AGENDA FOR

HEALTH AND WELLBEING BOARD

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To: All Members of Health and Wellbeing Board

Voting Member: Dr Gibson; Pat Jones- Greenhalgh (Vice Chair); Graham Atkinson; Dave Bevitt; Mark Carriline; Stuart North; Councillor Shori (Chair); Lesley Jones; Councillor Simpson; Carol Twist & Amber Waywell

Non Voting Member: Rob Bellingham

Dear Member/Colleague

Health and Wellbeing Board

You are invited to attend a meeting of the Health and Wellbeing Board which will be held as follows:-

Date:	Thursday, 18 September 2014
Place:	Bury Town Hall
Time:	2.00 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:	

AGENDA

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTEREST

Members of the Health and Wellbeing Board 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 MINUTES OF PREVIOUS MEETING *(Pages 1 - 6)*

4 MATTERS ARISING *(Pages 7 - 12)*

The forward plan is attached.

5 PUBLIC QUESTION TIME

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

Approximately 30 minutes will be set aside for Public Question Time, if required.

6 STARTING WELL WORK STREAM *(Pages 13 - 24)*

A report from the Director of Public Health is attached.

7 ANNUAL REPORT ON THE EFFECTIVENESS OF SAFEGUARDING CHILDREN IN BURY 2013/14 *(Pages 25 - 130)*

The Executive Director, Children and Families will report at the meeting. A report will be sent to follow.

8 PRIORITY 1 OF THE HEALTH AND WELLBEING STRATEGY - ENSURING A POSITIVE START TO LIFE FOR CHILDREN, YOUNG PEOPLE AND FAMILIES

The Director of Public Health will report at the meeting.

9 5 YEAR CLINICAL COMMISSIONING GROUP STRATEGY *(Pages 131 - 230)*

The Deputy Chief Operating, Bury Clinical Commissioning Group will report at the meeting. Report is attached.

10 CCG CO-COMMISSIONING PROPOSAL *(Pages 231 - 244)*

The Deputy Chief Operating, Bury Clinical Commissioning Group will report at the meeting. Report is attached.

11 SIGN OFF - BETTER CARE FUND

The Chief Operating Officer, Bury CCG and the Assistant Director, Commissioning and Procurement, Bury MBC will report at the meeting. A report will be sent to follow.

12 QUALITY AND EFFICIENCY SCORECARD FOR FRAIL AND ELDERLY - LOCALITY BENCHMARKING JUNE 2014 *(Pages 245 - 256)*

The Deputy Chief Operating Officer, Bury CCG will report at the meeting. A report is attached.

13 NHS ENGLAND - DIRECT COMMISSIONING QUARTERLY UPDATE REPORT *(Pages 257 - 284)*

The Head of Commissioning, Greater Manchester Area Team, NHS England will report at the meeting. A report will be sent to follow.

14 URGENT BUSINESS

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

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Agenda Item 3

Minutes of: **HEALTH AND WELLBEING BOARD**

Date of Meeting: 17th July 2014

Present: Cabinet Member, Councillor Rishi Shori (Chair); Chair, Healthwatch, Carol Twist; Interim Director of Public Health, Lesley Jones; Police Inspector Amber Waywell, Councillor Andrea Simpson; Executive Director of Children's Services, Mark Carriline; Dave Bevitt, Representing B3SDA; Chief Officer, CCG, Stuart North;

Also in attendance:

Harry Downie – Assistant Director Business Redesign and Development
Lorraine Tatlock – Integrated Health and Social Care Programme Manager
Ben Warner Business Development Manager
Paul Cooke – Strategic Lead (Schools, Academies and Colleges)
Jimmy Cheung – Greater Manchester Commissioning Support Unit
Stephen Wood – Greater Manchester Commissioning Support Unit
Heather Hutton – Health and Wellbeing Board Policy Lead.
Julie Gallagher – Democratic Services.

Apologies:

Executive Director, Graham Atkinson
NHS England, Mr. Rob Bellingham
Dr. A. Gibson
Executive Director, Communities and Wellbeing, Pat Jones-Greenhalgh

Public attendance: 3 members of the public were in attendance

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HWB.143 DECLARATIONS OF INTEREST

There were no declarations of interest.

HWB.144 MINUTES

Delegated decision:

That the Minutes of the meeting of the Health and Wellbeing Board held on Thursday 19th June 2014, be approved as a correct record and signed by the Chair.

HWB.145 MATTERS ARISING

Members of the Board reviewed the Health and Wellbeing Board Action Log.

In respect of Action 2, concerning funding for the Speakeasy Charity, the Chief Operating Officer, CCG reported that the Charity did not offer value for money; the CCG would review and if necessary reconsider its decision not to fund the charity at a later date.

The Board was informed that the Healthier Together Consultation commenced on the 15th July 2014. Contained within the consultation document are eight different options for reconfiguration. In response to a question from the Chair, the Chief Operating Officer, CCG reported that specialist stroke services were not part of the Healthier Together reconfiguration proposals and would therefore remain at Fairfield Hospital, Bury.

Delegated decision:

That the action log be noted.

HWB.146 PUBLIC QUESTION TIME

The Chair, Councillor R 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 Councillor Walker, the Chief Operating Officer reported that he would discuss with him what support the Clinical Commissioning Group may be able to provide to support Bury Hospice.

HWB.147 BURY PARTNERSHIPS FRAMEWORK PRESENTATION

The HWB considered a verbal presentation from the Assistant Director Business Redesign and Development, in relation to the new arrangements for Team Bury. The presentation contained the following information;

The Assistant Director reported that there is broad agreement from partners and stakeholders that Team Bury must work differently to meet future challenges, to make better use of resources through stronger governance and performance management.

The Assistant Director reported that there will be three priorities for the Borough;

- Stronger economy, reducing worklessness
- Stronger communities
- Health and wellbeing

The Assistant Director reported it is not envisaged that there will be implications for the HWB other than further clarification around the roles and responsibilities of Board members; greater emphasis on the governance and accountability of the Board as well as a need to clarify links with other groups, partners and stakeholders.

Delegated decision:

The presentation be noted.

HWB.148 HWB DEVELOPMENT PLAN – PERFORMANCE FRAMEWORK – OUTCOME BASED ACCOUNTABILITY – INTEGRATION OF HEALTH AND SOCIAL CARE

The Health and Wellbeing Board considered a verbal presentation from the Health and Wellbeing Board Policy Lead. An accompanying report had been submitted to the Panel providing an overview of work undertaken to develop the Health and Wellbeing Board. The report contained the following information:

The Health and Wellbeing Board has a duty to monitor the delivery of the Health and Wellbeing Strategy and members of the Board are committed to a refresh of the strategy.

The health and wellbeing strategy is an interactive document, refreshing the strategy is essential to ensure the document is fit for purpose, has a robust monitoring framework and has adequate governance arrangements that support the delivery of these priorities.

- Members of the Board considered a verbal presentation from the Interim Director of Public Health which provided details of the **Outcome Based Accountability** framework which will form part of the measures that the Board will use to assess their performance against key indicators contained within the refreshed strategy.

Outcomes based accountability is based on ensuring that performance measures are based upon common language, common sense and common ground. Outcomes accountability is made up of two parts, population accountability and performance accountability.

The Interim Director of Public Health provided Board members with practical examples of how the Outcomes Based Accountability tool could add value to the work of the Board for example, by measuring permanent admissions to residential and nursing care homes.

- Members of the Board Considered a verbal presentation from the – Integrated Health and Social Care Programme Manager which provided Members of the Board with details of the **Health and Social Care Integration** agenda.

The vision in Bury is that people will live well, stay well, remain active and have better outcomes & experiences with a focus on citizenship, prevention, self-care & independence. Agencies working together will Support people to enable them to live in their own homes and communities. As well as, providing sustainable and quality joined up services closer to home.

The Integrated Health and Social Care Programme Manager reported that there are three key deliverables that support the vision of integrated Health & Social Care, these are:

- Ageing well – a range of initiatives to support prevention & self care
- Reablement and Intermediate Care services to help people to remain as independent as possible
- Integrated community and primary care services to provide support closer to home.

The Integrated Health and Social Care Programme Manager reported that a revised better care fund plan must be submitted to NHS England by September 2014.

The Integrated Health and Social Care Programme Manager reported that £2.9m had been awarded from the Prime Ministers GP Challenge Fund to enable Bury GP surgeries to open for longer hours.

Members of the Board discussed the development of a revised Health and Wellbeing Strategy and the following issues were raised:

- Information held by the Council, partners and stakeholders must be up to date.
- Involvement of the third sector
- Avoid duplication with other strategies
- Effective data sharing
- Qualitative data to assist discussion
- Strategy must reflect Board priorities.
- Clarity and consistency around who delivers what?

Delegated decision:

The Health and Wellbeing Board agrees that the Health and Wellbeing Strategy will be refreshed.

HWB.149 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

The Interim Director of Public Health submitted a report which provided an update on the JSNA work programme commission research.

The Interim Director of Public Health reported that rather than commission the data scoping research a decision had been taken to appoint an interim post to undertake this work and to project manage the implementation of the other two strands of work.

Delegated decision:

The Health and Wellbeing Board notes the progress to date on the work programme and a further up date report will be presented at the meeting on the 18th September 2014.

HWB.150 OPEN OBJECTS – THE BURY DIRECTORY

Members of the Board considered a verbal presentation from the Health and Wellbeing Board Policy Lead, the Strategic Lead, Children's Services; the Business Service Manager, Open Objects, the presentation contained the following information:

The Council is required to respond to a number of statutory reforms, most notably the Care Act 2014 and the Children and Families Act 2014. A key aspect of these reforms is the focus on how the local authority, working with its partner agencies, engages with and provides advice, guidance, and access to support to its customers.

The Bury Directory is a way of combining all existing information, advice, directories and resources (strategies/policies/documents) into one that can be accessed by the public, customers, patients, health and social care professionals and the community and voluntary sector in order to deliver the requirements of both the Care Act and The Local Offer.

'The Bury Directory' is a community e-directory/information system provided by Open Objects which:

- Offers innovative IT solutions
- Makes best use of technology
- Is easy to use
- Supports the requirements of the Care & Support Bill for both Adults and Children's
- Is fully hosted by Open Objects with support available 24/7

In response to a members question the Business Service Manager reported that members of the public and staff will be able to access the website via the Bury Council website as well as through all major search engines.

The Website once live will automatically update to ensure the information held is up to date.

A full communications strategy will be produced to support the implementation of the Bury Directory.

Delegated decision:

The presentation be noted.

HWB.151 PHARMACEUTICAL NEEDS ASSESSMENT CONSULTATION (PNA)

Jimmy Cheung and Stephen Wood, Greater Manchester Commissioning Support Unit gave a presentation providing an overview of the PNA draft consultation document. An accompanying report had been submitted to the Panel 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

Members of the Board highlighted that representations had been made to the Board that there was insufficient Pharmacy provision in the Besses ward. This ward is in a relatively deprived community, and that a local pharmacy presence was required within the ward. The Chief Operating Officer reported that the strength of local feeling regarding the lack of pharmacy provision in the area must be reflected in the draft PNA.

The Chief Operating Officer reported that the PNA does demonstrate that Bury has the lowest number of pharmacies in the North West per 100,000 population.

Delegated decision:

1. The Chief Operating Officer CCG, will forward his comments in relation to the draft Pharmaceutical Needs Assessment, in particular, the failure to include public dissatisfaction within Besses ward about the lack of pharmacy provision and the low numbers of pharmacy compared to the national average within Bury; to the Interim Director of Public Health, for inclusion in the draft PNA.
2. The Health and Wellbeing Board delegates sign off of the Draft Pharmaceutical Needs Assessment to the Interim Director of Public Health in consultation with the Chair of the Health and Wellbeing Board.
3. Once the comments agreed above have been incorporated within the document, consultation will commence on the 1st September 2014.

HWB.152 NORTHWEST DIRECTOR OF PUBLIC HEALTH MANIFESTO

Delegated decision:

The Northwest Director of Public Health Manifesto will be considered at the next meeting of the Health and Wellbeing Board.

HWB.153 URGENT BUSINESS

There was no urgent business.

Councillor Rishi Shori
Chair

(Note: The meeting started at 6pm and ended at 8.10pm)

Board Date	Member Development Session	Interactive discussion/ focus	Agenda Items	
17th July 6pm	Draft Agenda • TOR • Role of Chair • Role of Policy Lead • Role Of Democratic Services • Member development requirements focus group	Draft Agenda **Future Role & Function of the Board** • Health & Wellbeing Strategy Update Report (Heather Hutton) • Bury Partnership framework Presentation (Harry Downie) • Outcome Based Accountability Presentation (Lesley Jones) • Overview of Integrated Health & Social Care (Lorraine Tatlock)	**Information**	• Update report on the JSNA (Lesley Jones) • North West DPH Manifesto (Lesley Jones)
			Discussion	• Open Objects- 'The Bury Directory' presentation (Heather Hutton/Paul Cook) • Pharmaceutical Needs Assessment Presentation (Lesley Jones/ CSU)
			Decision	
			TBC	

18th September 2pm	<u>Draft Agenda</u> • To be informed by the Member Development Action Plan	<u>(2) Draft Agenda</u> • Priority 1 of Health & Wellbeing Strategy- *Ensuring a positive start to life for children, young people and families* - Includes SEN Reforms - Includes Changes to Health Visitors • (1A) Proposal to establish a 'Starting Well' work stream (Lesley Jones)	**Information**	• (6) ADASS paper (Sharon Martin) • (7) Co – Commissioning Proposal (Sharon Martin)
			Discussion	• (3) Healthier Together Presentation (Sharon Martin) • (4) 5 year Health CCG Strategy (Sharon Martin)
			Decision	• (5) Sign off Better Care Fund
			TBC	• (1B) Bury Safeguarding Board/Children's Trust (Mark Carriline)

30th October 6pm	To be informed by the member development action plan	Draft Agenda Priority 4 of Health & Wellbeing Strategy- *Promoting independence of people living with long term conditions and their carers*	**Information**	• Report on the updated Health & Wellbeing Strategy, delivery plan and outcomes framework for Priority 1
			Discussion	• Independent Director of Public Health's Report (Lesley Jones)
			Decision	
			TBC	• Carers call to action (Alistair Mirfin) • Better Care Fund update (Julie Gonda) • Healthier Radcliffe (Michelle Armstrong/ Hemlata Fletcher) • Action Plan for Learning Disabilities and Challenging Behaviour (John Campbell/ Cath Tickle)
18th December 2pm	To be informed by the member development action plan	Draft Agenda Priority 3 of Health & Wellbeing Strategy- *Helping to develop strong communities, wellbeing and mental health*	**Information**	• Report on the updated Health & Wellbeing Strategy, delivery plan and outcomes framework for Priority 4 • Quarterly update on JSNA (Lesley Jones)
			Discussion	

			Decision	
			TBC	• Poverty Strategy (Amy Svensson)
29th January 6pm	To be informed by the member development action plan	<u>Draft Agenda</u> Priority 2 of Health & Wellbeing Strategy- *Encouraging healthy lifestyles and behaviours in a all actions and activities*	**Information**	• Report on the updated Health & Wellbeing Strategy, delivery plan and outcomes framework for Priority 3
			Discussion	
			Decision	
			TBC	
5th March 2pm	To be informed by the member development action plan	<u>Draft Agenda</u> Priority 5 of Health & Wellbeing Strategy- *Supporting older people to be safe, independent and well*	**Information**	• Report on the updated Health & Wellbeing Strategy, delivery plan and outcomes framework for Priority 2 • Quarterly update on JSNA (Lesley Jones)
			Discussion	

			Decision	
			TBC	• Pharmaceutical Needs Assessment FINAL Paper (Anna Barclay)
9th April 6pm	To be informed by the member development action plan	Draft Agenda TBC	**Information**	• Report on the updated Health & Wellbeing Strategy, delivery plan and outcomes framework for Priority 5
			Discussion	
			Decision	
			TBC	• Report on refreshed Health & Wellbeing strategy, progress on delivery plan and outcomes framework
Beyond... Working Well Protocol (June 2015)				

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Agenda Item 6

Health & Wellbeing Board Report template
Bury Health and Wellbeing Board

Title of the Report	Establishment of an Early Years Partnership Board strategic remit and vision for taking forward the Early Years agenda.
Date	18 September 2014
Contact Officer	Stephanie Mitchell/ Karen Whitehead/ Sue Reynolds
HWB Lead in this area	Lesley Jones

1. Executive Summary

Is this report for?	~~Information~~	~~Discussion~~	Decision √
Why is this report being brought to the Board?	To outline the proposal for a multi-agency Starting Well Partnership Board (SWPB) with responsibility for leadership, direction and oversight of the Early Years health improvement agenda on behalf of the Health and Wellbeing Board and the Children's Trust.		
Please detail which, if any, of the Joint Health and Wellbeing Strategy priorities the report relates to.	Priority 1: Ensuring a positive start to life for children, young people and families.		
Please detail which, if any, of the Joint Strategic Needs Assessment priorities the report relates to. (See attached JSNA)	It relates to the following priority areas outlined in the JSNA: 1. Pregnancy and Yearly Years 2. Children and Young People sections		
Key Actions for the Health and Wellbeing Board to address – what action is needed from the Board and its members? Please state recommendations for action.	To agree the establishment of the 'Starting Well' Partnership Board with remit for providing leadership, direction an oversight of the early year's health improvement agenda.		
What requirement is there for internal or external communication around this area?	Once established there will be a requirement to communicate to stakeholders around the establishment and remit of the Board.		
Assurance and tracking process – Has the report been considered at any other committee meeting of the Council/ meeting of the CCG Board/ other stakeholders.	No		

2. Introduction / Background

2.1 Introduction

2.1.1 Giving every child the best start in life was the most important of all the policy recommendations for reducing health inequalities in The Marmot Review (Marmot, 2010). The Chief Medical officers annual report also reaffirms that early support can make a huge difference to a person's "Life Readiness. Giving children the best start in life is crucial to reducing health inequalities across the life course. Although important, later interventions are considerably less effective where good early foundations have been lacking.

2.1.2 A child's experiences in the early years (antenatal – 4 years) can affect their health and opportunities later in life such as risk of obesity, heart disease and poor mental health, to educational achievement and economic status**Error! Bookmark not defined.**.

2.1.3 Good early year's provision is good for all children, but it has a disproportionately positive impact on the development of disadvantaged children.

2.1.4 Locally, Priority 1 of Bury's Health and Wellbeing Strategy outlines Bury's aim of ensuring a positive start to life for all children, young people and families. Identifying those in need of help and support, intervening early and addressing the whole family's needs is crucial to a child's development and realising our aspiration for laying the foundations for future life. Giving every child the best start in life identified as the highest priority in Bury from the consultation on the Health and Wellbeing Strategy. The strategy sets out actions to promote positive parenting, integrate health, educational and social care services and support educational attainment.

2.1.5 The Children's Trust Board has recently reviewed its priorities and has developed a clear strategic focus on supporting children& young people to be 'life ready' and to ensuring they can access the 'right help at the right time'.

2.1.6 At a Greater Manchester level, the importance of early years has been recognised as a significant element of the broader public service reform agenda. As we face rising demand for public services in the context of diminishing resources it is essential that we look to the long term as well as the short and medium term to address these challenges. The cycle of deprivation, disadvantage and poor outcomes across the life course can only be broken if we focus on prevention, early identification and intervention and supporting parents in the first few years of a child's life (starting in the womb).

2.2 Local need

2:2.1 Despite considerable efforts, the Bury JSNA and other sources show that there are several areas in Bury where further improvements are required to enable children to have the best start in life such as improving early access to maternity services1i, reducing smoking in pregnancy2i, increasing breastfeeding rates3ii, improving oral health4iii, reducing childhood obesity5iv, reducing childhood accidents and increasing the number of children that are assessed in Reception as school ready6v.

2.2.2 There remain noticeable synergies between deprivation, educational attainment and health outcomes in Bury. Areas of higher deprivation can be closely overlaid with poorer educational attainment and poorer health outcomes. As a result, individuals and families living in areas of high deprivations are most likely to depend on public services than the rest of society.

2.2.3 We still have too many children requiring a child protection plan and needing to be taken into care.

2.3 Recent Developments

2.3.1 There is a lot of excellent work being progressed in Bury in line with the Greater Manchester Early Years agenda including the increase in the Health Visiting workforce/ training and achievements against UNICEF Breast Feeding Initiative (BFI) Accreditation (maternity and community settings), imminent implementation of the Family Nurse Partnership and interest in the Baby Express Randomised Control Trial (RCT) and the Baby Triple P Positive Parenting Programme.

2.4 0-5 Healthy Child Programme

2.4.1 The Healthy Child Programme (HCP), published in 2009, is the government's early intervention and prevention public health programme for children, young people and families, which focuses on early intervention and prevention. It offers a programme of screening tests, immunisations, developmental reviews, information and guidance on parenting and healthy choices.

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[1] 63.5% of women access maternity services by week 12 of pregnancy

[2] Although reducing, 15.3% of mothers smoke whilst pregnant

[3] 2012/13 breastfeeding initiation rates were 68.9%, 6-8 week rates were 41%. These were below the England Averages (73.9% and 47.2%) but above the North West averages (62.2% (initiation only available)

[4] 2011/12 rate of 1.28 mean DMFT (decay, missing, filled teeth) per child. Tooth Decay in children aged 5. Worst than England average (0.94), but similar to the North West (1.29)

[5] Bury's rate of Obesity at Year 6 varies 9% in the lowest ward to 33% in the highest ward.

[6] 43% of children in Reception at school are assessed as not being school ready

2.4.2 Due to its universal reach the HCP aims to identify families who need additional support or are at risk of poor health outcomes. The HCP is made up of three documents;

1. Healthy Child Programme: pregnancy and the first five years
2. Healthy Child Programme: the two year review
3. Healthy Child Programme: from 5 to 19 years old

2.4.3 The delivery of the Healthy Child Programme is directed at many agencies, some of which include GPs, midwives, practice nurses, health visitors and the voluntary sector.

2.4.4 If effectively implemented, in terms of overall aims, the HCP should lead to:

- Strong parent-child attachment and positive parenting, resulting in better social and emotional well-being in children
- Care that helps to keep children healthy and safe
- Healthy eating and increased activity, leading to a reduction in obesity
- Prevention of some serious and communicable diseases
- Increased rates of initiation and continuation of breastfeeding
- Readiness for school and improved learning
- Early recognition of growth disorders and risk factors for obesity
- Early detection of – and action to address – developmental delay, abnormalities and ill health, and concerns about safety
- Identification of factors that could influence health and well-being in families
- Better short- and long-term outcomes for children who are at risk of social exclusion

2.4.5 A core element of the programme is the delivery of commissioned service provision through a HCP Team. This team is described as being a single provider, multiple provider, or a partnership arrangement that can involve a number of agencies:

"A cross-locality, multidisciplinary team delivering the HCP across a range of settings: primary care, education, the community, secure accommodation for children and young people ."

2.4.6 The HCP team can also facilitate access to a wider range of specialist support such as CAMHS, speech and language therapy, and support for children with acute or additional health needs.

2.4.7 The commissioning responsibility for 0-5 Healthy Child Programme services such as Health Visiting Services and the Family Nurse Partnership (FNP) currently lie with NHS England. But these will transfer to local authorities October 2015. In line with this transition of commisoning responsibility Health Visiting Services now deliver services to those who

are Bury residents. Previously, this was a commissioned service for those registered with a Bury GP practice or resident and not registered with a GP nationally.

2.4.8 Bury's Health Visiting Service provided by Pennine Care NHS Foundation Trust (PCFT) has been working to meet the Health Visiting – 'A Call to Action', which has seen the development of a revised service specification developed in line with the AGMA Early Years Delivery Model (see below) and an increase in the Health Visiting workforce, with several recent Health Visitor appointments linked to priority areas such as Domestic Violence, Children with Additional Needs, Looked after children, Mental Health and Teenage Parents.

2.5 Other related developments

2.5.1 From October 2014, Bury will be able to offer further support to vulnerable families through the provision of the Family Nurse Partnership programme - a voluntary intensive home visiting preventive programme for vulnerable young first time mothers from early pregnancy until age two.

2.5.2 In addition to this, Bury has expressed an interest in a Baby Triple P Positive Parenting Programme Greater Manchester wide trial with Glasgow University. Baby Triple P is an intervention to help parents prepare for transition to parenthood.

2.6 Early Years New Delivery Model

2.6.1 The proposed Early Years New Delivery Model is a key strand of the Public Sector reforms and was developed in a bid to address and increase the number of children in Greater Manchester who are not 'school-ready', with a broader long-term objective around equipping more GM residents with the skills they need to access the labour market. It has been designed as a vehicle through which to deliver the 0-5 Healthy Child programme.

2.6.2 As part of the GM Early Years Business Case a shared outcomes framework was agreed featuring short and medium term outcomes including; improving attainment, improved family health and wellbeing, improved economic wellbeing and home environment, parenting and successful engagement of services.

2.6.3 Other features of the model include:

- A common assessment pathway across GM, eight common assessment points for an integrated ('whole child' and 'whole family') assessment at key points in the crucial developmental window.

- Evidence based assessment tools to identify families reaching clinically diagnosable thresholds for intervention.

- A suite of evidence based interventions has been developed, to be sequenced as transformational support to families with appropriate

step-down packages of support rather than 'free fall', to help off-set the risk of re-entry to a high level of need in the future.

2.6.4 The Early Years Delivery model provides the core framework for development of a comprehensive integrated system to support children to get the best start in life. Implementation however is not straight forward and it will require a whole system partnership approach to take this forward in a meaningful way for Bury.

2.6.5 All of the main elements of the model have required a certain amount of infrastructure development at both a GM and local level, and this work continues particularly around data systems, data sharing, workforce development and more integrated contracts.

2.6.6 Bury have been involved in the whole process of this reform, and have co-operated in pilot stages as part of the broader GM agreements. However, an early pilot of an integrated 2-2 ½ year assessment in Bury has failed due to logistical difficulties.

2.6.7 Unfortunately, whilst there is a partnership consensus to following this framework, and a genuine belief that a framework that is built on sound principles and thorough research should be endorsed, the financial investment required to roll the model out prescriptively is not currently possible in Bury.

2.6.8 Bury partners are working collaboratively, and gathering current baselines of the stages in the framework and assessing what is affordable and realistic to develop locally, in line with other changes.

2.7 Children's Centres

2.7.1 The core purpose of Sure Start children's centres is to improve outcomes for young children and their families, with a particular focus on those in greatest need. They work to make sure all children are properly prepared for school, regardless of background or family circumstances. They also offer support to parents. At present, there are 14 Children Centre's operating across Bury, however, there are proposed changes to the current Children Centre operations which are being consulted upon.

2.8 Nursery places for 2yr olds

2.8.1 The census shows us that of the 448 eligible children, 292 Bury children were accessing a free 2 year old place. From April, Bury will be widening access criteria and commencing a marketing campaign with AGMA colleagues to meet the planned September increase of eligible vulnerable 2 year olds (40%) from September, equating to 1177 children

2.9 The Challenge

2.9.1 Whilst these developments are positive and welcome significant challenges remain, including:

A. UPSTREAMING OF RESOURCES to focus on prevention in a climate of financial austerity

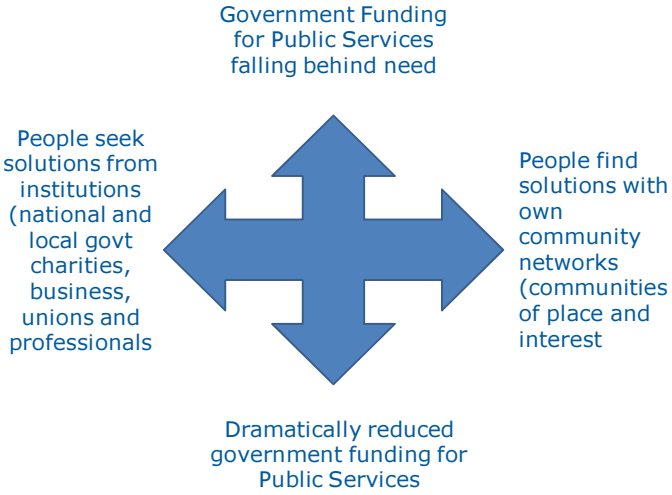
Although there is a shared understanding and commitment to the principle of focusing on prevention in the early years of life, we currently lack a coherent local whole system strategy to tackle the health improvement/universal prevention agenda for the 0-5 years (including antenatal care). Without such a strategy we are not in a position to ensure a sustained drive to improving outcomes or to ensure scarce resources are allocated to maximise impact.

It is clear that a new investment model is required to implement the Greater Manchester Early Years New Delivery Model in full. Initials estimates show that approximately an additional £38million per cohort over five years is required to implement the EY New Delivery Model across Greater Manchester. Bury faces a funding gap, estimated at £294,548 to cover costs for assessment tools, workforce training and interventions that are not currently in practice in Bury.

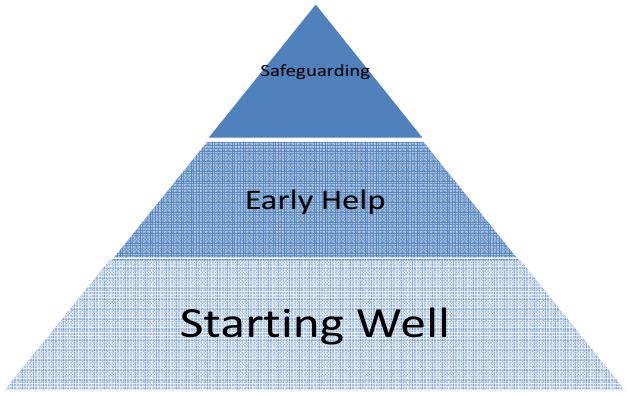
B. Development of INTEGRATED SERVICES across health services, social services, education and the voluntary and community sector

Securing better outcomes for children requires a whole system approach. We need shared leadership to align multiple objectives and a variety of professional cultures in order to operate effectively across cultured and geographical boundaries.

Furthermore, we need to find ways of securing the ownership and engagement of local communities in this agenda. The Centre for Innovation in Health Management University of Leeds published a document to review Public Service Futures which highlight levels of government funding in relation to need and consider a model to depict what is likely to be present in any UK future in 10 years time. The differences between the scenarios lie in how severe the cuts to government funding of public services have been (up/ down axis) and in how society responded (left/ right axis). Early action matters, the economic case is increasingly clear and an urgent shift to move from reactive to proactive care is needed, including school connectedness development to nurture resilience in children and young people and facilitate healthy choices to encourage families to be healthy to seek help with parenting and listen to communities. The Left/Right axis indicates localism and networked self organisation; these are relationships of reciprocity co-produced by the members of the network.



C. EARLY HELP: Supporting the systematic identification of those requiring more targeted help and support and reducing inequalities.



Bury has a well developed multi-agency safe-guarding hub (MASH) and Early Help Team to support those with safe-guarding issues and risk and for those with more complex problems and requiring extra help and support.

If this system is not underpinned by comprehensive population, community and individual level universal prevention we will lack the systems to enable proactive, systematic identification of those in need, fail to address inequalties and fail to stem the rise in demand for services over the medium to longer term.

2.10 Proposal

2.10.1 It is proposed that a 'Starting Well' Partnership Board be established to further develop and drive forward our vision for 'starting well'. The baord will initally focus primarily on the Early Years agenda (antenatal to the age of 4 years of age), but will also take consideration of the wider children and young people agenda (up to age 19 years). The Board will:

- Deliver Priority 1 of the Health and Wellbeing Strategy.

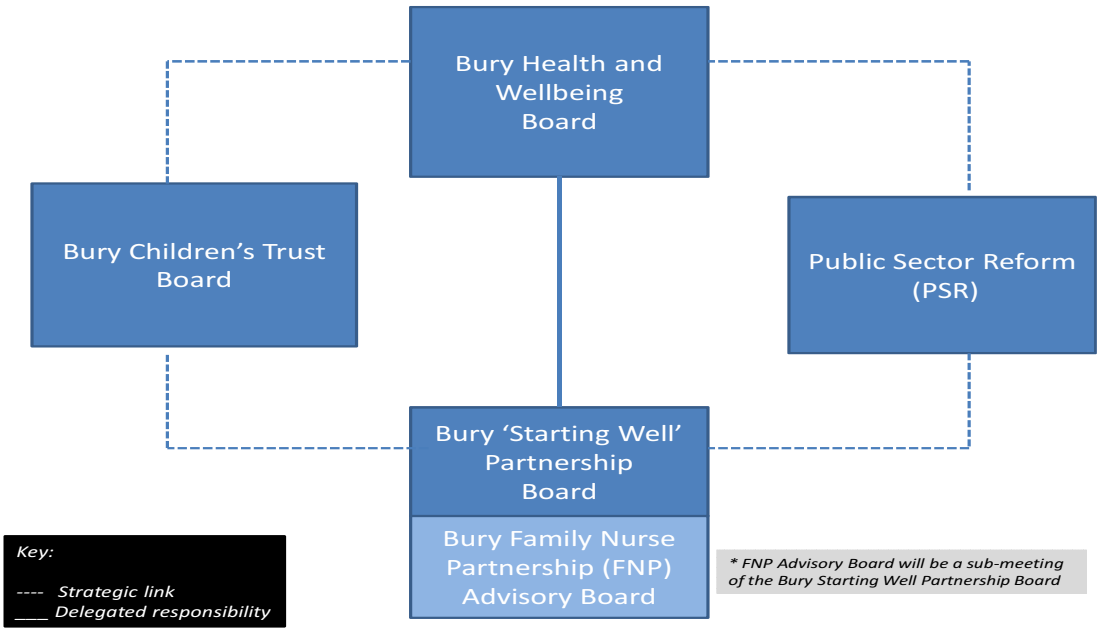
- Improve our performance against key performance frameworks, i.e. Public Health Outcomes Framework, NHS Outcomes Framework.
- Ensure better use of resources through up-streaming support/ action and embedding proportionate universalism and embedding prevention and health improvement programmes such as healthy weight, breastfeeding, mental wellbeing, accident prevention and oral health improvement, immunisation and vaccination uptake and antenatal and newborn screening.
- Build on work done to date and create linkage and synergy between emerging developments to secure better outcomes and efficient use of resources.

2.10.2 Early Priorities that the 'Starting Well' Partnership Board will focus on are:

- Development of an overarching Bury 'Starting Well' Strategy
- Evaluation of the various elements of the Greater Manchester Early Years New Delivery Model
- Maximising the full contribution of Bury's existing resources aligned to the Greater Manchester Early Years New Delivery Model
- Development of business cases for further developments
- Safe transition of commissioning arrangements from NHS England to Bury Council
- An outcomes based performance and monitoring framework

2.10.3 The group will have strong interdependent relationships with other areas/ team, for example the Early Help team, Safeguarding (including the Multi-agency safeguarding hub (MASH)) and Supporting Communities Improving Lives (SCIL)/ Complex Dependencies.

2.11 Governance



2.12 Membership

2.12.1 The Family Nurse Partnership programme as detailed above is a licensed programme with specific criteria to be met as part of the licence and important in creating the right environment to deliver the FNP programme. Fidelity to the programme licence and content is essential to realise the benefits from the research.

2.12.2 There is a requirement to establish the FNP Advisory Board under the licence criteria with very prescriptive membership as follows:

- Director of Public Health (LA)
- Executive Director of Children, Young People and Culture (LA)
- Senior Manager Children and Health Improvement (Provider)
- Assistant Director (Social Care and Safeguarding (LA)
- Head of Early Years and Early Help (LA)
- Head of Midwifery (Provider/s)
- Public Health Commissioner (NHS England Areas Team)
- Third Sector representative
- *service user/s (later stage)*

2.12.3 As the membership of the Starting Well Partnership Board is likely to include these members as a minimum, we anticipate that the FNP Advisory Board will run alongside the Starting Well Partnership Board, thus streamlining governance arrangements. Additional membership would be drawn from the Clinical Commissioning Group and the voluntary and community sector.

3. Key Issues for the Board to Consider

3.1 Recommendations for the Health and Wellbeing Board are:

3.2 To approve the establishment of the above stated 'Starting Well' Partnership Board with responsibility for leadership, direction and oversight of the Early Years health improvement agenda on behalf of the Health and Wellbeing Board and the Children's Trust.

4. Financial and legal implications (if any)
If necessary please see advice from the Council Monitoring Officer Jayne Hammond (J.M.Hammond@bury.gov.uk) or Section 151 Officer Steve Kenyon (S.Kenyon@bury.gov.uk).

Not applicable

5. Equality/ Diversity Implications

Not applicable

CONTACT DETAILS:

Contact Officer: Stephanie Mitchell
Telephone number: 0161 253 6885
E-mail address: s.mitchell@bury.gov.uk

Date: 10th Sept 2014

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[i] Bury JSNA Refresh 2013
[ii] https://www.gov.uk/government/statistical-data-sets/breastfeeding-statistics-q4-2012-to-2013
[iii] Public Health Outcomes Framework, http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000044/pat/6/ati/102/page/0/par/E12000002/are/E08000002
[iv] 2012/13 NCMP data
[v] Bury Council (2013) Bury Public Service Reform: first phase implementation plan

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Agenda Item 7

Health and Wellbeing Report (For information)

Bury COUNCIL

Agenda Item	

MEETING: **Health and Wellbeing Board**

DATE: **18.09.14**

SUBJECT: **BSCB Annual Report (2013-2014)**

REPORT FROM: **Bury Safeguarding Children Board**

CONTACT OFFICER: **Donna Green, BSCB Board Manager**

1.0 Purpose of the Report

Working Together to Safeguard Children 2013 requires that the LSCB Chair '*should publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area...'*

'The report should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the health and wellbeing board'.

The report should 'provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them a well as other proposals for action'.

2.0 Issues

Areas for the HWB to note:

The BSCB has played an important role in 2013/14 in the development of specialist services to address child sexual exploitation. A bid by members of the BSCB to secure funding from the Local Authority was successful and a local multi-agency specialist team has been established through participation in the Greater Manchester 'Project Phoenix' Team. The team is now fully operational with a Greater Manchester wide publicity campaign and launch planned for

18th September 2014. A request for Public Health funding for a specialist sexual health worker is still being considered (page 25).

Recommendation 7 of the Health Working Group Report on Child Sexual Exploitation states:

'to support appropriate local prioritisation, commissioning and local 'health scrutiny', health and wellbeing boards (HWBs) should ensure that the local joint strategic needs assessment (JSNA) and the joint health and wellbeing strategy (JHWS), reflect the impact of different forms of violence and abuse including child sexual exploitation; the JSNA being informed by evidence from a range of local sources including the local safeguarding children board and the community safety partnership'.

Appendix 4 of the annual report contains a report on activity of the SEAM (Sexual Exploitation & Missing) operational group.

The BSCB Business Plan 2014/14 identifies children who are emotionally vulnerable as a vulnerable groups warranting higher priority for scrutiny. Data supplied by the local CAMHs Team for inclusion in the BSCB annual report (page 48) notes a 55% increase in referrals in 2013/14 in respect of children presenting with self harming behaviours. The largest increase in referrals has come from schools.

This increase has coincided with capacity issues being identified in the school nursing service. School nurses provide a valuable service to those vulnerable children who may not meet the eligibility criteria to receive a service from other services such as CAMHS or Children's Social Care. They also play a key role in effective Common Assessment Framework processes often fulfilling the role of designated lead professional.

This year the BSCB has raised challenges with school nurse providers (Pennine Care NHS Foundation Trust) and commissioners within Public Health. School nurse capacity remains a standing item on the BSCB agenda.

The BSCB Business Plan 2014/14 also includes targeted work to support school staff who are working with young people who self-harm. This action will be led by the BSCB Safeguarding Schools and Colleges sub group.

List of Background Papers:-

CONTACT DETAILS:
Contact Officer: Donna Green
Telephone number: 0161 253 7329
E-mail address: Donna.Green@bury.gov.uk
Date: 11 September 2014

Annual Report on the Effectiveness of Safeguarding Children in Bury 2013/14

Bury Safeguarding Children Board,
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18/20 St Mary's Place, Bury, BL9 0DZ.

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Web : ***www.safeguardingburychildren.org***

Contents:

Foreword by Independent Chair of BSCB

Gill Rigg
Independent Chair of BSCB

As the Independent Chair of Bury Safeguarding Children Board (BSCB), I am very pleased to introduce this, the sixth BSCB annual report.

As ever, in safeguarding activities, it has been a busy and challenging year. April 2013 saw the introduction of Working Together to Safeguard Children guidance (2013), and we particularly welcomed the freedom to move away from a prescribed way of undertaking serious case reviews towards more of a learning culture. We also saw the piloting, and then the introduction of the new Ofsted framework of inspections, and the new approach of Ofsted reviewing the work of Local Safeguarding Children Boards (LSCBs).

The BSCB welcomed the implementation of the new Multi-Agency Safeguarding Hub (MASH) team, co-located at the police station, and breaking new ground in the initial responses to contacts and referrals. We also took a step forward in our work to protect sexually exploited young people. Additionally, we undertook three serious case reviews and published them.

We also had the advantage of a peer review of the safeguarding service, and their comments that Bury's greatest asset was its staff, that there was a passion and commitment to the right things, and that there was a genuine attempt to improve outcomes for children and young people in Bury, were particularly pleasing.

There has been a strong focus on Early Help, and in January 2014, Ofsted undertook a thematic review of our Early Help offer. The inspectors were pleased with the work in progress, felt that we knew ourselves well and were able to identify the gaps and the BSCB was described as "energetic."

The work of the BSCB, its Executive Group and the sub groups continues to drive the safeguarding agenda forward, and I am immensely grateful to all my colleagues in all of the agencies who work so hard to keep children and young people safe in Bury.
As ever, I feel privileged to have the role as the Chair of the BSCB and I would like to thank all of you who work so tirelessly.

Gill Rigg, Independent Chair of BSCB

June 2014

Role and scope of Bury Safeguarding Children Board (BSCB)

1. **Regulation 5 of the Local Safeguarding Children Boards Regulations (2006)** sets out that the functions of the LSCB as follows:

(a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

(i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;

(ii) training of persons who work with children or in services affecting the safety and welfare of children;

(iii) recruitment and supervision of persons who work with children;

(iv) investigation of allegations concerning persons who work with children;

(v) safety and welfare of children who are privately fostered;

(vi) cooperation with neighbouring children's services authorities and their Board partners;

(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

(c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

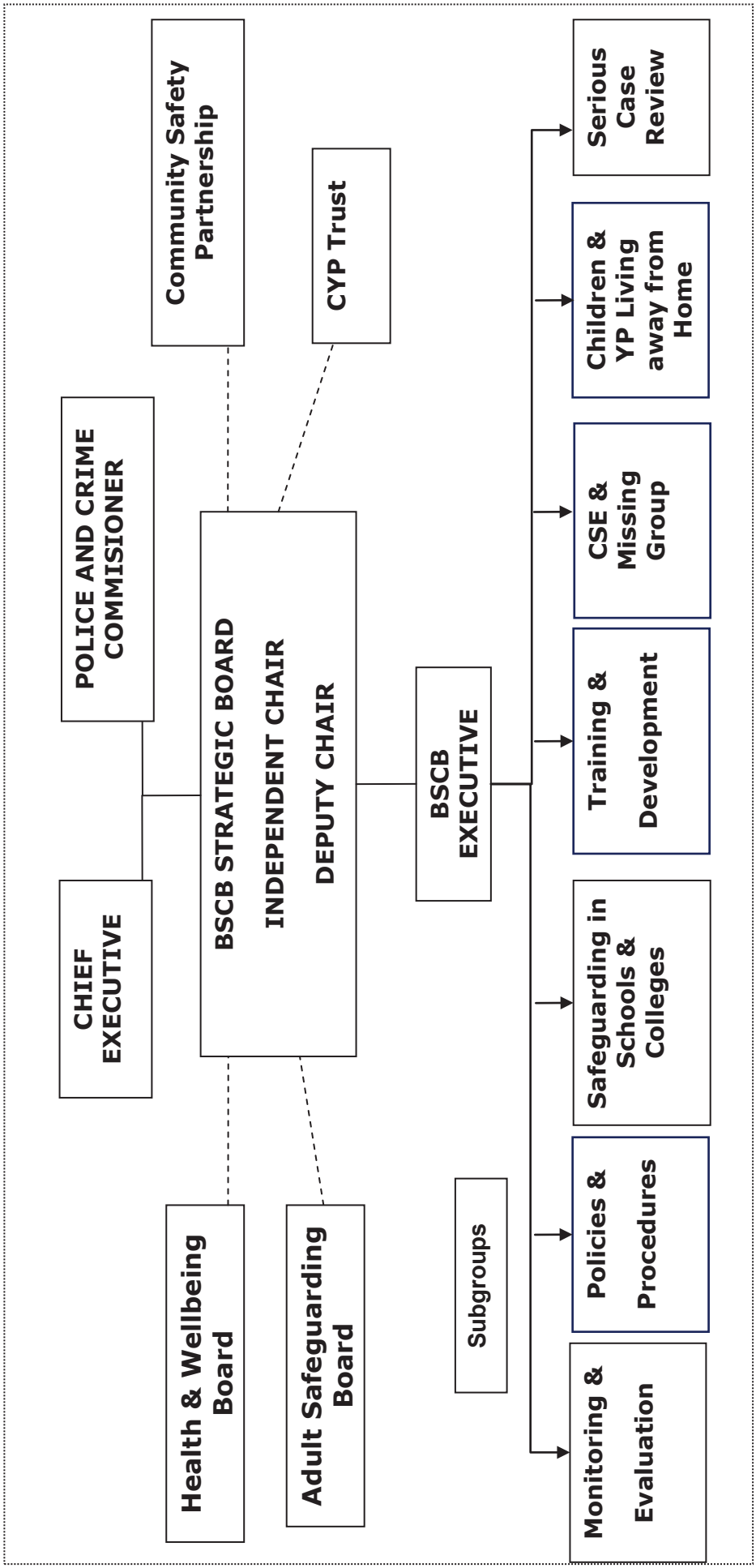
(d) participating in the planning of services for children in the area of the authority; and

(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

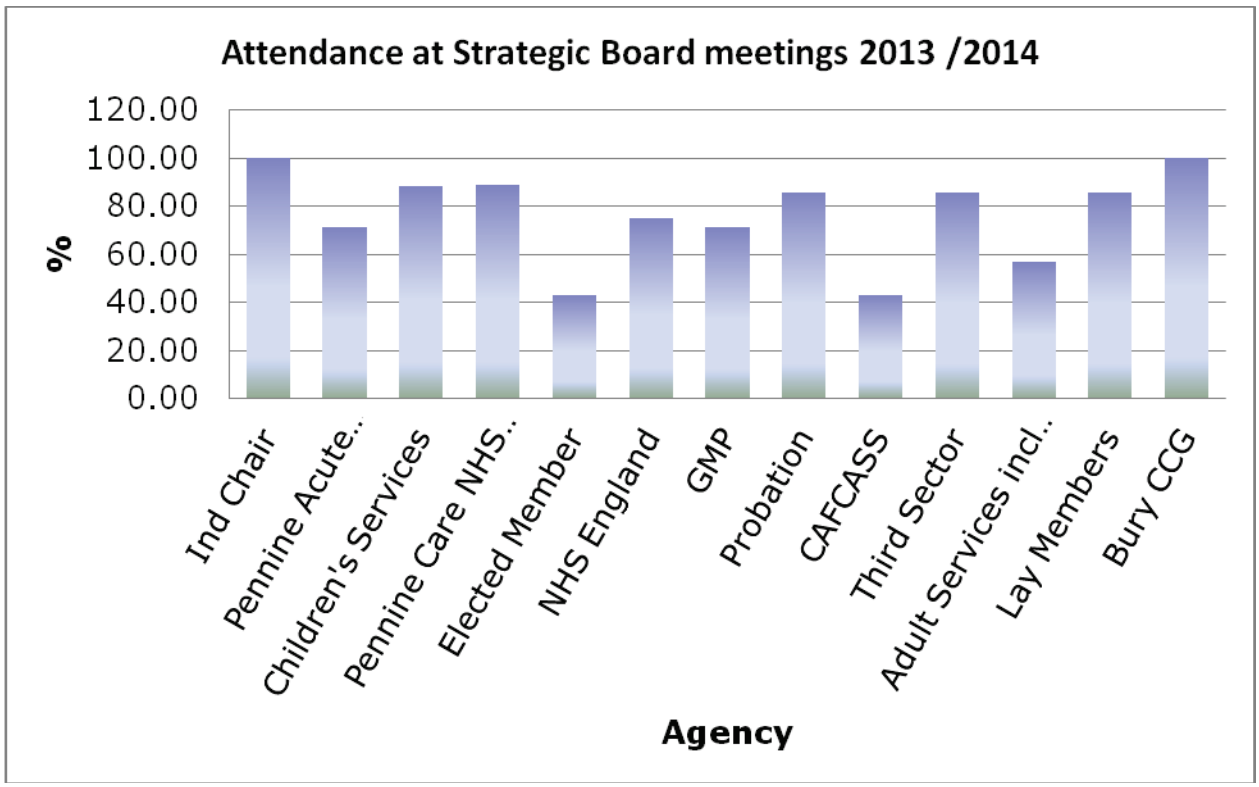
2. Regulation 5 (3) provides that a LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

3. The BSCB and Sub Group membership list is included as Appendix 1.

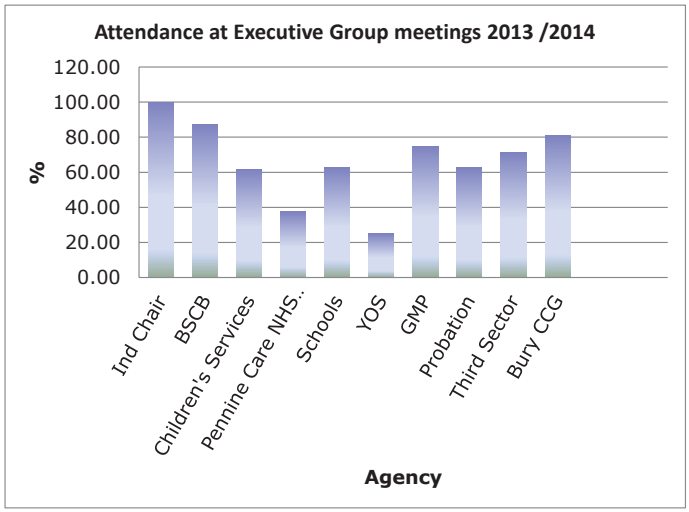
Structure of Bury Safeguarding Children Board BSCB (2013/2014)



Attendance at BSCB meetings 2013/2014



Attendance at Executive Group Meetings 2013/2014



The Bury Safeguarding Children Board (BSCB) met regularly in 2013/14. It has been a challenging year for some of our partners who have undergone further workforce reform and have experienced financial pressures. Accordingly the capacity of some of our partners to commit to the work of the Board has been challenged. This issue has been identified and is being addressed at the BSCB. We are pleased to note this year that we have increased representation at the BSCB from Cafcass.

The BSCB sub groups have met regularly and have continued to develop and deliver the BSCB key tasks as outlined in the Business Plan for 2013/14.

BSCB income and expenditure 2013/2014

Contributions/Income	**Pounds (£)**
Children's Services	72,145
Strategic Housing Unit	0
EDS	2,000
Bury CCG	37,142
Greater Manchester Police	11,850
CAFCASS	550
Probation Service	3,468
Brought Forward	47,955
Grant CDOP	34,900
Training Income	9,550
DSG contribution	39,850
TOTAL INCOME	**259,410**

Expenditure	**Pounds (£)**
Employee costs	179,105
Multi-Agency Training Costs	3,365
Serious Case Review	34,065
Independent Chair of BSCB	10,275
Travel & Subsistence	455
Advertising – staff	0
Postage	44
Telephone	996
Office overheads incl Equipment, tools & materials	9,539
Printing & Stationery	1,769
Legal – Courts & Community	2,000
CDOP	9,770
Staff Training	337
Miscellaneous	1,435
Emp Liability & 3rd Party ins	514
TOTAL EXPENDITURE	**253,669**
Carry forward to 2014/15	**5,741**

Projected income and expenditure 2014/2015

Contributions/Income	**Pounds (£)**
Children's Services	72,145
EDS	2,000
Strategic Housing Unit/Adults	0
Bury CCG	37,142
Greater Manchester Police	11,850
CAFCASS	550
Probation Service	3,468
Contribution from General Balance b/fwd	5,741
DSG	40,000
CDOP	34,900
Training income	7,500
Partners contribution for licence for section 11 audit toolkit	3,000
TOTAL INCOME	**218,296**

Expenditure	**Pounds (£)**
Employee costs	122,000
Multi-Agency Training Costs	10,000
Serious Case Review	40,000
Independent Chair of BSCB	10,000
Travel & Subsistence	1,200
Postage	200
Telephone	1,000
Office Equipment, tools & materials including licences	6,000
Photocopying	500
Printing & Stationery	2,600
Legal – Courts & Community	2,000
CDOP	10,600
Staff Training	1,000
Miscellaneous	2,500
Emp Liability & 3rd Party ins	500
TOTAL EXPENDITURE	**210,100**
Balance of funding – carry forward to 2015/16	**8,196**

Main achievements 2013/2014

- This year the BSCB took a keen interest in the welfare of young people placed in secure mental health settings in Bury. This led directly to improvements in safeguarding practice for those young people.
- We have undertaken a section 11 audit this year. Our partners agreed to share the costs of purchasing the 'e-academy' electronic tool.
- The BSCB communication strategy has been revised and the BSCB website has been upgraded.
- The BSCB has overseen the development of the Multi-Agency Safeguarding Hub (MASH).
- We have published a revised 'Thresholds for Intervention' document. A series of multi-agency workshops were held to launch the document.
- We have reviewed how we undertake Serious Case Reviews in accordance with Working Together to Safeguard Children (2013).
- We have employed a Learning Event model to undertake a Serious Case Review involving front line practitioners more fully in the process.
- This year we have concluded and published 3 Serious Case Reviews.
- We have delivered multi-agency safeguarding training to 771 participants.
- We have identified a higher number of privately fostered children.
- We have collaborated with the Greater Manchester Safeguarding Partnership to produce the first and second updates of the pan Greater Manchester Safeguarding Procedures.
- We have increased participation from Public Health partners in the Child Death Overview Panel (CDOP).
- Our lay members have begun to take an enhanced role by representing the BSCB in local community groups and forums.
- We have developed a BSCB Quality Assurance Framework.
- We have developed the Child Sexual Exploitation (CSE) & Missing strategy.
- We have participated in the development of the Phoenix Team.
- We have developed the CSE Task and Finish Group and Missing from Home Group into a full CSE & Missing Sub Group.
- We have appointed an Interim Board Manager.

State of Safeguarding in Bury

The BSCB is required to ensure the effectiveness of the work that is done to safeguard and promote the welfare of children and young people in Bury. The BSCB does this by discharging its statutory functions as detailed in this report at page 23 **'Discharge of statutory functions'.**

Our statutory partners have also prepared an analysis of their own agency contribution to keeping children safe in Bury which can be found on page 9 **'Main Achievements'**.

There has also been external scrutiny of the safeguarding arrangements in Bury through a *Local Government Association (LGA)'Peer Challenge' Review* and an Ofsted Thematic Inspection of Early Help discussed at page 33 **'Effectiveness of the BSCB'**

Multi-agency performance data analysis also assists us to understand whether a difference is being made to the lives of children and young people in Bury and is found at page 35.

How safe are children in Bury?

Together these reports tell us that 2013/14 has been a year characterised by rising numbers of children who are subject to a child protection plan and a marked increase in the conversion rate of contacts to Children's Social Care that progress to referrals. Improvements in service delivery such as the Multi-agency Safeguarding Hub, the implementation of a revised Threshold of Need document together with improvements in the reliability of children's social care performance data have indicated that historically, the threshold for access to children's social care was too high.

The result has been a rising rate of referrals to children's social care as a response to concerns about children's welfare. In 2013/14 we have seen a significant increase in the number of children requiring a statutory assessment and services and rising social work (including Independent Reviewing Officers) caseloads. The timeliness of the completion rate of assessments in 2013/14 is low and the number of child protection plans has almost doubled in two years. In response to these issues being identified the BSCB will continue to scrutinise social work capacity and children's social care performance reports over the next twelve months.

Domestic abuse continues to account for the largest number of child protection plans (over half), with neglect accounting for one third of plans. The largest number of referrals to Children's Social Care continues to be from the police and is in response to concerns regarding domestic abuse. The BSCB has held the Community Safety Partnership to account for the production of a revised domestic abuse strategy and over the next 12 months the BSCB will be producing a multi-agency strategy to respond to the issue of neglect.

The number of looked after children reduced in 2013/14 and is now stable and comparable with our statistical neighbours. More successful outcomes for children and young people have been achieved by increasing the options available to secure permanence for them.

The capacity of the Greater Manchester Police to respond to the rising number of child protection plans not just in Bury but across Greater Manchester has been challenged in 2013/14. This has been a difficult financial year for many of our partners who have faced rising demands on their services in the context of cuts to public sector funding. In response the BSCB has sought reassurances from the police that resources are

being prioritised and all referrals to the Public Protection Division to attend child protection conferences and reviews are being risk assessed. The local Police Public Protection Unit in Bury has also been challenged by an increasing workload with a rise in the numbers of historical cases of sexual abuse being reported and increasing requests for police participation in section 47 strategy meetings. In response a 'strategy meeting protocol' is being developed between Children's Social Care and the Police to ensure that those strategy meetings requiring an urgent response are prioritised.

Bury has an excellent record on road safety for children and young people and for the fifth consecutive year there have been no road traffic deaths involving children and young people (figures are for 0-16 years). The Bury Road Safety team undertakes a proactive campaign of road safety in Bury schools and faith groups to keep children safe on Bury roads.

The further development of an integrated Early Help offer is a priority for 2014/15 and this work is being driven through the Children's Trust Board. A number of initiatives have already taken place this year such as the development of the Early Help Panel to ensure that children and families who require co-ordinated services below the threshold for statutory intervention receive timely services, appropriate to their needs.

This year we have seen rising numbers of children and young people referred to local CAMHS due to concerns in respect of self-harm, the largest increase in referrals coming from schools. This has come at the same time as significant capacity issues in the school nursing service have been identified. Together with the Bury Children's Trust as part of the Early Help offer the BSCB has prioritised for scrutiny children who are emotionally vulnerable in 2014/15. Capacity issues in the school nursing service have been raised with providers and commissioners by the BSCB and will remain subject to scrutiny over the next 12 months. There have been no deaths by a suspected suicide in Bury reported to the CDOP this year

External scrutiny of safeguarding arrangements in the Ofsted Thematic Inspection and the *Local Government Association (LGA)'Peer Challenge' Review* found no significant safeguarding concerns in the work they reviewed.

There are many indications that there are effective safeguarding arrangements in Bury with a real commitment to safeguarding children demonstrated by BSCB partners. However the BSCB also recognises that there are significant challenges ahead and is not at all complacent about what more needs to be done to improve. The BSCB is grateful to its members for their continued commitment to safeguarding and to continue to strengthen and improve effective safeguarding arrangements for children in Bury.

Name of partner agency	Key achievements during 2013/14
Adult Services	It is essential that we empower and support our most vulnerable children, when the time comes, with the skills they need in order to navigate the adult world. Where they lack those skills, support links between services must be robust enough in order to make the transition into adult services as smooth as possible. Both Children and Adult social care services have been working hard this year to maintain clear and supportive cross-departmental collaboration in order to ensure successful transitions. Prevention however will continue to remain the key focus of adult safeguarding therefore it is essential that we work not only with our children who are transitioning into adult services to ensure they are best equipped to protect themselves from harm, but also with our counterparts in Children's Services in order to identify areas of risk and need.
Cafcass	Cafcass is a non-departmental public body, sponsored as of April 2014 by the Ministry of Justice. Its principal functions are to safeguard and promote the welfare of children who are subject to family proceedings, and to provide advice to the family courts. It employs about 1870 staff, over 90% of whom are frontline. In 2013/14 a total of 9,680 care applications (public law) were received, which is a decrease of 12% compared with the number received in 2012/13. Similarly there has also been a decrease in private law cases where a total of 42,888 applications were received in 2013/14 - a 7% decrease compared to 2012/13. Shorter case durations (within s31 cases), together with proportionate working and more efficient working practices have led to the stock of open cases reducing in both private and public law. In 2013/14 Greater Manchester Cafcass received a total of 695 care applications. Of these 47 were issued by Bury. Additionally Bury issued 5 discharge of care applications and 4 revocation of placement order applications. A total of 3,083 private law applications were received across Greater Manchester, the highest percentage age group being under 10. The following are examples of activities undertaken by Cafcass in 13/14 to improve practice, better safeguard children and make a positive contribution to family justice reform: Working with partners in family justice e.g. the Family Justice Board, Local Family Justice Boards (11 of which are chaired by Cafcass), judges; the Family Justice Young People's Board; and the ADCS, to promote family justice reform in preparation for the implementation of the Children and Families Act (April 2014). Contributing to the development of the Public Law Outline and Child Arrangements Programme (Practice Directions 12A and 12B respectively); and working with partners to reduce the duration of care

	cases (35 weeks as of quarter 3). Setting up demonstration projects designed to accelerate family justice reform e.g. a telephone helpline service in the North-East to divert from court cases where there are no safeguarding issues. Strengthening the workforce through a number of measures including: the talent management strategy; MyWork (a mechanism by which staff can understand and regulate their own performance); development of a health and wellbeing strategy. Revising the Child Protection Policy, Operating Framework and Complaints and Compliments Policy. Drafting service user minimum standards which will be joined with our workstream on child outcomes. Undertaking a number of pieces of research into the work of Cafcass and family justice including research into: expert witnesses in s31 cases; the work of the Children's Guardian; learning derived from Cafcass submissions to Serious Case Reviews (Cafcass having contributed to 30 such reviews in 13/14). The National Ofsted inspection took place in February and March 2014. Both private law and public law practice were judged to be good as was the management of local services. National leadership was judged to be outstanding. All of the Key Performance indicators, relating to the allocation of work and filing of reports, have been met.
Children's Social Care	The 2012/2013 Annual Report described the local authority Children's Social Care service as being in a state of transition. That Report covered a period in which many changes were taking place, many having been introduced by the new Assistant Director, Social Care and Safeguarding, appointed in January 2013. A service review in early 2013 identified a number of potential improvements that could be made to the performance management and information systems. Limited information about social care demand had meant that too few social workers were in post, particularly in Advice & Assessment (A&A). Better systems were needed to measure service impact and to improve the overall level of service. A service improvement action plan was drawn up. In May 2013 a consultant Head of Improvement was appointed on a temporary contract, to advise on performance measures. Case file auditing was introduced in September 2013. Reports on trends in social care events are now made available to every tier of Social Care management. A new post was created of Strategic Lead, Quality Assurance and Performance Management, to which an appointment is expected to be made in the summer of 2014. Steps are being taken to automate the creation of performance information, such that all managers will have available 'real time' data on team and service performance.

	During the year the Children's Social Care staff group increased in size. Whereas there was previously one Strategic Lead post covering the whole service, from May 2013 separate interim appointments were made for a Strategic Lead (Placement Services) and Strategic Lead (Safeguarding). A permanent appointment was made to the first of these in January 2014 and to the second in March 2014. The A&A service increased from one team manager to three, with an additional team manager being appointed to what became the Multi-Agency Safeguarding Hub (MASH) in October 2013. The A&A team was supplemented with a number of agency social work appointments and was divided into three teams following a duty rota. In addition to the MASH an Early Help service has been formed, delivered by a team which includes four experienced social workers. The Early Help Panel assesses the suitability of cases for help and support. New threshold guidance was introduced in September 2013. The Children with Disabilities service now has within it social workers with substantial safeguarding experience and is led by a social work Team Manager. The review revealed both strengths and relative weaknesses in the safeguarding service. The service's greatest strength is the quality and commitment of many of its staff, as reported through the Local Government Association (LGA) 'Peer Challenge' review conducted in February 2013. The January 2013 Ofsted Thematic Inspection of Early Help services also identified many positive and impressive features, both in individual work with families and in collaboration with other agencies. The LGA advised that the Children's Social Care service should be enlarged. An immediate response was to recruit some agency team managers and social workers but the long-term solution will be to recruit permanent staff. It has been found that the salary structure in Bury places the local authority at a disadvantage relative to its immediate and regional neighbours. To give one example, the Independent Reviewing Officer (IRO) post vacated in December 2012 remains without a permanent replacement, despite two rounds of advertising, and has otherwise been occupied by an agency IRO during the year. Ofsted's new inspection regime for safeguarding and looked after children services took effect in the autumn of 2013. Children's Social Care was throughout the remainder of the year in a state of constant alert and preparation. In anticipation of an inspection the service prepares weekly data lists of all current and recently closed referrals. The lists provide managers with the opportunity to weekly review all referrals involving safeguarding and this has led to a significant improvement in the completeness and accuracy of case recording. It is anticipated that the changes effected during 2013/2014 will become established features of the service in 2014/2015. The Independent Safeguarding Unit is in the process of reviewing and improving all business processes relating the planning and conduct of child protection conferences and reviews; social care and safeguarding quality assurance and performance management will be among the Unit's new functions. Experimentation and testing of the consultation and referral arrangements between A&A, the Safeguarding and Quality

	Assurance Unit, MASH, the Early Help Team and the safeguarding teams is expected to provide for the more certain identification of children in need of help and support, and of services appropriate to their needs.
Clinical Commission-ing Group (NHS Bury)	The last 12 months have been a period settling for the newly reformed NHS and NHS Bury Clinical Commissioning Group (the CCG) have continued to ensure that the wellbeing and safety of children in Bury is a high priority. The CCG continues to work across the Local Authority, the Bury Safeguarding Children Board, the Children's Trust and health providers to meet its aim. The vision for safeguarding within the CCG is to maintain robust, resilient and effective safeguarding services and to strengthen arrangements for safeguarding adults and children across Bury by working collaboratively with partner agencies. NHS Bury Clinical Commissioning Group will prioritise the safety and welfare of children and vulnerable adults across all commissioned and contracted services. The CCG will support and work to empower the health professionals across the health economy of Bury to be confident and knowledgeable in their decision making within safeguarding. To enable the CCG to fulfil its vision the CCG has an Executive Lead for Safeguarding and is accountable to the Governing Body of the CCG, who is a local GP and is an experienced safeguarding professional and is a member of the Strategic Board of BSCB. The CCG also has in place Designated Professionals who are members of the executive group and a number of sub groups of the BSCB. The designated professionals provide support to the named professionals in the health provider services, namely, Pennine Care Foundation Trust and Pennine Acute Hospital Trust. The CCG has a role in monitoring training within the providers and levels of safeguarding activity via an annual audit of safeguarding standards. Primary care services are commissioned by NHS England but the CCG has responsibility to ensure quality and equitable services are provided. Within this remit the CCG remains committed to providing proactive and responsive training for GPs locally and provides training to local GP's and practice nurses and has a rolling programme of training and peer support. During the last year there have been sessions on child sexual exploitation, lessons learnt for serious case reviews and domestic abuse, alongside basic awareness training.
Greater Manchester Police	The Bury Division of Greater Manchester Police (GMP) has been fundamental in supporting our new Multi-agency Safeguarding Hub, working closely with colleagues from the Public Protection Division and our partner agencies. We are proud of the fact that the project has been recognised by the Home Office as an area of good practice and colleagues from other boroughs have visited to see the practices and principles that we have adopted. GMP has increased its resource contribution within the team to support the early identification of children and young people at risk and it is our intention to increase even further with the inclusion of a Detective Sergeant post.

	We are committed to exploring new opportunities for expanding this work with partners, focusing on those individuals and families that are most at risk both as victims or offenders by co-ordinated screening, identification, support and enforcement.
Greater Manchester Probation Service	Quality of Safeguarding Work: This year the Rochdale office has volunteered for an internal audit or NOMs Audit to establish effectiveness of delivery of Child Safeguarding work locally. **Findings from the audit:** **Positive Points** • Found satisfactory to good on Delius contact logs - entries provided sound details of case history and order of events could be followed. • Logs confirmed Offender Managers (OMs) having regular contact with agency partners at key and critical stages of the cases. • Cases are appropriately flagged on the system. • Home Visits when recorded indicated that events were being undertaken with partner agencies. Found some quality recording by OMs. • High risk of harm cases reviews (RAMA) were being completed in a timely manner. • SARA (Risk of Serious Harm tool for Domestic Abuse) reports were found on all applicable case files, and of satisfactory quality. • There was good initial child/children screening found in most standard Pre-sentence reports (PSRs) reviewed. • Sentence plans on the whole reflected safeguarding issues. • Reports to Case Conferences by OMs were timely and meetings were mainly well attended by Officers. **Possible Improvements** (from Bury/Rochdale; Tameside and Salford) • Management focus on Home Visiting - example found in one case where HV not completed – offender did not live with children in this instance. • RAMA reviews to include standard review point on Child Protection (Child/Children Wellbeing - Last seen, how they were, school attending etc) - Reviews varied in this approach. ** New template for immediate implementation agreed. • Standard Child Protection review point to be included within Offender Manager case supervision sessions, eg wellbeing reviews – in all cases not just those of a higher risk/subject to child protection plan or child in need.

	• Standard template for RAMA reviews, found inconsistent recordings within contact logs, some of excellent quality. • Improvement to generic induction form requesting more in depth details of child/children (eg Schools, Known address other than offenders etc). • Trust wide protocol required with Police and DVU's in respect of daily DV call-out intelligence to OM's. However, this is fully implemented already in Bury Domestic Abuse: Findings from recent domestic homicide reviews and serious further offence reviews collated and briefing developed for delivery to staff by end May 2014. MASH: We continue to have daily representation at the MASH with referral information being analysed and information shared in a timely and proficient manner. This can at times include an assessment of non-statutory cases as well as input on those currently subject to probation intervention. There will be a change in attendance at the operational managers' group due to a staff member leaving, but our engagement continues with a view to robust engagement within the screening process. Quality and Performance : The aforementioned focused audit as well as structured random audits demonstrate positive working practices and qualitative information to allow us to understand quality of performance. Toxic Trio Audit information is about to be shared. Serious further offence and case reviews are another source of information which looks at the quality of risk assessment, management planning and intervention delivery. Learning from this is disseminated.
Learning Division	Safeguarding continues as a priority for Bury's Primary and Secondary Schools. This work continues to be well supported by the Safeguarding in Schools and Colleges Sub Group and by work of teams such as the Children and Young People in Care Education Team and the School Attendance Team . There is now a permanent member of the School Attendance Team on the Multi-Agency Safeguarding Hub. In the 23 school inspections undertaken by Ofsted between September 2013 and July 2014 in Bury, 83% of Primary, Secondary and Special Schools were judged to be good or outstanding in respect of the Behaviour and Safety of pupils. 3 schools were judged to have outstanding outcomes: Emmanuel Holcombe CE Primary, St Stephen's CE Primary and Tottington Primary. In 4 inspections – 3 Primary schools and the KS3/4 PRU - Behaviour and Safety was judged to be requiring improvement. However in each of these reports safeguarding was judged to be good whilst behaviour was the aspect that required improvement. These schools will now be receiving additional support from the Local Authority to help them move to Good or better. Attendance at Bury schools is well above national averages and the level of Permanent and Fixed Term Exclusions from Secondary Schools continues to decline, but is still an area for focused work. Over the last year substantial work has been done with schools on anti-bullying,

	including work on homophobic behaviour and bullying of disabled young people. The "Be Safe Be Cool" event for Y9 pupils has continued to be run in every High School and there has also been training provided to High Schools on the Prevent agenda (prevention of radicalisation). In Children's Centres a pilot project in Radcliffe of employing a social worker to support outreach workers on early intervention safeguarding work has proved very effective and will now be rolled out across all our Children's Centres.
NHS England	NHS England Safeguarding People in the Reformed NHS guidance outlines the area team's responsibilities to safeguarding children. Significant changes to the structure of the NHS came into effect on 1 April 2013. New organisations were created and others such as primary care trusts (PCTs) and Strategic Health Authorities (SHAs) were abolished. NHS England is a new national organisation with a local area team covering Greater Manchester. Its main role is to ensure that the overall system of planning and buying NHS services works well and that the NHS delivers better outcomes for patients. NHS England oversees the operation of CCGs making sure they successfully plan and buy services for their local population. It also looks at how well CCGs operate their budgets, engage with their local populations, and deliver the pledges, rights and values in the NHS Constitution. NHS England also plans and buys health services at a national level. These include: • Specialised services (such as those for rare diseases) including Tier 4 CAMHS • Prison health services • Some services for members of the armed forces. • Primary Care e.g. GP services, dentists, pharmacy and optometry. **Our responsibilities for safeguarding children** NHS England 'Safeguarding people in the Reformed NHS' guidance outlines the Area Teams responsibilities to safeguard both Children and Adults who are vulnerable. Our responsibilities are managed through the Greater Manchester Strategic Safeguarding Collaborative which is hosted by the Area Team. A full report is attached as Appendix 2.
Pennine Acute Hospitals NHS Trust	The Trust continues to ensure representation on all LSCBs and LSABs within its footprint. A full report provides evidence to the LSCBs of the safeguarding work undertaken within the Trust to enable it to discharge its duty against national guidance. A copy is attached as Appendix 3. The Safeguarding Team continue to develop systems and processes and work with staff and patients and other agencies to ensure the potential to protect adults at risk is maximised.
Pennine Care NHS Foundation Trust	**State of Safeguarding in Bury for BSCB Annual Report** Pennine Care NHS Foundation Trust (PCFT) provides mental health and community services to people living in the boroughs of Bury, Oldham and Rochdale. We also provide mental health services in Stockport and

	Tameside and Glossop, as well as community services in Trafford. **Community services include:** • Dentistry • Health visiting and school nursing • District nursing • Sexual health services • Cancer and end of life care • Long term conditions management • Health improvement and wellbeing • Learning disabilities • Paediatric and adult therapies PCFT Community Services Bury is committed to working across the Bury health economy in partnership with statutory, non statutory and third sector partner agencies to safeguard and protect children. PCFT contributes to the work of the Bury Safeguarding Children Board (BSCB), Children's Trust Board and Health and Wellbeing Board to achieve this. PCFT Community Services Bury contributes to the wider work of the BSCB with representation on the MASH, SEAM, MARAC and DV Steering groups. Safeguarding is represented at all levels within the organisation with the Executive Director of Nursing as PCFT Board lead for safeguarding. This role is supported strategically by a head of safeguarding. Within Community Services Bury Division, the Service Director has overall responsibility for safeguarding and sits on the BSCB board. This role is supported in Bury by the named nurse and the safeguarding team. The named nurse fulfils the role as outlined in Working Together (2013) and in the Intercollegiate Document guidance 2014. The named nurse ensures advice, support, supervision and training is in place for all frontline staff and provides assurance that PCFT Community Services Bury; fulfil their statutory requirements with regard to safeguarding children. Assurance at Borough level is given via the Quality Governance Assurance Group which reports to PCFT integrated Governance Group and to the Board. Safeguarding children training competencies for all health staff is outlined in the Intercollegiate Document 2014 and is mandatory. All staff are required to undertake safeguarding children training at induction and receive a mandatory refresher every three years at Levels 1 - 3 depending on the post holder's role and responsibility. Safeguarding audit is embedded in the Trust safeguarding calendar and ongoing and new audits are being developed to demonstrate compliance with safeguarding standards. Two cross-borough audits were developed and completed in 2013-14 on *Safeguarding Standards*

	in Record Keeping and *Management of Domestic Abuse Notifications.* PCFT Community Services Bury has representation on the subgroups of the BSCB along with the Executive group and the Board itself. It also contributes to Serious Cases Reviews and any additional critical case reviews and actively participates in multiagency audit. PCFT Community Services Bury will continue to work with partners to maintain and develop good practice in ensuring all children within the borough of Bury are safeguarded and protected.
Third sector	The third sector within the borough has undergone huge changes over the last year and has been impacted by the economic pressures faced by all. According to the Third Sector Survey June 2014 this has heightened unease in the sector not least with the 40% cuts to the Charity Commission itself. The vision for a Big Society where voluntary agencies flourish and take a bigger part in public service delivery is yet to be seen on the whole. Specific to Bury the sector has as always looked to rise to the challenges set before it. There has been consistent attendance at Bury Safeguarding Children Board and the BSCB Executive Group, with information shared within the sector when it is available. The sector has been represented on the Safe Networking Regional Forum and information flow has taken place within the Borough. Training by Bury Third Sector Development Agency (B3SDA) continued to support the sector with free training to smaller groups on Basic Safeguarding through its one day course. It's been over three years since this started and groups in the sector were reminded that they should repeat the course after three years. Three courses were run over the year, which saw over 30 attendees and 14 different small groups local to the borough. The review of the course was started in the year with the help of the BSCB. The sector also attended more advance courses delivered through the BSCB. The sector was also involved in the BSCB Training Needs Analysis to which they responded well. In terms of communication B3SDA has a quarterly newsletter which has carried safeguarding issues and its website has a Safeguarding Section and a link to the Safeguarding Board's website. Agencies were also able to support the Early Help Thematic inspection. The sector expects further infrastructure upheaval in the coming year an element of this will be a commitment to the Children and Young People Forum which is a platform for sharing experience and promoting safeguarding practice. The sector also bid a fond farewell to Barbara Jack Chief Executive of Early Break who retired in the year. She tirelessly represented the third sector on the BSCB for many years and who will be missed for her commitment, foresight and professionalism.

A word from our lay members

The Lay Members have continued to attend full Board meetings, Serious Case Reviews meetings and sub groups (Policies and Procedures and Training and Development), as well as at community level we are both school governors with responsibility for safeguarding. Our governor role provides a view of the practical interpretation and implementation of BSCB policies and recommendations at grass roots level and the opportunity to raise any issues arising.

To further extend our knowledge we have attended various training sessions, including the recent DBS conference. We have also attended an interesting meeting with the Children & Young People in Care Council where participants spoke openly to us about their experiences of services.

From September 2014 the new Children and Families Act will bring significant changes to schools, and to children and families with implications for all Local Authorities and other agencies involved with children, in particular those with SEN, SEND, in the care system or from military families. Working Together 2013 became mandatory for all agencies, creating even further demands on already over-stretched personnel, but hopefully this will be an opportunity to work more closely with families to enable these children to reach their full potential.

It will be interesting to follow the progress of implementation of the act in Bury and to see how tighter partnership working is reflected in all aspects of safeguarding.

Challenges ahead 2014/15

National

- National responses to historic cases of child sexual abuse.
- Impact on resources and the workforce in the context of austerity measures.
- Office of the Children's Commissioner progressing actions to address child sexual exploitation.
- The consultation launched by Ofsted, CQC, HMIC, HMI Probation and HMI Prisons on a targeted programme of integrated inspections of services for children in need of help and protection, children looked after and care leavers. The consultation includes proposals for joint inspections of the effectiveness of local safeguarding children boards.

For the BSCB

- Continuous self assessment so that as a LSCB we are effective and we are making a difference.
- Finance and resourcing challenges.
- Strengthening the voice of the child in all BSCB core activities.
- Strengthening the BSCB Quality Assurance functions by embedding the quality assurance framework.
- Ensuring commissioners have a clear understanding of the needs of vulnerable children in Bury when commissioning services.

For multi-agency safeguarding practice

- The development of a BSCB 'Neglect strategy'.
- The development of the Phoenix Team to tackle child sexual exploitation.
- Safeguarding children & young people from key priority vulnerable groups identified in the BSCB Business Plan 2014/15.
- Working with providers of newly commissioned services to ensure that safeguarding remains a priority.

BSCB Business Plan Objectives 2014/15

This year the Monitoring & Evaluation Sub Group commissioned an independent consultant to develop a revised BSCB Quality Assurance Framework. As part of this work a new approach was taken to the development of the BSCB Business Plan for 2014/15. BSCB Executive group members and sub group chairs were asked to complete a 'Safeguarding Needs Summary Template'. This summary contributed to the development of the business plan for the coming year (2014/15).

In addition to the "Safeguarding Needs Summary", the business plan was informed by the BSCB Hydra Development event, the learning from local research & audits, Serious Case Reviews, the refreshed Joint Strategic Needs Assessment 2014, BSCB Chair dialogue and annual structured sessions with partner agency leads. This has enabled us to identify vulnerable groups warranting higher priority over the next three years.

The Business Plan for 2014/15 has clear outcomes for the BSCB and for children and families in Bury. Each of the BSCB sub groups will draw up their (SMART) work plans based upon the outcomes and milestones in this plan. The plan will be reviewed at every BSCB meeting and in March 2015, new outcomes for each priority group will be considered.

This plan outlines the key priorities for Bury Safeguarding Children Board (BSCB) over the next three years.

Discharge of functions

Regulation 5 of the Local Safeguarding Children Boards Regulations (2006) sets out the functions of the LSCB. In order to fulfil its statutory functions the BSCB has undertaken activity in the following areas:

1. The action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention

In July 2013 the BSCB concluded a consultation with partners on a new 'Thresholds for Intervention' document. The document was endorsed by BSCB in September 2013 and is published on the BSCB website. This guidance is intended to provide professionals with clear thresholds that should be applied consistently to ensure the right help is given to a child at the right time.

To support the guidance the BSCB delivered a series of multi-agency workshops to our partners. In November 2013 the BSCB also held a series of practice workshops on the Graded Care profile tool. The workshops were attended by 89 participants.

2. Developing Policies and Procedures

The Policies and Procedures Sub Group is responsible for developing and reviewing multi-agency policies and procedures for safeguarding and promoting the welfare of children.

Due to launch of the pan Greater Manchester Safeguarding Partnership (GMSP) policies and procedures in February 2013 the sub group changed the frequency

of meetings from six weekly to three monthly. This project has led to a harmonisation of safeguarding procedures across all ten LSCBs. The GMSP group meets at frequent intervals and there are two updates per year. The BSCB is represented on the group by the Board Manager and by the Designated Nurse for Safeguarding, Bury CCG who is also the sub group chair.

The key areas of work for the 2012/13 have been as follows:-

- All BSCB polices were reviewed to ensure they were compliant with Working Together 2013. Member organisations of the BSCB were asked to review their policies and confirm that they are aligned to WT 2013.

- The group continue to review policies as they reach their review date. This is a large undertaking and takes considerable time.

- The group oversaw the development of a threshold document of intervention for the BSCB. This was launched in the autumn of 2013 with group members being part of the team that rolled it out to front line staff.

- Commenced work on guidance for professionals working with young people who are at risk of self-harm or suicide.

- Consideration is being given to routes of sharing information from the police where young people age 16 and 17 are living in household where there is domestic abuse.

3. Participation in planning of services

a) Phoenix Team

The CSE & Missing Sub Group was established in 2013 to oversee the implementation of the action plan developed by the Task and Finish Group that preceded it.

In a busy first year the group had three priorities:

- To ensure that there was an effective response to CSE in Bury;
- To develop a greater understanding of and response to children who go missing;
- To embed the use of the SEAM process.

<u>To ensure that there is an effective response to CSE in Bury</u>

A programme of awareness-raising for new staff in frontline services was maintained throughout the year, to ensure that the level of awareness of CSE was maintained at that of the previous year during which an extensive training programme had been delivered. Elected members were also invited to attend as it was felt important they should be aware of the issue. Training aimed at workers who may work directly with young people affected by CSE was also available. The uptake of training and feedback about the courses was consistently good. A follow up questionnaire indicated that awareness amongst participants was embedded.

The group considered the Government's response to the Home Affairs Select Committee report and concluded that the most effective way to ensure a consistent response to CSE was through participation in the Greater Manchester Project Phoenix. The approach was to secure a multi-agency team of specialist staff to work together to provide a co-ordinated response to young people and families affected by CSE and a CSE consultancy service to professionals. The team could work across Local Authority boundaries as part of a coordinated response if required. As the project had been led by Greater Manchester Police, police officers had already been identified to work exclusively on CSE cases; a bid from members of the sub group to the Local Authority for funding for social care staff was successful and Early Break (young people's substance misuse service) also committed to the project. A BSCB request for Public Health funding is still being considered.

The Team will be fully operational in July 2014.

<u>To develop a greater understanding of and response to children who go missing</u>

The group was aware that children who go missing were also in need of a more coordinated response and that this was an area where early identification and intervention might play an important preventative role. The group undertook a review of the procedures and practice in place and concluded that whilst the notification process by the Police was effective, Children's Social Care was not effective in its response and monitoring of these cases. The sub group oversaw work on the establishment of more effective practice in Children's Social Care that included a differentiated response for children who go missing for the first time, children who were the subject of Child in Need or Child Protection plans and children who go missing from care, including those who are children resident in Bury but looked after by other Local Authorities.

Improvements in the way the Emergency Duty Team record their work and changes to the electronic record system led to an immediate improvement in management oversight and the introduction of a pro-active approach to children who go missing from the Early Help Team has led to a significant improvement in Children Social Care practice.

The group reviewed the progress made against the Government's Statutory Guidance on children who run away or go missing from home or care, issued in January 2014 and used this as an opportunity to update practice and procedures.

The changes made in the way cases are managed and recorded will mean that more effective reporting to the BSCB will be in place in 2014/15.

The group was also mindful of the vulnerability of children who regularly go missing from school. In line with the DfE Guidance on missing from school the School Attendance Team has established a reporting mechanism for schools and a response from their service. There is a concern that two secondary schools in the borough do not buy their service and children missing from these schools may go unreported and enquiries may not be made into the circumstances of their absences. Work on this area will continue in 2014/15.

To embed the use of the SEAM process

The group has received regular reports and had the opportunity to comment on the operation of the SEAM process. In particular the group identified as part of its missing strategy that it would like to see more referrals to SEAM of children who go missing before CSE is identified as a concern. This will be the focus of an awareness raising exercise in 2014/15.

It is likely that the operation of the SEAM group will need to be reviewed once the Project Phoenix Team is operational and its practice embedded.

A full report from the SEAM Panel is available as Appendix 4 to this report.

Future plans

The group envisages that much of its work in 2014/15 will be to monitor the systems that have been put in place during the year; to ensure that good practice is properly embedded and that the linked issues of CSE and children missing from home and school continue to be recognised and young people and their families receive a timely and effective response. In order to reassure the BSCB that this is the case the group will undertake a multi agency audit of compliance by agencies with the recommendations arising from SEAM and will be making quarterly reports to the BSCB on children missing from home and care.

b) Multi-Agency Safeguarding Hub (MASH)

This year the BSCB has overseen the development of a Multi-Agency Safeguarding Hub (MASH). The MASH became operational in October 2013 and is the single point of contact for all safeguarding concerns regarding children and young people in Bury. It brings together designated officers from Children's Social Care, Police, Education, Probation, Health and Six Town Housing, who are now co-located within Bury police station. The team have responsibility for screening and risk assessing referrals and making decisions as to the most appropriate intervention or signposting to other agencies to meet identified need. Consultations are ongoing through the MASH strategic partnership group to identify and secure additional stakeholders to ensure that there is effective cross organisational representation and communication in decision making to safeguard children. Early identification of vulnerability, timely responses and targeted allocation of resources is one of the central objectives of the MASH. The BSCB receives six monthly performance reports detailing progress and developments in practice.

c) Domestic Abuse Strategy

The Bury Domestic Violence Strategy highlights the need for services to support children, education and reassurance that it is not their fault and opportunities to share their experiences. Partner agencies respond to this in a variety of ways; Police always refer children who have witnessed domestic violence to Children's Social Care, where a risk assessment is undertaken and support from a specialist children's worker is offered to children; most secondary schools have commissioned a service to counsel young people affected by domestic violence and ways of extending this to

younger children are being explored as the new strategy is being developed. As part of the strategy Children's Social Care have also commissioned Barnardo's to work with couples with children who want to stay together, the programme is child focussed assessing risk as the work develops and giving parents strong messages about the impact of domestic violence on children's health, development and emotional well being.

Young people who have affected by violence for partners are also now receiving support from the Young People's Violence Advisor, a new role for which a social worker from the Early Help Team has been trained by CAADA.

In an initiative arising out of the recommendations of a Serious Case Review a discussion was held between representatives of the SCR sub group and colleagues from adult services arising from which a number of services agreed to review their training on Domestic Violence to ensure that it dealt with the impact on children and the pathways for referrals of Safeguarding issues.

The Domestic Violence Strategy is under review in 2014 and the Business Group of the Board will receive regular reports to ensure the needs of children, young people and families are addressed within it.

4. Communicating and raising awareness

Key Achievements:

- The BSCB has reviewed and revised its Communication Strategy this year and this can be found on the BSCB website link to website www.safeguardingburychildren.org

- The BSCB has developed specific training events 'road shows' in response to emerging issues such as the lessons learned from our Serious Case Reviews, the Graded Care Profile & the DASH in order that the messages get out to front line staff.

- The BSCB website www.safeguardingburychildren.org has been upgraded this year and contains up to date information on key safeguarding issues and procedures, links to useful web sites, a page for children and young people, training information and training dates.

- The BSCB produces a quarterly communication e-bulletin which summarises recent BSCB activity. This is widely disseminated via e-mail.

- The BSCB lay members have promoted the work of the BSCB to community groups helping to improve public understanding of the BSCB's safeguarding work.

Lay members have:

- Represented the BSCB at the Bury Youth Cabinet.

- Represented the BSCB the North West Safe network.

- Represented the BSCB at a regional NHS England Safeguarding event.
- Represented the BSCB at a Bury third sector safeguarding event.
- Met with a focus group of young people from the Children in Care Council and reported key messages to the BSCB.

5. Recruitment and supervision of persons who work with children & investigation of allegations concerning persons who work with children

Key Achievements:

- The BSCB has delivered Safer Recruitment Training to 34 participants. The Bury Local Authority Designated Officer (LADO) has delivered Managing Allegations training to 27 participants from a wide range of partners.
- The Bury LADO has delivered targeted Managing Allegations training to a local secure mental health provider in response to emerging issues.
- In response to the learning from a national Serious Case Review (East Sussex) and a local critical case the Bury LADO has delivered an awareness session to Bury high schools and college staff. This focused on the use of personal social media and the inappropriate engagement with pupils through such mediums. The take up of this offer was high and the presentation was provided to 14 Bury high schools and colleges.
- In October 2014 in response to a critical case the Serious Case Review Sub Group undertook an audit of Safer Recruitment practice with all Bury high schools. High schools were requested to provide the BSCB with assurances around safer recruitment, managing allegations and safeguarding training. Responses have been followed up both by the Safeguarding in Schools & Colleges Sub Group and the Serious Case Review Sub Group.
- The Managing Allegations Training & Safer Recruitment Training has been revised to include the learning from national Serious Case Reviews and local critical cases. A full annual LADO report can be found as Appendix 5 to this report.

6. Safety and welfare of children who are privately fostered

The Private Fostering Steering Group was disbanded this year in favour of establishing a Safeguarding Children and Young People Living Away from Home Sub Group with a private fostering lead from Children's Social Care being identified. The full BSCB Private Fostering annual report can be found as Appendix 6 to this report.

Key achievements:

- The BSCB has continued a programme of awareness raising through BSCB training and by partner agencies.
- Publicity material has been made available in a range of languages. The material emphasises the legal requirement to notify the Local Authority and includes a variety of information within a poster and three leaflets; for parents & carers, children & young people & professionals.

- This year the number of private fostering arrangements identified has increased from 1 to 6.

7. Training

The BSCB Training & Development Sub Group is responsible for the implementation of the BSCB training strategy. Key achievements this year have been:

- *The development of a quality assurance framework*: The BSCB multi-agency trainer now submits a quarterly performance report to every Training & Development Sub Group meeting. This report contains an analysis of feedback from course participants, evidence of course revision including messages from local and national research, serious case reviews and policy development.

- *Single agency Group 3 safeguarding training*: Agencies/organisations that do not have their own well-established single agency training arrangements can purchase single agency training from the BSCB. In 2013/14 the sub group has delivered 8 one day courses to a range of private providers. This year a follow up audit was undertaken with course participants. All participants followed up rated the course as 'excellent' or 'good'. Participants were also asked to cite examples of how they had put the training into practice. Examples cited were being more confident in recognising signs and indicators of abuse and cascading the learning within their own organisation.

- *Further audit activity:* In September 2013 the sub group undertook an audit to test the impact of a series of CSE learning events on practice. The responses received were considered by the CSE & Missing Sub Group & the Training & Development Sub Group in October 2013. Responses included testimonial evidence from participants who cited examples of how they have put the training directly into practice.

- *Learning & Improvement Framework:* In response to the learning from Serious Case Reviews the BSCB has delivered a one day course 'Working with Black African Children & Families', we have also commissioned a new course 'Professional Challenge' in child protection decision making forums to be delivered in June 2014.

- The BSCB Multi-Agency Trainer has revised the BSCB Domestic Abuse training to include key learning from these reviews and from a Domestic Homicide Review undertaken by the Community Safety Partnership. The BSCB has also commissioned an external auditor from HAARV to review the BSCB Domestic Abuse training.

- The sub group has undertaken a refreshed training needs analysis. Responses were received from 25 partners. All responses have been scrutinised by the sub group to maximise learning across the partnership.

The analysis will inform the BSCB strategy over the next twelve months. A copy of the Training Needs Analysis can be found as Appendix 7 to this report.

- Training figures can be found at Appendix 8.

8. Cooperation with neighbouring children's services authorities and their Board partners

Bury Safeguarding Children Board collaborates on a Greater Manchester basis with other Greater Manchester Local Safeguarding Children Boards and is represented on the Greater Manchester Safeguarding Partnership (GMSP). The GMSP consists of representatives from all Local Safeguarding Children Boards and key agencies across Greater Manchester and coordinates collaborative projects and promotes a consistency of approach. The BSCB continues to be involved in the development of the pan Greater Manchester Multi-Agency Safeguarding Procedures.

This year the BSCB also participated in the GMSP's development of a multi-agency training tool 'Voice of the Child'. This powerful film was made by young people across Greater Manchester, who have all had experience of professional support from a wide range of services. It has been developed as a training resource for staff development and learning and serves as a reminder of why it's important to listen to the voice of the child. The BSCB held a Communicating with Children and Young People learning event on to launch the DVD on 4 February 2014 attended by 25 participants.

9. Monitoring effectiveness

The BSCB's responsibility for monitoring the effectiveness of safeguarding practice is carried out by the Monitoring & Evaluation Sub Group. The work of the sub group was challenged this year by a number of changes of key personnel. The sub group was chaired by the Interim Service Manager Safeguarding Unit from April to December 2013. Since January 2014, the sub group has been chaired by the BSCB Board Manager, pending the appointment of a Strategic Lead for Quality Assurance by Children's Social Care. The post holder will assume the responsibility for chairing the sub group when recruited. Despite these challenges the key achievements of the sub group this year have been:

- *Quality Assurance framework*: The sub group has revised the terms of reference for the sub group including the commissioning of an independent consultant to develop a BSCB Quality Assurance Framework. This has included a revised multi-agency data set (published on BSCB website).

- *Multi-agency audit activity:* An audit of the extent of practitioners' understanding of the *Concealed and Denied Pregnancy* procedure (developed in response to the learning from a Serious Case Review) was co-ordinated by the sub group during January & February 2014. Responses were analysed by the sub group and demonstrated that awareness of the procedure remains high across the Bury Children's Workforce.

- In September 2013 the sub group undertook a multi-agency audit of domestic abuse practice. Domestic abuse was identified as a key priority area for scrutiny in the BSCB Business Plan 2013/14. The audit was conducted between October & December 2013. The methodology was that each agency representative audited a sample of cases. In all cases chosen the children were subject to a child protection plan (14 children in total). The auditors considered their own agency findings, and results have been compared the recommendations will form part of a multi-agency tracker to monitor progress to be overseen by the sub group.

- A section 11 audit of statutory partners' compliance with their duties under section 11 of the Children Act (2004) to safeguard and promote the welfare of children has been undertaken. All section 11 statutory partners were requested to complete the audit by 17th April 2014. Although the audit has been slightly delayed by the purchase of the tool BSCB members considered that the delay was purposeful as the tool brings added advantages in terms of data analysis and efficiency. The sub group will be responsible for analysing the findings and this action will be carried forward to the sub group action plan for next year.

- *Child Protection Conference Audit:* In response to a recommendation from a Serious Case Review the BSCB has undertaken a multi-agency audit of observations of child protection case conferences. The recommendations will form part of a multi-agency tracker to monitor progress to be overseen by the sub group.

- The sub group now receives reports from the Children in Care Council reflecting the experiences of children who are in public care in Bury. In 2014/15 we are looking forward to hearing the voice of children and young people who are subject to a child protection plan leading on from the implementation of an advocacy project.

10. Serious Case Reviews

The BSCB Serious Case Review Sub Group oversees and quality assures all Serious Case Reviews (SCRs) undertaken by the BSCB. The sub group is also responsible for screening cases as and when necessary and determining whether any new reviews should be initiated and if so under which model the review will be conducted. The sub group is also responsible for monitoring the implementation of the action plans arising out of reviews. The sub group is also responsible for the implementation of the Learning and Improvement Framework in conjunction with the Training & Development Sub Group.

The Serious Case Review Sub Group has met at a minimum frequency of every eight weeks with a settled membership. This year the sub group has concluded three Serious Case Reviews. The sub group has considered the implications of Working Together (2013) in respect of the BSCB's responsibility for the conduct of Serious and Critical Case Reviews. Whilst the criteria for Serious Case

Reviews has not changed the expectation is that more cases will fall within the remit of Critical Case reviews and screening panels should exercise their judgement to include a wider range of cases within the review process. Working Together (2013) also gives the BSCB the opportunity to conduct reviews in a way that is proportionate to the needs of the case and following different models. Using this flexibility the sub group commissioned the most recent SCR (C13) to be held as a Learning Review Event.

- The first Serious Case Review (E12) concerned the death of an eleven week old baby girl (Baby E). It was reported that her parents had been drinking at home and both fell asleep, the mother on one sofa with the baby and the father on another sofa by himself. The Serious Case Review findings were discussed at Bury Safeguarding Children Board on the 8th July 2013 and recommendations agreed. Due to concerns expressed by BSCB that members of the family would be identified if the Overview Report was published in full, an Executive Summary was commissioned. With the agreement of the National Serious Case Review Panel the Executive Summary was published on 21st February 2014.

- The second Serious Case Review (B13) followed the death of a 17-year old young person (Child F). The young man was looked after by the local authority and placed in supported accommodation for young people aged 16 years and over. On the 3rd February 2013 Child F went missing. He was later found on the 4th February 2013 and had used a cord to hang himself. The Serious Case Review findings were discussed at Bury Safeguarding Children Board on 21 August 2013. The report was published in full on 21st February 2014. In response to the recommendations made, the BSCB established a Task & Finish Group to develop a multi-agency suicide & self-harm pathway/procedure. A multi-agency training course is also being developed to raise awareness of mental health issues in young people. A joint Working Together protocol has also been established between Housing Choices and Children's Services that aims to tackle and prevent homelessness of sixteen and seventeen year olds.

- The third Serious Case Review (C13) concerned the circumstances of a child aged 8 years old, who suffered a fatal asthma attack (Child H). At the time of his death Child H was subject to a child protection plan. The Serious Case Review on Child H (Case C13) was submitted to an extraordinary Bury Safeguarding Children Board (BSCB) meeting on Monday 6 January 2014. BSCB members agreed to accept the Serious Case Review Report and multi-agency action plan for submission. The report was published in full on 17th April 2014.

The learning from all three reviews has been disseminated to front line professionals by the BSCB. During February, March & April 2014 the BSCB held a series of SCR Learning Events to promote the lessons learned. The events were attended by 131 professionals from a wide range of agencies. Audit activity to assess the impact of the learning events on practice will be undertaken in the year 2014/15.

11. Child Deaths (Child Death Overview Panel)

In April 2008 Bury, Rochdale and Oldham joined to form a tripartite arrangement. The joint working of the three local authorities provides a wider data set to conduct analysis and investigate emerging trends. This year we

have welcomed the enhanced contribution to the CDOP from partners in Public Health who have agreed to chair the CDOP on a rota basis from January 2014. The CDOP is currently chaired by the Oldham Director of Public Health.

There has been no significant rise or fall in the number of deaths reported to the CDOP since 2008. Excluding 2012, Oldham has been the local authority with the largest number of child deaths each year and has the largest child population of the three local authorities. Of the three boroughs Bury continues to have the lowest number of child deaths year on year and has smallest child population of the three local authorities.

The 2007 Index of Multiple Deprivation average score gave Bury a national rank order of 122 out of 342 of the most deprived districts in England. Of the three local authorities, Bury is the most affluent and has much smaller pockets of deprivation in comparison to Rochdale and Oldham. Bury has the smallest child population (41,952) of the three local authorities as well as the comparatively lower levels of deprivation.

This year the CDOP has reviewed the deaths of 18 Bury children. In Bury chromosomal, genetic and congenital anomalies account for the most common cause of death followed by complications relating to a perinatal/neonatal event. One child died from a life limiting condition, one child was suffering from a terminal illness, one child died as a result of an asthma attack. This last case has been subject to a Serious Case Review (SCR C13).

In 2012/13 the CDOP reviewed 5 child deaths following a suspected suicide. All 5 children died as a result of hanging which all occurred at the parental home. The largest number of those deaths occurred in 3 children (60%) resident in Bury. In response to the death of one of those young people the BSCB has undertaken a Serious Case Review (SCR B13) concluded and published this year.

There have been no deaths following a suspected suicide reported to the CDOP in 2013/14. The BSCB has however identified children who are emotionally vulnerable as a priority group in the BSCB Business Plan for 2014/15.

Effectiveness of the BSCB

Through the work of the BSCB we have continued to monitor our effectiveness and functioning. We have undertaken BSCB development activity in the form of a MACIE Hydra event. The BSCB has also participated in external an Ofsted Thematic Inspection of Early Help and a Local Government Association (LGA) 'Peer Challenge' review.

In October 2013 a *Hydra Multi-Agency Critical Incident Exercise (MACIE)* was delivered by the College of Policing. As part of this event BSCB members participated in a multi-agency scenario of safeguarding practice.

At this event the following emerging eight themes were identified for further action by BSCB:

- Walking in the child's shoes
- Celebrating and learning from success

- Multi-agency work & understanding the perspectives of others
- Austerity
- Making a difference
- Communication and positive relationships
- Challenging normality the experts and poor practice
- Maintaining confidence in staff and providing motivation

In January 2014 the BSCB participated in an *Ofsted Thematic Inspection of Early Help*. Inspectors found:

- No significant safeguarding concerns in the work they looked at.
- There is strong partnership working and there are clear lines of accountability within the BSCB & Trust; mechanisms are there to provide challenge.
- We know ourselves well and have a realistic understanding of where we are. We know our own areas for development.
- There is a clear understanding of priorities and of the collective needs for commissioning services. We know where the gaps are and are using the local knowledge below the JSNA to identify gaps in service.
- Learning from Serious Case Reviews was evident in all the practitioners spoken to.

Areas for Development identified were:

- At a strategic level we need to strengthen the partnership and input from adult services.
- The recording of the child's voice & experience need to be strengthened.
- Feedback from families needs to be consistently sought to inform planning & to review impact of the help provided.

In February 2014 the BSCB participated in a *Local Government Association (LGA) 'Peer Challenge' review.*

In response to feedback from that review the BSCB has:

- Revised the agenda for BSCB meetings, to ensure that challenge is more explicitly recorded in BSCB minutes.
- Reviewing and clarifying expectations of inter agency co-operation with regard to strategy discussions and/or meetings and holding agencies to account for any non compliance.

The BSCB has also raised challenges this year with a number of our partners. A challenge log is regularly updated by the BSCB Interim Board Manager. Areas for scrutiny this year have included:

- high social work caseloads;
- rising numbers of child protection plans;
- attendance by key agencies at BSCB meetings and at strategy meetings;
- pre-birth assessments;
- engagement with MASH;
- partnership working;
- uptake of preventative CSE work;
- capacity in the school nursing service; and
- the welfare of young people placed in secure mental health settings .

Multi-Agency Safeguarding Performance Data

Table 1: Contacts and Referrals

	Total initial contacts (number)	**Accepted as Referral (number)**	**Dealt with as Contact only (number)**	**% of contacts proceeding to referral**
Full year 2009-10	2875	1956	921	68%
Full Year 2010-11	3775	2647	1128	70%
Full Year 2011-12	5088	3337	1751	66%
Full Year 2012-13	7876	1818		23.1%
Full Year 2013-2014	**8613**	**3215**		**37.3%**

- **There has been a slight upward trend in the Contacts measured over the last twenty-four months (April 2012 – March 2014)**
- **The figures pre and post 1 April 2012 cannot be compared because of changes in definitions and thresholds**
- **Conversion rate of Contacts to Referrals increased markedly in 2013-2014**
- **Previously published provisional figures for 2012-2013 have been updated**
- **The number of Contacts increased relative to the previous year, though the most significant change was in the rate of conversion from Contacts to Referrals.** The growth in Referrals is likely attributable to several factors, including changes in staffing, the introduction of the MASH and relaunch of revised threshold guidance.

Table 2: Contact sources

Contact source	Percentage of Contacts* 2011-2012	Percentage of Contacts 2012-2013	Percentage of Contacts 2013-2014
Police	40%	34%	48.7%
Via Emergency Duty Team (EDT) and social care	8%	6%	2.5%
Health	12%	10%	10.1%
Education	10%	12%	9.8%
Members of the public (including family)	4%	6%	11.0% (includes anonymous and self referrals)
Voluntary agencies	4%	2.5%	0.0%
Other local authorities	4%	5%	2.3%
Probation	2.5%	3%	0.3%
Housing	3%	2%	2.7%
Other sources	12%	19.5%	11.8%

*Note: The RAISE recording system did not distinguish between Contacts and Referrals. Figures for 2011-2012 are based on a distinction by outcome in order to provide a reasonable comparison between successive years.

- **The largest number and the greatest proportion of Contacts and Referrals come from the Police.** The most frequently recorded factor in police Contacts and Referrals is domestic violence, often associated with drug and alcohol misuse in the presence of children. The number and rate of Children's Social Care Referrals is therefore open to the influence of changes in policing policy and practice.

- **Preliminary analysis suggests a relationship between referring organisation and Referral outcome.** Referrals from organisations or individuals than know the child and family well (e.g. schools and health visitors) tend to progress to assessment.

- **A repeated referral rate to Social Care within 12 months of previous referral was 24.7%.** This represents a slight increase over last year's figure of 24%.

- **The number of Initial Assessments commenced increased significantly** from 1646 last year to 2571 this year.

- **The conversion rate from referral to Initial Assessment increased from 49% in 2012-2013 to 80.9%.** The conversion rate was previously improbably low compared with the then national average of 75% and the statistical neighbour rate of 78%. The conversion rate for 2013-2014 was within the range of what would be expected.

- **Timeliness of Initial Assessments remained poor, though an improvement on the two previous years.** Of the assessments commenced in the year, 54.3% were authorised within 10 working days. Of the assessments completed within the year, 62% were finished by the social worker and 57.4% were authorised by a manager. The 2012-2013 mean average for an extended group of statistical neighbours was 76.3%

- **There was a massive growth in the number of Core Assessments commenced in the year.** 1715 assessments commenced, compared to 601 in 2012-2013 and 573 in the year before that. Bury's rate of completed Core assessments in 2012-2013 was 131.1, well below that of the extended group of statistical neighbours at 211.7. For 2013-2014 the annualised rate per 10,000 child population was 328.6, which is a rate higher than for any comparable local authority.

- **The timeliness of Core Assessment has improved slightly in three years, but remains very low relative to the standard (i.e. authorisation within 35 working days) and to the extended statistical neighbour average.** The 2012-2013 report estimated that 48% of Core assessments in the year had been finished in time. Of the assessments commenced in the year, only 45.5% were authorised within 35 working days. Of the 2013-2014 assessments completed within the year, 65.4% were finished by the social worker and 57.3% were authorised by a manager. The 2012-2013 mean average for an extended group of statistical neighbours was 76.7%

- **The conversion rate from Section 47 Child Protection investigations to an Initial Child Protection Conference was 47.7%.** This figure represents a drop from 53.5% in the previous year but remains well above the 36% achieved in 2011-2012 and is broadly in line with the England average.

Conference Activity

There has been a dramatic reversal in the number of children subject to Child Protection plans. 115 children were subject to plans at 31 March 2013; 222 were subject to plans at 31 March 2014.

The growth is children subject to plans reflects an increase in commencements and a reduction in the number of children ceasing to be on plans. 299 plans commenced in the year, by comparison with 181 in 2012-2013; 192 plans ended, compared to 227 in 2012-2013.

The number of conferences held has almost doubled in two years.

The number of conferences resulting in a child protection plan has doubled in two years.

The rate of conversion from conference to CP plan has remained almost constant. 82.4% of Initial Child Protection Conferences held in 2013-2014 resulted in a plan.

Relatively few children remain the subject of plans for more than twelve months. The proportion of children of children on plans of less than twelve months at 31 March 2014 reflects the large number of plans that commenced in the year.

Table 3: **Current length of time subject to a plan**

Subject to plan as at end of:	Subject to plan less than 12 months	Subject to plan between 12 and 18 months	Subject to plan between 18 and 24 months	Subject to plan longer than 24 months	Total
March 2013	100	10	4	1	115
June 2013	130	8	2	1	141
September 2013	170	11	5	1	187
December 2013	202	10	4	1	217
March 2014	207	9	3	3	222

Table 4: Child protection conference activity

	Full Year 2011-2012	Full Year 2012-2013	Full Year 2013-2014	Q1 Apr-Jun 2013	Q2 Jul-Sep-2013	Q3 Oct-Dec 2013	Q4 Jan-Mar 2014
Total number of initial conferences held	105	124	**194**	**39**	**60**	**50**	**45**
Number of conferences resulting in CP plan	89	105	**160**	**36**	**49**	**39**	**36**
% of conferences resulting in CP plans	85%	85%	**82.4%**	**92.3%**	**81.6%**	**78%**	**80%**
Number of children involved in conferences	221	217	**369**	**78**	**115**	**98**	**78**
Children made subject to CP plans at conference	192	181	**299**	**70**	**90**	**78**	**61**
Total number of plans ended in period	208	227	**192**	**44**	**44**	**48**	**56**
Number (temporary) other local authority plans at end of period	11	4	**8**	**2**	**9**	**6**	**8**
Number of Bury children subject to plans at end of period	162	115	**222**	**141**	**187**	**217**	**222**
Total number of plans at end of period	173	119	**230**	**143**	**196**	**223**	**230**

Categories of Plan

One third of plans as at 31 March 2014 cite 'Neglect' and over a half cite 'Emotional abuse'. 'Emotional abuse' invariably incorporates domestic violence as a background factor and appears in almost exactly the same proportion as in the previous year.

The percentage categorisation of 'Neglect' is lower than the most recently published statistics for England as whole, which was 41.7% and lower than for 'Emotional abuse', which was 34.1% (CIN Census, 2012-2013, Table D4). The most noticeable divergence from the England statistics is in the 'Multiple' categorisation. This will almost certainly reflect differences in recording conventions rather than the distribution of risk.

Table 5: Current Child protection plans by category (as at 31st March, not necessarily the category that initially applied)

Category	**Bury March 31st 2012**	***England March 31st 2012***	**Bury March 31st 2013**	***England March 31st 2013***	**Bury March 31st 2014**
Neglect	64 (39%)	*42%*	38 (33%)	*41.7%*	**74 (33.3%)**
Physical abuse	19 (12%)	*11%*	12 (10%)	*9.9%*	**22 (9.9%)**
Sexual abuse	11 (7%)	*5%*	3 (3%)	*4.7%*	**6 (2.7%)**
Emotional abuse	68 (42%)	*29%*	63 (54%)	*34.1%*	**118 (53.2%)**
Multiple categories	0	*13%*	0	*9.5%*	**2 (0.9%)**
Total number of Bury plans	162		116		**222**

Children subject to Child Protection Plans – by Age

The age profile of children subject to a plan is broadly in line with the average for England.

Table 6: Child Protection Plans by Age

Age	Bury March 31st 2012	*England March 31st 2012*	Bury March 31st 2013	*England March 31st 2013*	**Bury March 31st 2014**
Unborn	-	*2%*	-	*2.0%*	**-**
Under 1 year old	13 (8%)	*11%*	14 (12%)	*11.3%*	**25 (11.3%)**
1-4 years	47 (29%)	*31%*	47 (40%)	*30.3%*	**64 (28.8%)**
5-9 years	40 (25%)	*29%*	31 (27%)	*28.7%*	**64 (28.8%)**
10-15 years	56 (34%)	*25%*	22 (19%)	*25.2%*	**61 (27.5%)**
16 years and over	6 (4%)	*2%*	2 (2%)	*2.6%*	**8 (3.6%)**
Total	162		116		**222**

Time subject to Child Protection Plan

There has been a decrease in ceased child protection plan which were of lengthy duration. Only 2 of the 192 plans ended were of 2 years+ duration (1%). In 2012-2013 16 plans of 2 years+ duration ended, equating to 6.8% of the 234 plans ended in the year, which is very high (England average for 2012-13 was 5.2%).

Table 7: Ceased Child Protection Plans by length subject to a CP Plan

Length of time subject to plan when ended	Number of Bury plans ceased full year 2011-12	*% plans ceased England 2011-12*	Number of Bury plans ceased full year 2012-13	*% plans ceased England 2012-13*	Number of Bury plans ceased full year 2013-14
Under 3 months	35 (17%)	*20.4%*	32 (13.7%)	19.3%	45 (23.4%)
3 to 6 months	16 (8%)	*9.7%*	34 (14.5%)	10.1%	38 (19.8%)
6 months but under 1 year	105 (50%)	*38.3%*	95 (40.6%)	39.0%	79 (41.1%)
1 year but under 2 years	49 (24%)	*25.9%*	57 (24.3%)	26.4%	28 (14.6%)
2 years and over	3 (1%)	*5.6%*	16 (6.8%)	5.2%	2 (1.0%)
Total	208		234		192

Repeated Child Protection Plans

The rate of repeat Child Protection plans has risen. The 2012-2013 rate was below the England average of 14.9% and was judged to be 'Good'. The 2013-2014 rate, though higher than that of statistical neighbours and England in previous years, possibly reflects the recovery of plans closed without full resolution in 2012-2013.

Table 8: Repeated child protection plans – percentages

	2010-11	2011-12	2012-13	2013-14
Bury	17.9%	20.3%	12.3%	**19.7%**
Statistical neighbours	11.6%	13.1%	14.4%	
England	13.3%	13.8%	14.9%	

Table 9: Conference monitoring: practice issues

	2011-12 Full year	2012 – 13 Full year	**2013 – 14 Full year**
Number of Initial Conferences held (families)	105	124	**194**
Conferences within 15 day timescale of initiating strategy meeting	91%	93.5%	**75.6%**
Parents seen Social Work report before conference	60%	74%	**80.9%**
Parents seen other agency reports before conference	Not recorded	61%	**54.6%**
% Initial conferences starting late	67%	59%	**54%**
Child's views recorded in initial conference reports	66%	90%	**52% (43% too young to express views)**
Number of Reviews held (families)	257	239	**280**
Reviews within time	99%	100%	**99.96%**
Child's views recorded in review conference reports (where applicable)	78%	79%	**50% (49.6% too young to express views)**
Number of reviews where children visited at standard monthly expected frequency (%)	219 85%	85%	**90.35%**
Number of reviews where core groups took place at required frequency (%)	220 86%	87%	**82.14%**
Number where plan progressed appropriately between reviews (%)	215 84%	80%	**74.28%**

Table 10: Attendance at Initial & Review Conferences

INITIALS	No. attending/ total possible	%	REVIEWS	No. attending/ total possible	%
Parents	172/194	89%	Parents	248/262	95%
Health Profs (HV/SN)	190/218	87%	Health Profs (HV/SN)	299/315	95%
Mental Health	13/19	68%	Mental Health	8/21	38%
CDAT	17/32	53%	CDAT	26/44	59%
CAMHS	8/17	47%	CAMHS	20/55	36%
Midwifery	32/43	74%	Midwifery	0/0	n/a
Education	135/168	80%	Education	162/243	67%
Children's Centres	64/110	58%	Children's Centres	128/148	86%
Police	152/192	79%	Police	6/248	2%
Probation	24/35	69%	Probation	36/73	49%
Social Worker (Current) Social Worker (Receiving)	193/195 73/131	99% 56%	Social Worker (Current) Social Worker (Receiving)	239/243	n/a 98%
Other	72/111	65%	Other	113/146	77%

SAFEGUARDING PERFORMANCE INFORMATION FOR CHILDREN IN CARE

Number of children and young people

Bury's LAC population has gradually declined from a high point in August 2012.

The rates for England, the North West and the statistical neighbour group rose between 2011-2012 and 2012-2013, continuing a trend evident since 2009.

Bury's rate was noticeably higher than all three comparative measures until October 2012. Bury's rate had fallen below the North West average by November 2012 and by February 2014 had fallen below the 2012-2013 mean for the extended group of statistical neighbours.

The month-end population rate in February and March 2014 was the lowest for three years.

At the end of March 2014 there were forty fewer children Looked after than eighteen months previously.

Table11: Number of Looked After Children per 10,000 child population

	2008 - 2009	**2009 - 2010**	**2010 - 2011**	**2011 - 2012**	**2012 - 2013**	**2013 - 2014**
Bury	67.1	69	77	77.6	76.7	73.4
Statistical neighbours	58.5	59.9	63.8	66	68	Not available
England	55	58	59	59	60	Not available
North West region	71	75	77	76	79	Not available

Table 12 Number of Looked After Children at 31 March 2014

	2008 - 2009	**2009 - 2010**	**2010 - 2011**	**2011 - 2012**	**2012 - 2013**	**2013 - 2014**
Number of looked after children	285	290	324	326	322	310
Child population	42,450	42,045	42,082	41,993	41,971	42,219

Registered Common Assessments between 1st April 2013 – 31st March 2014

Performance and activity

There were 439 CAFs registered in Bury between 1 April 13 and 31 March 14, this figure shows a decline of 74 registered CAFs in comparison to the previous year. However, due to changes in practice and policy there are various reasons for this reduction in numbers. Previously CAFs have been registered for all siblings in a family group even if the concerns were not about the siblings, since the latter end of 2013, this practice has changed and CAFs are now being registered as a family rather than individuals. Should issues be raised regarding individual children/siblings then it would be expected that a separate CAF was completed and registered in respect of this child.

Prior to March 14, the CAF was used as the referral document for concerns to social care and because of this there were many issues in regards to the quality and worth of these CAFs as they were not true assessments of need, rather a document of concerns; therefore in March 2014 a separate referral document was developed. Since the implementation of the referral there has been, a positive impact on CAFs received in terms of meaningfulness and quality. Taking a small look at the figures for March 14 in comparison to the same dates in March 2013 there is a decrease of 17 CAFs registered which I would hypothesis is due to the separation of the referral and CAF document.

Since December 2013, there has been a drive by the CAF Consultants to raise awareness with partner agencies. Consultation sessions have been held in schools, children centres, nurseries and health centres to improve the working relationship between practitioners and the CAF team.

There is growing confidence that practitioners are improving in their ability to identify when they need to commence a CAF and due to the support from the CAF Consultants are developing a greater understanding of the CAF as a process rather than a singular event. All assessments and team around the child minutes are quality checked by the CAF Consultants and should these documents not meet expected standards the author is contacted and advice given.

These numbers represent only the CAFs that have been completed and submitted to the CAF Team for registration, there remain some practitioners who are not submitting their CAF's and therefore these are not represented in the figures. The CAF Team have identified some areas where these CAFs are not being sent for registration or quality assurance and these appear to be when practitioners are completing them for a service such as parenting courses, children centre outreach or young carers. Work is being undertaken to develop a pathway to ensure that all CAFs are captured by the CAF team and registered therefore giving a true representation of completion rates in Bury.

For the full CAF report please see Appendix 9.

Below is a summary of key performance items that have informed the BSCB Business Plan priorities for 2014/15 reported as part of the BSCB multi-agency data set.

Content area	Quantitative	Commentary
Number of young people referred to young people's substance misuse service 2013/14	199 accessed Early Break for support for their drug and alcohol use a 3% increase from the previous year.	This increase demonstrates the efforts that have been made between services to improve referral pathways and to ensure young people have access to the appropriate information and support. Fewer young people re-present to the service compared to our local neighbours and national data. This data is fairly consistent with previous years. 110 using one substance alone. 64% using cannabis as their primary drug of choice 33% consuming alcohol as preferred drug of choice 3% stimulants such as cocaine and ecstasy 89 reported using two or more substances including: 60% Cannabis 29% Alcohol 4%Stimulants 68% male 32% female Alcohol-specific hospital stays (under 18s) are not significantly different from the England average (source Public Health England & Early Break).
No of young people accessing CAMHS 2013/14	Referrals 1587	Referrals resulting in assessment 72%. Few referrals require assessment without intervention. 90% of referrals result in active engagement with the service. A low DNA rate is reported. The Pennine Care Foundation Trust follows a DNA policy. All DNAs are tracked & re-appointed depending upon presenting concerns.
No of young people on waiting list for	57	Stable figure. CAMHS operate a "priority" and "routine" slot system, children waiting will be slotted into depending on

CAMHS 2013/14		practitioners' capacity. A daily "emergency'' appointment slot is managed daily by the appointed duty worker. Children slotted into this appointment are not on the waiting list. The waiting list includes those children waiting for a Tier 2 or 3 service (CAMHS and IAPT).
No of children presenting to CAMHS for self-harming behaviour 2013/14	150	Significant increase of 55% 2013/14. Largest increase -schools referring for deliberate self-harm. We no longer have an inpatient children's ward at Fairfield General Hospital and a number of children presenting at A&E are admitted to either Oldham or North Manchester paediatric wards. These admissions are counted in the numbers as children being discharged from hospital will receive a 7 day follow up from Bury CAMHS. Current coding systems do not allow for the differentiation between attempted suicide and other forms of deliberate self-harm. Referrals received are screened on a daily basis and coded under a deliberate self harm coding system.
Number of parents in treatment for substance misuse problems whose children are living with them 2013/14		New presentations year to date: Number of parents in treatment for substance misuse problems whose children are living with them-(drugs) 111 (46%) New presentations year to date: Number of parents in treatment for substance misuse problems whose children are living with them-(alcohol) 46 (16%) New presentations year to date: Individuals in treatment for alcohol misuse issues: living with children 72 (25%) New presentations year to date: Number of parents in treatment for substance misuse problems whose children are not living with them (alcohol) 43 (15%)

Acknowledgements

BSCB wish to thank the following organisations for their contributions as follows:-

Provision of training pool members/specialist trainers

NHS Bury

Pennine Care Foundation NHS Trust

Children's Services, Bury Council

Early Break

Greater Manchester Police

Sara Swann

AFRUCA

Barnardo's

Provision of meeting rooms/training venues free of charge

Children's Services, Bury Council

Greater Manchester Police

Greater Manchester Fire and Rescue Service

Contributors to the Annual Report

BSCB and Business Group (formerly Executive Group) members

BSCB Team

BSCB Sub Group Chairs

Barbara Long, Accountancy Department, Bury Council

Michael Nugent, Interim Strategic Lead for Quality Assurance, Bury Council

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PAHT LSCB report 2014.doc

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BSCB SEAM - first annual report June 2(

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Final 2013 2014 yearly LADO report 1

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Private Fostering Annual Report to BSC

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APPENDICES TO BSCB ANNUAL REPORT 2013-2014

APPENDIX 1 - BSCB and Sub Group members 2013 - 2014

BSCB Strategic Board

Gill Rigg	Independent Chair of BSCB
Shabana Abasi	Head of Service, CAFCASS (December 2013 – February 2014)
Cllr Gill Campbell	Lead Member for Children & Families, Bury Council
Mark Carriline	Executive Director, Children's Services, Bury Council
Ian Chambers	Assistant Director for Learning, Children's Services, Bury Council
Nigel Elliott	Assistant Chief Executive, Greater Manchester Probation Trust
Dr Cathy Fines	Safeguarding Lead, Bury Clinical Commissioning Group
Julie Gonda	Assistant Director, Commissioning and Procurement, Adult Services, Bury Council (until September 2013)
Jackie Gower	Assistant Director for Social Care, Children's Services, Bury Council
Mark Granby	Superintendent, Greater Manchester Police (until February 2014)
Glen Hagan	Service Manager, CAFCASS (until November 2013)
Karan Lee	Superintendant, Greater Manchester Police (from March 2014)
Helena Leyden	Head of Safeguarding & Professional Lead, Safeguarding and Community Provider Services, Pennine Care Foundation NHS Trust (until December 2013)
Maxine Lomax	Designated Nurse for Safeguarding, Bury Clinical Commissioning Group
Vicky Maloney	Chief Executive, Early Break (3rd Sector Representative)
Deborah McCallum	Head of Service, CAFCASS (from March 2014)
Mandy Symes	Safeguarding Adults Manager, Adult Care Services, Bury Council (from September 2013)
Jackie Taylor	Director of Community Services Bury, Pennine Care Foundation NHS Trust (from December 2013)
Cathy Trinick	Divisional Director for Women's and Children's Services, Pennine Acute Hospitals NHS Trust
Ian Trodden	Director of Nursing, Pennine Care NHS Foundation Trust (until November 2013)
Grace Wall	Patient Experience Manager, NHS England (from September 2013)
2 x Lay Members	
Safeguarding adviser:	Service Manager, Safeguarding Unit, Children's Services, Bury Council (until December 2013) Interim Business Manager, BSCB (from January 2014)

Bury Safeguarding Children Board Executive Group

Gill Rigg	Independent Chair of BSCB
	Assistant Director for Safeguarding & Social Care, Children's Services, Bury Council
	Named Nurse for Safeguarding, Pennine Care Foundation NHS Trust (Community Services Bury)
	Operations Manager, Greater Manchester Probation Trust
	Development Officer, BSCB (until December 2013)
	Interim Business Manager, BSCB (from January 2014)
	Detective Inspector, Bury PPIU, Greater Manchester Police
	Named Nurse for Safeguarding (Bury Borough), Pennine Care Foundation NHS Trust (Mental Health Services)
	Designated Doctor for Safeguarding, Bury CCG
	Designated Nurse for Safeguarding, Bury CCG
	YOS Manager
	Service Manager – Safeguarding Unit, Children's Services, Bury Council
	Strategic Lead – Placement Services, Children's Services, Bury Council (from January 2014)
	Headteacher, St Margaret's Primary School, Prestwich
	Strategic Lead – Inclusion and Vulnerable Children, Children's Services, Bury Council
	Acting Strategic Lead – Early Intervention Service, Children's Services, Bury Council
	Lead Officer Safeguarding for Schools and Extended Services, Bury Council
	Area Manager, Early Break (Third Sector representative)

Monitoring and Evaluation Sub Group

Chair	Service Manager, Safeguarding Unit, Children's Services, Bury Council (until December 2013)
Chair	Interim Business Manager, BSCB (from January 2014)
	Operations Director, Integrated Youth Service
	Operations Manager, Greater Manchester Probation Trust
	CAF Coordinator, Children's Services, Bury Council
	Detective Inspector, Bury PPIU, Greater Manchester Police
	Named Nurse for Child Protection (Bury Borough), Pennine Care Foundation NHS Trust (until January 2014)
	Designated Doctor, NHS Bury
	Resource Officer, Children's Centres, Childcare & Early Years, Children's Services, Bury Council
	BSCB Development Officer, BSCB (until December 2013)
	Team Manager, Safeguarding Team, Children's Services, Bury Council
	Specialist Nurse for Safeguarding, Community Services Bury, Pennine Care Foundation NHS Trust
	Business Manager for Neighbourhoods, Six Town Housing (from February 2014)
Sub Group Sponsor:	**Assistant Director for Safeguarding and Social Care, Children's Services, Bury Council**

Policies and Procedures Sub Group

Chair	Designated Nurse for Safeguarding, Bury CCG
	Team Manager, Early Intervention Team, Children's Services, Bury Council (until July 2013)
	Development Officer, BSCB (until December 2013)
	Interim Business Manager, BSCB (from January 2014)
(Vice Chair)	Service Manager, Safeguarding Unit, Children's Services, Bury Council (until December 2013)
	Operations Manager, Greater Manchester Probation Trust
	Manager, School Attendance Team, Children's Services, Bury Council
	Team Manager, Safeguarding Team, Children's Services, Bury Council (from November 2013)
	Area Manager, Early Break
	Strategic Lead for Schools and Academies, Children's Services, Bury Council
	Named Doctor, Community Services Bury, Pennine Care Foundation NHS Trust
	Research & Policy Officer, Strategic Housing Unit, Adult Care Services, Bury Council
Sub group sponsor:	**Lay Members**

Safeguarding in Schools and Colleges Sub Group

Chair	Head Teacher, St Margaret's C of E Primary School, Prestwich
	Team Leader, Connexions, Children's Services, Bury Council
	Deputy Head Teacher, Philips High School
	Detective Constable, Greater Manchester Police
	Deputy Head Teacher, Bury Grammar School (until November 2013)
	School Nurse, Bury Grammar School for Girls (from November 2013)
	Anti-Bullying Coordinator, Children's Services, Bury Council
	Head Teacher, Tottington High School (until June 2013)
	Head Teacher, St Monica's RC High School (from June 2013)
	LAC Education Team Manager, Children's Services, Bury Council
Vice Chair	Lead Officer for Safeguarding Schools and Extended Services, Children's Services, Bury
	Head Teacher, St John with St Mark C of E Primary School
	Director of Student Quality, Bury College
	Strategic Lead – Inclusion and Vulnerable Children, Children's Services, Bury Council
	Head Teacher, Unsworth Primary School
	Head Teacher, Christ Church C of E Primary School
	Team Leader, School Nursing Team, Community Services Bury, Pennine Care Foundation NHS Trust
	Development Officer, BSCB (until December 2013)
	Interim Business Manager, BSCB (from January 2014)
	Service Manager – CYPIC Team, Children's Services, Bury Council (from November 2013)
	Strategic Lead for Health & Families, Children's Services, Bury Council (from November 2013)
Sub Group Sponsor:	**Assistant Director – Learning, Children's Services, Bury Council**

Training and Development Sub Group

Chair	Development Officer, BSCB (until December 2013)
Chair	Interim Business Manager, BSCB (from January 2014)
	IYSS Manager, Children's Services, Bury Council
Vice Chair	Lead Officer Safeguarding for Schools & Extended Services, Children's Services, Bury Council.
	Detective Sergeant, Bury PPIU, Greater Manchester Police
	Curriculum Director for Early Years & Childcare, Bury College
	Reaching Children & Families Worker, Children's Centres and Childcare and Early Years, Bury Council
	Multi-Agency Training Officer, BSCB
	Employee Development Officer, Department of Communities & Neighbourhoods, Bury Council
	Workforce Development Officer, Children's Services, Bury Council
	Team Manager, Safeguarding Team, Children's Services, Bury Council
	Project Worker, B3DSA
	Safeguarding Adults Manager, Adult Care Services, Bury Council
	Specialist Nurse for Safeguarding, Community Services Bury, Pennine Care Foundation NHS Trust
	Lay Member, BSCB
	Family Support Worker, Safeguarding Team, Children's Services, Bury Council (Training Pool Representative) (from March 2014)
Sub Group Sponsor:	**Safeguarding Lead, Bury Clinical Commissioning Group**

Serious Case Review Sub Group

Chair	Service Manager, Safeguarding Unit, Children's Services, Bury Council (until December 2013)
	Strategic Lead – Placement Services, Children's Services, Bury Council (from January 2014)
	Detective Sergeant, Public Protection Section, Greater Manchester Police
	Lead Officer for Schools & Extended Services, Children's Services, Bury Council
	Designated Doctor for Safeguarding, Bury CCG
Vice Chair	Designated Nurse for Safeguarding, Bury CCG
	Safeguarding Lead, Pennine Care Foundation NHS Trust
	Named Nurse, Community Services Bury, Pennine Care Foundation NHS Trust
	Operations Manager, Greater Manchester Probation Trust
	Development Officer, BSCB (until December 2013)
	Interim Business Manager, BSCB (from January 2014)
Sub Group Sponsor:	**Superintendent, Bury Division, Greater Manchester Police (until February 2014)**
	Assistant Director for Safeguarding & Social Care, Children's Services, Bury Council (from March 2014)

Child Sexual Exploitation (CSE) and Missing Group

Chair	Service Manager – Safeguarding Unit, Children's Services, Bury Council (until December 2013)
Chair	Strategic Lead – Placement Services, Children's Services, Bury Council (from January 2014)
	IYSS Manager, Children's Services, Bury Council
	Licensing Manager, Bury Council
Vice Chair	Detective Inspector, Bury PPIU, Bury Council
	Development Officer, BSCB (until December 2013)
	Interim Business Manager, BSCB (from January 2014)
	Lead Officer Safeguarding for Schools & Extended Services, Bury Council
	LAC Education Manager, Children's Services, Bury Council
	Operations Manager, Greater Manchester Probation Trust
	Deputy Head Teacher, Philips High School
	Safeguarding Lead, Greater Manchester Fire Service
	Designated Nurse Safeguarding, Bury CCG
	Health Improvement Specialist, Public Health Department, Bury Council
	Service Manager, Safeguarding Unit, Children's Services, Bury Council
	Area Manager, Early Break
	Team Manager – CYPIC, Children's Services, Bury Council (from November 2013
	Missing Person Safeguarding Officer, Greater Manchester Police (from September 2013)
	Team Manager – MASH, Children's Services, Bury Council
	Team Manager, School Attendance Team, Children's Services, Bury Council (from November 2013)
Sub Group Sponsor:	**Superintendent, Bury Division, Greater Manchester Police**

Safeguarding Children and Young People Living Away from Home Sub Group (established January 2014)

Chair	Service Manager – Safeguarding Unit, Children's Services, Bury Council
Vice Chair	Strategic Lead for Health & Families, Children's Services, Bury Council
	Operations Director, Integrated Youth Service, Children's Services, Bury Council
	LADO, Children's Services, Bury Council
	Designated Nurse for LAC, Community Services Bury, Pennine Care Foundation NHS Trust
	LAC Education Strategy Manager
	ISS Senior Practitioner, YOS
	Private Fostering Lead, Children's Services, Bury Council
	Clinical Psychologist, CAMHS
	Principal Officer, Business Support, Children's Services, Bury Council
	Missing Person Safeguarding Officer, Greater Manchester Police
	Team Manager – CYPIC, Children's Services, Bury Council
	Manager, School Attendance Team, Children's Services, Bury Council
	Assistant Team Manager, Children's Disability Service, Children's Services, Bury Council
	Assistant Team Manager, Fostering Team, Children's Services, Bury Council
	Hospital Director, Alpha Hospital
Sub Group Sponsor:	**Chief Executive, Early Break (3rd Sector Representative)**

BSCB employees

LADO/Development Officer

LADO/Development Officer (part time)

Senior Admin Support Worker

Admin Support Worker (part time)

Multi-Agency Training Officer (part time)

APPENDIX 2 – NHS England Report

NHS England

NHS England (Greater Manchester) Safeguarding Information for LCSB Annual Reports

Who we are

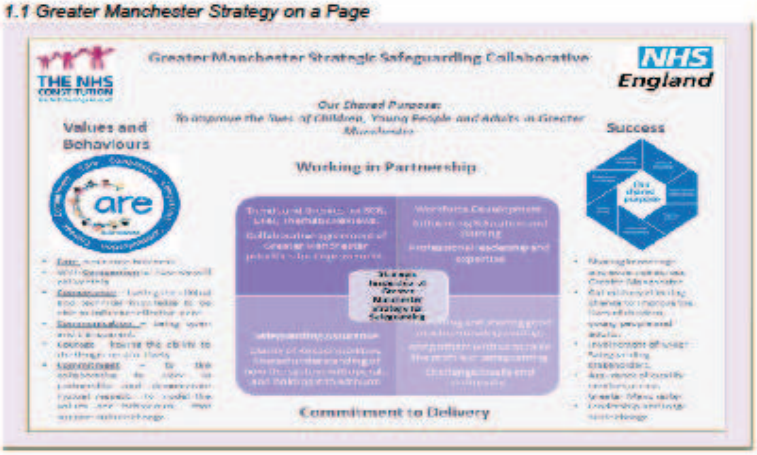
NHS England Safeguarding People in the Reformed NHS guidance outlines the area team's responsibilities to safeguarding children. Significant changes to the structure of the NHS came into effect on 1 April 2013. New organisations were created and others such as primary care trusts (PCTs) and Strategic Health Authorities (SHAs) were abolished. NHS England is a new national organisation with a local area team covering Greater Manchester. Its main role is to ensure that the overall system of planning and buying NHS services works well and that the NHS delivers better outcomes for patients. NHS England oversees the operation of CCGs making sure they successfully plan and buy services for their local population. It also looks at how well CCGs operate their budgets, engage with their local populations, and deliver the pledges, rights and values in the NHS Constitution. NHS England also plans and buys health services at a national level. These include:

- Specialised services (such as those for rare diseases) including Tier 4 CAMHS
- Prison health services
- Some services for members of the armed forces.
- Primary Care e.g. GP services, dentists, pharmacy and optometry.

Our responsibilities for safeguarding children

NHS England 'Safeguarding people in the Reformed NHS' guidance outlines the Area Teams responsibilities to safeguard both Children and Adults who are vulnerable. Our responsibilities are managed through the Greater Manchester Strategic Safeguarding Collaborative which is hosted by the Area Team.

1.1 Greater Manchester Strategy on a Page



Safeguarding Work that we have delivered in Greater Manchester in 2013/14.

Greater Manchester Safeguarding Incident Operating Framework and Log

Greater Manchester Safeguarding Incident Operating Framework and Log is intended to improve the reporting of safeguarding incidents that occur within commissioned health care settings and assist with identifying themes and trends where care may be sub-optimal or patients are at increased risk. The themes and trends will support the development of lessons learnt in relation to safeguarding incidents which inform the Greater Manchester Safeguarding Business Plan. There has been a significant increase in the reporting of safeguarding incidents in Greater Manchester which does not mean that there are more safeguarding incidents occurring but that we are better at reporting. The area team have facilitated two serious safeguarding incident workshops and plan to continue this work in 2014/15.

Greater Manchester Heatmap

Due to the size of Greater Manchester it has been agreed there is a need to focus resource on specific areas where support is required. In order to do this a heatmap has been developed which will assist in providing a Greater Manchester picture of issues/concern. The heatmap is designed to look at the Greater Manchester Safeguarding Health Economy as a whole and therefore includes Area Team, Specialist Commissioning, Health Visiting, Independent Section and Primary Care as well as CCG/Providers. It is vital to note the heatmap is not a performance monitoring tool but a supportive document to allow focussed work.

The Area Team was pleased with the CQCs comments about the heat map in the recent Salford Looked After Children Inspection.

"The Area Team in conjunction with Greater Manchester CCGs is currently developing a Safeguarding 'Heatmap' to provide early warning of safety or poor quality concerns. This should provide an effective model to benchmark the performance of a wide range of local health services and strengthen analysis of trends and learning from safeguarding incidents." Review of Health services for Children Looked After and Safeguarding in Salford 2014

The heatmap will continue to be developed in 2014/15.

Named Professional Service for Primary Care

Greater Manchester is currently not meeting its trajectory for named GP sessions whereby some Clinical Commissioning Groups are employing named GP and others are considering alternative models in collaboration with the Area Team. Greater Manchester is committed to achieving the trajectory of Named GP sessions across the economy in 2014/15.

Events and Conferences

Greater Manchester Safeguarding Conference 2013

The first GM Safeguarding Annual Conference was held in November 2013. The purpose of this was to provide a national as well as local update on Safeguarding. The conference was well attended with a mix of Health, Local Authority and Voluntary Sector Colleagues.

Well Women's Event 2014

Greater Manchester Area Team felt that it was opportune to link screening and immunisation and safeguarding the event to highlight the role of Practice Nurses in primary care. The focus of the day was 'Making Every Contact Count' and that when women attending for screening appointments it could be a valuable opportunity to consider safeguarding. This was based on recommendations from

DHRs and SCRs. Practice Nurses are a workforce who often know their patients, are a familiar face to their patients and are in a trusted position. It is important that Practice Nurses are equipped to understand the signs of abuse and know when and how to act. The event includes presentations on FGM, Domestic Abuse, and CSE.

Primary Care information sharing for Domestic Homicide Reviews

It was brought to the attention of NHS England (Greater Manchester Area Team) that a number of general practices had declined requests for information or to provide access to records of victims and/or family members and/or the perpetrator for the purposes of conducting a Domestic Homicide Review or Serious Case Reviews on the grounds of patient confidentiality. NHS England has clarified the position and has written to all GPs. In summary Practices are reminded that if informed consent is not feasible confidential information can nevertheless be disclosed to support the detection, investigation and punishment of serious crime and/or prevent abuse or serious harm to others and may disclose confidential information if there is an overwhelming public interest in disclosing the information which outweighs both the obligation of confidentiality owed to the individual and the public good of protecting trust in a confidential service. Establishing what lessons can be learned from a domestic homicide is in the public interest as it serves the interests of society as a whole to prevent future domestic homicides.

What our priorities are for 2014/15

Greater Manchester Area Team in partnership with Clinical Commissioning Groups will continue to, embed and sustain the work which was delivered in 2013/14.

Learning from Serious Case Reviews, Domestic Homicide Reviews, Themes/trends of serious safeguarding incident and recent CQC Reviews of Health services for Children Looked After and Safeguarding in Greater Manchester tells us that a focused effort is required to ensure that services are working together and communicating effectively in relation to children and adults who are vulnerable.

We commit to ensuring in 2014/15 we deliver:

- A primary care tool kit for safeguarding which will act as a 'one stop' guide for all professionals working within General Practice, Optometry, Pharmacy, and dental practices. The toolkit will include links to LCSBs and LCABs, Greater Manchester Safeguarding polices and practice guidance. The toolkit will also encompass a set of core safeguarding standards which all primary care contractors would be expected to be compliant against.
- Review pathways to ensure that there is effective two way information sharing between General Practice and services i.e. Midwifery, Health Visiting.
- Training and Development Strategy for Primary Care Contractors in collaboration with Clinical Commissioning Groups.
- Ensure senior level attendance at all Greater Manchester LSCBS. Board Attendance has been challenging in 2013/14 due to the number of LSCBs in Greater Manchester. A recent review of Board attendance has been undertaken and the Boards have been redistributed between Senior Managers within the Area Team, Board Representatives will be expected to active members of both the LSCB and SAB for their respective locality in Greater Manchester.
- Develop joint standards for inclusion in NHS Trust Contracts and agree an associated audit monitoring tool via the Strategic Safeguarding Collaborative to ensure a common approach across Greater Manchester.
- Continue to provide regular safeguarding updates to the Greater Manchester Quality Surveillance Group and escalate potential regional or national issues as appropriate.

APPENDIX 3 - Pennine Acute Hospitals NHS Trust report

The Pennine Acute Hospitals NHS
NHS Trust

Safeguarding Annual Report for LSCBs

April 2014.

1. Delivering the Safeguarding Strategy

1.1 **Walkround activity** has been demonstrated in the quarterly report to the Trust Board with a total of 26 visits being undertaken throughout the year. During the year the key actions arising from the walkrounds have been:

- Production of a video to enhance awareness of Mental Capacity Act 2005 (video now available on Trust Intranet).
- Raising awareness of Child Sexual Exploitation (CSE).
- Improve uptake of safeguarding training.
- Promote domestic violence training, awareness of Victim Support referral service and the link with alcohol abuse.
- Promotion of alcohol awareness as part of the alcohol strategy.

The safeguarding walkrounds that happen on every site each quarter include questions that address staff response, challenge and escalation to issues such as poor care and dignity, inappropriate behaviour of staff and visitors and whistleblowing.

1.2 Serious Case Review activity

Completed Serious Case Reviews / Agency Review (children) 2013/14		
Date commissioned	**Safeguarding Children Board**	**Progress**
September 2012	RBSCB	Chronology Due Jan 2013. IMR submitted Feb 2013. Revised IMR

		submitted 27 March.. Overview report completed. Report published 20 December 2013
February 2013	BSCB	IMR not requested from The Pennine Acute Hospitals NHS Trust. Later 'specific issues report' requested and provided.
February 2013	RBSCB	Chronology due 17 April (submitted). IMR due 29 May. SCR panel made decision not to request full IMR from PAHT. Chronology only submitted.
February 2013	RBSCB	Terms of Reference received. Chronology due 28 March (submitted) . IMR due 29 April 2013 - submitted. Report published 20 December 2013
February 2013	BSCB	Awaiting scope and terms of reference. IMR author to be identified. Specific issues report requested and provided.
March 2013	RBSCB	Scope and terms of reference received: Chronology due 22 April. First draft IMR due15 May. Submitted. Overview report submitted to DfE.

3. Commissioned Serious Case Reviews / Agency Review 2013/14		
Date commissioned	**Safeguarding Children Board**	**Progress**
June 2013	RBSCB	Initial report requested and submitted. Learning event planned November 2013 – postponed due to ongoing court processes.
Sept 2013	BSCB	Completed. Scope and terms of reference received. Chronology and IMR submitted. Final report received.

December 2013	RBSCB	Awaiting scope and terms of reference. Referred back to screening panel.
April 2014	OSCB	Awaiting scope and terms of reference.

The Department of Health had identified PAHT as one of the Hospital Trusts involved in an allegation of abuse against Jimmy Savile. The allegation dated back 40 years and on investigation transpired to be more likely to fall under the remit of CMFT where the case was transferred. All actions arising from the SCRs are on trajectory to be completed within timescale. Findings are disseminated via the Trust Lessons Learned framework including the production of a bulletin

1.3 Information sharing and referral activity.

Information sharing/safeguarding **children** referral activity by site for the year (the new form was introduced in Q2 2011/12)

SITE	Q1 TOTAL	Q2 TOTAL	Q3 TOTAL	Q4 TOTAL	GRAND TOTAL
FGH	127	121	139	122	**509**
TROH	402	443	393	487	**1725**
NMGH	393	394	385	378	**1550**
RI	86	98	103	96	**383**
TOTAL	**1008**	**1056**	**1020**	**1083**	**4167**
Total 2012/13	1015	1094	904	842	3855

The information above shows an increase in the numbers of information sharing forms raised compared to last year with the majority of activity coming from The Royal Oldham

Hospital. Over the year between 9% and 14% of the forms generated included referrals to the Local Authority Children's Social Care.

1.4 Training activity

As the table above shows, all Divisions have exceeded 80% uptake for Level 2 and, as with Safeguarding Children training, both levels continue to follow an upward trajectory.

	Children L2			Children L3		
Division	**Head Count**	**Trained**	**%**	**Head Count**	**Trained**	**%**
Medicine and Community Services	2061	1885	91%	95	71	75%
Surgery	1429	1269	89%	17	14	82%
Women and Children	717	644	90%	413	359	87%
Diagnostics and Clinical Support	1889	1822	96%	14	13	93%
Facilities	879	851	97%	-	-	-
Modernisation	667	635	95%	-	-	-
Corporate	550	537	98%	3	3	100%
Total Q4	**8192**	**7643**	**93%**	**542**	**460**	**85%**
Q3			91%			84%
Q2			86%			80%
Q1			86%			76%

Additional Training events

NAME	DATE	PRESENT
Documentation Workshop	19/4/2013	20
PREVENT Masterclass	19/07/2013	50
Domestic Abuse Awareness for Midwifery	Second course 19/02/2014	30
Documentation and Court Skills	01/04/2014	90
'Natalie's Story: A pregnant teenager's journey'	20/3/2014 25/3/2014 4/4/2014	26

1.6 Audit Activity

Title	Date	Action plan status
Caring Responsibilities	July 2013 and November 2013	Completed
Referrals to Children's Social Care	July 2013 and March 2014	On target
Child Protection Policy compliance	November 2013	Completed

Physician Confidence, and Current Child Safeguarding Practice in the Pennine Acute Hospital Trust	July 2013	Completed
Record keeping audit	February 2014	Ongoing
3R Learning Disability Audit	Awaiting completion	
13 – 17 yr olds unaccompanied by parents in A/E	Awaiting completion	
Consent Policy compliance audit	March 2014	Ongoing
Termination of Pregnancy Assessment	April 2014	Ongoing

2. S47 Service

Since June 2011 the s47 child protection medical service has been transformed. This has happened gradually starting with a single site service provided for Rochdale/Oldham children, developing to a parallel service to accommodate the N.Manchester/Bury children based on the positive findings of the Rochdale/Oldham model, and later developing into a single site service for all children within the PAHT footprint. In June 2013 and February 2014 a review of the service was undertaken by the Safeguarding Team.

During the review period, all children were seen within 24 hours of the medical being requested. 92% were seen on time or within 30 minutes of their appointment time representing a substantial improvement from the anecdotal evidence relating to the unscheduled arrangements prior to June 2011. Out of the appointment slots used, 42% are the last slot of the day. Those children that cannot be seen are either seen as part of the out of hours service or deferred to the following day. The need to access the out of hours service or wait to be seen the following day would be reduced if the service started later and finished later. The cost implications and feasibility of this require further consideration.

The review reports show that the current model of s47 child protection medical service provision is meeting the needs of children requiring a child protection medical and should continue pending further consideration of appointment times.

The number of s47 medicals completed during 2013-14 as part of the in hours service has increased slightly since 2012-13. The number of referrals from Bury has increased by 56% over the previous twelve month period whilst there has been a drop in referrals of 26% from Oldham Children's Social Care. The numbers of medicals completed per local authority are given below:

Local Authority	Q1 Total	Q2 Total	Q3 Total	Q4 Total	Grand Total
Oldham	12	10	16	20	58
Rochdale	21	11	14	18	64
Bury	7	17	22	15	61
Manchester	0	2	4	0	6
Total	**40**	**40**	**56**	**53**	**189**

3. Domestic Abuse

The Safeguarding Team receives notification of domestic abuse incidents in pregnancy reported to Greater Manchester Police. These are sent to community midwives to enhance awareness of domestic abuse among our patients attending maternity services.

	Q1 Total	Q2 Total	Q3 Total	Q4 Total	Grand Total
Oldham	8	14	7	19	48
Manchester	12	11	6	5	34
Bury	11	18	13	0	42
Rochdale	25	26	30	31	112

Salford	1	7	4	2	14
Tameside	0	1	0	0	1
Total	**57**	**77**	**60**	**57**	**251**

In November 2013 the Safeguarding Team worked collaboratively with Greater Manchester Police in launching a new initiative to improve providing support and intervening in cases of domestic abuse when they attend PAHT Emergency Departments. The initiative involves Victim Support workers working with ED staff, including the provision of training and support, and providing a 24 hour phone line for staff to make referrals with patient consent. The scheme builds on a successful pilot that took place at Fairfield General Hospital and resulted in women being afforded protection and relocation in the majority of cases referred at a much earlier stage than might otherwise have been the case. Emerging evidence from the scheme is that it is being well used by ED staff. Since the start of the Victim Support in A/E scheme at PAHT there has been an increase in the number of referrals to MARAC of PAHT patients. Last year, there were no referrals, this year there have been 10 as the table below shows:

Month		Nov-13	Dec-13	Jan-13	Feb-13	Mar-13
Number of referrals		0	7	5	4	8
MARAC referrals		0	3	2	2	3
Referring Departments						
A&E		0	7	5	3	5
T3 Ward Manager		0	0	0	0	1
Mental health team		0	0	0	1	0
Alcohol Liaison Officer		0	0	0	0	1
Community Midwife		0	0	0	0	1

4. PREVENT

The national Prevent strategy is a Home Office initiative that aims to stop people becoming terrorists or supporting terrorism. The DH (2011) document 'Building Partnerships: Staying Safe' provides the framework for all health trusts to adopt to ensure compliance with the PREVENT strategy. In PAHT the training is led by the Emergency Planning team with the Named Nurse Safeguarding Adults. Any referrals come through the Safeguarding Team and details of how to make a referral are available on the Trust website and Adults at Risk policy. PREVENT is highlighted in Level 2 Safeguarding training. In addition, the DH require all health trusts to deliver a particular form of training called the 'HealthWRAP'. Details of training uptake are given below and are submitted in a monthly return to Home Office Regional PREVENT Co-ordinators.

Total number of approved HealthWRAP Facilitators?	18
Total number of HealthWRAP sessions carried out to date?	28
Total number of staff who have attended HealthWRAP this month	22
Total number of staff who have attended HealthWRAP	361
How many staff have received Prevent awareness information e.g signposting, slides at induciton/training, Prevent leaflet etc?	Since March 2013 = 3795

5. Conclusion

The Trust continues to ensure representation on all LSCBs and LSABs within its footprint. The enclosed report provides evidence to the LSCBs of the safeguarding work undertaken within the Trust to enable it to discharge its duty against national guidance. The Safeguarding Team continue to develop systems and processes and work with staff and patients and other agencies to ensure the potential to protect adults at risk is maximised.

APPENDIX 4 – SEAM Panel report

Sexual Exploitation and Missing (SEAM) annual report 2013 -2014

SEAM Performance Statistics

The 2009 guidance 'Safeguarding Children and Young People from Sexual Exploitation', states that the identification, disruption and prosecution of perpetrators is key to protecting children and young people from sexual exploitation. The guidance explicitly states that:

"Local areas need to adopt a three-pronged approach to dealing with child sexual exploitation, including prevention, providing support and protection for young people and prosecuting offenders. These areas of work should not be undertaken in isolation."

Bury's response to this guidance is the development and implementation of Sexual Exploitation and Missing (SEAM) panel meetings, which commenced in December 2012.

The SEAM panel meets on the second Friday of each month between 09:00-13:00, at Bury Police station. The panel consists of multi agency management representatives from across Children's Services and is chaired by the Team Manager of the Safeguarding Unit. Case referrals are presented by the lead worker/agency, followed by discussion to ensure that all relevant information is shared. All police intelligence is logged, ongoing investigation updates are shared and recommendations are made with actions for service implementation. Panel actions are assigned to agency leads to disseminate to the relevant workers within each service involved, to ensure that a safety plan is developed and that appropriate safeguarding measures are implemented. Each case is reviewed the following month to ensure that previously agreed actions have been completed; any ongoing issues are further addressed. Multi agency involvement contributes to increasing awareness among, and referrals from, partner agencies.

This is the first Annual report for SEAM meetings and the collated information corresponds with that contained in the quarterly reports submitted to the BSCB Executive Group throughout the year. This report summarises and provides an overview of key performance information gathered during the year, together

with an explanatory narrative. The reader should note that only data on cases referred to SEAM are included in this report; there are however additional cases of child sexual exploitation that are not, for various reasons, reported to the SEAM panel. The data provided covers the full year April 2013 to March 2014.

Referrals to SEAM – throughout the year there were a total of 66 referrals made to SEAM. These referrals were mainly around concerns for children and young people thought to be at risk of sexual exploitation and in the latter part of the year a minority group of young people were referred for concerns around multiple 'Missing from home' episodes. The age range of referral subjects was between 11 and 17 years.

Declined referrals – in addition to the above referrals the panel introduced a screening system to ensure that only appropriate referrals were submitted, this commenced in September 2013. Between September and March 2014, there were 10 declined referrals, these deemed as inappropriate, the presenting issues being about confusion around sexuality and other circumstances not related to sexual exploitation. SEAM responded to these examples of the inclusion criteria being misunderstood by promoting further awareness-raising with social work staff and partner agencies. This has since resulted in a reduction in referrals judged to be inappropriate.

Referrals by agency – referrals are predominantly made by Social Care staff and the Police Service, followed closely by Child & Adolescent Mental Health Service (CAMHS). However, it is encouraging that as SEAM progresses the awareness-raising across partner agencies is increasing; as a result the panel are receiving increasing numbers of referrals from partner agencies. It is important to acknowledge the frequent consultations requested by our colleagues within education settings, who contact the Safeguarding Unit regularly for advice and support on potential referrals to SEAM.

Actions resulting from SEAM – All the referrals made to SEAM received a service. Some of the referrals had pre-existing interventions involving either single or multiple agencies at the point of referral; this level of intervention was often increased post-SEAM, with additional planning to safeguard. Where there was no involvement at the point of referral all the cases were given plans of support; these ranged from single agency to complex safeguarding plans within a CSE or the provisions of a child protection conference. In addition, criminal investigations and proceedings have been undertaken in some cases.

Proposed Action Plan –

1. Ongoing awareness-raising with agencies.
2. To understand why repeat referrals occur and to look at more effective planning to assist in reducing their incidence.
3. To work in conjunction with schools regarding awareness-raising within PHSE lessons.
4. Direct work with parents to be developed to support safeguarding children living at home.
5. To look at undertaking joint strategies with the Police to disrupt threat-associated behaviours, particularly in key areas of Radcliffe.
6. To continue awareness-raising within Children's Social Care and partner agencies.
7. To undertake awareness-raising throughout Bury, to ensure that residents are equipped to report issues of concern around child sexual exploitation.

Lisa Bell

Team Manager & SEAM Chair

Bury Safeguarding Unit

18 June 2014

APPENDIX 5 – LADO report

Bury Safeguarding Children Board Yearly LADO report

1st April 2013 to 31st March 2014

Yearly report of Managing Allegations activity and Development Work by the LADO in Bury – Mark Gay and Donna Green (April 1st 2013 – Dec 31st 2013.)

Total number of LADO related enquiries were 196 between 1st April 2013 and 31st March 2014, up from 161 last year, an increase of 21%. This means the number of LADO enquiries has almost doubled in 2 years from 101 in 2011/2012.

Distribution of LADO related enquiries

Enquiries by Sector	No. of LADO Related Enquiries
Education	46
Nursery & Childminders	28
Residential Homes	15
Children's Services	24
Health	32
Faith Setting	4
Fostering	28
Voluntary	3
YOT	1
Other	15
Total	**196**

Of the 196 LADO enquiries 51 reached the LADO threshold to referral.

2013/2014 Referrals Table

Sector	No. of Referrals	No. NFA after initial consideration	No. proceeding to investigation
Education	6	3	3
Nursery & Childminders	4	3	1
Residential Homes	4	0	4
Children's Services	2	1	1
Health	15	10	5
Faith Setting	1	0	1
Fostering	17	7	10
Voluntary	1	1	0
Other	1	0	1
Total	**51**	**25**	**26**

Category of 51 LADO referrals

Sector	Sexual	Physical	Conduct	Neglect	Emotional	Total
Education	1	2	2	1		**6**
Nursery & Childminders			3	1		**4**
Residential Homes		4				**4**
Children's Services	1	1				**2**
Health	4	6	3	2		**15**
Faith Setting		1				**1**
Fostering		13	3	1		**17**
Voluntary	1					**1**
Other			1			**1**
Total	**7**	**27**	**12**	**5**		**51**

Timescale for Completion of 26 investigations

Sector	Concluded in 4 wks	Concluded in 12 wks	Concluded in 26 wks	Concluded in 52 wks	Ongoing	Total
Education	1		2			**3**
Nursery & Childminders		1				**1**
Residential Homes	4					**4**
Children's Services				1		**1**
Health		2	2		1	**5**
Faith		1				**1**
Foster Carers	5	3	1		1	**10**
Other	1					**1**
Total	**11**	**7**	**5**	**1**	**2**	**26**

Key:

Education – Primary/Secondary/Independent/Out of School Care

Nursery & childminders – including private nurseries.

Residential – Private Children's Homes

Foster Carers - includes Independent Foster Carers

Children's Services – including escort services, ed psychology, carers and playworkers

Police – GMP officers

Secure Estate – including private security agencies

Health – including private health care providers

Other – voluntary sector and other agencies

Outcome referrals 1/4/13 – 31/03/14 ***(*) includes cases which are ongoing***

Sector	*Substantiated*	*Unsubstantiated*	*Unfounded*, false or malicious*	*Total*
Education	2		1	**3**
Nursery & Childminders			1	**1**
Residential Homes		2	2	**4**
Children's Services	1			**1**
Health	3		1 (1)	**5**
Faith	1			**1**
Foster Care		7	2 (1)	**10**
Other+ Voluntary	1			**1**
Totals	**8**	**9**	**7 (2)**	**26**

Delivery of Training by Bury LADO (Mark Gay)

Managing Allegations for BSCB	3
for Pennine Care	1
for Alpha Hospital	4
Safer Recruitment for BSCB	2
E-safety Awareness for BSCB to professionals	2
to parents	9
Social Networking Awareness to school staff	7
Total sessions	28

Mark delivered LADO/Managing Allegations Single agency training on behalf of the BSCB to senior managers of Pennine Care and 4 sessions to adolescent mental health staff at Alpha Hospital. The contact rate in health has now increased with the increased awareness from this training in particular.

However since the training was delivered to Alpha Hospital there has been a large turnover of staff and a greater use of Bank Staff not only in Alpha Hospital but in Prestwich Hospital, this greater use of Bank Staff in the secure mental adolescent wards has caused its own issues around managing allegations and Mark has arranged and delivered this training to safeguarding

and medical leads in Prestwich Hospital recently (May 2014) and is booked to attend Alpha Hospital (July 2014) again to support the new staff there.

Mark has also attended the Hope and Horizon Unit, Fairfield Hospital and spoken with the unit manager, ward manager and lead psychiatric doctor and explained the LADO/Managing allegations process to them direct.

This means that senior staff in all 3 of Burys secure adolescent mental health units have received the Managing Allegations training, bringing to the forefront the need for staff in such units to be aware of the process in order to protect children and young people (as young as 11) and staff alike in such institutions.

Mark chairs the Residential Providers network (meets every 6 months) and attends the Bury E-safety Working Group (meets every 4 months). Mark now sits on the Children in Care Living Away From Home Sub-group.

As part of his work with the E-safety Working Group, Mark has delivered E-safety Parent Awareness sessions in Children Centers across Bury speaking to over 110 parents about the dangers and risks children undertake on the internet. He has also delivered a similar session to Bury Foster Carers (10) and another to Earlybreak staff (40+).

Mark has been instrumental in organizing the first ever National LADO Conference, which was held in Manchester on 14th March 2014. 130 LADOs from across England attended to discuss national issue such as how to get a coordinated National LADO voice, a common approach to the recent change by the DfE from "unsuitability" to "pose a risk of harm" in the LADO threshold as set out in Working Together 2013 and a LADO records retention policy.

As a result of the Birmingham SCR, in to the "Little Stars" Nursery, Mark has liaised with Early Years and had circulated to all the private nurseries the outcomes and lessons to be learnt from that SCR. As there was a specific issue around safer recruitment from this SCR, Mark has offered specific Safer Recruitment training for private nurseries but sadly only one nursery requested to attend such an offer, however some private nurseries have attended the BSCB training safer recruitment courses.

Mark has liaised with Early Years and is preparing a flow chart to all PVI and nurseries and Early Years staff so that they know exactly what to do when they have concerns about a staff member or a child in an Early Years setting.

As a result of a number of cases of Bury teachers engaging in inappropriate contact with their pupils via social media and mobile technology along with the recent East Sussex SCR (child taken to France), Mark along with Lesley Davidson has created a 30 minute Social Networking/Mobile phone awareness session for teachers to be made aware of the dangers in engaging in such practice outside of school boundaries.

These have been well received with nearly all the Bury High Schools, independent schools and Colleges having either already had the training or have booked for a session to be delivered in 2014.

Mark has established a positive link with the Jewish Interlink Foundation and they regularly engage in mutual contact to assist with LADO issues within the Jewish community.

Mark is working on a similar link with the Muslim community and has established links with the Darul Uloom College and more recently the Parker Street Mosque; efforts are ongoing to incorporate the other Bury Mosques in to this work in 2014.

Mark Gay

Bury LADO

APPENDIX 6 – Private Fostering annual report

Report submitted by: **Gareth Millar, Team Manager**

Agency: **Children's Social Care**

Report submitted on: **03 June 2014**

Title of report or subject: **Private Fostering Annual report 2013-14**

Summary of report

This report is to brief the BSCB executive on the activity over the year 2013-14. The report will provide information about the private fostering arrangements that have been identified. It will also look at the revised action plan to be taken forward by the private fostering task and finish group.

History

The Private Fostering steering group ceased in March 2012. Following discussions by the Board in January 2013 it was decided that the Private Fostering Group needed to become a more formal sub group and officially met on the 7th March 2013, where the action plan was updated.

Recommendations

In addition to noting the outcome of the audit, Board members were asked to:

1. Raise awareness within their respective agencies and to support the identification of Private Fostering arrangements and ensure that these are notified to Children's Social Care.
2. Support the funding of further planned awareness raising campaigns.
3. Approve the updated Private Fostering Statement of Purpose which was revised in March 2013.

This was approved at the April 2013 BSCB Executive meeting.

The private fostering group was disbanded in favour of establishing a private fostering lead from Children's Social Care, and with a task and finish group being set up to progress this area of development.

Current situation

The responsibility for Private Fostering lead was delegated to Rebecca Sutton, Acting TM in Children's Social Care. This responsibility was reassigned in

February 2014 to Gareth Millar, Team Manager. The main focus for the new lead has been to understand the remit and current situation in order to report to the Board in April 2014; to refresh the PF action plan; and to meet with colleagues from the LSCB and Children's Social Care in order to plan the programme of activity for the forthcoming year.

Organisational and Structural Issues

Private fostering arrangements within Bury Council continue to be assessed and monitored by the Children's Social Care. New notifications are ordinarily processed and assessed by the MASH (from August 2013) and then transferred to the Advice and Assessment team for an initial assessment of the Private Fostering arrangement (unless a case is already open to a field social work team). In such circumstances where the child is already an open case, then the private fostering arrangement would be assessed by the allocated social worker for the child. The Safeguarding Unit is available for consultation regarding enquiries of the private fostering criteria.

The safeguarding unit procedurally arranges for each private fostering arrangement to be reviewed within the 'child in need' reviewing system, chaired by an Independent Reviewing Officer from the Safeguarding Unit. This will provide each case with an element of independent scrutiny and oversight as well as ensuring a mechanism for review, similar to children who are Looked After. A referral is made to the fostering team to appoint, if required, a Social Worker to support each private foster carer of the privately fostered child.

Statement of Purpose & PF procedures

The Authority's Private Fostering Statement of Purpose was reviewed and endorsed in April 2013.

The Private Fostering procedures were updated, this is in line with the purchase of TRI X, in conjunction with our neighbouring Authorities.

These procedures are being reviewed with a particular focus on ensuring they are reflective of the changed structure of MASH from August 2013; and on the need for a more formal approval of private fostering arrangements. It is proposed that the procedure for approval of private fostering arrangements, or not, is endorsed by a senior officer of Children's Social Care in the same way that foster carers are approved by an agency decision maker.

Efforts to identify Private Fostering situations and ongoing promoting awareness

The Local Authority has continued the programme dissemination of advice and information about private fostering. This information was redistributed mainly to internal services, health services, schools and partner agencies. Awareness raising through LSCB training and by Board member agencies continues.

> *"Michelle Walmsley has distributed leaflets and raised awareness throughout the year in safeguarding training specifically Foundation, Group 3 safeguarding and Day 2 domestic abuse."*
>
> *Donna Green, BSCB manager*

The publicity material has been made available in a range of languages. The material emphasises the legal requirement to notify the council and includes a variety of information within a poster and three leaflets; for parents & carers, children & young people & professionals.

> *"I have developed links with the faith sector namely the Jewish Interlink group and the awareness of private fostering is good. Engaging the Muslim community remains more challenging and there is still a long way to go."*
>
> *Mark Gay, LADO*

All presentations and publicity/information materials include a clear definition of private fostering along with the legal requirement for notifying the Local Authority of any known or proposed private fostering arrangements. This promotional material is being revised to include the new contact detailed for the MASH, and will be redistributed.

Bury was represented at the Greater Manchester Working Group for Private Fostering which commenced in March 2013. This group ceased to exist later in 2013.

Notification of Private Fostering Arrangements

	Number of Enquiries
2012-13	6
	Number of new referrals
2012 -13	3

The above table is from last year's annual report. They were described thus: "number continue to remain low in comparison to other Authorities but are higher than the previous year. Last year Bury's figures were lower than our North West neighbours."

The information generated from the Children's Social Care database for the 2013-14 year in line with the statistical return is:

Number of Private Fostering notifications received is 6.

1 arrangement started before 01.04.13 continued during this year.

1 arrangement ended during the year.

The total ongoing arrangements currently stated as ongoing is 6.

The breakdown of age and place of birth is:

All 6 are aged between 10 and 15 yrs old.

4 were born in the UK, 2 are Chinese nationals.

The private fostering return by children's social care was uploaded before the 30 May deadline with the above figures. In all the six cases there was an appropriate response but the initial visit was not in the required 7 days from notification.

Audit of the PF arrangements for the year 2013-14

The report author has audited the 6 Private Fostering arrangements and concluded that all are correctly assessed as PF arrangements, or are in the process of being assessed, and this is generally completed satisfactorily. In one case there has been significant delay and this has been brought to the attention of the strategic lead.

Case	Referred by	Comments
Child 1	Notification by parent from other UK region that child in PF arrangement in Bury for educational purposes.	Ongoing arrangement and assessed as suitable. Child regularly visited and reviewed by IRO.
Child 2	Notification from Rochdale Children's Services as YP moved from a PF arrangement in that area.	Ongoing arrangement is suitable, YP visited regularly and reviewed. Will be 16 soon, plans to remain in UK and complete education.
Child 3	Mother referred via fair access to education route.	Assessment ongoing as to suitability of arrangements. Regular visits.

Child 4	Notification from the PF carers as an arrangement which had started.	Ongoing arrangement is still being assessed, some significant delays identified.
Child 5	Notification from the Police SOMU, child living with his Great Grandmother and concerns that a sex offender was at the address.	Private Fostering arrangement assessed and concerns about the sex offender dealt with appropriately. Child seen regularly.
Child 6	Notification from High School.	PF arrangement assessed and YP regularly visited and reviewed.

Action Plan for 2014-15

The key points are:

Awareness Raising – Refresh of leaflets and posters, continue to distribute at key events and training; a briefing pack (electronic) for multi-agency teams to deliver at own team meetings and events; Children's Trust lunchtime learning event in June 2014; article in relevant newsletters and websites.

Review PF procedure – specific focus on dealing with notifications and approvals of arrangements.

Multi-agency Training – Children and families across Borders training event on 07 July 2014, Bury Town Hall.

Education establishment targeting – write to all Bury schools to remind about PF and ask Headteachers to review any potential arrangements and notify; focus on BME schools and language schools.

Reporting on numbers of privately fostered children – report regularly to the LSCB Exec (annually) and sub-group (bi-annually); audit of the arrangements at end of year to look at compliance and outcomes for children; report any trends or concerns to LSCB where appropriate.

APPENDIX 7 – Training Needs Analysis

Training Needs analysis for 2014-2015 training planning;

Please complete the attached questionnaire (1 per service) to inform us of the multi agency safeguarding children training requirements for your service. This will help us plan for 2014 to 2015.

Please complete & return to BSCB@bury.gov.uk BSCB Training administrator by Monday 31 March 2014.

1. Your Service	
2. Person filling out this form	
3. Your E mail address & tel. Number	
4. Total number of your workforce based in **Bury** *NB Please identify any issues regarding workforce development that may have an impact upon training e.g. staff turnover, vacancy rates, bank/agency staff*	
5. In your organisation what are the key issues with regards safeguarding children that have been fed back to you from your staff in supervision / Personal Development Reviews that suggest changes / additions to safeguarding children training? *NB – please reference any supportive evidence from your service that this is a required need / gap*.	
6. In your organisation what are the key issues for safeguarding training at induction level e.g. basic introduction to safeguarding children? *NB – please reference any supportive evidence from your service that this is a required need / gap*.	
7. What are the key issues for staff training at the multi-agency level? *NB – please reference any supportive evidence from your service that this is a required need / gap*.	

8. What are the key issues for training at the Specialist Safeguarding Children training level? *NB – please reference any supportive evidence from your service that this is a required need / gap*.	
9. Please use this space to include any further multi agency safeguarding children needs you have identified from local or national guidance (*NB – please reference any supportive evidence that this is a required need / gap.)*	

Please note the courses below, which are already in the BSCB Multi Agency Safeguarding Children Training programme.

Please answer Yes / No as to whether you feel they are appropriate for your staff to access / to be in the multi agency safeguarding children training programme

BSCB Multi-Agency training programme	Does all/some of your staff require this training? Yes / No	Comments re the content of this course (evidence based)
Safeguarding Courses targeted at Managers		
Risky Business (2 day)		
Safer Recruitment		
Managing Allegations		
Train the trainer		
Children in specific circumstances courses		
Core group (1 day)		
Domestic Abuse (day 1& 2)		
Child Sexual Exploitation (day 1 & 2)		
Parental substance misuse & the impact on the child (day 1 & 2)		
E-safety & cyber safety		
Safeguarding the Disabled Child		
Neglect		
Parental Mental Illness & the impact on the child		
Attachment		
Protecting Children before Birth		
Emotional Abuse		
Working with African Families		
Anti-trafficking		
Professional Challenge in Child Protection Decision Making Forums		
Learning events– open to all practitioners		

Child Sexual Exploitation		
Serious Case Review Learning Events		
Voice of the Child		
Graded Care Profile		
Workshops		
DASH Risk Assessment		
Core group re-fresher		
Safeguarding training		
Single agency (group 3) safeguarding training		
Foundation 2 day		

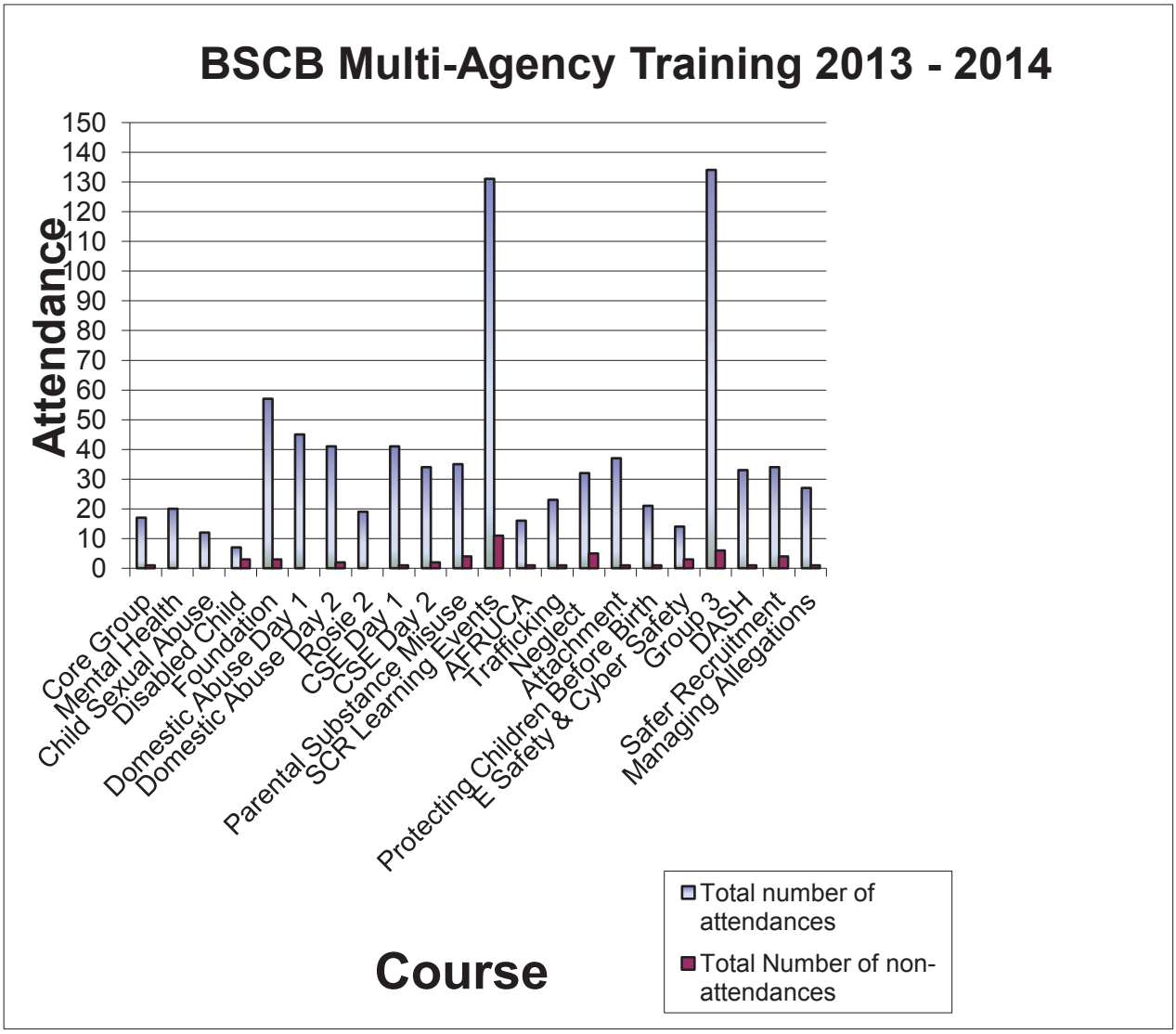
Space for your additional comments;

Please complete & return to BSCB@bury.gov.uk before Monday 31 March 2014.

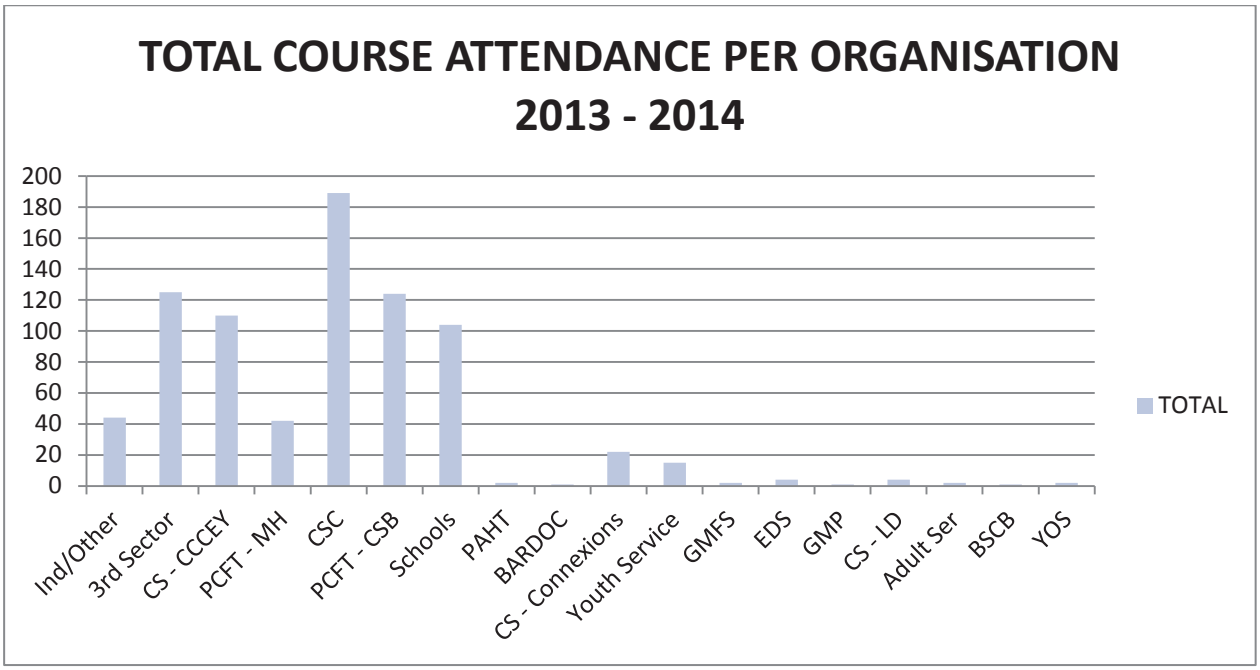
APPENDIX 8 – Training report

BSCB TRAINING REPORT 2013/14

The chart below shows the numbers of attendees and non-attendees for the courses that have been run in 2013-2014 by the Bury Safeguarding Children Board.



The chart below shows the number of course attendances per organisation.



The table below shows the number of attendees in total for each individual course held on BSCB key priority areas. This will be a cumulative number if the course has run on more than one date.

Total number attendances for target courses:

Course Title	**Number of courses**	**Total number attended**
Domestic Abuse Day 1	3	45
Domestic Abuse Day 2	3	41
Child Sexual Exploitation Day 1	2	41
Child Sexual Exploitation Day 2	2	34
Parental Substance Misuse (2 Day)	3	35
Parental Mental Health	1	20
Serious Case Review Learning Events	7	131

APPENDIX 9 – CAF report

Registered Common Assessments between 1st April 2013 – 31st March 2014

The CAF team in Bury has experienced disruption and many changes over this last twelve months. In summer 2013, the previous CAF Manager left the Authority leaving the team without a permanent manager; this resulted in a lack of direction and progression of the service. In September 13, the new Early Help Team in Bury was developed and the CAF team moved to be part of this service. There has been a change in staffs in the team, various practices have been changed resulting in a more positive, and thorough approach with agencies in terms of quality assurance, awareness raising, tracking and reviewing of CAF processes.

The CAF team's shift of focus is in line with national thinking around early help and Professor Eileen Munro's recommendations. The delivery of effective early support to children and their families in Bury is done through the monitoring of early intervention through the CAF. As such, the CAF team serves a vital role in supporting practitioners in Bury to:

- Identify needs earlier
- Deliver a co-ordinated package of child centred and family focused support
- Help to secure better outcomes for children and young people
- Share information effectively between organisations

The CAF team have a clear focus and solid understanding of the framework as a system, associated processes and correlated safeguarding thresholds, which they have been keen to impart to both internal and external colleagues in partner agencies. Working relationships with partner agencies are positive and there is a raised awareness of the work and support the CAF team offer in the CAF process.

Performance and activity

There were 439 CAFs registered in Bury between 1 April 13 and 31 March 14, this figure shows a decline of 74 registered CAFs in comparison to the previous year. However, due to changes in practice and policy there are various reasons for this reduction in numbers. Previously CAFs have been registered for all siblings in a family group even if the concerns were not about the siblings, since the latter end of 2013, this practice has changed and CAFs are now being registered as a family rather than individuals. Should issues be raised regarding individual children/siblings then it would be expected that a separate CAF was completed and registered in respect of this child.

Prior to March 14, the CAF was used as the referral document for concerns to social care and because of this there were many issues in regards to the quality and worth of these CAFs as they were not true assessments of need, rather a document of concerns; therefore in March 2014 a separate referral document was developed. Since the implementation of the referral there has been, a positive impact on CAFs received in terms of meaningfulness and quality. Taking a small look at the figures for March 14 in comparison to the same dates in March 2013 there is a decrease of 17 CAFs registered which I would hypothesis is due to the separation of the referral and CAF document.

Since December 2013, there has been a drive by the CAF Consultants to raise awareness with partner agencies. Consultation sessions have been held in schools, children centres, nurseries and health centres to improve the working relationship between practitioners and the CAF team.

There is growing confidence that practitioners are improving in their ability to identify when they need to commence a CAF and due to the support from the CAF Consultants are developing a greater understanding of the CAF as a process rather than a singular event. All assessments and team around the child minutes are quality checked by the CAF Consultants and should these documents not meet expected standards the author is contacted and advice given.

These numbers represent only the CAFs that have been completed and submitted to the CAF Team for registration, there remain some practitioners who are not

submitting their CAF's and therefore these are not represented in the figures. The CAF Team have identified some areas where these CAFs are not being sent for registration or quality assurance and these appear to be when practitioners are completing them for a service such as parenting courses, children centre outreach or young carers. Work is being undertaken to develop a pathway to ensure that all CAFs are captured by the CAF team and registered therefore giving a true representation of completion rates in Bury.

Total Common Assessments

2012-2013 Q1	Q2	Q3	Q4
Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar
190	**119**	**107**	**97**

2013-2014 Q1	**Q2**	**Q3**	**Q4**
Apr-Jun	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**
132	**61**	**119**	**127**

Quarter 1 2013

This quarter saw an improvement from the previous quarter (Jan-Mar 13) and the largest record of completed CAFs since July 12. I am unable to comment on the reason for this improvement during this quarter, as I was not involved with this service at that time.

Quarter 2 - 2013

This quarter demonstrates a considerable decline in CAFs from the previous quarter. The reduction in this period is consistent with previous years due to the long summer school holidays whereby practitioners in universal services who would normally initiate a common assessment such as, teachers, school nurses and health visitors are unavailable due to taking annual leave. However, this figure is the lowest since the same period in 2008, which could be explained by this period correlating with the then

CAF team manager leaving the Authority and a possible loss of focus, drive and direction by the remaining CAF team.

Quarter 3 & 4 – 2013/2014

The number of completed CAFs in both these quarters continues to rise steadily. This period corresponds with the CAF team becoming part of the Early Help Team and the start of a change in practice and procedures by the CAF Consultants.

During quarter 3 & 4, the CAF Consultants facilitated consultation sessions with various agencies, these were well attended and popular with partners. This has served to improve relationships between the CAF Consultants and other agencies and outline the service that the CAF Consultants offer in supporting practitioners in completing CAF's, chairing meetings and offering timely advice and support to lead professionals to assist in ensuring plans for children and young people are outcome focused.

Common Assessments completed by services

Chart 1

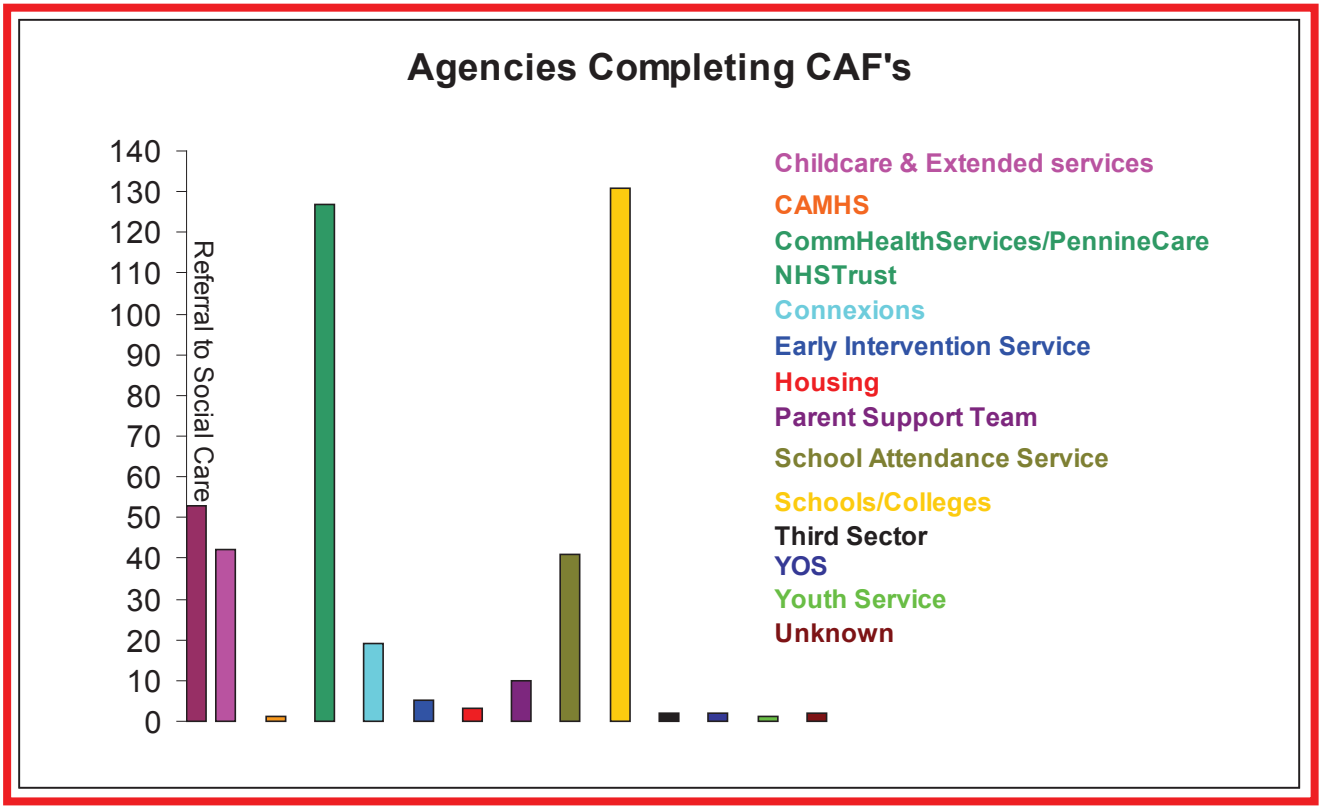
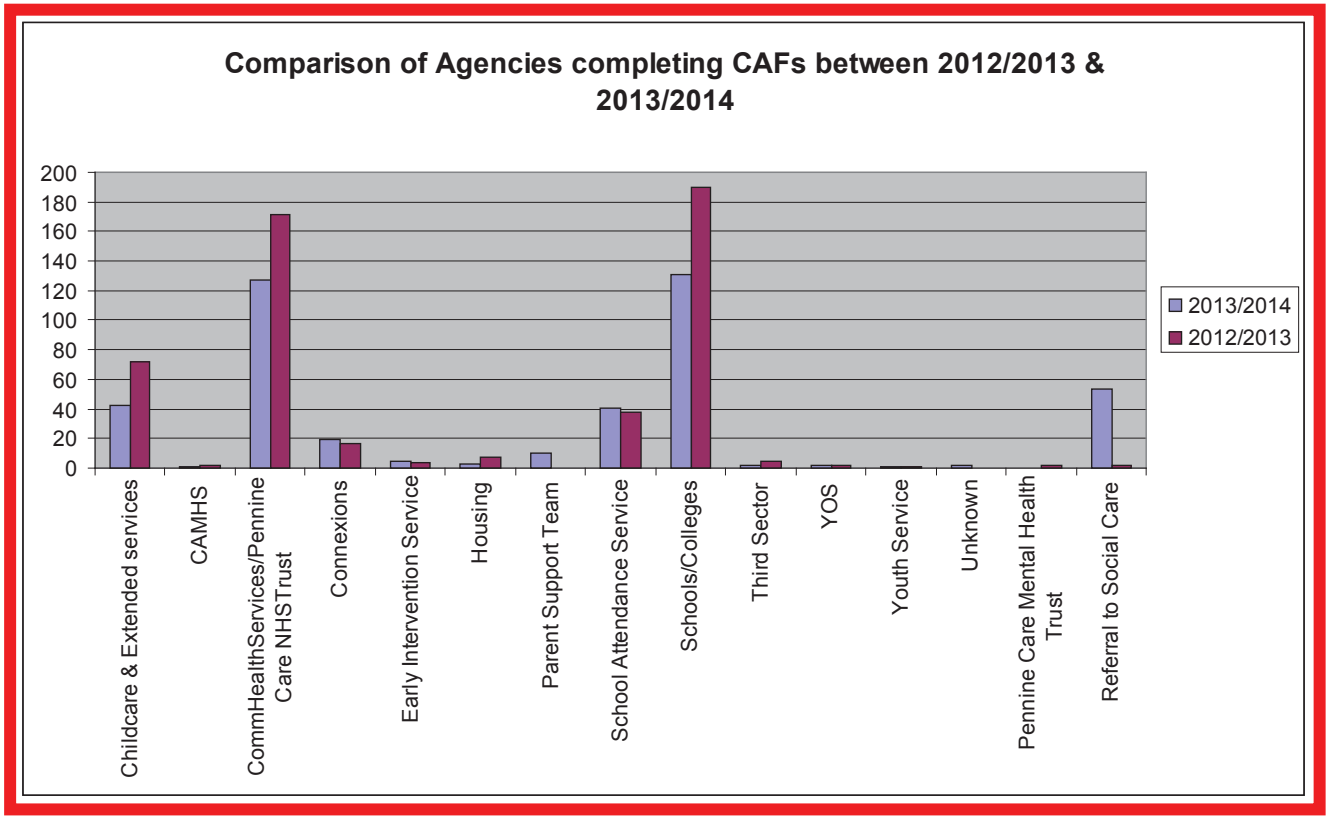

Agencies Completing CAF's
Referral to Social Care
140
130
120
110
100
90
80
70
60
50
40
30
20
10
0
Childcare & Extended services
CAMHS
CommHealthServices/PennineCare
NHSTrust
Connexions
Early Intervention Service
Housing
Parent Support Team
School Attendance Service
Schools/Colleges
Third Sector
YOS
Youth Service
Unknown

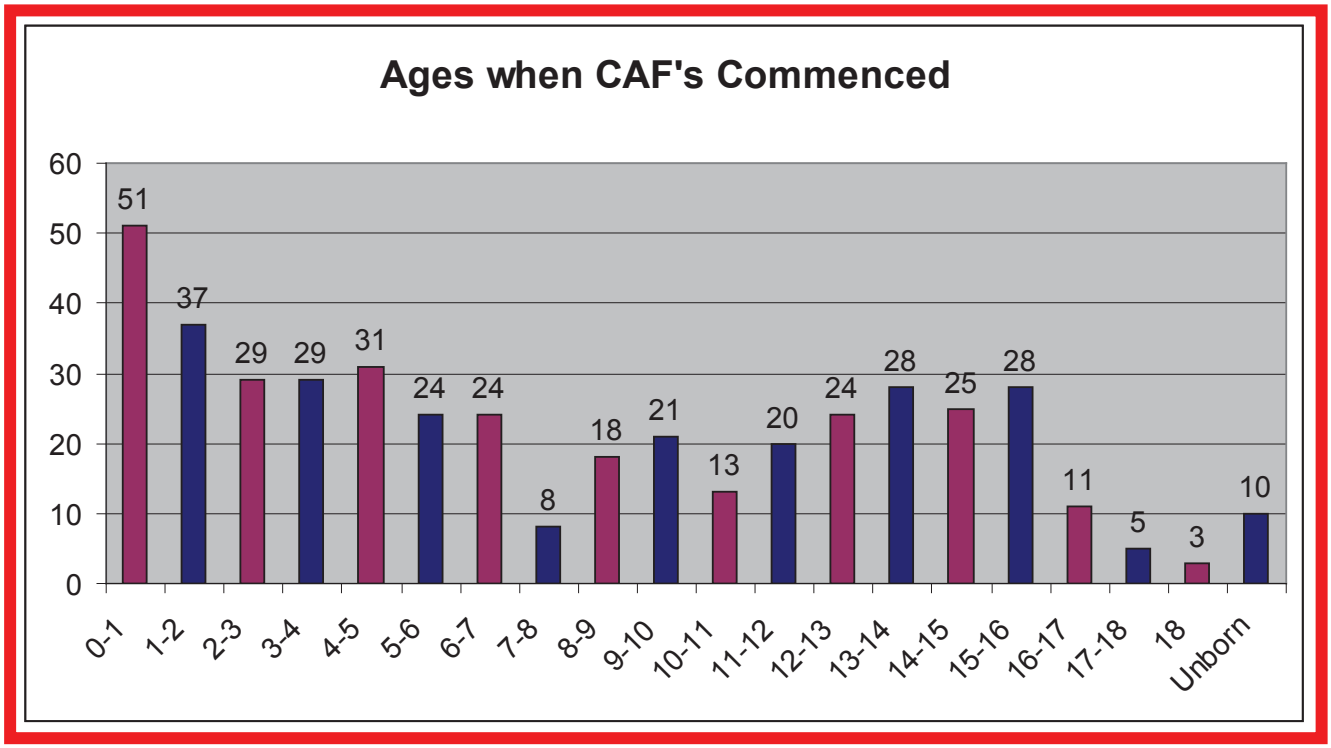
Chart 2



In the last 12months, the leading CAF authors has been schools, having completed 131 registered CAFs. They are closely followed by health services that have completed 127 registered CAFs. The data demonstrates that whilst some agencies have this process embedded, there are others that have shown little improvement in completing CAFs over the past two years. For instance, CAMHS have registered two CAFs between 2012/2013 and one between 2013/2014. This is a service where I would expect a greater commitment to this process given the vulnerability of the children and young people who use their service.

Age range of CAFs

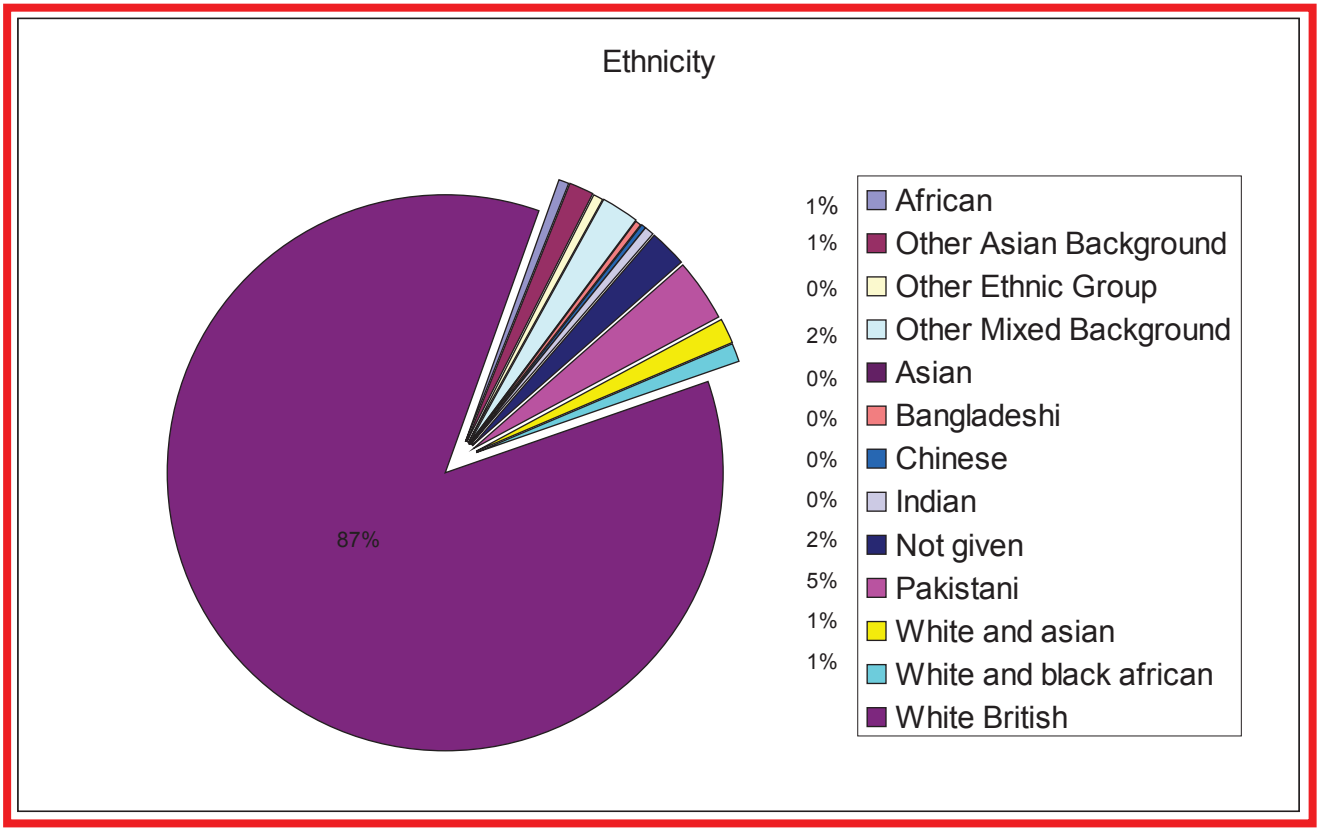
Chart 3



The largest group of CAFs submitted between 2013/2014 are in respect of children aged zero – 1year old. The data shows that from birth to 5 years there has been a higher rate of CAF's completed which given the vulnerability of this age group would be the expectation. The CAF's completed drops between the ages of 5– 13years and then start to rise again in the teen years. The total of completed CAFs for unborn babies is relatively low considering the much higher figure for children aged zero to 1year old. This information suggests that there could have possibly been more CAFs completed pre-birth and support plans identified, which would have reduced the CAF's being undertaken when babies when born as plans would already been in place ensuring need and support was identified at the earliest opportunity.

Ethnicity breakdown of Common Assessments completed

Chart 4



The number of white British children with CAFs is by far the largest number, with 87% in total.

CAF Team

The CAF Consultants have a varied role in supporting practitioners to undertake CAFs to enable them to achieve positive outcomes. The CAF Consultants are committed to raising awareness with other agencies and services to assist in the early identification of emerging needs of children, young people and families. In doing this, they are increasing professional confidence and knowledge of Bury's thresholds of need, which will increase the number of CAF's completed in the longer term.

The CAF Consultants are continuing to improve awareness with agencies regarding their CAF's being registered with the team, there is some concern that not all CAFs are registered when they have been completed.

Areas for development in 2014/2015:

- The profile of the CAF, TAC and LP will continue to be promoted across Bury.

- Currently the CAF Consultants register completed CAFs on an internal database. From mid June 2014, it is envisaged that a new electronic E-CAF system will have been implemented. Existing information will transfer from the database to the new system and any new registrations, reviews & Team Around the Child plans will be input directly on the E-CAF. In subsequent phases the E-CAF system will available to partner agencies for direct inputting of CAFs, however the timeframe for this is currently unknown.

- The voice of child within the CAF process will be promoted to ensure that their views, wishes, and feelings are documented.

- Improve child and young people evaluations

- Improve parents/carers evaluations

- Question and Answer consultations to continue to assist in capturing all services

- CAF and TAC training to be updated and improved

- New CAF and TAC training to be facilitated

- CAF clinics to be offered to identified services

- Closer links to be made with Social Care Teams when stepping down cases to ensure needs of children and young people are met with ongoing consistency.

- CAF Consultants to be available to professionals to give advice, support and assistance in moving plans forward ensuring positive outcomes

- CAF Consultants to continue to forge links with all partner agencies working collaboratively in line with Bury's vision ensuring the CAF process is fully embedded in every agency

- Identify, target and forge links with agencies whose CAF submission rate is poor to assist in understanding barriers and promote positive change

Report compiled by Kirsty Walton
Early Help Team Interim Manager

June 2014

Health & Wellbeing Board Report template

Bury Health and Wellbeing Board

Title of the Report	NHS Bury CCG Strategic Plan
Date	18th September 2014
Contact Officer	Sharon Martin – Deputy Chief Operating Officer / Head of Commissioning
HWB Lead in this area	Stuart North – Chief Operating Officer / Accountable Officer Dr Audrey Gibson – Clinical Director

1. Executive Summary

Is this report for?	Information ■	Discussion ☐	Decision ☐
Why is this report being brought to the Board?	The Health and Wellbeing Board are asked to discuss and comment on the CCGs Strategic plan		
Please detail which, if any, of the Joint Health and Wellbeing Strategy priorities the report relates to. (See attached Strategy) Living_well_in_Bury_ Making_it_happen_to	The strategy when implemented will deliver improvement in the 5 priority areas outlined in the H&WB strategy.		
Please detail which, if any, of the Joint Strategic Needs Assessment priorities the report relates to. (See attached JSNA) Bury JSNA - Final for HWBB 3.pdf	Improvement priorities identified from the JSNA: • Cardio Vascular Disease - Coronary Heart Disease and Stroke • Cancer • Chronic Obstructive Pulmonary Disease • Liver Disease/Alcohol • Mental Health and Learning Disability Mortality • Reducing unplanned activity		
Key Actions for the Health and Wellbeing Board to address – what action is needed from the Board and its members? Please state	The board is asked to review the strategy and concur that it aligns with the Health & Wellbeing strategy priorities.		

recommendations for action.	
What requirement is there for internal or external communication around this area?	Once the plan is finalised the CCG will collate a public / stakeholder document to externally communicate. Members of the public were invited to participate in development
Assurance and tracking process – Has the report been considered at any other committee meeting of the Council/meeting of the CCG Board/other stakeholders....please provide details.	• CCG Governing Body for decision. • CCG Clinical Cabinet for decision • SMT Adult Care for information / partnership discussion

2. Introduction / Background

The CCG is required to submit a Strategic Plan to NHS England to outline how they will commission services for their registered population. This plan was submitted in draft on the 20th June 2014, but will be refreshed and resubmitted following the review of the Better Care Fund.

The plan outlines how the CCG will deliver improvements in seven national outcome ambitions (these were agreed with the H&WB in May 2014):

- Securing additional years of life for the people of England with treatable mental and physical health conditions
- Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
- Increasing the proportion of older people living independently at home following discharge from hospital.
- Increasing the number of people having a positive experience of hospital care.
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community
- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

Bury CCG's Strategy includes ambitions aligned to the six transformation characteristics highlighted in the national Everyone Counts guidance identified by NHS England to ensure provision of high quality, sustainable health and care in five years' time.

- Citizen inclusion and empowerment
- Wider primary care, provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective care

- Specialised services concentrated in centres of excellence.

The CCG has devised transformational schemes that align to these characteristics with work programmes identified to achieve the required change.

Bury CCG has collaborated with the Local Authority to ensure that opportunities for partnership working are advanced in the coming years and the strategy outlines plans to further align work programmes and commissioning arrangements in the future.

3. key issues for the Board to Consider

This Strategy was previously discussed at the Health & Wellbeing Board on the 6th March 2014, by NHS Bury CCG's Chief Officer, prior to submission of the first draft in April.

4. Recommendations for action

For review please and consideration of alignment to the Health & Wellbeing Strategy

Highlight any gaps which may be identified.

5. Financial and legal implications (if any)
If necessary please see advice from the Council Monitoring Officer Jayne Hammond (J.M.Hammond@bury.gov.uk) or Section 151 Officer Steve Kenyon (S.Kenyon@bury.gov.uk).

None for the Health & Wellbeing Board – CCG Finance implications are contained within the document.

6. Equality/Diversity Implications

This covers all members of the population

CONTACT DETAILS:

Contact Officer: Sharon Martin

Telephone number: **01617623054**

E-mail address: **Sharon.martin14@nhs.net**

Date: **18th September 2014**

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NHS Bury Clinical Commissioning Group

Strategic Plan 2014-2019 and Delivery Plan 2014-2016

Contents

Chair and Chief Officers Foreword

"Welcome to our 5 year strategic Plan. This plan describes how services need to look in five years' time to meet the health needs and health challenges that we face in Bury. We need services to be fit for purpose, to improve health outcomes for patients and keep people well for longer. We have been engaging with local patients, carers and groups to hear their views about local services and what they feel works well, what could work better and what is missing. The feedback will be used to inform our plans.

There are ambitious plans for the year ahead, which are supported by the CCG, to improve access to GP services throughout the whole of Bury. Through the GP Federation, Bury has been awarded around £2.7 million to pilot increased access to GP services right across the town. This will mean that appointments will be available to all Bury patients into the evening and at the weekend. In addition to improved access to see a GP, new technology will also be used to make accessing GP services more simple. Bury is one of only 20 areas to be allocated money from the Prime Minister's Challenge Fund to fund this one year pilot. We are looking forward to seeing how the project progresses over the coming months for the benefit of local patients.

We hope you enjoy reading our 5 year strategic plan. If you have any comments on it, or the information contained within it, please let us know using the contact information on the back page. We would be pleased to hear from you."

Dr. Kiran Patel
Chair and
Clinical Lead,
NHS Bury Clinical
Commissioning
Group

Stuart North
Chief Officer,
Accountable Officer,
NHS Bury Clinical
Commissioning
Group

Section 1 - Our Vision; Values and Principles

1.1 Our Vision:

"To continually improve Bury's health and wellbeing by listening to you and working together across boundaries."

In Bury we are committed to transforming the whole health and social care system over the next five years, in order to support people 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.

1.2 Values and Principles

Our Strategic Plan will be delivered through effecting demonstrable change in pathways of care which will:

- Improve the health of the population
- Reduce health inequalities
- Deliver Parity of Esteem

The Strategic Plan is informed and shaped by these values and also by the national and local policy context. Bury faces significant challenges in addressing health deprivation and inequalities. Partners, the public, staff and stakeholders have been widely engaged during the development of the values.

Our local values are:

Figure 1- Local Values

Section 1 - Our Vision; Values and Principles

1.2.1 Listening to you and learning together

The public and patients are at the centre of everything we do and every decision we make, wherever possible they are involved themselves. People have a right and an expectation to be treated with dignity, respect and compassion. That is why we will always commission services and care that; promotes these ideals; improves access and makes sure that the public and patients are equal partners in decisions about their care. We are committed to listening to and acting on what really matters to local people by:

- Making their priorities our priorities
- Ensuring that the care and support given is tailored around their needs, goals and lives.
- Engaging through a whole range of approaches from events through to online communications
- Reaching out into local communities to systematically gather insights and ideas, as well as concerns that will directly inform commissioning and planning.

1.2.2 Value individuals and promote self development

It is recognised that some staff are being stretched; caring for more people, with more complex needs, in less time. This shows us that we need to continually consider how to ensure our workforce matches local need and demand. Some staff are simply in short supply such as, GPs, care staff, some hospital specialities and nurses, are well documented examples. We will need to work with local providers and the education system to encourage more people to follow fulfilling and rewarding careers in the NHS and Social Care sectors. We will ensure a workforce strategy is developed across all of our providers to support this strategy, which will ensure risk to staff from transformational change is minimised and we will involve Health Education England, the Academic Health Science network, the Deanery and local academia, in the development of this strategy to ensure innovative approaches.

1.2.3 People centred, clinically effective, efficient and sustainable care

Local patients deserve the highest quality care we can give, therefore our aim is to commission care which is safe, effective and delivers a good experience. We face a big financial challenge in our local NHS and Care system over the next five years, however we will never talk about the cost of services without talking about the quality of them; they are inextricably linked. Spending less time in hospital, with fewer cancelled appointments and living a full and independent life, supported by local services, is better for patients. Our Strategy is based around this value. In short, transforming services, not cutting them, is how we will keep services safe, of high quality and meet the financial challenges we face. To deliver both quality and value we will always listen to what local people and clinicians tell us about and we will combine this with what the data and information shows us, so that we can identify when things aren't right and address it. We will also support and empower staff to offer great care; we know that happier staff give better care, which means a better experience for the public.

1.2.4 Inclusive and transparent decision making

Staff delivering service are a driving force for change, because they know their services, their clients and often know the solutions to the problems that the NHS and care system faces. To realise the potential of staff we will provide excellent management support, from clear performance and programme management systems, to rigorous approaches to corporate management and business; it's this partnership that will make a difference for the people of Bury. Therefore our service redesign work will always be multi-disciplinary incorporating the skills and knowledge of a broad range of expert clinicians.

Section 1 - Our Vision; Values and Principles

1.2.5 Challenge inequalities with partnership working

Health and social care inequalities are a very real problem in Bury. There are areas amongst the most deprived in England and differences in life expectancy of ten years variance exists between different communities. We are committed to doing our part to reduce these inequalities over the life of this strategy and will review specific local needs for every clinical programme of change to:

- Improve our understanding of the issues local people face in access to services and in the outcomes they experience.
- Ensure that we can invest resources appropriately
- Develop services proportionally to the unique needs of different areas according to principles set out by Sir Michael Marmot (2010).
- Work in partnership putting joint plans in place for agreed joint areas of work, where we will focus on prevention through the Better Together programme.

Integration means that the Bury population experience joined-up care, because most people are not worried about who provides or commissions their care, so long as it is seamless, high-quality and delivered with compassion. To make this a reality we must work together, in collaboration with partners, breaking down the artificial barriers between organisations. We know that living with complex and multiple long-term conditions often requires complex health and social care responses and can mean the experience of care is confusing and dis-jointed. We have worked as a system to develop this strategy and the vision. This has set the precedent for a new way of working and for new ways of behaving, rooted in collaboration, innovation and transparency. Through strong integrated leadership we have developed plans to transform services, so that we can allow local providers to deliver these changes on the ground with our support. The work on integration will be part of this process.

1.2.6 Bold, innovative and supportive

General Practitioner (GP) Practices in Bury are grouped into sectors; they know their population well and therefore have an important role to play in meeting the unique and changing needs of local communities. The sectors are leading the commissioning of integrated care models in their locality. People don't look at health and social care as a set of services, organisations and teams; they see it as a journey; their journey from prevention, through to treatment and on to recovery. That is why we commission in that same way, along pathways. Working in this way helps us to remove duplication by reducing hand-offs between clinical teams, making the patient's journey as seamless as possible; it is also much more efficient and cost-effective to provide. This also means that we can design services to improve access and support providers, to develop innovative approaches to how they run their services. This will be important to ensure that the local NHS can continue to meet the rights set out in the NHS Constitution (2012) and will mean that services work better together, so that in partnership they can cope with changes in demand and growing system pressures. We know that seven-day working right across the system will be a key part of this. Taking a whole pathway approach in everything we do, also means that we can take a more holistic view of a person's wellbeing and have the opportunity to put prevention at the heart of service design, ensuring people get lifestyle support and signposting to support services, at every step of their journey. It also means that we can ensure that physical health and mental health are treated on an equal basis; delivering true parity of esteem for our population. New technologies, medicines and procedures have changed the way we can diagnose and treat people, which changes the way staff work. Whilst these are good for the population, they can increase the costs of providing care. To ensure that we can make the most of these improvements we must change the way we work to make funds available for reinvestment into new and emerging technologies.

Section 2 - Executive Summary

There is national recognition of increasing demand causing pressure on budgets for public services. In order to ensure that safe, sustainable services are available now and for future generations, changes will be required. The NHS and the Government announced the need for transformation to occur, by way of creating a single pooled budget to support health and social care, in the form of the Integrated Care agenda.

Representatives from across Bury have come together to form the Health & Wellbeing Board, to support and encourage partnership arrangements for health and social care services. A strategy has been produced, aiming to collaboratively meet the needs of the local population, using resources such as the Joint Strategic Needs Assessment (JSNA), which outlines five cross cutting local priorities. A partnership approach has been established to plan and deliver the changes required and a joint submission outlining the plans and the resources needed to support them called 'The Better Care Fund' was devised, to support the development of the Integrated Care agenda.

All plans have been developed taking the views of the public, patients and stakeholders into account and there is strong commitment to ensure local people are included in decisions, not only about the care being given, but also on the commissioning and delivery options for service provision.

Integrated care will include areas such as; prevention, promotion of wellness and self-care, early intervention, community based support programmes and extended primary care services for the population, delivered across the life course.

If the proposed integrated care model is to be a success, resources and demand must be redirected into the primary care, community based setting and away from the acute hospital, secondary care setting, wherever it is safe and appropriate to do so. The plan therefore is for the improved care provision in the community setting to bring about a reduction in the hospital setting by by 20% in urgent, 15% in elective care and 5% in both day cases and out patients appointments.

Bury CCG has developed a five year strategy with this focus, to facilitate the process of transformational change, while at the same time recognising that quality and safety must remain of the utmost importance. The CCG has also considered its role as a corporate organisation around; the risks, governance and implications of these changes, developing collaborative arrangements and partnerships, where necessary, to collectively manage the impact of change.

The Local Authority and the CCG are committed to further developing and strengthening the collaborative working agenda. The aim over the coming months and years is to align visions, strategies and processes, to achieve a one system approach to health and social care in Bury. It is understood that this will not be accomplished overnight or without difficulty, however the level of enthusiasm and determination within departments, to achieve the improvements required, will enable the challenges encountered to be overcome.

Section 3 - Context: About Bury

3.1 The Bury Population Profile

In the 2011 Census, the population of Bury was estimated to be 185,100. This is expected to rise to 199,300 by 2021.

Around 10.9% of Bury's population are from Black and Minority Ethnic (BME) communities.

The key headline regarding population changes is an ageing population. 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.

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.

3.2 Life Expectancy in Bury

Life expectancy in the borough is still 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 1 shows that for females, mental and behavioural disorders cause the greatest number of excess deaths (111), followed by respiratory diseases (106 combined) then circulatory diseases (63 combined). For males circulatory diseases cause the greatest number of excess deaths (83 combined), followed by cancer (45 combined), then respiratory diseases (37 combined). Lifestyle factors such as smoking, levels of physical activity, and healthy eating, greatly affect the risk of developing all of these conditions.

Table 1

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

Four themes are consistent throughout the JSNA, which still hold true in light of more up to date information:

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

Section 3 - Context: About Bury

- 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 the demand on services, increasing inequalities and will result in higher levels of ill-health and lower levels of wellbeing.

3.3 Local People Lifestyle

Liver disease in the UK is the fifth biggest cause of death in England and Wales, after heart disease, cancer, stroke and respiratory disease. The rate of death in all these major causes of death is reducing in the UK, except for one - liver disease. A total of 16,087 people died from liver disease in 2008 and if the rate continues at its current pace, deaths from liver disease are predicted to double in the next 20 years.

UK under 65 standard death rate for various diseases (1970 = 100%)

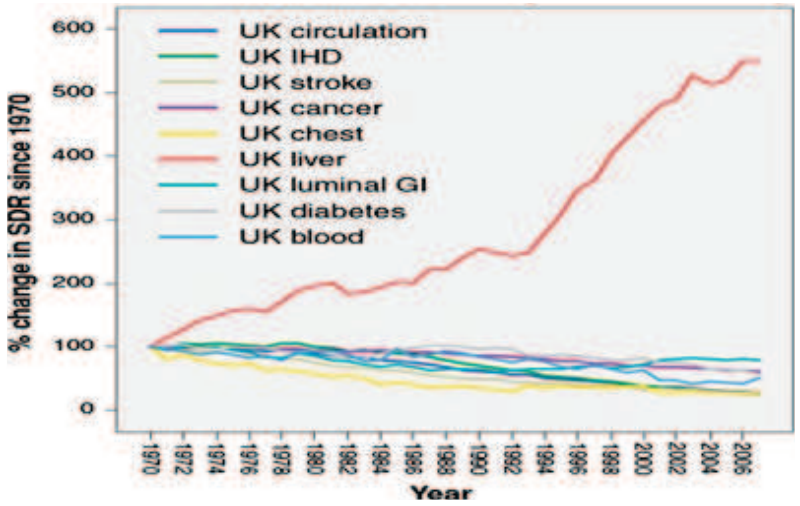


Figure 2 - Under 65 Standard Death Rates

Alcohol-related death rates, United Kingdom, registered in 2002-2012

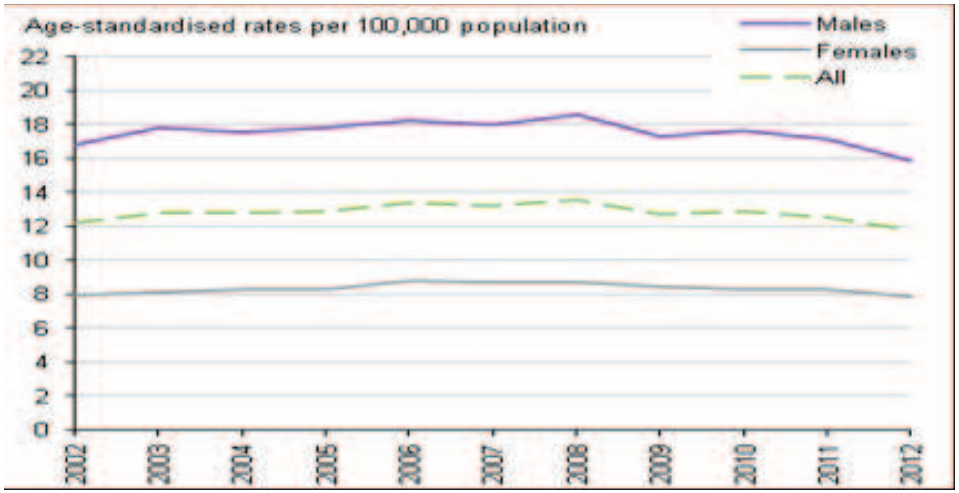


Figure 3 – Alcohol Related Death Rates

- In 2012 there were 8,367 alcohol-related deaths in the UK, 381 fewer than in 2011 (8,748).
- Males accounted for approximately 65% of all alcohol-related deaths in the UK in 2012.
- Death rates were highest among men aged 60 to 64 years (42.6 deaths per 100,000 population) and women aged 55 to 59 years (22.2 deaths per 100,000).
- Of the four UK constituent countries, only in Scotland were male and female death rates in 2012 significantly lower than in 2002.
- In England and Wales, 63% of all alcohol-related deaths in 2012 were caused by alcoholic liver disease, with 16% of these deaths occurring among those aged 55 to 59 years.
- In England, alcohol-related death rates were highest among regions in the North and lowest amongst those in the South throughout the period 2002–2012.

Section 3 - Context: About Bury

Research by the Association of Public Health Observatories has demonstrated the prevalence of alcohol-specific and alcohol-attributable hospital admissions increases with higher levels of deprivation. At a ward level the highest rates of admissions are indeed present in more deprived areas of the Borough, ranging from 32.0 per 1000 population in Moorside and 30.1 in East, to just 12.6 in Sedgley. Of great concern however is the synthetic estimate of the prevalence of binge drinking (intake of more than twice the daily recommended limit), developed by the North West Public Health Observatory. This suggests that the rate in Bury is in excess of national, regional and all comparators, with the exception of Stockton-on-Tees. Engaging in binge drinking is linked to accidental injury as well as the higher levels of A&E attendance observed during night time economy hours. Regular binge drinking can lead to significant health consequences, including liver damage, cancers, heart disease, diabetes and obesity. The Bury Health Survey 2010, found a significant association between BMI scores over 24.9 and drinking above sensible levels.

Many of the leading causes of death and ill health are preventable. A focus on healthy lifestyles is critical in increasing life expectancy and narrowing the inequalities gap, both locally and nationally. Smoking related deaths in Bury are significantly higher than the England average[1] Smoking levels are 22% in adults, which is higher than the England average of 20%[2]. In Bury, over half of the adult population is overweight or obese[3] and there are indications that this trend is being replicated in children with rising levels of obesity, according to the National Child Measurement Programme[4]. Levels of physical activity are low in adults in Bury[5] and alcohol related harm is higher than the England average[6]. The rates of new STI diagnoses in Bury have declined between 2012 and 2013 from 703.5 per to 648.8 per 100,000 population[7]. Unhealthy lifestyles are risk factors in the development of long term conditions and the burden of ill-health associated with them. Ensuring we have joined-up services, focused on addressing the needs of the customer, and the promotion of self-care will be critical.

Despite falling rates of teenage pregnancy, levels in Bury are still worse than the England average. In Bury, there are increases in both terminations and repeat terminations for conceptions amongst the under 18s[8]. Breastfeeding rates are below the national average and there is significant drop off between initiation and breastfeeding at 6-8 weeks[9].

Smoking in pregnancy is a key factor in low birth weight and infant mortality. Local levels of smoking in pregnancy are high at 16.6%, compared to the England average of 13%[10]. Giving children the best start in life is essential to their future social, health and economic outcomes right across life.

Bury's educational results remain significantly higher than the England average[11]. However there are educational attainment gaps between ethnicities. Those on free school meals and looked after children also experience lower attainment levels than the wider population.

Education has an impact on employment and wider wellbeing issues throughout life. Bury has an unemployment rate consistently below the regional average, but there are small areas that fall into the most deprived for employment nationally, particularly Chesham Fold and Coronation Road. Disadvantaged groups are likely to require greater support to help them into work.

[1] http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1215589013908

[2,6,9,10,11] Public Health England, 2012, Bury Health Profile

[3] NHS Bury, 2010, Bury Health Survey, Public Health Department

[4] Health and Social Care Information Centre, 2012, National Child Measurement Programme – England 2011/12

[5] NHS Bury, 2010, Bury Health Survey, Public Health Department

[7] NHS Bury 2012, Bury Sexual Health Strategy 2012 – 2015, Public Health Department

[8] Bury Council 2013, Teenage Pregnancy and Repeat Abortions In Depth Needs Assessment

Section 3 - Context: About Bury

Bury has high rates of unplanned admissions for:

- Asthma, Diabetes and Epilepsy in under 19s
- Acute conditions that should not usually require hospital admission
- Alcohol related liver disease
- Children with lower respiratory tract infections

- than similar CCGs and the England average.

3.4 Assessment Commissioning for Value Tool:

NHS England provided CCGs with a Commissioning for Value pack which identified areas for further local consideration. The areas below were identified for Bury CCG:

- The programme areas that appear to offer the greatest opportunity in terms of both quality and spending are: Circulation Problems (CVD), Respiratory, Cancer, Mental Health, Endocrine, Nutritional and Metabolic.

- The programme areas that appear to offer the greatest opportunity for quality-related improvements are: Circulation Problems (CVD), Respiratory System Problems, Cancer & Tumours, Mental Health Problems and Endocrine, Nutritional and Metabolic Problems.

- The programme areas that appear to offer the greatest opportunity for financial savings are: Circulation Problems (CVD), Cancer & Tumours, Musculoskeletal System Problems, Endocrine, Nutritional and Metabolic Problems and Genitourinary.

The CCG needs to balance the need to improve quality and reduce spend with the feasibility of making the improvements in the identified areas.

3.5 Health Care Provision in Bury

Health Care for Bury patients is made up of community and primary care, secondary acute (hospital) care, tertiary care (specialist hospital services), the ambulance trust, mental health and independent and third sector providers (such as Spire Hospitals).

Figure 4 summarises NHS Bury Clinical Commissioning Group providers and the current proportionate investment into the relevant provider services.

Provider Landscape

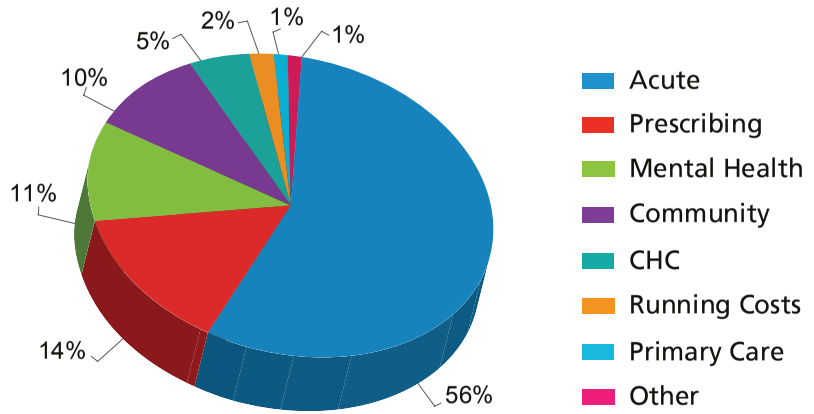


Figure 4 - Provider Landscape

The majority of our secondary care activity (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.

Section 3 - Context: About Bury

Care UK commenced in February 2009 providing services from mobile clinical units, which visit sites in Bolton, Denton, Longsight, Oldham, Rochdale, Salford and Trafford. The Clinical Assessment and Treatment Service, also known as CATS, provide a full clinical assessment of patients and subsequent treatment, or onward referral to secondary (hospital) care where this is indicated. Five specialties are provided, these are: general surgery, ear, nose and throat, musculoskeletal (muscles and bones), gynaecology and urology. The contract provides for an average of 85,000 referrals every year.

In addition, local independent sector providers are available as a choice for patients through Choose and Book (an electronic booking system), as an alternative to traditional secondary care (hospital) providers.

Figure 5 shows the split of provider on the basis of patient choice for their first booking.

Choice by Provider

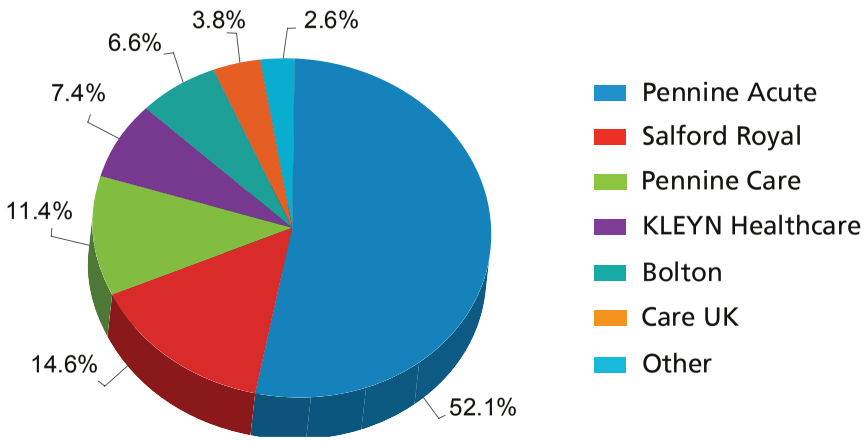


Figure 5 - Patient Choice by Provider

Pennine Care NHS Foundation Trust is the main provider of inpatient and community services for NHS Bury Clinical Commissioning Group's population. Primary care based mental health services have seen substantial expansion and investment in recent years, through the all age Improving Access to Psychological Therapies (IAPT) service.

There are 33 GP practices in Bury and 30 of these practices recently federated to form a GP federation. The NHS Commissioning Board (NHSCB) is responsible for commissioning primary care services i.e.

- Primary medical service commissioning i.e. GP services
- Primary dental service commissioning
- Pharmaceutical service commissioning, and
- Ophthalmic (optician) service commissioning

Whilst CCGs no longer directly commission primary care services, we have a statutory responsibility to support the NHSCB to improve the quality of primary medical care.

NHS Bury Clinical Commissioning Group commissions community services from Pennine Care Foundation Trust.

The future service model for integrated care in Bury requires wider development of integrated community based alternatives to hospital admission and a greater emphasis on health promotion, social wellbeing and disease prevention, for both physical and mental ill health. This will support people in making the lifestyle changes necessary to reduce future levels of chronic disease and ill health and where appropriate, enable people to manage their own conditions. This model will require a more integrated, multi-disciplinary team approach with greater specialisation in the primary, community and social care workforce. This will require providers to work together in integrated teams.

Section 3 - Context: About Bury

In Bury a small number of independent and Third Sector providers are currently commissioned across a wide range of services for all ages of the population. Some examples of this include: the advocacy provider (MIND) which offers advocacy services for community clients and inpatients, and Macintyre Care, which provides 24-hour intensive support to highly complex learning disability clients in their own homes.

Commissioning from the Third Sector is essential to ensure a full breadth of services is available. However, many Third Sector organisations are small and do not have the processes and procedures in place to work within the contractual frameworks required from commissioned services. Bury CCG and the Local Authority are already working with Bury Third Sector Development Agency (B3SDA) to empower local Third Sector services.

3.6 Summary of the review of the current position in Bury

The following summarises the findings from the analysis of demographic indicators, population health status, health needs, outcomes and lifestyle:

- Health outcomes in Bury are poorer than nationally and in some cases than the North West. Lifestyle factors are a major contributor to this, as are the needs of people requiring support to take responsibility for their health. Prevalence is in line with North West average but outcomes in some areas are worse.
- The ethnic profile of Bury is changing with the most rapid growth in the Pakistani community.
- The diseases which cause the highest mortality in Bury are
  - Circulatory Disease (CVD)
  - Stroke
  - Respiratory Disease
  - Cancer
  - Alcohol Related Liver Disease
- Cancer treatment and access rates for screening are overall good, but there are groups who do not know how to access services and this may affect their outcomes.
- Lifestyle choices are a major cause of poor health and health inequalities in Bury.
- Equality Target Groups are not consistently accessing available services and targeted community development work must be undertaken to improve this.
- Alcohol misuse is becoming a significant health issue for the population of Bury.
- Prevalence of hypertension will increase significantly as recording improves, this will have an impact on prescribing costs.
- Mental health issues need to be detected early and supported to reduce worklessness.
- The ageing population will have a significant impact on the utilisation of health services and therefore prevention of ill health and enabling care to be provided at home needs to be a significant focus.
- A focus on performance must be sustained to improve and to ensure patients experience is positive.

Section 4 - Context: Drivers for Transformation

4.1 National Drivers

- **Economic Position and the need to focus on Quality**
  In 2013, NHS England reflected on the 65 year success of the NHS and also the challenges that currently face NHS organisations, due to pressures that threaten to overwhelm the system in the future. The population in England is ageing, which brings a significant rise in the number of people with long term conditions, such as diabetes and heart disease, increasing the demand on services and raising costs. In order to ensure that the NHS can continue to meet the increased demands on its services, NHS England recognises things must be done differently and a new approach to health care must be taken in the future.

Figure 6 – NHS England Mission - http://www.england.nhs.uk/about/imp-our-mission/

In April 2013, NHS Improving Quality (NHS IQ) was established and is the driving force for improvement across the NHS in England. Working to improve health outcomes for people, providing improvement and change by bringing together expertise and experience from across the NHS, working to the five domains of the NHS Outcomes Framework.

There is a requirement for CCGs to focus on both quality and safety, particularly responding to the Francis, Winterbourne View, Keogh and Berwick reports, acting on recommendations and ensuring assurance processes are in place.

- **The NHS Constitution** contains details of what staff, patients and the public can expect from the National Health Service. It sets out rights and pledges, for patients, public and staff, which the NHS is committed to achieve. It also outlines the responsibilities of the public, patients and staff, to ensure resources are used responsibly and help the NHS to work effectively.

- **National direction for Integrated Health & Social Care, Partnership Approach / Care Bill**
  The Government announced in the June 2013 Spending Round, there was to be a transformation in integrated health and social care. This change creates a single pooled budget, to support health and social care services to work more closely together in local areas and is called the Better Care Fund (BCF).The Integrated Care agenda, not only brings together NHS and Local Government resources, but also provides a real opportunity to improve services and value for money, protecting and improving social care services by shifting resources from acute services into community and preventative settings.The national vision to deliver change is to be developed locally by Clinical Commissioning Groups, Local Authorities, Health and Wellbeing Boards and other partners working together with patients and the public, to identify local needs and form a five year strategic plan, which will drive

Section 4 - Context: Drivers for Transformation

change and create high quality sustainable health and social care services, to meet the needs of the local population.

- **Parity of Esteem**
  NHS England has prioritised improving services for people of all ages with mental health conditions, valuing mental health equally with physical health. A Parity of Esteem Programme has been developed in order to focus effort and resources on improving clinical services and health outcomes in this field. Three areas have been identified as initial priorities for urgent focus, for which, a system wide approach is required in order to deliver real progress. These are:

  Improving diagnosis and support for people with Dementia – with a national ambition of two thirds of people with dementia receiving a formal diagnosis and accessing care and support by the end of March 2015.

  Improving Access to Psychological Therapies (IAPT) – with a national ambition for at least 15% of those with anxiety or depression having access to clinically proven talking therapy services and that those services will achieve 50% recovery rates by the end of March 2015.

  Improving awareness and focus on the duties within the Mental Capacity Act – concerns have been raised that there is a low level of appreciation of the duties and expectations under this legislation which spans across patient groups.

- **A Call to Action**
  A national 'Call to Action' was created, to engage staff, stakeholders, patients and the public, in the process of designing an NHS that serves current and future generations. It created the opportunity for the public, NHS users and staff to debate the big issues and give a voice to all who care about the future of the NHS. Many health groups such as GPs, Pharmacies and Health Visitors were given the opportunity to engage in the broadest, deepest and most meaningful public discussion the NHS has ever undertaken.

Section 4 - Context: Drivers for Transformation

4.2 Greater Manchester Drivers

4.2.1 Reform of Acute Hospitals across Greater Manchester

It is widely recognised that the different parts of the health and social care system are inter-dependent, and that major changes to services in the community are required before significant hospital changes can take place. The wider Healthier Together programme brings together the locality programmes developing Community-based Care (Integrated Care and Primary Care) with the reform of "In Hospital" Care across Greater Manchester for the "in-scope" services (these are: Urgent, Acute and Emergency Medicine; General Surgery; and Women and Children's services).

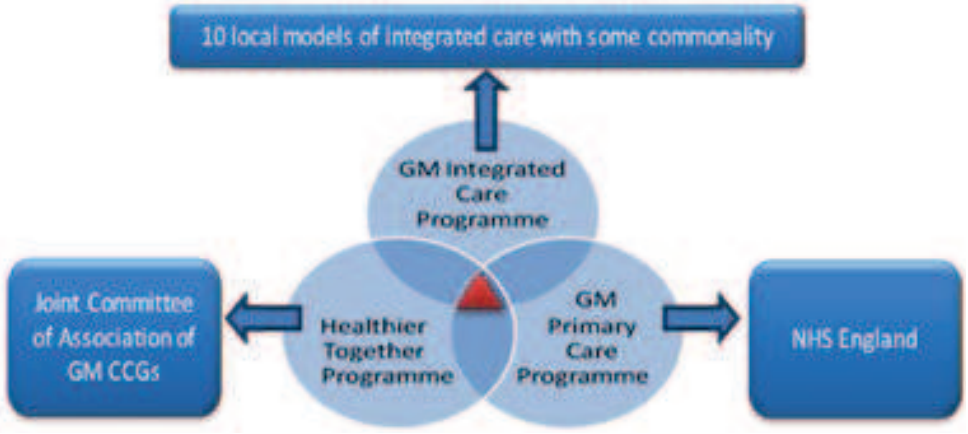


Figure 7 – Greater Manchester Reform

The way hospital services in Greater Manchester have evolved and are currently organised, with a hospital in each borough providing a similar broad range of services, was designed to meet the needs of the last century. It is clear that this is not suited to the way in which a broad range of individuals require care. Many of the excellent developments we have seen have arisen from local interest rather than from strategic planning. This has led to variations in the range and quality of services available in different areas, resulting in inequality of access to services in different areas. For example, the mortality of patients who undergo Emergency General Surgery varies from **23.1** to **51.7per** 1,000 spells across Greater Manchester, depending on where people are treated. This needs to change, with everyone entitled to the best outcome wherever they live, and yet we have a limited number of specialist clinicians, rising demand and serious financial pressures. An analysis by Mott McDonald has forecast the financial gap between expected activity in acute trusts and available funding across Greater Manchester over the next 5 years at £742 million, with a further £333 million gap in social care funding – a total system-wide pressure of over £1 billion. Doing nothing is not an option. Work on determining the figures for each locality will be completed in February 2014. As more people receive appropriate treatment at home or in the community, those patients that do need to be admitted into hospital, especially in an emergency, are likely to have more complex needs. They are most in need of very specialist care and being assessed by a senior doctor will improve their chances of recovery. Senior doctors are not available in all specialities on site 24 hours a day, 7 days a week due to the large spread of services across Greater Manchester. This means that Greater Manchester has an inequity of provision out of hours and at weekends often leading to poorer outcomes for patients.

Section 4 - Context: Drivers for Transformation

4.3 Local Drivers

4.3.1 Health and Wellbeing strategy priorities

The Bury Joint Health and Wellbeing Strategy has been developed creating a five-year vision for improving health and wellbeing in the borough, based on a range of information about health and wellbeing from a wide variety of sources, including the Joint Strategic Needs Assessment (JSNA). It identifies five cross-cutting local priorities:

Priority 1 - Ensuring a positive start to life for children, young people and families.
Priority 2 - Encouraging healthy lifestyle and behaviours in all actions and activities.
Priority 3 - Helping to build strong communities, wellbeing and mental health.
Priority 4 - Promoting independence of people living with long term conditions and their carers.
Priority 5 - Supporting older people to be safe, independent and well.

4.3.2 Children's Trust Priorities

The Bury Children and Young People's Plan sets out how the partners within the Children's Trust will work together towards agreed priorities and what is hoped to be achieved. The starting point is a shared desire to ensure that all children and young people in Bury should be the best that they can be. The Plan focuses on a small number of priorities, whereby partners working together are able to make progress and meeting these priorities is of fundamental importance. The priorities are:

Priority 1 - To improve the lives of families with multiple needs
Priority 2 - Ensure that all children and young people experience parenting that keeps them safe, healthy and ready to learn
Priority 3 - Ensure that all young people make a successful transition to adulthood.

4.3.3 Public Service Reform

The Public Service Reform (PSR) is a key strategic aim of the draft Greater Manchester Strategy (2013-2020) and forms part of the wider Greater Manchester PSR programme. The vision for Bury is to lead, shape and maintain a prosperous, sustainable Bury that is fit for the future.

The objectives of the Bury PSR programme are:
- To ensure that residents in the borough can benefit from future economic growth, by designing services that can better support them to make positive choices and be independent

and
- To meet the challenge of public sector austerity by reforming services collectively, such that outcomes for residents in the borough are better than they would have been, had reforms been undertaken solely by agencies acting alone

Team Bury Partners are committed at the highest level to meet these objectives for the people in Bury, through a collective PSR programme.

The PSR Programme is the means by which Team Bury and Bury Wider Leadership Group will ensure that this vision becomes a reality. It will form one of the primary strands of work undertaken by the Corporate and Adult Care Services Directorate.

Section 5 - Context: How we Commission

5.1 Commissioning with the Local Authority

5.1.1 Governance

In Bury we have collaborated through the Health and Wellbeing Board to produce a strategy with a clear vision and five agreed joint priorities, which are outlined in section 4.3.1.

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. 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. Several groups have also been established to enable the development of our plans this includes a Learning Disability Partnership Board. This Board makes sure that we have the right support in Bury to help people achieve the life they want. Members of the Board include people with learning disabilities, carers of people with learning disabilities, people who work for Bury Council, people who work for NHS Bury and people who provide services.

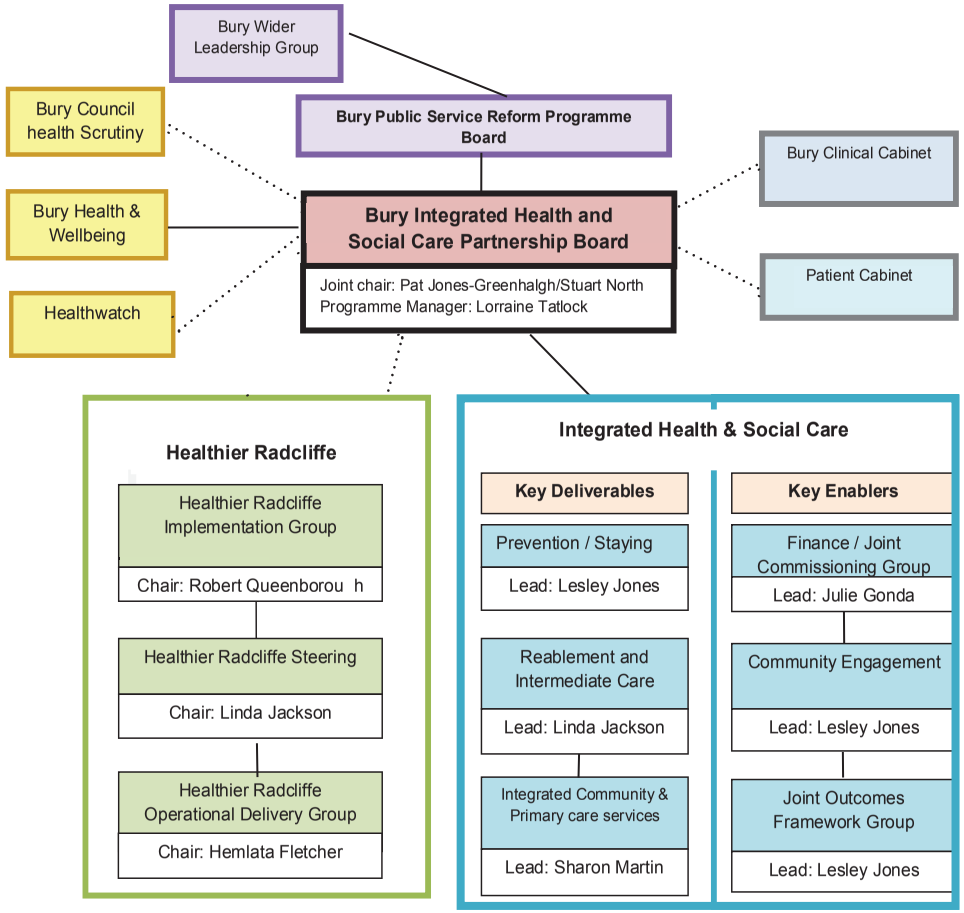


Figure 8 - The Bury Integrated Health and Social Care Governance and project structure

Section 5 - Context: How we Commission

5.1.2 The Integrated Health and Social Care Partnership Board

The Integrated Health and Social Care Partnership Board, oversee the progress and outcomes for the work on integrating 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 (CCG). The Partnership Board strategically leads the 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. The Bury Integrated Health and Social Care Governance and project structure is shown in figure 7 and further identifies the various work streams relating to the key deliverables and enablers as identified below. This governance structure is subject to review in June 2014 in line with the progression of the integration agenda in Bury.

5.2 Commissioning in Partnership with North East Sector CCGs

The CCGs in the North East Sector of Greater Manchester include:

- Bury
- Heywood, Middleton and Rochdale
- North Manchester, and
- Oldham

Together, the North East Sector CCGs have established a partnership, underpinned by a formal agreement. This formal agreement builds on the previously established arrangements in the North East Sector, with the aim of implementing a partnership approach to the commissioning of secondary care (hospital) services where this makes sense. A joint Commissioning Board has been established, which has authority to make decisions in the best interests of CCGs across the North East Sector - staff are working collaboratively across the sector to cover collective agendas e.g. performance improvement.
The North East Sector Commissioning Board has the responsibility to:

- Review, plan, procure and performance monitor agreed services to meet the health needs of Members' populations as follows:
  i. Acute (hospital) services, (particularly the contract with Pennine Acute Hospitals NHS Trust)
  ii. Mental health services
  iii. Community services
  iv. Cancer services
- To undertake reviews of services, manage the introduction of new services, drugs and technologies and oversee the implementation of NICE (National Institute for Health and Clinical Excellence) and/or other National guidance or standards relating to the services being collaboratively commissioned.

Section 5 - Context: How we Commission

- To co-ordinate a common approach to the commissioning of services from the defined providers, with a particular focus on the financial viability.
- To manage the budget for commissioning the agreed services, be held accountable for its use, and develop financial risk sharing arrangements.
- To develop, negotiate, agree, maintain and monitor service level agreements/ contracts for collaboratively commissioned providers.
- To work in partnership with other commissioners across Greater Manchester and the North West, and act as lead commissioner where agreed.

Principles upon which the Commissioning Board is based include:

- The Commissioning Board will support member CCGs in working to achieve financial stability, by effective collaborative commissioning of major contracts.
- The Commissioning Board will support Member CCGs in striving to reduce the inequalities in access to, and delivery of services for the populations the Member CCGs served through the effective negotiation of borough level schedules.
- Commitments made by the Commissioning Board will be binding on all Members.
- In commissioning and procuring services, the Commissioning Board will support member organisations to comply with all applicable statutory duties.
- The Commissioning Board will review, plan, develop and monitor the agreed services in partnership with clinicians, providers and service users.
- The Commissioning Board will maintain close working links with service providers, clinical networks and other commissioners or commissioning groups, fora and partnerships.
- A standard facilitation/arbitration procedure will apply should disputes between Members arise.

The North East Sector Commissioning Board (CB) is the body mandated by the four North East Sector CCGs as set out in the North East Sector Partnership Agreement. Delivery at a North East Sector Level is underpinned by two work streams

- **Programme Level Development Boards (DB)** with a focus on the development and implementation of new projects and work streams, to improve health outcomes and/or the efficiency of delivering those outcomes.
- **Operations and contracting** with a focus on contract, quality and performance monitoring and taking action to address performance issues will become the responsibility of this group.

Section 5 - Context: How we Commission

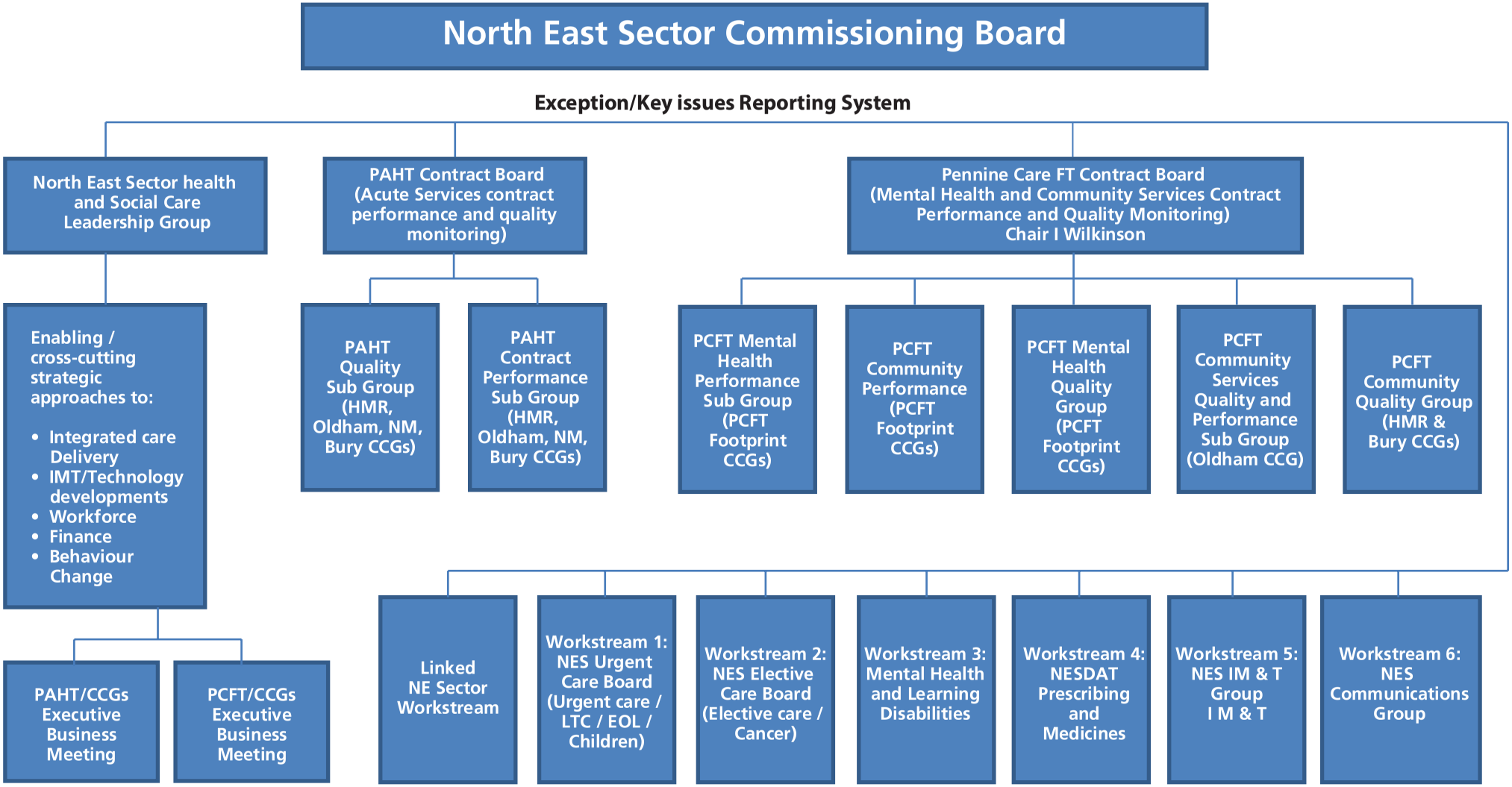


Figure 9 - North East Sector Structure

Section 5 - Context: How we Commission

Strategic Transformation

The priority work stream for 2013/14 has been the management of the economic challenges across the North East Sector Health and Social care economy over the next 5 years. To this end, a North East Sector Health and Social Care Board has been established, accountable to the North East Sector Commissioning Board.

The shift away from hospital based care, and the development of primary, community and social care, will lead to a reduction in bed utilisation by avoided admissions and a reduced length of stay for some patients. We recognise that whilst activity will decrease, the average length of stay for some patients may possibly increase, as the acute sector deals with a more complex patient spectrum. This will need careful modelling to determine appropriate bed configuration and income / expenditure analysis for the PAHT in particular, linked also to the plans the Trust has for service reconfiguration, to ensure financial viability. PAHT is developing its 5-year Business Plan to move to Foundation Trust Status. For the past 12 months the North East Sector CCGs have been working together with PAHT and the Trust Development Agency, to ensure all known activity assumptions around the Healthier Together, Integrated Care, Primary Care and QIPP schemes are reflected in this plan. To this end, the CCG's have jointly funded 2 roles to support a joint modelling of impact across the sector.

A series of strategic financial planning assumptions have been agreed with key partners across Health and Social Care. These reflect the activity shift assumptions expected to be delivered through the above programmes over the 5-year period. The plans acknowledge that reinvestment will be required in the community and other services to secure reductions in hospital capacity. The timing and level of investments required (recurrent, non-recurrent and transition costs) will be driven by the pace of change of the Greater Manchester and Borough wide programmes.

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 support the out of hospital agenda, whilst ensuring that PAHT is economically viable.

The financial plans and business cases for the Better Care Fund have been developed at Borough level in the context of the anticipated financial position for the 4 Councils and the Clinical Commissioning Groups over the next five years. The health and care sector challenges have been widely communicated across the North East Sector, and the significant task of reducing and managing the CCGs and Councils financial pressures, together with delivery of Pennine Acute and Pennine Care Cost Improvement Programmes, is being addressed through a variety of inter-dependent programmes, including monthly business meeting with PCFT and PAHT at a Director level.

Plans for year one reduction have been built into the PAHT contract for 2014/15 - the Trust has plans to reduce its capacity accordingly. The CCGs 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.

5.3 Commissioning in Partnership with Specialist Commissioners

The Cheshire Warrington and Wirral Area Team commission specialist services for 3 sub-regions (Greater Manchester, Lancashire and Cheshire & Merseyside). Each area has a dedicated Local Project Team. It is responsible for:

- Informing and supporting the development of the Greater Manchester contribution to the North West Specialised Service 5 Year Strategic Plan, in line with nationally prescribed timescales.

Section 5 - Context: How we Commission

- Framing its contribution within the context of improving outcomes for patients and achieving best value for money from specialised commissioning resources.
- Identifying priorities for action.
- Reporting to the North West Specialised Services Programme Board, which is accountable for development and delivery of the Strategic North West Specialised Services Plan.

We are currently working with specialist commissioners on the five year strategic plan, which will be published in autumn 2014, to develop, align and co-ordinate the Greater Manchester contribution to the North West Specialised Services 5 Year Strategic Plan through:

- Modelling impact of any changes and aligning with other system change
- Provider Management and Financial viability
- Prioritisation
- Communication and engagement

Strategic Clinical Networks (SCNs)

Bury CCG is part of the Greater Manchester Lancashire and Cumbria Strategic Clinical Network. Strategic Clinical Networks work in partnership with commissioners (including local government), supporting their decision making and strategic planning, by working across the boundaries of commissioner, provider and voluntary organisations, as a vehicle for improvement for patients, carers and the public. In this way, SCNs will:

- Reduce unwarranted variation in health and well-being services
- Encourage innovation in how services are provided now and in the future
- Provide clinical advice and leadership to support their decision making and strategic planning

SCNs focus on priority areas: Cancer, Cardiovascular (including Diabetes, Renal and Stroke), Maternity and Young People and Mental health (including Learning disabilities), Dementia and Neurological Conditions. Threaded through these areas are spreading good practice; advancing equality and tackling health inequalities; palliative and end of life care; patients, carers and public engagement

The work programmes for the next five years are:

- Improving mental & physical well being
  - Parity of esteem for people with mental health problems
  - Reducing premature death for people with learning disabilities
  - Unacceptable variation in maternity & children's services
- Improving pathway programme: prevention, early identification & diagnosis
  - Reduction in perinatal mortality
  - Cancer prevention, awareness & early detection programme
- Improving pathway programme: treatment & recovery
  - Improving treatment for people with neurological conditions
  - CAMHS early intervention, transition & integrated pathways
  - Improve pathways in maternity & children's services (including reconfiguration)
  - Treatment/acute care provision for cancer
  - Improving cardiology services to enable 24/7 working
  - Review & optimisation of stroke services
  - Vascular services review
  - Improving renal services
- Improving pathway programme: living with & beyond the condition
  - Cancer survivorship and patient/carer involvement
  - Improving services for people with diabetes
  - Improving life for people with dementia
- Improving pathways programme: palliative care & end of life
  - Increasing expected deaths in usual place of residence

Section 5 - Context: How we Commission

5.4 Commissioning in Partnership with Greater Manchester CCGs

5.4.1 Collaborative Commissioning

The 12 Clinical Commissioning Groups in Greater Manchester have developed arrangements to enable them to work together on matters of mutual benefit. There are a number of reasons for this:

- To support each other through lead commissioning arrangements for some specialised areas such as stroke, cancer, mental health, military veterans.
- The need for CCGs to collaborate to be, an effective single "voice" for CCGs in their relationship with Providers.
- Ensure governance arrangements for strategic change programmes e.g. Making it Better and Healthier Together, which allow and ensure mutual accountability between CCGs, when one leads on behalf of all on a particular issue.
- Maximise the benefits in adopting as far as possible, the same policies and procedures e.g. NICE guidance.
- Represent the views of the 12 CCGs collectively to other agencies and processes e.g. The Local Area Team (LAT), Association of Greater Manchester Authorities (AGMA).
- To support CCGs in sharing information and good practice and offering each other support when necessary and possible.
- To provide a focus for the development and reporting of joint work across the CCGs and reducing unnecessary duplication of effort.
- To provide a properly constituted forum for issues, where CCGs consider it beneficial to their own objectives, to have a collective decision of the GM CCGs in the spirit of mutuality, or to address issues necessitating formal agreement by the GM CCGs.
- To provide a basis for Collaborative Commissioning between CCGs in Greater Manchester consistent with the intentions of the Health and Social Care Act 2012.

5.4.2 Healthier Together

The Healthier Together programme is part of the Greater Manchester (GM) Programme for Health and Social Care (H&SC) Reform, which aims to provide the best health and care for Greater Manchester. It is the largest and most ambitious health and care reconfiguration programme in the country. Delivery of this programme will support the delivery of all of the mentioned transformation areas. The programme is responsible to the 12 Clinical Commissioning Groups across Greater Manchester, with the CCGs exercising our statutory responsibility for commissioning through a shared decision-making body, the Healthier Together Committees in Common (formally a sub-committee of each CCG).

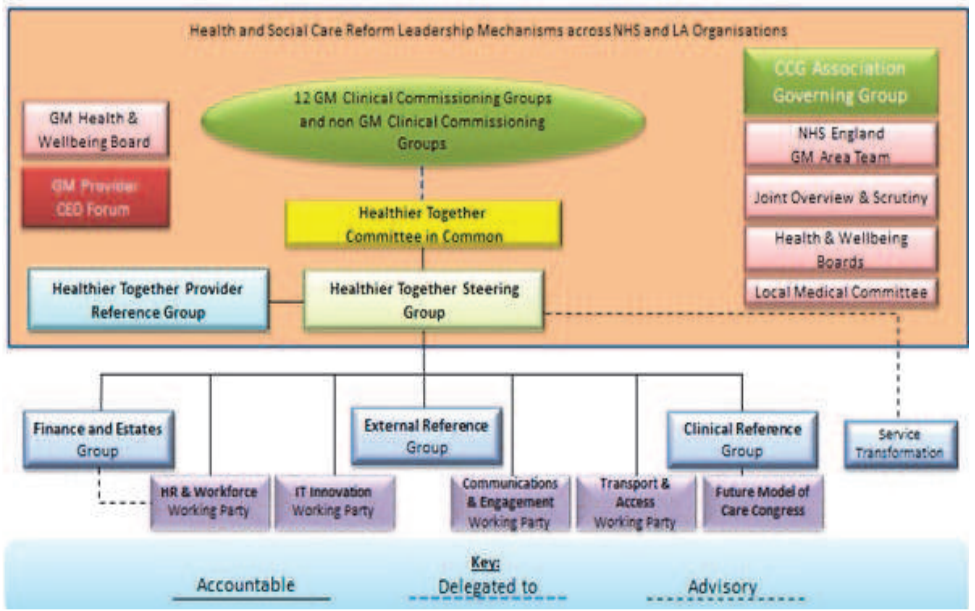


Figure 10 - Healthier Together

Section 5 - Context: How we Commission

5.4.3 Commissioning for the Armed Forces

Physical Health

- Members of the Armed Forces are typically younger and fitter than the general population. As such, there is low prevalence of long-term conditions but higher incidence of musculoskeletal injury. Combat-related injuries aside, Armed Forces healthcare needs can usually be met by standard NHS services. The greater investigation of the population, to meet occupational requirements, may give rise to asymptomatic but unmet health needs.
- The families and dependants of serving Armed Forces members have health needs typical of their age and gender. Maternity services and children's health services in particular must be planned and commissioned with the needs of military families in mind, where they are present in large numbers in a community.
- Members of the Armed Forces may also have specific Health needs that relate to their occupation or employment and have extensive occupational health support requirements.

Mental Health

- The ex-service population has comparable health to the general population and a broadly similar prevalence of mental health-related conditions.
- Current UK military personnel have higher rates of heavy drinking than the general population.
- The most common mental health issues experienced by ex-service personnel are alcohol misuse, depression and anxiety disorders. Military personnel with mental health problems are more likely to leave the armed forces and are at increased risk of adverse outcomes in post-service life.
- The minority who leave the military with psychiatric problems are at increased risk of social exclusion and on-going ill health.
- The overall rate of suicide is no higher than for the general UK population, with the exception of male veterans aged 24 or younger who are at increased risk compared to their general population counterparts.
- Early service leavers are more likely to have adverse outcomes and carry out risk taking behaviours than longer serving veterans.
- Deployment to Iraq or Afghanistan is associated with adverse mental health outcomes for some groups, particularly those with pre-service vulnerabilities, those who experience a high level of combat and reservists.

It is recognised that military personnel put themselves in harm's way in the service of their country, risking risk injury or death in the course of their duty. Successive governments have recognised the debt society owes to its Armed Forces, their families and veterans, and most recently Society's obligations were recently set out in the Armed Forces Covenant, a framework for the duty of care Britain owes its Armed Forces. In terms of healthcare, the key principle is that they experience no disadvantage in accessing timely, comprehensive and effective healthcare. They will also receive bespoke services in some agreed areas for their particular needs or combat-related conditions, including for instance, specialist limb prostheses and rehabilitation.
Bury CCG is the lead Armed Forces commissioner for Military Veterans services for the North West of England CCGs and works closely with NHSE to secure services in line with the covenant. This includes delivery of priorities as outlined in the plan on page (appendix 1) and commissioning a bespoke IAPTs service for Veterans.

Section 5 - Context: How we Commission

5.4.4 Ambulance Commissioning

Commissioning Intentions for the Paramedic Emergency Service (PES) have been produced by the lead commissioner, NHS Blackpool CCG, with the 33 CCGs in the North West (NW). The PES commissioning intentions document recognises the need for whole system transformation in order to move towards the healthcare system described by both the House of Commons Health Committee 'Urgent and Emergency Services' report (July 2013), and the Keogh 'Urgent and Emergency Care Review' (November 2013). Both reports describe PES as having a changed role within an enhanced system of urgent care; a role where conveyance to hospital will be one of a range of clinical options open to ambulance services and allow PES to become "mobile urgent treatment centres" (Keogh, 2013). One of these key required changes is to achieve a reduction in conveyance to hospital, and the PES contract for 2014/15 has been designed to encourage this by incentivising through CQUIN. This will allow the provider, North West Ambulance Service (NWAS), to build on the progress they have already made with commissioners over recent years; developing and implementing initiatives such as the Urgent Care Desk, Paramedic Pathfinder, Referral Schemes into Primary Care, Targeting Frequent Callers, and increasing the percentages of patients that are treated by 'See and Treat' and 'Hear and Treat'. All of these schemes support the achievement of 'Safe Care Closer to Home', which is a strategic goal of NWAS, as well as supporting our CCG plans for integration.

In Bury CCG, we have been engaging with NWAS, to understand their role in supporting extended access to primary care and integrated care teams, to manage patients with emergency and urgent care needs in their own home. This has included testing the Paramedic Pathfinder and GP Navigation Schemes. NWAS sits on the local Urgent Care Working Group / Board.

Bury CCG is actively engaged in Ambulance Commissioning and through Greater Manchester Coordinated Commissioner arrangements have a representative on the Strategic Partnership Board' (SPB), which maintains the strategic oversight of all county area reconfigurations, both at county and CCG level; acting as 'Change Management Board' and seeking assurance that county and local changes, translate into a North West level. A key element of the Ambulance Commissioning governance framework is the 'Clinical Development Group' (currently being refreshed to include NHS 111 to progress urgent care system transformation) and Greater Manchester has clinical and managerial representation on this group, which feeds directly into the local Urgent Care Network Board.

Arriva provide Patient Transport Services for Greater Manchester. The current service specification contains increased operating hours, and higher quality standards than the previous one. The service is provided for eligible patients. Planning for the next tender will begin during 2014/15, which will include reviewing the current service specification against new and emerging policy and guidance, such as 24/7 working. Bury CCG will engage in this process via the Greater Manchester Ambulance Commissioning Group.

Section 6 - Context: Engaging Providers in Service Transformation

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 Bury 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 (This is a joint Health and Social Care Commissioning Board Chaired by the Director of Adult Care Services and the CCG Chief Officer). The Bury 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. Some specific examples of our approach to demonstrate this are as follows:

6.1 Pennine Acute Hospital Trust (PAHT)

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 meets PAHT bi-weekly to work through the system impact of planned changes and to ensure their 5 year Integrated Business Plan includes all assumptions. CCG and PAHT Financial Analysts are working on an integrated finance plan at a Greater Manchester and North East Sector level. 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. 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.

6.2 Pennine Care Foundation Trust (PCFT)

The CCG commissions Mental Health and Community services from 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 Bury 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).

6.3 Primary Care

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.

6.4 Voluntary Sector

The CCG and Local Authority are committed to maximising the use of the Third Sector within the integrated care plan. 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 is currently planning 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.

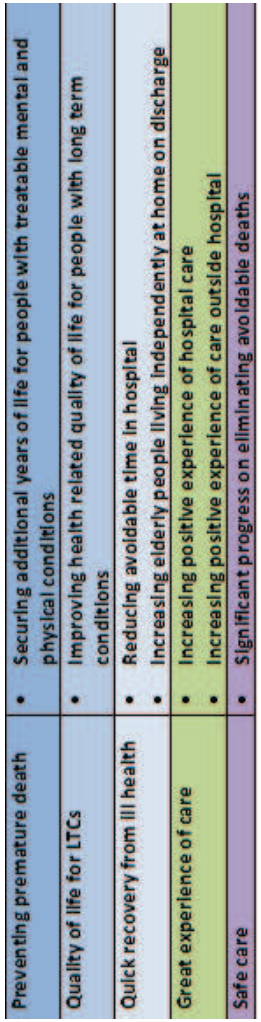
6.5 Local Authority

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 Healthier Radcliffe pilot. The initial outcomes from the 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 on-going 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. Adult Care Services engage 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.

Section 7 - The Vision for Bury

Vision

To continually improve Bury's health and wellbeing by listening to patients and the public, working together across boundaries to deliver a safe, sustainable, high quality health and social care system



Transformation schemes

Establish Collaborative Prevention, Wellness and Life Support Programmes

Living Well and Dying

Create an Integrated Community Based Care Programme

Ambitions delivered through interventions

- Delivery the Better Care Fund Integration Programme
- Engage in the Better Together Collaborative Programme
- Integrated Wellness Services
- Staying Well and Self Care Programmes
- Active Ageing, Falls Prevention and Affordable Warmth
- Immunization Programmes
- Mental Health and Learning Disability Support
- Extend GP Services via the GP Challenge Fund - 7 day Services
- Integrated Care Pathways
- Enhanced Therapy Services
- Enhanced Community Based Services for Diabetes, Respiratory, and Cardiac Patients

Streamline and Enhance Elective Care Service Provision

- Direct GP Referrals with direct access to diagnostics
- Improve access to Consultant led virtual clinics
- Develop an early supported discharge process
- Commission an Enhanced Recovery Programme
- Reduce unnecessary appointments

Future proofing Urgent Care Services in Bury

- Develop enhanced community based Urgent Care services
- Redirect appropriate Diabetes, Respiratory & Cardiac Services to Community
- Develop 111 Service
- Devise systems to inform and redirect the public

Enhancing Corporate Functionality

Commission for Quality

- Ensure Clinical and Public Engagement Programmes are Operational
- Implement strategies for Quality, Safeguarding, Equality and Diversity
- Procure OD, IMT, Estates, BI to facilitate all required work programmes

Governance arrangements:

- Weekly meetings between the Clinical work stream lead and service redesign manager.
- Monthly review of programme or project progress at CCG Clinical Cabinet Committee
- Monthly review of financial performance at the Audit Committee and Governing Body.
- Monthly review of performance issues at the Quality and Risk Committee
- Monthly review of the programme of Programmes jointly commissioned through the Better Care Fund through the Integrated Health and Social Care Partnership Board and the Director of Adult Care Services.
- Oversight and scrutiny of delivery through the Health and Wellbeing Board.

Measured using the following success criteria:

- Reduce the mortality Gap for patients with Dementia and Learning Disabilities
- Reducing mortality in CVD
- Reducing Alcohol attributable deaths
- Reducing deaths from COPD aged under 75
- Reduce Cancer deaths
- Reduce OP activity, EI & Non EI admissions

System values and principles:

- Reduce inequalities and improve outcomes
- Deliver transformational change
- Develop capability as commissioners and leaders
- Deliver improvements via QIPP to create high quality sustainable services
- Ensure citizenship, self-care and prevention is at the heart of what we do

Section 7 - The Vision for Bury

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 in 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 will influence how we commission and locate services too.

Vision to redirect care delivery over the coming five years in Bury

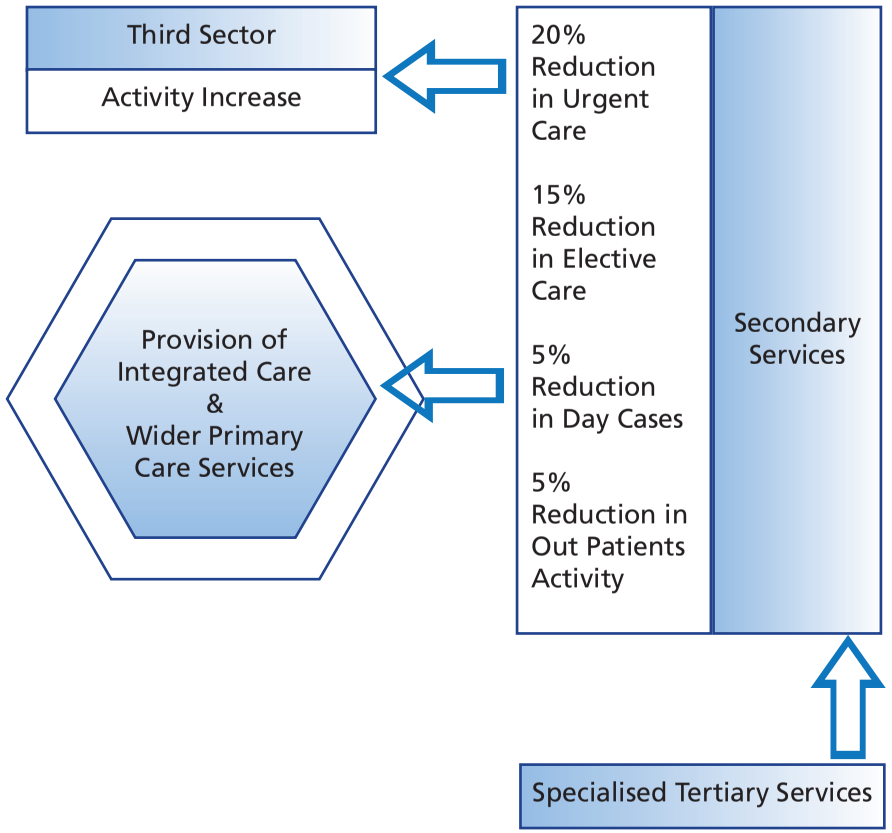


Figure 11 - Vision of Care Redirection in Bury

Section 7 - The Vision for Bury

7.1 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.

7.2 Primary Care

Primary care will continue to be the gatekeeper for patients' care. 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 continue to collaborate more effectively together in a more federated way.

7.3 Community and mental Health

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 the elderly 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.

7.4 Secondary care

Over the next 5 years we 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. Confidence from the local population in safe and effective care delivery will have been fully restored. Over the last 24 months, over twenty clinical congresses involving hundreds of clinicians have considered the issues facing our health system. They have explored the potential solutions to ensure services remain high quality, safe and cost effective for future generations. This work, which has been based on evidence and best practice from around the world has developed and contributed to this case for change. The proposals arising from these congresses are for services to 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

Section 7 - The Vision for Bury

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".

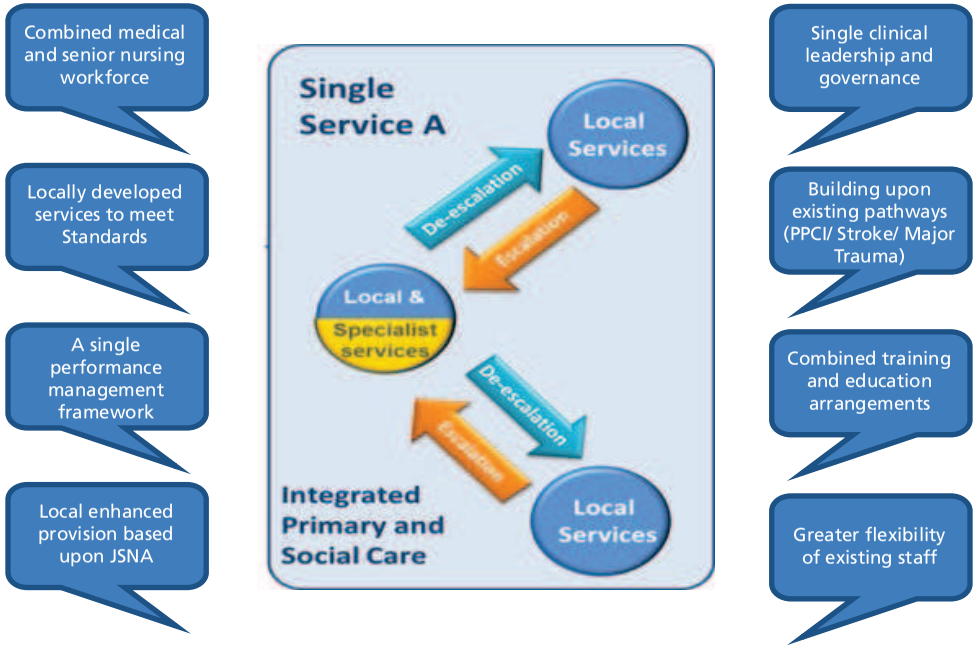


Figure 12 - Greater Manchester Proposal

The proposals to change hospital services will be subject to statutory public consultation, and must pass the requirements of the NHS Assurance process. Clinical assurance has already been secured for the model via the National Clinical Advisory Team (NCAT) – *"We unanimously support the Programme to proceed to Consultation. This is the most ambitious and well thought out work we have come across. We are highly impressed"*.

The determination of the viable options for consultation, are subject to a rigorous 9 stage process:

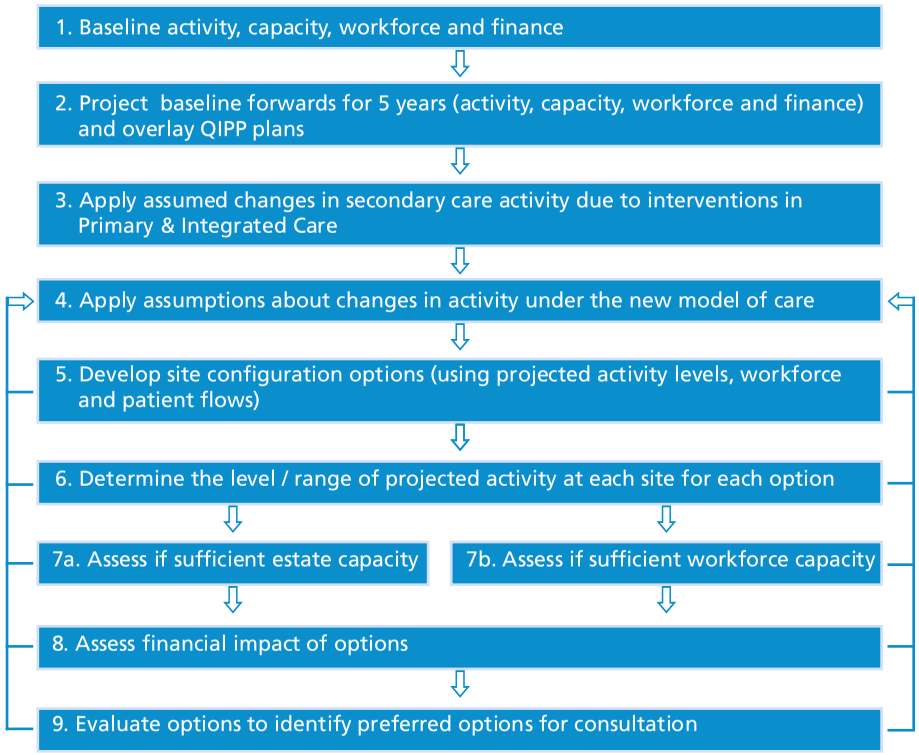


Figure 13 - 9 Stage Process

Section 7 - The Vision for Bury

Following extensive pre-consultation engagement, including with key partners such as the Association of Greater Manchester Authorities (AGMA), the Committees in Common of the CCGs will decide to proceed to consultation in June 2014. Subject to NHS Assurance, it is planned that formal consultation will take place in the summer of 2014, with a final decision at the end of 2014. There are considerable risks in a programme of this size and complexity, and given the proximity of a general election there is a possibility that the formal consultation and decision will need to be postponed until 2015 – this would clearly delay the programme and the delivery of the benefits expected to be realised.

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).

7.5 Social Care

We will continue to ensure integration with social care, both for children and older people. This will clearly focus on priority areas associated with the aging population (such as dementia and frail older people) and children and young people. There will be more integrated nursing and social care (e.g. short term intervention services and general domiciliary care) to support discharge from hospital and we will have drastically reduced delayed transfers of care. We will be jointly commissioning more services together (eg nursing and residential homes), for better value for money and market management and there will be more joint deployment of technology.

Section 8 - Our Ambitions and Goals

Section three of this document set out the context of health and needs in Bury. The NHS Outcomes framework describes five main Domains (categories) of better outcomes we want to see. NHS England has translated these outcomes into seven specific measurable Ambitions to be used by CCGs as indicators of success.

This gives rise to our Strategic Ambitions and Goals, which for the next 5 years are summarised in table 2:

Table 2

Domains	Ambitions	Outcomes Delivered By	Goals Set
1. Preventing premature death	1. Securing additional years of life for people with treatable mental and physical conditions	• Decreasing the potential years of life lost from causes considered amendable to healthcare • Decreasing the under 75 mortality rate from cancer, cardiovascular, respiratory and liver disease	PYLL (Rate per 100,000 population) Baseline 2660.5 to 2018/19 2261.2 3.2% applied year on year
2. Quality of life for LTCs	2. Improving health related quality of life for people with long term conditions	• Increasing the health-related quality of life for people with long term condition • Increasing the proportion of people feeling supported to manage their conditions • Reducing the unplanned hospitalisation for chronic ambulatory care conditions in adults and for asthma, diabetes and epilepsy in under 19's • Increasing the estimated diagnosis rate for people with dementia	Average EQ-5D score for people reporting having one or more long-term condition Baseline 70.4 to 2018/19 73.5 Aim to achieve the England rate by 16/17 The current England change rate of 0.2 applied each year thereafter. ii) Dementia % Diagnosis 2014/15 - 0.67 2015/16 - 0.68
3. Quick recovery from ill health	3. Reducing avoidable time in hospital 4. Increasing elderly people living independently at home on discharge (no CCG Measures set)	• Reducing the number of emergency admissions for acute conditions that should not usually require hospital admission • Reducing the number of emergency readmissions within 30 days of discharge from hospital • Increasing the total health gain as assessed by patients for both hip and knee replacements, groin hernia and varicose veins • Reducing the number of emergency admissions for children with Lower Respiratory Tract Infections	Emergency admissions composite indicator Baseline 2,874 2014/15 2,729 5% reduction 2015/16 2,298 15% reduction 2018/19 2,161 2% reduction year on year Activity Measures A&E Attendances - all types 15% reduction in first 2 years 2% for the years onward

Section 8 - Our Ambitions and Goals

4. Great experience of care	5. Increasing positive experience of care outside hospital	• Increasing the patient experience of primary (GP and Out of Hours)	The proportion of people reporting poor experience of GP and Out-of-Ours Services Baseline 6.2 to 2018/19 4.7 0.3 Reduction per year
	6. Increasing positive experience of hospital care	• Increasing the patient experience hospital care	The proportion of people reporting poor patient experience of inpatient care Baseline 115 to 2018/19 110 Reduction of 1 per year
		• Improving the findings of the Friends & Family Test for all relevant commissioned services	Do you plan to meet the nationally set objective for the Friends and Family Test in 2014-15 and 2015/16? - Yes
5. Safe care	7. Significant progress on eliminating avoidable deaths	• Reducing the incidence of healthcare associated infections in MRSA and C. Difficile	C. Difficile infection cases set at 63 for 14/15 as per National Directive for Bury MRSA Rate Set at 0 for 14/15

In addition NHS England has set out three further key measures:

Improving health – to ensure there is as much focus on health improvement as there is on treating illness by Commissioning for Prevention. The Bury Health & Wellbeing Board supports and encourages partnership arrangements for health and social care services. Its agenda includes the health and wellbeing of adults, children and families, as well as wider areas that impact on health such as housing, education and the environment.

Reducing health inequalities – to ensure he most vulnerable in our society receive better care through integration. The ambition in Bury is that in 5 years' time we will have fully integrated Health and Social Care neighbourhood teams wrapped around the patient and coordinated care through effective risk stratification.

Parity of Esteem – to ensure that there is as much of a focus on mental health as there is on physical health. The ambition in Bury is to reduce the gap in life expectancy of the population with mental health problems compared to the population without and ensure those with mental health problems do not suffer inequalities either because of their mental health problem itself or because they don't get the best care for their physical problems.

Section 8 - Our Ambitions and Goals

The Operating Framework also sets out the national expectations for quality and performance improvement against which CCGs are expected to deliver. Within this context, NHS England has set out a small number of key performance indicators. Whilst these may change in future as national priorities are met, for 2013/14 they were:

- Referral to Treatment
- A&E 4 hour wait
- Cancer - 62 day waits
- Stroke
- Mixed Sex Accommodation
- HCAI
- Ambulance Cat A.

Key measures are included alongside local outcomes in table 3; detailed targets for all required Operating Framework targets for 2012/13 are set out in Appendix 2.

Table 3

Performance / Quality Indicator	Target Performance	Performance 13/14
IAPT Recovery rate	50%	34.6%
IAPT Access rate	15 %	10.93%
Dementia Prevalence rate	67%	55.1%
Ambulance – Category A (Red 1) 8 minute response time	75%	NWAS 75.9% Bury CCG 71.4%
A&E 4 hour access standard	95%	95.4%
No. waits over 52 week wait	0	2
MRSA	0	2
Referral to Treatment wait over 18 weeks	Admitted - 90% Non Admitted - 95% Incomplete - 92%	Admitted – 92.2% Non Admitted – 96.4% Incomplete – 93.8%

The CCG will continue to ensure achievement of national standards through the contractual process, supported by CQUIN and other improvement initiatives, as well as the transformation programmes for Bury.

Section 9 - Quality Improvement Priorities

The duty of the quality agenda is that care will be clinically effective, safer and that patients will have an improved experience of health care. Bury CCG is committed to ensuring high quality underpinning all aspects of services from design through to delivery and a Quality Strategy has been developed, which is framed around five priorities:

Priority 1 - Patients will only receive quality health care because all commissioning decisions will be quality assessed and approved.

Bury CCG aims to ensure that any decision made regarding a health care service change has undergone a rigorous process to assess the quality impact of the change, prior to implementation. It is important that all commissioning decisions are evaluated for the quality impact and that risks have been adequately considered, to ensure an informed decision is reached. To do this a quality impact evaluation process, including the use of an appropriate tool will be developed.

Priority 2 - The quality of care will be improved by consistent scrutiny and challenge of all health care providers

This quality priority will ensure a consistent approach to quality surveillance of all healthcare providers, recognising that often our most vulnerable patients are cared for by small providers, providing low risk interventions, for example Care Homes.

Priority 3 - Patients will have a better experience of healthcare by ensuring providers are compliant with national recommendations

Bury CCG reviews national guidance as it is produced and seeks assurance from providers that plans are in place and they are progressing towards full compliance. The rationale for this priority is that the NHS continues to undergo wide reforms, systems continue to change and the quality agenda is a top priority, due to widespread failings over the past decade. Bury CCG must have assurance that providers deliver the nationally recommended standards of quality in all their services.

Priority 4 - The quality of health care will improve by working collaboratively with other commissioning colleagues

Bury CCG has close collaborative working arrangements with its partner CCGs across the NE Sector and with neighbouring CCGs in Stockport, Tameside and Glossop. NHS England Area Team has created effective lines of communication through their committees, called collaborative, for quality. Although the current working arrangements are established, they are not yet mature and it is vital that Bury CCG continues to effectively work with partners to deliver priorities 2 and 3 of this strategy, in order to ensure better outcomes for patients.

Priority 5 - 'No decision about me without me'. Patient experience will meet expectations by improved engagement

A fundamental value of the NHS Constitution is that patients and the public must have a say about the health care they receive. NHS Bury currently has a robust engagement strategy and has made good progress towards patient and public involvement. The focus of this priority is that engagement around the quality agenda is vitally important. Patients and the public demonstrate great interest in the quality of the services commissioned and what experience of healthcare feels like. The quality team will continue to build on the engagement work already in progress and find more consistent ways of engagement around the quality agenda.

Section 10 - The Public Voice

Over the past year NHS Bury CCG has sought to engage widely with stakeholders on 'Call to Action' related themes and the development of the Strategic Plan. The strategic plan addresses all areas of the feedback obtained.

From the public input the CCG has produced You Said We Will feedback:

You said you like……

Community Based Services
- Urgent Treatment Centres
- Ophthalmology
- Audiology

Same day GP appointments
Patient participation groups
Easy access to services
Support & Advice
Early discharge stroke team
Patient education

We will…..

Further enhance community services
Extend GP operating hours
Develop patient education
Improve ease of access to services
Aim for equitable services for all
Develop patient education programmes

What you said could be better…

Interlinking between education, health & social care
Community support services
Co-ordination of care, transport & appointments
Information sharing – telling your story only once
Continuity of services 7 days a week
Better services for chronic and long term conditions
Mental health services
Cancer and palliative care

We will…..

Create an integrated approach to health and social care
Collaborate to provide support
Implement extended hours for Primary Care services to operate 8-8 Monday to Friday and 8-6 at weekends.
Commission Consultant outpatients and pre-operative assessment clinics in Primary Care
Re-commission anticoagulant clinics in localities near to patients
Work on safe record sharing
Commissioning multi-disciplinary teams to support long term conditions
Improve access to psychological therapies and mental health services
Support people to die in their preferred place, implement training programmes

Your New Ideas Were…

To use alternative venues for health & care programmes e.g. libraries
To have one constant Bury approach at every contact
Encourage people to take responsibility for their own health
Simplify patient pathways
To improve communication, use text messages as reminders and phone calls to follow up.
Have immediate access to services on discharge from hospital

We will…..

Consider venue use within our integrated care programme
Engage in Partnership working for a consistent approach
Encourage self care
Work to improve patient pathways
Develop our communication processes and pass this message onto providers
Review access to community services following hospital discharge

Section 11 - The Membership Voice

Bury CCG has robust arrangements in place to facilitate two way engagement with colleagues within Primary Care, via monthly sector board meetings. The views and priorities of our members have been gathered and incorporated within the development of our plans.

Members have indicated:

Members say what works well……

We have good quality, personal, local services in Bury

Community based services e.g. anticoagulation service and incontinence service

The Care at the Chemist scheme

We will…..

Extend GP operating hours

Improve access to records for continuity

Re-commission anticoagulant clinics

Further enhance community services

Extend the care at the Chemist scheme

What members said could be better…

Growing demand is increasing pressure on the workforce

Community based care such as; paediatrics, mental health, alcohol services and physiotherapy

Communication across services and with social care

Integration with social care

Access for patients to:
The CRISIS Team; treatment rooms; the falls service; GP appointments.

Workforce issues:
Recruitment; training & development; sharing skill mix, appropriate use of resource

We will…..

Enhance the GP workforce

Develop speciality services in the community e.g. paediatrics

Improve access to psychological therapies and mental health services

Create an integrated approach to health and social care

Collaborate to provide support

Commission multi-disciplinary teams to support long term conditions

Enhance patient pathways to improve access

Collaborate on a whole systems approach to workforce

Your New Ideas Were…

To use alternative venues for health & care programmes e.g. libraries

To have one constant Bury approach at every contact

Encourage people to take responsibility for their own health

Simplify patient pathways

To improve communication, use text messages as reminders and phone calls to follow up.

Have immediate access to services on discharge from hospital

We will…..

Collaborate on the development of support for carers

Engage in partnership approach with public health initiatives where possible

Review the service offered in the Care at the Chemist Scheme

Encourage and promote wellness, self-care, and appropriate access to care

Work to improve patient pathways

Section 12 - Communication and Engagement Priorities

Good communication and engagement with all stakeholders is fundamental to the CCG achieving its strategic objectives over the next 5 years. Effective communication and engagement is essential to:

- Encourage our workforce to contribute fully so that the CCG can harness the knowledge, skill and experience we have in our team to achieve our vision
- Ensure a cohesive membership contributing to and supporting the delivery of the CCGs vision and objectives
- Enable the CCG to work with its strategic partners in the local authority and provider organisations to deliver true integration of health and social care services
- Empower patients and the public to have a voice in their own treatment and care as well as in wider commissioning decisions

To support the 5 year strategy the CCG has reviewed and refreshed its Communications and Engagement Strategy and in doing this invited feedback from some of our key stakeholders and our Patient Cabinet. The Strategy sets out our main priorities over the next five years. These include:

- Inform and support the significant transformation of health and social care that will take place locally, through service redesign, including the development of integrated models of care. The role for communications and engagement is to obtain and facilitate the transfer of views and opinions into the service redesign process and to promote information about changes to the community
- Help in the promotion of self-care within the community through a range of communications and engagement mechanisms
- Work with stakeholders and in particular the CCG's Patient Cabinet and Healthwatch, in understanding and responding to the needs of our communities and to make views and opinions obtained useful, by feeding into the commissioning process
- Utilise the experiences of our local patients in shaping future services
- Build, maintain and protect the reputation of the CCG with the public and stakeholders (both internal and external)
- Continue to work towards meeting best practice and delivering legal responsibilities
- Position NHS Bury CCG as the organisation able to improve the health of the people of Bury, improve the health services they receive and their experience of them and deliver this at good value for money
- Maximise the 'breadth' of engagement (the total number of patients and the public engaged) and maximise the 'depth' of engagement (reaching patients and members of the public who would not usually engage or who may face barriers to getting their voices heard).

The CCG is committed to listening, learning and acting on the views of our stakeholders and in this respect we are reviewing the outcomes of the latest NHSE commissioned 360o Stakeholder Survey and the feedback we have received from our engagement events with member practices and with local patients to inform our communications and engagement plans.

We are using 'Transforming Participation in Health & Care' to inform our approach so that we can ensure that our work on developing public and patient engagement is informed by best practice.

The CCG cannot achieve the priorities of the strategic plan on its own and the kind of whole system changes, which are necessary, require a genuine partnership approach. In this respect we will be building on early work with the local authority (adult social care and Public Health), key providers, Healthwatch and the 3rd Sector Development Agency to develop and implement a shared strategy to promote public and patient engagement in developing integrated care in Bury.

Section 12 - Communication and Engagement Priorities

Over the short term the CCG will be working on a number of priorities:

1. To use the 360o Stakeholder Survey and other feedback to work with our member practices at improving communication and engagement
2. Working with partners to promote public and patient engagement in the integration agenda
3. To develop and strengthen our Patient Cabinet
4. The development of a programme of work to broaden and deepen our public and patient engagement and build a 'community of interest' around the CCG. In particular we will be focusing on improving our engagement with protected groups in the Borough
5. The development of robust processes and associated governance arrangements to ensure that the CCG meets its statutory duties, in relation to engagement and consultation, when developing plans for significant changes in services

Section 13 - Financial Stability

The 5 year CCG Finance Plan has been developed, the summary of which is provided within table 4:-

Table 4

Revenue Resource Limit	2013/14 (£'000)	2014/15 (£'000)	2015/16 (£'000)	2016/17 (£'000)	2017/18 (£'000)	2018/19 (£'000)
Recurrent	213,060	221,360	231,326	231,604	235,470	239,401
Non-Recurrent	5,482	-	250	250	250	251
Total	218,542	221,360	231,576	231,854	235,720	239,653
Income and Expenditure						
Acute	124,462	121,792	119,812	120,866	120,768	120,557
Mental Health	22,861	25,117	24,525	24,696	24,972	25,231
Community	21,415	20,996	20,579	20,154	19,361	18,474
Continuing Care	11,602	11,133	11,515	11,524	11,533	11,542
Primary Care	32,038	31,872	32,315	32,560	32,807	33,056
Other Programme	3,710	4,422	17,220	16,442	20,646	25,141
Total Programme Costs	**216,089**	**215,333**	**225,966**	**226,243**	**230,088**	**234,002**
Running Costs	4,544	4,670	4,202	4,202	4,202	4,202
Contingency	-	1,107	1,158	1,159	1,179	1,199
Total Costs	**220,633**	**221,110**	**231,326**	**231,604**	**235,468**	**239,402**

This plan has been developed in light of the financial allocation for Bury. It reflects the notified financial allocations but, does not assume the increased levels that would be required, to bring the organisation closer to its allocation target.

The overall financial gap for Bury CCG is summarised in table 5:-

Table 5

	2013/14 (£'000)	2014/15 (£'000)	2015/16 (£'000)	2016/17 (£'000)	2017/18 (£'000)	2018/19 (£'000)
Recurrent (inclusive of full year effect)	4,600	505	1,238	3,678	1,101	942
Non-Recurrent		7,442	4,954	3,441	1,642	416
Total	**4,600**	**7,947**	**6,192**	**7,119**	**2,743**	**1,358**

13.1 QIPP Plan

The overall QIPP gap for Bury is outlined in table 6, which details the activity reduction assumptions within the acute sector that are the key to delivery of a balanced financial position moving forward for the CCG :-

Table 6

	2014/15 (£'000)	2015/16 (£'000)	2016/17 (£'000)	2017/18 (£'000)	2018/19 (£'000)
Total QIPP Required	7,947	6,192	7,119	2,743	1,358
Previous year over-achievement of recurrent QIPP target			-5,127	-2,205	-1,921
Total	**7,947**	**6,192**	**1,992**	**538**	**-563**
Strategic Plan - Acute Efficiencies					
Elective efficiencies - identified within strategic plan	-	-366	-426	-487	-548
Non-elective efficiencies - identified within strategic plan		-5,283	-300	-300	-300
A&E efficiencies - identified within strategic plan		-716	-30	-30	-30
Under / (Over) achievement of QIPP target	**7,947**	**-173**	**231,604**	**235,468**	**239,402**

The acute efficiencies have been calculated using planned activity reductions shown in tables 7 & 8

Section 13 - Financial Stability

A 15 % reduction in elective care activity is approximated to realise the following efficiencies:

Table 7

Year	% Deflections	Elective £	% Deflections	Day Case £
14/15	0	0	0	0
15/16	-3.0%	-£ 365,505	-0.5%	-£ 45,012
16/17	-3.5%	-£ 426,423	-1.0%	-£ 90,024
17/18	-4.0%	-£ 487,340	-1.5%	-£ 135,036
18/19	-4.5%	-£ 548,258	-2.0%	-£ 180,048
Total Deflection	**-15.0%**	**-£ 1,827,525**	**-5.0%**	**-£ 450,120**

A 20% reduction in urgent care activity and a 16.5% reduction in A&E activity; is approximated to realise the following efficiencies:

Table 8

Year	% Deflections	Non Elective £	% Deflections	A&E
14/15	-3.4%	-£ 1,317,170	-3%	-£ 179,079
15/16	-14.1%	-£ 5,282,770	-12%	-£ 716,319
16/17	-0.8%	-£ 299,732	-0.5%	-£ 29,847
17/18	-0.8%	-£ 299,732	-0.5%	-£ 29,847
18/19	-0.8%	-£ 299,732	-0.5%	-£ 29,847
Total Deflection %	**-19.9%**	**-£ 7,359,191**	**-16.5%**	**-£ 984,939**

The short term QIPP Plan centres on the completion of the integrated care initiatives, including the provision of seven day a week access to primary care, and implementation of integrated health and social care teams to support the most vulnerable patients.

These key initiatives will improve clinical quality and sustainability, integrate care for better patient experience and help to secure reductions in admission rates. The five year strategy is to reduce non-elective admission rates despite the increases in demand which we are expecting from an ageing population.

The CCG will seek to reduce paediatric non-elective admission rates by providing more accessible and child friendly, community based services. There will also be a reduction in elective referral rates which will be achieved through addressing procedures of limited clinical value and making available to GPs more effective decision making tools and providing referral management support. The long term condition strategy, which delivers pathway improvements in diabetes, respiratory and cardiac care, will also allow the CCG to achieve improved admission rates.

In addition to these plans there are a number of named transactional QIPP initiatives, such as continuing changes in GP prescribing practices and Continuing Health Care cost reduction.

An overall 4% efficiency target has also been built into contracts with all providers.

Most of the QIPP programme across the three years can be classified as transformational and more detail can be found in the transformational change delivery plan section 16.

Due to the range of transformational programmes and ongoing modelling the precise implcation of QIPP for acute and other sectors are not fully quantifiied. However a series of activity assumptions have been shared with the Local Authority and the Acute Trusts to guide development of five year plans. These reflect the actvity shift NHS Bury CCG expects to deliver through QIPP. The activity information and impact on provider bed days is outlined further in appendix 6.

Section 13 - Financial Stability

Work has been undertaken to identify an investment plan to resource schemes which will deliver Integrated Health and Social care and reduce admissions to hospital (Better Care Fund – see table 9 – the review and re-commissioning of these services will be key to the delivery of the CCG's required activity reductions. The impact of these investments will be collectively monitored across Health and Social Care using the programme's Joint Outcomes Framework (which is currently in development). This approach will allow the organisations to look at impacts across multiple organisations and projects, as it is not possible to isolate the impact of specific initiatives/investments upon whole systems. The business cases for each specific investment proposal will detail the method by which individual schemes will be monitored and evaluated.

We are currently working with the local authoirty to prioritise an iinvestment / disinvestment programme to support the Better Care Fund.

13.1 Better Care Fund

The financial plan and business case for the Better Care Fund 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

Following the fundamental review of allocations policy commissioned by NHS England, Bury CCG is funded significantly below the target allocation. The pace of change moves Bury nearer to target but only in the last three years of the formula. As a consequence of these current uncertainties, the CCG has formulated a financial plan based upon a significant QIPP plan for years one and two.

For 2014/15, the finance plan identifies the specific measures that are being put in place to deliver the £7.9m QIPP gap in this financial year. It is recognised that some of these measures are non-recurrent actions to allow time for recurrent service redesign proposals and deflection schemes to be fully implemented. Moving forward, a variety of service design initiatives are being developed, to deliver the QIPP target in future years including £9.27m savings over the 5 year period relating to Healthier Together assumptions about changes in activity levels.

To achieve this level of QIPP the vision in Bury is that in 5 years' time there will have been a significant shift of activity and therefore funding, from secondary care into primary care services. The Better Care Fund, Healthier Together and Better Care programmes all support the development of an integrated wellness, prevention and care programme, which is to be developed in Bury. To date there has been recognition of required funding of £11.7 million to support this. The development of the integrated care plans are expected to realise; a 16.5% reduction in Urgent care activity; a 15% reduction in Elective Care; a 5 % reduction in Day cases and a 5% reduction in Out Patient activity. 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 average length of stay may 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

Section 13 - Financial Stability

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. 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.

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.

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 within 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. Identified risks are outlined in appendix 3

Table 9

BCF Investment	2015/16 spend	
	Recurrent	Non-recurrent
Staying well – self-care and early prevention		£ 811,000
The schemes to be considered under this theme are: Carers Centre; Falls Prevention; Digital Inclusion for Older People; Sheltered Housing.		
Reablement and intermediate care		£ 2,773,000
The schemes to be considered under this theme are: Intermediate care; Crisis response; Reablement Service; Nursing Home beds spot purchase; Discharge Liaison services; Equipment; Discharge Liaison service.		
Integrated and community care services		£ 1,729,000
The schemes to be considered under this theme are: Transfer of care team, domiciliary care agencies, care home LES, health related support into residential and nursing homes; Cambeck Close; Excess Stroke Days; End of life care;		
Long Term Conditions - diabetes, cardiology, respiratory		
Mitigation of pressure on core social care services which already provide a health benefit	£ 5,828,000	
Capital - DFGs		£ 781,000
Capital - Council capital grant		£ 455,000
Contingency element		£ 586,000
A 5% contingency has been set, in case some of the schemes don't achieve their expected outcomes		
Total	**£5,828,000**	**£7,135,000**

Section 13 - Financial Stability

Work streams are in place currently to develop work plans within the areas identified in table 10.

Table 10

Bury Integrated Health and Social Care joint work programme key deliverables with timescales		
Ref	**Description**	**Timescale**
1. Prevention/ helping people staying well		
1.1	Better Together	April 2014 onwards
1.2	Integrated wellness services	April 2015
1.3	Staying well	April 2015
1.4	Self-care programmes	April 2014 onwards
1.5	Active ageing	April 2014 onwards
1.6	Falls prevention	April 2015
1.7	Affordable warmth	Sept – Feb Annually
1.8	Seasonal Flu uptake	Sept– Feb Annually
1.9	Dementia awareness	May 2014 onwards
2. Reablement and Intermediate care		
2.1	Data gathering	April 2014
2.2	Analysis and identification trends/ gaps	May 2014
2.3	Development of emerging models for discussion	June 2014
2.4	Development of business cases for discussion at board	July 2014
2.5	Implementation of new model	2016
3. Integrated community and primary care services		
3.1	Enhanced access to primary care	Oct 13 – April 15
3.2	Establish wider integrated health and social care team	July 14 – March 16
3.3	Admissions avoidance	July 14 – March 16
3.4	Enhanced discharge	July 14 – March 16
3.5	Integrated community services for children	April 14 – March 16

Section 14 - Our CCG Organisational Development (OD) Priorities

The OD Plan is designed to show how the CCG will grow and develop as an organisation, in order to deliver its key vision and objectives. Clearly the plan will change and evolve as the CCG develops and this early plan focuses on many of the issues any high performing organisation needs to have in place, in order to deliver its business aims effectively.
The plan is based around developing 6 areas:

- Clinical focus and added value
- Organisational capacity and capability
- Clear and credible plans
- Engagement with partners, patients and community's
- Leadership capacity and capability
- Collaborative organisation

The CCG OD Strategy is being currently refreshed.

Bury Clinical Commissioning Group
Delivery Plan 2014-2019

Section 15 - Achieving Our Ambitions

Ambition 1 - Securing additional years of life for the people of England with treatable mental and physical health conditions

This will be achieved through a reduction in mortality in the following areas:

- Reducing Mortality from Cardiac Disease
- Reducing Mortality from Stroke
- Reducing Mortality from Respiratory Disease
- Reducing Mortality from Cancer
- Reducing Mortality within the Mental Health and Learning Disabilities population
- Reducing Mortality from Liver Diseases

These areas have been selected a priority areas based on the evidence from the JSNA outlined in section 3.2 of this document.

The table 11 outlines modelled information which provides an estimate of the potential number of deaths that could be prevented in one year if the above are targeted by evidenced based interventions. There are lots of assumptions in this model, such as how well we are already doing in relation to the modelled interventions, how well we could potentially do (achievable coverage) leading to an estimate of the number of deaths we could prevent in one year. The theoretical maximum number of preventable deaths in one year is 229, with the biggest gains to be made (in the short term) from the optimal treatment and prevention of cardiovascular diseases. An achievable goal for Bury would be to prevent 100 premature deaths each future year. Better Together will provide the platform for this work and will include improving the accuracy of disease registers to establish a clear picture of the present position and the required scaling and targeting of the interventions in order to prevent 100 deaths. Whilst the modelled interventions will guide us in how to address the inequalities caused by circulatory and respiratory diseases it will also be crucial to focus on the gap attributable to mental health conditions in women.

The high impact interventions outlined will be implemented through

- NHS Health Checks with prioritisation of those at highest risk of Cardio Vascular Disease and a drive to continually improve uptake rates
- Integrated services for cardiology, diabetes and respiratory services, with a focus on greater uptake and completion of cardiac and pulmonary rehabilitation, will bring expertise into primary care and provide training and support to improve management of the conditions
- Implementation of GRASP-AF will improve identification and clinical review of patients with AF not presently anti-coagulated
- Anticoagulation services will be re-designed, to improve care delivered closer to home, which is cost-effective, with a focus on improving the amount of time patients are within the therapeutic range.
- Better Together', a collaboration between Public Health, the CCG and individual practices, will improve the management of long term conditions
- Integrated care planning for adults and children, integrated Physical and Mental Health approaches, collaborating with Bury council supporting people to live healthier lives including:
  - Shared decision making to empower patients to maximise self-care, self-management and choice
  - Telehealth.
  - Risk stratification and care planning
  - Reablement and Crisis Response services
- Promote implementation of the Alcohol Local Enhanced Service
- Alcohol liaison nurses working directly in A&E
- NHS Health Checks will include a mandatory dementia element to increase the rates and meet the National target
- Local RAID CQUIN and indicator, relating to reducing alcohol A&E attendance and hospital admission, and improved engagement with alcohol services
- A talk cancer program to further enable staff to engage in discussions around cancer awareness

Section 15 - Achieving Our Ambitions

Table 11 – Estimated potential postponed deaths in one year, life expectancy gain and 'Number Needed to Treat'

Assumed treatment coverage of eligible population (%)	Intervention	Potential postponed deaths in one year (based on 2006-08 data)			Estimated population eligible for treatment			Number Needed to Treat (NNT) to postpone one death	Life expectancy gain (for local authority)		Change in All Age All Cause Mortality (AAACM) rate per 100,000 from 2006-8 actual rate	
		Males	Females	Persons	Males	Females	Persons	Ratio	Males	Females	Males	Females
	Cardiovascular disease: Secondary prevention Four treatments (beta blocker, aspirin, ACE inhibitor, statin) for all patients with a previous CVD event											
	Currently untreated											
100%	CHD deaths averted	7	8	16	707	719	1,426	56	0.08	0.06	-6.57	-3.95
	Stroke deaths averted	3	7	10					0.03	0.05	-2.84	-3.08
100%	**Currently partially treated**											
	CHD deaths averted	14	15	30	5,373	3,854	9,227	189	0.16	0.12	-12.57	-7.52
	Stroke deaths averted	6	13	19					0.06	0.09	-5.43	-5.87
100%	**Additional treatment for hypertensives with no previous CVD event**											
	Additional hypertensive therapy	22	26	48	18,846	14,293	33,138	479	0.25	0.26	-20.15	-14.78
	Statin treatment for hypertensives with high CVD risk	10	11	21					0.13	0.12	-9.27	-5.86
100%	**Treatment for heart attack**											
	Primary angioplasty (PCI) for heart attack	2	1	3	-	-	295	107	-	-	-	-
100%	**Anticoagulant therapy (Warfarin) for all patients over 65 with atrial fibrillation**											
	Stroke deaths averted	5	9	15	293	257	550	38	0.04	0.06	-4.49	-4.02
100%	**Diabetes**											
	Reducing blood sugars (HbA1c) over 7.5 by one unit	8	3	11	1,830	893	2,723	245	0.08	0.03	-7.4	-1.72
40%	**Chronic obstructive pulmonary disease (COPD)**											
	Statins to address CVD risk among COPD patients	29	21	50	1,250	970	2,220	44	0.3	0.19	-26.22	-11.41

Section 15 - Achieving Our Ambitions

Assumed treatment coverage of eligible population (%)	Intervention	Potential postponed deaths in one year (based on 2006-08 data)			Estimated population eligible for treatment			Number Needed to Treat (NNT) to postpone one death	Life expectancy gain (for local authority)		Change in All Age All Cause Mortality (AAACM) rate per 100,000 from 2006-8 actual rate	
		Males	Females	Persons	Males	Females	Persons	Ratio	Males	Females	Males	Females
100%	**Reducing smoking in pregnancy**											
	Eliminating smoking in pregnancy (infant deaths averted)	0.3	0.4	0.7	-	-	451	684	0.26	0.32	0	-0.01
10%	**Harmful alcohol consumption**											
	Brief intervention for 10% of harmful drinkers	1.2	0.5	1.7	434	273	707	416	0.03	0.01	-1.44	-0.54
100%	**Lung cancer**											
	Increasing rates of early presentation	1.6	1.2	2.8	*	*	*	*	0.02	0.02	-1.52	-0.92
10%	**Smoking cessation clinics (setting a quit date)**											
	Results shows deaths postponed in short term (1-2 years)**	0.9	1	2	1,031	1,124	2,155	1092	0.01	0.02	-0.88	-0.62
	Total	**112**	**117**	**229**	**-**	**-**	**-**	**-**	**1.45**	**1.35**	**-98.77**	**-60.29**

Section 15 - Achieving Our Ambitions

Ambition 2 - Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions

Will be achieved through

- Ensuring equality of access to health services for all people within Bury
- A Clinical Leadership model with identified experienced clinical leads for LTC and Mental Health, having paid sessions to support the work of the CCG
- Patient Engagement supported by a robust Patient Cabinet, with identified leads for the Long Term Condition categories
- The CCG is actively participating in the LTC AQUA programme on risk stratification of patients, the development of MDTs and the promotion of shared decision making
- Development and implementation of an integrated community Diabetes Service
- Wider roll out of the pilot scheme 'Healthier Radcliffe'; an enhanced primary care 7 day service for the residents of Radcliffe to become 'Healthier Bury'
- Further development of the Care Home Local Enhanced Service will capture a large proportion of patients with LTC, reducing Non Elective Activity as a result of additional support from GP practices
- Establishing arrangements for Integrated Community Respiratory Services
- Establishing arrangements for Integrated Community Cardiology Services
- Winter Planning to prioritise the co-ordination of services and ensure support for those with LTC's
- Provision of a Crisis Response Service, to respond to referrals within 2 hours undertaking a comprehensive assessment, developing a package of care wrapped around the patient for up to 72 hours, to allow the patient to recover in their own home
- Develop of a blueprint for improving partnership working between GPs and third sector organisations, to provide support for patients with dementia and their carers
- Work with Bury IAPTS to further enhance partnership working with statutory and non-statutory third sector providers and expand the co-location of IAPTS in GP surgeries and community settings
- Promote the range of brief Cognitive Behavioural Therapy based interventions available to people of all ages
- Implementation of the Joint Dementia Strategy and Action Plan with the Local Authority

Ambition 3 - Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.

Will be achieved through

- Delivering the ambitions within the Better Care Fund Business Case
- Developing support for patients with LTCs
- Working with PAHT to develop pathways for in patients requiring IV therapy, to be discharged (stepped down) to community IV services
- Delivering primary care interventions to reduce the incidence of elective and non-elective admissions for patients with varicose veins
- Procuring an Integrated Community Respiratory service for Adults and Children
- Review the Stroke Early Supported Discharge service pilot programme, to identify any improvements realised and the benefit of continued investment
- Procuring an Integrated Community Cardiology Services
- Development and implementation of an integrated community Diabetes Service
- Wider roll out of the pilot scheme 'Healthier Radcliffe'; an enhanced primary care 7 day service for the residents of Radcliffe, to become 'Healthier Bury'
- Establishing a MDT Process- targeting regular attendees at A&E due to alcohol misuse
- Reviewing the End of Life and Palliative Care service, with a view to having improved co-ordination and communication

Section 15 - Achieving Our Ambitions

Ambition 4 - Increasing the proportion of older people living independently at home following discharge from hospital.

Will be achieved through

- Improved access to primary care service via Better Together (primary care health improvement programme)
- Provision of a Crisis Response Service, to respond to referrals within 2 hours undertaking a comprehensive assessment, developing a package of care wrapped around the patient for up to 72 hours, to allow the patient to recover in their own home
- Support for carers
- Rapid access to professional advice
- Multi-disciplinary teams aligned to GP practices to co-ordinate and plan care
- Integrated Reablement
- Self-care programme
- Integrated wellness service
- Staying Well programme, targeting older population at risk of dependency
- Helping yourself to health a self-care programme
- Active ageing programme
- Falls prevention intervention programme
- Affordable warmth
- Increasing seasonal flu jab up take, with a stretch target for the population aged over 75, to 90%

Ambition 5: Increasing the number of people having a positive experience of hospital care.

Will be achieved through

- The CCG aims to cultivate Learning Organisations by encouraging feedback, positive and negative, in order to review, assess and develop services to meet the needs and expectations of the patients and public who use them.
- PAHT obtains patient experience feedback across the 5 key domains:
  - Access and Waiting;
  - Safe, high quality, co-ordinated care;
  - Better information, more choice;
  - Building closer relationships;
  - Clean, comfortable friendly place to be.

  Using multiple techniques such as; Ward level – 'techno huddle' data, providing real-time patient feedback; The Friends and Family Test and Local Patient Surveys.
- Pennine Care Foundation Trust (PCFT) captures patient experience via a number of channels including; using 'Elephant kiosks'; email and telephone numbers on appointment cards; Patient Advisory Liaison Service (PALS) and Complaints.
- PCFT are completing a review to triangulate PALS, patient experience and complaints data
- Monthly feedback reviews to be undertaken at NE Sector Clinical Quality Leads Meetings – with CCG assurance sought around data capture
- Improvements in A&E performance
- Managing the discharge of patients if they are medically fit and a focus on delayed discharge
- Expansion of systems designed to capture patient satisfaction and experience e.g. patient Kiosks, SMS text messaging
- Enhanced therapeutic environments realised through a range of ward improvement schemes

Section 15 - Achieving Our Ambitions

Ambition 6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community

Will be achieved through

Monthly performance & quality reporting and monitoring for all Out of Hours providers

- Services to be targeted to at risk patient groups (Mental Health and Learning Disabilities) and move to a system of measuring outcomes and harm reduction.
- Physical health checks for people with severe and enduring mental health
- NHS Health Checks (Cardio Vascular Disease) – explore the possibility of expanding these to include Mental Health and Learning Disabilities
- Develop a community pharmacy questionnaire to encourage patients to ask questions about their medication and understand the implication on mental and physical health ('10 Questions to Ask Your Pharmacist'). Pharmacies to provide signposting/referral information for patients.
- End of life pathway for patients with Learning Disabilities – work with the Pennine Care Adult Learning Disabilities Team
- Health Trainers and developing pathways for people with Learning Disabilities
- Reducing A&E attendance for people with Learning Disabilities - work with Pennine Care Adult Learning Disabilities Team to develop pathways between providers to work with patients to reduce avoidable attendance at A&E and avoidable hospital admissions

Ambition 7: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

Will be achieved through

- Undertaking a monthly collaborative incident review management process, of root cause analysis and lessons learned

- Commissioning an infection control service, managed by the Public Health department for a further 3 years
- SLA to include infection control audit in general practice
- Monthly review of the HCAI action plan developed with Acute and Community providers and NES CCGs
- The medicines management team supporting prescribing and case management, to raise awareness of HCAI within General Practice and liaise with microbiology any issues and concerns
- The Provider Trust is undertaking triple testing for C-Difficile, the CCG aims to mirror the approach in the community and work with GPs to reduce Community retesting

Section 15 - Achieving Our Ambitions

Ambition 8 –Key Measure 3: Parity of Esteem

Will be achieved through

Developing an Outcomes Based Framework for Primary Care

- Move to an outcomes based framework - utilise 'Better Care' to develop measures to monitor reductions in the following areas in Years 1 & 2 amongst people with Learning Disabilities (LD) and Mental Health (MH) issues
- Practices to be benchmarked through 'Better Care'
- Services to be targeted to at risk patient groups and move to a system of measuring outcomes and harm reduction.

Adherence to Medications for Patients with MH and LD

- Develop shared care guidance and clinical correspondence between primary and secondary care – priority areas to be identified
- Develop a community pharmacy questionnaire to encourage patients to ask questions about their medication and understand the implication on mental and physical health ('10 Questions to Ask Your Pharmacist'). Pharmacies to provide signposting/referral information for patients
- Anti-psychotics and Dementia – reduction in the use of anti-psychotics

Ensuring Equal Access to Health services for People with MH and LD

- Equal access to health services for people with MH and LD; including comparable waiting times, equitable treatment for all in line with need and the same level of choice and quality of services regardless of conditions.

Embedding Mental Health and Physical Health Initiatives in Health Services

- GPs/Secondary Care and 3rd Sector - develop pathways to embed mental health/physical health services in relevant service specs e.g. IAPT services, links to LTC, links to challenging behaviour; and developing methods to measure patient health outcomes

Addressing Parity of Esteem Across The Life Course

- Training/Signposting - Making secondary care and primary care professionals aware of the range of physical and mental health services available in Bury and how to refer patients
- Review the Self-Care programme linked to Mental health and LD
- Mobilising communities (Citizenship/Patient Engagement)
- In reach into Lesbian and Gay Federation agenda
- BME Communities – Dementia, Carers and BME Communities pilot – sharing of blueprint for improved partnership working between GPs and third sector agencies.
- Embed parity of esteem across the life course – build into school nurse contract/health visitor contract/early years agenda
- Roll out of dementia friendly communities - via dementia action plan
- Map model from dementia friendly communities to create LD friendly communities model

Section 16 - Delivering Transformational Change in Bury

Our aim is to engage on a Health and Social care collaborative range of programmes, covering the life course aligned to the Health and Wellbeing Strategy. To maximise Patient participation in the NHS and care system, to develop a system that will truly put patients at the heart of both service planning and delivery and also put them in greater control of their own care.

Bury CCG has devised five Transformation Schemes to deliver the required changes, to fulfil our long term ambitions and support the significant shift in activity and resource that is necessary, from hospital into the community. The CCG aims to maintain a focus on quality, safety and improvement throughout all of these schemes.

The service improvement leads have worked in collaboration with clinicians to devise work plans for their individual service areas. The CCG now has a clear vision of how services should look in five years time and has begun to identify the steps required to achieve the vision. Work programmes have been developed and the CCG will undergo a prioritisation process to identify those with the greatest impact.

Transformation scheme initiatives linked to service plans, the Health & Wellbeing strategy life course and the NHS Outcomes Framework can be found in appendix 4. Work stream plans on a page can be found in appendix 5.

All work stream plans are expected to continue to evolve and become the basis of service development. The CCG recognises that collectively these plans are very ambitious and that achieving all the changes would take more resources than are available, however we are committed to ensure that output is maximised to deliver optimum improved outcomes for the public and patients in Bury.

16.1 Transformation Scheme 1 - Establish Collaborative Prevention, Wellness and Life Support Programmes - Living Well and Dying Well

Our ambition is to engage on a Health and Social care collaborative range of programmes, covering the life course aligned to the Health and Wellbeing Strategy. To maximise Patient participation in the NHS and care system, to develop a system that will truly put patients at the heart of both service planning and delivery and also put them in greater control of their own care.

Bury's Health and Wellbeing Strategy is based on the principles of promoting prevention, early intervention and self-care; reducing health inequalities and improving health outcomes across the life-course.

Delivery of the Health & wellbeing Strategy requires coordinated action at:

Population level: Developing strategy, policy and large-scale service reform to address the wider determinants of ill-health and health inequalities e.g. developing local poverty, housing and digital inclusion strategies; advocacy for policies on a minimum unit price for alcohol, food labelling and incentives for active travel; Implementation of Greater Manchester Public Sector Reform e.g. early years, troubled families/complex dependency, health & social care integration, working well, transforming justice.

Community level: Creating the conditions within education, health and care, workplace and neighbourhood settings that enable people to maintain and improve their health e.g. through a culture of wellbeing, equitable access to services, provision of healthy food choices, provision of shower and changing facilities

Individual level: Ensuring easily accessible information, advice and support to help individuals maintain and improve their health e.g. via digital, telephone and face to face methods.

Section 16 - Delivering Transformational Change in Bury

Bury Public Health have identified a number of work programmes to help take this agenda forward working closely with the rest of the local authority, the CCG, community and voluntary sector and other partners.

* Denotes programmes aligned to the Better Care Fund plans

Health & Wellbeing Strategy Priority 1: Ensuring a positive start to life for children, young people and families.

- To improve contribution of ante-natal and maternity services to public health outcomes
- Develop an early years health improvement strategy for Bury based on the Greater Manchester Public Service Reform New Delivery Model
- Re -establish a Healthy Schools Programme

Health & Wellbeing Strategy Priority 2: Encouraging healthy lifestyle and behaviour in all actions and activities.

- Advocate for a minimum unit price on alcohol
- Commission an appropriately scaled healthy lifestyle service supporting individuals with stopping smoking, weight management, safe alcohol consumption, healthy eating, physical activity and positive mental wellbeing.*
- Build on the Sport England funded 'I Will if You Will' programme to achieve a step change in participation in physical activity by the population of Bury *
- Establish a Healthy Workplace Programme
- To develop an adult sexual health promotion programme

Health & Wellbeing Strategy Priority 3: Help to build strong communities, wellbeing and mental health

- Implement the 'Community Engagement for Health' programme which aims to create the conditions for effective community engagement in health improvement and health care*
- Promote the 'Five ways to wellbeing' – Connect, Be Active, Give, Take Notice, Learn

Health & Wellbeing Strategy Priority 4: Promoting Independence of those with long term conditions and their carers

- Establish the 'Better Together' programme in primary care to ensure systematic implementation of primary and secondary chronic disease management in primary care. *
- Embed and expand the 'Helping Yourself 2 Health' self-care programme which builds confidence, motivation and health literacy to enable people to self-care.*
- Establish and evaluate a holistic 'Staying Well' service for older people who have high potential for developing a social care and higher level health need in the future to help maintain health, wellbeing and independence.*
- To review and redesign the falls prevention pathway from prevention, early identification and treatment of falls and osteoporosis through to management, treatment and rehabilitation of falls related injuries.*
- Develop a fuel poverty assessment tool to help systematic identification of households I or at risk of fuel poverty and target support to help keep people warm and well through winter.*
- To drive a step change in uptake of the seasonal flu vaccine*
- To build awareness among local people and the workforce of the preventable element of dementia, encourage early symptom recognition and support the national 'Dementia Friends' programme locally.*

Section 16 - Delivering Transformational Change in Bury

16.2 Transformation Scheme 2 - Create an Integrated Community Based Care Programme (covering the transformation areas of Primary Care and Integration)

Our aim is to create proactive, coordinated integrated community based care systems which anticipate, rather than react to need, that are accountable for overseeing care and empower the public to self-care and for service users to be actively involved in their care.

This will be delivered through the collaborative programmes identified in the Better Care Fund which will involve considering:

- New approaches to self-care, communications technologies and clinical collaboration
- Local systems of extended primary care that work to prevent unnecessary hospital admissions and support safe discharge seven days a week
- Shared decision making (addressing physical, mental and social care needs)
- Wider availability of community based diagnostics
- Improved patient access, including greater availability of consultations outside of traditional opening hours, and consultations outside of surgery
- Greater use of telephone, email and video consultations within Primary Care
- Closer working between OOHs and other community based providers, with a view to avoiding unnecessary secondary care activity
- One single shared Health and Social Care record
- Utilising the services of Community Pharmacists more effectively
- A Health and Social Care directory of services which asset maps all available resources so that all professionals know what assistance is available and a SPA to get into these services.
- Social prescribing that enables people with non-clinical needs to access voluntary services i.e. self-help groups, education classes, clubs and other hobby related activities

Our aim is to be a centre of excellence for elderly care and dementia. Through our integrated care model we will commission:

- **Wider Integrated Health and Social Care Team** – The team's initial focus will be on frail older people and children from complex families. The development of a new Integrated Community care model, leading to a whole system partnership, to deliver Risk stratification, neighbourhood teams, care planning, care coordination and case management.
- **Admissions Avoidance** – This will include standardised services provided to people in care homes by GPs for all patients, Named GP for all patients over 75, Admissions avoidance pathways, Unplanned Admissions DES for GPs, Implementation of Vulnerable Adults Local Enhanced Service.
- **Enhanced Discharge Pathways** – This incudes commissioned services which ensure that evolving multidisciplinary assessment for transfer of people back to the community is initiated soon after admission and prioritised and reduce injuries due to falls by reducing the number of falls in the community that result in decreased function and greater dependency.
- **Integrated Community Services for Children** – The model of care for children and families follows the principle of Early Intervention in the early years, supporting and empowering families to reduce reliance on public service. This model of care prioritises plans to bring more services back into a community setting, by commissioning integrated community based services, which reduce avoidable emergency and non-elective admissions. Care Co-ordination and Care Plans to be put in place for the most complex children and increase out of hour's access. An integrated model will ensure early intervention and facilitate the health requirements of the Special Educational Needs and Disability agenda.

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Wider Primary Care, Provided at Scale

Our aim is for Primary Care services to operate 8-8 Monday to Friday and 8-6 at weekends. Access in core hours will improve through collaborative working between practices, in partnership with NHS England. There will be consistently high-quality care: removing unwarranted variation in effectiveness, patient experience and safety, in order to reduce inequalities and achieve faster uptake of the latest knowledge regarding best practice. To test this we have established a Demonstrator Community - A Healthier Radcliffe. We have agreed that this is the initial phase of our integrated delivery model in Bury (Healthier Bury) and enables us to focus on one geographical location.

The Demonstrator Community has adopted the Bury integration aims and principles, implemented by a multi-disciplinary partnership of health and social care providers working together in Radcliffe. The partnership is a coordinated network of Radcliffe people, carers and local health providers including six GP Practices, public health, social care, third sector, North West Ambulance Service (NWAS), Bury Hospice and voluntary services. The team identify vulnerable people needing intensive targeted support and work collaboratively as partners in Radcliffe to deliver an integrated, coordinated approach. People will be helped to take control of their own care through integrated care plans that are person-centred, complimenting and building on their assets.

The successful Prime Ministers Challenge Fund Bid will enable roll out of this service to all practices in Bury in 2014/15; therefore plans are now progressing for this to be delivered Bury wide which cover four main areas for development:

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

Have very patient's notes available to the GP providing cover during extended hours

Telephone consultation - Ensure that all patients who request an appointment are offered the option of a telephone consultation:

- Currently about 35% of practices offer telephone consultation to patients
- We believe that such consultations can be a better use of GP and patient time
- Patients are often capable of knowing whether they need to see the clinician face-to-face
- A higher proportion of telephone consultations would release GP time and reduce waiting times for appointments

Increased Online Access - from current 4% of patients to 60%+:

- Currently patients who register can make appointments or re-order prescriptions using online
- All practices in Bury are enabled for online access
- Registration is a difficult process which is not user friendly – we plan to change this significantly and offer help to patients to register and use online services
- More services should be available to patients over time including them having access to their own health records and the ability to 'email' their GP.
- Increasing registration will significantly widen access

Comparison website - Develop a "GP-Comparison" website to enable patients to make better choices about GP services:

- Current websites offer limited information to patients
- This website would offer information in a detailed and searchable form, modelled on successful comparison-style sites used elsewhere
- The website would enable patients to search for staff availability, service availability, staff expertise etc. and would show information for all relevant practices in Bury

Section 16 - Delivering Transformational Change in Bury

16.3 Transformation Scheme 3 - Streamline and Enhance Elective Care Service Provision

Our aim is to provide sustainable services to the local population by a workforce skilled in delivery, in an appropriate setting with the minimal disruption to their lives as possible. In order to achieve this, our aim is to reduce the need for elective care in the secondary care setting by 15%, day cases by 5% and out-patient activity by 5% over the next 5 years.

Our key objectives for elective care over the next 5 years are:

- To promote, commission and develop seamless integrated care, closer to home across the whole spectrum of elective care, commissioned with a sound evidence base
- To remove the inequalities in access to and delivery of services for the residents of Bury
- To ensure patients get access to the service they need, as close and as convenience to them as possible
- To reduce non-elective attendances and admissions for conditions that could be managed elsewhere
- To ensuring patients with a hospital admission do not stay longer than necessary. Day surgery, rather than inpatient surgery, will be the norm.
- Our clinicians will be of the highest calibre, supported in their role and developed to provide first class care, treating sufficient numbers of patients so to be experts in their field

The ambition in Bury is to become a centre of excellence for elective care and the initiatives identified to achieve this are in appendix 4.

16.4 Transformation Scheme 4 - Future proofing Urgent Care Services in Bury

For those people with urgent but non-life threatening conditions services need to be highly responsive, effective and personalised. These services should deliver care in, or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families. For those people with more serious or life threatening emergency needs we aim to ensure they are treated in centres with the very best expertise and facilities, in order to reduce risk and maximise their chances of survival and a good recovery.

In two years' time Bury CCG plans to have reduced Non Elective Activity by 15%, in five years' time the plan is to have extended this further and consolidated delivery of urgent care and care for those with Long Term Conditions (LTC), within a new integrated approach to primary care. The only way to achieve this is to grasp the opportunities that present themselves within the integration agenda and to refocus attention on better more integrated management of patients with LTC. The goal will be to have a system that delivers urgent care where access to secondary care based emergency care becomes a truly last option for those that need it due to the robustness of a co-ordinated and integrated care system for patients with LTC.

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16.5 Transformation Scheme 5 - Commissioning for Quality and Enhancing Corporate Functionality

The CCG aims to provide a robust sustainable corporate programme, which will facilitate commissioning processes of the highest quality. This can only be achieved with appropriate support, development and delivery mechanisms, operating within a transparent, risk managed organisation incorporating stringent governance arrangements.

16.5.1 Quality Priorities

Priority 1 - Patients will receive quality health care because all commissioning decisions will be quality assessed and approved

- A quality assurance tool will be developed, which will be used consistently when commissioning decisions are made.
- A Risk register will be maintained
- An evaluation of process will be undertaken after 12 months

Priority 2 - The quality of care will be improved by consistent scrutiny and challenge of health care providers

- A register of all providers will be held
- The process for measuring quality will be strengthened and consistently applied
- All forms of intelligence will be triangulated e.g. Performance, Incidents, Complaints
- All external intelligence will be reviewed
- An accurate, current database will be maintained, with information about safety, clinical effectiveness and patient experience for all of the services commissioned

Priority 3 - Patients will have a better experience of health care by ensuring that providers are compliant with national recommendations

- Current national recommendations: Francis, Berwick, Keogh, Cavendish, Winterbourne reports
- There will be an up to date CCG action plan for each report, both current and as they are published
- The Quality and Risk committee will support the Quality Team in producing an action plan and reviewing compliance against the plan
- The Governing Body will ratify all plans
- The Quality Team will seek assurance from all providers about their plans and compliance to national recommendations
- All plans from providers will be critically appraised for completeness and assurance will be sought that plans are embedded within the organisation and become usual custom and practice
- Walkarounds to clinical areas will provide a platform to test compliance to national recommendations
- Bury CCG Quality Team will contribute when appropriate to national guidance through membership of GM collaboratives, by working with academic institutions when opportunities arise and through national projects, discussion, webinars

Priority 4 - The quality of health care will improve by working collaboratively with other commissioning colleagues

- Bury CCG will work collaboratively with the following organisations:
  - HMR CCG, Oldham CCG
  - Other surrounding CCGs
  - Greater Manchester Area Team (GMAT)
  - Health and Well Being Board
  - Local Authority
- The Quality Team will support other organisations where able with the quality agenda
- The Quality team will support the current working arrangements with the NE Sector but be flexible to change working arrangements as the reforms continue

- The Quality Team will be members of the following bodies:
- GMAT Quality Collaborative
- GMAT Quality Surveillance Group
- GMAT Direct Commissioning Collaborative
- Bury CCG will participate in the quality agenda for not only Bury CCG but on a wider footprint, particularly participating in debate, process and learning from and sharing learning with GMAT

Priority 5 - 'No decision about me without me'. Patient experience will meet expectations by improved engagement with patients, partners and stakeholders

- A quality engagement plan will be developed considering current position and identified gaps
- Use of focused consultations with patients / service users / carers
- Use of 'citizen's jury' type methodologies to meaningfully involve patients and public in complex service redesign
- Use of patient reps (e.g. patient cabinet members) working directly alongside service redesign and clinical leads
- Use of patient / service user / carers groups to help specify quality & safeguarding related standards in service specifications
- Use of patient panels working alongside commissioner panels in assessing tenders / interviewing potential providers
- Triangulation of patient experience information through patient surveys and the like with PALs / Complaints information
- Use of patient / carers to support CQUIN development
- Patient / public involvement in service walkabouts
- 'Mystery shopper' type exercises
- Promotion of pals / complaints pathways (current low uptake by Bury patients)
- Critical analysis of current standard patient experience methodologies e.g. patient satisfaction surveys may be convenient to deliver but often provide little useful insight across a range of dimensions of quality (e.g. Access; Communication; Timeliness)

16.5.2 Safeguarding Priorities

The safeguarding priorities identified to be addressed during 2014-2016 are:

- To embed PREVENT within the CCG ensuring 80% of staff are trained
- To ensure provider uptake of PREVENT through monitoring systems
- To monitor training within provider organisations on child protection, adult safeguarding and MCA/DOLS via quarterly reports
- To embed the Designated Professionals for Looked After Children into the CCG and ensure expertise is available
- To ensure that the Early Help agenda continues to be embedded into the services for children provided by health
- To extend the work on Harm Free Care to encompass the data collected by our community care providers to enable analysis of the data to improve health outcomes for patients
- To continue the GP training and peer review programme
- To develop a process to ensure that all children with a CP plan or a Child in Need plan have a robust health plan that meets their needs
- To develop a process where each care leaver has a robust transition health plan which includes all the information needed to access effective health care

Safeguarding Priorities for 2016/17 to 2018/19

Priority 1 - Holistic Looked after Children and Care Leaver's Service
The aspiration is to review the pathways and providers and to provide an integrated pathway which will be seamless and delivered within a range of settings that are acceptable to the children and young people.

Priority 2 - Drop in provision for young people with tier 1 mental health difficulties
The aspiration is that the service will offer early intervention and peer support for young people who do not meet the threshold for young people's mental health service but may find themselves in need of advice and signposting at point of challenge or crises in their lives.

Priority 3 - School/college health provision for post 16 year olds
The aspiration is that all young people up to the age of 18 and in some cases up to the age of 25 (in line with the SEND agenda) will have access to a school/college health advisor. The service would be a joint initiative with Public Health and it is expected that it would support a number of targets including reducing risk of Child Sexual Exploitation, pregnancy, STI's, self-harm etc.

Priorities 4 and 5 - Health services for children living with domestic abuse and adult victims of domestic abuse

The above priorities are linked but would potentially require different services to meet the needs or 2 separate arms to one service. A recent serious case review in Bury identified the potential impact of domestic abuse on the physical health of a child and it is well documented the impact on their emotional well-being.

Violence against women has serious consequences for their physical and mental health, and women who have experienced abuse from her partner may suffer from or chronic health problems of various kinds.
The aspiration would be for a targeted service, possibly from a 3rd sector provider to undertake work with the children identified as being at risk of significant harm due being exposed to domestic abuse and to provide support to adult victims.

16.5.3 Prescribing Priorities

The CCG has developed priorities for prescribing 2014 to 2019, this includes

- Managing patients' expectations and supporting ownership of their health
  - Ensuring people understand the limitations of the NHS budget and accept that some treatments need to be by individuals to allow for investment into newer drugs and newly identified conditions.
  - People access and utilise, preventative, self-care and treatment services, at community pharmacies –rebadged as 'healthy living pharmacies' aligning with national strategy
  - Addressing the increasing problem of dependence and addiction to prescribed and over-the-counter drugs
- Improving the patient experience
  - Enhanced 'shared care' arrangements to allow patients to receive drug treatments and monitoring closer to home
- Increasing access to prescribing support and medicines optimisation services - Enhanced pharmacist and pharmacy technician roles within general practices to:
  - Improve efficiency and safety of repeat prescriptions
  - Improve transfer between care settings
- Discharge information shared with Community Pharmacy
- Dedicated medication reviews post discharge (practice-based pharmacists/pharmacy technicians)
  - Include membership of multidisciplinary team supporting elderly and high risk patients and residents in Care Homes, for input into:
- Medication reviews
- System reviews in Care settings e.g. evaluation of bulk prescribing for commonly used medicines in care homes introduction of Homely remedy policies and other standard items that care homes should have in place as part of their care offer.
  - Educate and support practice staff to deliver on national and local priorities e.g. prescribing of antibiotics, benzodiazepine & z-drugs, NSAIDs, GM formulary and shared care arrangements

- Aligning prescribing responsibility to delivery of clinical care - Prescribing responsibility is owned by the most appropriate Healthcare professional for that aspect of the patient's care
  - The Stoma and Continence Prescribing Service which was commenced in November 2013 aligns prescribing responsibility to specialist clinicians to improve quality of care to patients via reductions in urgent care/ A&E attendances due to UTI/other catheter/ stoma related issues and aims to deliver efficiency savings to reinvest in the increased resource required in Continence & Stoma teams. It will mean that the service is accountable for its own prescribing budget.
  - Likewise, the prescribing of dressings and other items for wound care should be removed from GP practices and transferred to Community nursing staff that treat and monitor this group of patients.
  - Patients requiring enteral feeds (both 'sip feeds' and tube feeds) should be under the care of a dietician, and therefore the responsibility for prescribing/supply and monitoring of these patients should be removed from GP practices and transferred to Community dieticians. This does not remove the responsibility of all health and social care professionals to be cognisant of the risks of malnutrition and screen patients as part of routine care.
- Collaborative working and peer support - Bury practices develop a mature and supportive collaboration with their peers and with secondary care to share and promote good practice in prescribing.
  - Regular peer review meetings to:
  - challenge prescribing practice where data shows that practices are outliers
  - share difficult-to-manage cases and gain insight, advice and support from colleagues
  - Improve engagement with specialists and gain expertise in treating more complex conditions in primary care e.g. diabetes, dementia

16.5.4 Equality and Diversity Priorities

Priority 1 - Develop data to monitor, information to manage and knowledge to act

Readily available, up-to-date, accurate data, regularly analysed and presented, is vital for decision making, support in planning and commissioning dialogues. It improves the focusing of provision, the evaluation of outcomes and supports innovation:

- Develop better (more detailed and disaggregated) population data in partnership with local authorities and the third sector.
- Improve the collection, quality and disaggregation of population and public health data and demonstrate how this data is informing commissioning of services that meet the needs of the local population.
- Work towards an understanding of what the information means for both workforce and services, so that development and activity is focused on areas that are urgent and important, rather than where they have always been in the past.
- Ensure all strategies, plans and activities are subjected to equality analysis in accordance with national directives and equalities legislation.

Priority 2 - Develop the right services, targeted, usable, useful and used

Knowing who the population is and understanding the different health needs of groups and localities will improve precision of service delivery, lessen waste and could have a dramatic effect on the success of major health programmes. It will also facilitate the development and evaluation of focused development and pilot initiatives.

- Target health improvement initiatives to particular groups underpinned by robust and up to date intelligence
- Develop the relevant capacity, capability and knowledge for commissioners/ providers to meet the needs of the diverse population of Bury
- Assure that effective engagement and involvement models with equality groups are in place

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- Encourage high quality health services by ensuring the involvement and engagement of all sections of the population particularly vulnerable or marginalised groups.
- Improve the efficiency and targeting of health services and thus value for money, by ensuring commissioning meets the health needs of all sections of the population.
- Enable the development of local third sector provision.
- Develop robust contracts/service specs that make equality and diversity activities and responsibilities explicit.
- Ensure the integrated health and social care programme is underpinned by equality, diversity and health inequalities.

Priority 3 - Move beyond compliance to initiating best Practice

It is not enough to be legally compliant, although it is essential at all levels in all NHS organisations. Aiming for development and adoption of best practice will improve both working and service conditions; improving health outcomes whilst lessening wasted resources spent on litigation or high turnover.

- Develop Equality Objectives/EDS plans that are in line with existing legislation which are evidence based and outcome focused and where, commissioner and provider plans are reflective of each other's outcomes.
- An equality analysis framework is collaboratively developed, shared and adopted. The framework promotes evidence-based equality analysis carried out with and informed, by the different equality target groups.
- Integrate, where possible, analysis with other impact assessments e.g. health impact assessments.
- Improve collaborative working across organisational boundaries, particularly through third sector.
- Collaboratively develop a clear and consistent framework and guidance for procurement and commissioning locally to assure all contracts and service specs address equality and diversity.
- Develop capability of procurement, contracting and commissioning personnel in terms of equality and diversity requirements.

Priority 4 - Workforce and leadership

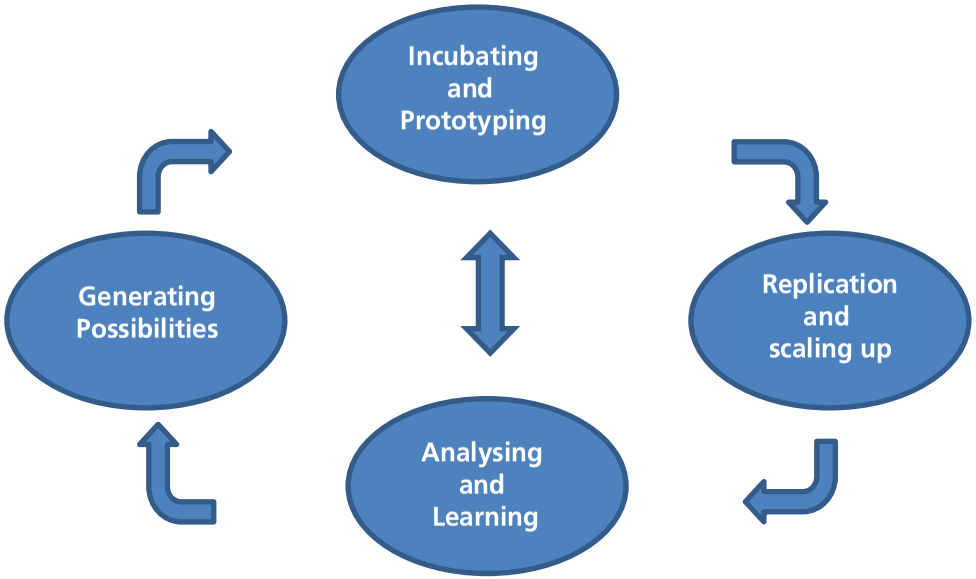
Managing and maintaining an inclusive, representative, knowledgeable and culturally competent workforce at all levels. The capability and capacity of clinical and non-clinical workforce within the CCG including wider membership is developed, at all levels to promote equality of opportunity and address health inequalities;

- Demonstrate year on year improvements towards developing a diverse workforce that reflects the local population, at all levels, through the setting of stretch targets (including the robust monitoring of provider workforce's and CSUs)
- Deliver an equality competent and diverse future workforce that can plan and deliver appropriate and accessible services through improved Education Commissioning.
- Develop equality awareness, capability of the existing workforce at all levels (including wider membership), in order to deliver equality competent services to all sections of the population.
- Organisations to provide evidence of a commitment to improve diversity at board level.
- CCG to become exemplar employer, with a focus on supporting staff achieve work life balance
- Full sign up of member practices to 'Pride in Practice'

Section 17 - Enablers

17.1. Bury CCG model of Innovation

A better understanding of the process of innovation can illuminate where there is room for improvement and where there are blockages[1]. NHS Bury **Clinical Commissioning Group** uses selected Mulgan and Alburys model to support the development of a culture which fosters innovation and creativity, in the figure below.



[1]Geoff Mulgan and David Albury (2003) Innovation in the Public sector

Generating Possibilities
NHS Bury Clinical Commissioning Group understands most innovations come from service users, frontline staff and middle managers. We will create an environment where ideas and suggestions are welcomed and all are explored for feasibility. Either through sector meetings, individual meetings with practice members, walking the wards on quality visits, clinical work stream meetings the NHS Bury Clinical Commissioning Group will take every opportunity to listen and allow teams, staff and patients the space to create innovation.

Incubating, prototyping and managing risks
When an organisation faces financial challenges it can stifle any innovation which needs small amounts of funding. NHS Bury Clinical Commissioning Group has committed to securing a budget for innovation for the clinical cabinet to utilise to fund small projects, test ideas and allow assessment of the impact which changes can have. This will include fostering development of the 3rd sector.

- Use of CQUIN – the NHS Bury Clinical Commissioning Group will utilise CQUINs to drive quality and innovation. This gives a 12 month window for assessment of impact before more innovative pieces of work are mainstreamed.
- Examples of where we have used a small amount of resource to pilot small changes and scale them up are outlined below.

Replication and Scaling Up
If a scheme demonstrates results the challenge is then to further improve results. In 2011/12, NHS Bury Clinical Commissioning Group was very effective in scaling up medicines management efficiencies, by stretching targets year on year. A clear project management system was in place for this; however the on-going success of the replication and scaling up was dependent on engagement of clinicians and practice staff and dedicated support to deliver the change.

Analysis and Learning
Good Business Intelligence informs and supports an innovative organisation, providing the intelligence to support decision making and improve performance. The move towards a proactive, BI architecture will drive the development of the strategic plan.

There are a number of areas where the Business Intelligence service will be enhanced to support Bury CCG: -

1. Review of internal BI processes, identifying where reports can be automated. This will free up resource to support the move towards a business intelligence led service, rather than an information service.
2. Better use of monitoring tools. This will be a combination of centrally developed performance tools e.g. better care fund and local dashboards that monitor activity. These tools will help the CCG determine if a combination of QIPP schemes and service re-design are delivering the expected outcomes.
3. Business Plans
   i. To improve the data modelling behind business plans, with clinical input on the expected outcomes.
   ii. To move to a robust process for providing data for business plans. The new process should model different activity scenarios and include the methodology used to extract data.
4. Benchmarking data–a new Greater Manchester (GM) database has provided an opportunity to compare data across CCGs. This will help identify where the CCG are an outlier and where other CCGs have reduced activity, indicating possible areas for service re-design.
5. Providing drill down reports behind areas of over and under performance.

17.2. Information Sharing & Interoperability

A key enabler to all the CCGs work is to develop integrated records. The following requirements have been identified in order to support an integrated care programme in the North East Sector:

- A Clinical Portal: 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 easily integrate with organisations' own source systems.
- A Patient Portal: an electronic window that will allow patients to actively participate in their own care. It will allow patients to review and update their health records, manage appointments and prescription renewals, access personalised information or discharge materials, and communicate in complete confidentiality with care providers.

These requirements are fully compatible with local IT and organisational strategies across the Sector and a gap analysis has been undertaken to ensure that current systems are compatible and have the capability of interacting with the Integrated Patient Care solutions investigated.

Clinical Portal

The clinical portal will be implemented in at least two phases:

Phase I would include a read-only view of patient information from GP, Social Care, Pennine Acute and Pennine Care systems and would contain Patient Consent Management, Patient demographics, Core Patient Clinical Details e.g. allergies, co-morbidities, Patient Letters and Electronic Discharge Summaries, Patient PACS Images and Test Results, Patient Activity, Messaging and Alerts to care providers when patient's status changes e.g. admitted, Care Pathway and Status Management (developed further in future phases)

Phase II and beyond would look to expand the user base further. It would see the development of the system to allow users to use the portal to update agreed information held in organisations' source systems. In addition the following information could be included in the portal:

- Care Pathway and Status Management (further development)
- Workflows and care plan management
- Booking and scheduling of appointments
- Ordering and Booking of Tests
- Imaging and Videos (non-PACS)
- Telehealth including review of discharged patients
- Diary Management
- Clinical Trial Results
- Prescription Tracking

Patient Portal

A patient portal will allow patients to carry out the following, ability to view pre-existing clinical records, monitor and track symptoms, alert clinicians when symptoms change, online consultations (messaging, Skype), ability to upload files, integrate with telehealth apps, personalised care plans, library of relevant resources, online journal for patients to keep a diary, smartphone compatible. All new systems will be NHS Number compliant and we are working with the LA to make the NHS number the unique identifier.

We have an on-going programme of migration of primary care systems to hosted environments. This is to improve business resilience and continuity as well as supporting information sharing at the detailed care record level. As a by-product this will also achieve efficiency savings in the longer term through improved support arrangements and the decommissioning of on-site clinical servers. Business intelligence is a by-product of high quality clinical data capture as well as good administrative practices. Our work with the Commissioning Support Unit is allowing us to design, build and implement a full data extract which, when blended with other administrative information, supports more effective analysis of this aggregated information.

17.3. Procurement

NHS Bury CCG is developing a robust system for the procurement of new and improved services. This will dovetail with the prioritisation process alluded to under 'transformational schemes' and will involve the strict adherence to a timeline. This timeline will include provision for:-

- Wider clinical and public involvement in service design
- Wider provider involvement and the facilitation of provider networking
- Wider public involvement in the evaluation process, aided by an increased use of out of area clinicians where local clinicians may have a conflict of interest.

Services will be ready to 'go live' 18 months after the start of this process.

The CCG is also working with partners in the Local Authority to better align procurement processes and to better realise the potential of joint working. This will be particularly evident in the procurement of integrated services.

The CCG is confident that these improvements will lead to a better delivery of the visions espoused in this document

17.4. Estates

CCG Estates Strategy Development

We are currently working with NHS Property Company and NHS England to develop our Strategic Estates Plan. This will be finalised in line with the CCGs strategic plan.

It is critically important that property strategy is service led and directly supports the successful achievement of core Health Service priorities and the wider reform programme. The Estates strategy is service led and all property investment or divestment decisions must be able to demonstrate clear linkage to Health outcomes within each locality.

The drivers for this are that:

- CCGs and NHS England Area Teams have a duty to tackle health inequalities and are instructed to work together to develop 5 year strategic plans with 2 year operational plans. (CCG co-ordination will reflect the inter-relationships between local health systems)
- Primary Care provision is changing: reduction in single and double handed practices; improved access to services; 7 day opening.
- Drive to move services into the community from the acute sector.
- Integration with local authority services increasingly important and urgent.
- NHS needs to identify significant revenue savings that cannot be found through efficiencies alone, but need services to be fundamentally realigned.
- A sustainable funding solution for estate improvements is needed.
- There is significant revenue cost and capital tied up in poorly used estate.
- Identifying surplus land for housing is a government priority. Whilst not directly impacting commissioners, it will accelerate disposals and release the holding costs of unused assets that can burden commissioners.
- Strategically planning the estate is an essential element in enabling these objectives - whilst still delivering flexibility and without encumbering the system with long-term liabilities.

A more strategic service led approach is being taken to ensure the estate is fit for purpose, efficient and flexible to be able to meet the needs of frontline services. The approach that is being taken is based on a supply and demand model. The diagram below illustrates the approach being taken to identify opportunities and challenges that will underpin the local plans and priorities;

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From initial assessment and anecdotal evidence there is an oversupply of property in Bury but this will be more formally assessed in consultation with the CCG and other key stakeholders as a priority action for the early part of 2014. This exercise will establish surplus capacity within the estate then consideration will be given to how this could be better used or released.

It is also accepted that improvements in frontline services delivery, access to services and space utilisation can be achieved by increased collaborative working with partners within the District.

Section 17 - Enablers

The Council boundary and CCG boundary are identical which aids planning and co-ordination. Local Authorities are also seeking to identify and implement significant efficiencies from property and see collocation as an opportunity to save money and improve services at a local level. A cross public service strategic estates group (SEG) is already established and will have responsibility for the service led property strategy as its key agenda to progress over the next 3 to 5 years. It is proposed that the SEG's terms of reference, membership and work programme is redefined during April/May 2014 to ensure it is fit for purpose and has the mandate and support from the sponsoring organisations.

The SEG will maintain a public service led approach but with a specific focus on property and 'Place' within its widest sense. This will include but not be limited to;

- **Suitability** – is it fit for the purpose intended? Is it accessible for service users?
- **Sufficiency** – Is it the right size? How well is it utilised?
- Condition – Is it in a safe and in satisfactory condition for the purpose intended?
- **Running Cost** – Taking a lifecycle approach is it a cost effective solution when benchmarked against good practice. Consider opportunities gain economies of scale through combined FM supply chain procurement and management.
- **Investment** – When a requirement is identified could it be satisfied by making better use of an existing asset in the wider public sector estate. Could that single service investment be joined up with funding and requirements to make a greater impact at a local level? What impact will the investment have on the local 'Place' and wider regeneration?
- **Divestment** – Consider other public sector uses before going to the market. Consider marketing combined surplus asset to generate higher capital receipt. Consider the regeneration and place shaping opportunities.

To support this more strategic approach all buildings will be categorised based on an agreed standard and in consultation with the CCG and other key stakeholders. The categories will represent the importance or otherwise of each building within the estate and focus management attention on properties particularly at the top and bottom of the list.

17.5. Workforce

Bury Health & Social Care Workforce

Consequences of the Health & Social Care reform will, inevitably, not only affect the current workforce but will have huge implications for future workforce. Whilst acknowledging this disturbance as a risk, it is essential to achieve the new service delivery models required.

A whole systems approach will be adopted within Bury and the wider North East sector through a multi-organisational, multidisciplinary workforce group. The workforce group will work in partnership with Health Education England (HEE) through the Greater Manchester Integrated Care Workforce Collaboration Group and ensure that plans are aligned to the wider workforce strategies including Healthier Together. Key stakeholders will be involved at all stages.

The workforce group aim to utilise and further develop current strong relationships within the health and social care system to mitigate disruption to the workforce and retain and appropriately reskill the valuable human resource within the Borough and sector.

Proposed work plan:

Table 12

Year	Actions	Status
2014-15	Integrated Care strategy	Completed March 14
	Collaborative aims & objectives agreed	Completed March 14
	Engage with GM Integrated Care Workforce Collaboration Group	Completed May 14
	Share agreed governance arrangements with stakeholders and staff	In progress June/July 14
	Link partner OD plans	Working group proposed May 14
	Develop cross-boundary working governance structures	
	Identification of risks/issues to collaborative working	Through workforce group
2015-16	Review current workforce position	
	Development of integrated pathways	All actions to be addressed through workforce group throughout 15/16
	Develop integrated leadership and management	
	Evaluate current integrated working to inform strategy	
	Engage and support carers	
2016-17	Develop innovative/general roles and plan and deliver appropriate education and training	

17.6. Research

The CCG has the power to conduct, commission or assist the conduct of research into any matters relating to the causation, prevention, diagnosis or treatment of illness; and any such other matters connected with any service provided under the 2006 Act.

The CCG has within its duty to support and promote evidence based practice and research; and use the evidence from research when carrying out its commissioning functions.

The CCG is a partner of the National Institute for Health Research (NIHR) and the Greater Manchester Collaboration for Leadership in Applied Heath Research and Care (CLAHRC).

The CLAHRC presents an opportunity for partnership working across disciplines, organisations and sectors in carrying out high quality applied research and putting research into practice, as well as building organisational capacity for these activities.

CLAHRC is already engaged with the CCG via the Chronic Disease Management through the Long Term Conditions work stream lead. Our CLAHRC team is continuing to work with 5 practices not previously recruited to our heart failure (GM-HFIT) programme.

Additionally, the CCG actively supports the local Providers in their research projects, for example part of the Commissioning for Quality and Innovation (CQUIN) funding is for research initiatives. The CCG reviews and appraises research projects from our Providers in the Clinical Quality meetings as appropriate and the findings presented to a wider stakeholder audience.

The Academic Health Science Network

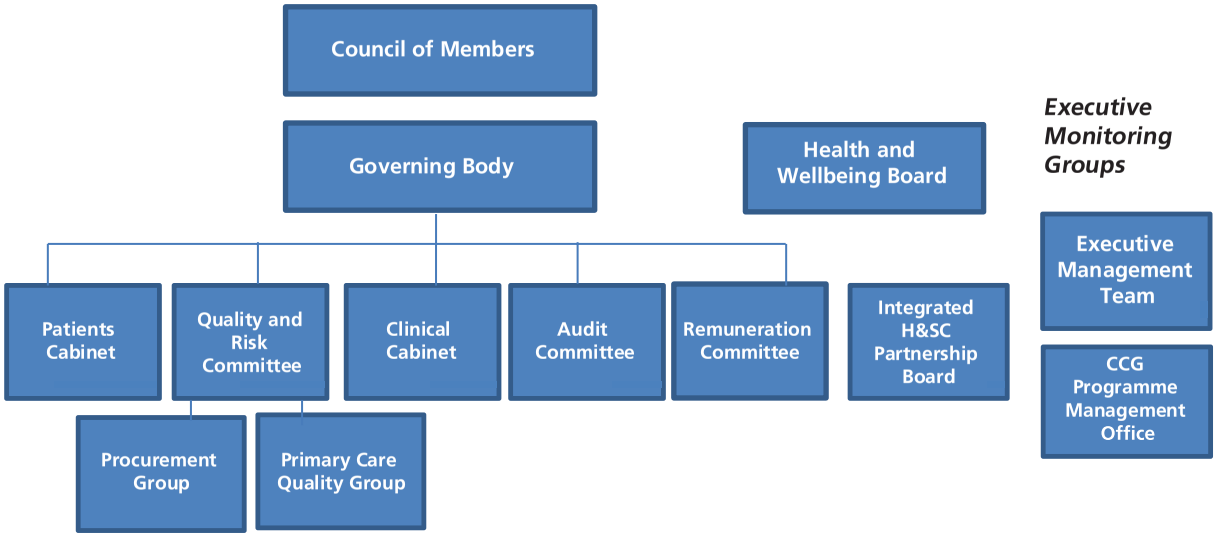
To support research and development Bury CCG are part of the greater Manchester Academic Health Science Network they are working with us on innovative solutions in the following areas:

- Cardio-vascular disease programme
- Vascular risk management.
- Improving patient safety.
- Shared patient data.

Importantly, they are forging relationships with universities and the corporate sector that are likely to bring innovations to the health care needs of our populations, and additional resource to our members as they pursue their health improvement goals.

Section 18 - Governance to Deliver

The CCG has a robust governance infrastructure, which is outlined below. Each of the subcommittees is chaired by a Non-Executive Director or Clinical Board Member.



The Executive Monitoring Groups ensure performance management of the Work stream / QIPP / Performance leads

To ensure that Bury CCG remains focused on delivery of its plans throughout 2014/16 and beyond it will implement the following tracking mechanisms.

- Weekly meetings between the Clinical work stream lead and service redesign manager.
- Monthly review of programme or project progress at CCG Clinical Cabinet Committee
- Monthly review of how the CCG is doing against its Quality Premium indicators at the Quality and Risk Committee.
- Monthly review of financial performance at the Audit Committee and Governing Body.
- Monthly review of performance issues and risks* at the Quality and Risk Committee (and the most significant risks (at the governing body).
- Monthly review of project progress at operational team meetings, run by the Deputy Head of Commissioning and Deputy CFO. Where possible, the benefits of each project should be tracked to monitor its effectiveness in achieving its objectives. The aforementioned fora will be used to check whether benefits have been realised. If they have not been realised, a decision will be taken about whether the project continues or is adapted.
- Monthly review of the programme of Programmes jointly commissioned through the Better Care Fund through the Integrated Health and Social Care Partnership Board which is chaired by the Chief Officer of Bury CCG and the Director of Adult Care Services.
- Oversight and scrutiny of delivery through the Health and Wellbeing

*Risks – recognised risks are outlined within appendix 3.

Section 18 - Governance to Deliver

18.1 Decommissioning and Disinvestment

To ensure that limited resources are consistently directed to the highest priority areas the CCG have identified the need to develop a Decommissioning and Disinvestment Plan that sets out the agreed principles for decommissioning services to allow funds to be redirected where appropriate. There is a need to ensure that when approval has been given to decommission, or disinvest from, a service, a clearly defined process is followed with clear lines of accountability and responsibility.

18.2 Conflict of Interest

The CCG takes conflicts of interest very seriously. Declarations of interest are published on the CCGs website http://www.hmr.nhs.uk/attachments/article/13/Governing%20Body%20Decs%20of%20Interest%20for%20Website.pdf.

When an interest has been declared the declarer will ensure that before they inform the chair of the meeting. The chair of the meeting will then determine how this should be managed and inform the member of their decision. Where no arrangements have been confirmed, the chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual will then comply with these arrangements, which must be recorded in the minutes of the meeting.

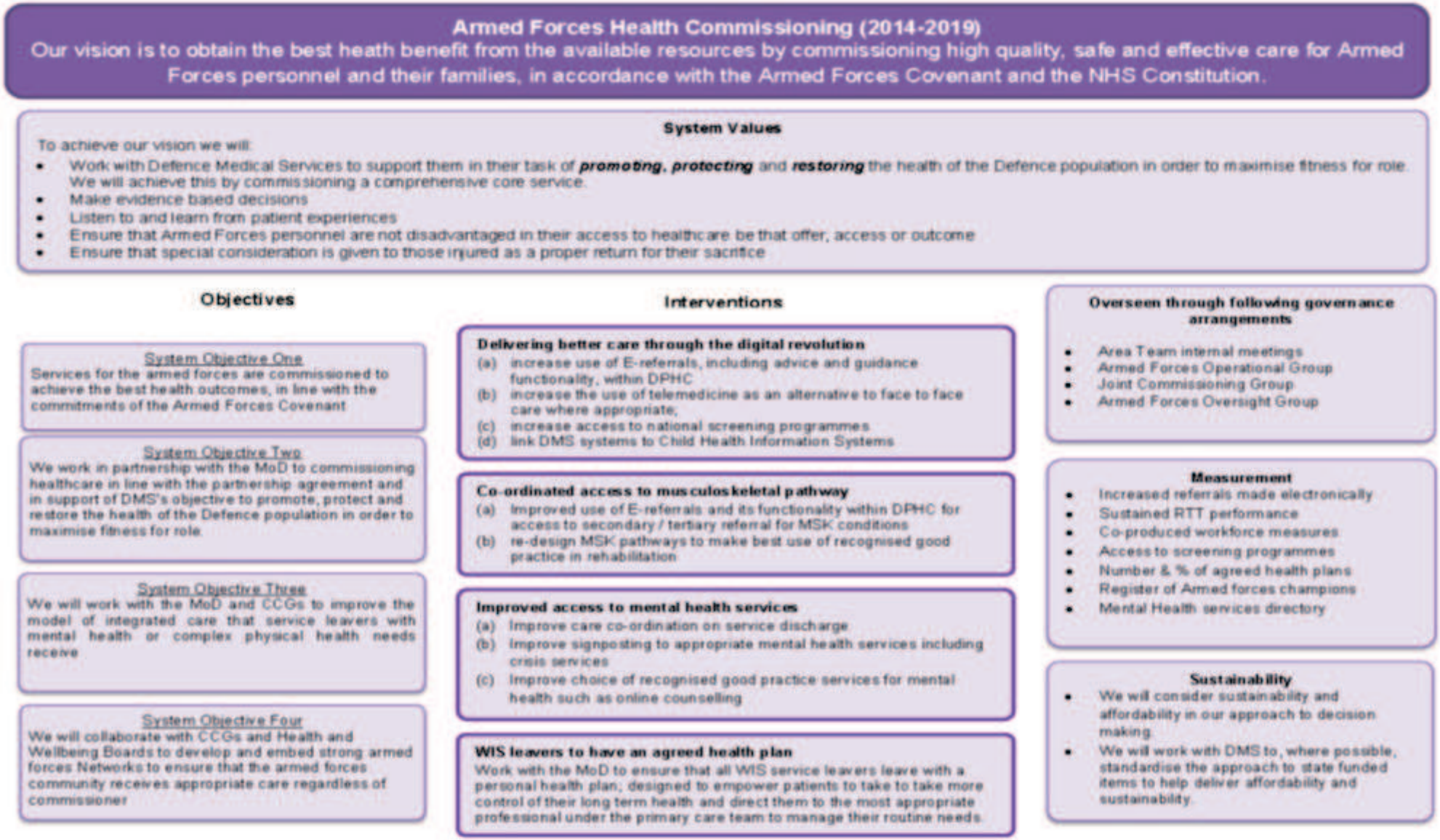
Get in touch

If you have any comments on the report, or questions on the information contained within it, we'd really like to hear from you:

- If you have an enquiry or would like to give us your feedback, you can do this through the 'We're here to help' section of our website www.buryccg.nhs.uk
- You can email us at buccg.communications@nhs.net
- You can give us a call on 0161 762 3106
- And you can reach us via our Twitter account www.twitter.com/NHSBURYCCG

NHS BURY CLINICAL COMMISSIONING GROUP
STRATEGIC PLAN 2014-2019
APPENDICES

APPENDIX 1


Armed Forces Health Commissioning (2014-2019)
Our vision is to obtain the best heath benefit from the available resources by commissioning high quality, safe and effective care for Armed Forces personnel and their families, in accordance with the Armed Forces Covenant and the NHS Constitution.
System Values
To achieve our vision we will:
Work with Defence Medical Services to support them in their task of promoting, protecting and restoring the health of the Defence population in order to maximise fitness for role. We will achieve this by commissioning a comprehensive core service.
Make evidence based decisions
Listen to and learn from patient experiences
Ensure that Armed Forces personnel are not disadvantaged in their access to healthcare be that offer, access or outcome
Ensure that special consideration is given to those injured as a proper return for their sacrifice
Objectives
System Objective One
Services for the armed forces are commissioned to achieve the best health outcomes, in line with the commitments of the Armed Forces Covenant
System Objective Two
We work in partnership with the MoD to commissioning healthcare in line with the partnership agreement and in support of DMS's objective to promote, protect and restore the health of the Defence population in order to maximise fitness for role
System Objective Three
We will work with the MoD and CCGs to improve the model of integrated care that service leavers with mental health or complex physical health needs receive
System Objective Four
We will collaborate with CCGs and Health and Wellbeing Boards to develop and embed strong armed forces Networks to ensure that the armed forces community receives appropriate care regardless of commissioner
Interventions
Delivering better care through the digital revolution
(a) increase use of E-referrals, including advice and guidance functionality, within DPHC
(b) increase the use of telemedicine as an alternative to face to face care where appropriate;
(c) increase access to national screening programmes
(d) link DMS systems to Child Health Information Systems
Co-ordinated access to musculoskeletal pathway
(a) Improved use of E-referrals and its functionality within DPHC for access to secondary / tertiary referral for MSK conditions
(b) re-design MSK pathways to make best use of recognised good practice in rehabilitation
Improved access to mental health services
(a) Improve care co-ordination on service discharge
(b) Improve signposting to appropriate mental health services including crisis services
(c) Improve choice of recognised good practice services for mental health such as online counselling
WIS leavers to have an agreed health plan
Work with the MoD to ensure that all WIS service leavers leave with a personal health plan; designed to empower patients to take to take more control of their long term health and direct them to the most appropriate professional under the primary care team to manage their routine needs
Overseen through following governance arrangements
Area Team internal meetings
Armed Forces Operational Group
Joint Commissioning Group
Armed Forces Oversight Group
Measurement
Increased referrals made electronically
Sustained RTT performance
Co-produced workforce measures
Access to screening programmes
Number & % of agreed health plans
Register of Armed forces champions
Mental Health services directory
Sustainability
We will consider sustainability and affordability in our approach to decision making
We will work with DMS to, where possible, standardise the approach to state funded items to help deliver affordability and sustainability

APPENDIX 2

	Measure	Definition	Threshold	13/14	Plans to secure performance
PHQ 01	Ambulance quality - Cat A response times	Cat A response within 8 mins	75%	75.9%	
PHQ 02		Cat A response within 19 mins	95%	95.8%	
PHQ 03	Cancer 62 day waits	Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	85%	87.5%	
PHQ 04		Percentage of patients receiving first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	90%	89.3%	Immediate recovery plan in place. Transformational change outlined in section 16
PHQ 05		Percentage of patients receiving first definitive treatment for cancer within 62 days of a consultant decision to upgrade their priority status	85%	91.6%	
PHQ 06	Cancer 31 day waits	Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis	96%	99.2%	
PHQ 07		Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is Surgery	94%	98.2%	
PHQ 08		Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is a Radiotherapy Treatment Course	94%	99.5%	
PHQ 09		Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is an Anti-Cancer Drug Regime	98%	100.0%	
PHQ 10	Mental health measures - EI	The number of new cases of psychosis served by early intervention teams year to date	30.00	35.00	
PHQ 11	Mental health measures - CR/HT	Commissioner measure is number of episodes, provider measure is % of inpatient admissions that have been gate kept by CR/HT	408.00	391.00	
PHQ 12	Mental health measures - CPA	The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric inpatient care during the quarter (QA)	95%	95.3%	
PHQ 13	Mental health measures - IAPT	Proportion of people with depression who receive psychological therapy	n/a	n/a	Immediate recovery plan in plan, long term recovery plan being developed with the CCG by the National Intensive support team.
		Proportion of people who complete therapy who are moving to recovery	40.1%	34.6%	
PHQ 14	People with Long Term Conditions feeling independent and in control of their condition	% of people with LTCs who said they had enough support from local services/orgs	79%	66.0%	CCG has invested in enhanced care planning for people with LTC and elderly patients, including MDTs outlined in section 16

	Measure	Definition	Threshold	13/14	Plans to secure performance
PHQ 15	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)	Proportion of unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) per 100,000 population	908.94	809.36	
PHQ 16	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	Proportion of unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s per 100,000 population	495.86	380.30	
PHQ 17	Emergency Admissions	Emergency admissions for acute conditions that should not usually require hospital admission	2838.8	2480.4	
PHQ 18	Patient experience survey	Outliers identified using NHS PF approach + narrative & results of local surveys	n/a	n/a	
PHQ 19	RTT waits	RTT - admitted % within 18 weeks	90%	87.9%	Immediate recovery plan in place, Transformational change outlined in section 16
PHQ 20		RTT - non-admitted % within 18 weeks	95%	95.8%	
PHQ 21		RTT- incomplete % within 18 weeks	92%	93.9%	
PHQ 22	Diagnostic waits	% waiting 6 weeks or more	0.9%	0.79%	
PHQ 23	A&E	% of patients who spent 4 hours or less in A&E	95%	95.8%	
PHQ 24	Cancer 2 week waits	Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	93%	96.9%	
PHQ 25		Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected	93%	94.3%	
PHQ 26	MSA breaches	Numbers of unjustified breaches	0	2	Performance recovered 2014/15, on-going maintenance managed through contractual routes
PHQ 27	HCAI measure (MRSA & CDI)	MRSA bacteraemia	0	2	Robust infection control plan in place across all providers and managed through contractual routes.
PHQ 28		CDI	54	50	
PHQ 29	VTE risk assessment	% of all adult inpatients who have had a VTE risk assessment	95%	95.9%	

APPENDIX 3 – Risks

The table below provides an overview of some of the key risks identified through the Better Care Fund co- design process to-date:

Risk	Impact	Likelihood	Risk	Mitigating Actions
If resources are redirected to fund new joint interventions and schemes it may destabilise current service providers, particularly in the acute sector	5	3	15 High	• 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
If resources are reallocated within the BCF to fund integration initiatives it may destabilise the CCG and/or the LA	5	3	15 High	• A set of principles for the establishment of the BCF pooled budget will be agreed between the CCG and the LA as part of the BCF plan governance process by 4th April 2014 • The plan is to increase 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 • A new governance arrangement for the integrated commissioning between the CCG and the LA will has been established to monitor the Better Care Fund
If we do not have accurate data our financial and performance, targets for 2015/16 onwards are unachievable	4	2	8 Med	• 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 • 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 • An integrated workforce strategy will be developed to support the Integrated Care development
If operational pressures continue to increase across all agencies, 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 reality	4	3	12 High	• Our 2014/15 schemes include specific non- recurrent investments in the infrastructure and capacity to support overall organisational development
If improvements in the quality of care and in preventative services do not translate into the required reductions in acute and nursing / care home activity by 2015/16 there will be an impact on the overall funding available to support core services and future schemes through Better Care.	4	2	8 Med	• We have modelled our assumptions using a range of available data • 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications

If the introduction of the Care Bill results in a significant increase in the cost of care provision from April 2016 onwards it will impact on the sustainability of current social care funding and plans	4	3	12 High	• We have undertaken an initial impact assessment of the effects of the Care Bill and will continue to refine our assumptions around this as we begin to deliver upon the associated schemes • We believe there will be potential benefits that come out of this process, as well as potential risks
If there is insufficient clinical engagement in the transformation models they will be clinically un sound and not deliver the transformational change required	3	3	9 Med	• Clinical leads for each work stream has been identified • Clinicians will be involved within the steering groups and work stream groups. • Robust locality infrastructure to ensure Primary care Engagement • Provider clinicians engaged via local working groups.
If IM&T solutions to integrated care records are not available it will impact on our ability to integrate services.	4	3	12 High	• IM&T clinical lead to be integral to the development of the transformations models • The technology solution to be developed alongside the Academic Health Science Network to ensure the most innovative solutions. • Small changes to be tested across providers
If robust Information Governance processes policies are not in place, data sharing across agencies will be restricted	4	2	8 Med	• Information governance lead and Caldecott guardians to be involved in project from start and develop policies to support the service model.
If patients, customers and community are not involved and engaged in planning new models of integrated care they will not meet their needs	4	2	8 Med	• Proactive focus on development of range and effectiveness of service user, equality and wider public reference groups • Development of mechanisms to connect these to the strategic planning process
If patients, customers and community are not involved and engaged in sufficiently in maintaining and improving their own health & wellbeing we will fail to deliver the improvement necessary	4	4	16 High	• Adoption of a more systematic, evidence based and scaled approach to community engagement for health.
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 IBP. This will result in CCGs paying for the activity commissioned in the community and the activity delivered within PAHT	4	4	16 High	• 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
If PAHT remove the capacity which 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.	4	4	16 High	• 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.

If the delivery of a reduction in A&E activity results in patients with low level need being seen in Primary Care, this may 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	4	4	16 High	• The CCG and Council will review ways to deliver services in an integrated way with A&E which continue to support deliver of the standard.
If transformational change disrupts services there could be a reduction of service, reduction in quality, continuity of care and performance.	4	2	8 High	• 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 work stream leads • Risk assessment methodology will be applied consistently to service redesign • Tactical groups in place to monitor system change impact on cancer, RTT and A&E targets to ensure we can swiftly act to any sign of variation from the norm. • NES approach to quality assuring Provider Cost Improvement Plans to ensure rigor and deliverability. • Dedicated CCG quality team to work with providers to ensure focus on the key priority areas i.e. Francis, Berwick Keogh.
If management costs reduce further or NHS England transfer responsibility for commissioning other services without adequate resource the CCG will be unable to deliver the breadth of transformation within this strategy	4	4	16 High	• CCG will not accept any delegation without appropriate resources • CCG will continue to use CSU for as many products as is feasible to maximise VFM.
If the CCG does not develop effective partnerships it will be unable to deliver the transformation outlined in this strategy	4	2	8 Medium	• CCG and LA have in place partnership infrastructure • CCG works with NES colleagues to meet with large providers every two weeks to ensure adequate planning is in place • CCGs across the NES have developed a leadership team, made up of CCGs Chief Officers and Chairs, Provider Chief Executives and Council Directors to work through the most difficult system issues.
If staff are not adequately skilled to deliver transformational change the CCG will not deliver the strategic intent.	4	2	8 Medium	• CCG OD plan being refreshed in line with the strategy • Programme of mentorship and coaching being developed for staff involved in transformational change • Development programme in place with CSU

APPENDIX 4 - Transformational Schemes

This contains the transformation scheme work programmes, which will continue to evolve over the duration of the strategy. It is not anticipated that resources will allow ALL to be delivered however the visionary plans for each work stream have identified areas where development may be of value.
The work streams are identified in the PLAN column where the lead plan for the initiative is in bold and associated plans, which also have input, appear alongside.

Plan Legend	**Driver Legend** - The drivers section outlines where the initiative is identified to be of value
C - Cancer I - Integrated Primary Care W - Women's & Children L - Public Health E - Elective Care U - Unplanned Care M - Mental Health/Learning Disabilities P - Palliative Care	Q - Quality Improvement CfV - Commissioning for Value JS - Joint Strategic Needs Assessment BCF - Better Care Fund HT - Healthier Together Programme BT - Better Together Programme NT - National Target

National Framework Legend - All initiatives are linked to the NHS Frameworks

Domains	**Ambitions**	**Transformation Characteristics**
1. Preventing premature death 2. Quality of life for LTCs 3. Quick recovery from ill health 4. Great experience of care 5. Safe care	1. Securing additional years of life for people with treatable mental and physical conditions 2. Improving health related quality of life for people with long term conditions 3. Reducing avoidable time in hospital 4. Increasing elderly people living independently at home on discharge 5. Increasing positive experience of hospital care 6. Increasing positive experience of care outside hospital 7. Significant progress on eliminating avoidable deaths **8. Key Measure 3** - Parity of Esteem	1. Including citizens 2. Wider Primary Care provided at scale 3. A modern model of integrated care 4. Access to the highest quality urgent and emergency care 5. Step Change in Elective Care 6. Specialised services concentrated in centres of excellence

Transformation Scheme 1 — Establish Collaborative Prevention, Wellness and Life Support Programmes

National Frameworks	Initiatives	Drivers	Plan(s)	Financial Impact	Timeline	Starting Well	Developing Well	Living Well	Working Well	Ageing Well
						Health & Wellbeing Strategy Life Course				
A1 A7 K1	Devise a cancer Risk Stratification system for age 24+	JS CfV	C		Y1-5	X	X	X	X	X
A1 A7 K1	Bury branded cancer communication programme	JS CfV	C		Y1-5	X	X	X	X	X
A1 A7 K1	Deliver cancer prevention & education initiatives	JS CfV	C		Y1-5	X	X	X	X	X
A1 A7 K1	Develop a programme to identify barriers to uptake of Cancer prevention initiatives	JS CfV	C		Y1-5	X	X	X	X	X
A1 D4	Provide Smoking cessation programme	BT BCF	U W M C		Y1-5	X	X			
A1 D4	Provide Flu immunisation programme	BT BCF	U							
A1 A2 D4	Provide Respiratory Technique Training Programme	BT BCF	U W	-£49,951	Y1		X	X	X	X
A2	Consider the implications of adopting EPACCS or other IT solutions	Q	P		Y1					
A2	Develop a Bury Wide EoL Integrated Pathway	BCF Q	P C M U	-£140,721	Y1				X	X
A2	Explore the use of CQUINs to support the EOL care agenda	BCF Q	P		Y1			X	X	X
K3 A2	Support stakeholder education and training use MPET funding to find the 1%	Q	P		Y 2-5					X
K3 A2	Scope LD Friendly Community Model	BCF	M		Y2-4			X		
K3 A1 A2	Ensure mental and physical health are given equal status in care pathways	Q	M		Y1-5		X	X		
K3 A6	Develop plans for offender and veteran health	Q	M		Y2			X		
K3 A1	Promote non-medication management approach in MH & reduce antipsychotics for dementia	Q BCF	M		Y1-5			X		
K3 A6	Embed parity of esteem principles for mental health across the life course including BME & LD groups	BCF Q	M L		Y1-5	X	X	X	X	X
K3 A1	Develop pathways to improve uptake of screening/health check for people with MH & LD	BCF Q	M		Y 1		X			
K3 A2 A6	Promotion of health trainers in mental health and LD population	BCF Q	M		Y 1		X	X		
K3 A1	Promotion of alcohol awareness and screening with clinicians	JS CfV	M		Y 1		X			
K3 A2 A6	Develop a community based, needs led cognitive impairment service & improve assessment detection and diagnosis rates	BCF Q	M		Y1-5		X	X	X	
D4 A1 A5 A6	Engage in a wellness programme around Maternity Care	Q	W L		Y1-5	X	X	X		

Transformation Scheme 2 — Create an Integrated Community Based Care Programme

National Frameworks	Initiatives	Drivers	Plan(s)	Financial Impact	Timeline	Starting Well	Developing Well	Living Well	Working Well	Ageing Well
						Health & Wellbeing Strategy Life Course				
T3 A1	Ensure equity of access to services	Q BCF	W I L M	Better Care Fund 11.7 million joint investment	Y1-5	X	X	X		
T2 A2 A6	Increase community based MDTs	BCF	I U W M		Y1-2		X	X	X	X
T2 A1 A2 A6	Develop Integrated Community Cardiology Services	BCF CfV JS	I U E		Y1-2		X		X	X
T2 A6 D4	Increase access to GPs	BCF HB	I U W		Y1-2	X	X	X	X	X
T2 A1 A2 A6	Deliver the Stroke Support Programme	BCF JS CfV	U I		Y1		X		X	X
T3 A1 A2 A6	Deliver Integrated Community Diabetes Programme	BCF JS CfV	U W		Y1-2		X		X	X
T3 A1 A2 A6	Increase Integrated Community Respiratory Clinics	BCF JS CfV	U I W		Y1-2		X		X	X
T3 A2 K3	Identify Opportunities for a Shared Care Model for MH/LD e.g. ADHD	BCF CfV	M		Y1-2				X	
T2 K3	Undertake a Pharmacy Questionnaire MH/LD	BCF CfV	M		Y1-2		X			
T3 A6	Develop signpost and referral systems to available support programmes	BCF	M		Y1-2		X			
T3 A6 D4	Deliver the Crisis Response Service	BCF HT BT	I U		Y1-2				X	X
T4 A6 D4	Enhance the Care Home LES	BCF	I U E P		Y1				X	X
T3 A4 A6	Implementation of named GPs for the over 75's	BCF	I P U		Y1		X		X	X
T3 A6	Develop Gold Standard Framework accreditation in Care Homes	BCF	P		Y 2-3				X	X
T3 A2	Develop an Outcomes Based Framework to monitor lifestyle risk factors for MH/LD population	BT	M W		Y1-5	X	X	X		
T3 A6	Redesign CAMHS to develop a multidisciplinary, integrated children's MH Community service	BCF HT BT	M W		Y1 -Y2			X		
T2 A6	Provide improved access to Ophthalmology services	BCF	I E		Y1-5					
T2 A6	Provide improved access to community IV services	BCF	I E		Y1-5				X	X
T2 A2 A6 D2	Provide improved access to Continence Services.	BCF	E I							
T2 A6	Devise & Implement Paediatric Community workforce proposal	BCF	W		Y1-5	X	X	X		
T2 A6	Paediatric Service and pathway review & redesign	Q	W		Y1 -5	X	X	X		
T2 A6	Re procurement of Paediatric Community Services	Q	W		Y2	X	X	X		
T2 A6	Develop Single Point of Access Paediatric OOH care centre	BCF HT	W		Y1-2	X	X	X		
T3 A2 A6 D2	Establish cancer support groups with the voluntary sector	BCF	C							
D5 A7	Delivery of the Winterbourne Strategic Action Plan	Q	M		Y 1-5					
T3 A6 D4	Improve clinical correspondence between primary and secondary care	Q	M		Y 1					
T3 A2	Ensure IAPT services achieve prevalence and recovery targets and equality of access for LD	NT	M		Y 1			X		
T3 A2	Implementation of the SEND Agenda and integrated EHC plans	Q	M		Y1-5	X	X			

National Frameworks	Initiatives	Drivers	Plan(s)	Activity / Measures	Financial Impact	Timeline	Starting Well	Developing Well	Living Well	Working Well	Ageing Well
							Health & Wellbeing Strategy Life Course				
T5 A3	Identify opportunities to transfer cancer services into the community	BCF JS CfV	C	15% Reduction in Elective Activity 14/15 - 0% 15/16 - 3.0% 16/17 - 3.5% 17/18 - 4.0% 18/19 - 4.5%	Year Value 14/15 £0 15/16 -£365,505 16/17 -£426,423 17/18 -£487,340 18/19 -£ 548,258 5 Year Total -£1,827,525	Y1	X	X	X	X	X
K3 A5 A6	Ensure the choice of Mental Health provider agenda is exercised	NT	M			YI			X	X	X
K3 A5	Embed parity of esteem principles for MH & LD across elective care	Q	M E			Y1-5			X	X	X
T5 D5	Reduce Caesarean Section Rate	Q	W			Y1	X	X			
T5 D5 D6	Develop direct GP referrals to secondary care	BCF	E			Y1	X	X	X	X	X
T5 D3	Develop and commission an enhanced recovery programme	BCF	E			Y2-5	X	X	X	X	X
T5 D5 A1 A7	Review pre and post-operative assessments services	Q	E			Y2-5	X	X	X	X	X
T5 D4 A1	Develop end to end condition specific pathways	Q	E			Y1-5	X	X	X	X	X
T5 A5 A6	Evaluate the Referral Gateway and EUR Process	Q	E	5% Reduction in Day Case 14/15 0% 15/16 -0.5% 16/17 -1.0% 17/18 -1.5% 18/19 -2.0%	Year Value 14/15 £0 15/16 -£45,012 16/17 -£90,024 17/18 -£135,036 18/19 -£ 180,048 5 Year Total - £450,120	Y1-2	X	X	X	X	X
T5 D4 A1	Improve access to Consultant led virtual clinics	BCF	E I			Y1-2	X	X	X	X	X
T5 D4 A3 A5 A6	Develop an early supported discharge process	BCF	E I			Y2-5	X	X	X	X	X
T5 D5 A7	Target workforce and retention issues in key areas	Q	E W			Y1-5	X	X	X	X	X
T5 T6	Improve links between specialist and generalist areas	BCF	E W			Y1-5	X	X	X	X	X
T5 D4	Reduce unnecessary appointments	BCF CfV	E			Y1-4	X	X	X	X	X
T5 A3 A6	Improve access to diagnostic and treatment services in the community, including re-procurement of the ISCATS contract	BCF	E			Y1-5	X	X	X	X	X

National Frameworks	Initiatives	Drivers	Plan(s)	Activity / Measures	Financial Impact	Timeline	Starting Well	Developing Well	Living Well	Working Well	Ageing Well
							Health & Wellbeing Strategy Life Course				
T4	LTC AQUA	BCF AR	U I	20% Unplanned Activity Reduction 14/15 - 3.4% 15/16 - 14.1% 16/17 - 0.8% 17/18 - 0.8% 18/19 - 0.8% 16.5% Reduction in A&E Attendance 14/15 - 3% 15/16 - 12% 16/17 -0.5% 17/18 -0.5% 18/19 -0.5%	LTC AQUA - £12,975 14/15 Baseline 15/16 -£5,282,770 16/17 -£299,732 17/18 -£299,732 18/19 -£ 299,732 5 Yr Total - 6,181,965 14/15 Baseline 15/16 -£716,319 16/17 -£29,847 17/18 -£29,847 18/19 -£29,847 5 Yr Total -£805,859	Y1		X		X	X
T4 A1 D5	111 Service Development	BCF	U			Y1-5	X	X		X	X
T4 A2 A3	Redirect Respiratory activity into the community	BCF CfV	U W			Y1-2	X	X		X	X
T4 A2 A3	Redirect Cardiology activity into the community	BCF CfV	U			Y1		X		X	X
T4 A2 A3	Redirect Diabetes activity into the community	BCF CfV	U W			Y1	X	X	X	X	X
T4 D4 A5	Minimum 95% A&E <4 Hour wait target	NT	U			Y1-5			X	X	X
T4	Review the Local Impact of RAID and enhance where appropriate	BCF	M U L			Y1-5			X		X
T4 A2 A3	Monitoring of Asthma presentations to A&E	HT CfV	U W			Y1		X		X	X
T4 A2 A3	Undertake an audit of Paediatric respiratory presentations	CfV	W U			Y1				X	
T4 K3	Implement alcohol frequent flyers project across Bury	JS	M L			Y 1-2			X		
T4 K3 A2	Develop pathway with GP and Adult LD team to prevent unnecessary attendance at A&E	BCF	M			Y 1		X	X		
T4 K3 A2	Develop evidence based model to reduce admissions and length of stays for adults with acute mental health problems	BCF	M			Y3-5			X		

Appendix 5 – Work stream plans on a page

End of life

1

Our vision for Bury is to have an integrated and co-ordinated palliative and end of life pathway that supports patients and their families to have care that is tailored to their needs and allows them to live and die in their preferred place of care.

2

System Objective One Understand the totality and interdependencies across the EOL Pathway	Delivered through interventions: EOL Review due to report in Q1 2014/15 • Reflect the outputs from the Bury wide, January 2014 stakeholder scoping event.
System Objective Two Develop systems for the transfer of data across agencies	Delivered through interventions: • Review the implications for adoption of Integrated Electronic System and other potential IT solutions.
System Objective Three Review usage of DNACPR and promote service via eol Information pack	Delivered through interventions: • Develop a Bury wide Integrated Pathway building on the outputs from the January 2014 stakeholder scoping event. • Localise examples of best practice such as, Midhurst. • Review religious/ethnicity/social impact on EOL care • Develop a system wide Bury Patient Charter for EOL
System Objective Four Reduction NEL Admissions and XBDs for EOL patients. Increase deaths in preferred place.	Delivered through interventions: • Develop plans beyond the Rapid Transfer Pilot • Support proactive hospital in reach mechanisms • Encourage further uptake of the Care Home LES • Promote EOL care within the implementation of named GPs for the over 75's • Explore the use of CQUINs to support the EOL care agenda
System Objective Five Identify undiagnosed patients and support Education and Training across Bury	Delivered through interventions: • Support practice via MPET to 'find the 1%'. • Support stakeholder education and training through MPET
System Objective Six Develop GSF accreditation in Care Homes	Delivered through interventions: • Use MPET funding to support Care Homes

3

5

Overseen through the following governance arrangements:

Clinical Lead for EOL
LA & Joint (Health and Wellbeing Board)
CCG Governance (Cabinet, Patient Cabinet)
NES Commissioning Board
Altogether Better/Healthier Together
Bury CCG Sector Meetings
Sector Led Practice Liaison

4

Measured using the following success criteria:

Reduction in NEL Admission
Reduction in XBDS
Increase in death is Preferred Place of Care (PCC)
All key stakeholder are engaged in the early planning stages of commissioning, including providers and patients
Bury as a best practice in the national picture

6

System values and principles:

Reduce inequalities and improve outcomes
Deliver transformational change
Develop capability as commissioners and leaders
Deliver improvements via QIPP to create high quality sustainable services
Ensure citizenship, self-care and prevention is at the heart of what we do

Cancer

1 ***To improve health and wellbeing of the population and to enable people to live longer, healthier lives and feel supported to have best quality of life possible***

2

Prevention

Reduce preventable cancers by 2% each year

Detection

Increase screening uptake by 2% each year

Intervention/Treatment

Work with Providers to ensure treatments are delivered closer to home, which are safe, of high quality, and delivered within national performance targets and standards

Survivorship

Design, develop and embed a survivorship framework with protocols that help patients, carers and families to regain confidence to continue to live their lives

3

- Engage in partnership with Local Authorities, NHS England, Primary Care, Secondary Care, Patients, Public and Voluntary sector to deliver a creative, Bury branded, collaborative cohesive communication programme that is effective and fit for purpose and that uses a broad range of technologies, media and materials
- Expand current risk stratification systems to include risk profiling all adults 24 years and over

- Build on the outputs from prevention interventions ie – raised public awareness and risk stratification of patients, and additionally develop a programme that systematically identifies barriers to uptake.
- Shift monies from incentivising practices to motivating patients – work with commercial sector to explore opportunities for reward

- Commission high quality services, that have evidence based clinical outcomes, are local and forward thinking and that are compliant with national standards
- Scope and plan to shift appropriate interventions out of acute settings and into patient's homes on geographical footprints that provide adequate service volumes ie NES domiciliary Herceptin service
- Work with voluntary sector to establish local support groups ie practical support for frail vulnerable/single parents/carers

- Build on the existing National Action Plan for Survivorship to develop a framework that is recognised by and supports patient, family and carers
- Ensure clinicians are enabled to influence Local Authority strategies and develop models that are outcomes orientated
- Work with voluntary sector to establish local support groups ie practical support for frail vulnerable/single parents/carers

4 Overseen through the following governance arrangements

- North East Sector Cancer Board
- CCG Health and Wellbeing Board
- Cancer Leads

5 Measured using the following success criteria

- Year on year reduction in preventable cancers
- Increased screening uptake
- Improved outcomes
- Reduced mortality rates
- More patient and public involvement
- Reduced cost
- Compliant with standards as set out in the NHS Manual for Cancer
- Consistent achievement of national cancer targets ie 14/31/62 day

6 System values and principles

- Reduce inequalities and improve outcomes
- Deliver transformational change
- Develop capability as commissioners and leaders
- Deliver improvements via QIPP to create high quality sustainable services
- Ensure citizenship, self-care and prevention is at the heart of what we do

Women's and Children's

1 To provide world class health care to the children of Bury in the most appropriate setting with the most appropriate practit ioner. To reduce unacceptable variations in outcomes. To maximise opportunities.

2

System Objective 1
Reduction in avoidable emergency and non-elective admissions, especially non-elective admissions for Asthma, Diabetes and Epilepsy and Lower Respiratory tract infections

3

Delivered through intervention
- Review the community paediatric service & review the pathways commissioned
- Review and increase access to primary care through the emerging integrated primary care hubs and a Single Point of Access (SPA) paediatric out of hours care centre
- Develop a bespoke pathways to specific performance areas such as for Asthma, Diabetes and Epilepsy and Lower Respiratory tract infections

System Objective 2
Reduce inequalities and offer timely and equal access to all children closer to home via improved integrated pathways

Delivered through intervention
- Develop an integrated pathway for Children's services that links to all types of care with a SPA
- Act on the findings with regard to any inequalities identified in Maternity Service review
- Consider the impact of wider community procurements

System Objective 3
Provide OOH care with GPs switching to the front ending of ED with primary care triage and staffed with multi professional including GPs, CCNT and paediatric nurses

Delivered through intervention
- Develop paediatric urgent care centre as a coordinated approach, as a catalyst for whole system redesign of paediatric urgent care
- Consider the impact of wider community procurements

System Objective 4
Review knowledge base in primary care and assess variation in referral/outcomes. Upskill primary care team and assess skill mix

Delivered through intervention
- Stocktake of competency levels and skill mix across primary care in order to develop a Bury wide training and development plan
- Maximise current infrastructure to raise the profile of W&C across Bury
- Develop a proposal to secure a GPSI in each sector
- Consider the impact of wider community procurements

System Objective 5
To review local maternity provision benchmarked against best practice to inform future commissioning and redesign priorities

Delivered through intervention
- Conclude the maternity review
- Develop a midwifery led continuity model
- Consider the impact of wider community procurements

4

Overseen through the following governance arrangements
- Bury CCG Governing body (Clinical, cabinet and patient cabinet)
- NE Sector Commissioning Board
- NE W&C Board
- Covalent
- Clinical lead for Women and Children's
- Healthier Together

5 Measured using the following success criteria
- A set of robust KPIs (to be developed)
- Comprehensive benchmarking exercise
- Agree on good quality information/ data to be received from the Trusts

6

System values and principles
- Reduce inequalities and improve outcomes
- Deliver transformational and innovative change
- Develop capability as commissioners and leaders
- Deliver improvements via QIPP to create high quality sustainable services
- Ensure citizenship, self-care and prevention is at the heart of what we do
- Provide genuine Value for Money
- Comply with best practice and all relevant

Primary Care

1 To standardise the services available to patients within the community regardless of whom they are registered. Whilst ensuring that quality markers are met

2

System Objective One
Increased access to Primary Care Services

System Objective Two
proactive, coordinated care: anticipating rather than reacting to need and being accountable for overseeing your care, particularly if you have a long-term condition.

System Objective Four
health-promoting care: intervening early to keep you healthy and ensure timely diagnosis of illness – engaging differently with communities to improve health outcomes and reduce inequalities.

System Objective Five
onsistently high-quality care: removing unwarranted variation in effectiveness, patient experience and safety in order to reduce inequalities and achieve faster uptake of the latest knowledge about best practice.

System Objective Six
holistic, person-centred care: addressing your physical health, mental health and social care needs in the round and making shared decisions with patients and carers.

4

Delivered through intervention – Sector Based Integrated Care Models

- Each sector is currently working through what their local requirements for integrated care are; based on historic usage of both Secondary and Primary Care Services. This will include:
  - Extended opening
  - Integrated care pathways
  - Shared care records
  - Access to specialist advice from medical specialists without the patient needing to travel to hospital or have their care handed over
  - Enhanced access to care professionals and therapists. Mental health, occupational therapy, community nursing or social care staff are directly attached to practices

Delivered through intervention – Increased access to a wider range of services delivered in the community

- Local practices, pharmacies, community health services, voluntary agencies and the local authority work as a group to engage with their community, collaborating with them in asset-based approaches to improving health and wellbeing.
- increased use of technological solutions/interventions
- Standardisation of enhanced service delivery amongst practices
- Community diagnostic services. Local practices collaborate to arrange diagnostic services in the community, reducing travelling for patients and speeding access to results.

Delivered through intervention - Implementation of a Primary Care Quality Strategy

- Systematic review of performance using a suite of information sources to identify outliers
- Clinically led supportive practice visits and practice development programmes to reduce variation Peer-to-peer challenge and learning.
- Identification and dissemination of best practice
- Continual monitoring and support with potential problem areas

5 Overseen through the following governance arrangements

- Primary Care Quality Group
- Integrated Care Model Development group
- CCG Sector Meetings

3 Measured using the following success criteria

- Outliers brought in line with CCG average
- Increase in patient satisfaction of primary care services
- No. of patients over 75 with named clinical lead
- Reduction in emergency admissions

6 System values and principles

Reduce inequalities and improve outcomes
Deliver transformational change
Develop capability as commissioners and leaders
Deliver improvements via QIPP to create high quality sustainable services
Ensure citizenship, self-care and prevention is at the heart of what we do

Elective Care

1

Vision 18: Bury as a Centre of Exce llence for Elective Care

Through clinically led review and transformational change, we aim to deliver a productive and efficient elective care service that is safe and sustainable. By 2018, every patient will have excellent care delivered by the right person, in the right place, at the right time.

2

System Objective One
Seamless evidence based integrated care, closer to home across all specialities

System Objective Two
To remove the inequalities in access to and delivery of services for Bury residents

System Objective Three
Patients can access the service they need, as close and convenient to them as possible

System Objective Four
To reduce NEL attendances and admissions for conditions that could be managed elsewhere

System Objective Five
Patients are seen as a day case for all elective care surgery where appropriate

System Objective Six
Our clinicians are enabled to offer the very best care, and as such are of the highest calibre

3

Delivered through interventions:

Development of end to end condition specific pathways so that patients are seen <18 weeks and low volume specialities and procedures of limited value are on a downward trajectory

Working with primary and secondary care colleagues to develop GP direct referrals to secondary care

Improving access to and commissioning of additional community services such as ophthalmology, IV and continence

Delivered through interventions:

Utilise all providers equitably in meeting the diagnostic and treatment needs of the community.

An extension of the musculoskeletal single point of access, advice and guidance and community clinic model to include further services and specialities

Evaluate the function of the Referral Gateway and EUR process

Improve access to consultant led virtual clinics

Use specialist and joint commissioning to drive value for money

Delivered through interventions:

Undertake a review of evidence base and work with providers to commission an Enhanced Recovery Programme

To strengthen pre-and post-operative assessments to ensure patients are prevented from having a NEL and poorer outcome

Delivered through interventions:

Targeting workforce and retention issues in key areas

Improving the links between generalist and specialist areas

All specialities work together to reduce unnecessary

5

Overseen through the following governance arrangements:

LA & Joint (Health and Wellbeing Board)

CCG Governance (Cabinet, NES Elective Care Board, Patient Cabinet)

PAHT Contracting Board

NES Commissioning Board

Altogether Better/Healthier Together

Sector Led Practice Liaison

4

Measured using the following success criteria:

High levels of self-care and patient education

Reduction in conditions affecting health

Reductions of up to 20% in elective and non-elective admissions and resulting acute provider activity

Improved outcomes for patients

All key stakeholder are engaged in the early planning stages of commissioning, including providers and patients

Bury as a best practice in the national picture

6

System values and principles:

Reduce inequalities and improve outcomes

Deliver transformational change

Develop capability as commissioners and leaders

Deliver improvements via QIPP to create high quality sustainable services

Ensure citizenship, self-care and prevention is at the heart of what we do

1 Mental Health & Learning Disabilities

To ensure patients, families and carers are at the core of services and decisions relating to their health care. Services will empower patients to promote well-being, become aware of psychological distress and self-manage their conditions. Patients will have equal access to services and health outcomes will be comparable to the rest of the population. We will provide seamless services across a range of physical and mental health services and a wide choice of evidenced based services from voluntary and statutory organisations

2 Reducing the rate of unnecessary A&E attendance and hospital admissions for alcohol, dementia, LD and acute mental illness

4 Actions:

- Develop an Outcomes Based Framework to monitor and reduce lifestyle related risk factors e.g. smoking and alcohol benchmarked through Better Together
- Review the local impact of RAID and develop a business case for RAID
- Explore opportunities to enhance the RAID model
- Delivery of the Winterbourne Strategic Action Plan
- Improving detection, assessment and diagnostic rates for people with cognitive impairment
- Increase uptake of Health Checks for LD and SMI
- Improve clinical correspondence between primary and secondary care
- Implement alcohol frequent flyers project across Bury
- Develop pathway with GP and Adult LD team to prevent unnecessary attendance at A&E
- Develop plans for offender and veteran health
- Develop an evidence based model to reduce admissions and length of stay for adults with acute mental health problem

A Whole system approach to patient care, which builds resilience and focuses on harm reduction

Actions:

- Review of IAPT services to achieve prevalence and recovery targets
- Joint training for LD and IAPT staff to manage LD referrals to IAPT service
- Developing a community based, needs led cognitive impairment service
- Identify opportunities for a Shared Care Model for MH/LD e.g. ADHD, Depot
- Work with primary and secondary care to reduce the use of antipsychotics for dementia patients
- Promoting non-medication approaches to the management of patients
- Embed mental and physical health initiatives into care pathways across a range of health services, starting with LTC and access to IAPT services
- Redesign of CAMHS (including ASD/ADHD services) to develop a multidisciplinary, integrated children's mental health service embedded within the community.
- Implementation of an identification and referral pathway to ensure all carers are signposted from GPs to

A whole community approach that includes integrated collaborative working

Actions:

- Scope and review equality of access to services for MH/LD population and address inequalities
- Implementation of the SEND Agenda and integrated EHC plans
- Map a Potential LD Friendly Community Model against Dementia Model
- Engagement and promotion of key stakeholders working together to improve patient outcomes
- Develop plans to access hard to reach groups e.g. BME using community resources/dementia alliance

Promotion of self-care and prevention initiatives

Actions:

- Develop a community pharmacy questionnaire to encourage patients to ask questions about their medication and understand the impact on mental and physical health
- Scoping exercise to identify appropriate initiatives to embed parity of esteem principles across the life course e.g. early years
- Developing pathways with Primary care and Adult LD to improve uptake of cancer screening programmes for people with LD
- Explore with Public Health opportunities to develop the mental wellbeing agenda and work with minority groups and LD
- Promote physical and mental health checks for at risk groups
- Promotion of health trainers in mental health and LD population
- Promotion of alcohol awareness and screening with clinicians

5 Overseen through the following governance arrangements

- Clinical Cabinet
- CCG Governing Body
- Partnership Board
- Public Sector Reform Board
- HWBB
- PCFT Mental Health Contract Governance Arrangements

3 Measured using the following success criteria

- Achievement of outcomes in outcomes framework
- Reduced rate of hospital admissions, unnecessary A&E attendance and length of stay for alcohol related conditions, dementia, acute mental illness and LD
- Cognitive impairment service operational and managing patients in primary care
- Reduction in the number of inpatient cases for LD and an increase in people managed in community settings
- Increase in the number of people on prevalence registers
- Integrated pathways between mental health, social care and physical health services
- Audit trail to show shared care records
- Increase in the number of referrals entering into treatment for IAPT and increase in IAPT recovery rate
- Increased number of LD patients accessing IAPTS
- CAMHS service delivering reduced waiting times and better outcomes for young people through early intervention
- Integrated EHC plans in place
- Increase in people with LD accessing cancer screening
- Number of patients completing pharmacy questionnaire
- Number of referrals for health trainers/BEATS/know alcoholics
- Increase in number of health checks for LD and SMI
- Increased dementia diagnosis rate
- Evidence of work with 3rd sector

6 System values and principles

- Reduce inequalities and improve outcomes
- Deliver transformational change
- Develop capacity as commissioners and leaders
- Deliver improvements via QIPP to create high quality sustainable services
- Ensure citizenship, self care and prevention is at the heart of what we do
- Person centred and evidence based

Urgent Care and LTC

1 To provide an integrated urgent care model that is accessible in the right place at the right time through the development of a high quality, clinically safe system that is easy for both patients and professionals to navigate through and provides outstanding value for money. In order to facilitate this ensure LTC patients receive integrated co-ordinated care.

2 System Objective One
Minimum of 95% A&E patients seen within 4 hours

3 Delivered through interventions:
- Managed via the NES UC Network, daily monitoring and escalation process in place.
- Intergrated Primary care including the 7 day working.

System Objective Two
A 20% reduction in Urgent Care activity

Delivered through interventions:
- Care Home Les/LTC AQUA/Primary Care Integration/Better Care Fund/Reablement/Out of Hours/111/Self Care/Integrated Diabetes – Respiratory – Cardiology services/Paediatric Urgent Care Centre

System Objective Three
Realise a shift in appropriate urgent care delivery from secondary care to primary care

Delivered through interventions:
- Care Home Les/LTC AQUA/Primary Care Integration/Better Care Fund/Reablement/Out of Hours/111/Self Care/Integrated Diabetes – Respiratory – Cardiology services.

System Objective Four
Ensure the maximisation of national emergency department re-classifications

Delivered through interventions:
- Healthier Together outcomes delivery.
- Primary Care Integration/Better Care Fund
- 111 development
- LTC AQUA

5 Overseen through the following governance arrangements:
Clinical Lead for UC and LTC
Covalent reporting
LA & Joint (Health and Wellbeing Board)
CCG Governance (Cabinet, Patient Cabinet)
NES UCNB
NES Commissioning Board
Altogether Better/Healthier Together
Bury CCG Sector Meetings
Sector Led Practice Liaison

4 Measured using the following success criteria:
Reduction in NEL Admission
Reduction in XBDS
Increase in death is preferred place
All key stakeholder are engaged in the early planning stages of commissioning, including providers and patients
Bury as a best practice in the national picture

6 System values and principles:
Reduce inequalities and improve outcomes
Deliver transformational change
Develop capability as commissioners and leaders
Deliver improvements via QIPP to create high quality sustainable services
Ensure citizenship, self-care and prevention is at the heart of what we do

Appendix 6

Bed Reduction Impact from Proposed Bury CCG Deflection Plans - All Figures calculated using Pennine Acute Average Length of Stay

Pennine Acute	Elective				Non-Elective				No. Beds Reduced 100% Occupancy
Year	Activity Spells	Activity Bed Days	Bed Day Reduction	% Reduction	Activity Spells	Activity Bed Days	Bed Day Reduction	% Reduction	
13/14	3502	9876	n/a		16383	61436	n/a		
14/15	3730	10519	643	6.5%	15733	58999	-2438	-4.0%	-5.1
15/16	3600	10152	-367	-3.5%	13222	49583	-9416	-16.0%	-27.8
16/17	3460	9757	-395	-3.9%	13089	49084	-499	-1.0%	-2.5
17/18	3300	9306	-451	-4.6%	12958	48593	-491	-1.0%	-2.7
18/19	3128	8821	-485	-5.2%	12828	48105	-488	-1.0%	-2.8
									-40.9

Bolton	Elective				Non-Elective				No. Beds Reduced 100% Occupancy
Year	Activity Spells	Activity Bed Days	Bed Day Reduction	% Reduction	Activity Spells	Activity Bed Days	Bed Day Reduction	% Reduction	
13/14	232	654	n/a		904	3390	n/a		
14/15	234	660	6	0.9%	867	3251	-139	-4.1%	-0.4
15/16	227	640	-20	-3.0%	773	2899	-353	-10.8%	-1.1
16/17	219	618	-23	-3.5%	767	2876	-23	-0.8%	-0.1
17/18	210	592	-25	-4.1%	761	2854	-23	-0.8%	-0.1
18/19	201	567	-25	-4.3%	755	2831	-23	-0.8%	-0.1
									-1.8

CMFT	Elective				Non-Elective				No. Beds Reduced 100% Occupancy
Year	Activity Spells	Activity Bed Days	Bed Day Reduction	% Reduction	Activity Spells	Activity Bed Days	Bed Day Reduction	% Reduction	
13/14	505	1424	n/a		861	3229	n/a		
14/15	509	1435	11	0.8%	843	3161	-68	-2.1%	-0.2
15/16	494	1393	-42	-2.9%	850	3188	26	0.8%	0
16/17	476	1342	-51	-3.6%	857	3214	26	0.8%	-0.1
17/18	457	1289	-54	-4.0%	864	3240	26	0.8%	-0.1
18/19	436	1230	-59	-4.6%	871	3266	26	0.8%	-0.1
									-0.4

Health & Wellbeing Board Report template

Bury Health and Wellbeing Board

Title of the Report	Co Commissioning Bid
Date	18th September 2014
Contact Officer	Sharon Martin – Deputy Chief Operating Officer / Head of Commissioning
HWB Lead in this area	Stuart North – Chief Operating Officer / Accountable Officer Dr Audrey Gibson – Clinical Director

1. Executive Summary

Is this report for?	Information ■	Discussion □	Decision □
Why is this report being brought to the Board?	The Health and Wellbeing Board are asked to note the CCGs plan for Co Commissioning		
Please detail which, if any, of the Joint Health and Wellbeing Strategy priorities the report relates to. (See attached Strategy) Living_well_in_Bury_ Making_it_happen_to	This will support delivery of all elements of the H&WB strategy. Through co commissioning the CCG can work with NHS England Local Area Team to ensure Primary Care services are commissioned to meet the needs of the local population.		
Please detail which, if any, of the Joint Strategic Needs Assessment priorities the report relates to. (See attached JSNA) Bury JSNA - Final for HWBB 3.pdf	Through co commissioning the CCG can work with NHS England Local Area Team to ensure Primary care services are commissioned to deliver improvement in priority areas identified in the JSNA.		
Key Actions for the Health and Wellbeing Board to address – what action is needed from the Board and its members? Please state recommendations for action.	The H&WB Board are asked to note the content of this report.		

What requirement is there for internal or external communication around this area?	The CCG has communicated this to members and partners through the Integrated Health and Social Care Partnership Board.
Assurance and tracking process – Has the report been considered at any other committee meeting of the Council/meeting of the CCG Board/other stakeholders....please provide details.	• CCG Governing Body • CCG Clinical Cabinet • Integrated Health and Social Care Partnership Board

2. Introduction / Background

NHS England invited CCG to submit bids to Co Commission services with NHS England Local Area Teams in June 2014. The attached bid was made by NHS Bury CCG to undertake co-commissioning of primary care services. Although the bid was made by Bury CCG, it was been developed as part of a Greater Manchester (GM) framework for the development of primary care commissioning across GM.

NHS England assessed the bids based on two national criteria;

- The entry level of co-commissioning required. The Area Team judged category C to be equivalent to Greater Manchester's Levels 3 & 4 (outlined in Appendix 1 of the attached document).
- speed of implementation (The speed of implementation was judged as Ready Now, Ready Soon and Ready Later)

Bury CCG were judged to be READY NOW and at Category C which meant that the CCG can start to collectively work with NHS England Local Area Team to understand how we can facilitate this and associated staffing resource transfer required.

3. key issues for the Board to Consider

The Health and Wellbeing Board are asked to consider:

- How they want to be kept updated on progress
- Implications for partner organisations they would like the CCG and NHS England Area Team to consider.

4. Recommendations for action

The H&WB Board are asked to note the proposal.

5. Financial and legal implications (if any)
If necessary please see advice from the Council Monitoring Officer Jayne Hammond (J.M.Hammond@bury.gov.uk) or Section 151 Officer Steve Kenyon (S.Kenyon@bury.gov.uk).

Nil

6. Equality/Diversity Implications

Nil this will allow the CCG to work with NHS England to target services to local populations.

CONTACT DETAILS:

Contact Officer: Sharon Martin

Telephone number: 0161 762 3954

E-mail address: Sharon.martin14@nhs.net

Date: 30th August 2014

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Co-commissioning of Primary Care - NHS Bury CCG Proposal.

1. Introduction

This bid is made by NHS Bury CCG to undertake co-commissioning of primary care services. Although the bid is by Bury CCG, it has been developed as part of a Greater Manchester (GM) framework for the development of primary care commissioning across GM. The 12 CCGs across GM have been working closely with GM Area Team to develop a strategy and standards for the delivery of primary care services, and are keen that a GM approach to the development of primary care is retained. This recognises that commissioning is a process which involves management of a number of activities. It also recognises that a strategic approach across GM to certain issues (such as workforce planning) and the development of common contract platforms across GM will have significant benefits. This is described in the attached diagram and framework at appendix 1, which details a stepped approach to the development of co-commissioning across GM which sets out how CCGs may wish to approach commissioning.

2. CCGs involved

NHS Bury CCG

3. Scope of the Proposal

3.1 General Practice

NHS Bury CCGs bid covers the following elements of commissioning in the first instance, aiming to operate at level 3 on the attached framework (appendix 1).

- The CCG will lead the strategic planning and design of primary care locally and design new models of service delivery which work across whole pathways of care, including primary care.

- Strategic planning of GP primary care services – undertaking the needs analysis for local services, assessing how current service provision meets those demands, feeding in the views of local people and local stakeholders (including liaison with Health & Well Being Board) and developing strategic plans and priorities for local primary care services. This would enable the CCG to develop more comprehensive plans for the local area and ensure synergy across plans for primary, community and hospital services.

- 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. This would be delivered in line with the agreed GM Primary care strategy and standards. The CCG will use their established systems and knowledge of member practices to improve quality. The approach taken will be developmental: the aim is that all practices would be supported to meet key performance indicators and core standards. The CCG would utilise the Area Team provided Primary care data to develop a practice profile for each practice which would enable the CCG to understand provision, capacity, performance and quality issues. This area of commissioning would include supporting practices to meet the required CQC standards and support the development and delivery of action plans to remedy any issues. The CCG would not take on responsibilities of Performers List Management or Responsible Officer, but would take a much more active role in the management of quality improvement plans and resolution of local quality concerns that do not require regulatory action. This would be supported 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 which would enable the CCG to ensure that robust workforce plans would be in place to support the development of primary care.

- Designing, reviewing and managing GMS and PMS contracts:

- Directly managing appropriate arrangements for practice splits/mergers

- Jointly agree (with the Area Team) the priorities for discretionary spend on premises etc
- Jointly reviewing (with the Area Team) APMS contracts and deciding strategic direction and scope
- Contract management of Directed Enhances Services alongside Locally commissioned services to ensure that there is no duplication or confusion about expected outcomes/deliverables and to ensure that there is a comprehensive picture of service delivery across all enhanced services.
- Organisation of Primary Care Education & Training programmes in support of CCG commissioning priorities.
- First line safeguarding management for Bury issues.

In support of this work the CCG will work with GM Area Team to confirm the resource envelope available from 'core' primary care spend to ensure that we have a firm set of financial planning assumptions to underpin the strategic and service plans which we will develop and facilitate transfer of responsibility for implementation.

Over the course of 2014/15 the CCG would plan to work with the Area Team to explore whether moving to level 4 on the framework within 12 – 18 months and assuming a greater responsibility and delegated arrangements would be appropriate.

Pharmacy and Optometry

As well as an enhanced role in co commissioning GP services Bury CCG would like to enhance integration and co commission Pharmacy and Optometry services including

- Planning of services
- Jointly designing services/models
- Developing strategic direction for services
- Joint liaison with partners on direction of services
- Strategic Planning of local Estates with prioritisation of investment via GM governance arrangements
- Improving quality and reducing variation

Over the course of 2014/15 the CCG would plan to work with the Area Team to explore co commissioning of Pharmacy and Optometry services further.

4. How does this fit with Local Plans

We already work in partnership with NHS England and Bury Council. The ambitions and potential improvements outlined below demonstrate this. Co-commissioning would allow a more cohesive approach to incentives for general practice and other local health organisations across all commissioning organisations, so that providers are held to account for, and rewarded for, similar outcomes, e.g. for population health. It will also (as outlined below) support the strong joint commissioning programme we have in place with the Local Authority to commission more integrated health and social care for local communities to improve community health and wellbeing. More formal Co Commissioning with NHSE will allow us to pool resources and to make better commissioning decisions, ensure better links between in-and out-of-hours services, and support the better health and social care integration to deliver a stable Health and Social Care economy over the next five years..

Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care Our ambition is to maximise Patient participation in the NHS and care system, to develop a system that will truly put patients at the heart of both service planning and delivery and also put them in greater control of their own care. Our integrated care plan is built around citizenship including the following programmes:	**'Better Together' -** This programme aims 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. This scheme will be developed jointly with the Local Authority and NHS England as co commissioner to ensure we maximise the resource and incentives available to us. **Integrated wellness services -** We have a number of existing services and programmes which aim to provide support to help people live a healthier lifestyle and be better able to manage their own health and care. The LA have a plan to appropriately scale and better integrate these services with primary care to ensure contribution to population level health outcomes. A new service model will be in place from April 2015. Through co commission the CCG and Health and Wellbeing Board can better influence all resources within Primary Care to support this agenda **Staying Well -** We will establish and evaluate a new service from April 2015, 'Staying Well', 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. **Altogether Better** - NHS Bury CCG, the Local Authority and GP Federation have been exploring an opportunity to work with 'Altogether Better' to develop an approach to patient and community engagement around use of health services, self care and health improvement. Following initial meetings involving representatives from A Healthier Radcliffe, the CCG and the Local Authority, 'Altogether Better' have agreed to work with us to support the development of 180 practice based champions across the 6 GP practices and work through them to a) support patients to get the most out of consultations with health and social care professionals b) facilitate appropriate use of services c) empower self care and d) stimulate wider community action around health improvement. Altogether Better would work with us over a 12 month period to both embed the approach in Radcliffe but also help build capacity locally to roll the approach out across Bury. Through co commission the CCG and Health and Wellbeing Board can better influence all resources within Primary Care too support this agenda. **Seasonal Flu Jab uptake -** We already have a programme of work in place through the work on enhancing care to the over 75 population to increase flu vaccination uptake in the over 65. Will drive a step change in the uptake of the seasonal flu vaccine and through co commissioning we can work with Public Health England to ensure coordinated approach. **Dementia Awareness -**We will build awareness among local people and the workforce about the preventable element of Dementia, encourage early symptom recognition and presentation and support the national 'Dementia Friends' programme locally. We aim to raise diagnosis rates on GP practice registers from 55% to 75% by 2016.

Wider primary care, provided at scale Our vision is for Primary Care services to operate 8-8 Monday to Friday and 8-6 at weekends	Access in core hours will be standardised through co commissioning working between the CCG and member practices in partnership with NHS England. There will be consistently high-quality care: removing unwarranted variation in effectiveness, patient experience and safety, in order to reduce inequalities and achieve faster uptake of the latest knowledge regarding best practice. To test this with the support of NHS England established a Demonstrator Community - **A Healthier Radcliffe.** We have agreed that this is the initial phase of our integrated delivery model in Bury (Healthier Bury) and enables us to focus on one geographical location. It is providing us. The Demonstrator Community has adopted the Bury integration aims and principles which will be achieved by a multi-disciplinary partnership of health and social care providers working together in Radcliffe. The partnership will be a coordinated network of Radcliffe people, carers and local health providers including six GP Practices, public health, social care, third sector, North West Ambulance Service (NWAS), Bury Hospice and voluntary services. The team will identify vulnerable people needing intensive targeted support and work collaboratively as partners in Radcliffe to deliver an integrated, coordinated approach. People will be helped to take control of their own care through integrated care plans that are person-centred and compliment and build on their assets. The CCG then supported Primary Care Providers through a local GP Federation to submit a bid for the Prime Minister's Challenge Fund to roll this service out to all practices in Bury in 2014/15. This was successful and Bury GP Federation (which represents 30 or the 33 GP in Bury is working through plans to go live with this second phase of implementing Wider Primary Care at Pace by September.
A modern model of integrated care Our ambition is that in 5 years' time we will have fully integrated Health and Social Care neighbourhood teams wrapped around the patient and coordinated care through effective risk stratification. Our ambition is to be a centre of excellence for elderly care and dementia. Through our integrated care model we will commission:	**Wider Integrated Health and Social Care Team -** The team's initial focus will be on frail older people and children from complex families. The development of a new Integrated Community care model leading to a whole system partnership to deliver Risk stratification, neighbourhood teams, care planning, care coordination and case management. **Admissions Avoidance –** This will include standardised services provided to people in care homes by GPs for all patients**,** Named GP for all patients over 75, Admissions avoidance pathways, Unplanned Admissions DES for GPs, Implementation of Vulnerable Adults Local Enhanced Service. **Enhanced Discharge Pathways –** This incudes commissioned services which ensure that evolving multidisciplinary assessment for transfer of people back to the community is initiated soon after admission and prioritised and reduce injuries due to falls by reducing the number of falls in the community that result in decreased function and greater dependency **Integrated Community Services for Children** The model of care for children and families follows the principle of Early Intervention in the early years, supporting and empowering families to reduce reliance on public service. This model of care prioritises plans to bring back more services back into a community setting by commissioning integrated community based services which reduce avoidable emergency and non-elective admissions, for Asthma, Diabetes and Epilepsy and Lower Respiratory tract infections. Care Coordination and Care Plans in place for most complex children and increase out of hour's access through an integrated service by providing 8.00pm -8.00am hubs providing acute care with GPs switching to the front end of A & E with primary care. The model will ensure early intervention and prevention and implementing the requirements of SEND. Identification of Troubled Families and shared intervention plans
A step-change in the productivity of elective care Our ambition is that we will be a centre of excellence for Planned care; commissioning more streamlined pathways,	NHS Bury CCG intends to secure long term high quality, sustainable elective care services through, the creation of innovative community based elective care solutions and maintaining our focus with Primary Care clinicians on high quality, appropriate referrals in-line with our current upper quality performance when compared to our peer group.

Access to the highest quality urgent and emergency care	Our ambition is that urgent care systems will be more responsive and systems will deliver integrated urgent and emergency care services for all patients, but most importantly, for our large elderly population and a growing number of people living with one or more long-term condition such as diabetes, COPD or dementia. The Healthier Bury programme will enable the CCG to bring a radical change to our approach to Urgent and emergency care shifting the focus from reactive care to proactive preventative care. The introduction of our integrated community care teams will enhance care management of those people with the most complex care needs, pre-empting and planning for escalating need whether they are physical, mental or social care. Through our Lead Commissioning role in Greater Manchester with the Ambulance service we are strongly supporting the introduction of see and treat approaches under-pinned by the introduction of "pathfinders". We recognise the scale and scope of the opportunity that exists for primary care to take a leading role in urgent & emergency care and our 5 year plans include expanding the role of practices in pre-emptive care in care homes, the introduction of new Urgent Primary care services and improving overall access to primary care. The CCGs plans also include the need to improve access to more specialised urgent and emergency care.

5. Benefits

The CCG has identified the following measures of success:

Contribution to delivery of 5 years strategy

Domains	Ambitions	Outcomes Delivered By	Goals Set
Preventing premature death	Securing additional years of life for people with treatable mental and physical conditions	Decreasing the potential years of life lost from causes considered amendable to healthcare Decreasing the under 75 mortality rate from cancer, cardiovascular, respiratory and liver disease	PYLL (Rate per 100,000 population) Baseline 2660.5 2018/19 2261.2 3.2% applied year on year
Quality of life for LTCs	Improving health related quality of life for people with long term conditions	Increasing the health-related quality of life for people with long term condition Increasing the proportion of people feeling supported to manage their conditions Reducing the unplanned hospitalisation for chronic ambulatory care conditions in adults and for asthma, diabetes and epilepsy in under 19's Increasing the estimated diagnosis rate for people with dementia	Average EQ-5D score for people reporting having one or more long-term condition Baseline 70.4 2018/19 73.5 ii) Dementia % Diagnosis 2014/15 - 0.67 2015/16 - 0.68
Quick recovery from ill health	Reducing avoidable time in hospital Increasing elderly people living independently at home on discharge (no CCG Measures set)	Reducing the number of emergency admissions for acute conditions that should not usually require hospital admission Reducing the number of emergency readmissions within 30 days of discharge from hospital Increasing the total health gain as assessed by patients for both hip and knee replacements, groin hernia and varicose veins Reducing the number of emergency admissions for children with Lower Respiratory Tract Infections	Emergency admissions composite indicator Baseline 2,931 2014/15 2,784 2015/16 2,345 2016/17 2,298 2017/18 2,252 2018/19 2,207 A&E Attendances - all types Forecast Growth 14/15 -3% 15/16 -12% 15% reduction in first 2 years 2% for the years onward.
Great experience of care	Increasing positive experience of care outside hospital	Increasing the patient experience of primary (GP and Out of Hours)	The proportion of people reporting poor experience of GP and Out-of-Ours Services Baseline 6.2 2014/15 5.9

Domains	Ambitions	Outcomes Delivered By	Goals Set
	Increasing positive experience of hospital care	Increasing the patient experience hospital care	2015/16 5.6 2016/17 5.3 2017/18 4.0 2018/19 4.7 The proportion of people reporting poor patient experience of inpatient care Baseline 115 2018/19 110
Safe care	Significant progress on eliminating avoidable deaths	Reducing the incidence of healthcare associated infections in MRSA and C. Difficile	C. Difficile infection cases set at 63 for 14/15 as per National Directive for Bury MRSA Rate Set at 0 for 14/15

- Acceptability to members via 360 degree feedback and local review mechanisms
    - Improvement in local members satisfaction in the 360 degree questionnaire

- A workforce plan

- Quality monitoring through a local dashboard

- A broad education programme in place covering statutory, professional and strategic issues.

- A plan for strategic development of primary care services

6. Timescales

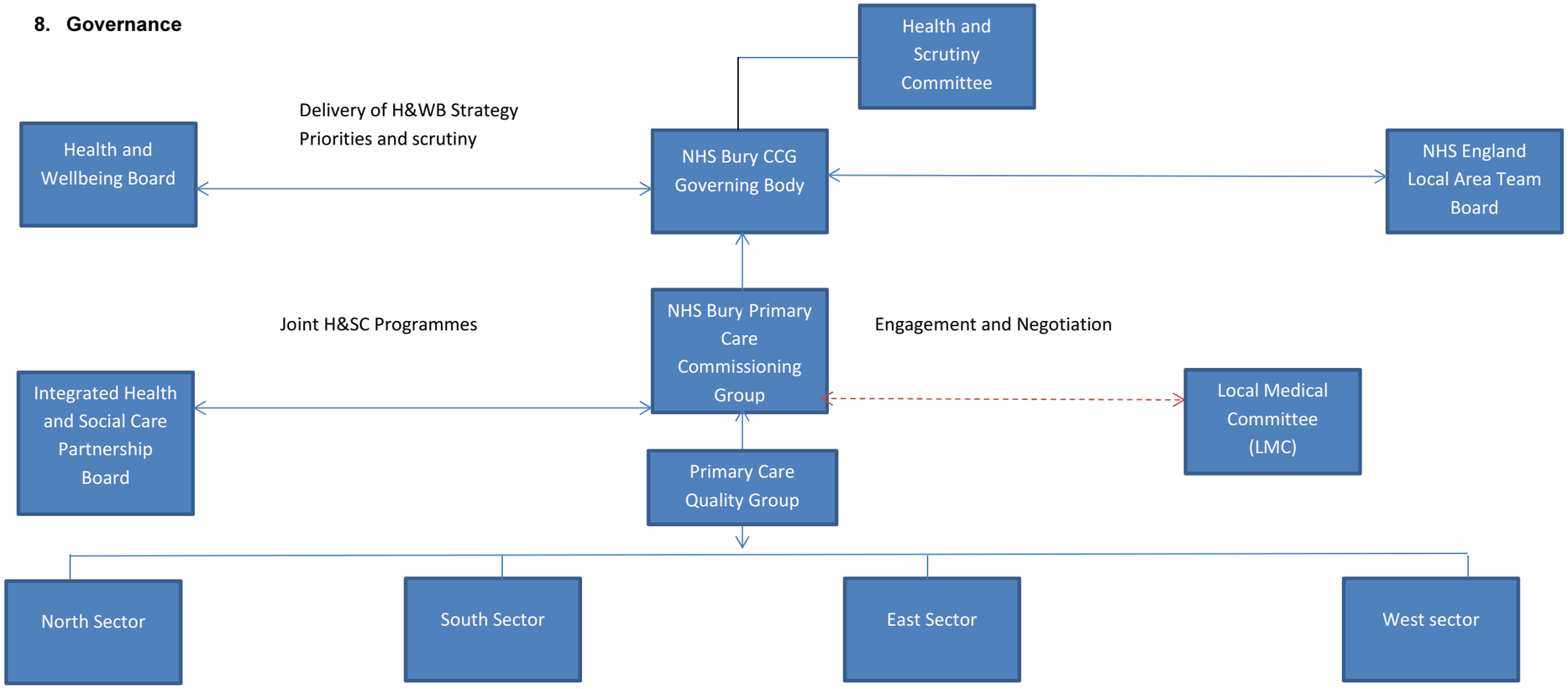
NHS Bury CCG will work with the NHS England Area Team to agree the co commissioning framework within 2014 once approval is given.

7. Involving Stakeholders

The CCG has involved the following stakeholders in the decision

- Patients Cabinet – a group of patients who represent the 4 localities of Bury. The expression of interest will be taken to their next meeting 3rd July for approval.
- Due to the timing of papers the CCG will take to the Health and Wellbeing Board on Thursday 18th September 2014.
- GP Members – we have discussed through our clinical cabinet, at locality meetings and via an engagement meeting with GP members.

8. Governance



The flow chart above outlines the proposed governance around Primary Care Co-Commissioning.

The role of each group is outlined below:

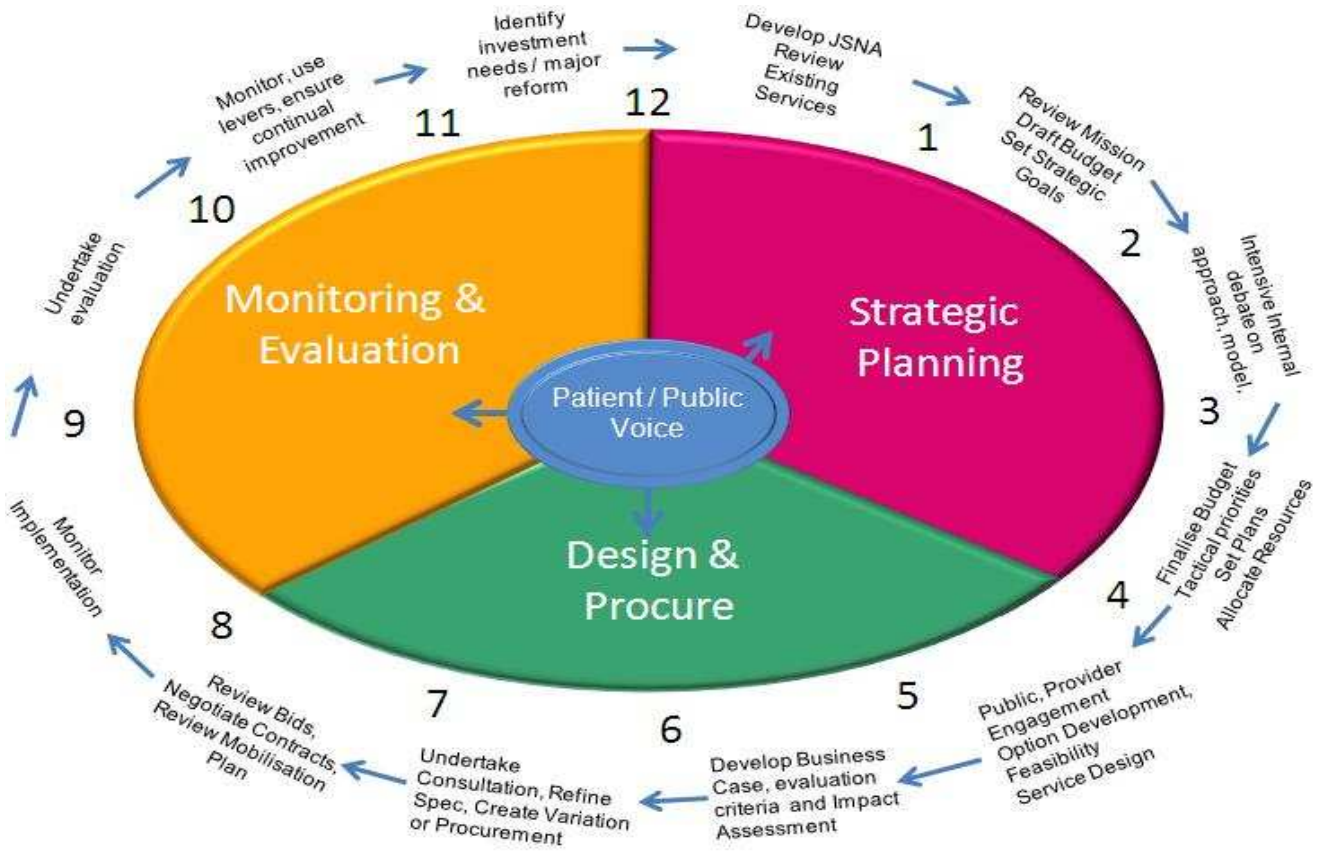
- **Health Scrutiny Committee** – To scrutinise Health Service Commissioning in Bury
- **Health and Wellbeing Board** - Health and wellbeing boards have strategic influence over commissioning decisions across health, public health and social care, setting priorities through the H&&WB strategy and scrutinizing implementation.
- **NHS Governing Body** accountable for commissioning decisions around agreed delegated budgets
- **NHS Bury Primary Care Commissioning Group –** This group will be chaired by a lay member to ensure transparency and management of any conflicts of interest. Member ship will include
    - Lay Member Chair
    - A Clinical Director
    - A CCG Executive
    - Public Health Representative
    - NHS England Area Team representative
    - LMC Representative
    - Patient Representative

- **NHS Bury Primary Care Quality Group -** 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.
    - CCG Clinical Governance Lead
    - A Clinical Director
    - The chair from each of the four CCG sector groups (made up of all 33 member practices),
    - A practice manager representative (from one of the four sectors)
    - NHS England Area Team representative
    - LMC Representative

- **Integrated Health and Social Care Partnership Board** – Ensuring alignment of Primary Care Commissioning to support Bury CCG integration agenda.
- **CCG Sector Groups –** 4 locality based groups made up of the 33 CCG members which will be used for engagement and negotiation of Primary Care Commissioning decisions in partnership with the LMC.
- **Local Medical Committee** – representative committee to support any Primary Care Contract negotiation.

9. Appendix 1 - Greater Manchester Framework

The proposed framework for Bury CCG to Co-Commissioning is through partnership with NHS England. The framework recognises that commissioning is a process from needs assessment, design and planning of services, procurement, contract management and review. The diagram below shows the elements of the commissioning cycle.



The proposal is based on a number of principles:

- Planning of primary care services should be done as locally as possible
- Improving quality of primary care services should be done as locally as possible
- Co-commissioning will support the already agreed Greater Manchester Primary Care Strategy and standards
- Some plans and decisions will need to be consistent across Greater Manchester to support the strategic development of primary care (e.g. Primary Care support to shared care prescribing protocols)
- There needs to be transparency of resource allocation/management so those planning services are confident about the level of resources available to support those plans
- The direction of travel is towards a ‘place’ based budget
- Data about practices (quality, performance, workforce) will be shared across the AT and CCG commissioner in support of this (via transparent agreements and safeguarded and governed appropriately)
- Co-commissioners will work together to make the most effective use of the scarce commissioning support available.

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10 Appendix 2 - Co-commissioning Framework GP Services

			Level 4 Level 1,2,3 plus - Managing a devolved primary care budget for local APMS/PMS/GMS Contracts • Contract management of APMS/PMS/GMS contracts including any contractual sanctions resulting from performance issues • This would include decisions on practice mergers/splits/vacancies and management of associated contractual process • Managing the GP primary care market by leading on procurement of new services • Management of EPRR for GP services • Possibly provision of complaints / FOI management function for AT
		Level 3 • Level 1&2 plus - Delegated budget for aspects of primary care contracts and associated contract management: • Contract management of Directed Enhances Services alongside Locally commissioned services • Managing discretionary payments • Workforce planning	
	Level 2 Level 1 plus - Jointly designing, reviewing and managing contracts: • GMS/PMS/APMS contracts • Jointly deciding appropriate arrangements for practice splits/mergers • Jointly agreement priorities for discretionary spend on premises etc • Jointly reviewing PMS contracts and deciding strategic direction and scope • Jointly reviewing APMS contracts and deciding strategic direction and scope		
Level 1 Planning of Primary Care services: • Assessing needs • Designing services/models • Developing strategic direction for services • Liaison with partners • Strategic Planning of local Estates with priorisation of investment via GM governance arrangements • Improving quality and reducing variation Safeguarding e.g. named doctor • Primary Care Education & Training			
Common GM Commissioning Support Platforms provided by GMAT Provision of primary care 'dashboard' containing performance/quality (inc complaints)/QMAS/QOF/workforce data in support to CCGs on a monthly (?) basis, Management of QOF/QMAS closedown, Management of Complaints about GPs (shared with CCGs in support of quality management), technical contract management – issuing of contract variations etc, model guidance on handling 'Conflicts of Interest', facilitation of agreement of GM Primary Care Standards			
AT Responsibilities Core GMS\PMS\APMS contract Payments, Performers List Management, Responsible Officer, Revalidation and appraisal, provision of statutory primary care returns, Commissioning of Dental, Pharmacy and Optometry services, system management of primary care (either via direct commissioning or holding CCGs to account as commissioner), clarification of core GMS/PMS provision to underpin CCGs quality and development role, signing off CCGs annual and financial and service commissioning plans for primary care (enabling CCGs to implement investment/commissioning intentions).			

Health & Wellbeing Board Report template

Bury Health and Wellbeing Board

Title of the Report	ADASS Benchmarking Report
Date	18th September 2014
Contact Officer	Stuart North –Chief Operating Officer / Accountable Officer
HWB Lead in this area	Stuart North – Chief Operating Officer / Accountable Officer Dr Audrey Gibson – Clinical Director

1. Executive Summary

Is this report for?	Information ■	Discussion □	Decision □
Why is this report being brought to the Board?	To update the Health and Wellbeing Board on the CCG and LA performance against the ADASS standards.		
Please detail which, if any, of the Joint Health and Wellbeing Strategy priorities the report relates to. (See attached Strategy) Living_well_in_Bury_ Making_it_happen_to	The good performance for Bury demonstrates delivery against Priority 3,4,5		
Please detail which, if any, of the Joint Strategic Needs Assessment priorities the report relates to. (See attached JSNA) Bury JSNA - Final for HWBB 3.pdf	• Care for Older People at home • Reduction in Hospital Admissions		
Key Actions for the Health and Wellbeing Board to address – what action is needed from the Board and its members? Please state recommendations for action.	Despite the CCGs underfunding and funding constraints placed on the LA, the CCG and LA are the best performing organisations in the North West of England for these indicators. This places challenges on the CCG and LA ability to further reduce the Non		

	Elective Admissions required to deliver the Better Care Fund. However this is being targeted through the: • Integrated Healthier Radcliffe Schemes. • Prime Ministers Challenge Fund • Existing LA and CCG commissioned service. • Targeted support for older people through the Unplanned Admission DES and Vulnerable Adults LES which target enhanced care planning for people with Dementia, in Nursing and Residential Homes and the 2% of the population at highest risk of admission to hospital. • Named GPs for everyone over 75.
What requirement is there for internal or external communication around this area?	The CCG and LA have communicated this achievement to wider stakeholder
Assurance and tracking process – Has the report been considered at any other committee meeting of the Council/meeting of the CCG Board/other stakeholders....please provide details.	• CCG Governing Body • Integrated Health and Social Care Partnership Board

2. Introduction / Background

The attached report outlines the CCG and Local Authority performance against benchmarked standards across the North West. The report shows the CCG and LA are the highest performing against these standards.

This is an excellent achievement, despite the CCGs underfunding and funding constraints place on the LA.

3. key issues for the Board to Consider

The Health and well-being Board are asked to note the challenges on the CCG and LA ability to further reduce Non Elective admissions to hospital to the level required to deliver the Better Care Fund.

4. Recommendations for action

The H&WB Board are asked to note the achievements outlined in the ADASS report.

5. Financial and legal implications (if any) If necessary please see advice from the Council Monitoring Officer Jayne Hammond (J.M.Hammond@bury.gov.uk) or Section 151 Officer Steve Kenyon (S.Kenyon@bury.gov.uk).

Nil

6. Equality/Diversity Implications

Nil

CONTACT DETAILS:

Contact Officer: Stuart North

Telephone number: 01617623054

E-mail address: stuartnorth@nhs.net

Date: 30th August 2014

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NHS & Local Government

Quality and Efficiency Scorecard for Frail Elderly

Locality Benchmarking

June 2014

AQuA Advancing Quality Alliance

NHS

North West Utilisation Management Unit

directors of adass adult social services

Contents

ADASS / AQuA whole system quality and efficiency locality benchmarking summary table

	Population aged 65 and over	(a) Non-elective admissions aged 65+ per 1000 pop 65+	(b) Non-elective bed days aged 65+ per head of 1000 pop 65+	(c) Non-elective re-admission rate within 30 days aged 65 and over	(d) Non-elective re-admission rate within 90 days aged 65 and over	(e) No of bed days - delayed transfers of care aged 18+ per 100,000 pop	(f) Proportion of people aged 65+ discharged direct to residential care	(g) Permanent admissions to residential/ nursing care aged 65+ per 100,000 pop 65+	(h) Proportion of local authority ASC spend on aged 65+ on res/nursing care		(i) Proportion of all deaths which occur at home / in care homes - aged 65 and over
Source System	**NASCIS**	**SUS**	**SUS**	**SUS**	**SUS**	**UNIFY**	**SUS**	**Local Authorities**	**NASCIS**		**ONS via NHS NW**
Date range		**Apr 13 - Mar 14**	**Apr 13 - Mar 14**	**Apr 13 - Mar 14**	**Apr 13 - Mar 14**	**Apr 14 Bed Days**	**Apr 13 - Mar 14**	**Apr 13 - Mar 14**	**Apr 12 - Mar 13**		**Jan 12 - Dec 12**
Locality		Less is better	Less is better	Less is better	Less is better	Less is better	Less is better	Less is better	Less is better	**TREND**	more is better
Blackburn	18,065	294	2692	15.9%	25.8%	198	5.9%	1,140	55.3%	Improving	41.7%
Blackpool	27,135	267	2718	16.6%	26.7%	299	0.9%	988	61.8%	Deteriorating	40.9%
Bolton	42,215	248	2084	17.8%	28.0%	396	2.4%	870	49.1%	Deteriorating	41.8%
Bury	29,345	235	1622	16.1%	25.0%	210	1.2%	695	49.8%	Improving	48.4%
Cheshire E	70,260	223	2043	15.8%	25.0%	233	4.1%	613	52.4%	Deteriorating	46.3%
Cheshire W & C	60,490	237	2361	16.5%	25.6%	160	4.7%	812	58.0%	Deteriorating	42.2%
Cumbria	101,440	220	1876	15.8%	24.4%	255	2.0%	483	56.5%	Improving	47.0%
Halton	17,365	319	2750	18.7%	29.5%	263	2.7%	638	49.5%	Deteriorating	40.6%
Knowsley	23,275	342	2814	20.2%	30.8%	72	1.7%	883	58.0%	Improving	41.0%
Lancashire	210,130	249	2463	16.0%	24.9%	265	2.6%	823	55.6%	within 5%	44.9%
Liverpool	63,055	315	2749	18.6%	29.3%	216	2.3%	767	50.6%	Deteriorating	39.9%
Manchester	50,225	364	3610	20.2%	31.1%	243	2.5%	770	51.4%	Deteriorating	36.8%
Oldham	33,070	282	1609	19.4%	30.0%	165	1.3%	726	58.5%	Deteriorating	37.5%
Rochdale	30,510	274	1759	18.1%	27.5%	199	1.0%	766	58.4%	Deteriorating	41.6%
Salford	33,370	329	2627	20.3%	32.0%	129	4.2%	906	66.3%	Deteriorating	42.5%
Sefton	56,350	262	2361	15.7%	24.0%	218	1.8%	819	59.3%	Improving	43.9%
St Helens	30,755	286	2362	18.3%	29.3%	116	1.5%	856	49.9%	within 5%	44.7%
Stockport	50,895	298	2594	19.1%	30.0%	146	2.5%	776	51.7%	Deteriorating	41.7%
Tameside	34,170	275	2770	18.4%	28.7%	122	2.8%	617	53.9%	Improving	33.8%
Trafford	35,211	273	3037	17.9%	28.3%	379	2.3%	698	49.7%	within 5%	33.6%
Warrington	31,995	273	2351	17.1%	27.4%	330	5.5%	738	59.0%	Improving	45.7%
Wigan	50,945	261	1849	19.2%	28.9%	153	3.2%	812	52.1%	Improving	39.9%
Wirral	59,225	293	2470	17.6%	27.4%	84	2.9%	848	62.3%	within 5%	45.7%
NORTH WEST	**1,159,496**	**295**	**2631**	**17.5%**	**27.3%**	**237**	**2.7%**	**855**	**55.0%**	within 5%	**42.6%**

Advancing Quality Alliance

Benchmarking order (exc trend)	
Best 1-6	
7th-12th	
13th-18th	
19th - 23rd	

PLEASE SEE DATA CAVEATS ON PG 5

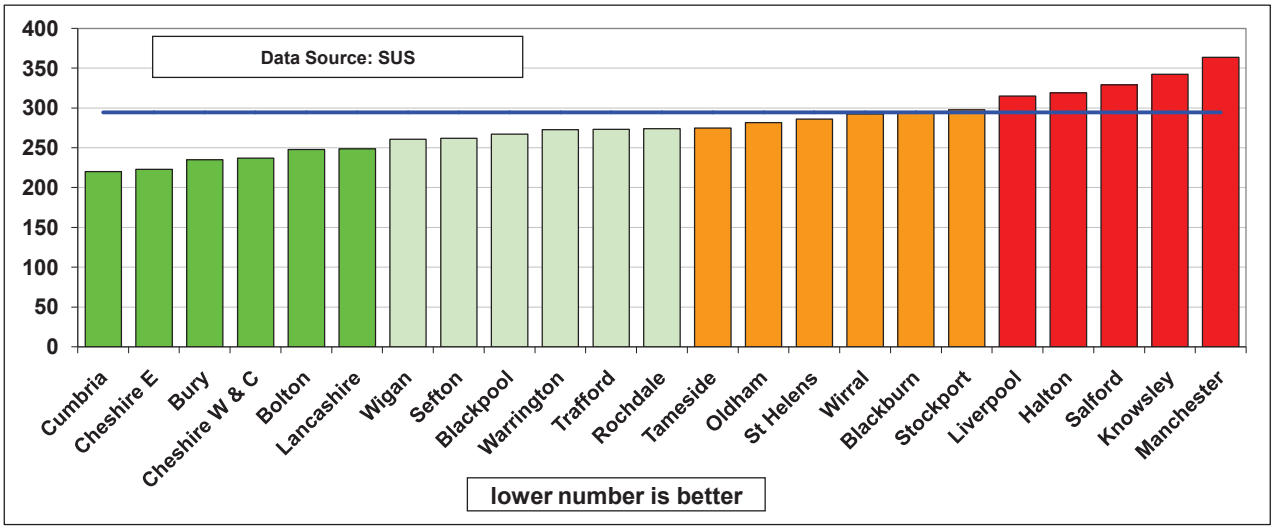
North West Utilisation Management Unit

directors of adass adult social services

ADASS/AQuA whole system quality and efficiency locality benchmarking graphs: a,b,c

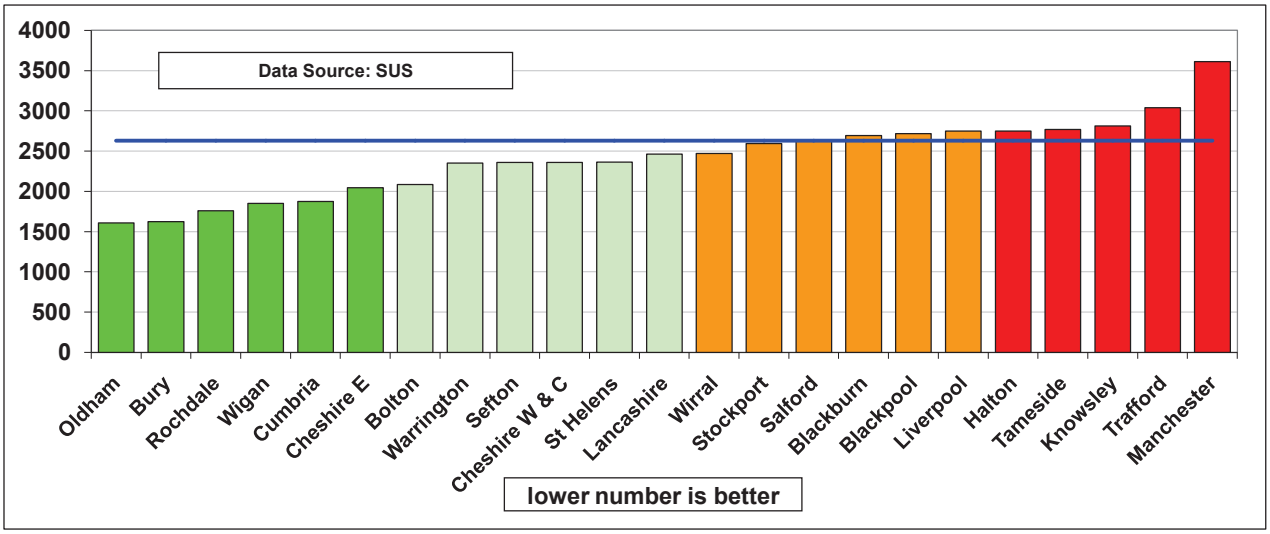
(a) Non-elective admissions aged 65+ per 1000 pop 65+

Apr 13 - Mar 14



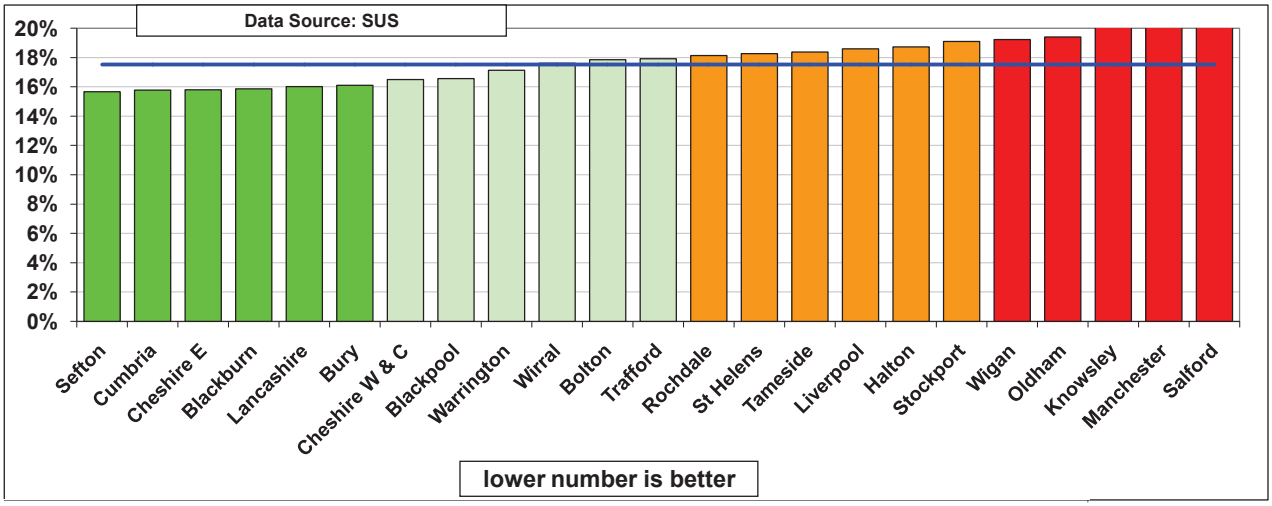
(b) Non-elective bed days aged 65+ per head of 1000 pop 65+

Apr 13 - Mar 14



(c) Non-elective re-admission rate within 30 days aged 65 and over

Apr 13 - Mar 14



Graph Key

North West Average

AQuA Advancing Quality Alliance

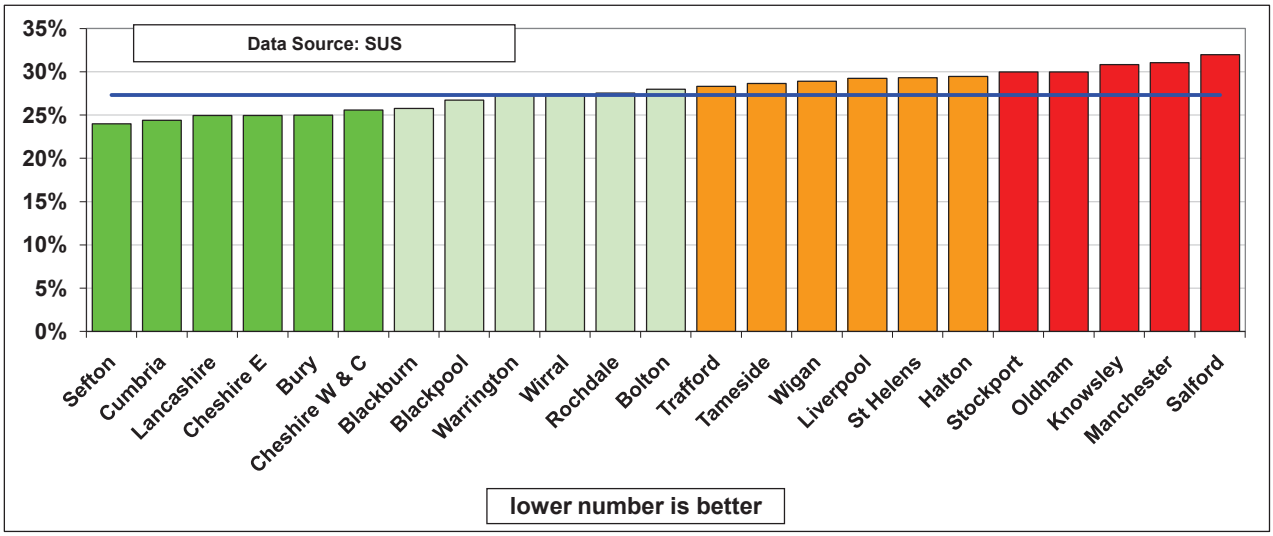
NHS North West Utilisation Management Unit

directors of adass adult social services

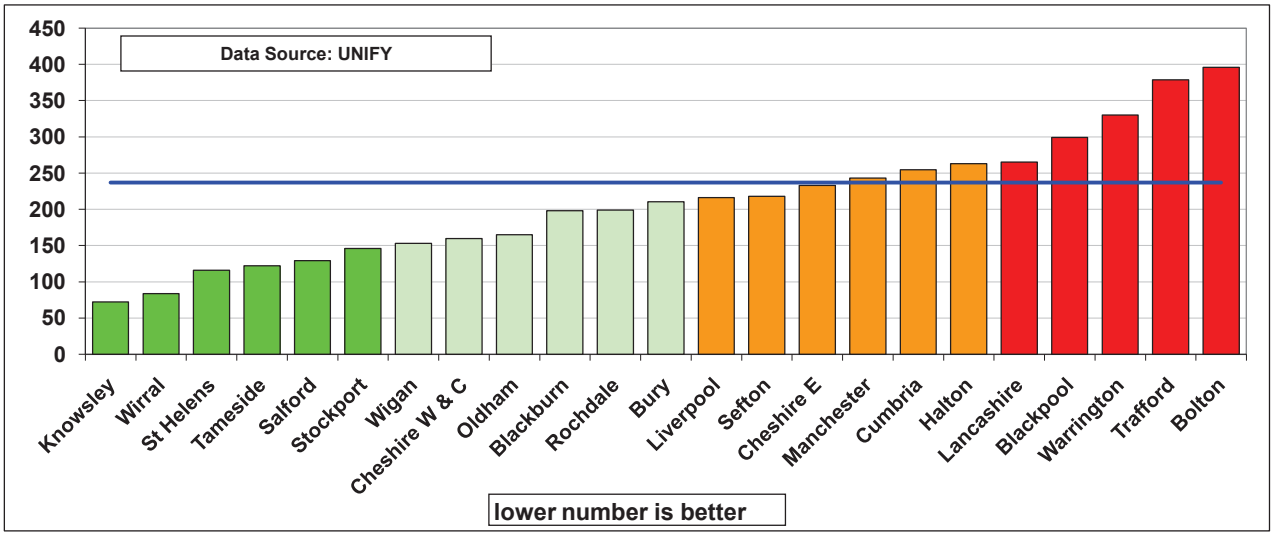
PLEASE SEE DATA CAVEATS ON PG 5

ADASS/AQuA whole system quality and efficiency locality benchmarking graphs: d,e, f

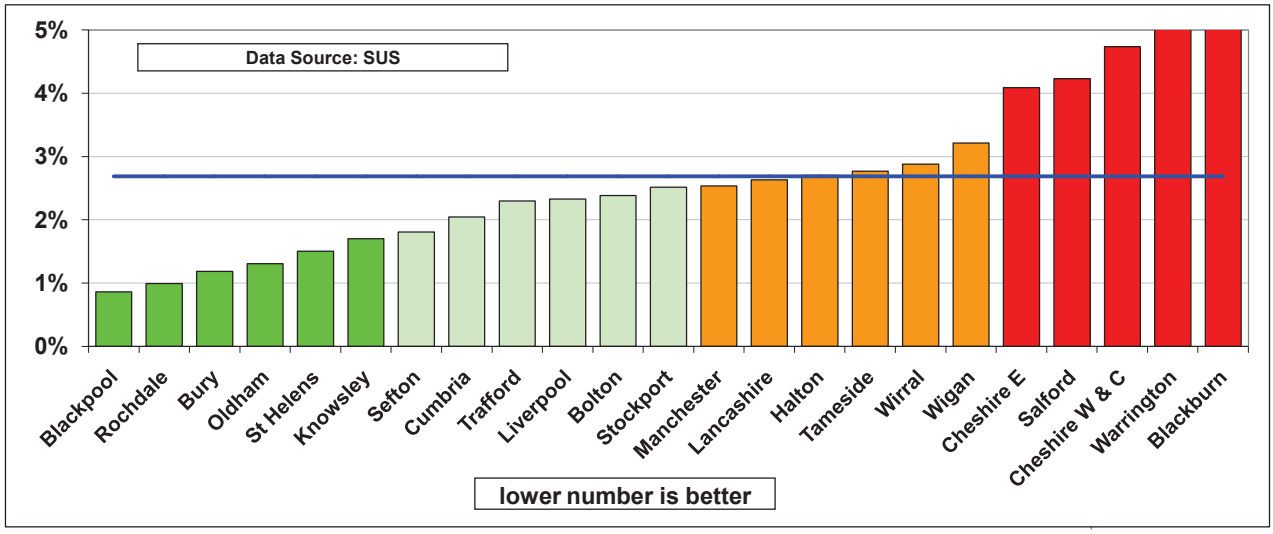
(d) Non-elective re-admission rate within 90 days aged 65 and over — Apr 13 - Mar 14



(e) No of bed days - delayed transfers of care aged 18+ per 100,000 pop — Apr 14 Bed Days



(f) Proportion of people aged 65+ discharged direct to residential care — Apr 13 - Mar 14



Graph Key

North West Average ——

AQuA Advancing Quality Alliance

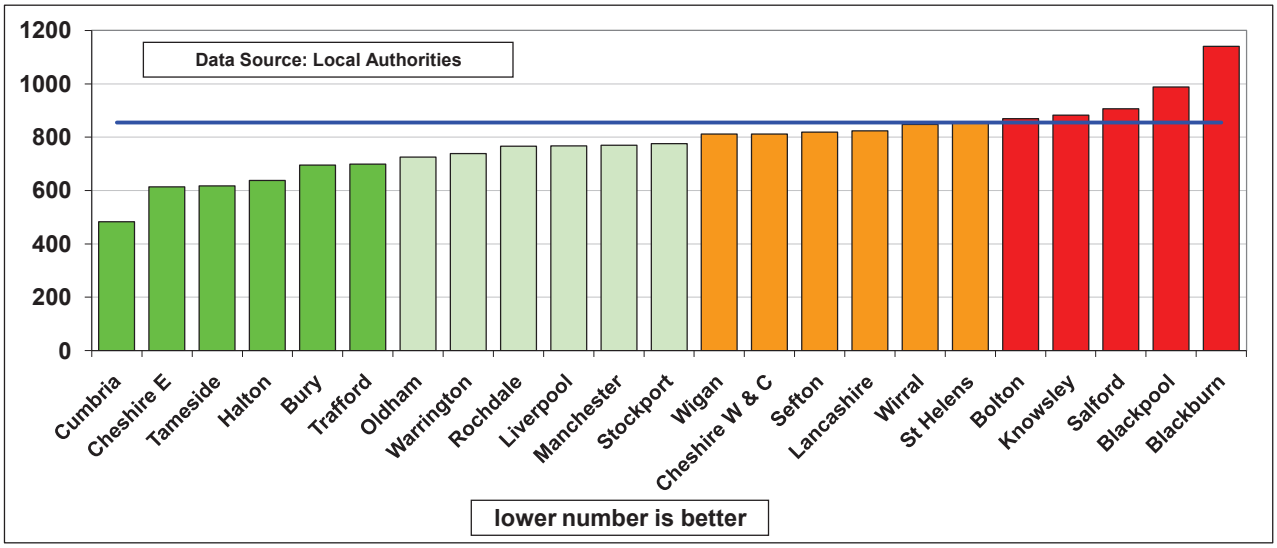
NHS North West Utilisation Management Unit

directors of adass adult social services

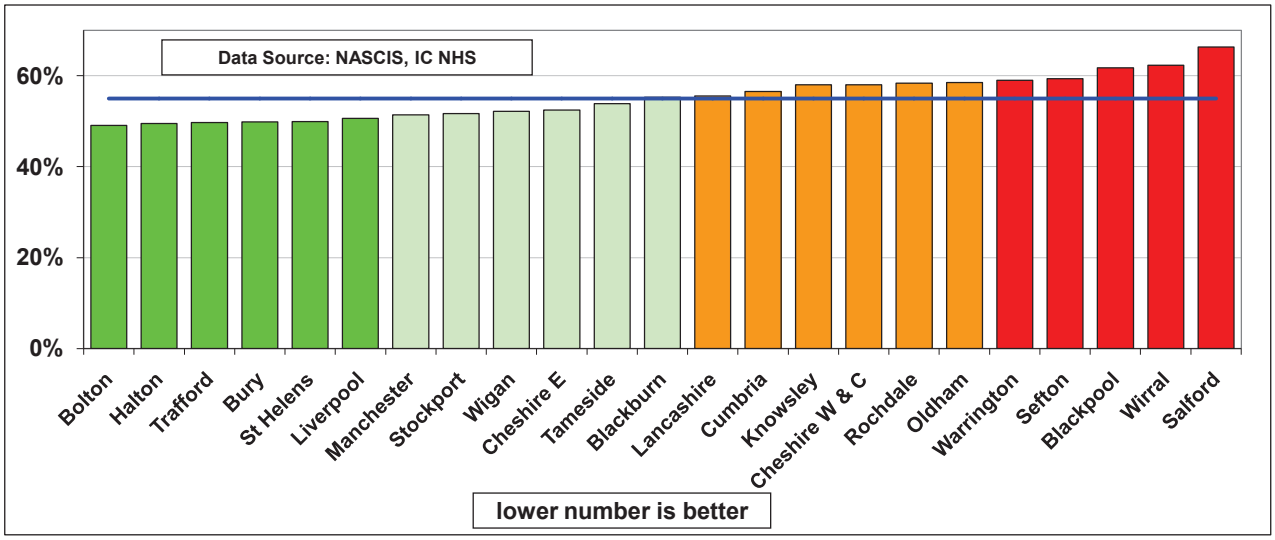
PLEASE SEE DATA CAVEATS ON PG 5

ADASS/AQuA whole system quality and efficiency locality benchmarking graphs: g,h,i

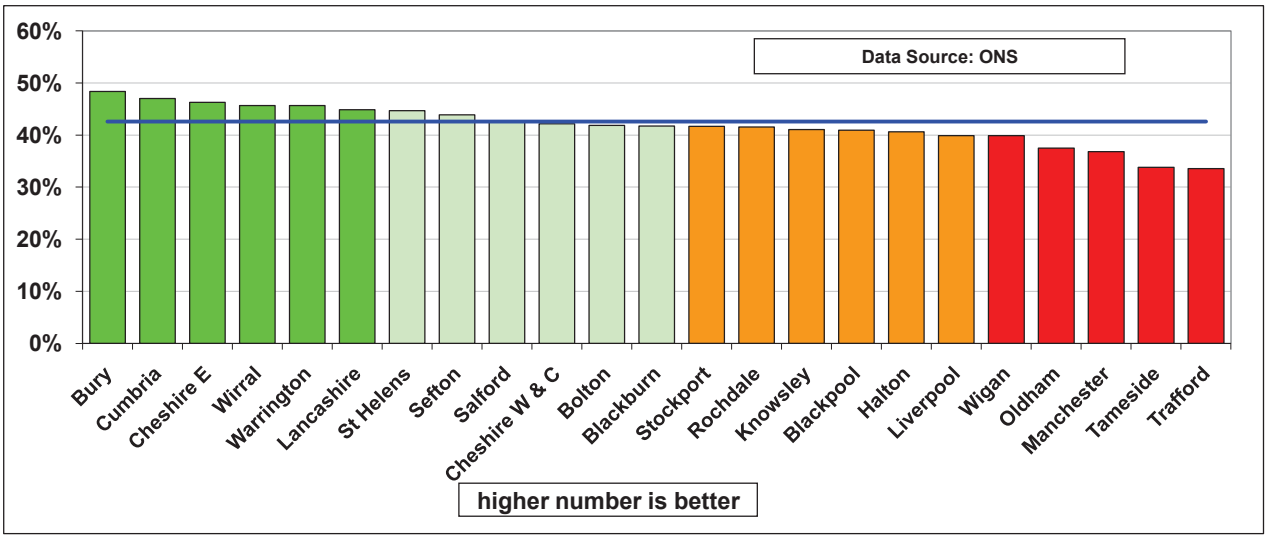
(g) Permanent admissions to residential/ nursing care aged 65+ per 100,000 pop 65+ — Apr 13 - Mar 14



(h) Proportion of local authority ASC spend on aged 65+ on res/nursing care — Apr 12 - Mar 13



(i) Proportion of all deaths which occur at home / in care homes - aged 65 and over — Jan 12 - Dec 12



Graph Key

North West Average

AQuA Advancing Quality Alliance

NHS North West Utilisation Management Unit

directors of adass adult social services

PLEASE SEE DATA CAVEATS ON PG 5

METADATA for the measures in the ADASS / AQuA whole system quality and efficiency scorecard

Measure name	Data Source	Geography/Location	Data parameters/specification for source data	Data equation/calculation	Date range	Data Caveats
(a) Non-elective admissions aged 65+ per 1000 population aged 65+	SUS	By local authority boundary based on the address of the patient	Number of non-elective admissions to any hospital of patients aged 65 and over living within the local authority area.	1. non-elective admissions aged 65 and over / population 65 and over *1000	Apr 13 - Mar 14	All of the data for measures (a)-(d) is extracted from the SUS data system and so the last two months data are potentially subject to significant change. The last month of this data will have two more refreshes from local systems onto SUS and the data from the second to last month will have a final refresh. This will effect the data in this scorecard for these measures meaning admissions, bed days and repeats may appear lower or higher than they will actually be. THE DATA IN THIS SCORECARD FOR MEASURES (c) AND (d) WILL BE DIFFERENT TO THE APRIL-11 DRAFT VERSION DUE TO A CHANGE OF METHODOLOGY FOR CALCULATING REPEATS From April 2013 Cumbria is accessed via PbR tables. These only contain data for Cumbria CCG patients and may exclude small numbers of Local Authority residents.
(b) Non-elective bed days aged 65+ per 1000 population aged 65+	SUS	By local authority boundary based on the address of the patient	Number of non-elective bed days in any hospital of patients aged 65 and over living within the local authority area.	2. emergency bed days aged 65 and over / population 65 and over *1000	Apr 13 - Mar 14	
(c) Non-elective re-admission rate within 30 days aged 65+	SUS	By local authority boundary based on the address of the patient	Number of non-elective re-admission episodes within 30 days in any hospital of patients aged 65 and over living within the local authority area.	3. non-elective readmissions in 30 days aged 65 and over / 1. non-elective admissions	Apr 13 - Mar 14	
(d) Non-elective re-admission rate within 90 days aged 65+	SUS	By local authority boundary based on the address of the patient	Number of non-elective re-admission episodes within 90 days in any hospital of patients aged 65 and over living within the local authority area.	4. non-elective readmissions in 90 days aged 65 and over / 1. non-elective admissions	Apr 13 - Mar 14	
(e) No of delayed transfers of care aged 18+ per 100,000 population aged 18+	Monthly DTOC collections from provider trusts from the Unify System	By local authority boundary based on the address of the patient	DTOC bed days for month including acute and non acute, and DTOC for any reason and any organisation being responsible. This data is for people aged 18 and over only.	5. all delayed transfer of care bed days aged 18 and over / population 18 and over *100,000	Apr 14 Bed Days	This data can be accessed at the DH at the following website: http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/
(f) Proportion of people aged 65+ discharged direct to residential care	SUS	By local authority boundary based on the address of the patient	Number of people aged 65 and over with a discharge code of 54. NHS run care home, 65. Local Authority residential accommodation i.e. where care is provided, 85. Non-NHS (other than Local Authority) run care home	6. total for codes 54, 65 and 85 / total of all discharges	Apr 13 - Mar 14	The data for the last twelve months can be subject to change throughout the year so it may appear differently to previous refreshes of the scorecard. This data could include self funders of residential care. Some patients/service users may have lived in a different authority to the one in which they enter residential care.
(g) Permanent admissions to residential/ nursing care aged 65+ per 100,000 population aged 65+	Collected from indivudal local authorities	By local authority boundary based on the address of the patient	Number of LA supported PERMANENT admissions aged 65 and over to residential care, nursing care and adult placements (excluding admissions to group homes),	7. Admissions to res care aged 65 and over / population 65 and over *100,000	Apr 13 - Mar 14	This data is collected directly from local authorities and has not all been verified by the Information Centre NHS so is subject to change
(h) Proportion of local authority ASC spend on aged 65+ on res/nursing care	NASCIS - IC NHS	By local authority boundary based on the address of the patient	Gross total expenditure by Local authorities on adults aged 65 and over including mentally ill. Including 8.spend on residential and nursing care and 9. total spend.	8. total gross expenditure on adults aged 65+ res and nurs care / 9. total gross expenditure on adults aged 65+	Apr 12 - Mar 13	
(i) Proportion of all deaths which occur at home / in care homes - aged 65+	Office of National Statistics (ONS) via NHS North West	By local authority boundary based on the address of the patient	Proportion of deaths occuring at home aged 65 and over. All deaths aged 65 and over	8. Proportion of deaths occuring at home or in care homes aged 65 and over / 9. all deaths aged 65 and over	Jan 12 - Dec 12	Data no longer available at this level as of December 2012

* CBS = Commissioning Business Service

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Health & Wellbeing Board Report template

Bury Health and Wellbeing Board

Title of the Report	Direct Commissioning Quarterly Update Report
Date	September 2014
Contact Officer	Rob Bellingham, Director of Commissioning, NHS England Greater Manchester Area Team. Email robbellingham@nhs.net – telephone 0113 825 5193
HWB Lead in this area	

Is this report for?	Information ☒	Discussion ☐	Decision ☐
Why is this report being brought to the Board?	For information		
Please detail which, if any, of the Joint Health and Wellbeing Strategy priorities the report relates to. (See attached Strategy) Living_well_in_Bury_ Making_it_happen_to			
Please detail which, if any, of the Joint Strategic Needs Assessment priorities the report relates to. (See attached JSNA) Bury JSNA - Final for HWBB 3.pdf			
Key Actions for the Health and Wellbeing Board to address – what action is needed from the Board and its members? Please state recommendations for action.	The Bury Health and Well Being Board are requested to note the content of the update report.		
What requirement is there for internal or external communication around this area?			
Assurance and tracking process – Has the report been considered at any other committee meeting of the Council/meeting of the CCG Board/other stakeholders....please provide details.			

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PRIMARY CARE - MEDICAL BRIEFING PAPER

BURY CCG

Introduction

The GP Contracts Team forms part of the Primary Care Team in the Direct Commissioning Directorate of the NHS England Area Team for Greater Manchester. The team has overall responsibility for the contract management of primary medical care services and, through partnership arrangements with other local commissioners across Greater Manchester, supports the co-commissioning of wider primary care from general medical practice. The team also has responsibilities in terms performance management of those contracts (including the assurance of areas such as Safeguarding and reporting of incidents) and management of those contractors who give cause for concern.

The information detailed within the report is intended to provide an overview of primary medical care within the Bury CCG area in key areas covered by the team. Further detailed information is available and can be provided on request.

Bury CCG

There are 33 practices in Bury, serving a registered population of 197,364 as at June 2014. The breakdown is as follows:

	Bury CCG	GM Total	% GM total
	01G		
General Practice			
Number of GP practices	**33**	**499**	**6.61%**
Number GMS contracts	**21**	**301**	**6.98%**
Number PMS contracts	**10**	**160**	**6.25%**
Number APMS contracts	**2**	**38**	**5.26%**

- General Medical Services (GMS), nationally directed contract between NHS England and a practice
- Personal Medical Services (PMS), local contract agreed between NHS England and the practice, together with its funding arrangements
- Alternative Provider Medical Services (APMS), allows NHS England to contract with 'any person' under local commissioning arrangements.

Contractual Matters

The following section sets out the activity that has taken place during 2013/14 and 2014/15 (to date) that relate to material changes to the contracts held by medical contractors in Bury. For example, where a single handed GP has retired, NHSE is then responsible for ensuring those patients can still access high quality primary medical care services. This could be by procuring a new provider, implementing care taking arrangements, or dispersing the practice list. In all instances the area team seeks the views of the CCG, Local Medical Committee and Healthwatch.

Retirements		
Full Retirement 2013/14	**6**	
Full Retirement 2014/15	**1**	*as of 01.09.2014
Practice Mergers		
2013/14	**0**	
2014/15	**0**	*effective 01.10.2014

List Closures and Boundary Changes

Practices are able to apply to close their lists. In general, practices will only do so on a temporary basis to help them manage things such as, short term internal capacity issues or major premises refurbishments taking place. The process for approving or not approving applications is governed by The NHSE 'Managing Closed Lists Policy'. Closing a list means that the practice cannot register any new patients for the agreed period of time, however they are still able to accept an application for inclusion on their list from a person who is an immediate family member of a registered patient

	GM	Bury CCG
List Closures		
Application to close list 2013/14	7	1
Approved list closures 2013/14	2	0
Application to close list 2014/15	2	1
Approved list closures 2014/15	0	0
Lists currently closed	1	0

All Practices have practice boundaries and these are set out within the practices contract. In rare occurrences a practice will apply to change its boundary. There is no formal policy for this and therefore the AT applies the principles of the 'Managing Closed Lists Policy' when reviewing each application.

	GM	Bury CCG
Boundary Changes		
Application to reduce boundary 2013/14	2	0
Approved boundary reduction 2013/14	2	0
Application to reduce boundary 2014/15	1	0
Approved boundary reduction 2014/15	0	0

Care Quality Commission (CQC)

CQC monitors, inspects and regulates GP services (amongst others) to make sure they meet core standards of quality and safety. Findings are published on the CQC website and practices are required to make available to their patients the outcomes of any CQC inspections.

To date 6 practices in Bury have received a CQC inspection with 4 meeting the core requirements, and 2 practices requiring compliance actions. This means that the 2 practices had to put in place and implement an action plan detailing how they would address the areas where they failed to meet the standards. Both practices have subsequently received a follow up visit and now meet all standards.

GP High Level Indicators (GPHLI) and General Practice Outcome Standards (GPOS)

(i) GPHLI

The Primary Medical Services Assurance Framework is designed to support Area Teams and CCGs to work with GP practices to assure the quality of GP services by promoting continuous improvements in quality. Area Teams and CCGs work in collaboration to review practice performance across a range of indicators and identify practices who are outliers in six or more of the indicator sets.

The most recent data (published July 2014) shows that in Greater Manchester 35 out of the [1]504 practices included, are outlier practices in 6 or more indicators. This compares with 51 of the 531 practices included in the previous year.

CCG Name	Total no of Practices	Number of outlying Practices	%
NHS Bolton CCG	50	1	2.00%
NHS Bury CCG	33	1	3.03%
NHS Central Manchester CCG	35	3	8.57%
NHS Oldham CCG	46	1	2.17%
NHS Heywood Middleton & Rochdale CCG	38	6	15.79%
NHS Salford CCG	49	4	8.16%
NHS North Manchester CCG	36	3	8.33%
NHS South Manchester CCG	25	6	24.00%
NHS Stockport CCG	50	3	6.00%
NHS Tameside and Glossop CCG	42	4	9.52%
NHS Trafford CCG	35	3	8.57%
NHS Wigan Borough CCG	65	0	0.00%

[1] *The difference in practice numbers is due to the fact that any practice mergers/terminations that occurred during 2013-14 are not reflected due to timing differences in the data collection and publication process for the GPHLI.*

Of the 33 practices in Bury, only 1 has been identified as an outlier. The practice is an outlier in 9 areas of the framework. Further work is currently taking place to review the data for all outlying practices across Greater Manchester and this will be shared with CCGs. It should be noted that the framework does not take into account whether the variation is positive or negative. Further investigation may determine that some of the variation is positive i.e. higher levels of prevalence due to the patient demographic etc.

ii) GPOS

GPOS has been developed to support quality improvement. GPOS uses a wider indicator set than the GPHLI, and this is the reason that more practices are either i) identified for review or ii) approaching review compared to the outcome of the GPHLI indicators. The GPOS indicators can be used for peer review and benchmarking and also to provide a consistent platform for CCGs to identify local areas for quality improvement.

For this data set, practices are grouped as follows:

Group	Number of Bury Practices
High Achieving Practices	5
Achieving Practices	20
Approaching Review	4
Identified for Review	4

Patient Survey

The GP patient survey provides information to patients, GP practices and Commissioning organisations on a range of aspects of patients' experience of their GP services and other local primary care services.

The table below provides an overview for Bury CCG Practices position. The Greater Manchester information enables comparison of the CCG against 4 of the key indicators that are measured in the survey.

Indicator	Bury CCG Range	GM Average
% of patients who rated the overall experience of their surgery as good	Practices results ranged from 46% (lowest) to 99% (highest) The CCG average is 85% ↓	86%
% of patients who would recommend their surgery to someone new to the area	Practices results ranged from 40% (lowest) to 97% (highest) CCG average is 77% ↓	78%
% of patients satisfied with the opening hours of their surgery	Practices results ranged from 53% (lowest) to 98% (highest) CCG average is 77% ↓	78%
& of patients who rated the overall experience of making an appointment as good	Practices results ranged from 33% (lowest) to 91% (highest) ↓ CCG average is 72%	74%

Quality and Outcome Framework

QOF is important because of its incentive to drive up quality and improve health outcomes. It is a voluntary incentive scheme that rewards GPs based on the quality of care delivered to patients across 4 domains (Clinical, Public Health, Quality & Productivity, and Patient Experience).

The focus in the clinical domain is long term conditions. The identification and treatment of patients with certain conditions (CHD, Diabetes, Stroke, COPD etc.) by controlling blood pressure and cholesterol levels can make a significant difference to a patient's quality of life.

A detailed QOF outcome report (based on 2013/14) is currently being developed for each CCG locality. The report will focus on areas such as actual prevalence vs predicted prevalence, detailed review of manual exception reporting levels and review of performance against key indicators.

The information below provides a 'headline' view of Bury CCG practices performance in relation to 2013/14.

Overall Achievement

	Clinical Domain	Public Health Domain	Quality & Productivity Domain	Patient Experience Domain	Total
Bury CCG Average	565 / 610 max	148 / 157 max	100 / 100 max	33 / 33max	855.19 / 900 max
Practices achieving below CCG average	11 / 33 practices	6 / 33 practices	0 / 33 practice	0 / 33 practices	10 / 33 practices
GM Average	546.41 / 610 max	147.67/ 157 max	98.32 / 100 max	32.80 / 33 max	843.20 / 900 max
Bury Practices achieving below GM average	12 /33 practices	6 / 33 practices	0 / 33 practices	0 / 33 practices	10 / 48 practices

Exception Reporting

Practices are able to exclude patients from clinical domains when data is collected to calculate QOF achievement. For example patients on a specific register can be manually excluded if the patient is unsuitable for treatment, is newly diagnosed, is newly registered or has given informed dissent. Exception reporting can influence the levels of achievement and therefore the financial outcome for practices

Review of manual exception reporting shows that there are 4 practices in Bury identified as outliers, that is, they are at least double or more, than the average level of exception reporting for Bury CCG in 5 or more of the clinical domains of the QOF. The 3 identified practices are being followed up in line with Greater Manchester's Quality Outcomes Framework (QOF) Pre-Payment Verification Process 2013/14.

Enhanced Services

Directed Enhanced Services are national services that Area Teams (on behalf of NHSE) are required to offer contractors the opportunity to provide. They are often linked to national priorities and agreements and have standard specifications and pricing tariffs.

The table below shows the numbers of practices in Bury that are signed up to provide each service and provides the Greater Manchester position as a comparison.

Directed Enhanced Service Uptake 14/15	GM uptake		Bury Uptake	
	No. of practices providing	% of practices providing	No. of practices providing	% of practices providing
Total Practices	*499*		*33*	
Alcohol risk reduction scheme	457	92%	25	76%
Avoiding unplanned admissions	491	98%	33	100%
Dementia scheme	487	98%	18	55%
*Extended hours access	356	71%	29	88%
Learning disabilities	467	94%	23	70%
Patient participation	433	87%	29	88%
***Public Health DES**				
Childhood Influenza	483	97%	32	97%
Hepatitis B (new born babies)	484	97%	33	100%
Influenza & Pneumococcal	487	98%	32	97%
MenC (freshers)	485	97%	33	100%
MMR (aged 16 and over)	488	98%	33	100%
Pertussis (pregnant women)	497	100%	32	97%
Rotavirus (childhood immunisation)	494	99%	33	100%
Shingles (catch up aged 78 & 79)	486	97%	32	97%
Shingles (routine aged 70)	485	97%	32	97%

** Extended Hours – 6 x GP Challenge funded sites*
**1 No response for Shingles x2, Childhood Influenza, Influenza & Pneumococcal*

Where possible, alternative arrangements are put in place to enable patients of practices that do not sign up to DESs to access services. Further discussions will take place about how we ensure access for patients and this will also be fed into the co-commissioning arrangements, as appropriate.

APMS Contract Reviews – for noting

Greater Manchester must review the time limited APMS contracts, considering the best outcome and future of each existing APMS contract. In order to assess the existing and future service needs of the population it will be necessary to undertake a range of activities including (but not exhaustive):

- Needs assessment

- Value for money
- Impact assessment
- Consultation
- Procurement / extension / dispersal (dependent upon commissioning intention)

It is proposed this process is undertaken with support, input and local consultation from key stakeholders, including CCGs, Local Authority, patients, patient participation groups, LMC, Healthwatch, Local Health and Care Overview and Scrutiny Committee and providers to name but a few.

A letter has been drafted and is being circulated to Healthwatch and Local Heath and Care Overview Scrutiny Committees seeking engagement and details of individuals from the organisations that will participate in the process.

Contact Details

If you require more information around primary medical care services, please do not hesitate to contact the Greater Manchester Area Team (Medical Team) via email england.gmpcs@nhs.net

PRIMARY MEDICAL CARE CONTRACTS TEAM
SEPTEMBER 2014

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Dental Briefing Paper (Bury)

From April 2013, the NHS Commissioning Board took over commissioning responsibility from Primary Care Trusts for all NHS Dental Services: primary, community and secondary, including dental out of hours and urgent care. This includes commissioning dental services provided in high street dental practices, community dental services, and dental services at general hospitals and dental hospitals.

The NHS Commissioning Board commissions NHS dental services based on historic activity and local oral health need.

Responsibility for commissioning Oral Health Improvement now sits with the Local Authorities.

Information for Bury and Greater Manchester arising from a dental survey of five year olds 2012

Despite an overall improvement in the number of children free of tooth decay, over 37% of five year olds in Greater Manchester have tooth decay according to a survey published by Public Health England (September, 2013). Children with decay have, on average, nearly four teeth affected by decay, which is treated or untreated.

The study '*National Dental Epidemiology Programme for England, oral health survey of five-year-old children 2012*' is the second national survey undertaken with the current methodology, the previous survey was in 2008. Comparison between 2008 and 2012 shows an apparent overall improvement in decay levels in young children.

In England the 2012 survey found:

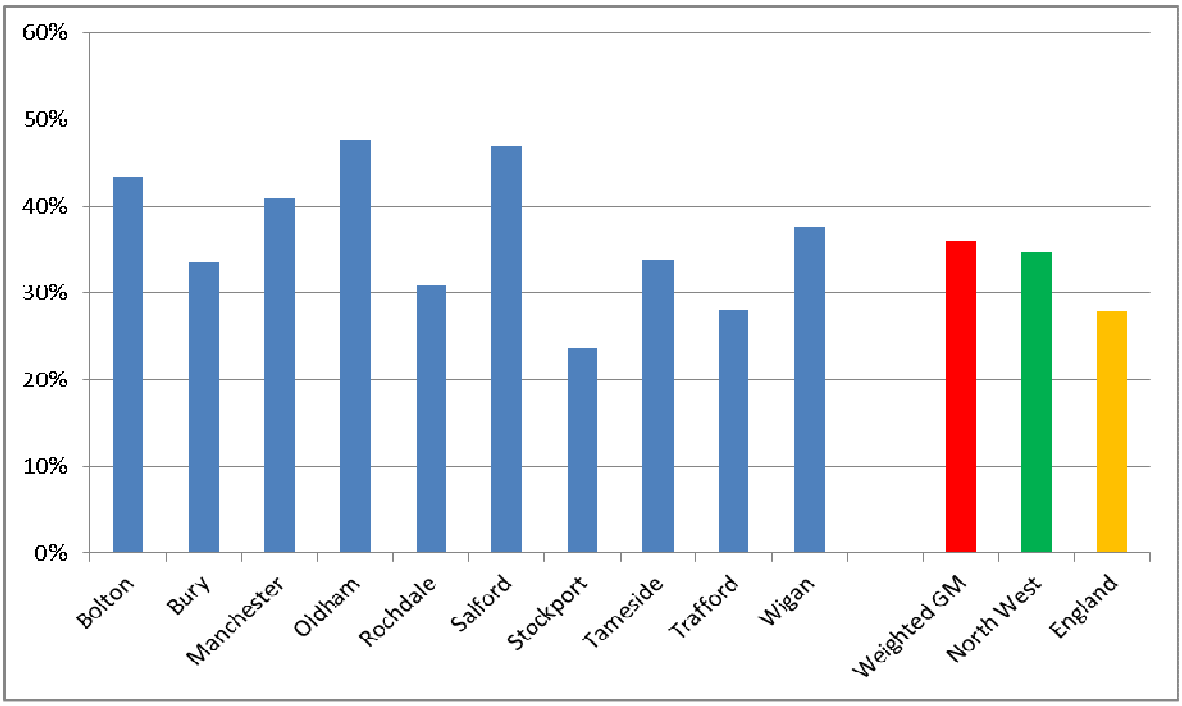
- Overall the proportion of five year old children with any tooth decay has reduced from 30.9% to 27.9%
- The proportion of children with untreated decay has reduced from 27.5% to 24.5%
- Children with sepsis in their mouths has reduced from 2.3% to 1.7% since 2008
- 72.1% of five year olds are free from tooth decay, up from 69.1% in 2008
- The survey is likely to underestimate the true level of disease

Whilst there has been an apparent improvement in disease levels in the country overall there is no room for complacency in the Greater Manchester area as the inequalities in health persist in comparison with the rest of the country and within the region from one Local Authority to another.

Levels of decay in the North West are higher than any other region in the country with 34.8% of children having one or more teeth that are decayed, extracted or filled. This compares with 27.9% in England and 21.2% in the South East.

Within Greater Manchester there are also inequalities in health with only 23.7% of children in Stockport being affected by decay compared with 47.7% in Oldham.

Graph below shows the proportion of 5-yr-olds with one or more decayed, extracted or filled teeth in Greater Manchester, 2012:



Data arising from the survey described above has been analysed by the Public Health England Dental Public Health team in Greater Manchester to provide more detail for Bury at a township level. A higher proportion of five year olds living in Bury East and Whitefield & Unsworth are affected by experience of decay than in the other townships, while fewer in Radcliffe and Bury West have experience of decay. The severity of decay has a similar pattern with children in Bury East and Whitefield & Unsworth having, on average, more teeth affected by disease. Severity is lower in Prestwich and least in Radcliffe.

Early childhood caries (ECC) typically affects smooth surfaces of upper front teeth and can affect many other teeth as well. It is usually associated with long term use of a baby bottle containing sugared drinks, especially if given at night. In some areas it is culturally acceptable to put a baby or toddler to bed with a bottle and allow them to drink freely from a bottle during the day. If water or milk were given in this way there would be no harm to teeth but drinks containing sugar can cause this rapid and disfiguring type of decay. The measures of decay at age five include decay that may have been caused during the first two years of life. Where this type of decay is widespread, for example in Bury East and in Ramsbottom, Tottington & North Manor, action needs to be taken to tackle it early on, otherwise decay levels at age five will remain high.

The observation that general decay severity is moderate in Ramsbottom, Tottington & North Manor but prevalence of ECC is relatively high suggest that a large proportion of the disease measured at age five is attributable to ECC in that area.

General Dental Practices Responsibilities for Access to the Service

Under the current GDS contract (2006) there is no formal registration with a dental practice. Patients who have received a course of treatment on the NHS are entitled to a 12 month guarantee period relating to that course of treatment. Most practices operate a recall system, through which patients are invited back on a regular basis for a routine check-up, in line with NICE guidance. Recall intervals can vary from 3 months to 12 months depending on the dental health of the patient. Compliance with NICE recall guidelines should create further access for new patients.

Practices have a policy for managing FTAs (fail to attend) and this may include no longer offering appointments to patients who have failed to attend on two or more occasions. It is the patient's responsibility to cancel any appointment they cannot attend. Such a policy is to enable practices to manage their limited resources. The decision not to offer future appointments is considered on an individual basis.

It is the responsibility of each practice to ensure that their NHS Choices entry is up to date and correct. The Dental Commissioning Team at GMAT is working with all practices across Greater Manchester to ensure that this is done.

Patients are entitled to access NHS dental services in any part of Greater Manchester. The Area Team continues to ensure that practices take the time to update NHS Choices, providing a central resource for everybody to access, including patients, to be better informed about availability within Greater Manchester.

Contract Numbers

The table below shows Primary Care Dental provision in the Bury area and at a Greater Manchester level:

Contract Type	Bury	Greater Manchester
General	29	381
General and Orthodontic	2	18
Orthodontic	1	38
Pilot (Type 1)	0	2
Pilot (Type 2)	0	2
Pilot (Type 3)	1	3
Community (PDS)	1	4
Total	**34**	**448**

In total there are 16 secondary care contracts across Greater Manchester.

Performance 2013 / 2014

The headlines for 2013 / 2014 performance across Greater Manchester are as follows:

- Underperformance equates to 1% of the total 13/14 contacted activity for UDAs (Units of Dental Activity) & UOAs (Units of Orthodontic activity)
- For Contractors delivering less than 96% - £1.54m (Equates to 57,111 UDAs) will be recovered from contractors before March 2015
- For Contractors delivering between 96.1% - 99.9% 42,739 UDAs will be carried forward and delivered in 14/15
- For Contractors delivering between 100% - 102% 34,352 UDAs will be carried forward and UDA delivery will be reduced for 14/15
- Any Contractor delivering over 102%, the UDAs will not be carried forward as per the policy this equated to 17,235 UDA's at a cost of £545k

The headlines for 2013 / 2014 performance in Bury are as follows:

- Performance achievement for Units of Dental Activity (UDAs) was 98.22%
- Performance achievement for Units of Orthodontic Activity (UOAs) was 100.22%

The table below summarises the year end position for 2013 / 2014 for Bury:

	Contracted Activity	Completed UDA / UOA	Performance Achievement (%)	Over / Under Performance (UDA / UOA)	Under / Over Performance (£)
Unit of Dental Activity (UDA)	304,875	299,459	98.22%	-5,416	-147,880.79
Unit of Orthodontic Activity (UOA)	9,056	9,076	100.22%	20	-2,927

GP Patient Survey

The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. The survey is sent out to over a million people across the UK.

The GP Patient Survey has been designed to give patients the opportunity to comment on their experience of their GP practice and other local NHS services including dentists. The survey asks questions about experiences at local GP surgery and other local NHS services, and includes questions about general health. The survey includes questions about a range of issues, such as how easy or difficult it is for patients to make an appointment at their surgery, satisfaction with opening hours, the quality of care received from their GP and practice nurses, amongst other things. Replies to the survey help surgeries and NHS England understand where improvements are needed. The survey is an opportunity for patients to have their say about how well their practice is doing at providing these services to patients.

Below are the responses to two questions relating to dental practices from the 2013 / 2014 survey. Responses include all those who tried to get an NHS dental appointment within the last two years.

1. Were you successful in getting an NHS Dental Appointment?

	% Yes	% No	% Can't remember
England	93%	5%	2%
Greater Manchester	90%	7%	2%
Bury	90%	8%	2%

According to the above both Greater Manchester and Bury have a slightly lower success rate for patients trying to get an NHS Dentist compared to England as a whole.

2. What was your overall experience of NHS Dental Services?

	% Very good	% Fairly good	% Neither good nor poor	% Fairly poor	% Very poor
England	48%	36%	9%	4%	3%
Greater Manchester	49%	34%	9%	4%	4%
Bury	51%	32%	9%	4%	3%

According to the above Greater Manchester have a slightly higher percentage of patients who stated their experience of NHS Dental Services was very good.

Bury also has a slightly higher percentage of patients who stated their experience of NHS Dental Services was very good.

Access

It is a key priority for NHS England to improve access to dental services. The national measure of access to general dental services is determined as the number of unique patients seen by NHS primary care dental services over the previous 24 month period. Within Greater Manchester access continues to gradually increase at a rate above the regional (North of England) and National rate (see table below):

Greater Manchester Access – March 2006 to June 2014

Name	Patients seen in previous 24 months at 31 March 2006	Patients seen in previous 24 months at 31 March 2013	Patients seen in previous 24 months at 31 March 2014	Patients seen in previous 24 months at end of June 2014
Greater Manchester	1,553,258	1,658,990	1,664,335	1,665,267
North of England Commissioning Region	8,751,351	9,231,335	9,249,297	9,244,868
England	28,144,599	29,775,762	29,915,994	29,915,895

Name	% of Access levels compared to end of March 2006	% of Access levels March 2013 compared to end of March 2006	% of Access levels March 2014 compared to end of March 2006	% of Access levels June 2014 compared to end of March 2006
Greater Manchester	100.0%	106.81	107.15	107.21
North of England Commissioning Region	100.0%	105.48	105.69	105.64
England	100.0%	105.80	106.29	106.29

Bury Dental Access – December 2013 to June 2014

Below are the most recent access figures for Bury:

Local Authority	Patients seen in previous 24 months at end of December 2013 (total adults and children)	Patients seen in previous 24 months at end of March 2014 (total adults and children)	Patients seen in previous 24 months at end of June 2014 (total adults and children)
Bury	108,586	107,455	106,650

Local Authority	% of Access levels compared to end of December 2013	% of Access levels March 2014 compared to end of December 2013	% of Access levels June 2014 compared to end of December 2013
Bury	100.0%	99.0%	98.2%

Areas of Work

Working with the Consultants in Dental Public Health (CDPH) and clinicians from the Local Dental Network (LDN) we have identified specific areas of work that aim to improve oral health. These are:

1. Healthy Gums DO Matter Pilot 2014 / 2015

The gap between how periodontal care (care of the gums) is delivered in General Dental Practices and the recommended guidance is widening. Guidance and care pathways are crucial to improving the quality and care. This area of work aims to improve the clinical management and oral health of adults by improving attendance and quality of periodontal therapy delivered in NHS practices and by increasing, proactive prevention to increase good homecare habits.

Objective / Scope to support practitioners in Greater Manchester to improve the care management of periodontal disease in primary care, to have a set of guidelines and care pathways for treating periodontal disease in NHS dental practices to support local practices improve quality of periodontal care provision and reduce the number of medico legal cases involving periodontal disease and its treatment.

This are of work aims to embed the Healthy Gums DO Matter pilot scheme into the GDS contract from April 2014. To achieve this, each practice will need to take a total of 23 patients through the periodontal pathways:

- 15 from the Disease and Advanced Disease pathway
- 5 from the risk pathway
- 3 from the health pathway

The pilot will run from 1st April 2014 until 31st March 2015.

A total of 12 practices are piloting the Health Gums DO Matter Scheme, of these none are based in Bury.

2. Baby Teeth DO Matter 2014 / 2015

Despite an overall improvement in the number of children free of tooth decay, over 37% of five year olds in Greater Manchester have tooth decay according to a survey published in September 2013 by Public Health England. Children with decay have on average nearly four teeth affected by decay, treated or untreated.

Objective / Scope – to encourage dental attendance among the under 5 year olds, increase proactive prevention at all primary dental care sites, improve clinical management of 3 to 5 year olds, reduce GA referrals, improve overall quality of care of 3 to 5 year olds, better outcomes for patients, cost effective use of NHS resources that reflect local need, empower parents and caregivers to take care of oral health needs and increase good home care habits among the under 5 year olds including brushing with fluoride toothpaste last thing at night and in the morning.

Following the success of the Baby Teeth DO Matter Pilot in 2012 / 2013 Greater Manchester Area Team has developed the Baby Teeth DO Matter scheme which was launched in April 2014. This area of work aims to embed the Baby Teeth DO Matters scheme into the GDS/PDS contract from April 2014. To achieve this, practices will need to deliver the following:

- Actively identify children age 0-5 years who have not attended in the previous two years and positively promote the initiative
- Provide access to the eligible children
- Provide an assessment with advice and intervention according to protocols
- Provide fluoride varnish application
- Provide evidence based oral health based oral health messages and reinforced using leaflets to promote tooth friendly routine for life
- Provide re-attendance opportunities in 2 – 3 month period.
- Complete oral health needs assessment form and return to area team on a quarterly basis.

Non- Recurrent Funding

In financial year 2013 / 2014 a total fund of £506K was invested in non-recurrent activity. A total of 18,066 non recurrent UDAs at £28 per UDA were offered to practices, providing access to an additional 5,200 patients (on an average of 3.5 UDAs per patient). This additional funding was primarily for children age 0-5 years, in order to build on the work of Baby Teeth Do Matter Scheme 2012 / 2013.

Three practices in Bury expressed an interest in the non-recurrent scheme and were awarded a total of 651 UDAs, providing access to an additional 186 patients (based on an average of 3.5 UDAs per patient).

NHS England is currently reviewing non-recurrent funding opportunities in 2014 / 2015.

Dental Assurance Framework

The DAF UDA Framework has 14 clinical and non-clinical indicators (see below) which the Area Team use to support an initial view that practices are delivering a good service.

- Under-delivery of UDAs
- Radiographs Rate per 100 FP17s
- Fluoride Varnish Rate per 100 FP17s (3-16 yr old patients)
- Fissure Sealants Rate per 100 FP17s (3-16 yr old patients)
- Endodontic Treatment Rate per 100 FP17s
- Low Extractions Rate per 100 FP17s
- High Extractions Rate per 100 FP17s
- Extractions as a % of Extractions + Endodontic Treatment – Adults
- Inlay Rate per 100 FP17s
- Re-attending within 3 months – Child
- Re-attending within 3 months – Adults
- Average Band 3 to Band 3 rates
- % satisfied with dentistry received
- % satisfied with wait for an appointment

The above data is provided on a quarterly basis by the NHS Business Services Authority Dental Services (NHSBSA) to the Area Team in table format indicating the number of flagged indicators individual practices have. Indicators are benchmarked to identify outliers by comparing individual contract performance to England averages whilst taking into account the contract size.

The Area Team then uses the Assurance Framework as one of its formal tools to identify and reduce variation by setting a transitional standard that none of our dental practices should have more than four flagged indicators.

Flags for Bury as of June 2014 are:

Contract Type	Number of Flags
GDS General	1x practice with 7 flags 1 x practice with 5 flags 3 x practices with 3 flags 5 x practices with 2 flags 12 x practices with 1 flag 8 x practices with 0 flags
General and Orthodontic	1 x practices with 3 flags 1 x practice with 1 flags
Orthodontic	1 x practice with 0 flags

Referral Management

A central dental referral management has been in place in Greater Manchester in pilot form since 2012, launched via a phased roll out across all localities. The current pilot service now has 100% coverage of Greater Manchester and includes all dental specialties and pathways across primary and secondary care. The service provides invaluable data relating to pathways development e.g. oral surgery, oral and maxillofacial surgery and orthodontics, as well as improving the quality of referrals. The overall aim of the service is to ensure that patients are referred in to the most appropriate service according to need.

During 2014 / 2015 the Area Team are undertaking Referral Management Service procurement. Expected date of commencement of the newly procured service is 1 July 2015.

Community Dental Services

Community Dental Services provide special care dentistry. The speciality of special care dentistry is concerned with the improvement of the oral health of individuals and groups in society who have a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability or, more often, a combination of these factors, which results in them being unable to access routine dental care. It pertains to adolescents and adults.

Bury Community Dental Service is delivered by Pennine Care NHS Foundation Trust and provides dental services limited to people with disability, who have complex needs and are unable to use general dental services. Patients may be referred to the service by other dentists, doctors, health and social care professionals and Support Workers.

The service provides:

- specialised dental services to people with complex needs who are unable to use general dental services
- assessments for general anaesthetic for paediatric and special needs patients
- Treatment using inhalation sedation for paediatric patients
- Home visits for people with complex needs who cannot be treated by a general dentist

Contact Details

NHS Choices

Patients who are seeking access to dental care are able to source information regarding local dental services from the NHS Choices website (www.nhs.uk)

Urgent Dental Care

- Bury - Urgent In Hours Care (8.00am – 6.30pm) 0161 447 9898
- Bury - Urgent Out of Hours Care (6.30pm – 8.00am) 0161 763 8941

Community Dental Service

- Pennine Care NHS Foundation Trust (Bury) 0161 447 9866

Area Team

If you require more information around Primary Care / Secondary Care Community Dental Care, please do not hesitate to contact the Greater Manchester Area Team (Dental Team) via email england.gmdental@nhs.net OR telephone 0113 825 5264 / 5231 / 5144.

Eye Health Briefing Paper

Optometrists are found in the high street, supermarkets, and within the heart of local communities. Optometry provision is available seven days a week.

Due to the abolishment of the PCTs, all existing General Ophthalmic Services (GOS) contracts became the responsibility of NHS England Area Teams.

A GOS mandatory contract is for the provision of NHS eye sight tests from a fixed premise. A GOS additional contract is for the provision of domiciliary NHS eye sight tests in a patient's home, residential/care home and day centres.

Both GOS mandatory and additional contracts cover the provision of NHS eye sight tests, which includes sight correction and a detailed examination of the eye that can identify early signs of diseases such as high blood pressure and cancer.

Up to 800,000 people in Greater Manchester are at risk of eye sight loss, which could be prevented. Promotion of eye sight tests is an important prevention tool, it is recognised that patients eye health needs, do extend beyond the scope of the GOS contracts. CCGs can commission a service that transfers the treatment of acute conditions and/or the monitoring of stable eye conditions from secondary to primary care. They can also commission services which seek to minimise inappropriate referrals.

The table below shows optometry provision in the Bury area and at a Greater Manchester level:

Optometrists:	Bury	Greater Manchester
Mandatory Contracts (GOS)	18	297
Additional (including mandatory) Contracts	0	83
Additional Contracts	9	*30
Total:	***27***	***410***

*Greater Manchester additional contracts also include local area provision for domiciliary NHS eye sight tests.

In 2012/13 41,618 GOS sight tests were performed in Bury.

Ophthalmic Public Health

There is now an ophthalmic public health indicator in the public health outcomes framework.

According to the latest HSCIC Data as at March 2014
- 365 people were registered blind.
- 590 people are registered partially sighted.

The indicator as outlined on the Public Health England website shows that the current indicators (2012/13) are as follows:

4.12iv – Preventable sight loss – sight loss certifications - 80
4.12iii – Preventable sight loss – diabetic eye disease – 0
4.12ii – Preventable sight loss – Glaucoma – 9
4.12i - – Preventable sight loss – Age related macular degeneration – 25

All indicators appears to be 'similar' rating to the benchmark, although Greater Manchester Local Eye Health Network is exploring these metrics and their alignment as we believe there are discrepancies across GM between the registered figures with the local authority and those reported nationally to be reflected in the indicator. This may give the appearance of higher or lower than expected certifications.

Commissioning

Community optometrists are also able to provide a range of services which would fall under the commissioning responsibility of Public Health/Local Authorities, known as locally commissioned services.

These services support health improvements, reduce health inequalities and improve quality of life. Optometrists can help meet the current and future needs of the local population in several ways:

- By developing services for long term care of patients with eye sight loss, in particular the elderly. Implementing low vision services (including relevant aids), can help support good management of cases and reduce the dependency of social care intervention with this group of patient's

- The vision and falls links is very strong with a significant proportion of fall caused by poor vision and it is vital that vision checks area a part of the falls pathway and falls assessments. Community optometrists can support the falls agenda with the provision of these checks.

- By improving access to care and quality of care, by working collaboratively with Public Health England colleagues and reviewing pathways, with the potential to transfer secondary care based diabetic retinopathy screening services into primary care – improving access across a multitude of locations and uptake. Diabetic Retinopathy is a significant cause of visual impairment in England, with a rising number of diabetics, screening and treatment is an integral part of the eye health care provision.

Currently Bury CCG has commissioned the Minor Eye Conditions service from community optometrists and this is delivered from 10 practices across Bury. This services delivers a patient self-referral service for minor eye conditions ensuring urgent eye conditions are seen within 24hrs and non-urgent within at least 5 days if not sooner.

Community optometrists have joined with Pennine Acute Hospital FT to bid to deliver the Community Glaucoma service and Low Vision service as currently being procured by Bury CCG – this bid is also being supported by the Bury Society for the Blind.

Contact Details

If you require more information around community pharmacy and the contribution they can make, please do not hesitate to contact the Greater Manchester Area Team (Optometry and Pharmacy Team) via email AGM.optometry-pharmacy@nhs.net or telephone 0113 825 5162/5139/5270.

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Community Pharmacy Briefing Paper

Community Pharmacies provide a convenient and less formal environment for those who cannot easily access or do not choose to access other kinds of health service, or who simply want readily available, sound professional advice and help to deal with everyday health concerns and problems. Many pharmacies now have dedicated consultation rooms, specifically designed for private discussions.

Information shows that 99% of the population (even those living in the most deprived areas), can get to a pharmacy within 20 minutes by car and 96% by walking or using public transport [1]. Pharmacies are open at times which suit patients, many late into the evenings or at weekends. In England, since April 2005, over 400 new pharmacies have been approved to open for at least 100 hours per week, every week of the year. In 2013, 1 billion prescription items were dispensed in the community; this is an increase of 3% (30 million items) on the number dispensed in 2012[2] . People receive their prescribed medicines promptly, safely and efficiently.

The table below shows pharmaceutical provision in the Bury area and at a Greater Manchester level:

Pharmacies:	Bury	Greater Manchester
Standard (40 hours)	35	567
100 hours	4	97
****DSP***	2	24
****DAC***	0	8
Overall Opening Hours	***Mon – Fri:*** 0600 – 2359 ***Sat:*** 0600 - 2200 ***Sun:*** 0800 - 1800	***Mon – Sat***: 0000- 0000 ***Sun:*** 0600 - 2300

*Dispensing Appliance Contractors (DACs), specialise in the supply of appliances, stomas and incontinence appliances on a prescription. Distance selling pharmacies (DSP) are also referred to as internet pharmacy sites, they provide the same essential services has community pharmacies, but not via face to face.

National Contractual Framework

All community pharmacies have to adhere to their national contractual framework which comprises of essential, advanced, clinical governance and locally commissioned services. The essential (core) services and clinical governance must be provided by all pharmacies, this includes dispensing medicines and appliances, providing prescription linked healthy lifestyle advice, disposal of unwanted medicines, complaints, clinical audits, support for self-care and signposting. Advanced services which pharmacies can choose to provide upon accreditation,

[1] 'Pharmacy in England, Building on strengths-delivering the future' – April 2008
[2] 'Health and Social Care Informatics Centre (HSCIC website)'

includes medicine use reviews (MURs), appliance use reviews (AURs) and the new medicine services (NMS), to support patients with long- term conditions who are prescribed new medicines.

The contractual framework has specific public health elements such as:

- ***Promotion of healthy lifestyles*** – requires pharmacies to participate in up to six health promotional campaigns annually, on topics such as obesity, cancer and healthy lifestyles;
- ***Support for self-care/signposting*** - requires pharmacies to help people understand the correct use and management of their medicines, as well provide healthy life style advice. Pharmacies are obliged to help and support people asking for advice and information, by signposting them to the appropriate source of help.

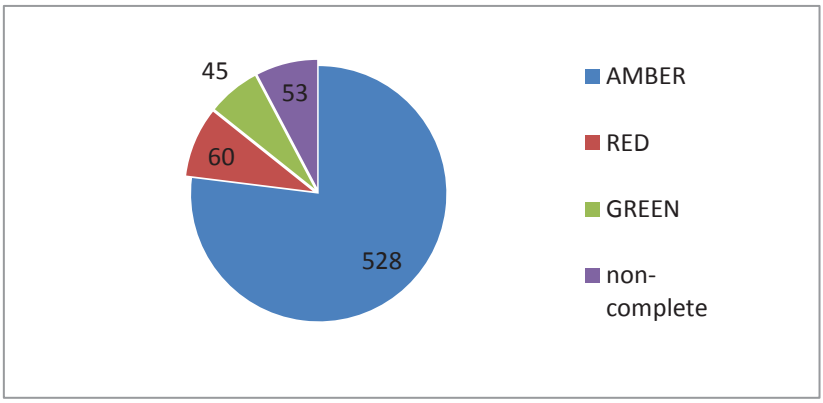
NHS England's Area Teams (ATs) have responsibility for monitoring the national contractual framework and provide assurance of contractor's compliance with the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended. ATs currently use the Community Pharmacy Assurance Framework (CPAF), to monitor pharmacy contractors' compliance.

The CPAF is made up of two parts – a pre-visit questionnaire which is completed by the pharmacy contractor before the monitoring visit and a section used by the ATs during a monitoring visit. To enable Greater Manchester Area Team (GMAT) to undertake this work they have deployed PharmaOutcomes (an electronic web based tool), for Community Pharmacies to complete the self-assessment questionnaire and for the AT to review.

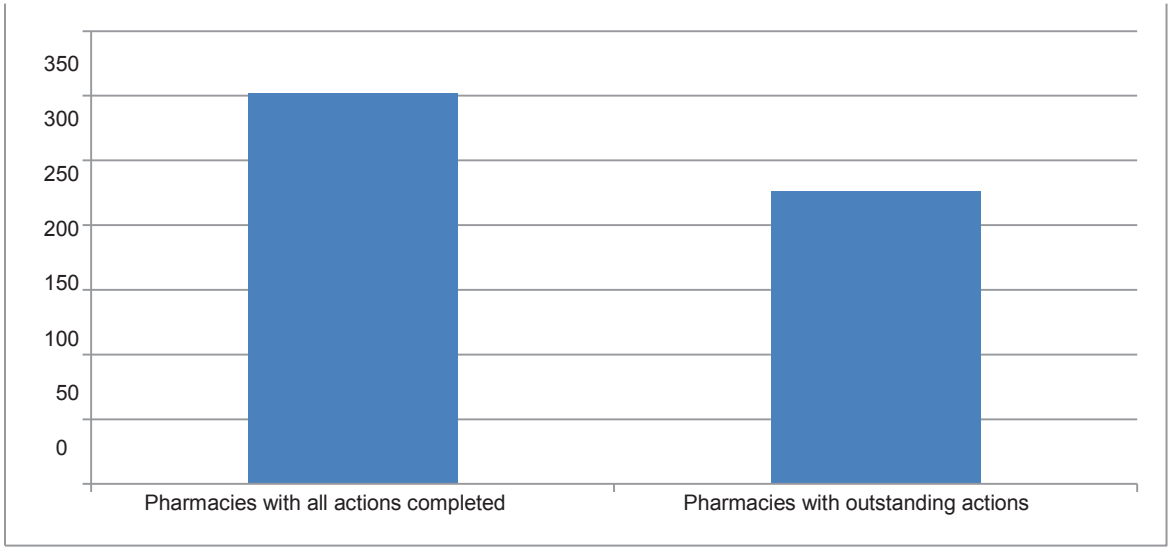
Assessment of CPAF 2013/14 data

The GMAT undertook a manual data analysis review of each pharmacies responses from the 2013/14 CPAF, to establish how each pharmacy was performing overall against their essential and clinical services. Each pharmacy was RAG rated to assess their compliance with the NHS terms of service. The RAG rating was based on local criteria because no national rating was available. Pharmacies that fell below standard were rated red; those that met the standard were rated amber; and those that were above the standard were rated green.

The outcome of the review (as per pie chart below), identified 528 (77%) pharmacies had an amber rating, including 2 pharmacies from the Bury area. These pharmacies will be required to complete an action plan and implement any identified actions within a specified timeframe.



The bar chart below shows the number of pharmacies from the amber group that has now completed all their actions and are fully compliant against their national contract. The remaining 226 will be required to complete CPAF for this year (2014/15).



CPAF process 2014/15

NHS England's process for this year is that any pharmacies that submitted the CPAF questionnaire in 2013/14, reviewed and rectified areas of non-compliance will not be asked to submit any further information this year. There will be a rolling programme of assurance visits to manage the assurance process and to inform commissioning decisions; relating to Enhanced /Locally Commissioned Services.

Assurance visits will be undertaken where pharmacies fit the following criteria:-

- Pharmacies who did not complete CPAF in 2013/14
- New pharmacies
- New change of ownerships
- Particular pharmacies, where concerns and issues have been identified

GMAT visits will commence October 2014, with the intention to complete all the assurance visits by January 2015.

Dementia Friendly pharmacy work

The GMAT is developing a Greater Manchester Dementia Friendly Pharmacy Framework as part of the Local Professional Network medicines optimisation work. The aim is to have a dementia friend in every single pharmacy and pharmacy teams are ideally placed to discuss with individual patients with dementia how they could be better supported within the pharmacy environment. The launch of the framework is planned for November 2014.

Screening and Immunisation Health Promotional Campaign

The current GMAT directed health promotional campaign for the pharmacies is Screening and Immunisation for September 2014 through to November 2014.

Public Health England (PHE) has produced national communication for the seasonal flu vaccination programme, this will aide and support the pharmacies in delivering this campaign. The creative route and media plan are being finalised following research and it is planned the campaign will be launched on 8 October 2014. The specific target audiences will be; under 65s with long-term conditions, pregnant women and parents of children aged 2, 3 and 4 years old.

PHE will provide Local Authorities and the NHS with a campaign briefing sheet, PR toolkit, posters and digital assets in mid-September. GMAT is looking to build on this national campaign with the local communication teams.

The GMAT public health commissioning colleagues have now concluded discussions with Community Pharmacy Greater Manchester on behalf of the Greater Manchester Local Pharmaceutical Committees regarding the implementation of the Greater Manchester seasonal influenza vaccination pharmacy scheme for 2014/2015. The scheme will continue to target those aged 18 - 64 years in a clinical at risk group and carers. The Pharmacies who agree to take part in the scheme will be offering the vaccination from 1 November 2014 to 28 February 2015. If you have any queries regarding this service please contact initially the CPGM team at secretary@manlpc.co.uk.

Contact Details

If you require more information around community pharmacy and the contribution they can make, please do not hesitate to contact the Greater Manchester Area Team (Optometry and Pharmacy Team) via email AGM.optometry-pharmacy@nhs.net or telephone 0113 825 5162/5139/5270.