigating actions will be undertaken to reduce the likelihood of the risk arising or to address the risk. If this is not possible and potentially means that plans could go off track, then this will be escalated to the Integrated Health & Social Care Partnership Board.

What are the key success factors for implementation of this scheme?

- Engagement of GP practices
- Information sharing agreements for Health and Wellbeing Co-ordinators with GP Practices to enable access to practice registers
- Employing the right people with conversational, engagement and motivational skills
- Taking time to engage and form a relationship with clients and support for their behaviour change

ANNEX 1 – Detailed Scheme Description

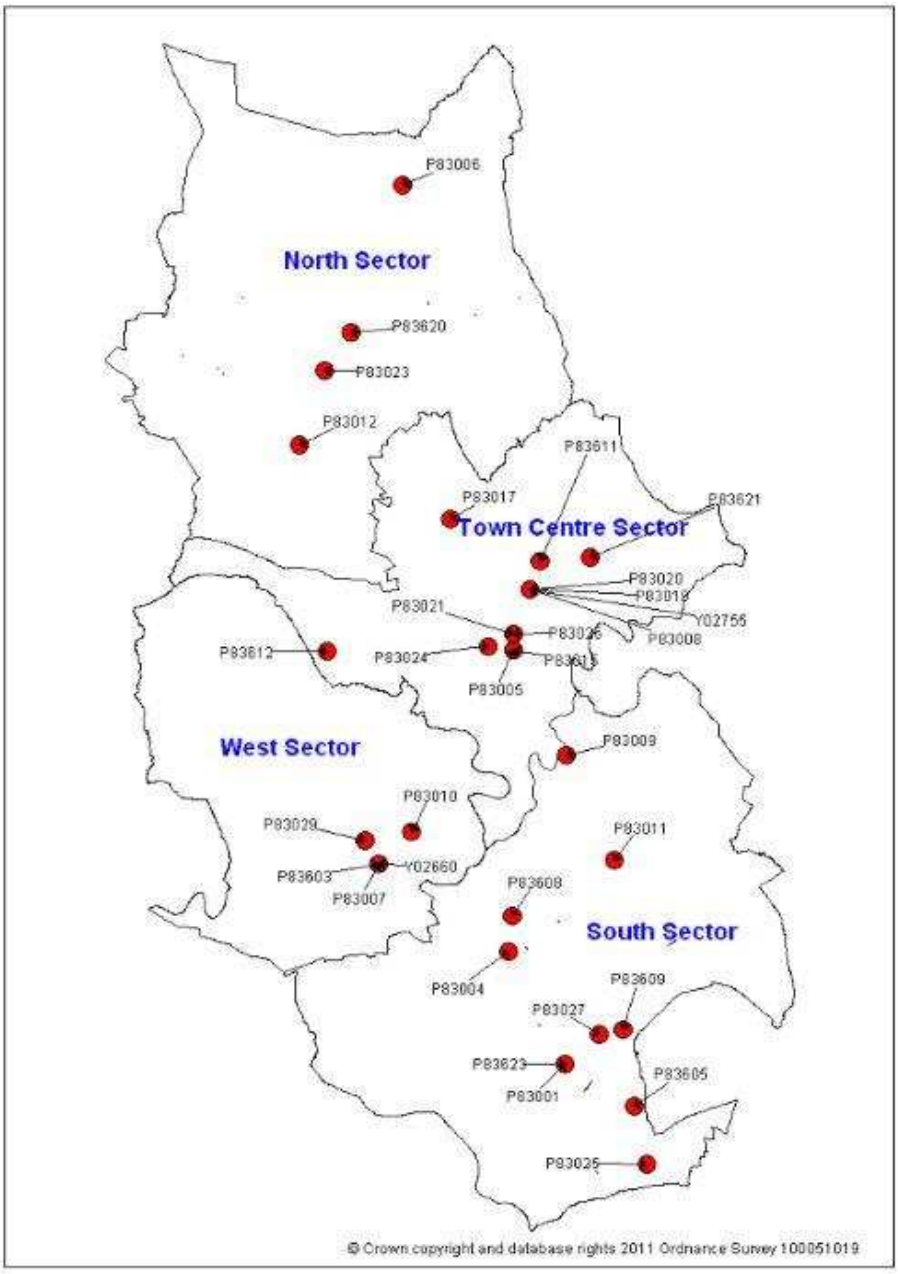
SCHEME 2

Scheme ref no.
Bury BCF 02
Scheme name
Extended Access to Primary Care
What is the strategic objective of this scheme?
The key strategic objectives for this scheme are: • To extend access to General Practice over 7 days a week. This will be achieved via the roll out of the Prime Ministers Challenge Fund. • Place greater emphasis on primary and community care and reduce risk and incidence of crisis or emergency admissions to hospital As explained in Part 1, our Health & Wellbeing Strategy is underpinned by 4 key principles which are at the core of all we do. This scheme directly links to each of these core principles: • Promoting prevention, early intervention and self care • Reducing inequalities in health and wellbeing • Developing person-centred services • Planning for future demands The strategic objectives for this scheme also support the delivery of the Better Care Fund's five priorities: • Ensuring a positive start to life • Encouraging healthy lifestyle and behaviours in all actions and activities • Helping to build strong communities, wellbeing and mental health • Promoting independence of people with long term conditions and their carers • Supporting older people to be safe, independent and well

Overview of the scheme
This is a good example of co commissioning between the GP Federation, NHS England and Bury CCG. **Extending Access to Primary Care** Bury is one of 20 Prime Ministers Challenge Fund national pilot sites. Led by the GP Federation the 6 practices that form Bury CCG west sector are currently delivering extended access as part of the national pilot. Bury CCG in partnership with the GP Federation and GP practices has defined a structured model for the roll out of extended access across remaining three sectors in Bury. Through a staged approach all 192,000 registered patients in Bury will have extended access to General Practice by 2015/2016.
This will be complemented by a further Better Care Fund Scheme, BCF 03 which aims to develop integrated health and social care services that complement and wrap around extended access to General Practice. Given the extended opening of GP practices this will also increase the ability for opportunistic falls screening for older people. The structured approach across Bury sees the extended access to General Practice scheme being delivered via four specific projects:- **Project 1 - Extended Hours** Extended access to General Practice in Bury will deliver: • Extended weekday opening (8am to 8pm) • Saturdays and Sundays (8am to 6pm) • All services available locally but not in every GP practice • Every patient's notes available to the GP providing cover during extended hours • Reducing likelihood of people needing to go to hospital • Making it easier for those who work or have school age children to avoid disrupting their working/school day • Easier for families to attend with elderly relatives From December 2014 this project rolls out to all 33 GP practices in Bury as shown in the list of practices below. The project was initially rolled out in the West Sector of Bury. The West Sector of Bury encompasses six GP practices covering 3 local authority wards that make up the local authority Radcliffe Township of Bury. The GP registered population for these six practices is 34,162. Extended access in Radcliffe commenced in September 2013, the six GP practices are currently delivering extended access to General Practice, weekday opening (8am to 8pm) and Saturdays and Sundays (8am to 6pm). The service is delivered from a central point in Radcliffe, the Radcliffe Primary Care Centre. From December 2014, additional practices in Bury will be offering a similar service, weekday opening (8am to 8pm) and Saturdays and Sundays (8am to 6pm). The service will also be delivered from central points in each locality.

North (North Sector)	South (South Sector)
P83006-Ramsbottom Medical Practice	P83001-Fairfax Group Practice
P83012-Tottington Medical Practice	P83004-The Uplands Medical Practice
P83017-Woodbank Surgery	P83009-Blackford House Medical Centre
P83023-Greenmount Medical Centre	P83011-Unsworth Medical Centre
P83620-Garden City Medical Centre	P83025-St Gabriels Medical Centre
East (Town Centre Sector)	P83027-Greyland Medical Centre
P83005-Ribblesdale Medical Practices (Subbiah)	P83605-Whittaker Lane Med Centre
P83008-Minden Medical Centre Practice No.1 (Shekar)	P83608-The Elms Medical Centre
P83015-Ribblesdale Medical Practices (Woodcock)	P83609-The Birches Medical Centre
P83019-Minden Medical Centre Practice No.2 (Deakin)	P83623-Longfield Medical Practice
P83020-Minden Medical Centre Practice No.3 (Saxena)	**West (West Sector)**
P83021-Peel GPs - Dr Jackson	P83007-Radcliffe Medical Practice
P83024-Knowsley Medical Centre	P83010-Monarch Medical Centre
P83026-Peel GPs - Dr Cleary	P83029-Spring Lane Surgery
P83030-Peel GPs - Dr Chacko	P83603-Red Bank Group Practice
P83611-Walmersley Road Medical Practice	P83612-Mile Lane Health Centre
P83621-Huntley Mount Medical Centre	Y02660-The Rlc Surgery
Y02755-Rock Healthcare Limited	

Please also see sector map on the next page.



The model for extended access sees the sector practices working together to provide a sector based service from central locations within each sector as follows:

- West Sector: Radcliffe Primary Care Centre
- North Sector: Tottington Medical Centre
- South Sector: Prestwich Walk-in Centre
- East Sector: Townside Primary Care Centre & Moorgate Primary Care Centre

Project 2 - Tele-consultations

The Tele-consultation project will:

- Assure that all patients who request an appointment are offered the option of a telephone consultation
- Increase the number of General Practices, currently about 35%, offering telephone consultation to patients
- Make better use of GP and patient time
- Offer patients choice as to whether they need to see the clinician face-to-face
- Release GP time for more appointments and reduce waiting times for appointments

Via the GP Federation, telephone guidance has been issued to all member practices. Practices are now enabled to start to operate / change procedures to offer alternatives to 'face to face consultation'. An incentive scheme has been agreed which aims to encourage practices to offer patients greater choice and flexibility in how they access/interact with GP services.

To further support the roll out across Bury a practice 'buddying scheme' has been introduced to support the adoption and implementation of the new telephone consultation guideline. The 'buddying scheme' aims to bring practices across Bury together to share/promote good practice in the delivery of telephone consultations.

Project 3 - Increased Online Access

The increase online access project will:

- Increase the use of online services
- Enable patients who register to make appointments or re-order prescriptions online
- All practices in Bury are enabled for online access
- Improve online registration. Increasing registration will significantly widen access
- Extend services available to patients over time including having access to health records and the ability to 'email' their GP

'How to guides' have been developed to aid practices to run targeted initiatives and to manage the new vision online system (VOS) process effectively.

Project 4 - GP Comparison Website

The GP comparison website project will deliver:

- A website to enable patients to make better choices about GP services
- Enhancement to current websites which offer limited information to patients
- A website which will offer information in a detailed and searchable form, modelled on successful comparison-style sites used elsewhere
- A website which will enable patients to search for staff availability, service availability, staff expertise, etc will show information for all relevant practices in Bury

The delivery chain

Bury Clinical Commissioning Group and NHS England are lead commissioners for ensuring delivery of extended access to General Practice over 7 days a week. Bury CCG are the lead commissioners for ensuring reductions in emergency admissions to hospital. The CCG has a lead clinician for Urgent Care and the reduction of emergency admissions is within the Urgent Care work plan. In order to deliver this there are a host of local providers that all have a part to play, these include:

- Bury CCG Clinical Lead
- Bury GP Federation
- All Bury GP Practices
- Bury Local Authority
- Pennine Care Foundation Trust (Community)
- Pennine Care Foundation Trust (Mental Health)
- BARDOC
- Pennine Acute Hospital Trust
- North West Ambulance Services
- Bury Pharmacists
- Bury Carers Centre

There is also an infrastructure of reporting and meetings to support delivery which is described in the feedback loop section of the document.

The other key components in the delivery chain for this scheme are the other schemes detailed in this plan, in particular, Integrated Teams and Care of Vulnerable Adults.

The Evidence Base

National Evidence
The national direction of travel for extended access in GP services has seen a £50m investment in pilot sites via the Prime Minister's Challenge Fund. NHS England commissioned the National Institute for Health Research to perform an interim evaluation which reported in June 2014. This evaluation focussed mainly on the progress of sites in establishing arrangements. The 20 national sites are currently being nationally evaluated by the company MotMacDonals for NHS England to assess impact.

Greater Manchester Evidence
The 5 year strategy for primary care in Greater Manchester states a commitment to:

- commission quality health services delivered as close to home as possible
- delivering transformed out of hospital care for all
- improving access to General Medical Practice and
- delivering services that support people to retain independence

It also sets key primary care commitments to:

- the production of transparent, publicly available benchmarking data

- services where patients have choice, access to their own records and to accessible information in order to work as partners with professionals to manage their health
- easy access to high quality, preventative primary care including rapid response to urgent needs so that fewer patients reach crisis

The scheme moves the health community in Bury closer to all of the above aims and either directly or by the creation of a firm platform on which to build more integrated services, thus preparing the way for a much greater shift of services from hospitals into our community.

A more flexible offer around general practice offers particular benefits to older people enabling them to have quicker appointments and making it easier for family members to attend them when visiting their General Practice.

Through greater use of online access, people will have a greater stake in their own care and will move towards the ambition of sharing with professionals. They will be able in time to access their care records and to have greater access to online services as these are developed centrally. More accessible information on care options will empower patients to make informed choices about their general practice service provider.

Local Evidence
As Bury is one of the national demonstrator sites for Extended Access, the emerging impact in Bury is already beginning to be evidenced. Whilst the national evaluation is important, Bury CCG has worked with the GP Federation to agree a set of monthly measures. These local measures will be extended to track progress in more detail for the other three sectors in 2015/2016.

The extended hours sessions are being well utilised and the latest available monthly measurement performed by the CCG, as at November 2014, is beginning to evidence an impact on Non Elective Activity in Radcliffe as follows:

- A&E attendances down by 2.52%
- A&E minor attendances down by 2.87%
- Non elective admissions down by 3.16%

Full details can be seen in the Healthier Radcliffe Dashboard attachment in the feedback loop section below. Although not all the local measures are currently achieved it is anticipated that further improvements will be reported.

By April 2015 it is planned to have the same level of local monthly measurement in place for all four sectors.

Bury CCG are in discussions with NWCSU to develop a local extended access evaluation. This will incorporate the current local monthly measures. The full parameters for the evaluation are currently being discussed. It is planned to see this evaluation presented to the CCG no later than November 2015. This will then inform future commissioning plans for extended access into 2016/17.

It is anticipated that this evidence will become more sustained and substantial when the BCF projects, BFCO3 and BCFO4 are fully operational.

Investment requirements

Extended access to Primary Care - £1,240K per annum.

Impact of scheme

The Extended Access to Primary Care scheme will help to deliver against each of the six Better Care Fund Metrics. The impact is most significant for reablement, avoidable emergency admissions and patient experience as detailed in the table below. The metrics mapping exercise that relates to all of the schemes is available in part 1, appendix 1.

		Metric 1 - Residential Admissions		Metric 2 - Reablement		Metric 3 - Delayed Transfers of Care		Metric 4 - Avoidable Emergency Admissions		Metric 5 - Patient experience	Metric 6 - Local metric - Falls	
Scheme ID	**Scheme Description**	%	Nos of people	%	Nos of people	%	Nos of people	%	Nos of people	%	%	Nos of people
BCF02	Extended access to Primary Care	10%	1	25%	2	5%	13	30%	296	20%	5%	2

As illustrated above in the six Radcliffe practices the following reductions have been seen:

- A&E attendances down by 2.52%
- A&E minor attendances down by 2.87%
- Non elective admissions down by 3.16%

There is an expected significant impact on avoidable emergency admissions as patients in Bury become increasing confident in evening and weekend primary care services. Equally the enhanced confidence in local services should flow through to improve patient experience scores. When fully operational across all sectors extended access will deliver an additional 1,425 appointments per week and equity of access, available to all Bury residents.

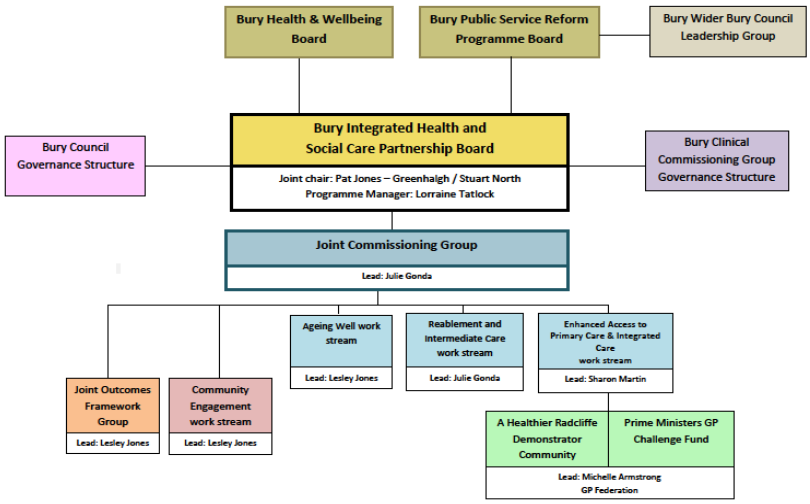
As extended access will be supported by a number of wrap around schemes via the Integrated Health and Social Care Teams scheme it is expected that this will also significantly help to deliver against the reablement metric

Feedback loop

Governance Structure
This Better Care Fund scheme is project managed by a scheme lead who reports to the Joint Commissioning Group via the Enhanced access to primary care and integrated care

workstream. The Joint Commissioning Group reports to the Integrated Health and Social Care Partnership Board and subsequently to the Health and Wellbeing Board as shown in the structure below.

Bury Integrated Health & Social Care Governance Structure



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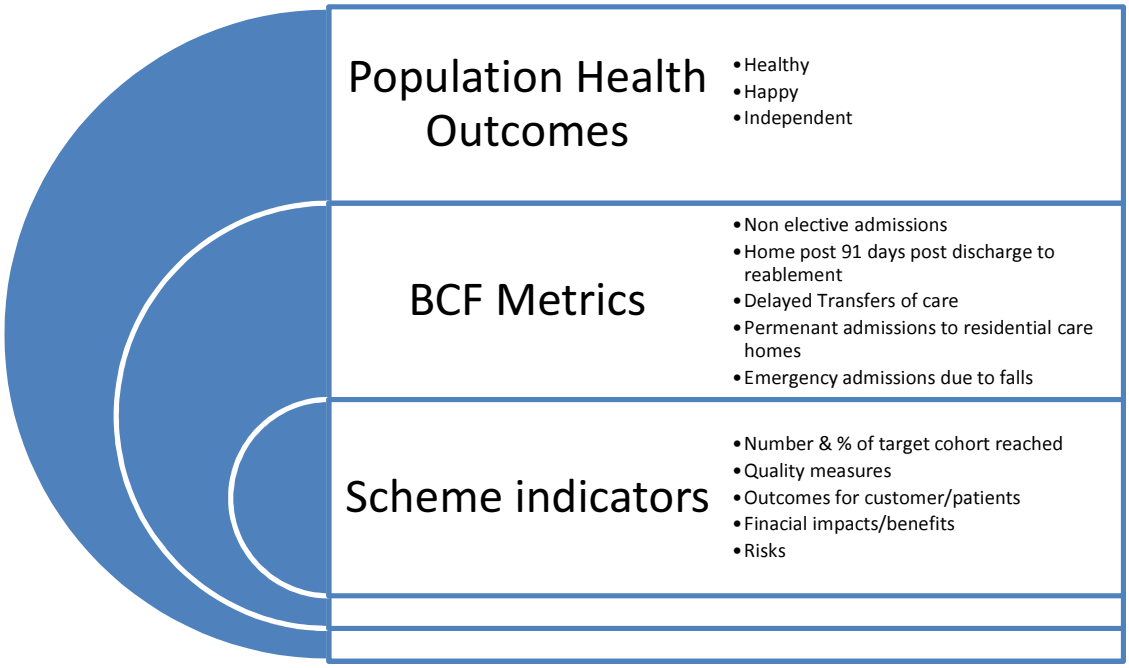

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JOF overarching indicators June 14 v2

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Healthier Radcliffe Pilot Dashboard - as a


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Scheme indicators
The indicators for this scheme are set in the attachments above and in the impact of the scheme section also above. The key indicators on progress will be incorporated into the above dashboard in time. Meanwhile monthly progress reports will be collated and provided to the Joint Commissioning Group, Provider Partnership with exception reporting to the Health & Social Care Integration Partnership Board.

As identified in part 1 section 4b, there is also a robust project level governance structure in place to receive reports and updates and to then develop mitigation plans where required for the extended access to General Practice schemes

With reference to this particular BCF scheme there are also additional board/meetings as follows:

Prime Minister's Challenge Fund Contract Board Meeting

- Chaired by NHS England, this board is attended by the GP Federation and the Bury CCG. This forum holds the GP Federation to account against delivery of the Prime Ministers Challenge Fund.

Bury Integration Group – A Healthier Radcliffe

- Chaired by the GP Federation, this group is attended by all the local stakeholders including the CCG Urgent Care Lead and the CCG Better Care Fund lead. The group receives updates and progress from the four stage two projects.

Bury GP Sector Meetings

- The local sector infrastructure will be the vehicle through which the roll out of the extended access and integrated health and social care teams will take place.

The Healthier Radcliffe Demonstrator Performance Dashboard will be further developed for the rest of Bury moving forward. There will also be a national evaluation of all PMCF schemes and Bury CCG is seeking a more detailed local evaluation for Bury.

Risks
Risk associated with the delivery of the Better Care Fund Plan and associated schemes have been identified in the Risk Log in Part 1 Appendix 3.

Any risks that may affect the delivery of the Better Care Fund Schemes will be raised with the

Joint Commissioning Group as part of the regular reporting of the performance of the scheme. Mitigating actions will be undertaken to reduce the likelihood of the risk arising or to address the risk.If this is not possible and potentially means that plans could go off track, then this will be escalated to the Integrated Health & Social Care Partnership Board.
What are the key success factors for implementation of this scheme?
The delivery of extended access in Bury is being driven by Bury CCG, the GP Federation and supported by NHS England via the Prime Minister's Challenge Fund. The key success factors are: • Delivery of extended access to GP Services over 7 days a week • Robust governance in place • GP engagement • Patient awareness • Changes in traditional behaviour patterns • Management of risk via risk register and regular contact with schemes in-between meetings

ANNEX 1 – Detailed Scheme Description

SCHEME 3

Scheme ref no.
BURY BCF 03
Scheme name
Integrated Health and Social Care Team
What is the strategic objective of this scheme?
The integrated care system will support frail older people, children and people with Long Term Conditions in their own homes to manage their long terms conditions effectively providing care closer to home and a coordinated multi-disciplinary response for a targeted population. Linking to the extended access scheme, this scheme will place greater emphasis on primary and community care and reduce risk and incidence of crisis or emergency admissions to hospital. As explained in Part 1, our Health & Wellbeing Strategy is underpinned by 4 key principles which are at the core of all we do. This scheme directly links to each of these core principles: • Promoting prevention, early intervention and self-care • Reducing inequalities in health and wellbeing • Developing person-centred services • Planning for future demands The strategic objects for the Integrated Health and Social Care scheme also support the delivery of the four of the five Better Care Fund priorities: • Encouraging healthy lifestyle and behaviours in all actions and activities • Helping to build strong communities, wellbeing and mental health • Promoting independence of people with long term conditions and their carers • Supporting older people to be safe, independent and well
Overview of the scheme
Four bespoke schemes are being piloted via A Healthier Radcliffe, Stage Two. Scheme 1 - Prevention and early intervention task team Scheme 2 - Targeted Frail Elderly MDT with care co-ordination and reablement Scheme 3 - Community Paramedic Service

Scheme 4 - Domiciliary medicines optimisation service

It is intended that the learning from these four pilots will help to inform the wider roll out of Integrated Health and Social Care Teams across Bury. These schemes will deliver coordinated health and social care services that will wrap-around the extended hours GP practices in Radcliffe with GPs holding accountability for all aspects of care. The model will facilitate the further development of integrated services and care plans and provide the blue print for the roll out of Integrated health & Social Care across the other three sectors.

Scheme 1 - Prevention and early intervention task team
Commenced in Radcliffe in November 2015, the provision of an Early Intervention Task Team identifies and supports families who do not meet the criteria for existing community services support. By having earlier contact it is hoped that the team will reduce the likelihood of needing support from statutory services. The team will include a Social Care Officer, Housing Officer and Health Trainers who will actively seek referrals through GP surgeries and make contact with families. At a Radcliffe scoping session it was identified that there are a number of families and individuals who would benefit from information, advice or signposting into other preventative services. This could include services such as health trainers, or the local "I will if you will" initiative, taking an active part in self-care etc. as well as other services such as IAPT and Age UK provision to support the social isolation agenda. The objectives of the team fit exactly to the aims of A Healthier Radcliffe in that they will:

- Ensure people take responsibility for their own health and well-being through self-care, ownership and accountability for their lifestyles
- Provide access to information and advice to help people understand what is available in the community and facilitate them taking ownership and accountability for their lifestyles
- Provide support which will involve the person's/family's natural circle of support and maximise the use of community assets
- Integrate to help facilitate services by providing the right workforce in the right place, at the right time
- Identify and sign post carers for assessments and support services to enable them to continue in their role
- The team will be focused specifically on frail older people and people with long term conditions as well as children in complex families
- They will work flexibly over seven days to support the community and individuals to understand what is available and access services to support self-care
- Through social prescribing, GP's will signpost patients and their carers onto Health promotion services within the community. This in turn helps people manage their own health conditions and reduce the burden on GP's and potentially A&E
- The team will have a co-ordination role for 3rd sector organisations in the patient's community, to sign post and assess the difference these services are making

Scheme 2 - Targeted Frail Elderly MDT with care co-ordination and reablement
Commenced in Radcliffe in November 2015, this team will aim to support frail elderly people to manage their LTCs effectively in the community, reducing the risk and incidence of admission or crisis. This multi-disciplinary team led clinic for Frail Older People will assess the needs of

patients on an individualised basis, ensuring that both primary, secondary and NWAS care plans are in place and are linked. The aim is to make every attempt to maximise the health and self-management of the patient, and therefore reduce the risk of potentially avoidable A&E presentation and emergency admissions. If these are unavoidable the MDT clinics will ensure that secondary care interventions are targeted, appropriate and timely, and support the primary care plans in place, thus minimising the risk of further harm.

The scheme also sees the creation of an additional Reablement worker and the widening of reablement and community nursing teams which are aligned to the six GP practices in Radcliffe. The Reablement worker will work closely with the GP practices and current Care Coordinator to target individuals and their families who are at risk of their health deteriorating without targeted intervention. The Reablement worker and current Care Coordinator will work closely and proactively with the GP surgeries, NWAS and secondary care to target individuals and their families who are at risk of their health deterioration without targeted health and social care intervention.

It is also proposed that the MDT Frail Older People clinics will link into a pilot assessment scheme within secondary care (see Scheme 3 below) which will assess all 65+ Radcliffe patients who have been admitted as an emergency, against an agreed Frailty Risk Assessment Tool. This will be done with the Care Coordinator and Reablement worker so Frail Older People under the Care Coordinator and Reablement worker can be referred to the clinic. The Frailty Risk Assessment Tool will establish the patient's recent baseline, and agree, with all care agencies, a target status for the patient, when discharge is optimal. This agreed plan will link into the primary care management plan and will ensure that clinical care and diagnostic investigations are measured and appropriate for the target statuses of the patient concerned. This individualised approach will ensure that the clinical teams, the patient, family and other supporting agencies are all clear about the management plan for the patient in question and this will aid timely and appropriate discharge, and aim to reduce the potential of re-admission. Holistic assessment and care planning are an essential part of Scheme 2 which will see the Care Coordinator, Reablement worker and wider MDT working together as a team to provide targeted interventions which will aim to keep those frail elderly people most at risk of crisis at home and managing their health conditions.

Some of the proposed operational arrangements are as follow:

- All service users discussed at the MDT meetings and MDT clinic will have been assessed as appropriate for discussion, either by the GP, Care coordinator, secondary care clinician, Reablement worker, NWAS referral or Discharge Champion
- It is envisaged that this MDT clinic would involve partners for primary, secondary and social care with close links to other services such as crisis response teams, out of hours GPs, NWAS, care home providers, patients and next of kin/carers
- The MDT clinics could be virtual and make use of innovative technologies to aid the engagement of so many different sectors involved in patients care, or they could be face to face
- The MDT will review the management plans in place and assess, with the wider care community (including the patient and carers) the effectiveness of current plans,

assessing against provider activity data, and then agree any modifications to plans

- Once agreed, the management plans will be communicated to all relevant care agencies and involved parties and an on-going assessment and review process will check their effectiveness
- The MDT would be supported and managed through the Care Coordinator and dedicated administrative support worker. One of the reasons why the MDT approach has not worked in some areas is because of a lack of co-ordination and administration of the process. It is suggested that the lead for identifying key patients to be presented at the MDT is the Care Co-ordinator through an administrative support worker, with the support of the reablement worker
- For those service users deemed most at risk, Scheme 2 will see targeted health and social care interventions. These will be provided by the Care Coordinator and the Reablement worker. The Reablement worker, is trained to assistant practitioner level, and is able to provide therapy support to individuals, undertake health checks, assessments for equipment etc. It is felt that these skills will be beneficial to support the Care Coordinator for patients who are at risk of crisis or deterioration of their health condition but have presenting needs and factors impacting on their health that are predominantly social care
- Targeted intervention will include reablement support; facilitate access to Intermediate Care
- The process will also support the navigation and input of wider health and social care services to meet the individual's identified needs
- The out of hours Reablement worker will link with existing out of hours services for support if there is an urgent healthcare need, including OOH Community Nursing team and the Crisis response service
- The wider reablement and crisis teams will support the reablement worker and care coordinator and will work across the extended hours, seven days per week to complement the existing care co-ordinator for Radcliffe who works 9-5, Monday-Friday

Scheme 3 - Community Paramedic Service

By placing a Community Paramedic to serve a locality catchment area effective care will be tailored by a local Paramedic meeting the local population's health needs alongside health & social care partners, in effect bringing the Paramedic back to the Community.

The Community Paramedic in Radcliffe became operational on 5th January 2015, 10am – 6pm responding to the lower acuity green calls emergencies. These are the calls that are more likely to be dealt with leaving the patient safely at home with either a self-care pathway in place or by a GP attending the patient through the GP referral scheme.

The Community Paramedic works closely with other health and social care professionals in the area to help identify and implement individual community care pathways which can be left at home with the patient. These contain patient's normal baseline observations and professional

network providers contact details. If the patient safely fits the pathways referral flowchart the patient can avoid admission to hospital and get the right treatment and care in the comfort of their own home.

The Community Paramedic could support the health & social care needs of the local 'Frequent Callers' utilising best practice developed by the NWAS Frequent Caller Team. The local healthcare economy in Bury has agreed additional funding for additional capacity to support the NWAS Frequent caller Team via System Resilience Monies. With the development of integrated working the Community Paramedic could mirror the successes on a more local basis and hone the skills associated with this element much more quickly due to the concentration of the area and team work.

As the resource will be a Rapid Response Car, the patients who will be attending hospital would largely be conveyed by a requested ambulance and therefore ensure that the Paramedic remains in the area of their responsibility.

Scheme 4 - Domiciliary medicines optimisation service

The service will enable the GPs, several pharmacists and social care providers in Radcliffe to work in a collaborative partnership to provide an innovative service to patients who have 2 or more long term conditions, aged 65 or over, who would benefit from a medicines optimisation review. The pharmacist will arrange an appointment and visit the patient in the comfort of their home. In total 200 medication reviews will be performed in Radcliffe by 31 March 2015.

All reviews will be delivered by a qualified pharmacist. This will include a documented review which includes adherence, adverse drug reactions, knowledge of medication, medicine optimisation, prescription ordering, wastage of medicines, out of date medicines, hoarding of medicines, and the requirement of compliance aids or other adjustments under the Disability Discrimination Act (DDA) will be completed. Cognitive Abilities Test (CAT) score, inhaler technique and smoking status and referral, if appropriate will all be included. Other appropriate measures of wellness will also be included.

Patients with long term conditions who collect their medication and visit the pharmacy are able to access pharmaceutical services. Medication reviews take place and the pharmacist is able to provide support to the patient to ensure they manage their condition effectively. Patients who are housebound, often frail elderly and suffering from long term conditions receive a two tier service. Whilst the pharmacist is able to provide ordering and delivery service for repeat medication and also supply compliance aids where necessary, no face to face contact or formal review takes place. This is where the role of the social care professional could prove to be beneficial, through a joint service which monitors medication compliance.

Visiting the patient at home and carrying out a documented medicine optimisation review will support people by promoting self-confidence and self-care and will have a more outcome focused approach to the joint planning and reviewing their care plan. The pharmacist medication review will consist of an integrated approach which will include feedback from social care staff putting the patient and their carer at the heart of the service:

- Understanding the patient's experience of taking the medicines
- Checking on inhaler technique, CAT score if applicable, this could also include those

patients where Social Care administer medication
- Highlighting potential adverse drug reactions and what actions should be taken by either the patient or their formal care agencies in responding to these
- Ensuring medicines are used safely as prescribed and recommended
- Review medication and making recommendations to the prescriber
- Checking the storage of medicines
- Checking the expiry date of medicines
- Ensuring no hoarding or sharing of medicines is taking place
- Reviewing that the patient therapy is being monitored
- Providing advice and counselling to patient, carer or professionals involved in support as appropriate
- Reviewing the current ordering arrangements of repeat prescriptions
- Placing appropriate patients on a repeat dispensing service
- Identifying where synchronisation of medication is necessary
- Carrying out a DDA assessment and reviewing any reasonable adjustments being made
- Validating the approximate cost of any medicine wastage
- Healthy lifestyle advice
- Smoking cessation referral , if appropriate
- Referring into Public Health schemes where appropriate
- Enhance local relationships between healthcare and Social care professionals
- Information from reviews could form part of the NWAS community care plan

Patients would take more ownership of their condition and be empowered to self-care. Pharmacists would use shared decision making and motivational interviewing skills to help patients become more in control of their lives.

The delivery chain

In order to deliver this scheme there are a host of local providers that all have a part to vital play, these include:

- Bury CCG Clinical Lead
- Bury GP Federation
- All Bury GP Practices
- Bury Social Services
- Pennine Care Foundation Trust (Community)
- Pennine Care Foundation Trust (Mental Health)
- BARDOC
- Pennine Acute Hospital Trust
- North West Ambulance Services
- Bury Pharmacists
- Bury Carers Centre

There is an robust infrastructure of reporting and meetings to support delivery which is described in part 1 section 4b.

The governance structure includes The Bury Integrated Partnership Board, The Bury Joint Commissioning Group and The Health and Wellbeing Board for this particular scheme it also includes:

Prime Minister's Challenge Fund Contract Board Meeting

- Chaired by NHS England, this board is attended by the GP Federation and the Bury CCG. This forum holds the GP Federation to account against delivery of the Prime Ministers Challenge fund.

Bury Integration Group – A Healthier Radcliffe

- Chaired by the GP Federation, this group is attended by all the local stakeholders including the CCG Urgent Care Lead and the CCG Better Care Fund lead. The group receives updates and progress from the four Stage two projects.

Bury GP Sector Meetings

- The local sector infrastructure will be the vehicle through which the roll out of the extended access and integrated health and social care teams will take place.

The other key components in the delivery chain for this scheme are the other schemes detailed in this plan, in particular, Extended Access and Care of Vulnerable adults.

The evidence base

Bury CCG is currently designing a set of measurement with the GP Federation for the four pilots in Radcliffe. Each scheme will have a defined set of metrics. As schemes only became operational in November 2014 and January 2015 there is no actual, directly reportable, evidence to date.

Once developed these metrics for Radcliffe will be added to the local dashboard already developed and inserted below in the feedback loop section. Similar measurement will be developed for the other three Bury sectors to track the impact of Integrated Health and Social Care as implemented.

There is a lot of wider evidence detailed below to indicate the value of pursuing the schemes detailed above.

The evidence around individual care plans

A care plan is a document owned by the person receiving care and their general practice. It should be co-created with them and set out their agreed year of care. For long-term conditions or for people whose conditions need regular management, having a proactive care plan is vital. The care plan should be wellness focused and should cover a comprehensive and up-to-date understanding of the persons' needs and circumstances[1].

[1] North West London – Whole systems integrated care toolkit, 2014

North West London Integrated care toolkit highlights the following key principles of an individualised care plan[2]:

- Focus on patients most at risk of hospitalisation
- Patients and carers own care plans with agreed goals
- Access to single electronic health record
- Information sharing across health and social care
- 7 of 11 published reviews which were analysed found a positive impact of assessing care plans[3]. Other studies have shown a reduction in hospitalisations by ~23%3.

Further evidence on individualised care plans:

- Graffyetal, Primary Health Care Research & Development, 2009,10(3), 210-222
- NHS England, Transforming participation in health and care 2013, http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc- guid1.pdf

The evidence around care coordination

Care co-ordination is the practice of having someone (not necessarily a clinician) co-ordinate the care received by an individual that has been designated as needing additional support. Typically, these are older people and those with chronic conditions who often represent 10-20% of the population and 30-70% of costs in the health and care system. There are several essential steps that are required to implement care co-ordination including the identification of individuals who would benefit from care co-ordination, the enrolment of those individuals into a programme, the development of care plans for those individuals and then on- going follow-up in line with the plan.

The evidence base highlights the following techniques:

- A holistic focus supporting self-care at home
- Single entry point to provide continuity
- Shared electronic health records
- Coordinating care at the neighbourhood level with engagement of local community
- Prioritising engagement with GPs and links with secondary care

8 out of 13 reviews, which were analysed, assessed care co-ordination and found a positive impact. Other reviews of literature have concluded that hospitalisations may be reduced by approximately 37%[4] Interventions involving care co- ordination have shown to reduce HbA1c (in patients with diabetes) by 22% more than interventions without care co-ordination[5]

[2] Ibid.

[3] North West London – Whole systems integrated care toolkit, 2014, pooled estimate only reported in 2 relevant reviews

[4] North West London – Whole systems integrated care toolkit, 2014, pooled estimate only reported in 2 relevant reviews

[5] Shojana et al, JAMA, 2006, 296(4), 427-440

Further evidence on care co-ordination:

- 'Case management: what it is and how it can be best implemented'
- 'South Devon & Torbay: Proactive case management using the community
- Virtual ward and the Devon predictive model'
- Goodwin N, SonolaL,Thie IV, Kodner D (2013).Co-ordinated care for people with complex chronic conditions. London: The King's Fund.

The evidence around case management

Case management focuses on the small proportion of the population (e.g. <5%) with much more intense needs than the population addressed by care co- ordination. Given these needs, a case manager is required who can help to actively manage the condition of a person. The evidence base highlights the following techniques:

- A focus on early action and prevention, targeted at particular communities to mobilise local people
- Community-based multi-professional teams based around general practices or groups of practices that promote close working and communication between staff in different organisations, for example, through co-location
- A single point of access, single assessment and shared clinical records
- Targeting individuals who are at high risk of future emergency admission to hospital, before they deteriorate, which requires access to good quality health and social care data
- The evidence base for case management is "promising but mixed' (Purdy, 2010). This is in part due to difficulty in attributing any positive changes to case management when there are multiple factors at play (for example, how to disentangle the effect of case management from any specific interventions that might be planned e.g. falls prevention, reablement, self-care)

Further evidence on case management:

- Ross S, Curry N, Goodwin N (2011). Case management: what it is and how it can best be implemented. London: The King's Fund.
- Challis D, Hughes J (2011) Intensive care / case management, PSSRU, Manchester
- Graffy J, Grande M, Campbell J(2008).' Case management for elderly patients at risk of hospital admission: a team approach'. Primary Health Care Research and Development, vol 9, no 1, pp 7–13

The evidence around multidisciplinary teams

Multidisciplinary teams (MDTs) bring together the relevant professionals needed to care for someone with complex needs. MDTs should include everyone required to look after the physical, mental and social health and care needs of the individuals they serve. The aim is to manage the complexity of individual cases and facilitate the delivery of the best possible care.

The evidence base highlights the following techniques:

- Multi-disciplinary teams
- MDT meetings about every person admitted to hospital
- Hire specialists to work in community settings rather than hospitals
- Expanded hours for GPs and coordinators
- Dedicated housing workers for SEMI/vulnerable groups
- Allow nurses or nurse practitioners to prescribe certain drugs
- Mental health liaison teams
- Direct phone/email access from GPs to Mental Health experts

Further evidence on MDTs:

- Hollandetal,Heart,2005,91,899-906
- Proactive care partnership
- http://www.sussexcommunity.nhs.uk/Downloads/services/proactive_care/proactivecare_coastal_leaflet.pdf
- Case study examples: NHS North West London, Torbay, Towers Hamlets

The evidence around community paramedic service
NWAS alongside Clinical Commissioning Groups (CCGs) has spent time putting provisions in place to safely manage patients in their home environment. These include Paramedic Pathfinder pathways, GP referral schemes and Community Care Pathways. In spite of this the average A&E attendance to admission ratio in urban areas across the North West is higher than the national average (Information from Ambulance CQI Data). The challenge is to reduce A&E attendances for those patients appropriate for treatment by alternative services.

Across Greater Manchester the team have identified 286 frequent caller patients since its inception in November 2013. 23 of those identified are resident in the Bury CCG yet due to the team's capacity only 10 of those patients are receiving interventions to support their needs. The success associated with those receiving interventions has been really positive, in both improving the patient's quality and reducing ambulance & A&E attendances. Data relating to April identify 10 identified Frequent Callers in the Bury catchment area that generated seventy-nine 999 calls in the preceding 28 days. Following intervention from the team the same group of patients generated twenty nine 999 calls, a 63% reduction in 999 calls.

The evidence around domiciliary medicines optimisation service
Medicines remain the most common treatment offered to patients, and dispensing prescriptions and supplying medicines safely is at the heart of what community pharmacy does and what patients expect.

The NHS spends over £13 billion on medicines with 80% of this in primary care. However, avoidable medicines wastage in primary care is estimated to be in the region of £150 million annually, an unacceptable situation that needs to be addressed.

- A partnership for Older People Project (POPP) financed by Dept of Health provided a reduction in overnight hospital stays by 47% and reduced A&E usage by 29% amongst the target group

- A US PACE (Programme for all inclusive care of the elderly) targeting frail older people and involving a multidisciplinary team , found a 50% decrease in hospital use, 20% decrease in nursing admission, patients used 16 fewer bed days. Patients took ownership of their health with 43% reporting good health and 72% a more satisfying life
- A pharmacy Domiciliary Review Service in Croydon conducted 2012/13 involving Medicine Use Reviews to 230 patients resulted in the avoidance of 130 emergency admissions. The cost avoidance cost was calculated at over 400k
- NICE reports that 30-50% of medicines are not taken as the prescriber intended, which means the patient does not get the full benefit of the treatment and the NHS does not get the full value of its investment

Apart from medicines wastage, not taking medicines correctly can have serious consequences for patients, as studies have found that up to 15.4% of hospital admissions were drug related and preventable; the commonest causes were prescribing and monitoring problems (53%) and non-adherence (33%). Waste medicines result predominantly from patients not taking medicines as intended (non-adherence).

Investment requirements

Integrated Health & Social Care - £2,372k per annum across all four sectors.

Impact of scheme

The Integrated Health Social Care scheme will help to deliver against each of the six Better Care Fund Metrics. This scheme will have a significant impact on residential admissions, reablement and avoidable admissions as detailed in the table below. The metrics mapping exercise that relates to all of the schemes is available in part 1, appendix 1.

		Metric 1 - Residential Admissions		Metric 2 - Reablement		Metric 3 - Delayed Transfers of Care		Metric 4 - Avoidable Emergency Admissions		Metric 5 - Patient experience	Metric 6 - Local metric - Falls	
Scheme ID	**Scheme Description**	%	Nos of people	%	Nos of people	%	Nos of people	%	Nos of people	%	%	Nos of people
BCF03	Integrated Health & Social Care	35%	2	30%	2	15%	39	30%	296	20%	20%	8

Bury CCG is currently designing a set of measurement with the GP Federation for the four pilots in Radcliffe. Similar measurement will be developed for the other three sectors to track the impact of Integrated Health and Social Care as implemented.

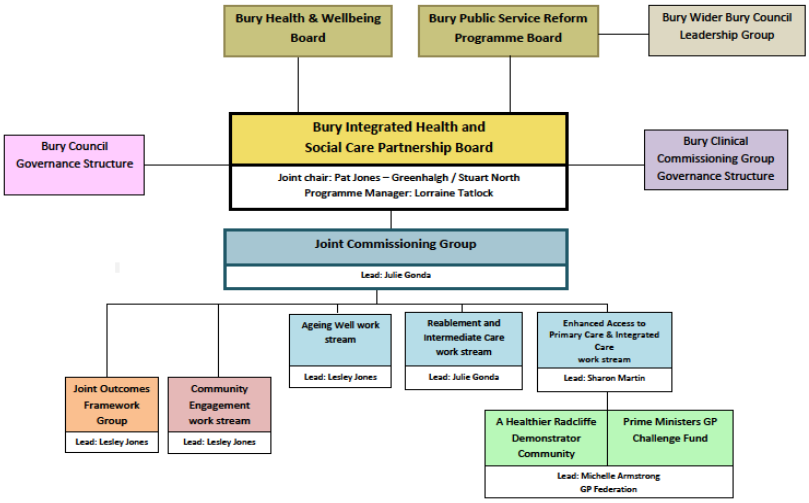
There is an expected significant impact on residential admissions as patients in Bury become increasingly supported by the additional services in the community. Equally as schemes begin to mobilise around extended access there is expected to be significant improvements against the reablement measure and reductions in avoidable admissions.

Feedback loop

Governance Structure

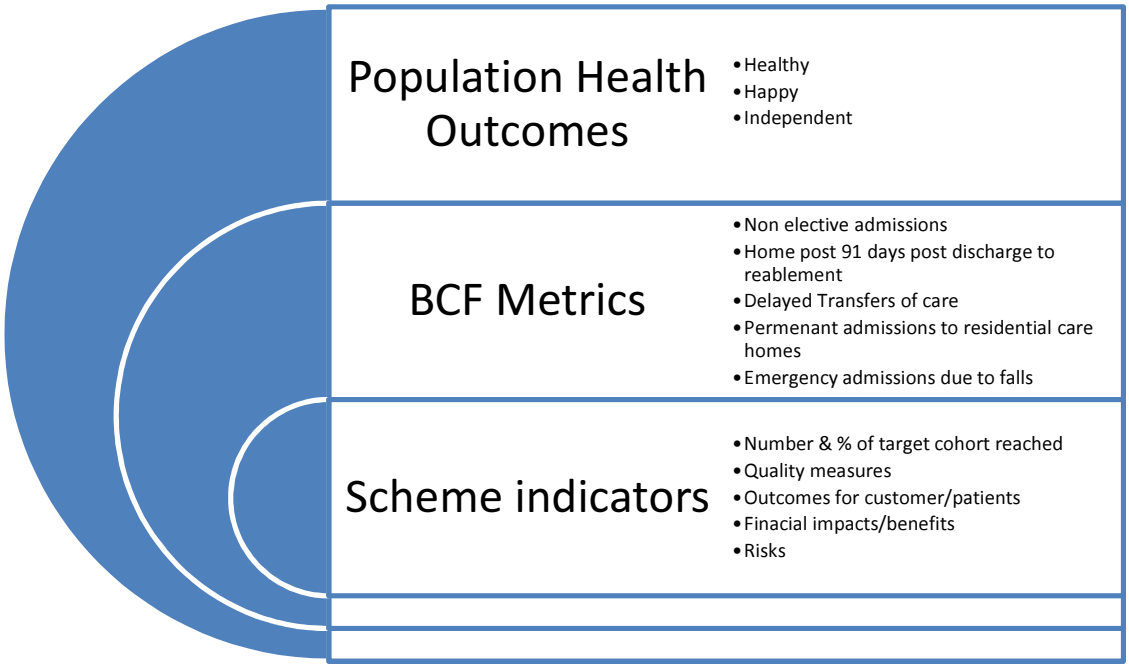
This Better Care Fund scheme is project managed by a scheme lead who reports to the Joint Commissioning Group via the Enhanced access to primary care and integrated care workstream. The Joint Commissioning Group reports to the Integrated Health and Social Care Partnership Board and subsequently to the Health and Wellbeing Board as shown in the structure below.

Bury Integrated Health & Social Care Governance Structure



Bury Health & Social Care Partnership Board are in the process of developing a Joint Outcomes Framework through which to monitor the impact of work-streams including the Better Care Fund Schemes on the health and social care system and ultimately on the health of our population. This work is being taken forward by the Joint Outcome Framework Group comprising performance and intelligence specialists from Public Health and Adult Social Care within the Local Authority and the CSU on behalf of the CCG.

The Outcomes Framework



Population Outcome measures

We are clear that health and social care integration is a means to an end and not an end in itself and that whilst there is an immediate focus around creating a financially sustainable system, this can only be achieved in the longer term if we create a system which improves the health and wellbeing of our local population and reduces the need for treatment services.

We have therefore agreed a set of indicators through which we can determine whether our work has a positive impact on people's health, wellbeing and independence.

The embedded document outlines the measures agreed and associated data sources and gives the current picture for Bury against each indicator.

JOF overarching indicators June 14 v2

Better Care Fund Metrics

The Better Care Fund metrics provide us with more immediate feedback on whether the work we are doing is delivering the system changes that we are driving towards. We are building on work undertaken by Greater Manchester CSU on developing a Performance dashboard for the Healthier Radcliffe Demonstrator and the Non Elective Story Board (see embedded documents) to develop a single whole Borough , whole system dashboard incorporating the BCF metrics using software recently purchased by the Local Authority.

As an interim whilst the dashboard is developed, we will be collating current performance reports on the different metrics to create a single monthly report provided to the Joint Commissioning Group, Provider Partnership Group with exception reporting to the Health & Social Care Integration Partnership Board.


Healthier Radcliffe Pilot Dashboard - as a


NEL.xls

Scheme indicators
The indicators for this scheme are set out in the attachments above and in the impact of the scheme, section, also above. The key indicators on progress will be incorporated into the above dashboard in time. Meanwhile monthly progress reports will be collated and provided to the Joint Commissioning Group, Provider partnership with exception reporting to the Health & Social Care Integration Partnership Board. Scheme risks are captured in the risk log in part one.

A specific set of measurements has been developed for Healthier Radcliffe, as detailed in the above attachments, and is currently being used to measure the impact of extended hours in Radcliffe. This model will be further developed to include measurement for the four integrated Health and Social Care Schemes.

As identified in part 1 section 4b, there is then robust project level governance structure in place to receive reports and updates and the develop mitigation plans where required. The governance structure includes The Bury Integrated Partnership Board, The Bury Joint Commissioning Group and The Health and Wellbeing Board for this particular scheme it also includes:

Prime Minister's Challenge Fund Contract Board Meeting

- Chaired by NHS England, this board is attended by the GP Federation and the Bury CCG. This forum holds the GP Federation to account against delivery of the Prime Minister's Challenge fund.

Bury Integration Group – A Healthier Radcliffe

- Chaired by the GP Federation, this group is attended by all the local stakeholders including the CCG urgent care lead and the CCG Better Care Fund lead. The group receives updates and progress from the four stage two projects.

Bury GP Sector Meetings

- The local sector infrastructure will be the vehicle through which the roll out of the extended access and integrated health and social care teams will take place.

Risks
Risk associated with the delivery of the Better Care Fund Plan and associated schemes have been identified in the Risk Log in Part 1 Appendix 3.

Any risks that may affect the delivery of the Better Care Fund Schemes will be raised with the

Joint Commissioning Group as part of the regular reporting of the performance of the scheme. Mitigating actions will be undertaken to reduce the likelihood of the risk arising or to address the risk. If this is not possible and potentially means that plans could go off track, then this will be escalated to the Integrated Health & Social Care Partnership Board.
What are the key success factors for implementation of this scheme?
The delivery of an Integrated Health and Social Care system in Bury is being driven by all the local stakeholders. The key success factors are: • Stakeholder engagement • Releasing capacity across stakeholders to support delivery • Delivery of extended access to GP Services over 7 days a week • Robust governance in place as schemes cut across the whole health and social care economy • GP engagement • Patient awareness • Changes in traditional behaviour patterns • Management of risk via risk register and regular contact with schemes in-between meetings

ANNEX 1 – Detailed Scheme Description

SCHEME 4

Scheme ref no.
Bury BCF 04
Scheme name
Care of Vulnerable Adults
What is the strategic objective of this scheme?
To reduce the number of avoidable admissions within secondary care by improving the coordination and quality of care for those who need it most. The scheme aligns with the core principles underpinning Bury's Health & Wellbeing Strategy: • Promoting prevention, early intervention and self-care • Reducing inequalities in health and wellbeing • Developing person-centred services • Planning for future demands
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
All 33 practices have signed up to deliver the following modules of care: **Module 1 – Increased Awareness/Administration of Flu Vaccinations** This module has two components that are targeted at over 65s: 1. Localised flu campaign • All patients over the age of 65 to be invited to receive their flu vaccination 2. Increased vaccination levels • Targeted payment rewards based on a higher level of achievement (80%, 85%, 87.5% and 90%) **Module 2 - Quality Improvements via Coordinated Care** This module has three key components which by the nature of their remit will cover all ages (197,376 registered population) but in particular those aged 65 and over (33,751) (as of June 2014). 1. Comprehensive care plans to be offered to the following cohorts of patients: • All patients within a residential establishment (Nursing/Residential (est no. 1,297),

Mental Health & Temporary residences) and registered with a Bury GP
- All patients on the practice's dementia register (currently 1,490)
- Any other patients as identified using local intelligence (e.g. those with co-morbidities or multiple A&E attendances/admissions). All care plans will be uploaded to the patients Summary Care Record (SCR) and Electronic Referral and Information Sharing System (ERISS) which is web-based application, designed to enhance information sharing and collaborative working between the North West Ambulance Service (NWAS) and its key stakeholders.

2. Increasing access to General Practice (general enabler supporting all ages):
   - All patients cohorts will benefit from practices delivering a minimum threshold of appointments per 1000 patients based on the average from benchmarking data (5.4 per 1000 patients)
   - Measured/monitored using bespoke software

3. Delivery of Multi-Disciplinary Teams for those who need one (all ages)
   - Coordination of appropriate attendance
   - Ensuring actions are documented and acted upon
   - Monitoring of outcomes/evaluation

Module 3 - Dementia identification and management
- Named dementia lead in every practice
- Localised training on dementia identification/assessment/investigation and management
- Increased prevalence recording (68% of predicted being the target)
- Implementation of a practice based pathway for dementia and alzheimer's disease
- Patients on the practices dementia register to be offered a comprehensive care plan (under Module 2)

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The services described will be delivered by the 33 practices within Bury through the use of a Locally Commissioned Service (LCS) contract which has been funded under the BCF. How general practice deliver the core expectations of this contract within their own practices will be for them to determine (i.e. staffing/skill mix) although cross stakeholder working will be required if the overall scheme is to be successful as illustrated on the next page.

Within the LCS Contract is the requirement for practices to deliver against a specific set of key performance indicators (KPIs) which will be measured and reported against on a monthly basis as shown in the table below:

Performance Indicator	Threshold	Read Code	Method of Measurement	Frequency
Delivery of a stretched target for flu (age 65 and over)	=>80% =>85% =>87.5% =90%		Extracted via vision by Sector Analyst	Monthly
Equitable access to appointments across the CCG to be achieved by 31 March 2015 (all ages) Practices should be able to demonstrate that they have sufficient capacity to match demand	By 31st October 2014 practices will have undertaken the initial run of software By 12 November 2014 the CCG will present an initial benchmarking analysis and agree a minimum threshold per 1000 patients By Jan 2015 practices will re-run the appointment software to validate any increase needed has been implemented	N/A	The use of agreed appointment software (Monitoring will continue to ensure any required increase is maintained) Practices will not be penalised where deadlines have not been met due to CCG capacity	Once as per deadlines
Increased identification and management of patients with dementia (all	68% of the practices estimated prevalence identified		Extracted by vision by Sector Analyst	Monthly
	A named dementia lead has been identified	N/A	Practices must be able to demonstrate compliance	On request
	Dementia lead has attended	N/A		

ages)	training on identification, assessment, investigation and management of dementia			
	A practice based pathway for identification, assessment, investigation and management of dementia and Alzheimer's Disease has been implemented	N/A	Practices must be able to demonstrate compliance on request (see Dementia Resource Pack)	On request
Care Plans (all ages)	100% of dementia diagnosed patients to have been offered 90% received a standardised care plan	13F6 "nursing / other home"	Practice Search / submission	Monthly
	100% of patients within Nursing/Residential Establishments including other care facility settings/respite settings (this includes temp residents) and mental health establishments to be offered, 90% received a standardised care plan	13F6 "nursing / other home"	Practice Search / submission Consideration for 13F6 – which is "nursing / other home"	Monthly
	100% of Quarterly reviews have been conducted	8CMG.00	Practice Search / submission	Monthly
	Where patients may be suitable but do not fall into the above categories (for example => 75 or on 4+ medications and 4 GP appointments /admissions in the last 12mths or local intelligence)	13F6 "nursing / other home"	Practice Search / submission	Monthly
MDTs (all ages)	Appropriate patients to receive the benefit of an MDT attended by relevant Health and Social Care professionals, the outcomes of which are clearly documented and acted on.	#3876 multidisciplinary assessment #6AE multidisciplinary review	Practice Search / submission Standardised MDT outcome template submitted to CCG	Monthly
Quality assurance	undertake/submit a random sample of care plans as part of a quality assurance process	N/A	Random sample of care plans by CCG (No. dependent on findings)	as requested
Overall Measure Performance Indicator	**Threshold**	**Read Code**	**Method of Measurement**	**Frequency**
A combined reduction which against (all ages) • NEL Admissions • A&E attendances	Baseline achievement against plan Further 5% reduction against plan	N/A	Practice/Sector and CCG reductions will be monitored through SUS/SLAM by the sector analyst and presented to Sectors and PMO on a monthly basis.	Monthly

This will not only give assurance to the Health & Social Care Governance Structure that measureable outcomes are being achieved but will also support general practices to have peer to peer discussions around the implementation of each module in order to share any good

practice and identify areas were further additional support may be required at the earliest opportunity.

Key milestones:

Vulnerable Adults	Start Date	End Date
Overall Project	**10/2/2014**	**30/9/2015**
Stakeholder Engagement	10/2/2014	19/6/2014
Specification Development	18/4/2014	1/10/2014
Financial modelling	14/3/2014	15/8/2014
Performance/Outcome Monitoring	15/7/2014	30/9/2015
Ongoing Support	1/10/2014	30/9/2015

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Local evidence

General overview of local intelligence

The Joint Strategic Needs Assessment for Bury states that, by 2022 the population in every 5-year age band over 50 years old is expected to increase by at least 20% :

- The over 65 year olds population is expected to increase by 29% (9,000 more)
- The over 85 year olds population is expected to increase by 54%. (2,000 more)

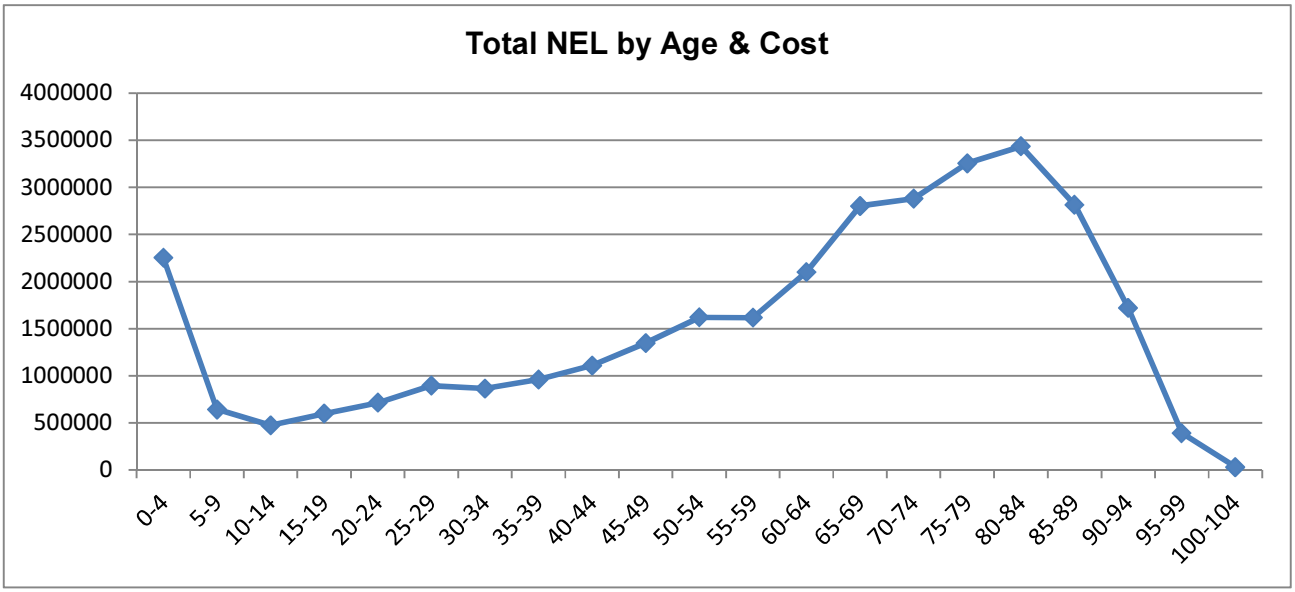
The demographic data in the report gives a clear indication of the ageing nature of the population with an estimated 10,000 more people over the age of 65 by 2025 (a 35% increase on 2010 levels). In addition, these people will be living longer. Females will continue to live longer than males although this gap is set to close due to increased life expectancy of males over the age of 80. In the next 15 years, there will be 79% more very elderly men compared to only 38% more females. The combined effect equates to 55% more over 80s by 2025.

Current projections suggest that by 2025:

- 5,000 more people will have long term limiting conditions (+35%)
- 10,000 people are likely to have some form of continence problem
- 8,500 will have some problem getting around (+40% on current levels)
- Some 10,000 older people will be classed as obese with almost 5,000 people suffering from diabetes
- There will be 1,000-1,500 more people with dementia
- Other limiting condition such as visual and hearing impairment are also expected to rise by between 35% and 45%

Of particular concern is the number of falls amongst older people. In Bury admission rates for fractured femurs are already higher than average and with falls predicted to increase by up to 3,000 (+38%) by 2025, this could result in around 1,000 people per annum (10% of the total)

being admitted to hospital.
On looking at the total spend of non-elective admissions against all ages it is clear to see that this age band of patients are the most resource intense population; it is therefore imperative that any schemes delivered must be aimed at this cohort of patients.



Module 1 – Increased Awareness/Administration of Flu Vaccinations
Bury historically underperforms against a 75% target for the administration of Flu vaccinations for those aged 65 and over:

Year	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14
% uptake	71.9	72.3	72.2	71.4	72.1	74.5	72.3	72.6

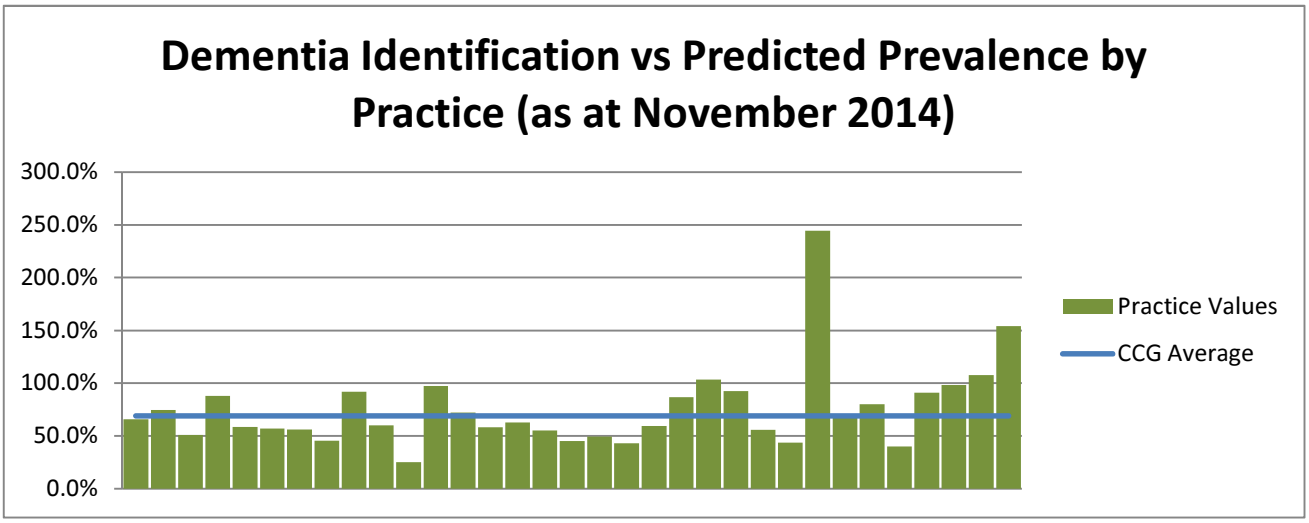
Module 2 – Quality Improvements via Coordinated Care

Local Schemes Already in Delivery - Care Home LCS
Proactive coordinated care planning is already in place for a specific cohort of patients through the Care Home LCS which has 18 out of 33 practices providing a dedicated GP role to specific homes within the borough. It hoped that by expanding the ethos of this model we will replicate the positive outcomes already seen which include:

- 22 out of a possible 30 homes covered (although not all patients within the homes have chosen to change GPs)
- Improved patient/carer experience
- Improved quality of care
- Reduction and prevention of non-elective admissions -86 compared to a 22 rise in those homes not covered (2012/13 verses 2013/14)
- Reduction in A&E attendances -30 verses a 39 increase in homes not covered by the LCS (2012/13 verses 2013/14)
- Promotes self-care and carer confidence

- Up-skilling of existing care home staff
- Alleviate pressure within Primary Care services
- An EOL evaluation and ADASS data indicates that Bury has moved from a national regional position of 42, to the third best performing region for death in usual place of residence (DiUPR.) Between 2009 and 2012, the proportion of people in Bury dying in their usual place of residence improved from 36% to 44%

Module 3 - Dementia Identification and Management
There is significant clinical variation across practices in terms of prevalence identification (Predicted versus actual, current highest 244%, lowest 25%)



National Evidence

Module 1 – Increased Awareness/Administration of Flu Vaccinations

- http://www.evidence.nhs.uk/search?q=flu+jabs

Module 2 – Quality Improvements via Coordinated Care

- Admission Avoidance Direct Enhanced Service (DES) http://www.nhsemployers.org/~/media/Employers/Publications/Avoiding%20unplanned%20admissions%20guidance%202014-15.pdf
- Delivering better services for people with long-term conditions - Building the house of care the Kings Fund 2013 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf
- A collaborative process of personalised care between the clinician, patient and if applicable the patient's carer(s).“My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes.” (National Voices)
- Health policy has consistently advocated personalised care and care planning, emphasised within ‘Our health, our care, our say’ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/272238/6737.pdf

- Personalised Care Plans for long term conditions - Quality and Productivity http://www.evidence.nhs.uk/qipp
- Shared Decision Making - http://sdm.rightcare.nhs.uk/
- NHS England, Transforming participation in health and care 2013, http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf
- Graffy et al, Primary Health Care Research & Development, 2009, 10(3),210-222
- Graffy J, Grande M, Campbell J. (2008) Case management for elderly patients at risk of hospital admission: a team approach. Primary Health Care Research and Development, 2008: 9 (1): 7-13.
- Care Planning "Putting Patients first." http://www.england.nhs.uk/wp-content/uploads/2013/04/ppf-1314-1516.pdf

Increasing Access To General Practice (General Enabler):

- GP Survey Results http://www.gp-patient.co.uk/results
- Improving General Practice – a call to action http://www.england.nhs.uk/wp-content/uploads/2013/09/igp-cta-evid.pdf
- Daly JM, Buckwalter K, Maas M. Written and computerized care plans. Organizational processes and effect on patient outcomes. J Gerontol Nurs 2002;28(9):14-23.

Module 3 - Dementia Identification and Management

- Dementia CG42: http://www.nice.org.uk/guidance/CG42/chapter/1-Guidance
- Improving the identification and care of patients with dementia has been prioritised by the Department of Health through its mandate to NHS England and by NHS England through its planning guidance for clinical commissioning groups (CCGs) .The commitment to improving patient care and early diagnosis in primary care is in the NHS England business plan "Putting Patients first." http://www.england.nhs.uk/wp-content/uploads/2013/04/ppf-1314-1516.pdf

How We Used National and Local Evidence

A series of events were held and 100% of Practices were represented (clinicians and managerial staff). A number of evidence based interventions (provided by the Kings Fund) were presented under the following broad headers:

- Healthy active ageing and supporting independence
- Living well with simple or stable long-term conditions
- Living well with complex comorbidities, dementia and frailty
- Rapid support close to home in crisis
- Good acute hospital care when (and only when) needed
- Good discharge planning and post-discharge support
- Good rehabilitation and reablement after acute illness or injury
- High-quality nursing and residential care for those who truly need it
- Choice, control and support towards the end of life

(King's Fund, 2013)

Practices were asked to pick their top four initiatives under these headers likely to achieve the desired outcome (to reduce NEL admissions) which were:

1. Influenza and pneumococcal pneumonia vaccination

2. An identified key worker who acts as a case manager and coordinator of care across the system
3. Expert decision makers are available at the front door of the acute hospital from 8am to 8pm, seven days a week. Specialist assessment should be available within 12 hours of admission, seven days per week
4. There should be a multi-disciplinary team located at the front door of the hospital integrated with the community team focused on the facilitation of discharge

Through a further series of meetings all initiatives where scoped into a project initiation document which took into account:

- Ease of implementation
- Delivery model (including potential financial envelope needed)
- Enablers
- Likely timescales for delivery and key milestones (by when and by who)
- KPIs for success
- Local/National Evidence
- Stakeholders
- Risks and possible mitigating actions
- Commissioned Provider (i.e. from practice/alternate provider)
- Outcomes / incentive payments for achievement of KPI's

This enabled a rationalisation exercise to take place and the main areas for implementation then agreed as:

Module 1 – Increased Awareness/Administration of Flu Vaccinations
Module 2 – Quality Improvements via Coordinated Care
Module 3 – Dementia identification and management

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

A budget allocation of £1,215,620 has been made available to the practices. This figure includes the national recommendation of £5 per head as well as an additional sum of funding to ensure 100% coverage of registered patients within care facilities (such as Nursing/Care Homes, respite facilities, mental health establishments etc. The following table explains how this investment will be deployed. It should be noted that only the performance element of the scheme is being funded through the BFC pool (in green) and that the remaining elements are funded by the CCG (in yellow).

Area	Target	Financial Reward
Module 1 – Increased Awareness/Administration of Flu Vaccinations (Incremental increases up to a total of 140K achievable)	Advertisement	£10,000
	80%	£77,000
	85%	£7,000
	87.5%	£14,000
	90%	£42,000
Module 2 - Co-ordinated Care (expectation that practices deliver all KPIs i.e. care plans/appointment software MDTs etc.)	KPIs	£397,029
Module 3 - Dementia Identification and Management	68%	£60,781
Overall Reward Payment (based on a financial saving against a planned practice budget)	Baseline	£486,248
	5% Reduction on baseline	£121,562
Total Budget		**£1,215,620**

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The main impact of this scheme is to reduce the number of non-elective (NEL) admissions, as shown in the table below and in part 1, appendix 1, both general and acute (estimated as a reduction of 328 with an average spell cost of £1,765).

		Metric 1 - Residential Admissions		Metric 2 - Reablement		Metric 3 - Delayed Transfers of Care		Metric 4 - Avoidable Emergency Admissions		Metric 5 - Patient experience	Metric 6 - Local metric - Falls	
Scheme ID	Scheme Description	%	Nos of people	%	Nos of people	%	Nos of people	%	Nos of people	%	%	Nos of people
BCF04	Care of Vulnerable Adults	35%	2	5%	1	15 %	39	30%	296	20%	20 %	8

The wider impact of the scheme will include:

Module 1 – Increased Awareness/Administration of Flu Vaccinations

- Reduced clinical variation for the administration of flu vaccines (89% highest practice, lowest practice 55.9%)
- Increased administration of flu vaccinations for over 65s (baseline 13/14 72.6%)
- Reduction in the number of respiratory classified admissions

Module 2 – Quality Improvements via Coordinated Care

- Reduced NEL admissions, general and acute
- Reduced length of stay
- Reduced Excess bed days
- Encourage collaborative working across the whole health care system (including other primary care providers, secondary care, community care, social care, third sector, out of hours medical services, ambulance, and 111 services) in order to ensure patient care is delivered in a 'joined up' manner
- Emergency re-admissions within 30 days of discharge from hospital
- Amenable/preventable mortality
- Improving people's experience of integrated care
- Health-related quality of life for carers/carer-reported quality of life
- Health-related quality of life for people with long-term conditions/social care related quality of life
- Reduce the number of minor A&E attendances
- Increased (equitable) access provision within General Practice (5.4 appointments per 1000 patients across all practices)
- Enhance the patient experience in terms of responsiveness and improved access

Module 3 - Dementia identification and management

- Reduced clinical variation across providers for the identification of Dementia (Predicted versus actual with 68% being the target – current highest 244%, lowest 25%)
- Dementia effectiveness of post-diagnosis care in sustaining independence and improving quality of life
- Provide clinicians with the skills and knowledge to detect assess and manage patients at potential risk of dementia

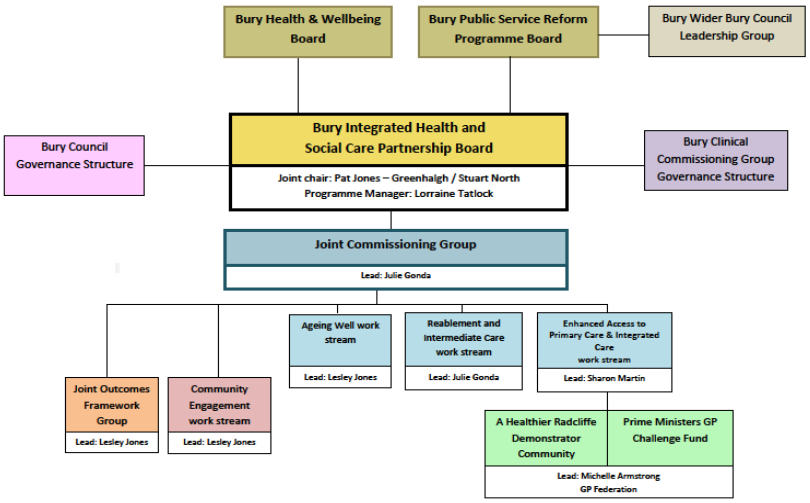
Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Governance Structure

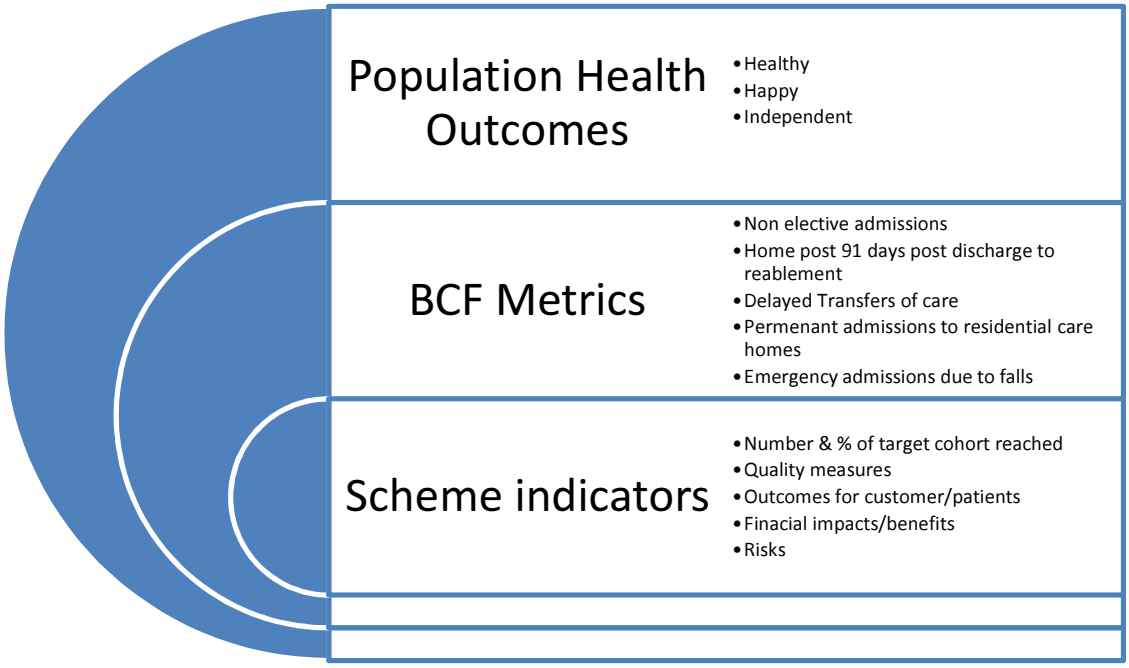
This Better Care Fund scheme is project managed by a scheme lead who reports to the Joint Commissioning Group via the Enhanced access to primary care and integrated care workstream. The Joint Commissioning Group reports to the Integrated Health and Social Care Partnership Board and subsequently to the Health and Wellbeing Board as shown in the structure below.

Bury Integrated Health & Social Care Governance Structure



Bury Health & Social Care Partnership Board are in the process of developing a Joint Outcomes Framework through which to monitor the impact of work-streams including the Better Care Fund Schemes on the health and social care system and ultimately on the health of our population. This work is being taken forward by the Joint Outcome Framework Group comprising performance and intelligence specialists from Public Health and Adult Social Care within the Local Authority and the CSU on behalf of the CCG.

The Outcomes Framework



Population Outcome measures
We are clear that health and social care integration is a means to an end and not an end in itself and that whilst there is an immediate focus around creating a financially sustainable system, this can only be achieved in the longer term if we create a system which improves the health and wellbeing of our local population and reduces the need for treatment services.

We have therefore agreed a set of indicators through which we can determine whether our work has a positive impact on people's health, wellbeing and independence.

The embedded document outlines the measures agreed and associated data sources and gives the current picture for Bury against each indicator.


JOF overarching indicators June 14 v2

Better Care Fund Metrics
The Better Care Fund metrics provide us with more immediate feedback on whether the work we are doing is delivering the system changes that we are driving towards. We are building on work undertaken by Greater Manchester CSU on developing a Performance dashboard for the Healthier Radcliffe Demonstrator and the Non Elective Story Board (see embedded document) to develop a single whole Borough, whole system dashboard incorporating the BCF metrics using software recently purchased by the Local Authority.
As an interim whilst the dashboard is developed, we will be collating current performance reports on the different metrics to create a single monthly report provided to the Joint Commissioning Group, Provider Partnership Group with exception reporting to the Health & Social Care Integration Partnership Board.


NEL.xls

Scheme indicators
The indicators for this scheme are set out below. The key indicators on progress will be incorporated into the above dashboard in time. Meanwhile monthly progress reports will be collated and provided to the Joint Commissioning Group, Provider Partnership with exception reporting to the Health & Social Care Integration Partnership Board.

- Avoidable emergency admissions
- Permanent admissions of older people to residential and nursing care
- Effectiveness of Reablement for people 65 and over
- Delayed transfers of care
- Patient/service user experience
- Falls

A project dashboard which pulls together all of the key outcomes/KPIs intended to be delivered is reported to practices on a monthly basis in order for them to assess the impact of schemes and address any concerns at an early stage in the project via the Sector Support Groups which meet on a monthly basis.


Vulnerable Adults

Risks
Risk associated with the delivery of the Better Care Fund Plan and associated schemes have been identified in the Risk Log in Part 1 Appendix 3.

Any risks that may affect the delivery of the Better Care Fund will be raised with the Joint Commissioning Group as part of the regular reporting of the performance of the scheme.

Mitigating actions will be undertaken to reduce the likelihood of the risk arising or to address the risk. If this is not possible and potentially means that plans could go off track, then this will be escalated to the Integrated Health & Social Care Partnership Board.

What are the key success factors for implementation of this scheme?

- Clinical leadership
- 100% sign up to the Locally Commissioned Service Contract
- Clear targets/objectives for the provider
- A coordinated approach to care delivery across providers
- Effective communication across wider system stakeholders
- Utilisation of all resources available within the community
- Regular reporting/monitoring of outcomes

As a result of this achievement of the specific targets referred to above which will ultimately lead to improved care for vulnerable people.

ANNEX 1 – Detailed Scheme Description

SCHEME 5

Scheme ref no.
Bury BCF 05
Scheme name
Review Programme - Integrated Intermediate Care , Reablement and other related services
What is the strategic objective of this scheme?
The vision for health and social care services in Bury is one of self-support, self-care, prevention and early intervention. Our plans cover not only service integration for those with existing health and social care need and their carers, but also feature a strong health improvement and prevention element to prevent people needing services in the first place. AQUA ADASS Locality benchmarking Despite being the best performing area according to AQuA data as recently as September 2014, as illustrated in the document embedded above, to achieve even better use of resources, we will need to maximise the capacity of existing services, making sure they are 'fit for purpose' for the future, avoid duplication, are outcome focussed and fit to meet market demand. The success of this programme of reviews will be assessed by measuring its contribution to the following performance measures within the BCF; it is expected that the scheme will have most impact on Reablement, Delayed Transfers of Care and Falls metrics, whilst indirectly supporting Residential Care and Non Elective admissions. The capital elements of the BCF, relating to Disabled Facilities Grants (DFGs) and the social care capital allocation are linked to this scheme in terms of prevention and intermediate care services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
NHS Bury CCG and Bury Councils Adult Social Care Services have agreed to undertake a joint commissioning review of a number of services within Bury which have a direct influence on the numbers of patients being admitted to hospital and which support effective and early discharge.

Some of these services, but not all, form part of a cluster of services currently delivered by both health and social care providers that already support patients and customers in line with Better Care Fund outcomes, hence they have been aligned with the Better Care Fund. The objective of the review is to explore the feasibility and impact of integrating these services to provide a pathway which reduces system blockages and referral points. This means that elements of these services may be de-commissioned, re-commissioned or re-designed for example brought under single line management of one agency.

The significant majority of customers within these services are older people, latest reports (at Q2, September 2014) showing in Reablement 75% of customers are aged 75 or over, in Crisis Response 80% and in Intermediate Care 82%. It is expected that this demographic will continue for the foreseeable future.

The services also deal with a significant proportion of people who are referred into services due to falls/mobility issues, again with September 2014 reports showing Reablement at 68%, Crisis Response at 32% and Intermediate Care at 44%.

Outcomes from current operation of the schemes are expected to continue until the review is completed; At Quarter 2 (Sept 2014) some of the successful outcomes are:

Reablement – 50% of customers completed reablement and were discharged without a care package; 19% received a reduced (are package)

Crisis Response – 39% of customers were discharged and supported at home with a social care package; 19% of customers were discharged with no further actions; 27% of customers were transferred to short term residential or nursing care, indicating their need could not be met at home in the short term.

Intermediate Care – 72% of customers were discharged home, but 14% were discharged to hospital, indicating a deterioration in condition during the Intermediate Care episode of care

The services in scope and current investment levels are shown in the table below; those highlighted in green will form part of the Better Care Fund from 2015/16 whilst those in yellow complement the BCF schemes and are therefore included in the wider review, but not at this point in the BCF. Once the review is complete, the wider schemes may also be included within the BCF in future.

Service Name	Commissioned by	2015/16 £000
BCF schemes		
Integrated intermediate care	CCG	820
Integrated intermediate care	LA	315
Crisis response	LA	254
Crisis response	CCG	400
Discharge liaison	CCG	354
Reablement Service	LA	2,300
Total - included in BCF		**4,443**
Related schemes		
Bealeys - bed	CCG	
Access to beds (crisis response)	CCG	
Access to beds (50:50 beds)	CCG	
Access to beds (50:50 beds)	LA	
Access to beds (spot purchase)	CCG	
Access to beds (assessment)	CCG	
Schemes currently outside BCF but to be reviewed		

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

These services sit within the current patient / customer pathway as illustrated in the diagram below, with the discharge liaison service being a key referral point into service hence the inclusion of this team within the review.

IMC & REABLEMENT services.pdf

The current delivery chain in respect of the scheme is detailed below; changes to this will be identified clearly as part of the review programme. However, the main providers of Intermediate Care, Reablement and other related services in Bury are Pennine Care Foundation Trust and the Local Authority.

Intermediate Care Residential Service - a 36 bed service, social care rather than clinical model.	Provided by the Local Authority, majority commissioned by CCG
Crisis response – a joint service comprising social workers	Provided jointly by LA and Pennine Care Foundation Trust (PCFT) under line management from the LA; commissioned by CCG and LA
Discharge Liaison Team	Provided by PCFT but under line management from the LA Commissioned by the CCG
Reablement – this is a service that is both provided and funded by the Local Authority, under the same senior line management as IMC. It works closely with the hospital social work team, and with Domiciliary Care Brokerage Team in respect of on-going placements.	Provided by the LA; funded in full by the LA
• Assessment beds • crisis response • 50/50 beds • assessment beds • spot purchase beds	Commissioned directly from independent providers by the CCG
Bealeys Community Hospital	Provided by PCFT, commissioned by CCG

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Strong national evidence exists to show that intermediate care and reablement services are a significant part of the Government's agenda around prevention, aimed at keeping people independent and free from long term support for as long as possible; research demonstrates that a reablement approach also has a positive impact on people's own perception of quality of life.

SCIE (Social Care Institute for Excellence) have published a number of research items, including Social Care TV videos, between 2011 and 2013, ranging from cost effectiveness of such services to engagement with families and carers around reablement.

http://www.scie.org.uk/topic/careservices/preventionreablement/reablement

Section 2 of the Care Act provides a statutory framework for focussing on 'Preventing, reducing or delaying needs'. It outlines the duty for local authorities to 'identify and target those individuals who may benefit from particular types of preventative support'. The expectation of building strong links with health professionals such as GPs and community nurses to undertake some of the identification is clear, and there are projects underway in Bury to support this approach , such as Staying Well, which is part of the BCF programme.

Intermediate Care has been evidenced by the King's Fund as a positive way of supporting people moving through the health and wider care system
http://www.kingsfund.org.uk/publications/intermediate-care

and more recent King's Fund evidence pertinent to this cluster of services indicates that reablement forms a key component of effective integrated care which focuses on effective co-ordinated care and reduced delays for patients moving around the care system.

http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population

However, it should be noted that this BCF scheme is not only about reviewing and reshaping the Reablement Service and the Intermediate Care Service, but wider services which provide short interventions to support people's recovery on discharge from hospital, as well as shifting the emphasis to a 'step up' model of prevention. The case for change is strong – whilst Intermediate Care Services are a good example of collaborative working across the NHS and social care in Bury and the positive contribution that these services have made to the health and social care economy is positively acknowledged, both Local Authority and CCG commissioners' vision for services is a better integrated one, albeit with the recognition that the range of services may continue to be run by different partner agencies.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Service Name	Commissioned by	2015/16 £000
BCF schemes		
Integrated intermediate care	CCG	820
Integrated intermediate care	LA	315
Crisis response	LA	254
Crisis response	CCG	400
Discharge liasion	CCG	354
Reablement Service	LA	2,300
Total - included in BCF		**4,443**

As outlined above, the funding from BCF is £4.443m currently spent on these schemes, it is expected that this will continue until the review is completed.
The capital element of the BCF totals:

Capital element of BCF	£
Disabled Facilities Grants	781,000
Social Care Capital	455,000
Total Capital	1,236,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Specific targets have not yet been identified in terms of the reviewed services, but the following outcomes will be delivered by the review: • Service model which ensures self-care and self-support – the aim of these services is to bring people up to baseline ability, then either discharge with no further support or minimal long term support. The review will assess how well do services meet that objective, how could they be improved, and measurements for success • Delivery of the Better Care Fund measures – Four of the key measures within the Better Care Fund are: o Avoidance of emergency admissions to hospital; o Reduction in admissions into permanent residential care o Maintenance of an individual at home 90 days after discharge. o Delayed Transfers of Care It is expected that this review will provide a series of recommendations that are evidence based as to how the services in scope could be re-designed to contribute more effectively to the measures, in particular prevention of hospital admission • Delivery of the CCG Commissioning Intentions 15/16, it is expected that the services in scope form Stage 4 of a procurement exercise in which decommissioning notice is served in October 2015, with new services live from October 2016. The outcomes from this review will develop the specification which the CCG will use to tender or re-design • Support to the Integrated Health & Social Care model– the CCG and Council want to commission community based services supporting people in their own home, linked to primary care and other community based services to promote better wellbeing for the residents of Bury. The review will assess how well do services meet that objective now, how could they be improved, measurements for success against this objective • Efficiencies - The review will identify potential savings through avoidance of duplication, system wide efficiencies and reduction in hospital admissions which will be outlined in a Business Case • In addition, without going into detailed operational re-design, the review is expected to provide an overview of changes needed in respect of referral points in and out of these services to ensure that we adopt a ‘tell us once’ approach for the patient / customer, identify potential blockages within the customer journey and provide proposals on how providers can work together to resolve any issues. This scheme will contribute towards the following metrics and financial benefits realisation as detailed in the table below and also in part 1 appendix 1

		Metric 1 - Residential Admissions		Metric 2 - Reablement		Metric 3 - Delayed Transfers of Care		Metric 4 - Avoidable Emergency Admissions		Metric 5 - Patient experience	Metric 6 - Local metric - Falls	
Scheme ID	Scheme Description	%	Nos of people	%	Nos of people	%	Nos of people	%	Nos of people	%	%	Nos of people
BCF05	Integrated Intermediate Care, Reablement and other related services	10%	1	40%	2	65%	167	5%	49	20%	50%	21

Action Plan

The high level action plan for this scheme is as follows:

Workstream	Activity	Key Milestone	Start Date	End Date	Owner	Status
A	**Review of Services**		**01/08/2014**	**30/09/2015**		**On Target**
1	Development of key material to support review process (prioritisation matrix/ joint processes/review template)		01/08/2014	31/12/2014	**Tracy Minshull**	**On Target**
2	Review to be completed and clusters of services identified	**Y**	31/12/2014	31/12/2014	**Tracy Minshull**	**On Target**
3	Data analysis (identification of trends/gaps ion services) Risk log maintained and existing metric reviewed.		31/12/2014	31/03/2015	**Liz Hodgkinson**	**On Target**
4	Review of existing practice and research around innovative models		31/12/2014	31/03/2015	**Zena Shuttleworth**	**On Target**
5	Emerging models developed for discussion		01/03/2015	30/04/2015	**Review Team**	**Not Started**
6	Options appraisal developed (where appropriate) Future metrics finalised.		01/04/2015	30/04/2015	**Review Team**	**Not Started**
7	Future service design to be finalised	**Y**	30/04/2015	31/05/2015	**Review Team**	**Not Started**
8	Implement findings of IMC review		01/06/2015	30/09/2015	**Review Team**	**Not Started**

The review team is a joint team made up of staff from both the CCG and the LA. The team members are:

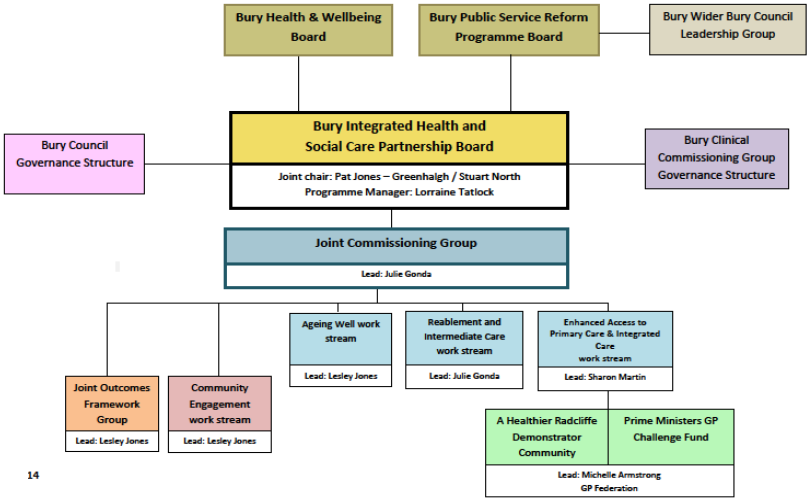
Tracy Minshull – Strategic Project Lead, Head of Commissioning & Strategy, Bury Council
Zena Shuttleworth – Strategic Planning Officer, Bury Council
Liz Hodgkinson – Economist, Bury Council

Sally Deaville – Deputy Head of Commissioning - Bury CCG
David Latham – Programme Manager, Bury CCG

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

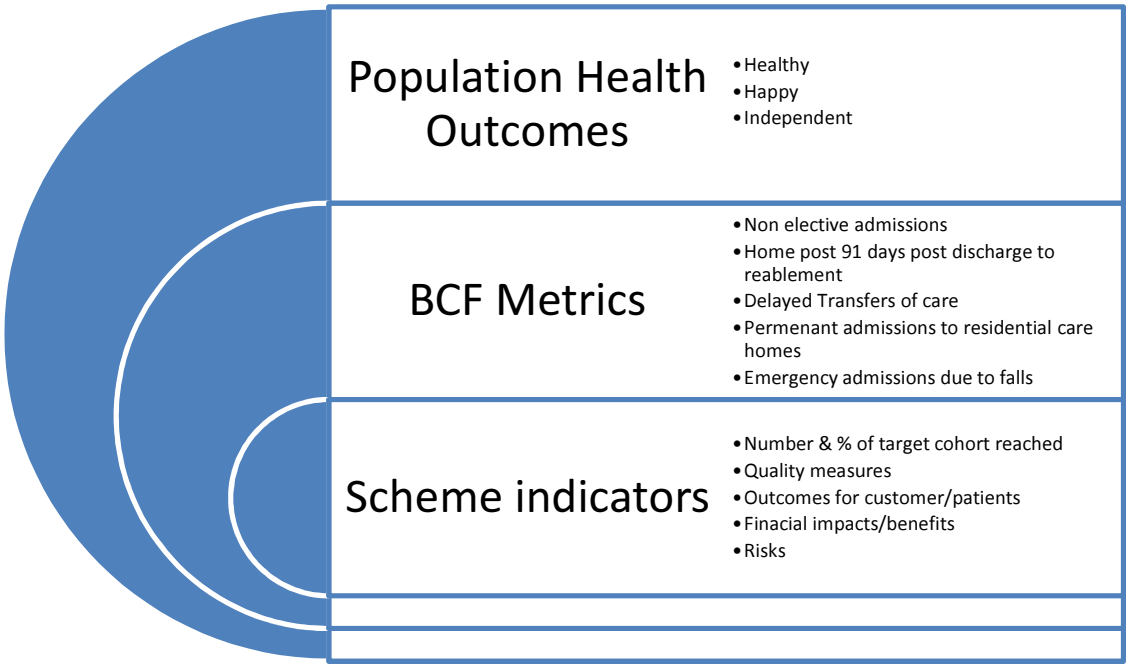
Governance Structure
This Better Care Fund scheme is project managed by a scheme lead who reports to the Joint Commissioning Group via the reablement and intermediate care workstream. The Joint Commissioning Group reports to the Integrated Health and Social Care Partnership Board and subsequently to the Health and Wellbeing Board as shown in the structure below.

Bury Integrated Health & Social Care Governance Structure



Bury Health & Social Care Partnership Board are in the process of developing a Joint Outcomes Framework through which to monitor the impact of work-streams including the Better Care Fund Schemes on the health and social care system and ultimately on the health of our population. This work is being taken forward by the Joint Outcome Framework Group comprising performance and intelligence specialists from Public Health and Adult Social Care within the Local Authority and the CSU on behalf of the CCG.

The Outcomes Framework



Population Outcome measures

We are clear that health and social care integration is a means to an end and not an end in itself and that whilst there is an immediate focus around creating a financially sustainable system, this can only be achieved in the longer term if we create a system which improves the health and wellbeing of our local population and reduces the need for treatment services.

We have therefore agreed a set of indicators through which we can determine whether our work has a positive impact on people's health, wellbeing and independence.
The embedded document outlines the measures agreed and associated data sources and gives the current picture for Bury against each indicator.

JOF overarching indicators June 14 v2

Better Care Fund Metrics

The Better care Fund metrics provide us with more immediate feedback on whether the work we are doing is delivering the system changes that we are driving towards. We are building on work undertaken by Greater Manchester CSU on developing a Performance dashboard for the Healthier Radcliffe Demonstrator and the Non Elective Story Board (see embedded document) to develop a single whole Borough , whole system dashboard incorporating the BCF metrics using software recently purchased by the Local Authority.

As an interim whilst the dashboard is developed, we will be collating current performance reports on the different metrics to create a single monthly report provided to the Joint Commissioning Group, Provider Partnership Group with exception reporting to the Health & Social Care Integration Partnership Board.


NEL.xls

Scheme indicators
The key indicators on progress will be incorporated into the above dashboard in time. Meanwhile monthly progress reports will be collated and provided to the Joint Commissioning Group and Provider Partnership with exception reporting to the Health & Social Care Integration Partnership Board.

Risks
Risk associated with the delivery of the Better Care Fund Plan and associated schemes have been identified in the Risk Log in Part 1 Appendix 3.

Any risks that may affect the delivery of the Better Care Fund will be raised with the Joint Commissioning Group as part of the regular reporting of the performance of the scheme. Mitigating actions will be undertaken to reduce the likelihood of the risk arising or to address the risk. If this is not possible and potentially means that plans could go off track, then this will be escalated to the Integrated Health & Social Care Partnership Board.

What are the key success factors for implementation of this scheme?

- Integrated pathway
- Improved patient journey
- Effective Navigation service in the Acute Trust both in A&E and Discharge
- Robust pathway development
- Efficient collection and analysis of data
- Buy-in of external stakeholders

Appendix 1 - Impact of schemes Metrics Mapping

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		Metric 1 - Residential Admissions		Metric 2 -Reablement		Metric 3 -Delaged Transfers of Care		Metric 4 -Avoidable Emergency Admissions		Metric 5 - Patient experience	Metric 6 - Local metric - Falls	
Scheme	**Scheme Description**	%	Nos of people	%	Nos of people	%	Nos of people	%	Nos of people	%	%	Nos of people
BCF01	Staying Well	10%	1	0%	0	0%	0	5%	49	20%	5%	2
BCF02	Extended access to Primary Care	10%	1	25%	2	5%	13	30%	296	20%	5%	2
BCF03	Integrated Health & Social Care	35%	2	30%	2	15%	39	30%	296	20%	20%	8
BCF04	Care of Vulnerable Adults	35%	2	5%	1	15%	39	30%	296	20%	20%	8
BCF05	Integrated Intermediate Care, Reablement and other related services	10%	1	40%	2	65%	167	5%	49	20%	50%	21
Total		100%	7	100%	7	100%	258	100%	986	100%	100%	41

Annual change in admissions - 7
Annual change in admission % -3.2

Annual change in proportion 1.3 (equate to 7 people)
Annual change in proportion % 1.5%

Annual change in admissions - 258
Annual change in admission % - 10.7%

P4P annual change in admissions - 986 P4P annual change in admissions % -5%

Annual change in emergency hospital admissions for injuries due to falls (65+) -41 Annual change in emergency hospital admissions for injuries due to falls (65+) -6.7%

2015-16 change (from 2014-15)

Low = up to and including 10%

Moderate = 11-20%

Significant = greater than 20%

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Back to BCF Programme Plan

Current period

Start Date	End Date	Status
05/01/15	**30/04/16**	On Target
08/12/14	17/12/14	On Target
24/12/14	24/12/14	Not Started
14/03/15	14/03/15	Not Started
14/03/15	28/03/15	Not Started
14/03/15	04/04/15	Not Started
01/03/15	31/03/15	Not Started
01/04/15	30/06/15	Not Started
05/01/15	**30/04/16**	Not Started
05/01/15	14/01/15	Not Started
14/01/15	31/01/15	Not Started
01/02/15	14/02/15	Not Started
14/02/15	01/03/15	Not Started
14/03/15	14/03/15	Not Started
21/03/15	21/03/15	Not Started
01/04/15	01/04/15	Not Started
01/06/15	30/04/16	Not Started
01/11/14	**31/01/16**	Not Started
01/11/14	30/11/14	Completed On Time
01/12/14	31/12/14	Not Started
05/01/15	31/01/15	Not Started
01/02/15	31/03/15	Not Started
01/03/15	Ongoing	Not Started
31/01/16	31/01/16	Not Started
01/02/15	**14/03/15**	Not Started
01/02/15	28/02/15	Not Started
14/02/15	14/03/15	Not Started
01/02/15	28/02/15	Not Started
05/01/15	**28/02/15**	On Target
01/12/14	15/12/14	On Target
16/12/14	24/12/14	Not Started
01/01/15	28/02/15	Not Started
01/02/15	**Ongoing**	Not Started
01/11/14	30/11/14	Completed On Time
01/02/15	30/03/15	Not Started
01/02/15	30/03/15	Not Started
31/05/15	Monthly	Not Started
31/05/15	Monthly	Not Started

Project Implementation Plan
2 Enhanced Access to Primary Care

Back to BCF Programme Plan

Gantt Chart Key

Workstream
Activity
Milestone

Current period

Workstream	Activity	Key Milestone	Start Date	End Date	Status
A1	**Enhanced Access to PC**		**01/12/13**	**01/12/15**	**On Target**
1	Development Healthier Radcliffe (extended hours one borough) (GP Fed Lead)		01/12/13	01/12/14	On Target
2	Extended access role out to all GP practices to commence (GP Fed Lead)		05/05/14	01/12/15	Completed On Time
3	Deliver Borough wide communications campaign (linked to SRG, GP Fe Lead)		01/09/14	01/12/15	Completed On Time
4	Review other services and identify any duplication and synergise pathways (GP Fed Lead)		01/09/14	17/12/14	Completed Late
5	Agree local evaluation process (CCG Lead)		01/12/15	09/03/15	Behind Schedule
6	GP Federationation application for additional funding and notification from NHS E (GP Fed Lead)		01/12/15	12/01/15	On Target
A2	**EA - Telephone Consultations (Copied directly from the NHS E Performance Report)**				
	Delivery of stakeholder workshops		07/07/14	07/07/14	Completed On Time
	Define list of services to be offered under telephone consultation		24/07/14	31/08/14	Completed On Time
	Demand profile established		21/08/14	21/08/14	Completed On Time
	Sign off service model		05/05/14	1710/14	Completed On Time
A3	**EA - Increased Online Access (Copied directly from the NHS E Performance Report)**				
	Deliver workshop to understand barriers and streamlining opportunities		05/05/14	18/06/14	Completed On Time
	Patient smartphone app released		05/05/14	04/08/14	Completed Late
	Pilot 'how to guides', VOS process and targeted initiatives in one practice		10/10/14	10/10/14	Completed On Time
	Review pilot interim findings and agree roll out plan for each practice		05/05/14	19/11/14	Completed Late
	Update 28-10-14 Easy GP Patient Services smartphone app delivered by INPS		05/05/14	31/01/15	Behind Schedule
	Update 28-10-14 Targeted initiatives complete for all practices		05/05/14	31/03/15	Behind Schedule
A4	**EA - GP Comparison Website (Copied directly from the NHS E Performance Report)**				
	Delivery of patient engagement workshops to capture design		30/06/14	31/08/14	Completed Late
	Initial design of website		08/08/15	30/09/14	Completed Late
	Submit technical solution to Programme Board for go/no go decision based on affordability.		29/08/14	30/09/14	Completed Late

ect Implementation Plan
Integrated Health and Social Care

Back to BCF Program

t Chart Key

Workstream
Activity
Milestone

				Current period
Activity	**Key Milestone**	**Start Date**	**End Date**	**Status**
Intergrated Health and Social Care Teams				
Mobilise the Prevention and Early intervention Task Team Scheme (GP FED & LA)				
Mobilise scheme in Radcliffe in Novemeber		04/08/14	01/12/14	**Completed On Time**
Establish monitoring and KPIs		01/11/14	31/01/15	**On Target**
Establish Bury wide role out and finacial model		01/11/14	31/03/15	**On Target**
Mobilise the Targeted Frail Elederly MDT with care co-ordination and re-ablement Scheme (GP FED & LA)				
Mobilise scheme in Radcliffe in Novemeber		04/08/14	01/12/14	**Completed On Time**
Establish monitoring and KPIs		01/11/14	31/01/15	**On Target**
Establish Bury wide role out and finacial model		01/11/14	31/03/15	**On Target**
Mobilise the Community Paramedic Scheme (GP FED & LPC)	**Y**	05/01/15	05/07/15	**On Target**
Mobilise scheme in Radcliffe in January		04/08/14	01/01/15	**On Target**
Establish monitoring and KPIs		01/11/14	31/01/15	**On Target**
200 review to be completed		01/01/15	31/03/15	**On Target**
Establish Bury wide role out and finacial model		01/11/14	31/03/15	**On Target**
Domiciliary medicines optimisation service (GP FED & NWAS)	**Y**	05/01/15	31/03/15	**On Target**
Mobilise scheme in Radcliffe in January		04/08/14	01/01/15	**On Target**
Establish monitoring and KPIs		01/11/14	31/01/15	**On Target**
Establish Bury wide role out and finacial model		01/11/14	31/03/15	**On Target**
Developing the Alcohol Liaison Role within the RAID (Rapid Access, Interface and Discharge) Model				
Review Alcohol Liaison linked to RAID		01/09/14	01/04/15	**On Target**
Review Dementia Advisor Service		01/09/14	01/04/15	**On Target**
Finalise serrvice specification with HMR		01/08/14	31/03/15	**On Target**
Agree KPIs to reflect outcome data from PAHT		01/08/14	15/02/15	**On Target**
Meet with TPM to confirm contract changes requiresd		01/08/14	28/02/15	**On Target**

ect Implementation Plan
Care of Vulnerable Adults

Back to BCF Programme Plan

tt Chart Key

Workstream
Activity
Milestone

Current period

Activity	Key Milestone	Start Date	End Date	Status
Stakeholder Engagement		**10/02/14**	**19/06/14**	**Completed On Time**
Set up initial meeting with General Practice		10/02/14	14/03/14	Completed On Time
Prepare background/evidence material to support potential schemes		14/03/14	14/03/14	Completed On Time
Initial Discussions		14/03/14	14/03/14	Completed On Time
£5 per head workshop feedback collation		14/03/14	28/03/14	Completed On Time
Set up 2 additional workshops to process the £5 per head interventions 1 in 3weeks and 1 in 6		14/03/14	04/04/14	Completed On Time
Prepare options based on outputs from initial meeting		31/03/14	31/03/14	Completed On Time
Workshop 1		03/04/14	03/04/14	Completed On Time
Rework options based on outputs of workshop 1		18/04/14	18/04/14	Completed On Time
Workshop 2		01/05/14	01/05/14	Completed On Time
Rework options based on outputs of workshop 2		16/05/14	16/05/14	Completed On Time
Smaller Task and Finish Group		19/05/14	19/05/14	Completed On Time
Rework options based on outputs of T&F Group		06/06/14	06/06/14	Completed On Time
Final Workshop 3		19/06/14	19/06/14	Completed On Time
Specification Development		**18/04/14**	**01/10/14**	**Completed On Time**
Draft initial specification based on workshop feedback		18/04/14	30/06/14	Completed On Time
Circulate to practices for comment		30/06/14	30/06/14	Completed On Time
Summarise practice comments received and review drafted spec accordingly		31/07/14	31/07/14	Completed On Time
Meet with Practice Managers to review intended KPIs		13/08/14	13/08/14	Completed On Time
Complete EIA and gain sign off from E&D lead		18/04/14	06/06/14	Completed On Time
Present draft proposals to Clinical Cabinet	Y	02/07/14	02/07/14	Completed On Time
All practices requested to submit final feedback on £5 schemes		04/07/14	04/07/14	Completed On Time
Prepare final specification/paper for clinical cabinet		15/08/14	24/08/14	Completed On Time
Present final specification for sign off	Y	03/09/14	03/09/14	Completed On Time
Final Spec to be shared with General Practices for sign up		15/09/14	15/09/14	Completed On Time
Go live	Y	01/10/14	01/10/14	Completed On Time
Financial modelling		**14/03/14**	**15/08/14**	**Completed Late**
Ascertain level of investment required under national guidelines		14/03/14	14/03/14	Completed On Time
Consider any additional investment needed		19/06/14	19/06/14	Completed On Time
Model potential upfront and reward based payments based on agreed outputs from workshops		14/03/14	14/03/14	Completed On Time
Include proposals within draft for clinical cabinet		02/07/14	02/07/14	Completed Late
Rework financial modelling to allow for 12mths Oct - Sep (providing assurance that max cost does not exceed potential saving and include a high cost patient contingency)		18/07/14	15/08/14	Completed Late
Performance/Outcome Monitoring		**15/07/14**	**30/09/15**	**On Target**
Create vision searched, test with practices throughout September ready for October 'GO LIVE'		15/07/14	31/10/14	On Target
Create an easy to understand monitoring proforma for any returns which may be needed including a reporting performance dashboard which will go through PMO		15/07/14	30/09/14	Behind Schedule
Ongoing reporting of performance against work programme to PMO and sectors		13/11/14	30/09/15	Not Started
Formal review of performance against plan to be presented to PMO	Y	08/01/15	08/01/15	Not Started
Formal review of performance against plan to be presented to Sector Meetings	Y	06/01/15	27/01/15	Not Started
Review of performance/specification report back to Clinical Cabinet	Y	04/02/15	04/02/15	Not Started
Ongoing Support		**01/10/14**	**30/09/15**	**On Target**
Put on an educational event to support the development of good care plans through the use of a standardised guideline	Y	15/10/14	15/10/14	Completed On Time
Outcomes from event circulated to all pratices		15/10/14	15/10/14	Completed Late
Certificates of attendance to be sent to all attendees		31/10/14	31/10/14	On Target
Ensure practices understand how to implement guideline including summary care record up load and flagging on ERISS		15/10/14	30/11/14	On Target
Regular discussions at Sector Meetings		01/10/14	30/09/15	On Target
Future event based on outputs of monitoring if needed		01/02/15	01/02/15	Not Started

Project Implementation Plan

5 Intermediate Care and Reablement

Back to BCF Programme Plan

Gantt Chart Key

Workstream
Activity
Milestone

Current period

Workstream	Activity	Key Milestone	Start Date	End Date	Status
A	**Review of Services**		01/08/14	30/09/15	On Target
1	Development of key material to support review process (prioritisation matrix/ joint processes/review template)		01/08/14	31/12/14	On Target
2	Review to be completed and clusters of services identified	Y	31/12/14	31/12/14	On Target
3	Data analysis (identification of trends/gaps ion services)		31/12/14	31/03/15	Not Started
4	Review of existing practice and research around innovative models		31/12/14	31/03/15	Not Started
5	Emerging models developed for discussion		01/03/15	30/04/15	Not Started
6	Options appraisal developed (where appropriate)		01/04/15	30/04/15	Not Started
7	Future service design to be finalised	Y	30/04/15	31/05/15	Not Started
8	Implement findings of IMC review		01/06/15	30/09/15	Not Started

05-May-14 | 12-May-14 | 19-May-14 | 26-May-14 | 02-Jun-14 | 09-Jun-14 | 16-Jun-14 | 23-Jun-14 | 30-Jun-14 | 07-Jul-14 | 14-Jul-14 | 21-Jul-14 | 28-Jul-14 | 04-Aug-14 | 11-Aug-14 | 18-Aug-14 | 25-Aug-14 | 01-Sep-14 | 08-Sep-14 | 15-Sep-14 | 22-Sep-14 | 29-Sep-14 | 06-Oct-14 | 13-Oct-14 | 20-Oct-14 | 27-Oct-14 | 03-Nov-14 | 10-Nov-14 | 17-Nov-14 | 24-Nov-14 | 01-Dec-14 | 08-Dec-14 | 15-Dec-14 | 22-Dec-14 | 29-Dec-14 | 05-Jan-15 | 12-Jan-15 | 19-Jan-15 | 26-Jan-15 | 02-Feb-15 | 09-Feb-15 | 16-Feb-15 | 23-Feb-15 | 02-Mar-15 | 09-Mar-15 | 16-Mar-15 | 23-Mar-15 | 30-Mar-15 | 06-Apr-15 | 13-Apr-15 | 20-Apr-15 | 27-Apr-15 | 04-May-15 | 11-May-15 | 18-May-15 | 25-May-15 | 01-Jun-15 | 08-Jun-15 | 15-Jun-15 | 22-Jun-15 | 29-Jun-15 | 06-Jul-15 | 13-Jul-15 | 20-Jul-15 | 27-Jul-15 | 03-Aug-15 | 10-Aug-15 | 17-Aug-15 | 24-Aug-15 | 31-Aug-15 | 07-Sep-15 | 14-Sep-15 | 21-Sep-15 | 28-Sep-15 | 05-Oct-15 | 12-Oct-15 | 19-Oct-15 | 26-Oct-15

Project Implementation Plan

Reduction in the rate of injurious falls in 65+ population

Back to BCF Programme Plan

Gantt Chart Key

Workstream
Activity
Milestone

Current period

Workstream		Activity	Key Milestone	Start Date	End Date	Status
A	**Improve Patient Outcomes and improve efficiency of care after hip fractures**			**10/11/14**	**31/03/16**	
1	Analyse findings of Royal College of Physician's Falls and Fragility Fracture Clinical Audit		Y	10/11/14	28/11/14	Completed On Time
2	Commissioners to utilise findings to drive any service improvements where indicated			24/11/14	30/01/15	On Target
3	Review current falls and fragility fracture care in acute setting			08/12/15	30/01/15	On Target
4	Identify opportunities for improvement in falls and fragility fracture care with Orthogeriatrican in acute setting, in turn supporting achievement of Best Practice Tariff			12/01/15	06/02/15	Not Started
5	Develop and implement improvement plan		Y	09/02/15	31/03/15	Not Started
6	Monitor and evaluate delivery of improvement plan			01/07/15	31/03/16	Not Started
7	Analyse findings of next Falls and Fragility Fracture Audit and recommence cycle		Y	01/12/15	31/12/15	Not Started
B	**Respond to a first fracture and prevent the second through fracture liaison type services**			**05/01/15**	**30/04/16**	
8	Review current fragility fracture care in Acute setting to ensure systematic FLS type approach to secondary fracture prevention		Y	08/12/15	30/01/15	On Target
9	Review Community Falls Service			01/01/15	31/01/15	Not Started
10	Develop Business Case for a Falls and Fracture Liaison Service as a redesign			01/02/15	28/02/15	Not Started
11	Develop Falls Service and FLS Specification			01/02/15	28/02/15	Not Started
12	Agreement to proceed from Joint Commissioning Group		Y	14/02/15	28/02/15	Not Started
13	Agree spec with provider		Y	01/03/15	21/03/15	Not Started
14	Commence Delivery		Y	01/04/15	01/04/15	Not Started
15	Develop infrastructure to undertake risk stratification around osteoporosis (audit and Qfracture facilities)		Y	01/01/15	30/04/15	Not Started
16	Contract Monitoring Meetings			01/07/15	20/04/16	Not Started
17	Include osteoporosis in primary care quality dashboard and monitor accordingly			01/12/14	31/02/2015	Not Started
C	**Early intervention to restore independence through falls care pathway linking acute and urgent services to secondary falls prevention**			**01/11/14**	**31/01/16**	
18	Review falls care pathway across health and social care sectors to optimise patient outcomes and system efficiency			01/11/14	31/03/15	On Target
19	Incorporate review of falls care within intermediate care review		Y	15/02/14	31/03/15	On Target
20	Redesign pathway where necessary		Y	01/01/15	28/02/15	Not Started
21	Joint commissioning of falls care pathway by health and social care through Joint Commissioning Group		Y	01/03/15	21/03/15	Not Started
22	Incorporate review of falls care within physiotherapy review			08/12/14	31/01/15	On Target
23	Review falls care within other relevant services e.g. OT, Postural Stability etc.			08/12/14	31/03/15	On Target
24	Redesign provision where necessary to deliver optimal falls care, maximising skills mix and resource		Y	01/02/15	31/06/2015	Not Started
25	Review GP Exercise Referal Scheme (BEATS)			08/12/14	31/01/15	On Target
26	Include osteoporosis, risk of fracture, risk of falls, history of falls as key criteria within revised BEATS scheme			15/12/14	31/01/15	On Target
27	Map all relevant physical activity assets			01/12/14	31/01/15	On Target
28	Develop capacity and capability within existing assets to work with relevant cohorts			01/02/15	30/06/15	Not Started
29	Develop new sustainable physical activity model and pathway offering evidence based interventions to sit alongside falls care pathway.		Y	01/12/14	28/02/15	Not Started
D	**Prevent frailty, promote bone health and reduce accidents**			**01/02/15**	**14/03/15**	
30	Implement NICE CG161 on Assessment and Prevention of Falls: Routine identification through health and social care contacts, interventions to improve strength and balance; offer of multifactorial assessment from community falls service		Y	01/01/15	14/03/15	Not Started
31	New Community Falls and Fracture Liaision Service to offer dedicated programme for care homes		Y	01/03/15	Ongoing	Not Started
32	Develop and implement Active Ageing programme (primary prevention), utilising opportunities through the I Will if You Will		Y	01/10/14	Ongoing	On Target
33	Incorporate bone health in Bury's proposed new Healthy Schools programme			01/06/15	30/06/15	Not Started
	Supportive Actions					
34	To continually assess need through maintenance of an up to date data profile around falls, related injuries including fragility fractures and osteoporosis		Y	01/11/14	Ongoing	On Target
35	Present data profile to Provider Partnership to mobilise the whole system around reducing injurious falls		Y	14/01/15	14/02/15	Not Started
36	To participate in PHE's Falls and Fragility Fractures Audit Programme (FFFAP), subject to resource decision by GM DPHs.		Y	01/12/14	31/03/16	On Target
37	To lead a GM Collaborative around falls and bone health			01/04/14	Ongoing	On Target

Date	Sheet	Cells
28/07/14	Payment for Performance	B23
28/07/14	1. HWB Funding Sources	C27
28/07/14	HWB ID	J2
28/07/14	a	Various
29/07/14	a	AP1:AP348
28/07/14	All sheets	Columns
30/07/14	8. Non elective admissions - CCG	
30/07/14	6. HWB supporting metrics	D18
30/07/14	6. HWB supporting metrics	D19
30/07/14	7. Metric trends	K11:O11, G43:H43,G66:H66
30/07/14	Data	Various
30/07/14	5. HWB P4P metric	H14
31/07/14	1. HWB Funding Sources	A48:C54
01/08/14	5. HWB P4P metric	G10:K10
01/08/14	5. HWB P4P metric	H13
01/08/14	5. HWB P4P metric	H13
01/08/14	5. HWB P4P metric	H14
01/08/14	4. HWB Benefits Plan	J69:J118
01/08/14	4. HWB Benefits Plan	B11:B60, B69:B118
Version 2		
13/08/14	4. HWB Benefits Plan	I61, I119, J61, J119
13/08/14	4. HWB Benefits Plan	rows 119:168
13/08/14	4. HWB Benefits Plan	rows 59:108
13/08/14	3. HWB Expenditure Plan	rows 59:108
13/08/14	a	M8
13/08/14	HWB ID	J2
13/08/14	6. HWB supporting metrics	C11, I32, M32
13/08/14	6. HWB supporting metrics	C12, I33, M33
13/08/14	6. HWB supporting metrics	C21
13/08/14	6. HWB supporting metrics	C22

13/08/14	6. HWB supporting metrics	D21
13/08/14	6. HWB supporting metrics	D21
13/08/14	6. HWB supporting metrics	E21
13/08/14	6. HWB supporting metrics	E21
13/08/14	6. HWB supporting metrics	D22
13/08/14	6. HWB supporting metrics	E22
13/08/14	5. HWB P4P metric	J14
13/08/14	5. HWB P4P metric	N9:AL9
13/08/14	4. HWB Benefits Plan	H11:H110, H119:H218
13/08/14	2. Summary	G44:M44

Description
formula modified to *=IF(B21-B19<0,0,B21-B19)*
formula modified to *=SUM(C20:C26)*
Changed to Version 2
Data mapped correctly for Bournemouth & Poole
Allocation updated for changes
Allowed to modify column width if required
Updated CCG plans for Wolverhampton, Ashford and Canterbury CCGs
Updated conditional formatting to not show green if baseline is 0
Comment added
Updated forecast formulas
Changed a couple of 'dashes' to zeros
Removed rounding
Unprotect cells and allow entry
Updated conditional formatting
formula modified to *=IF(OR(G10<0,H10<0,I10<0,J10<0),"",IF(OR(ISTEXT(G10),ISTEXT(H10),ISTEXT(I10),ISTEXT(J10)),"",IF(SUM(G10:J10)=0,"",(SUM(G10:J10)/SUM(C10:F10))-1)))*
Apply conditional formatting
formula modified to *=if(H13="","",-H12*J14)*
Remove formula
Texted modified
Delete formula
Additional 50 rows added to 14-15 table for orgaanisations that need it. Please unhide to use
Additional 50 rows added to 15-16 table for orgaanisations that need it. Please unhide to use
Additional 50 rows added to table for orgaanisations that need it. Please unhide to use
Add Primary Care to drop down list in column I on sheet '*3. HWB Expenditure Plan*'
Changed to Version 3
Change text to *'Annual change in admissions '*
Change text to *'Annual change in admissions %'*
Change text to *'Annual change in proportion '*
Change text to *'Annual change in proportion %'*

Change formula to *=if(D19=0,0,D 18 -C 18)*
Change format to 1.dec. place
Change formula to *= if(E19=0,0,E 18 -D 18)*
Change format to 1.dec. place
Change formula to *=if(D19=0,0,D 18 /C 18 -1)*
Change formula to *=if(E19=0,0,E 18 /D 18 -1)*
Cell can now be modified - £1,490 in as a placeholder
Test box for an explanation of why different to £1,490 if it is.
Change formula to eg. *=H11*G11*

Test box for an explanation for the difference between the calculated NEL saving on the metrics tab and the benefits tab

Minutes of: **HEALTH AND WELLBEING BOARD**

Date of Meeting: 30 October 2014

Present: Cabinet Member, Councillor Rishi Shori (Chair); Director of Public Health, Lesley Jones; Police Inspector Lee Parker; NHS England, Mr. Rob Bellingham; Executive Director, Communities and Wellbeing, Pat Jones-Greenhalgh; Chief Operating Officer, Stuart North; Councillor Andrea Simpson; Dr. Audrey Gibson; Barbara Barlow representing Healthwatch.

Also in attendance:

Karen Whitehead, Strategic Lead Health and Families – representing Mark Carriline.
Derek Burke, Chief Officer B3SDA – representing Dave Bevitt.
Heather Hutton, Health and Wellbeing Board Policy Lead.
Julie Gallagher, Democratic Services.

Apologies:

Executive Director, Children and Families, Mark Carriline
Dave Bevitt

Public attendance: 3 members of the public were in attendance

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HWB.393 DECLARATIONS OF INTEREST

There were no declarations of interest.

HWB.394 MINUTES

Delegated decision:

That the Minutes of the meeting of the Health and Wellbeing Board held on Thursday 18th September 2014, be approved as a correct record and signed by the Chair.

HWB.395 MATTERS ARISING

Members of the Board reviewed the Health and Wellbeing Board forward plan.

Delegated decision:

The Health and Wellbeing Board forward plan be noted.

HWB.396 PUBLIC QUESTION TIME

The Chair, Councillor Shori, invited questions, comments and representations from members of the public present at the meeting and the following issues were raised;

In response to the questions raised by representatives from Save Bury Children's Centre, Councillor Shori reported that consultation with regards to the closure and re-designation of some of the children's centre is ongoing. The Council is in the process of reviewing all of its community assets to ensure that services provided in the centres continue to be joined up and fully integrated.

The Strategic Lead Health and Families reported that they are very aware of the current provision, the consultation is wide ranging and some services will continue at other venues.

The Director of Public Health reported that a Starting Well Partnership Board has been established as a sub-committee of the Health and Wellbeing Board.

In response to a question from Councillor Walker; the Director of Public Health reported that there are maps available that provide information in relation to Cancer prevalence within the Borough.

HWB.397 UPDATE ON THE BURY DIRECTORY

The HWB considered a verbal presentation from the Health and Wellbeing Board Policy Lead in relation to the Bury Directory.

The Department for Communities & Wellbeing and the Department for Children & Culture have worked in partnership to respond to the requirements set out by the Care Act 2014 and the Children and Families Act 2014 by developing 'The Bury Directory'.

The Bury Directory provides a mechanism for members of the public to access advice and information about a range of services.

A full communications strategy has been produced to support the implementation of the Directory. The strategy provides details of how the system will be marketed.

The Health and Wellbeing Policy Lead reported that training can be provided to key stakeholders on how the system will be implemented.

Delegated decision:

The presentation be noted.

HWB.398 PRIORITY 4 OF THE HEALTH AND WELLBEING STARETGY – PROMOTING INDEPENDENCE OF PEOPLE LIVING WITH LONG TERM CONDITIONS AND THEIR CARERS

Members of the Board discussed priority four of the health and wellbeing strategy.

There was consensus amongst the Board members that the priority, actions and measures of success needed to be refreshed.

Delegated decision:

1. The Health and Wellbeing Board Policy Lead and the Director of Public Health will meet prior to the next Board meeting.
2. A refreshed Priority Four will be prepared for consideration at the next meeting of the Health and Wellbeing Board.

HWB.399 LETTER FROM THE SECRETARY OF STATE

Members of the Board discussed a letter received from the Secretary of State for Health Jeremy Hunt MP. The letter contained the following information:

- The letter emphasises the importance of working together across the health and social care landscapes.
- Effective engagement between Health and Wellbeing Boards and the major providers who serve their communities is critical to shared success.
- Strong constructive dialogue from all partners involved in developing and delivering the Better Care Fund will be crucial to success.
- Boards and providers must be positively engaged in the local decision making process.

In the discussion that followed Members considered the Boards relationship with the Borough's major providers in particular Pennine Acute NHS Trust and Pennine Care Foundation NHS Trust.

Delegated decision:

1. Democratic Services will respond to the letter from the Secretary of State on behalf of the Health and Wellbeing Board.
2. The Chief Executive of the Pennine Acute NHS Trust and the Pennine Care NHS Foundation Trust will be invited to attend the next meeting of the Health and Wellbeing Board due to be held on the 18th December 2014.
3. Provider representatives will be invited to attend future meetings of the Health and Wellbeing Board when their input/expertise is required.

HWB.400 PRIORITY ONE OF THE HEALTH AND WELLBEING STRATEGY ENSURING A POSITIVE START TO LIFE FOR CHILDREN, YOUNG PEOPLE AND THEIR FAMILIES.

Members of the Board discussed a refreshed report in relation to priority one of the health and wellbeing strategy.

The refreshed report contained the following revised actions:

- Improve health and developmental outcomes for under 5s.
- Develop integrated services across education health and social care which focus on the needs of the child especially those with the most complex needs.
- Support positive and resilient parenting, especially for families in challenging circumstances.
- Narrow the attainment gap amongst the vulnerable groups.

The refreshed priority one report identified key measures of success and indicators.

Members of the Board discussed how best to benchmark the key measures and indicators of success. The Director of Public Health reported that quarterly Health and Wellbeing Strategy performance reports will be considered by the Health and Wellbeing Board.

Delegated decision:

The Health and Wellbeing Board approves the Health and Wellbeing Strategy refreshed priority one actions, measures of success and indicators.

HWB.401 TEAM BURY UPDATE

Members of the Board considered a verbal presentation from the Health and Wellbeing Board Policy Lead in relation to Team Bury.

At a meeting of the Team Bury Forum three priorities for the Borough were agreed; developing a stronger economy, stronger, safer community; Health and Well Being.

The Bury Wider Leadership Group is accountable to the Team Bury Forum. A single partnership group is accountable to the Bury Wider leadership Group for each priority.

The Policy Lead reported that some existing groups will be merged and other disbanded.

The Policy lead reported that the structural changes although not particularly radical will require a change of mindset and culture.

Delegated decision:

The report be noted.

HWB.402 ETIQUETTE AND EXPECTATIONS DOCUMENT

The Etiquette and Expectations document is intended to provide a practical guide to the operational running of the meetings for members, deputies and guest speakers.

Delegated decision:

The Board approves the Health and Wellbeing Board's Etiquette and Expectations document.

HWB.403 REVISED GREATER MANCHESTER HEALTH AND WELLBEING BOARD

Members of the Board considered the proposals for the refocusing of the Greater Manchester Health and Wellbeing Board.

Delegated Decision:

The report be noted.

HWB.404 BURY HOSPICE

In response to a question from the Chair, Councillor Shori, the Chief Operating Officer, Bury CCG reported that the CCG would continue to work with Bury Hospice to offer advice and support. The CCG have agreed to provide some additional monies to support the hospice.

HWB.405 PUBLIC ACCOUNTS COMMITTEE

The Chief Operating Officer, Bury CCG reported that the Parliamentary Public Accounts Committee have received evidence from the Director of Finance, NHS England in relation to the under-funding of some CCGs.

The Chief Operating Officer reported that Bury CCG is considerably underfunded and if the rules are amended and equalised this could result in additional monies being made available.

Councillor Rishi Shori
Chair

(Note: The meeting started at 6pm and ended at 7.25pm)

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