AGENDA FOR

HEALTH AND WELLBEING BOARD

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To: All Members of Health and Wellbeing Board

Councillors : Pat Jones-Greenhalgh (Vice-Chair), D Bevitt, M Carriline, S North, R Shori (Chair), Jones, A Simpson, K Patel, B Barlow and J Marshall

Non –voting member: R 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, 29 January 2015
Place:	Meeting Rooms A&B Bury Town Hall
Time:	6.00 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)*

Minutes attached.

4 MATTERS ARISING *(Pages 7 - 14)*

Forward plan 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 PHARMACEUTICAL NEEDS ASSESSMENT *(Pages 15 - 218)*

A report produced by the North West Commissioning Support Unit in conjunction with NHS England Greater Manchester Area Team, Bury Clinical Commissioning Group and the Local Pharmaceutical Committee is attached.

7 BETTER CARE FUND UPDATE *(Pages 219 - 396)*

The CCG Chief Operating Officer will report at the meeting. Report attached.

8 QUARTERLY REPORT ON HWB STRATEGY INDICATORS *(Pages 397 - 424)*

A report from the HWB Policy Lead is attached.

9 CHILDREN AND YOUNG PEOPLE'S PLAN *(Pages 425 - 440)*

The Executive Director for Children, Young People and Culture will report at the meeting. Report attached.

10 QUARTERLY NHS ENGLAND AREA REPORT

Rob Bellingham, Director of Commissioning NHS England will report at the meeting. A report will be sent to follow.

11 PRIMARY CARE CO-COMMISSIONING *(Pages 441 - 448)*

The Chief Operating Officer will report at the meeting. Letter attached.

12 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: 18 December 2014

Present: Cabinet Member, Councillor Rishi Shori (Chair); Director of Public Health, Lesley Jones; Police Inspector Lee Parker; NHS England, Mr. Rob Bellingham; Executive Director, Communities and Wellbeing, Pat Jones-Greenhalgh; Chief Operating Officer, Stuart North; Councillor Andrea Simpson; Dr. Audrey Gibson; Executive Director, Children and Families, Mark Carriline; Representing B3SDA; Dave Bevitt.

Also in attendance:

Michael McCourt – Chief Executive, Pennine Care NHS Foundation Trust
Keith Walker – Director of Operations, Pennine Care NHS Foundation Trust
John Wilks – Facilities Director, Pennine Acute NHS Trust
Jo Marshall - Chief Inspector, Integrated Neighbourhood Policing & Partnerships, Bury Division
Jimmy Cheung – Senior Medicines Optimisation Pharmacist, North West Commissioning Support Unit
Stephen Wood – North West Commissioning Support Unit
Nicola Hine – Strategic Planning and Development Officer, Bury Council.
Heather Hutton - Health and Wellbeing Board Policy Lead.
Julie Gallagher - Democratic Services.

Apologies:

Barbara Barlow, Healthwatch

Public attendance: There were no members of the public in attendance

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HWB.406 DECLARATIONS OF INTEREST

There were no declarations of interest.

HWB.407 MINUTES

Delegated decision:

That the Minutes of the meeting of the Health and Wellbeing Board held on Thursday 30th October 2014, be approved as a correct record and signed by the Chair.

HWB.408 MATTERS ARISING

Members of the Board reviewed the Health and Wellbeing Board forward plan.

Delegated decision

The Health and Wellbeing Board forward plan be noted.

HWB.409 PUBLIC QUESTION TIME

There were no questions from members of the public.

HWB.410 PHARMACEUTICAL NEEDS ASSESSMENT CONSULTATION UPDATE

The HWB considered a verbal presentation from representatives from the North west Commissioning Support Unit; Jimmy Cheung, Senior Medicines Optimisation Pharmacist and Stephen Wood, in relation to the Pharmaceutical Needs Assessment consultation. An accompanying report had been submitted to the Board at a previous meeting, which provided an evaluation of the pharmaceutical need across the Borough.

The formal PNA consultation ran from 1st September 2014 until 24th November 2014. The draft PNA and consultation response were issued by the Local Authority communications team. The number of responses totalled 88, the majority of the respondents 76, were in the M45 post code area.

The main area of contention was in relation to the pharmaceutical need in the Besses area. The consultation draft PNA identified a potential gap in service provision in the Besses ward and made suitable requirements for this gap to be fulfilled. The Senior Medicines Optimisation Pharmacist reported that there were a number of challenges to this gap analysis and some stakeholders felt that there were no gaps in Bury and existing pharmacy contractors on the ward boundary could support the pharmaceutical needs of the Besses population.

In discussion that followed there was consensus amongst Board members that the PNA must be explicit in terms of pharmacy requirements within the Besses/M45 post code area. Failure to do so, could cause confusion and leave the document open to interpretation.

Following discussion, representatives from the North West Commissioning Support Unit acknowledged that the pharmacy need identified in relation to the Besses/M45 could only be meet by the provision of a new pharmacy.

In response to a Board Member's question, the Senior Medicines Optimisation Pharmacist reported that the cost of establishing a new pharmacist would be between £40,000 and £60,000, this cost would have to be met by NHS England.

Delegated decision:

1. The representatives from the North West Commissioning Support Unit will amend the Pharmaceutical Needs Assessment to include explicit guidance in relation to the Pharmacy requirements in the Besses/M45 post code area.
2. The final Pharmaceutical Needs Assessment and all the appendices will be considered at the next meeting of the Health and Wellbeing Board due to be held on the 29th January 2015.

HWB.411 BETTER CARE FUND UPDATE

The Chief Operating Officer, CCG provided members of the Board with an update in relation to the Better Care Fund. The presentation contained the following information:

Bury's Better Care Fund plan was signed off by the Health and Wellbeing Board on 18th September & submitted to NHS England on the 19th September 2014. The plan was then subject to a national assurance process and was approved with conditions. Aspects of the plan are currently being revised to address the national conditions and this is work in progress.

The revision focuses on providing more detail and assurances over:

- risk share arrangements
- risks and mitigation
- impact on the metrics
- data sharing
- partnership working with providers
- agreed impact on the acute care sector

In response to a Member's question, the Chief Operating Officer reported that all the stakeholders involved in the development of the Better Care Fund submission recognise the risks involved in developing the proposals, in particular, the need to reduce activity within A&E.

The Chief Operating Officer reported that A&E is under significant pressure despite, significant investment in the Healthy Radcliffe pilot as well as more GP appointment slots being made available within Primary Care.

The Executive Director Communities and Wellbeing reported that, work is ongoing with health partners to identify those patients known to social care who are at risk at presenting at A&E.

Delegated decision:

1. The Health and Wellbeing Board note the actions being taken to address the conditions relating to the Better Care Fund plan.
2. The Health and Wellbeing Board agrees to delegate sign off of the revised plan on 8th January 2015 for submission on the 9th January 2015 to the Chair of the Health and Wellbeing Board, Councillor Rishi Shori.

HWB.412 UPDATES FROM REPRESENTATIVES OF THE PENNINE ACUTE AND PENNINE CARE NHS TRUSTS

Pennine Acute NHS Trust – John Wilks, Director of Facilities, Pennine Acute NHS Trust provided members of the Board with an update in relation to the Trust. The Trust had recently been invited to attend a workshop event with partners from the CCG and the Local Authority to discuss future clinical transition. The Pennine Acute NHS Trust will begin a further reconfiguration exercise, in addition to the Healthier Together consultation, this will commence in 2015.

Pennine Care NHS Foundation Trust – Michael McCourt, Chief Executive, Pennine Care NHS Foundation Trust and Keith Walker, Director of Operations

Pennine Care NHS Foundation Trust provided members of the Board with an update in relation to the Trust. Within Bury, the Trust have developed an integrated community care model, as well as the living well academies.

The Trust has recently developed a Rapid Access Interface Discharge service. The development of this service has generated large savings for the commissioning CCGs. An external evaluation of the service has shown that patients are six times less likely to be re-admitted to an Acute ward following involvement of the RAID service. The Trust would like this service extended to all conditions.

Delegated decision:

Representatives from Pennine Acute and Pennine Care be thanked for their attendance.

HWB.413 NEW LEARNING DISABILITY STRATEGY FOR BURY CONSULTATION

The Health and Wellbeing Board considered a verbal presentation from the Strategic Planning and Development Officer. An accompanying report had been circulated to members of the Board. The report contained the following information:

The Learning Disability Strategy is due to be refreshed. The absence of national guidance provides Bury with an opportunity and flexibility to set the strategic vision for the future of learning disability services.

It is proposed that the new Learning Disability Strategy will include the following themes:

1. More people will be supported to leave in their own homes
2. More people will be supported to have meaningful lives
3. More people will feel safe and secure
4. More people will live healthier lives and have better life expectancy.

The Learning Disability Strategy will primarily focus on adults (aged 18+). It is proposed that an Outcomes Based Accountability approach is taken to developing a new Learning Disability Strategy.

Members discussed a partnership approach to the development of the strategy ensuring that the police and key stakeholders are involved in the development of the proposals.

In response to representation from the Chief Inspector, Integrated Neighbourhood Policing & Partnerships, Bury Division, the Strategic Planning and Development Officer reported that the strategy would contain proposals in relation to "Hate crime".

Delegated decision:

1. The Health and Wellbeing Board support the use of an outcomes based accountability approach to developing a new Learning Disability Strategy for Bury.
2. Approve the four themes identified above for inclusion within the Learning Disability Strategy.

3. The Strategic Planning and Development Officer would liaise with police representatives to ensure that the new strategy incorporates concerns raised in relation to Learning disability and "hate crime".

HWB.414 SUPPORTING WORKING CARERS

Delegated decision:

The supporting working carers report will be deferred for consideration at a future meeting of the Health and Wellbeing Board.

HWB.415 REPORT ON THE UPDATED HEALTH AND WELLBIENG STRATEGY, DELIVERY PLAN AND OUTCOMES FRAMEWORK FOR PRIORITY FOUR

The Health and Wellbeing Board Policy Lead reported that the Board are committed to refreshing the HWB Strategy. Priority four "promoting independence of people living with long term conditions and their carers" includes refreshed actions, measures of success and indicators.

Delegated decision:

The Health and Wellbeing Board approves the refreshed priority four actions, measures of success and indictors of the Health and Wellbeing Strategy.

HWB.416 REPORTS ON THE REFRESHED GOVERNANCE ARRANGEMENTS FOR REFRESHED PRIORITY ONE OF THE HEALTH AND WELLBEING STRATEGY

Members of the Board considered the proposals for the refreshed governance arrangements for the refreshed priority one of the Health Wellbeing Strategy.

Delegated Decision:

1. The Health and Wellbeing Board will consider the Children's & Young Peoples Plan on an annual basis.
2. The Annual Safeguarding Children's Report and Child Death Overview Report be considered by the Health and Wellbeing Board on an annual basis.
3. The work programme of the Children's Trust Board will be determined by the Children & Young People's Plan. The Children's Trust Board must also have regard to any issue referred to it by the HWB.
4. The Children's Trust Board can make recommendations to the Health and Wellbeing Board arising from work undertaken on behalf of the Board.
5. It is important that all Health and Wellbeing Board members are kept aware of the work of the Children's Trust Board and Bury Children's Safeguarding Board, minutes will be circulated for information on a regular basis.
6. The Children's Trust Board will oversee the delivery of the priority one of the HWB Strategy in doing so, the Health Wellbeing Board will receive bi-annual reports in July 2015 and January 2016.

HWB.417 UPDATE ON PRIMARY CARE CO-COMMISSIONING

The Chief Operating Officer, CCG reported that the a letter had been circulated to all Local Authorities Chief Executives and Chairs of the Health and Wellbeing Board to update them on primary care co-commissioning.

Delegate Decision:

The Chief Operating Officer of the Clinical Commissioning Group will provide members of the Board with a report at the next meeting of the Health and Wellbeing Board due to be held on 29th January 2015 in relation to the Primary Care Co-commissioning proposals.

HWB.418 RESIGNATION FROM THE HEALTH AND WELLBEING BOARD OF DR AUDREY GIBSON

The Chair informed members of the Board of the impending resignation from the Health and Wellbeing Board of Dr. Gibson.

On behalf of the Board, the Chair thanked Dr Audrey Gibson for her contribution and wished her well for the future.

Councillor Rishi Shori
Chair

(Note: The meeting started at 2pm and ended at 3.25pm)

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	Draft Agenda • To be informed by the Member Development Action Plan	(2) Draft Agenda • 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 1. Priority 4 of Health & Wellbeing Strategy- *Promoting independence of people living with long term conditions and their carers* 1.A) Presentation on The Bury Directory (Heather Hutton)	**Information**	
			Discussion	2. Letter from Secretary of state re: Effective engagement between Health & Wellbeing boards and providers (Julie Gallagher) 3. Proposals for a revised Greater Manchester Health & Wellbeing Board (Cllr Shori/Pat Jones-Greenhalgh) 6. Update on Team Bury Forum (Heather Hutton)
			Decision	4. Member Development Day update and Etiquette & Expectations document (Heather Hutton) 5. Report on the updated Health & Wellbeing Strategy, delivery plan and outcomes framework for Priority 1 (Heather Hutton)
			TBC	

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**	• PNA Consultation Update report (Jimmy Cheung) • Supporting working Carers (Zena Shuttleworth)
			Discussion	• Briefing on the Inquiry into Health Equity for the North (Lesley Jones) • Presentation Update on Better Care Fund (Lorraine Tatlock) • Pennine Care & Pennine Acute update • New Disability Strategy for Bury Consultation.
			Decision	
			TBC	

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**	• Quarterly report on Health & Wellbeing Strategy refreshed indicators/baseline priority 1 & 4 (Anna Barclay) • PNA Consultation final report (Jimmy Cheung) • Quarterly NHS England area report (Rob Bellingham)
			Discussion	• Children and Young People's Plan 2015 to 2018 (Mark Carriline/ Lindsey Dennis) • Primary Care co-commissioning (Stuart North) • Greater Manchester Strategy for Public Health (Lesley Jones)
			Decision	• Better Care Fund Ratification report (Stuart North/Pat Jones Greenhalgh)
			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 3 (Heather Hutton) • Report on Priority 4 governance arrangements (heather Hutton) • Report on the updated Health & Wellbeing Strategy, delivery plan and outcomes framework for Priority 2 • Report on Priority 3 governance arrangements (Heather Hutton) • Independent Director of Public Health's Report (Lesley Jones)
			Discussion	
			Decision	
			TBC	• UPDATE report Supporting working Carers (Zena Shuttleworth)

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 • Report on Health & Wellbeing Strategy refreshed indicators/baseline priority 2 (Anna Barclay) • Report on Priority 2 governance arrangements (Heather Hutton
			Discussion	
			Decision	
			TBC	• Report on refreshed Health & Wellbeing strategy, progress on delivery plan and outcomes framework
Beyond... • Working Well Protocol (June 2015) • Annual Safeguarding Children's Report (Sept 2015) • Child Death Overview Report (Sept 2015) • Priority 5 governance & PI/baseline reports • Healthier Together Reconfiguration update				

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Agenda Item 6

Bury Health and Wellbeing Board

Title of the Report	Post Consultation Pharmaceutical Needs Assessment (PNA)
Date	15th January 2015
Contact Officer	Jimmy Cheung (Senior Medicines Optimisation Pharmacist) at North West Commissioning Support Unit (NWCSU)
HWB Lead in this area	Anna Barclay and Lesley Jones

1. Executive Summary

Is this report for?	Information ☐	Discussion ☐	Decision ☒
Why is this report being brought to the Board?	This document needs final approval by Bury Health and Wellbeing Board after changes made post the 60-day consultation.		
Please detail which, if any, of the Joint Health and Wellbeing Strategy priorities the report relates to.	The development of the PNA is undertaken in the context of the needs described in the JHWS and JSNA. The PNA does not duplicate the JHWS and JSNA intentions but provides an overarching plan where pharmaceutical services can support those priorities.		
Please detail which, if any, of the Joint Strategic Needs Assessment priorities the report relates to.			
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.	Approval of the Pharmaceutical Needs Assessment ready for publication on Bury Council's website. Either full approval or subject to minor changes with authority delegated to the Director of Public Health for Bury Council for final sign off.		
What requirement is there for internal or external communication around this area?	Continuous update between PNA Steering Group and HWB		
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.	HWB meeting Health Scrutiny meeting		

2. Introduction / Background

As per previous briefings

3. key issues for the Board to Consider

The 60-day consultation period of this PNA ran from 1st September 2014 until 24th November 2014. The draft PNA and consultation response form were issued by the Local Authority communications team to:

- all pharmacy contractors,
- dispensing appliance contractors,
- Bury CCG,
- Bury LPC,
- Bury LMC
- GM AT
- Local Healthwatch
- Local Acute Trusts
- Neighbouring HWB
- General public

Consultation responses can be found in Appendix 3 of the draft PNA if further details are required.

4. Recommendations for action

The HWB will be asked to agree and ratify the final version of the PNA in January 2015 to ensure it can be published by the deadline of March 31st 2015.

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).

6. Equality/Diversity Implications

Equality Impact Analysis will be available in Appendix 10 of the PNA document

CONTACT DETAILS:
Contact Officer: Jimmy Cheung
Telephone number: 0161 212 6221
E-mail address: jimmy.cheung@nhs.net
Date: 15th January 2015

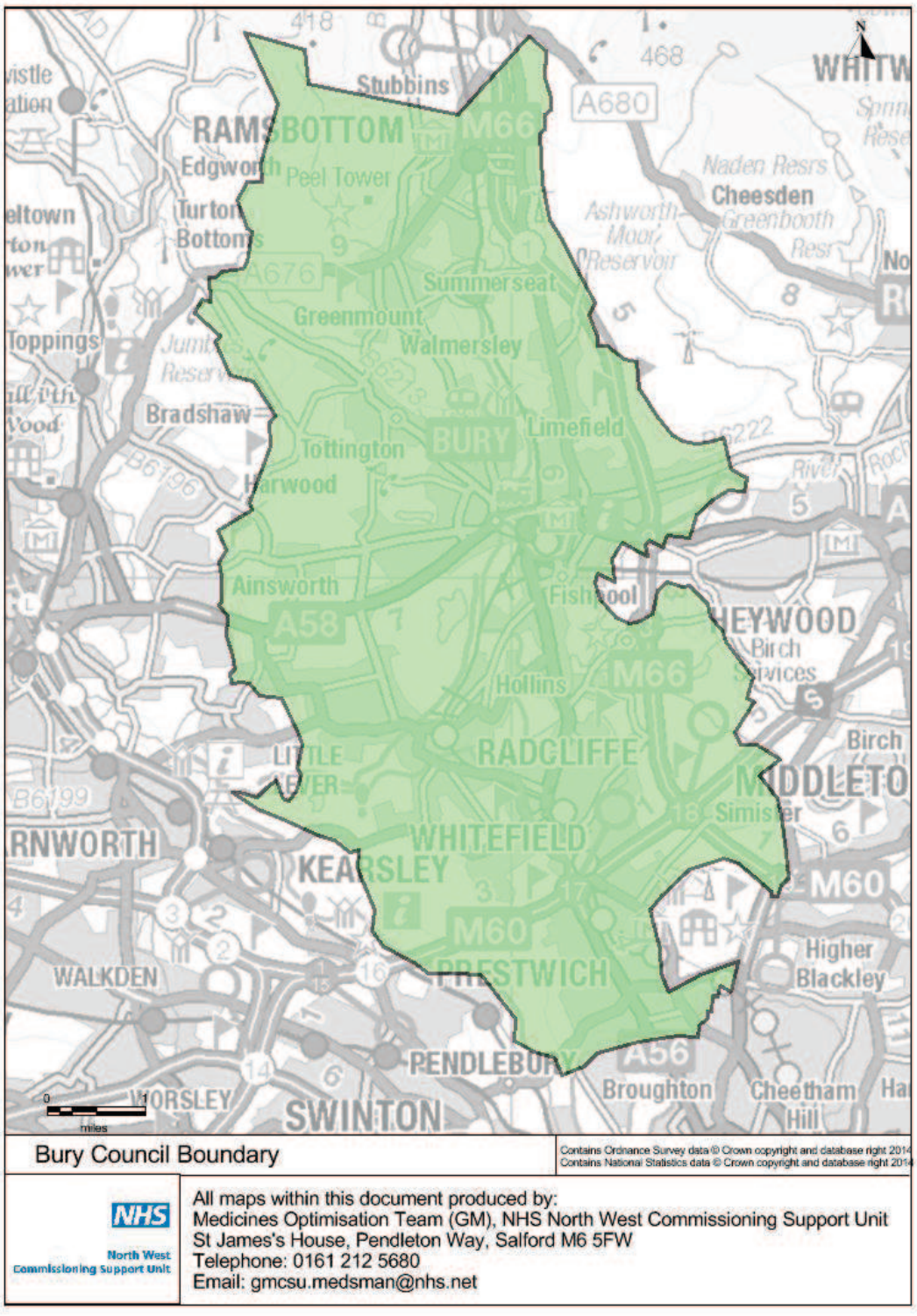
North West
Commissioning Support Unit

Bury Council

Pharmaceutical Needs Assessment

2015-2018
Post Consultation Draft v0.13

Post Consultation Draft



This Pharmaceutical Needs Assessment (PNA) has been produced for Bury Health and Wellbeing Board (HWB) by Bury Council in conjunction with North West Commissioning Support Unit (NWCSU), the NHS England Greater Manchester Area Team (GMAT), Bury Clinical Commissioning Group (CCG) and the Local Pharmaceutical Committee (LPC).

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1.0 Foreword and Executive Summary

This Pharmaceutical Needs Assessment (PNA) looks at the current provision of pharmaceutical services across Bury Health and Wellbeing Board (HWB) footprint and whether this meets the needs of the population and identifies any potential gaps to service delivery.

The PNA will be used by NHS England in its determination as to whether to approve applications to join the pharmaceutical list under The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended[1].

The PNA is required to be published by each HWB by virtue of section 128A of the 2006 Act updated in 2009[2].

The conclusion of this PNA is that all wards in Bury with the exception of Besses Ward are well provided for by pharmaceutical service providers and have not identified a current need for new NHS pharmaceutical service providers in the area. There are a number of reasons for this conclusion:

- There are 41 pharmacies across Bury, of which five have 100 hour contracts and three are distant selling pharmacies. This is an increase from 38 in the previous PNA in 2011.
- According to the Health and Social Care Information Centre (HSCIC) data 2012-13, Bury has 22 pharmaceutical service providers per 100,000 registered population, which is equal to the national average and considered sufficient to meet the dispensing demands of the area.
- Each month the Bury pharmacies dispense on average slightly more items than the monthly national and North West regional average items. However, overall, the majority of respondents (91%, n=70) were either satisfied or very satisfied with all aspects of service they receive from their pharmacy.
- Based on the responses from the public survey, 83% of respondents use a regular or preferred pharmacy and the most commonly selected reason for using one particular pharmacy was location and the proximity to the respondent's home or doctors.

In general, the review of the locations, population density, access for patients and prescription numbers suggest there is adequate access to NHS Pharmaceutical Services in most of Bury HWB footprint. The conclusion drawn in terms of the opening hours for pharmacies around the Bury area is that most wards have a satisfactory access to pharmacy services.

The evidence for such conclusion includes:

- Bury pharmacies have good coverage in terms of locations across all areas of high population density and within their one mile buffer zones. Areas that are not covered in the one mile buffer zone are considered rural and largely uninhabited.
- Pharmacies are easily accessible with the majority of respondents (85%) travelling less than two miles to the pharmacy on foot (43%) or by car, as a passenger or driver (54%).
- The level of car ownership throughout the Bury area (76% of households own at least one car) is greater than both the regional (72%) and national average (74%).
- It was noted that only around 1% of the survey respondent are unable to get to a pharmacy of their choice due to mobility issues. To support patient pharmacy accessibility, pharmacies also offer a home delivery service which can help to

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provide medications to those who have poor mobility, do not have access to a car or who are unable to use public transport. In Bury, there are three distance-selling pharmacies that can also provide home delivery. Other distance-selling pharmacies in the country can provide the same.

- Five pharmacies have 100-hour contracts in the Bury area. They are centrally located and accessible by public transport, walking or own transportation.
- It is considered maintaining the current availability and distribution of 100 hour/longer opening pharmacies is important to ensure high quality out-of-hour access for the population.
- Over two thirds of the pharmacy contractors in Bury are open on a Saturday and access can be found between the hours of 6am to midnight within Bury. This gives adequate cover for Bury (except in Besses Ward) on Saturdays both in terms of opening hours and number of locations.
- On Sunday only a quarter of pharmacy contractors in Bury are open. However, the public survey identified only 12% (n=10) of respondents were unsatisfied by the current pharmacy opening hours.
- Due to changes in shopping habits a number of pharmacies now open on many Bank Holidays although they are not contractually obliged to do so. GMAT works with community pharmacies to ensure an adequate rota service is available for Christmas Day, Boxing Day, New Year's Day and Easter Sunday as these are days where pharmacies are traditionally closed.
- Bury West Township is poorly served on Sundays. However, there are 12 pharmacies in the neighbouring Bury East Township. Of these, four have 100 hour contracts which are accessible to a large population (including the Bury West Township) via public transport, walking or their own transportation.
- Similar to Bury West; Ramsbottom, Tottington and North Manor Township have no pharmacies open on Sundays. However, such wards are considered predominately the least populated, least deprived within Bury and are likely to have access to transportation allowing patients to travel within the borough to another location quite readily.

In contrast, the Radcliffe North and Besses Wards did raise some concerns as there are no pharmacies and potentially could be identified as gaps in service provision. Although the public survey did not identify this finding and no negative comments were made about pharmacy access in those wards, representatives of the local community from Besses Ward have highlighted to the Bury HWB and the Clinical Commissioning Group (CCG) that there is a lack of easy access to pharmaceutical services.

After due consideration it has been concluded that there is a need for pharmaceutical service provision within the Besses Ward for the following reasons:

- Besses Ward has three Lower Layer Super Output Areas (LSOAs) which are ranked in the worst 10% for deprivation
- There are a large number of households with no access to a car or van
- Although there is reasonable access to public transport, the cost is a deterrent to its use
- Besses Ward has high levels of teenage conception, smoking prevalence and known drug-use (as stated in the Whitefield Health and Inequalities Area Action plan 2014)

Whereas for Radcliffe North Ward it has:

- A relatively low population
- A high number of households with cars and therefore less affected by accessibility to pharmacies in neighbouring wards
- Pharmacies accessible by walking, public transport or own transportation within neighbouring wards both inside and outside of Bury

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- There have been no complaints or public representation concerning access to pharmaceutical services

Based on these finding it is considered that the population of Radcliffe North Ward are adequately served by other pharmacies within a mile distance or by pharmacies offering a home delivery service. However, for Besses Ward, a need has been identified for pharmacy provision within the Hillock Estate area. Any new pharmacy contractor within this area should deliver all locally commissioned services that will support this population. Currently these locally commissioned services include smoking cessation support, chlamydia screening and treatment, treatment of minor ailments, provision of Emergency Hormonal Contraceptive (EHC), needle exchange and observed consumption to support recovery of drug misuse. Any pharmacy contractor would be expected to deliver pharmaceutical services including all essential and at least two of the advanced services, medicines use review (MUR) and new medicines service (NMS) (subject to continuation of commissioning).

In addition to the above recommendation, a need has been identified for the following hours of pharmaceutical service availability.

- Monday to Friday - a minimum of 40 hours between 08:30 and 18:00 hours daily;
- And Saturday - a minimum of 5 hours between 10:00 and 18:00 hours;
- And Sunday - a minimum of 2 hours between 11:00 and 15:00 hours.

Over the coming years the population in Bury is expected to both age and grow substantially in numbers. Housing and commercial developments are in progress and it will be a collective number of factors that may influence the potential need for any additional pharmaceutical service providers. To facilitate commissioning of pharmaceutical service providers responsive to the potential population changes the Health and Wellbeing Board and partners will monitor those changes and development, and carry out a complete review of the PNA if deemed necessary, in accordance with regulations.

The current pharmacy services commissioned from Bury pharmacies, in addition to their NHS contract, supports Bury's HWB in achieving the required health priorities and outcomes outlined in their strategy. Overall 91% of the respondents in the public survey were either satisfied or very satisfied with the service they received from their pharmacy. However, there is also a need for ensuring that those additional services commissioned by Bury Council and CCG from Bury pharmacies are promoted to the local population so as to improve their uptake. The patient survey indicated that on average 77% of respondents have not used services already on offer. There may be a number of reasons for this including, lack of awareness and/or the service in community pharmacy does not meet their needs.

It is important that commissioners continue to review the currently commissioned pharmaceutical services and assess service delivery and health outcomes achieved. Review should include whether all pharmacy contractors should be engaged in commissioned additional services or whether targeted delivery by a small number of contractors would be preferential. It is important that any review includes possible or actual service delivery by other providers where they also meet specific pharmaceutical needs.

At the time of writing the PNA (June 2014), some commissioning arrangements are awaiting clarification. However, following the current assessment of Bury pharmacies locally commissioned services, the following recommendations were noted:

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1. Smoking cessation activities in community pharmacies in Bury have increased, but there are still many community pharmacies that do not provide a smoking cessation service. Bury Council has commissioned smoking cessation services in just over half of the pharmacies (24 of the 41 contractors) and although existing contracted pharmacies are covering areas of high prevalence there are still other areas that maybe beneficial for further development. For example, although lower prevalence the Northern area of Bury e.g. Ramsbottom have no commissioned smoking cessation service. This can additionally complement other medical services provisions and educate patients in self-care, thereby reducing the impact on GP consultations.

2. Only two pharmacies in Bury have signed up to the Chlamydia Screening and Treatment programme so there is opportunity to expand this across Bury. Areas with high population of 15- 24 year olds such as Radcliffe West, Redvales, Ramsbottom and Besses should be considered. In addition, chlamydia screening could be offered when EHC is provided, since those requiring such contraception may also be at risk of infection. The extent to which local services signpost to services or carry out testing when EHC is provided could be examined in an audit, to stimulate best practice in this area.

3. Needle exchange service is commissioned from seven pharmacies in Bury and there are 15 pharmacies providing supervised consumption of methadone/ buprenorphine. There is limited access to both services during extended hours on weekdays, Saturdays and on Sundays. The key priorities are to ensure adequate access and monitor the quality, service outcomes and patient experience; and to work with existing pharmacy contractors to address any issues identified.

4. Opportunistic alcohol screening and provision of brief advice is another area where pharmacies could potentially contribute to improving the health of the local population. One of the public health campaign themes for 2014/15 planned for Bury pharmacies by NHS England includes alcohol awareness and this could, for example, potentially be integrated into agreements around medication checks.

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2.0 Introduction and process for developing the Pharmaceutical Needs Assessment (PNA)

2.1 Background

The Health Act 2009 128A made amendments to the National Health Service Act 2006 stating that:

(1)Each Primary Care Trust must in accordance with regulations -

(a) Assess needs for pharmaceutical services in its area, and,

(b) Publish a statement of its first assessment and of any revised assessment.

The regulations stated that a PNA must be published by each Primary Care Trust (PCT) by the 1st February 2011. There was a duty to rewrite the PNA within three years or earlier if there were any significant changes which would affect the current or future pharmaceutical needs within the PCT's locality. This meant that subsequently revised PNAs were due to be produced by February 2014.

However the Health and Social Care Act 2012 brought about the most wide-ranging reforms to the NHS since its inception in 1948. These reforms included abolition of PCTs and the introduction of CCGs who now commission the majority of NHS services. Public Health functions were not transferred to CCGs and are now part of the remit of Local Authorities.

In order to ensure integrated working and plan how best to meet the needs of any local population and tackle local inequalities in health the 2012 legislation calls for Health and Wellbeing Boards (HWB) to be established and hosted by Local Authorities. These boards should bring together the NHS, public health, adult social care and children's services, including elected representatives and Local Healthwatch.

The Health and Social Care Act 2012 transferred responsibility for the development and updating of PNAs to HWBs. It also made provision for a temporary extension of PCT's PNAs and access by NHS England and HWBs to them.

In order that these newly established HWB had enough time to gather the information and publish a new PNA the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended now gives a requirement that each HWB must publish its first pharmaceutical needs assessment by 1st April 2015, unless a need for an earlier update identified. The Department of Health (DH) recently published an Information Pack to help HWB undertake PNA[3].

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3.0 Context of the PNA

3.1 Purpose of a PNA

Despite the recent NHS reforms, along with an unprecedented era of economic, demographic and technological changes, it is clear there will be challenges and opportunities for the pharmacy profession. In March 2013 the RPS identified and established the Commission on future models of care delivered through pharmacy. The 'Now or Never: Shaping pharmacy for the future' report highlights the vision for pharmacists, together with the pharmacy team, of providing innovative and effective access to medicines information and advice for all patients in all pharmacy settings[4]. With the predicted increase in patients with long term conditions, people taking multiple medicines and an emphasis of self-management, there is greater focus on the provision of effective patient centred pharmacy services.

The PNA will use the Joint Strategic Needs Assessment (JSNA), the Joint Health and Wellbeing Strategy (JHWS) and other Board approved documents to identify the local health priorities. From this it should look at current demographics and future trends and developments which may impact on the health of the local population. The PNA will look at issues that may affect it across the three years it could be valid for.

The PNA will also identify where pharmaceutical services are currently used to address these priorities and where changes may be required to fill any current identified gaps or to address possible future health issues.

The PNA should be a tool which is used to inform commissioners of the current provision of pharmaceutical services and where there are any gaps, in relation to the local health priorities, which could be addressed by improving services or access to services in that area[5]. The commissioners who would find it most useful are CCGs, Local Authorities Public Health and NHS England.

The PNA is of particular importance to NHS England who since 1st April 2013, has been identified in the Health and Social Care Act 2012, as responsible for maintaining pharmaceutical lists. The PNA is a key document in making decisions with regard to applications made under the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended.

The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013: No. 349 Part 3 Regulation 13 states that:

Current needs: additional matters to which the NHS Commissioning Board (NHSCB) must have regard*

13 (1) If the NHSCB receives a routine application and is required to determine whether granting it, or granting it in respect of some only of the services specified in it, would meet a current need -*

(a) for pharmaceutical services, or pharmaceutical services of a specified type, in the area of the relevant HWB; and.

(b) that has been included in the relevant pharmaceutical needs assessment in accordance with paragraph 2(a) of Schedule 1. Under these revised market entry arrangements, routine applications are assessed against Pharmaceutical Needs Assessments.

**NHSCB (NHS Commissioning Board) is now known as NHS England*

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3.2 Scope of Assessment

A pharmaceutical needs assessment is defined in the regulations as:

"The statement of the needs for pharmaceutical services which each HWB is required to publish by virtue of section 128A of the 2006 Act(1) (pharmaceutical needs assessments), whether it is the statement of its first assessment or of any revised assessment, is referred to in these Regulations as a "pharmaceutical needs assessment".

The pharmaceutical services to which each pharmaceutical needs assessment must relate are all the pharmaceutical services that may be provided under arrangements made by the NHSCB for -*

a) the provision of pharmaceutical services (including directed services) by a person on a pharmaceutical list;
b) the provision of local pharmaceutical services under an LPS scheme (but not LP services which are not local pharmaceutical services); or
c) the dispensing of drugs and appliances by a person on a dispensing doctors list (but not other NHS services that may be provided under arrangements made by the NHSCB with a dispensing doctor)."*

It follows, therefore, that we must understand what is meant by the term "pharmaceutical services" in order to assess the need for such services in the local authority's area.

3.2.1 Definition of Pharmaceutical Services

Pharmaceutical services are defined by reference to the regulations and directions governing pharmaceutical services provided by community pharmacies (which may be LPS providers), dispensing doctors and appliance contractors.

Whether a service falls within the scope of pharmaceutical services for the purposes of PNA depends on who the provider is and what is provided. For the purposes of this PNA we have adopted the following scope:

Pharmacy Contractors

For pharmacy contractors the scope of the services that need to be assessed is broad and comprehensive. It includes the essential, advanced and enhanced service elements of the pharmacy contract (full details are given at 3.2.2) whether provided under the terms of services for pharmaceutical contractors or under Local Pharmaceutical Services (LPS) contracts.

There are 41 pharmacy contractors in the Bury HWB area. Of these, five have 100 hour contracts and three are distance-selling (internet) pharmacies.

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**NHSCB (NHS Commissioning Board) is now known as NHS England*

Figure 1: Location of Community Pharmacies in Bury and Ward Boundaries



Local Pharmaceutical Service (LPS) Contractors
LPS contracts are locally commissioned pharmacy contracts to deliver specific services, over and above the essential and advanced services, to their local population or service users. LPS complements the national contractual framework for community pharmacy but is an important local commissioning tool in its own right.

LPS provides flexibility to include within a single local contract, a broader or narrower range of services (including services not traditionally associated with pharmacy) than is possible under national pharmacy arrangements. In Bury, there are no LPS contractors (30th June 2014). LPS contracts are now commissioned by NHS England Area Team and for the Bury HWB footprint; such contracts will fall under the remit of the GMAT.

Dispensing doctors
Dispensing doctors are GPs who are allowed to both prescribe and dispense prescription-only medicines to patients registered with their surgery. Doctors are only allowed to become dispensing practices in very specific circumstances. The control of entry system, which is already tightly regulated, requires the GP practice to be located in a designated rural area, and with a specified minimum distance (currently 1.6km) between a patient's home and the nearest community pharmacy.

The PNA would need to take these into account but would not be concerned with assessing the need for other services dispensing doctors may provide as part of their national or local contract arrangements. The Bury area has no dispensing doctors.

Dispensing Appliance Contractors (DACs)
For appliance contractors the scope of the service to be assessed in the PNA is the dispensing of appliances and the provision of the recently introduced Appliance Use Review (AUR) service and Stoma Appliance Customisation Service (SAC). This means that, for the purposes of the PNA, we are concerned with whether patients have adequate access to dispensing of appliances, AURs and SACs where these may be undertaken by an appliance contractor but not concerned with other services appliance contractors may provide.

There are no DACs in the Bury area although patients can use DACs outside the Bury and Greater Manchester area. This will need to be taken into account when assessing the needs of the population.

It should be noted that pharmacy contractors can also dispense appliances and provide AURs and SAC services as part of their Essential and Advanced services.

Other independent contractors
Other providers may deliver services that meet a particular pharmaceutical service need, although they are not considered pharmaceutical services under the relevant regulations. It is therefore important that these are considered as part of the assessment e.g. the local domiciliary oxygen service.

3.2.2 Pharmaceutical Services Contractual arrangements [5, 6]

The Community Pharmacy Contractual Framework (CPCF) is made up of three different service types. These are defined below, for a complete description please see Appendix 1.

Essential Services – which are set out in schedule 4 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended. All pharmacy contractors must provide the full range of Essential Services, these include:

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- Dispensing medicines and actions associated with dispensing (e.g. keeping records)
- Dispensing appliances
- Repeat dispensing
- Disposal of unwanted medicines
- Public health (Promotion of healthy lifestyles)
- Signposting
- Support for self-care

Advanced Services – Any contractor may choose to provide Advanced Services. There are requirements which each Advanced Service needs to meet in relation to premises, training or notification to the NHS England Area team. Each of the service is intended to support and empower patients to optimise their safe and effective use of medicines or appliances and to reduce waste. The current Advance Services include:

- Medicines Use Review (MURs)
- New Medicines Service (NMS)
- Appliance Use Reviews (AUR)
- Stoma Appliance Customisation Service (SAC)

At the time of writing this PNA (June 2014) each pharmacy may undertake up to 400 MURs per annum if they have informed the NHS England Area Team of their intention to provide the service. If a pharmacy informs the Area Team after 1st April but before the 1st October they may will be paid for up to a maximum of 200 MURs.

Pharmacy staff may also undertake a limited number of AURs linked to the dispensing of appliances and as many SACs as required.

Enhanced Services - Only those contractors directly commissioned by NHS England Area Team can provide these services. The National Health Service Act 2006, The Pharmaceutical Services (Advanced & Enhanced Services) (England) Directions 2013, Part 4 14.-(1) list the Enhanced Services as:

- Anticoagulant Monitoring Service
- Care Home Service
- Disease Specific Medicines Management Service
- Gluten Free Food Supply Service
- Independent Prescribing Service
- Home Delivery Service
- Language Access Service
- Medication Review Service
- Medicines Assessment and Compliance Support Service (This is more clinical than MURs)
- Minor Ailments Service
- Needle and Syringe Exchange Service
- On Demand Availability of Specialist Drugs Service
- Out of Hours Service
- Patient Group Direction (PGD) Service (This would include supply of any Prescription Only Medicine via PGD)
- Prescriber Support Service
- Schools Service
- Screening Service
- Seasonal Flu vaccination Service

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- Stop Smoking Service
- Supervised Administration Service
- Supplementary Prescribing Service

The regulations are intended to be permissive and allow NHS England to interpret how any of the above Enhanced Services could be commissioned, its scope and method of delivery. NHS England Area Team may make arrangements for the provision of these services in its area. In Greater Manchester the GMAT has responsibility for managing Enhanced Services.

3.2.3 Locally Commissioned Services

Community pharmacy contractors can also provide services commissioned locally that fall outside of the NHS (Pharmaceutical Services and Local Pharmaceutical Service) Regulations 2013, as amended. Locally commissioned services do not impact on the commissioning of new pharmacy contracts.

The 2013 regulations set out the Enhanced Services which may be commissioned from pharmacy contractors. It is important to note that the definition of 'Enhanced Services' have changed, and the current commissioning arrangements can now be seen as more complex since pharmacy services previously commissioned by one organisation (PCTs) can now be commissioned by at least three different organisations (CCGs, Local Authorities and NHS England) and the responsibility for commissioning some services is yet to be resolved and clarified. For example, the CCG or Local Authority may request NHS England to commission a service listed in the NHS Pharmaceutical Services Directions 2013 on their behalf, e.g. a CCG requests that a minor ailments service is commissioned as an Enhanced Service.

In such scenario it should be borne in mind that the cost of these services will be invoiced back to the CCG or Local Authority. Services commissioned in this way would be commissioned under pharmaceutical services and consequently the public health, NHS standard or local contracts would not be used.

Locally commissioned services within the Bury HWB footprint may be reviewed within the planned lifespan of this document but must be considered alongside other pharmaceutical service provision in order that a full picture of current provision is identified across the HWB footprint.

Public health services[7]

Particular mention should be given to the locally commissioned services which have been designated as public health services such as population screening or prevention of disease states. The commissioning of these Enhanced Services which were listed in the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2012 transferred from PCTs to Local Authorities with effect from 1st April 2013:

- Needle and syringe exchange
- Screening services such as chlamydia screening
- Stop smoking
- Supervised administration of medicines service
- Emergency hormonal contraception (EHC) services through patient group directions.

Where such services are commissioned by Local Authorities they no longer fall within the definition of Enhanced Services or pharmaceutical services as set out in legislation and therefore cannot be referred to as Enhanced Services.

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However, the 2013 directions do make provision for NHS England to commission the above services from pharmacy contractors when asked to do so by a Local Authority. Where this is the case they are treated as Enhanced Services and fall within the definition of pharmaceutical services.

CCG services[8]
CCGs now have a role to commission most NHS services locally, aside from those commissioned by NHS England such as GP core contracts and specialised commissioned services. CCGs engage with clinicians in their area to ensure commissioned services are responsive to local needs. CCGs will be able to commission services from pharmacies but similar to public health classification these will be known as locally commissioned services and fall outside the definition of Enhanced Services, and so have no impact on pharmacy applications.

For a brief summary on who can commission which services please refer to the Pharmaceutical Services Negotiating Committee's "Community Pharmacy Local Service Commissioning Routes; July 2013"

3.3 Non-Commissioned Added Value Community Pharmacy Services

Community pharmacy contractors can provide services directly to patients that are not commissioned by NHS England, Local Authorities or CCGs but are considered to provide added value to the patients.

Examples include pharmacies providing blood pressure checks and/or providing compliance support for those patients that do not fall under the Disability Discrimination Act (DDA). Community Pharmacists are free to choose whether or not to charge for these services as part of their business model.

These non-NHS services will not be included as part of the PNA.

3.4 What is Excluded from Scope of the PNA?

The PNA has a regulatory purpose which sets the scope of the assessment. However pharmaceutical services and pharmacists are evident in other areas of work in which the local health partners have an interest but are excluded from this assessment. For example in prisons, those patients may be obtaining a type of pharmaceutical service which is not covered by this assessment.

3.4.1 Prison Pharmacy

Pharmaceutical services are provided in prisons by providers contracting directly with the prison authorities. There are no HM Prisons within the Bury Council area.

3.4.2 Hospital Pharmacy

Patients in the Bury Council area have a choice of provider for their elective hospital services. Information about the choice of hospital used by the Bury residents is shown in Figure 2**.** Most (64%) of our residents choose to be treated at Pennine Acute Foundation NHS Trust.

The PNA makes no assessment of the need for pharmaceutical services in hospital settings; however the HWB is concerned to ensure that patients moving in and out of hospital have an integrated pharmaceutical service which ensures the continuity of support

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around medicines. Each of the hospital trust will also have their own hospital pharmacies providing services to the Bury population visiting.

Figure 2: Hospital choice for the Bury residents 2012-14

Source: Secondary Uses Service (SUS)

Hospital Trust	Patient numbers		Percentage share	
	2012-13	2013-14	2012-13	2013-14
Pennine Acute	39,942	34,871	63.9%	63.6%
Salford Royal	8,647	8,085	13.8%	14.7%
Central Manchester	4,962	4,519	7.9%	8.2%
Other	8,909	7,392	14.3%	13.5%
Total	62,460	54,867		

3.5 Process followed for Developing the PNA

The PNA followed guidance set out by:

- National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) (Amendment) Regulations 2013, as amended[1]
- Pharmaceutical Needs Assessment, Information Pack for Local Authority Health and Wellbeing Boards (May 2013, DoH) [3]

Stage 1:
The PNA was developed using a project management approach and a steering group was established in February 2014 consisting of Local Authority representatives, NWCSU Medicines Optimisation Team, GMAT representatives, Local Pharmaceutical Committee and a Project Manager. This steering group has been responsible for the completion of the PNA and to ensure that the PNA meets at least the minimum requirements. This steering group approved the template for the PNA, along with all public facing documentation.

Stage 2:
The Steering group approved the pre-consultation pharmacy survey that was then issued to all pharmacies to complete. Also during this stage a public survey was approved and distributed including advertisement on the Local Authority website and on posters in pharmacies. The survey results were then analysed.

Stage 3:
NWCSU developed the content of the PNA. This included demographics, mapping, analytics and background information. This draft PNA was then approved by the HWB to go to consultation.

When preparing the PNA for consultation, the PNA did take into account the JSNA and other relevant strategies, in order to ensure the priorities were identified correctly. The PNA will inform commissioning decisions by the Local Authority (Public Health services from pharmacy contractors), by NHS England and CCGs. For this reason the PNA is a separate statutory requirement.

Stage 4:
The formal consultation took place from 1st September 2014 to 24th November 2014 for a minimum period of 60 days, in line with NHS (Pharmaceutical and Local Pharmaceutical

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Services) Regulations 2013, as amended, on the development of the PNA. This is based on the Health and Social Care Act 2012 amendment which requires HWB to involve users of services in:

- The planning and provision of services;
- The development and consideration of proposals for changes in the way services are provided
- Decisions affecting the operation of services.

The draft PNA and consultation response form were issued to all of the stakeholders listed in Appendix 2. The documents were posted on the intranet and publicised. The consultation responses were collated and analysed and the full consultation report can be found in Appendix 3.

Stage 5:
The consultation responses have been analysed and used to pull together the final PNA document which was approved by the HWB on DD MM 2015. The PNA was then published on the website on the 1st April 2015.

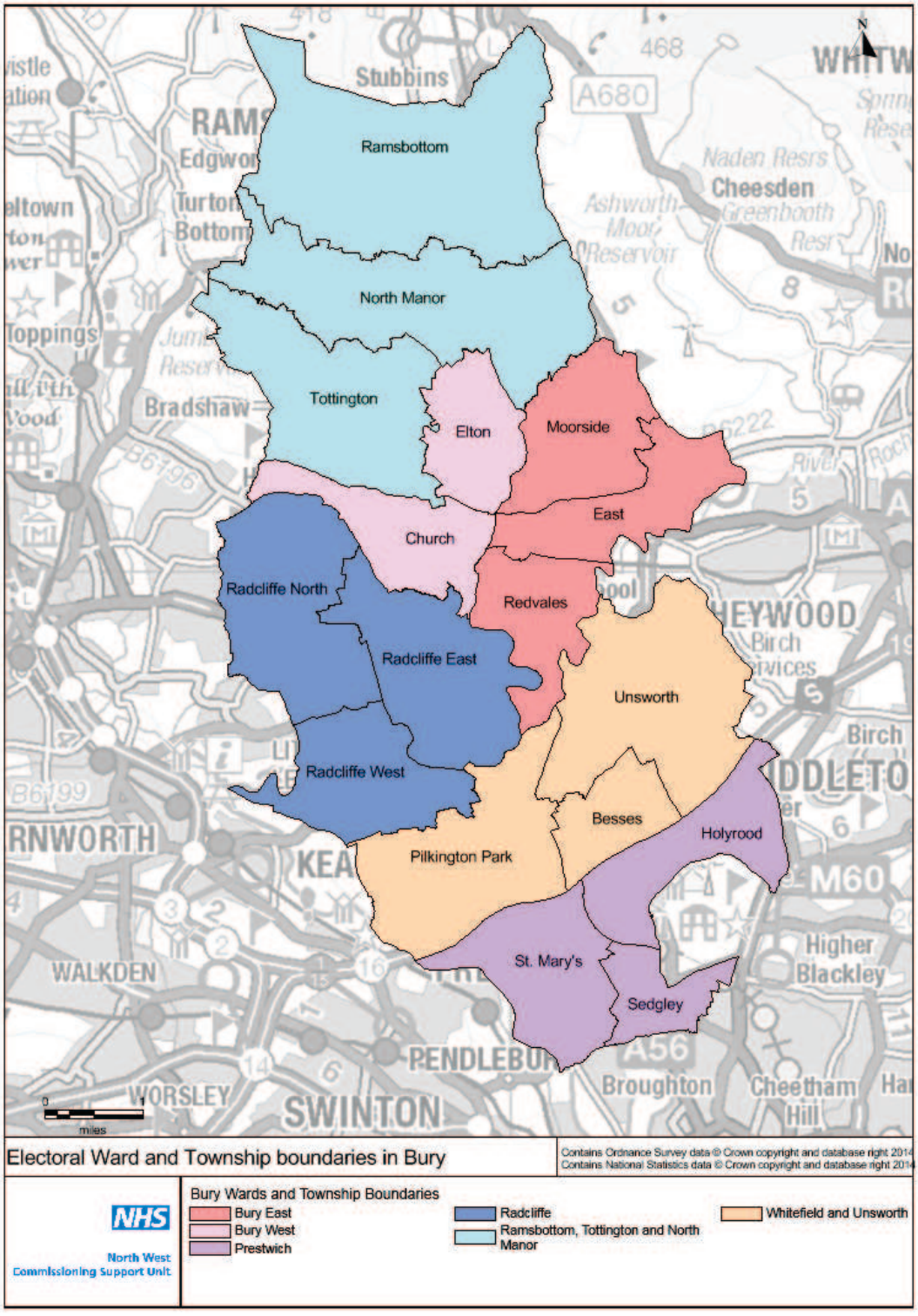
3.6 Localities for the purpose of the PNA

The PNA steering group decided on how the areas around the borough would be defined. It was agreed that we would use the current system of Bury Ward boundaries and their collective Township areas. This was because the majority of available healthcare data is collected at ward level. Also wards are a well understood definition within the general population as they are used during local parliamentary elections.

Where ward level data is not available, we have used smaller geographical areas known as Super Output Areas (SOA). SOAs are a smaller population unit than wards and designed for the collection and publication of small area statistics. They are established by the Office of National Statistics (ONS) and currently there are two layers of SOA, Lower Layer SOA (LSOA) and Middle Layer SOA (MSOA).

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Figure 3: Electoral Ward and Township boundaries in Bury



3.7 PNA consultation

Prior to the commencement of the draft PNA, a seven week public survey was carried out to identify how the public currently use their pharmacy and whether they had any problems with areas such as access to services. We also asked them what future services they would be interested in using. A summary for the public survey can be found in Section 5.5 and the full results in Appendix 7.

A Pharmacy survey was also undertaken over approximately seven weeks. This asked the pharmacy staff to identify their hours of opening, provision of current services and ease of access to services e.g. if the pharmacy had any facilities for disabled patrons or whether the staff could speak any languages other than English. We also asked them which, if any, services they would like to deliver in the future. The results of the pharmacy survey can be found in Appendix 5.

Following completion of a draft PNA, a formal 60 day consultation process was carried out amongst the local Health Partners and other stakeholders to enable feedback from them before the PNA was published.

To facilitate this process a comprehensive communication plan was devised identifying all the local partners who had a stake in pharmaceutical service provision around the borough. This can be found in Appendix 2.

Feedback was gathered from the consultation and the results were analysed. From this analysis the PNA steering group determined whether any amendments were required and updated the PNA accordingly.

3.8 PNA review process

Bury HWB will be required to publish a revised assessment as soon as is reasonably practical after identifying significant changes to the availability of pharmaceutical services since the publication of its PNA unless it is satisfied that making a revised assessment would be a disproportionate response to those changes.

Where changes to the availability of pharmaceutical services do not require a revision of the PNA and involve a change in pharmaceutical service provision by pharmacy contractors e.g. the opening of a distance selling pharmacy; they will be required to issue a supplementary statement as soon as practicable.

The HWB will ensure there are systems in place to monitor potential changes that will affect the delivery of pharmaceutical services and have a process in place to decide what action it needs to take.

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4.0 Population Demography[10]

4.1 Overview

The ONS published the first results of the 2011 Census on the 16th July 2012 revealing a population increase in the Bury area. The population has risen 2.4 per cent since the last census in 2001; up from 180,700 to 185,100. This is expected to follow current trends and rise to 191,000 by 2017.

It is also worth noting for health purposes that according to the NHS Prescription Service data 2012, Bury CCG has a registered population of 196,280. This means that Bury CCG is responsible for over 11,000 patients who do not live in Bury but have a GP in Bury. This has implications for joint working between agencies in Bury as well as cross boundary working.

Whilst overall population trends are useful in predicting future population volume, often it is population characteristics which are most important when developing a PNA. A comprehensive overview shall predict the structure and characteristics of Bury's population and determine how changes are likely to impact upon specific population groups. Some of the key headlines for Bury's population demographics include:

- Bury's population is increasing and this trend is set to continue.
- Bury's population is ageing. With people also living longer, it is estimated that 4,500 more people will be in the 65 and over age range by 2017 (a 30% increase on 2011 levels).
- Life expectancy for males in Bury is 78 years compared with 79.2 years for England
- Life expectancy for females in Bury is 81 years compared to 83 for England
- Across the Bury area there is big difference 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 area.
- Bury has a growing ethnic minority profile.
- Approximately two thirds of Bury Wards All Age All-Cause Mortality rates are worse than national mortality rate.
- In Bury there is a consistent picture of increased All Age All-Cause Mortality rates in areas of higher deprivation like Radcliffe West, Bury East and Moorside Ward

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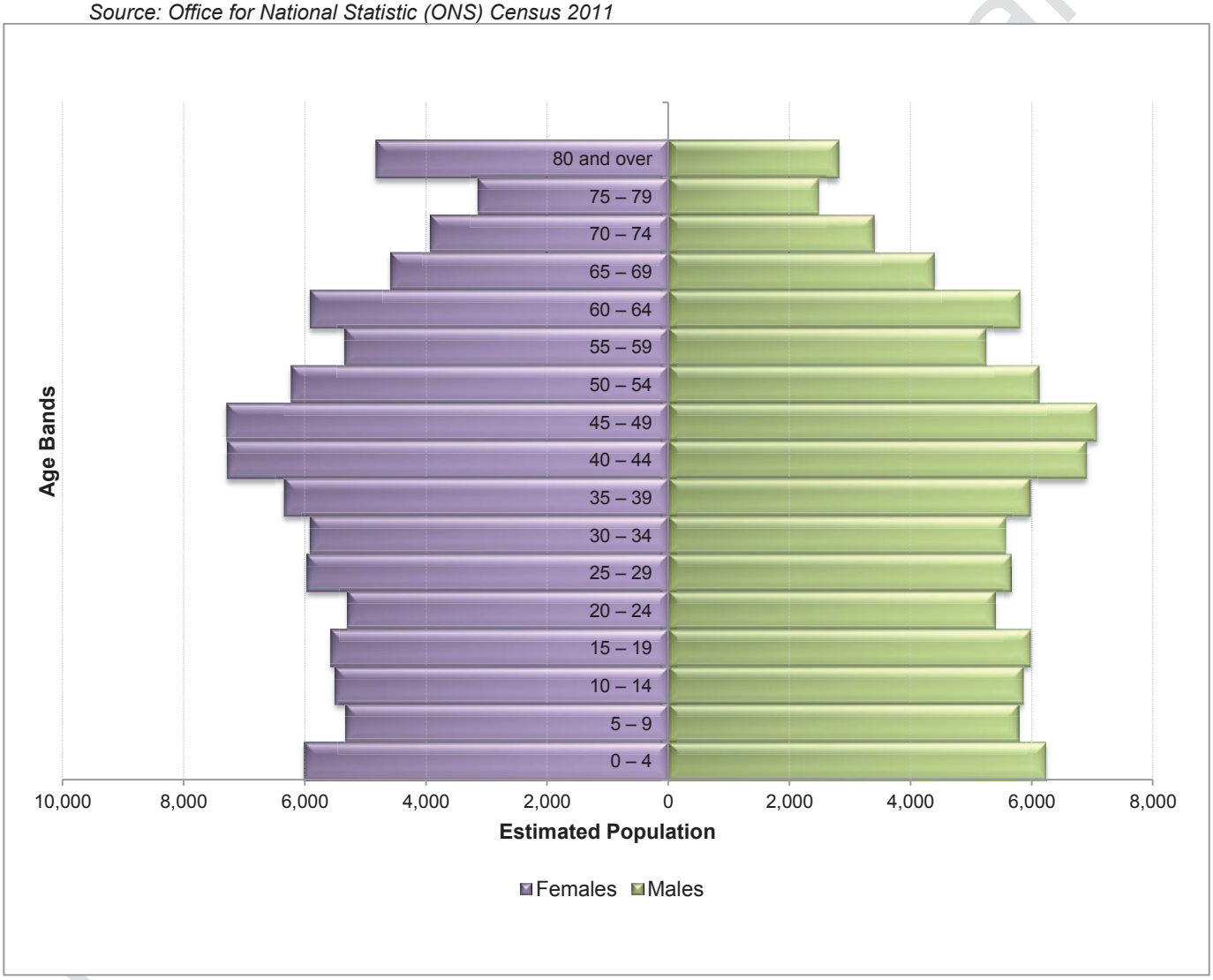
4.2 Age of Population

Figure 4 shows the spread of age ranges across Bury in five year stages for males and females from the year 2011. The largest group of the Bury population (14.6%) is made up of residents aged 40-49 this is slightly lower than the England population (15.5%).

Currently 51% of the population in Bury are female and this is comparable to Greater Manchester, North West and national figures and is not expected to change significantly in the years to come. The gender split will however vary in terms of the proportion of each sex within age bands as shown in Figure 4.

Figure 4: Mid-Year 2011 Population Estimates

Source: Office for National Statistic (ONS) Census 2011



4.3 Future Age Trends

The health and social care needs of an individual in Bury will change substantially during their lifetime and consequently one of the key characteristic of a population overview is the age profile.

Figure 5 provides a comparison of the current (2011) age profile compared to the 2017 predicted population and this reveals some significant changes in the spread of the population between age bands.

By 2017:

- The population of 0-44 year olds is predicted to increase by just 8.5% (just over 2,600 more).
- The proportion of people 45-64 years old is expected to reduce by half a percentage point (increase by 1,100).
- The 65-74 years old population is expected to increase by 17% (over 2,700 more).
- The over 75 year olds population is expected to increase by 13%. (over 1,700 more).

In broad terms, the proportion of younger people is expected to reduce, whilst there will be a large growth in older age groups and fewer people of working age. This will lead to significant increases in long-term limiting conditions like coronary heart disease, diabetes, respiratory disorders, obesity, dementia, sensory impairment, and incontinence. These problems will be further exacerbated as the ONS anticipates, between 2010 and 2025 that 15,000 more people over the age of 65 will be living alone.

Figure 5: Bury Population projection to year 2017

Source: ONS Census 2011



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The population overview and forecast will undoubtedly put further strain on the health and social services of Bury HWB. As discussed in the Prescriptions Dispensed in the Community Statistics for 2002 – 2012[10, 11] such age ranges (especially over 65 year olds) are the most frequent users of pharmacy services and health services in general

"A new collection of data on prescriptions dispensed free of charge shows that over 90.6 per cent of all prescriptions were dispensed free of charge. Sixty per cent of items were dispensed free to patients exempt from the prescription charge because of old age (aged 60 and over) and five per cent went to the young (aged under 16 or 16-18 and in full-time education) who are also exempt from the charge."

Commissioners should ensure when looking to commission future services that sufficient resources are in place to manage this expected increase in elderly population.

4.4 Ethnicity

According to the 2011 Census, approximately 89% of Bury's population is of white ethnicity compared with both England and Greater Manchester which is 85.4% and 83.8% respectively. Around 11% of Bury's population are from Black and Minority Ethnic (BME) communities, of that, Pakistani ethnicity accounts for the second largest group in Bury at 4.9% (see Figure 6).

Figure 6: Ethnic Profile of Bury's population based on 2011 Census

Source: ONS Census 2011

Ethnicity	Bury	Greater Manchester	England
White British	86.6%	81.1%	80.7%
Other White	2.6%	2.7%	4.7%
Mixed	1.8%	2.3%	2.3%
Indian	0.7%	2%	2.6%
Pakistani	4.9%	4.8%	2.1%
Bangladeshi	0.2%	1.3%	0.8%
Chinese	0.6%	1%	0.7%
Other Asian	0.9%	1.1%	1.5%
Black	1.0%	2.8%	3.5%
Other	0.7%	1%	1%

Some ethnic populations have increased health problems in certain disease areas[10], e.g. Black African and Black Caribbean populations have a higher stroke incidence rate than in the White ethnic population. South East Asians, which includes those from Pakistan and India, have an increased risk of diabetes and myocardial infarction; whereas ethnic populations with fairer skin are more likely to suffer from skin cancer. Smoking prevalence also varies between the ethnic groups. The prevalence of smoking in England is approximately 25%, but for Indian men this drops to 20%. Yet this increases to 40% in Bangladeshi males, although only 2% in Bangladeshi females.

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Figure 7: Ethnic Minority Group variation by Ward in Bury

Source: ONS Census 2011

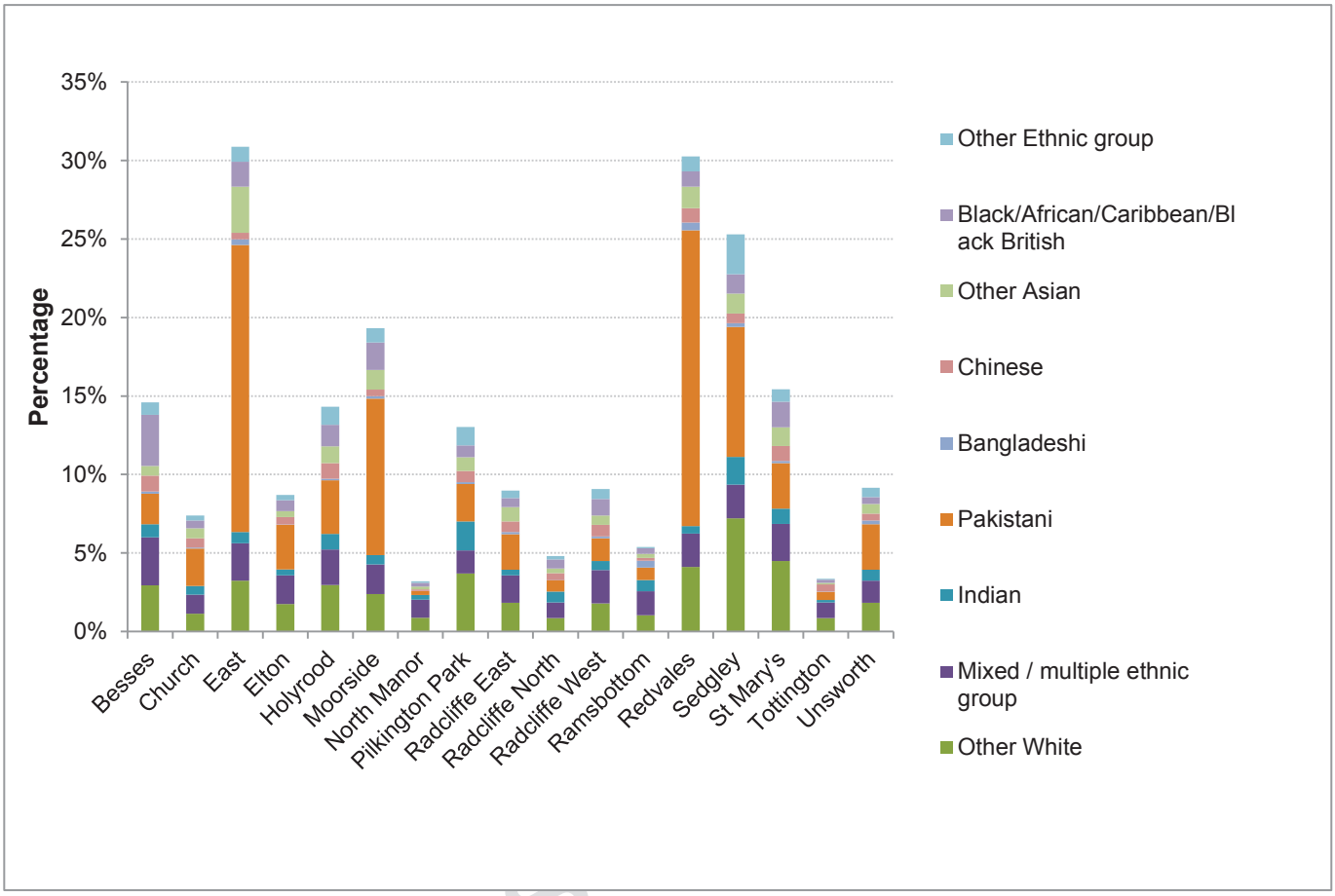


Figure 7 above presents a stacked bar chart of the BME communities in each Bury ward which demonstrates considerable variation.

Pharmacy contractors located within areas where there is a high population and variation of a certain ethnic groups should provide services that are targeted to achieve improved health outcomes in those populations. They should also look at how best to communicate with their patients. Cultural differences account for a wide variation in patients' view of medications and the healthcare system. Pharmacy contractors should ensure that they are able to deliver the Essential and Advanced Services to different ethnic groups in a way that meets their needs.

As described in the Bury pharmacy contractor survey (Appendix 5), which all pharmacy contractors were sent, 50% (of the six Bury pharmacy respondents) already have staff who can communicate in languages, other than English, which are spoken within their community. However, it is worth noting that this statistic was taken from a very poor survey response rate and is not an accurate reflection of the pharmacy workforce ability to communicate in other foreign languages. Pharmacy contractors recruit staff from their local community, which helps them to ensure that local cultural and language diversity is respected.

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4.5 Life Expectancy

In 2012 the average life expectancy for males in Bury was 78 years compared with 79.2 years for England, and for females in Bury, life expectancy was 81 years compared to 83 for England (see Figure 8). Although both are below the national averages we have seen steady and lasting improvements in how long people live, partly due to the significant on-going support in those disease areas which have the greatest impact on life expectancy.

Unsurprisingly there will be more and more people living to what we currently consider to be extreme old age (90+) and again this steady increase in life expectancy will lead to an increase in people using local health and social care services.

Figure 8: Life Expectancy Gap at Birth in Bury 2010-12

Source: ONS 2010-2012

Gender	Life expectancy (years)			Gap between Bury and England
	Bury	Greater Manchester	England	
Male	78.0	77.3	79.2	-1.2
Male gain from 2010-12	-	+0.5	+0.3	-0.3
Female	81.0	81.2	83.0	-2.0
Female gain from 2010-12	-0.1	+0.1	+0.1	-0.2

Across the Bury area there is big difference 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 (see Figure 9 and 10). There is still room for improvement and commissioners should focus on the areas within the Bury HWB footprint where the needs and gaps are the greatest.

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Figure 9: Bury Life Expectancy at Birth by Electoral Ward (Male)

Source: Public Health England - Local Health - 2011

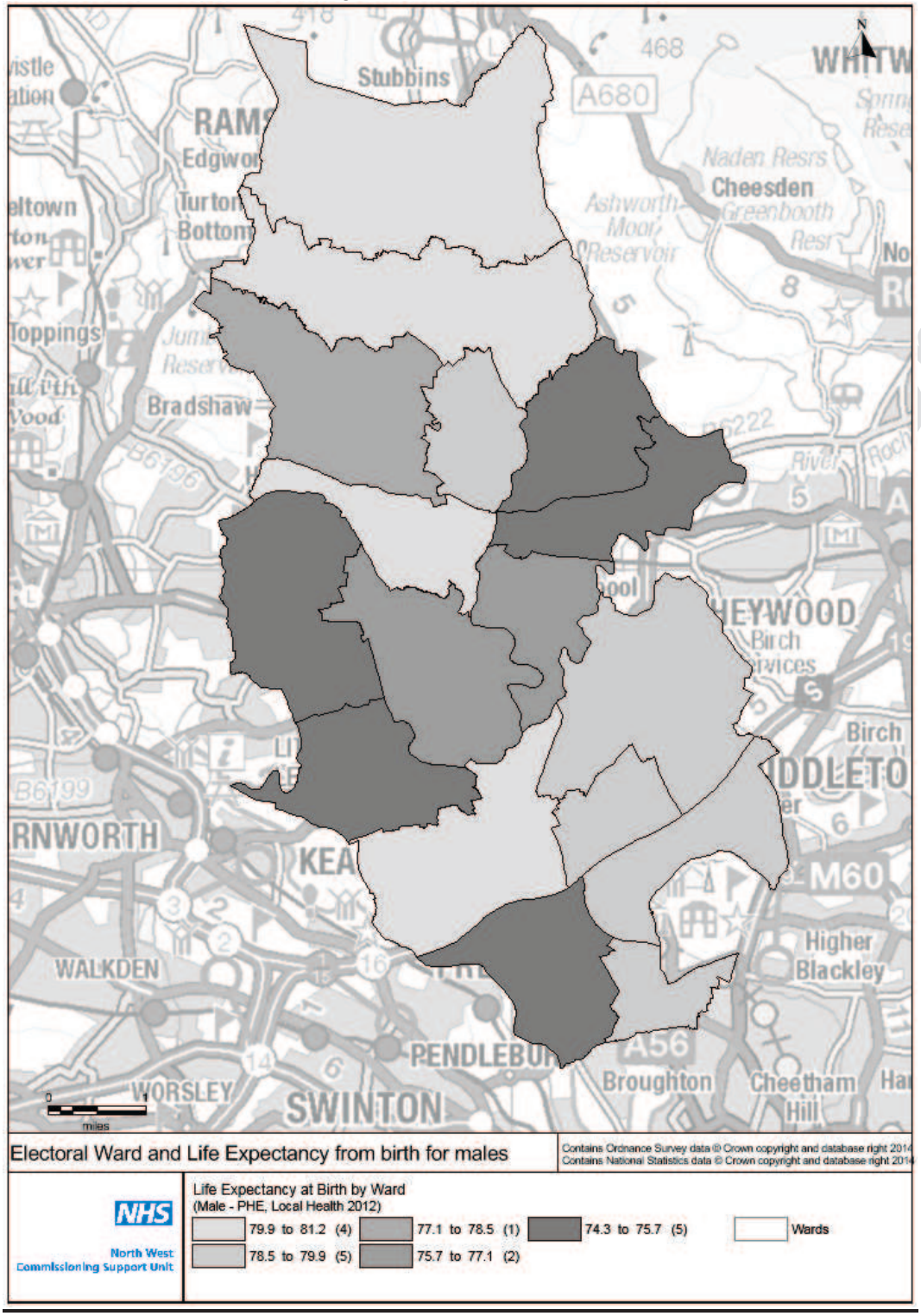


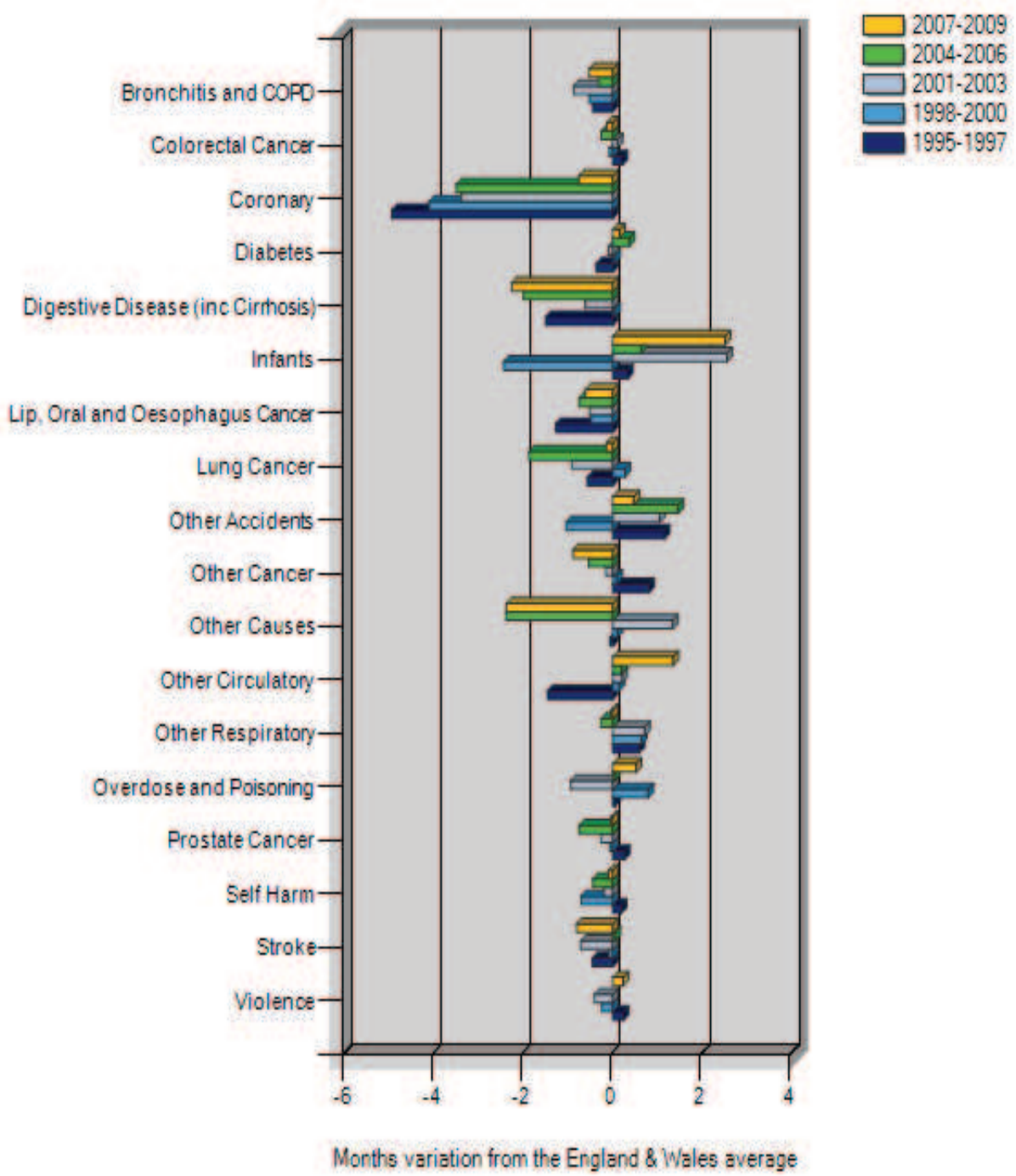
Figure 10: Bury Life Expectancy at Birth by Electoral Ward (Female)

Source: Public Health England - Local Health - 2011



From 1995 to 2009 (latest available data), Figure 11 and 12 below shows the difference in life expectancy from England and Wales by disease area for men and women respectively. The yellow bars show where Bury was in 2009 compared to previous years. The zero line is where England and Wales average lies.

Figure 11: Contribution factors to the Life Expectancy Gap for Men in Bury
Source: North West Public Health Observatory



In Bury, the contributory factors in men (Figure 11) with the greatest life expectancy variation from national average are digestive disease (including cirrhosis) and those classified under other causes.

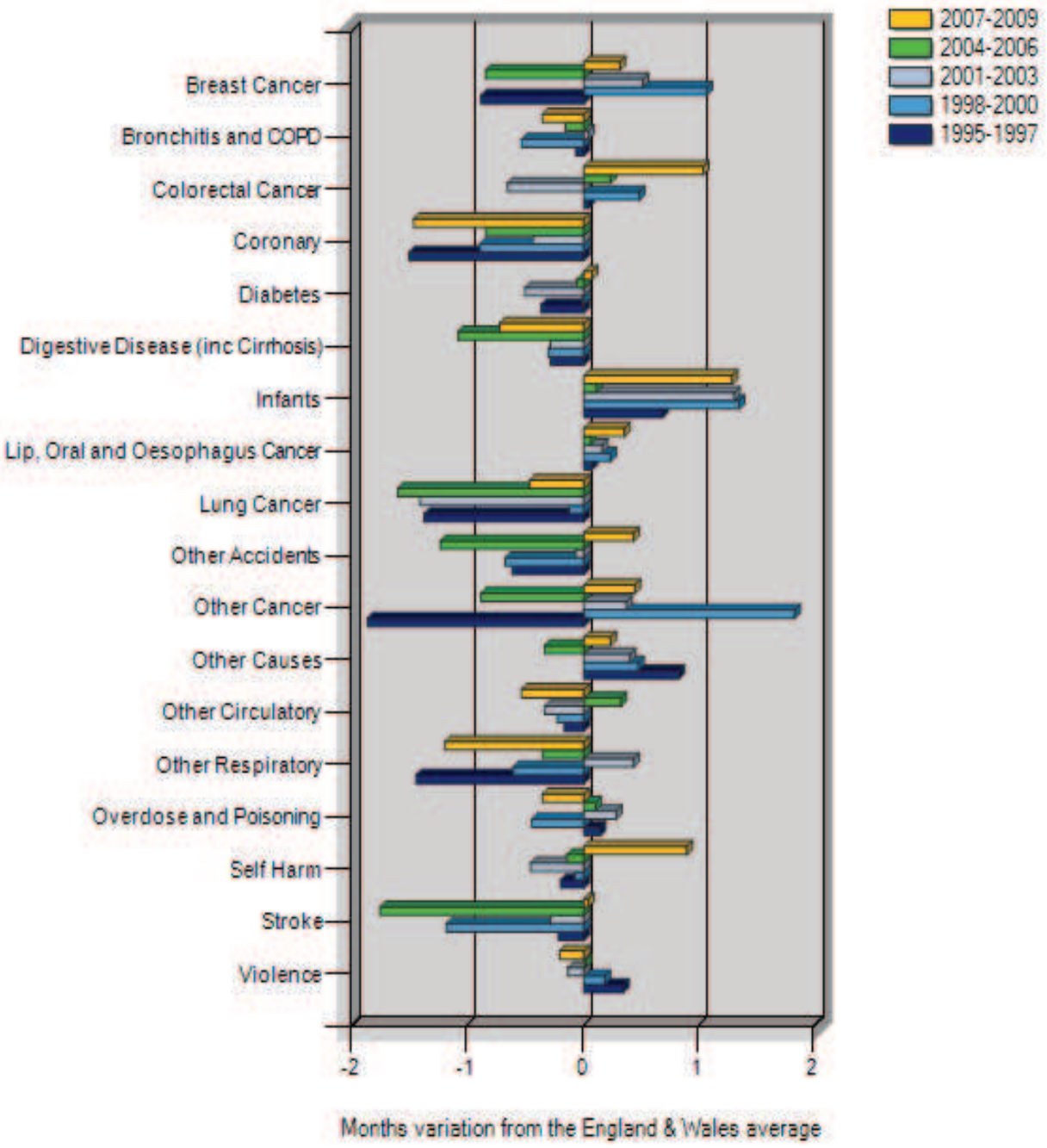
Other causes would include those deaths due to natural causes and those requiring coroner referral particularly where the death was sudden and the cause unknown, or for deaths where there was no doctor in attendance, which may have been referred directly by the police. The significant variance of other causes from national average is cause for concern but the uncertainty of the details would be difficult for the PNA to address. Greater investigation would be required if this trend continues.

The second largest area of variation for men against the national average is digestive disease (including cirrhosis). Unlike some of the other disease areas this variation from the national average has increasingly worsened. It is clear that improvement in local residents' alcohol awareness, public health initiatives to reduce the spread of hepatitis infections and reduction in population obesity could all impact on the prevalence and reduce the increasing numbers of deaths attributed to digestive diseases.

Other significant contributors for men in Bury to life expectancy variation from national average are coronary disease, stroke, respiratory conditions, bronchitis, chronic obstructive pulmonary disease (COPD) and other cancers including lung, oral or throat cancers.

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Figure 12: Contribution factors to the Life Expectancy Gap for Women in Bury
Source: North West Public Health Observatory



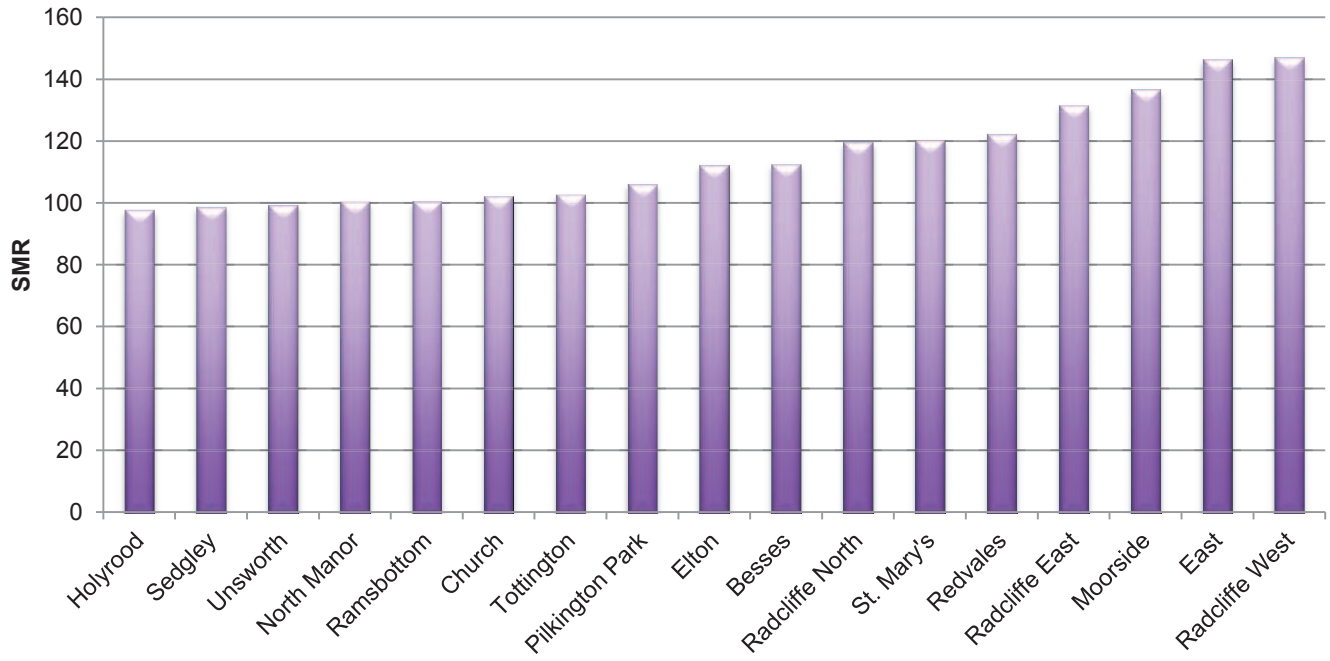
Similarly to men, the three main contributors for women in Bury (Figure 12) to life expectancy variation from the national average are coronary, respiratory and digestive disease. Although over the years, life expectancy had varied in those areas they are still considerably worse than the national average.

In summary for men and women, Bury has just over 1,750 deaths a year with the main causes being broadly circulatory, lung, liver and cancer related. They are the greatest

contributors to the all age all causes mortality (AAACM) gaps between wards and reducing AAACM rate is a key priority for all HWB strategies.

In the 2011 Census, deaths from potentially avoidable causes accounted for approximately 24% of all deaths registered nationally. Figure 13 shows that approximately two thirds of Bury Wards are above the national standardised mortality average for AAACM. Evidently, reducing inequalities between Bury wards will in turn reduce variation in life expectancy between the areas.

Figure 13: Bury All Age, All-Cause Mortality (AAACM) by Wards



Source: Public Health England - Local Health - 2011
SMR: Standardised Mortality Rate (England SMR =100)

4.6 Deprivation

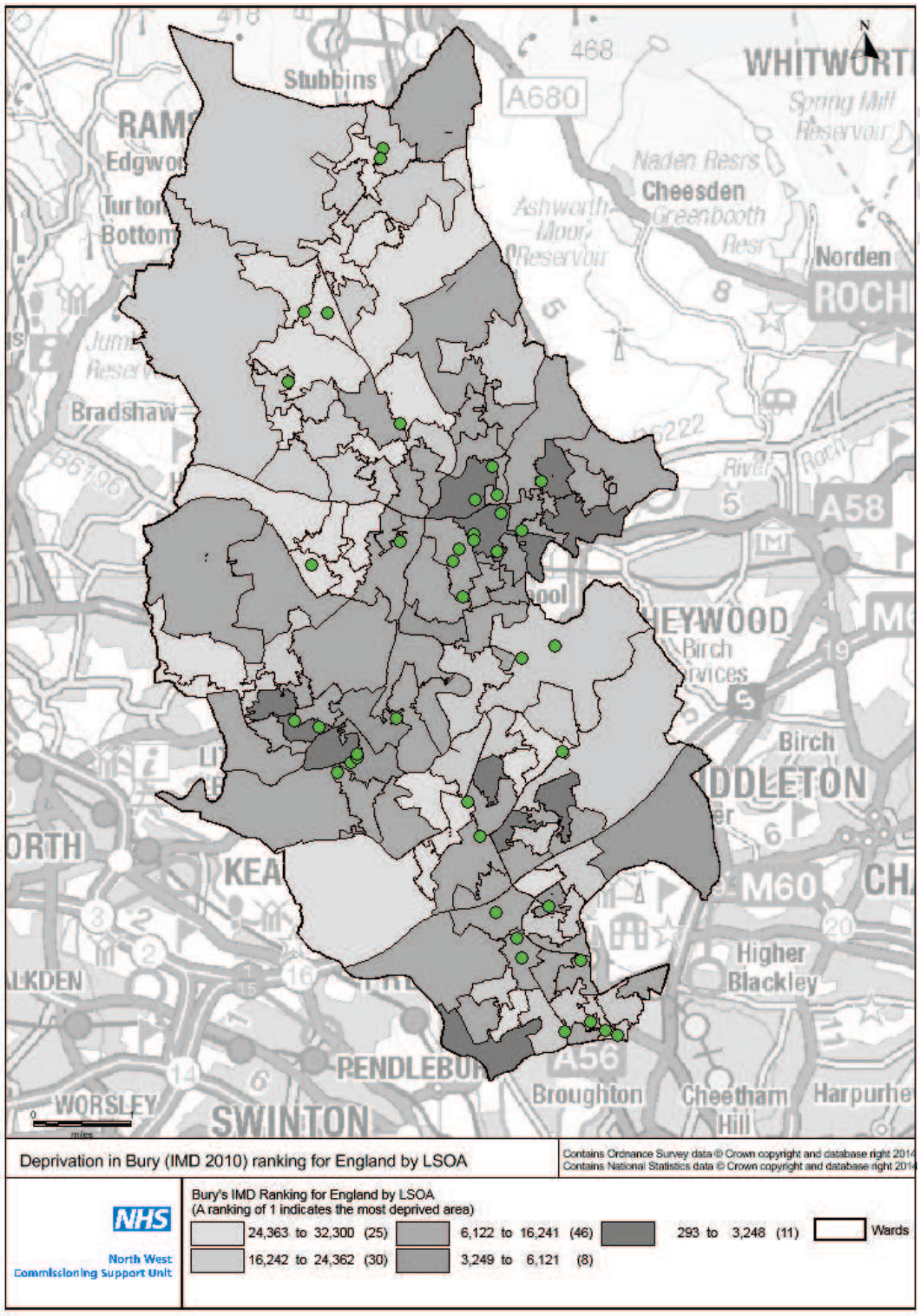
Just over 5 million people live in the most deprived areas in England, of which 38% people are income deprived. Almost all (98%) of the most deprived areas in England are in urban areas. The English Indices of Deprivation 2010 use 38 separate indicators, organised across seven distinct domains of deprivation - income, employment, health and disability, education skills and training, barriers to housing and other services, and crime and living environment.

All domains are combined, using appropriate weights, to calculate the Index of Multiple Deprivation 2010 (IMD 2010). This is an overall measure of multiple deprivations experienced by people living in a small geographical area known as LSOA. IMD 2010 is ranked nationally in terms of LSOA according to their relative level of deprivation.

In Bury, Figure 13 and 14 depicts consistent correlation of increased AAACM rates in areas of higher deprivation like Radcliffe West, Bury East and Moorside Wards. There is clearly a

strong link between deprivation, inequalities and poor health outcomes. Life expectancy is longer in the Tottington, Ramsbotton, Sedgley and Pilkington Park Wards; as they are considered less deprived in the Bury area.

Figure 14: Deprivation in Bury (IMD 2010) ranking for England by LSOA



5.0 Locally Identified Health Need and Service Provisions

5.1 Overview of Services

Community pharmacies have an important role in improving the health of local people. They are easily accessible, often first point of contact and can offer a valuable opportunity for reaching people who may not otherwise access health services. Community pharmacies can contribute to the local public health agenda in a number of ways, including but not limited to:

- Motivational interviewing
- Providing education, information and brief advice
- Providing on-going support for behaviour change
- Signposting to other services or resources

Bury Council considers community pharmacies a key public health resource and recognises that they offer potential opportunities to commission health improvement initiatives and promote health and wellbeing and support in achieving the required outcomes identified in the JHWS (see section 5.2 below).

At the time of writing the PNA (June 2014), some commissioning arrangements are awaiting clarification. However, following the current assessment of local health needs, Bury pharmacies locally commissioned services and public survey results the following findings were noted:

- Pharmacies are ideally placed to provide a stop smoking service in the community. As evaluated by National Institute for Health and Care Excellence (NICE), smoking cessation service is extremely cost effective compared with many other health service interventions.
- Bury Council has commissioned smoking cessation services from 24 of the 41 pharmacies across the footprint.
- Those wards with the highest prevalence of smokers have pharmacies offering smoking cessation service.
- Local community pharmacy services are well placed to support the public health need to tackle obesity through a supportive weight management service.
- In the Bury HWB footprint there are two community pharmacies providing the Chlamydia Screening and Treatment programme for 15-24 year olds.
- In 2013, Bury had a chlamydia diagnosis rate of 2,029 per 100,000 15-24 year olds compared to 2,358 in Greater Manchester and 2,016 in England (Public Health England recommends target diagnosis rate of 2,300 per 100,000).
- There are 17 known pharmacy contractors of the 41 in the area providing EHC service.
- In 2012, Bury has a significantly higher rate of teenage conceptions (42 per 1,000 females aged 15-17) than the national average (38 per 1,000).
- It is advised to offer chlamydia screening at the time of EHC provision because those who require EHC contraception are likely to be at risk of infection.
- Community pharmacists are able to offer opportunistic advice around alcohol awareness.
- There are seven pharmacies in Bury that provide access to sterile needles and syringes, and sharp containers for drug misuse users.
- In Bury, there are 15 pharmacies that provide supervised methadone/buprenorphine consumption.
- Pharmacists and their staff already provide a signposting service to other sources of information, advice or treatment.

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- Pharmacists are also involved in the early detection of some cancers, for example, through the provision of advice on skin care and sunbathing, and participating in the Be Clear on Cancer campaign
- Currently all patients (excluding pregnant and breastfeeding women) registered with a GP surgery located within the boundaries of Bury can use the Common Ailment service.
- There are currently 34 registered pharmacies contracted to provide the Common Ailment service in Bury.
- One designated pharmacy is contracted to supply agreed palliative care medicines in the community at the point of need which may be urgent and/or unpredictable.
- The survey was completed by 79 people with the majority of respondents being female aged between 45-64 years old and was of a White British ethnicity.
- 83% of the Bury's public uses a regular or preferred pharmacy.
- The most commonly selected reason for using a pharmacy was location and the proximity to the respondent's home or doctors.
- The service related motivations for the use of a pharmacy are friendly and knowledgeable staff.
- A small number of respondents did not feel that their needs were met when using some services in particular EPS and Common Ailments scheme. This should be addressed in future service review.
- There were a small number of respondents who were unsatisfied with waiting times and private consultation areas.
- Overall, 91% of the respondents were either satisfied or very satisfied with the service they receive from their pharmacy.
- Over 77% of respondents have not used services already on offer.

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5.2 Bury Strategic Priorities

This PNA for Bury is undertaken in the context of the needs of the local population. Health and wellbeing needs for the local population are described in the Bury's JSNA[12]. This PNA does not duplicate these detailed descriptions of health needs in the relevant JSNAs and should be read alongside the JSNA.

Informed by the JSNA and in consultation with stakeholders, Bury HWB were able to produce the JHWS to provide an overarching plan to respond to those health needs identified. The needs are addressed by five strategic priorities each of which are subdivided by the JHWS desired outcomes to measure success.

Figure 15 below outlines those intentions and throughout the PNA there will be a focus to those action plans.

Figure 15: Bury HWB Strategic Priorities and Outcomes 2013-18

	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***
Outcome 1	*An increase in the number of children achieving a good level of development at age 5*	*Reductions in the levels of smoking, physical inactivity, excess weight and harmful alcohol consumption in adults, children and young people*	*An increase in the proportion of adults with mental illness who are in employment*	*Reduced admissions of people with long term conditions*	*A reduction in injuries and hip fractures due to falls in the over 65s*
Outcome 2	*A reduction in the number of child protection plans*	*A reduction in under 18s conception*	*An increase in the percentage of adults with mental illness living independently*	*An increased number of adults and carers receiving self-directed support via a direct payment*	*A reduction in permanent admissions to residential and nursing care homes*
Outcome 3	*A reduction in the number of children in care*	*An increase in life expectancy at age 75*	*An increase in self-reported wellbeing*	*An increased number of adults accessing a recognized self-care course*	*An increase in the number of over 65s who remain at home following support by reablement services*
Outcome 4	*Increases in breastfeeding initiation and maintenance at 6-8 weeks after birth*	*Reductions in the gap in life expectancy and healthy life expectancy between communities*	*A reduction in hospital admissions as a result of self-harm*	*A reduction in proportion of long term sick*	*An increase in people feeling safe and secure as a result of adult care services*

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	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*
Outcome 5	*A reduction in the number of mothers smoking during pregnancy*	*Reductions in early deaths from cancer and cardiovascular, liver and respiratory diseases*	*A decrease in first time entrants to the youth justice system*		*A reduction in excess winter deaths*
Outcome 6	*Improvements in differences in levels of educational attainment across the borough and between groups*	*A reduction in the level of long term conditions*	*A reduction in domestic violence*		*An increase in early diagnosis of dementia*
Outcome 7			*A reduction in homelessness.*		*An increase in the number of people dying in their own home where they wish to do so*
Outcome 8			*A reduction in the length of stay of families in temporary accommodation*		*An increase in the number of people dying with an end of life plan*

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5.3 Role of Community Pharmacy in Improving Local Health Needs

Pharmacy professionals are responsible and accountable for maintaining and improving the quality of their practice by keeping their knowledge and skills up to date and relevant to their role and the services they offer (General Pharmaceutical Council Standards of conduct, ethics and performance July 2012)[13].

As well as the pharmacists and dispensing technicians referred to above, pharmacies also employ medicines counter assistants, trained to at least National Vocational Qualification (NVQ) level 2. Many are trained to provide brief interventions, and some act as Healthy Living Champions, Dementia Friends, Carers Champions and more. They add significantly to the skill mix available in pharmacy teams.

As a result it is recognised that community pharmacies are resourced with highly trained and experienced healthcare professionals that are able to offer a wide range of services including healthy life style advice, advice on medicines and long term conditions, health screening, support for the prevention of diseases and treatment of minor ailments, and signposting to other services. Allowing pharmacists to take professional responsibility for assessing and declaring their own competence to provide a service is expected to significantly improve service continuity.

Historically community pharmacy professionals were required to complete an accreditation process in order to deliver specific Enhanced Services commissioned by the former PCT organisation and the lack of availability of an accredited pharmacist may potentially have limited patient access to those services. However, following the NHS reform, changes in NHS structure and movement of commissioned services, a national solution to assuring the competence of pharmacists was developed by Health Education North West in conjunction with the Centre for Pharmacy Postgraduate Education (CPPE). The Declaration of Competence for Community Pharmacy Services framework allows pharmacy professionals to self-assess their competence and demonstrate to themselves, their employers and the service commissioners that they have the skills and knowledge necessary to deliver the Enhanced and locally commissioned services[14].

There are many ways in which pharmacy services can impact on improving the HWB strategic priorities. We will look at each proposed strategic priority and discuss these by focusing on the three sections of the community pharmacy contract, as set out in section 3.2.2. Examples of how the current pharmacy service meets the Bury HWB strategic priorities are laid out in section 5.3.5 Figure 16.

5.3.1 Essential Services

These are mandatory within the pharmacy contract and are managed and monitored by GMAT. As all pharmacy contractors must provide these services they should be utilised across all wards to reduce health inequalities.

Essential services should be used by all pharmacy contractors to help deliver the local authority public health messages, improving outcomes by targeting people using a proactive approach.

Should any of the local health partners feel that a more directed service is required e.g. targeted to specific age groups or in specific wards then discussions with the Local Pharmaceutical Committee or the GMAT about how this could be managed within the desired budget could raise a number of solutions. This could include locally commissioned services or enhanced services.

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5.3.2 Advanced Services

Any contractor may choose to provide Advanced Services. There are requirements which need to be met in relation to premises, training or notification to the GMAT. Advanced services offer an opportunity for pharmacy contractors to engage patients and empower them to take greater responsibility for their health through their prescribed medication or appliance. Similarly dispensing appliance contractors would do the same for patients to whom they supply appliances.

Providing patients with a better understanding of their medication or appliance can help to prevent unnecessary exacerbations of conditions and reduce the possible risk of patients accessing urgent care services; hopefully leading to better health outcomes.

5.3.3 Enhanced Services

These services can be commissioned locally from pharmacies by NHS England and they are aimed to complement services provided by GPs. Examples of Enhanced Services that could be commissioned from pharmacies are listed in section 3.2.2.

These services can only be referred to as Enhanced Services if they are commissioned by NHS England. If local services are commissioned by CCGs or Local Authorities, they are referred to as Locally Commissioned Services. See section 3.2.3 above and 5.3.4 below.

At the time of writing the PNA the GMAT had commissioned an influenza vaccination community pharmacy Enhanced Service from pharmacies across Greater Manchester, including Bury. This pilot service had been commissioned from pharmacies from November 2014 to February 2015, and targets under 65 at risk individuals. Over 200 accredited community pharmacies in Greater Manchester (10 community pharmacies in Bury) had been commissioned to provide the service with the aim of increasing average flu vaccination uptake across GM to the target 75%. The pilot will be evaluated to inform commissioning of subsequent influenza vaccinations programmes.

5.3.4 Locally commissioned services

The following local services are commissioned in Bury community pharmacies by Bury Council Public Health and Bury CCG to support the local public health agenda:

- Smoking Intermediate Advice (Council)
- Chlamydia Screening and Treatment (Council)
- Emergency Hormonal Contraception (Council)
- Needle and Syringe Exchange Service (Council)
- Supervised Methadone/Buprenorphine Administration Service (Council)
- Minor Ailments Service (CCG)
- Palliative care service (CCG)

The range of services provided by community pharmacies varies due to several factors, including: the availability of self-declaration competent pharmacists, capacity issues in the pharmacy, changes to service level agreements and by the will and ability of commissioning bodies to commission the services. Existing pharmacies have demonstrated a willingness to provide any local service that is commissioned from them. In order to maximise value for public money, any service to meet local need will be offered to existing community pharmacy contractors in the first instance.

Note: Pharmacy applications must relate to pharmaceutical services (i.e. Essential, Advanced and Enhanced services) and should not be submitted solely on gaps identified for Locally Commissioned services.

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A list of which locally commissioned services each community pharmacy is delivering currently (30th June 2014) is available in Appendix 6.

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5.3.5 Community pharmacy services impact on the HWB Strategic Priorities

Figure 16: Provision of Pharmaceutical Service impact on the HWB Strategic Priorities

Community Pharmacy Service *(Refer to table in Appendix 1 for a service description)*	***Which of the Bury JHWB Strategic Priorities will this impact?*** *(Refer to Figure 15 for detailed list of priorities)*	***Comments/Examples*** ****Note: Pharmacy contractors express a willingness to engage in all potential locally commissioned and enhanced services and they need to work with commissioners, through the LPC, in order to be able to produce business cases or tenders for the provision of those services.***
Essential Services*		
Dispensing Medicines or Appliances	***Priority 1*** *Outcome: 1,5* ***Priority 2*** *Outcome: 1,2,3,4,5,6* ***Priority 3*** *Outcome: 2,4* ***Priority 4*** *Outcome: 1,4* ***Priority 5*** *Outcome:1,2,3,4,5*	Explanation of medicines prescribed at the time of dispensing can increase the understanding of why and how medicines should be taken. This should lead to a more informed medicine user and reduce adverse effects which may require interventions such as A&E admission. ***Example:*** Pharmacies dispensing and providing an emergency supply of repeat medications prevents calls to Out-of-Hours GP service, Walk-In Centres and/or Accident and Emergency (A&E) departments.
Repeat Dispensing	***Priority 1*** *Outcome: 1,5* ***Priority 2*** *Outcome: 1,2,3,4,5,6* ***Priority 3*** *Outcome: 2,3,4* ***Priority 4*** *Outcome: 1,4* ***Priority 5*** *Outcome: 1,2,3,4,5*	Patients who use a repeat dispensing (RD) service use less GP staff time and appointments whilst ordering their medication. This leaves GP's and their staff more time to help the people who have more severe health needs and therefore more health services could be identified to remain in the community. The regular checking of how patients use of their prescribed medication can avert incidences arising from inappropriate use. ***Example:*** Patients with an increased use of their analgesics could be identified by patients returning for repeats earlier than anticipated. Increase use could be a sign of inadequate pain control, a reduction in the patient's quality of life, overuse and subsequent adverse effects like excessive drowsiness and falls. **Note:** the uptake of the RD service in Bury is low, but its benefits are expected to be better received following the implementation and roll out of Release 2 of the Electronic Prescription Services (EPS)

Disposal of unwanted medicines	***Priority 1*** *Outcome: 1,5* ***Priority 2*** *Outcome: 1,2, 3,4,5,6* ***Priority 3*** *Outcome: 2,3,4* ***Priority 4*** *Outcome: 1,4* ***Priority 5*** *Outcome:1,2,3,4,5*	Again this is another area where pharmacy staff have the opportunity to identify patients who have not taken the medicines they were prescribed. This can initiate a discussion and problems such as compliance, side effects or dosage regimes which can be addressed to help improve the patients' health outcomes. ***Example:*** CCGs would be very interested in knowing whether issued medicines are not being used correctly. A significant amount of wasted NHS resource is attributed to medications being used incorrectly or not at all*.
Public health (Promotion of healthy lifestyles)	***Priority 1*** *Outcome: 1,5* ***Priority 2*** *Outcome: 1,2, 3,4,5,6* ***Priority 3*** *Outcome: 2,3,4* ***Priority 4*** *Outcome: 1,4* ***Priority 5*** *Outcome:1,2,3,4,5*	At the request of NHS England, NHS pharmacists are required to participate in up to six campaigns each year to promote public health messages to their users Where requested to do so by NHS England the NHS pharmacist records the number of people whom they have provided information as part of one of those campaigns. Themes of public campaigns in Bury carried out or planned for 2014/15 include: 1. Obesity 2. Cancer 3. Alcohol 4. Screening and Immunisation 5. Wider Winter Health Care HWBs have the discretion to run alternative campaigns and typically each pharmacy may obtain posters, leaflets, and key message fact sheets as part of the campaigns, from relevant resource centres. Promotion of these messages will reinforce wider campaigns to improve health in the locality and are a useful tool to engage the public in meaningful discussions about preventing illness and staying well. ***Example***: An Obesity campaign will encourage and support patient weight management, fat and sugar intake, healthy eating and lifestyle changes. All of which supports the priorities listed to the left.

Signposting	***Priority 1*** *Outcome: 2,4,5* ***Priority 2*** *Outcome: 1,2,5* ***Priority 3*** *Outcome: 3,4* ***Priority 4*** *Outcome: 2,3* ***Priority 5*** *Outcome: 3,4,5,6*	Pharmacies need to be equipped to provide opportunistic advice, information and facilitate signposting of patients to other services. ***Example:*** Pharmacists directing patients to the local Brook Advisory Service or equivalent local service for routine contraception.
Support for Self Care	***Priority 1*** *Outcome:4,5* ***Priority 2*** *Outcome:1,3* ***Priority 3*** *Outcome:2,3,4,5* ***Priority 4*** *Outcome:1,3,4* ***Priority 5*** *Outcome:1,3,4,5,6,7*	The provision of advice and support to enable patients to derive maximum benefit from caring for themselves or their families. This may include self-limiting conditions as well as long term conditions. ***Example:*** If patients used pharmacies for advice on a more frequent basis this would free other health care settings which they might otherwise have accessed. Such as A&E or GP practices. This would free resources including money to be redirected into patient care thereby further enhancing the population's health outcomes.
Advanced Services*		
Medicines Use Review (MURs)	***Priority 1*** *Outcome: 1,5* ***Priority 2*** *Outcome: 1,2,3,4,5,6* ***Priority 3*** *Outcome: 2,3,4* ***Priority 4*** *Outcome: 1,4* ***Priority 5*** *Outcome:1,2,3,4,5*	The MUR and Prescription Intervention Service consists of accredited pharmacists undertaking structured adherence-centred reviews with patients on multiple medicines, particularly those receiving medicines for long term conditions. National target groups have been agreed in order to guide the selection of patients to whom the service will be offered. Targeted MURs are required to make up 70% of the service. The MUR process attempts to establish a picture of the patient's use of their medicines – both prescribed and non-prescribed. The review helps patient understand their therapy and it will identify any problems they are experiencing along with possible solutions. An MUR feedback form will be provided to the patient's GP where there is an issue for them to consider.

		Example: MURs could be targeted to support patients taking high risk medicines, patients recently discharged from hospital that have had changes to their medicines, or support specific cohorts of patients within the HWB strategic priorities e.g. respiratory disease. The latter could be further supported by the MUR Plus service, whereby the improvement of inhaler technique could be provided by community pharmacists.
New Medicine service (NMS)	***Priority 1*** *Outcome: 1,5* ***Priority 2*** *Outcome: 1,2, 3,4,5,6* ***Priority 3*** *Outcome: 2,3,4* ***Priority 4*** *Outcome:1,4* ***Priority 5*** *Outcome:1,2,3,4,5*	The NMS increase patients' engagement with their condition and medicines, supporting patients in making decisions about their treatment and encourage self-management. The service provides particular support for those people with long-term conditions newly prescribed a medicine to help improve medicines adherence. ***Example:*** *W*hen a person is discharged from hospital they may have had their medication regime altered and not realise they should stop a certain medicine. This could lead to the person taking two medicines which interact and they could return to hospital for treatment. NMS would aim to stop a problem such as this, before it occurred by helping the patient to understand why certain medicines have been stopped or started.
Appliance Use Review (AUR)	***Priority 2*** *Outcome:4* ***Priority 3*** *Outcome:3* ***Priority 4*** *Outcome:1,4* ***Priority 5*** *Outcome:2,3*	AURs can be carried out by a pharmacist or specialist nurse in the pharmacy or at the patient's home. AURs should improve the patient's knowledge and use of any 'specified appliance'. ***Example:*** Patient's knowledge could be improved by establishing the way they use the appliance and experience of such use, advising on safe and appropriate storage as well as safe and proper disposal of used or unwanted appliances. Also identifying, discussing and assisting in the resolution of poor or ineffective use of the appliance by the patient.
Stoma Appliance Customisation Service (SAC)	***Priority 2*** *Outcome:4* ***Priority 3*** *Outcome:3* ***Priority 4*** *Outcome:1,4* ***Priority 5*** *Outcome:2,3*	The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste. ***Example:*** If a patient is able to manage their stoma products themselves they are less likely to need costly, intensive nursing and also less likely to be admitted to a residential or nursing home.

Enhanced Services		
Seasonal Influenza Vaccination	***Priority 1*** *Outcome: 1* ***Priority 2*** *Outcome: 3,4,5,6* ***Priority 3*** *Outcome: 1, 3* ***Priority 4*** *Outcome:1, 4* ***Priority 5*** *Outcome: 2,3,5*	GMAT commissioned the 2014/15 seasonal influenza vaccination plan. It aims to improve accessibility to the vaccine and addressing the historically low uptake. Community pharmacies are well placed, accessible, often open extended hours to provide the vaccine without the need for an appointment. The service targets under 65 at risk individuals and aims to increase average influenza vaccination uptake in all groups except healthy children to the national target of 75%. ***Example:*** The pharmacy patient records may also be used to identify, and proactively target people who may benefit from immunisation. There is emerging evidence to support the role of community pharmacies delivering this (and other) vaccination services.
Council– Locally Commissioned Services ***(Refer to table in Appendix 1 for a service description)***		
Emergency Hormonal Contraception	***Priority 2*** *Outcome:2*	The service involves the supply of oral EHC, when appropriate, to clients in line with the requirements of the Patient Group Direction (PGD). ***Example:*** If a patient has unprotected sexual intercourse and requires EHC or advice over a weekend, often their GP surgery and many of the health clinics are closed. Pharmacy locations are the ideal place to receive treatment especially during out of hours. If patients were unable to get EHC promptly they may decide to go to A&E which would be an inappropriate use of NHS funding.
Sexual Health - Chlamydia Testing and treating	***Priority 3*** *Outcome:3*	Pharmacies can be an integral part of a comprehensive sexual health service for the general public. For example pharmacies are ideally places to provide routine oral and barrier contraception for appropriate patients, if commissioned*. Other parts of sexual health would include the confidential and accessible Chlamydia testing and treatment. This is the provision of testing kits for chlamydia to the target population and treatment for persons testing and their contacts on referral from the managing provider.

		Example: If patients used pharmacies for their confidential Chlamydia testing and treatment on a more frequent basis this would free other health care settings which they might of otherwise have accessed. Such as A&E or GP practices. This would free resources including money to be redirected into patient care thereby further enhancing the population's health outcomes.
Supervised Methadone/ Buprenorphine	***Priority 2*** *Outcome: 1,3,4,6* ***Priority 3*** *Outcome: 2,3,4* ***Priority 4*** *Outcome:1,4*	This service provides a pharmacist and suitably qualified staff to supervise the consumption of prescribed medicines at the point of dispensing in the pharmacy, ensuring that the dose has been administered to the patient. Pharmacies will offer a user-friendly, non-judgemental, client-centred and confidential service. ***Example:*** Supervised consumption of medicine, methadone or buprenorphine for example, for some individuals leads to a more stable routine and reduction in street drug misuse. This is particularly important during the initial phase of recovery treatment or after a relapse. Other examples include supervised consumption of benzodiazepines to aid recovery from prescribed induced dependence and anti-tubercular drugs to aid compliance with complex treatment regimens*.
Needle Exchange	***Priority 2*** *Outcome: 1,3,4,5,6* ***Priority 3*** *Outcome: 2,3,4* ***Priority 4*** *Outcome:1,4*	Pharmacies provide access to sterile needles and syringes, and sharps containers for return of used equipment. Associated materials (for example condoms, citric acid and swabs) to promote safe injecting practice and reduce transmission of infections by substance misusers, will also be provided. Pharmacies will offer a user-friendly, non-judgmental, client-centred and confidential service. The service user will be provided with appropriate health promotion materials. The pharmacy will provide support and advice, including referral to other health and social care professionals and specialist drug and alcohol treatment services where appropriate. The pharmacy will promote safe practice to the user including advice on sexual health, STIs, HIV and Hepatitis C transmission and Hepatitis A & B immunisation. ***Example:*** Needle exchange is a harm reduction programme designed to stop the spread of disease via needles sharing between drug users. The pharmacies are also asked to take the opportunity to talk to their patients about reduction of self-harm and health benefits resulting from this. Also promoting other services which would be beneficial to the drug users.

Smoking Cessation	***Priority 2*** *Outcome: 1,3,4,6* ***Priority 3*** *Outcome:3* ***Priority 4*** *Outcome:1,4*	The aim of this service is to support the reduction of smoking prevalence by enabling smokers to access a choice of support to stop, which best suits their needs. Pharmacies provide a high quality, accessible, convenient and comprehensive stop smoking service. This supports the achievement of 4 week quit targets as a proxy indicator for reduction of smoking prevalence. ***Example:*** Pharmacist provision of stop smoking services gives patients access at a time convenient for them and reduces their need for GP appointments and repeat supplies of nicotine replacement therapy (NRT).
CCG – Locally Commissioned Services ***(Refer to table in Appendix 1 for a service description)***		
Common Ailment Scheme	***Priority 1*** *Outcome: 1,5* ***Priority 2*** *Outcome: 1,6* ***Priority 3*** *Outcome:3* ***Priority 4*** *Outcome:1,4* ***Priority 5*** *Outcome:1,5*	This service involves the provision of advice and support to people on the management of minor ailments. ***Example:*** Minor ailment scheme allows easy access to advice and medication from pharmacies thereby reducing the number of GP appointments booked for minor conditions. This allows greater appointment times to be available which can target patients with long term complicated conditions hopefully improving the health outcomes of a local population.
Palliative Care	***Priority 5*** *Outcome:7,8*	Palliative care is the care of any patient with an advanced, incurable disease. It involves the control of symptoms, such as pain and aims to improve quality of life for both patients and their families. Drug treatment plays a major role in symptom control in palliative care. The aim is to ensure that appropriate palliative care drugs are available in the community at the point of need. In addition to the prompt supply, pharmacies can support carers and clinicians by providing them with up to date information and advice, and referral where appropriate. ***Example:*** Palliative care patients' health often deteriorates rapidly. If there is no facility to ensure there is prompt access and availability to medicines then this may result in the patient being taken into hospital.

5.4 Bury Local Health Needs

This section aims to consider local health needs and the local services offered.

5.4.1 Smoking

According to the Public Health profiles, Bury has seen a significant improvement in the prevalence of adults smoking in 2012/13 (20.9%) compared to 2011/12 (23.3%). Despite this improvement, the death rate from smoking related conditions remain higher than the England average. In particular the incidence of cancer is increasing with little reduction in mortality, of which about a third of cancer deaths are due to smoking.

Smoking is the most important cause of preventable ill health and premature mortality in the UK. It is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix. Smoking is a modifiable lifestyle risk factor and as a main contributor to many diseases states and poor health, particular focus should be on the wards where smoking prevalence is greatest.

Figure 17: Prevalence of Smoking among persons aged 18 years and over

Source: Public Health Outcomes framework

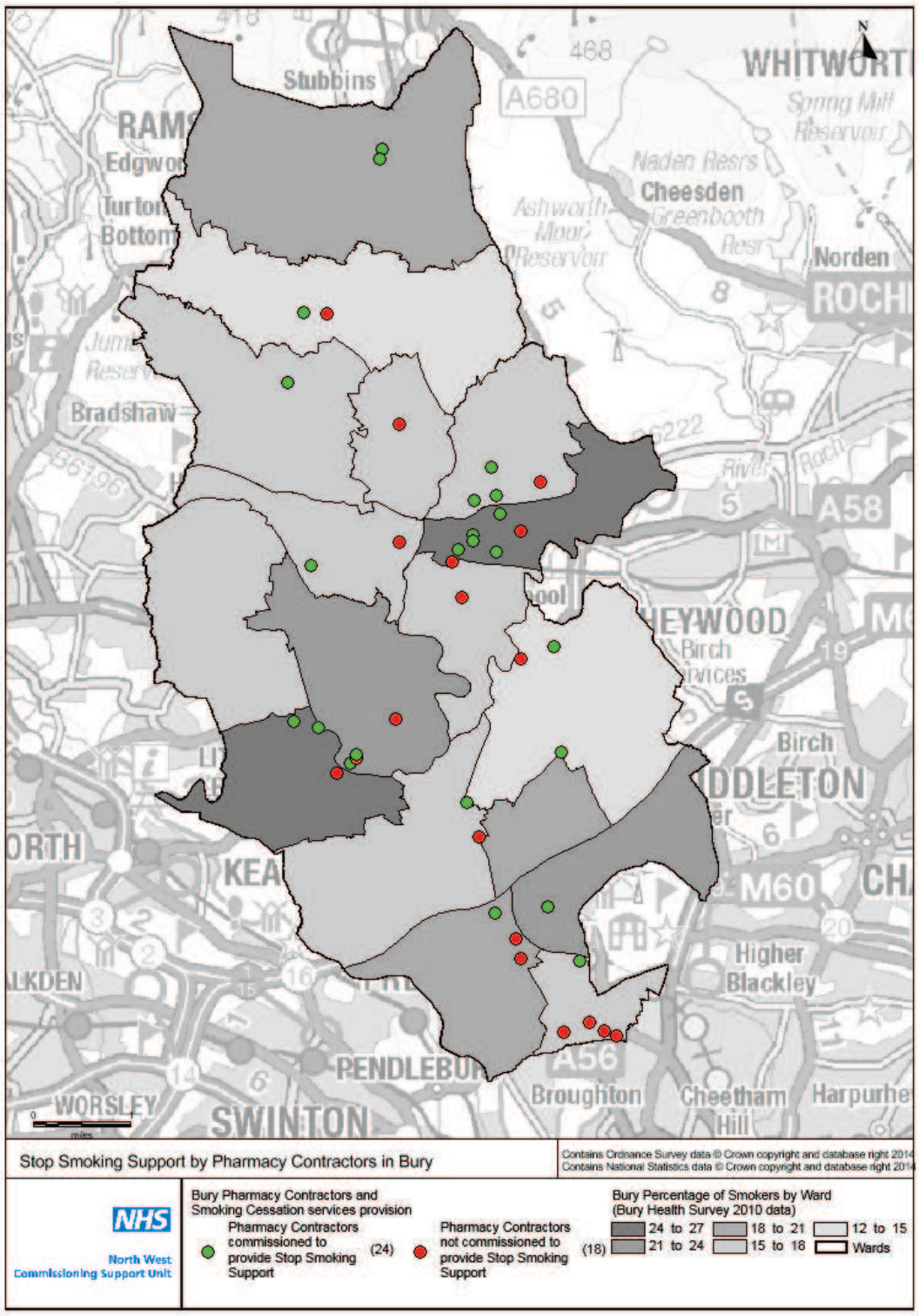
Period	Prevalence of smoking among persons aged 18 years and over (%)		
	Bury	North West	England
2010/11	22.2	23.0	20.8
2011/12	23.3	22.0	20.2
2012/13	20.9	21.6	19.5

The HWB partners have already identified reducing smoking prevalence in all adults and specifically in women during pregnancy as a priority for the borough. In Bury, the rates of smoking in pregnancy are lower than the North West (17.3%) but higher than national averages (13.2%) in Bury (16.9%). Evaluation of the smoking cessation services is required to ensure the desired outcomes are being delivered. Future commissioning of this service should include specific key performance indicators which relate to long term smoking cessation targets.

Pharmacies are ideally placed to provide a stop smoking service in the community. As evaluated by NICE[15], smoking cessation service is extremely cost effective compared with many other health service interventions and pharmacies in Bury are offered the opportunity to receive training and a contract to provide stop smoking services. At the point of writing this PNA (December 2014), Bury Council has commissioned smoking cessation services from 24 of the 39 pharmacies across the footprint. The service is offered to anyone over the age of 12 years old. As further commissioning arrangements emerges it is likely further pharmacy contractors will be providing this service.

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Figure 18: Prevalence of Smokers by Ward and Pharmacies commissioned to provide Stop Smoking Support



5.4.2 Healthy weight

In Bury, half of the adult population is overweight or obese and results from the National Child Measurement Programme indicate that this trend is being replicated in our children. In 20012/13, 19.5% of Reception children and 33.2% of Year 6 children were overweight or obese. The 2008 Bury Health survey showed that only 10.1% of the adults met the Chief Medical Officer's (CMO's) recommendations for physical activity, with 20.9% of adults not taking part in any physical activity[16].

To address such health needs there are several possible opportunities through local pharmacies or other types of services that could be applied. Local services could provide advice, signposting to services like the Bury Exercise and Therapy Scheme (BEATS) and providing on-going support towards achieving behavioural change for example through monitoring of weight and related measures*.

5.4.3 NHS Health Checks

The risk factors for vascular disease include diabetes, smoking, obesity, physical inactivity, high blood pressure and raised cholesterol levels. The aim of the NHS Health Checks programme is to offer preventative checks to eligible individuals aged 40-74 years to assess their risk of vascular disease, followed by appropriate management interventions. The Department of Health indicated that it would expect access to the NHS Health Checks Programme to be developed through a number of routes including community pharmacies* and GP surgeries.

The NHS Health Checks programme in Bury is currently delivered by all general practices. Data from April 2012-March 2013 show that an NHS Health Check was offered to 15.1% of eligible people in Bury; 18.3% of eligible people in North West of England and 16.5% of eligible people in England as a whole[17]. The programme runs in five year cycles, which means that on average 20% of the eligible population is invited for an NHS Health Check each year. At this point the programme has not yet been in operation long enough for five year data to be available.

5.4.4 Sexual Health

Genital chlamydia trachomatis infection is the Sexually Transmitted Infection (STI) most frequently diagnosed in Genitourinary Medicine (GUM) clinics in England. Untreated infection can have serious long-term consequences, particularly for women, in whom it can lead to Pelvic Inflammatory Disease (PID), ectopic pregnancy and tubular factor infertility. Since many infections are asymptomatic, a large proportion of cases remain undiagnosed, although infection can be diagnosed easily and effectively treated.

It is difficult to assess changes in local chlamydia occurrence over the last decade due to changes from absolute numbers being diagnosed to diagnostic rates

Public Health England recommends that local areas should be working towards achieving chlamydia diagnosis rate of at least 2,300 per 100,000 15-24 year old resident population annually. In 2013, Bury had a diagnosis rate of 2,029 per 100,000 compared to 2,358 in Greater Manchester and 2,016 in England.

Community pharmacies are easily accessible for young people and are crucial for offering treatment of chlamydia infections. In some cases it can be challenging to offer testing in the

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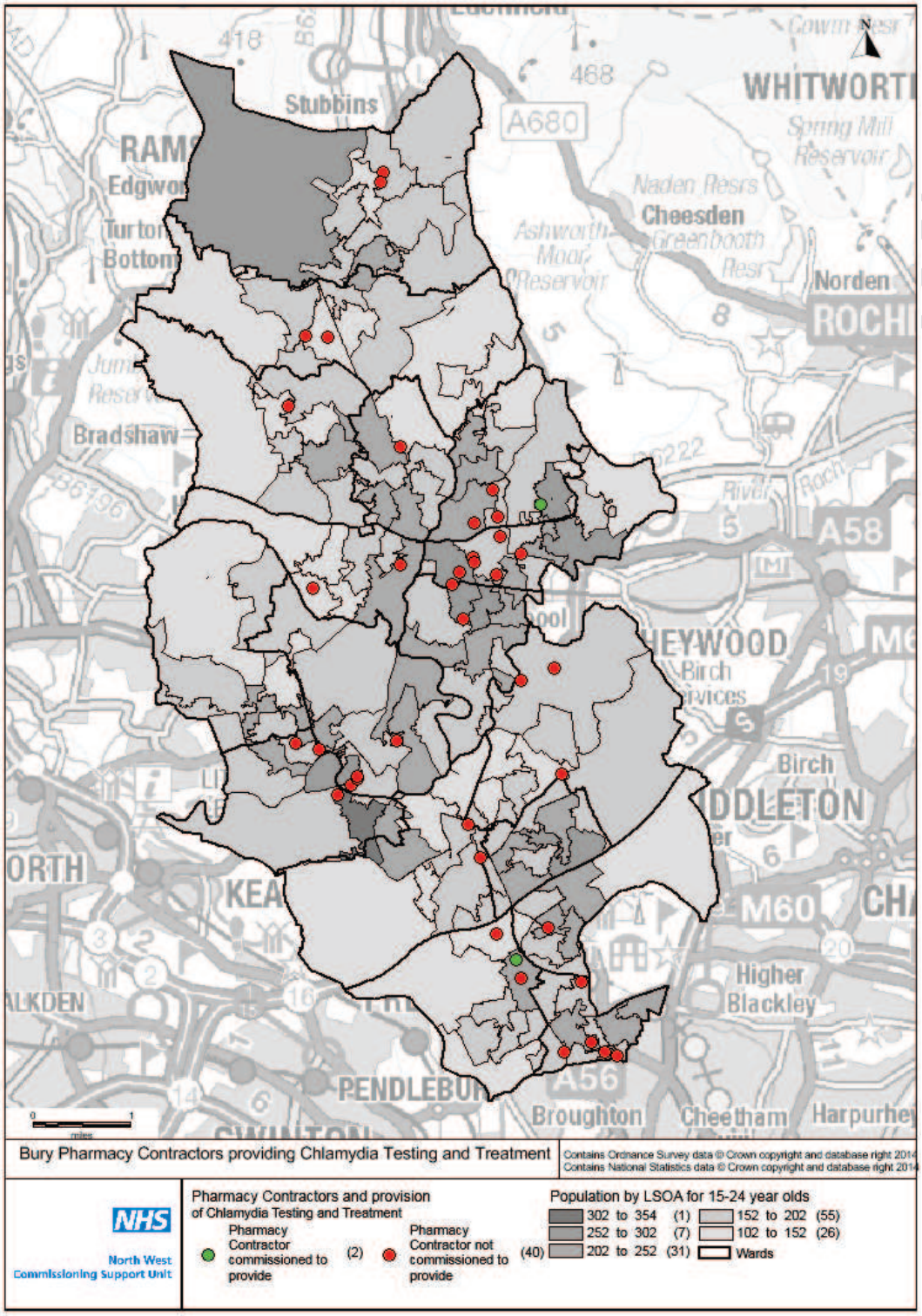
pharmacy setting as not all pharmacies have the facilities required to enable patients to provide a urine sample for diagnostic testing on site. However, there is a potential for offering advice on barrier contraception methods and raising awareness of HIV, chlamydia and other STIs*.

In the Bury HWB footprint there are two community pharmacies providing the Chlamydia Screening and Treatment programme for 15-24 year olds. It is unclear if there is any inequity in the provision of community sexual health service in the area and at the time of writing this PNA (June 2014), the services is currently under negotiation and evaluated to ensure such service can meet the desired targets and address any inequity in access*.

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Figure 19: Population of 15-24 year olds by LSOA and Pharmacies commissioned to provide Chlamydia Screening & Treatment service



5.4.5 Emergency Hormonal Contraception (EHC)

According to the latest figures from the Public Health profiles, Bury has a higher rate of teenage conceptions (32.6 per 1,000 females aged 15-17) than the national (27.7) and regional (31.6) averages.

Figure 20: Under 18 conceptions; Rates are per 1000 female population aged 15–17

Source: Public Health Outcomes framework

Period	Under 18 conceptions; Rates are per 1000 female population aged 15–17		
	Bury	North West	England
1998	55.6	50.3	46.6
2010	40.9	35.3	30.7
2012	32.6	31.6	27.7

Reducing the teenage conception rate and increasing the number of teenage parents who can access and sustain places in education, employment or training are important to improve outcomes for young people and their babies. Studies indicate that making EHC available over the counter has not led to an increase in its use, to an increase in unprotected sex, or to a decrease in the use of more reliable methods of contraception[18].

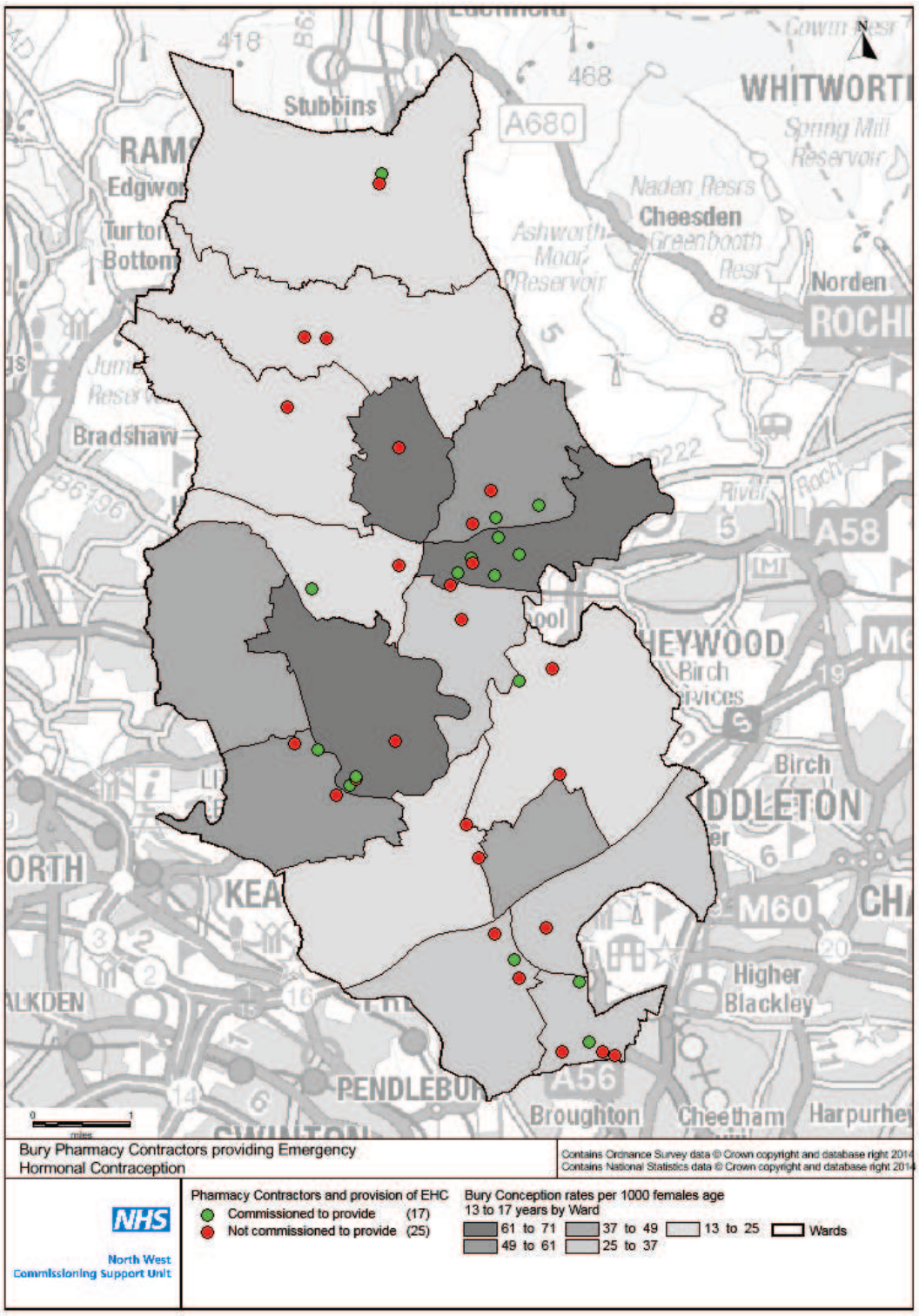
Pharmacies in Bury are offered the opportunity to provide EHC, which is available as a council locally commissioned service in 17 of the 41 pharmacies in the borough. The service is part of the overall contraception service offered by sexual health, contraception clinics and GP practices across Bury.

In pharmacies it would be ideal that more than one pharmacist is available to provide EHC to ensure continuity of services. EHC may only be supplied by a pharmacist making their own self-declaration of competence. Allowing pharmacists to take professional responsibility for assessing and declaring their own competence is expected to significantly improve continuity and accessibility. Medicine counter staff must be trained to refer each request for EHC to the competent pharmacist(s).

It is advised to offer chlamydia screening at the time of EHC provision because those who require EHC contraception are likely to be at risk of infection. The extent to which local services offer signposting to services or carry out testing when EHC is provided could be examined in an audit. Such an audit could stimulate best practice in this area.

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Figure 21: Rate of Teenage Conception per 1000 females aged 13-18 (2012) by Ward and Pharmacies commissioned to provide EHC Service



5.4.6 Alcohol Use

Local authorities are responsible for the commissioning of alcohol prevention and treatment services. Alcohol misuse has an impact on the whole community through crime, health and wellbeing, affecting families and the wellbeing of children, placing significant strain on key health services and council resources. In 2012/13, Bury had just over 600 admissions to hospital per 100,000 population for alcohol–related conditions. This is less than regional and national averages.

Figure 22: Number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause per 100,000 population (age standardised)

Source: Public Health Outcomes framework and ONS - Mid Year Population Estimates.

Period	Number of admissions per 100,000 population (age standardised)		
	Bury	North West	England
2010/11	628	750	652
2011/12	643	756	652
2012/13	616	731	637

Digestive disease including cirrhosis was a significant contributory factor in worsening life expectancy in Bury compared to national average (see Figure 11 and 12 above). Cirrhosis can affect anyone[19] and those that drink too much are often at risk. Community pharmacists are able to offer healthy lifestyle advice aimed at raising awareness of the harmful effects of excess alcohol. This can be through opportunistic advice and brief interventions. For example, this could be integrated into agreements around medication checks. Additionally for those patients who are picking up dental information, vitamins and any other related issues, alcohol awareness health information could also be provided. Most pharmacies have consultation rooms that could be shared with other community services[*].

Community pharmacists are potentially able to offer supervised monitoring of medicines to treat alcohol withdrawal and could through prescribing, or supply via a Patient Group Directions (PGD), provide medicines related to reducing alcohol intake[*].

5.4.7 Drug Misuse Related Harm

Illicit drug use contributes to the disease burden both globally and in Bury. Efficient strategies to reduce disease burden of opioid dependence and injecting drug use, such as delivery of opioid substitution treatment and needle and syringe programmes, are needed to reduce this burden at a population scale[20].

In 2011/12, the Home Office estimated the number of Opiate or Crack Users (OCU) in Bury being 856 individuals. When this is divided into a rate per 1000 population it works out at 7.09, which compares to rates of 9.99 in the North West and 8.4 for England. About half of this cohort is either already in, or is known to, our treatment services. These individuals present a variety of significant risk factors to Bury in terms of social and family impacts, health, crime and resources

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Figure 23: 2011/12 Estimated total number and prevalence rate of Opiate and/or Crack Cocaine use in Bury, regional and national levels.

Source: Public Health England

**OCU = Opiate and/or crack cocaine use, including those who inject either of these drugs. It does not include the use of cocaine in a powder form, amphetamine, ecstasy or cannabis, or injecting by people who do not use opiates or crack cocaine. Although many opiate and/or crack users also use these drugs it is very difficult to identify exclusive users of these drugs from the available data sources.*

Region	Local Authority	15-64 Population	Number of users	Rate per thousand of the population
			OCU*	
	Bury	120,700	856	7.09
North West	**-**	**4,639,600**	**46,337**	**9.99**
England	**-**	**34,991,400**	**293,879**	**8.40**

a) Needle Exchange

People who use illicit drugs are often not in contact with health care services and their only contact with the NHS may be through the service within a community pharmacy. At a minimum, the pharmacy can provide advice on safer injecting and harm reduction measures. In addition community pharmacies can provide information and signposting to treatment services, together with information and support on health issues other than those that are specifically related to the patient's addiction.

Currently there are seven pharmacies (see Figure 24) in Bury that provide access to sterile needles and syringes, and sharps containers for return of used equipment. The pharmacies can provide support and advice to the user, including referral to other health and social care professionals, specialist drug and alcohol treatment services where appropriate and promote safe practice to the user, including sexual health, STIs, HIV and Hepatitis C transmission and Hepatitis B immunisation*.

The contracted pharmacies provide sufficient level of privacy and safety and have a duty to ensure that pharmacists and staff involved in the provision of the service have relevant knowledge and are appropriately trained in operation of the service. Usage of the needle exchange services can be difficult to capture as users tend to provide little information which can be recorded.

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Figure 24: Bury Pharmacies commissioned to provide Needle Exchange Service by Ward



b) Supervised Consumption

In Bury, there are 15 pharmacies that provide supervised methadone/buprenorphine consumption. Contracted pharmacies aim to offer a user-friendly, non-judgmental, patient-centred and confidential service. They provide support and advice to the patient, including referral to primary care or specialist centres where appropriate.

Terms of agreement are set up between the prescriber, pharmacist, patient, and patient's key worker (a four-way agreement) to agree how the service will operate, what constitutes acceptable behaviour by the patient and what action will be taken by the Specialist Drug Treatment Service and pharmacist if the user does not comply with the agreement.

The pharmacy contractor has a duty to ensure that pharmacists and staff involved in the provision of the service have relevant knowledge and are appropriately trained in the operation of the service and are aware of and operate within local protocols. The pharmacy contractor must maintain appropriate records to ensure effective on-going service delivery and audit and share relevant information with other health care professionals and agencies, in line with locally determined confidentiality arrangements.

In Bury, there are also other non-pharmacy specialist drug services in the community which can offer doctor appointments, psychosocial interventions (including cognitive behavioural therapy), structured day programmes and substitute medication in community based settings. The Bury Drug and Alcohol Treatment Services must also be taken into account when looking to evaluate any drug misuse related services in community pharmacies.

Once patients are being treated within the NHS, community pharmacies can provide supervised administration of drug therapies and instalment dispensing. Patients often need support to prevent them stopping treatment.

In some cases a local pharmacy could, through independent or supplementary prescribing and PGDs provide support to the patients. This could cover both advice and immunisation to protect the person from diseases from blood-borne viruses. Testing for Hepatitis B and Hepatitis C and vaccination against Hepatitis B in community pharmacies are opportunities that could potentially be explored and piloted if it seems feasible to put the necessary systems in place[*]. The aim of such an initiative would be to facilitate access to services and thereby provide earlier diagnosis and/or protection, in a group that is both at high risk and hard to reach.

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Figure 25: Bury Pharmacies commissioned to provide Supervised/Observed Consumption Service by Ward



5.4.8 The Health of Older People

In Bury the proportion of 65-74 years old is expected to increase by 17% (over 2,700 more) by 2017. The over 75 year olds population is expected to increase by 13% (over 1,700 more). Preventative approaches are important to ensure older people remain healthy and independent in the community for longer, and to reduce the unsustainable cost of health and social care services for this growing population[21].

Community pharmacies can support self-care where appropriate, as well as referring back to the GP service or signposting patients to other appropriate services. Many patients receive a range of different medications and up to 50% of patients do not take their prescribed medicines as intended[22]. To help with this, particularly for those who have complex medication regimens or have problems with taking regular doses, pharmacists could offer advice and support to the patients, carers and to other healthcare professionals. This could be undertaken as part of a local clinical team whether in a pharmacy or other primary care setting.

A 'level 3 medication review' is a clinical medication review specifically undertaken by a doctor, nurse or pharmacist in the presence of the patient with access to the patient's clinical records and laboratory test results as required[23]. A level 3 medication review may be appropriate at agreed intervals for patients with a long-term condition, when a patient has recently been diagnosed with a long-term condition, when a patient has experienced an adverse effect associated with medicine-taking, when a patient/carer requests a review or reports that they have stopped taking a prescribed medication.

Target patient groups for level 3 medication reviews* include older people, care home residents, people on four or more medications, people receiving medications from different sources (e.g. GP and hospital), people recently discharged from hospital on complex medicines[23].

In the future, community pharmacists could become further involved in more targeted pharmaceutical care, for example, domiciliary visiting for those on complex medicine regimes, and also within the multidisciplinary care and case management teams, working closely with community matrons, care co-ordinators and the Medicines Management Team within Bury CCG.

New technologies are also being developed to assist patients in taking their medication as prescribed. Pharmaceutical service providers could have an increasing role to work with others in primary care team to utilise these to improve patient concordance.

5.4.9 Long Term Conditions (LTC)

Patients with LTCs are likely to be taking medicines, often several. These patients have a particular need to understand the role medicines play in managing their condition in order to gain maximum benefit and reduce the potential for harm. Several types of interventions (e.g. reduced dosing demands as well as monitoring and feedback) may help in improving medication adherence[24].

Under NHS contractual arrangements community pharmacists already have the opportunity to carry out MURs. Any issues or concerns raised are then referred to the appropriate health care professional for follow up. Pharmacy MURs are designed to improve the patient's understanding of the importance of the medicine in controlling their disease and

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the reason for taking medicine appropriately. These can improve patient concordance and support and reinforce the advice given by the prescriber. There are opportunities to increase the uptake of MURs and in the future to target pharmaceutical care towards complex cases.

The HWB and its partners recognise the importance of improving awareness of the risks associated with LTC. Health campaigns aimed at improving medicines-related care for people with LTC and therefore reducing emergency admissions could be provided through community pharmacies[*]. In addition pharmacists and their staff already provide a signposting service to other sources of information, advice or treatment.

Community pharmacists could be involved in monitoring the use of, for example: statins and blood pressure regulating medication and through supplementary or independent prescribing, making adjustments to the treatment being received by the patient[*].

Pharmacists are also involved in the early detection of some cancers, for example, through the provision of advice on skin care and sunbathing, and participating in the Be Clear on Cancer campaign[26], which aims to improve early diagnosis of cancer by raising awareness of symptoms and making it easier for people to discuss them with their GP.

5.4.10 Mental Health

About one in six adults have a mental health problem at any one time, equating to approximately 25,000 people in Bury[16]. Bury pharmacy staff can play a role in promoting awareness of good mental health, for example signposting to information about local support networks, mental health help lines etc.

Community pharmacists can also help by promoting simple mechanisms to help patients and carers understand and take their medicines as intended. If necessary the patient could receive medication by instalment dispensing or through supervised administration.

5.4.11 Healthcare Associated Infections

Pharmacy providers are involved in part of the public advice and campaign network to increase public awareness of antibiotic resistance and the rational approach to infection control matters regarding, for example, Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C. *diff).*

Senior specialist antimicrobial pharmacists within hospitals, primary care pharmacists and microbiology/infectious diseases/infection control teams must work together to develop, implement and monitor antimicrobial guidelines across the local health economy. This will involve community pharmacists and GPs working together with hospital teams to align prescribing with the agreed local policy.

Increasingly patients are treated with intravenous antibiotics at home and the patient's regular community pharmacy, together with hospital pharmacy services, should be aware of, and could be involved in their treatment.

Within primary care, dispensing staff are able to reinforce the message that antibiotics are not always necessary and explain the relationship between excessive use of antibiotics and Health Care Acquired Infections (HCAI). In addition they are able to inform other primary care practitioners when an item prescribed is not normally available in the community. The

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minor ailment service (detailed below) allows pharmacists to provide symptom relief for viral infections, reassure patients that they do not need antibiotics and reduce pressure on GPs to prescribe unnecessarily.

5.4.12 Medication Related Harm

The National Patient Safety Agency (NPSA) report - Safety in doses: improving the use of medicines in the NHS[27], stated the following

- The most serious incidents included 100 medication related incident reports of death and severe harm.
- The most serious incidents were caused by errors in medicine administration (41%) and, to a lesser extent, prescribing (32%).
- Three incident types – unclear/wrong dose or frequency, wrong medicine and omitted/delayed medicines – accounted for 71% of fatal and serious harms from medication incidents.

In the community, pharmacists should work with GPs and nurse prescribers to ensure safe and rational prescribing of medication. NHS England works with all pharmacies and other agencies to ensure that they are contributing to the system wide implementation of safety alerts – for instance NPSA alerts on: anticoagulant monitoring, methotrexate, lithium safety, cold chain integrity etc.

Through the provision of MURs, clinical screening of prescriptions and identification of adverse drug events pharmacy staff work with patients to help them understand their medicines. This also ensures that medicines are not omitted unnecessarily and that medication allergies and dose changes are clearly documented and communicated.

5.4.13 Community Pharmacy Common Ailments Service

The White Paper Pharmacy in England – Building on Strengths, Delivering the Future[28] set out the introduction of minor ailments services that promotes pharmacy as the first port of call for people with minor ailments and complements GP and out-of-hours medical provision.

A common ailments service is commissioned by Bury CCG. The service aims to provide greater choice for patients and carers, and improved access to health care professionals by utilising the expertise of the pharmacists, so they become the first port of call for common ailments. This can complement other medical services provisions and educate patients in self-care, thereby reducing the impact on GP consultations.

Currently all patients (excluding pregnant and breastfeeding women) registered with a GP surgery located within the boundaries of Bury can use the service, There are currently 34 registered pharmacies contracted to provide the common ailment service in Bury.

5.4.14 Community Pharmacy Palliative Care Service

Palliative care is the care of any patient with an advanced, incurable disease. It involves the control of symptoms, such as pain and aims to improve quality of life for both patients and their families.

Drug treatment plays a major role in symptom control in palliative care. The aim is to ensure that appropriate palliative care drugs are available in the community at the point of need which may be urgent and/or unpredictable. All pharmacies carry stock of regularly prescribed palliative care drugs and can obtain stock of other items quickly when needed. The enhanced service is to ensure access to urgently required items outside of normal opening hours. In addition to the prompt supply, pharmacies can support carers and

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clinicians by providing them with up to date information and advice, and referral where appropriate.

In Bury one designated community pharmacy is contracted to hold the essential, locally agreed palliative care drugs for easier access out of pharmacy opening hours.

5.4.15 Healthy Living Pharmacies (HLP)

The Healthy Living Pharmacy (HLP) framework is a tiered commissioning framework aimed at achieving consistent delivery of a broad range of high quality services through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities.

The HLP programme initiative provides a framework for commissioning public health services through three levels of increasing complexity and required expertise with pharmacies aspiring to go from one level to the next. It is also an organisational development framework underpinned by three enablers of:

- workforce development – a skilled team to pro-actively support and promote behaviour change, improving health and wellbeing;
- premises that are fit for purpose; and
- engagement with the local community, other health professionals (especially GPs), social care and public health professionals and Local Authorities.

Where commissioners wish to adopt the HLP principles then community pharmacies wishing to become HLPs are required to consistently deliver a range of commissioned services based on local need and commit to and promote a healthy living ethos within a dedicated health-promoting environment.

There are currently 16 pharmacies working towards HLP status in Bury, and the plan is to expand this to more pharmacies over the next 3 years.

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5.5 Public Survey

Further to the health needs identified through the local statistics by the HWB, the public also have opinions about how they would like their pharmacies to provide services. These were explored in a survey which the PNA steering group developed. Details of the survey methodology and findings together with a copy of the questions asked can be found in Appendix 7.

Summary of the Bury Public Survey

A survey about local pharmacy provision was created and ran from the 7th April 2014 until the 25th May 2014 to gather people's views on what works well, and what could be improved.

The survey was completed by 79 people with the majority of respondents being female aged between 45-64 years old and was of a White British ethnicity.

The results to the survey of pharmacy services and experiences tell a positive story about the pharmacy services in Bury. Shortage of provision is not an issue; most residents (83%, n=65) use a regular or preferred pharmacy. The most commonly selected reason for using a pharmacy was location and the proximity to the respondent's home or doctors. Friendly and knowledgeable staff is the most frequent service-related factor selected.

Pharmacies are easily accessible with the majority of respondents (85%) travelling less than two miles to the pharmacy on foot (43%, n=28) or car, either as a driver or passenger (54%, n=35). It was noted that 1% (n=3) of respondents are unable to get to a pharmacy of their choice due to mobility issues.

With regards to opening hours, only 12% (n=10) of respondents were unsatisfied by current opening hours. The majority of unsatisfied respondents live in the M45 postcode area (Whitefield and Unsworth Township). While the majority of respondents were satisfied with opening hours, 62% (n=21) of respondents from the M25 postcode area (Prestwich Township) would use pharmacies if open late at night and 47% (n=16) would use pharmacies if open on a Sunday. There is currently only one pharmacy in the Prestwich Township area offering extending opening hours.

When asked about their knowledge, awareness and use of pharmacy services such as blood pressure checks only 11% (n=8) of respondents use this service although 36% (n=28) of respondents would use this service if available; therefore pharmacies who provide this as part of their business model may wish to advertise this service more. Also if commissioners identified a need for particular services then it would be worthwhile investing in the promotion or communication of the service to ensure the public took full advantage of it. A small number of respondents did not feel that their needs were met when using some services in particular Electronic Prescription Service (EPS) and Minor Ailments scheme. This should be addressed when a service review is undertaken

Overall, the majority of respondents (91%, n=70) were either satisfied or very satisfied with all aspects of service they receive from their pharmacy. There were however, a small number of respondents who were unsatisfied with waiting times and private consultation areas.

A key recommendation arising from these results would be that the council, CCG and pharmacies need to communicate better benefits of accessing additional services from the pharmacies as on average over 77% of respondents have not used services already on

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offer. There may be a number of reasons for this including, lack of awareness and the service in community pharmacy does not meet their needs.

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6.0 Current Pharmacy Provision and Services

This section examines in more detail the level of dispensing activity, access and locations of pharmacies in the Bury area. The levels of provision of pharmaceutical services locally are compared with provision elsewhere, and are considered in the context of feedback from local stakeholders.

6.1 Overview

Community pharmacies and pharmacists have an impact on the health of the population by contributing to the safe and appropriate use of medicines. This section aims to assess the adequacy of pharmaceutical provision and information was collected up until 30th June 2014. Up-to-date information on community pharmacies (including opening hours) is available on the NHS website:
www.nhs.uk/servicedirectories/Pages/ServiceSearch.aspx

Following the review, this PNA has not identified a current need for new NHS pharmaceutical providers in the Bury area except with the Besses Ward. There are a number of reasons to support this conclusion:

- There are 41 pharmacies in Bury, an increase from 38 in the previous PNA in 2011.
- The dispensing of appliances has not been raised as an issue during the pre-consultation on the PNA as appliances are also available from community pharmacies and nationwide DACs.
- There are three distance-selling pharmacies in Bury.
- Patients have the right to access pharmaceutical services from any community pharmacy including mail order/wholly internet pharmacy of their choice and therefore can access any of the many distant selling pharmacies available nationwide.
- There are 22 pharmaceutical service providers per 100,000 registered populations in Bury. This is less than the North West region average of 26 per 100,000 but equal to national average of 22 per 100,000.
- Each month the Bury pharmacies dispense on average slightly more items than the monthly national and North West regional average items.
- Items prescribed by the Bury CCG GPs - over 91% (3.3million items/year) are dispensed within the Bury area pharmacies.
- Approximately, 7% (250 thousand) of items annually were dispensed by non-Bury Borough pharmacies however, the majority of these (over 82%) were dispensed within Greater Manchester.
- Just over 1% of Bury prescribed items are dispensed out of the Greater Manchester region.
- Pharmacies are easily accessible with the majority of respondents (85%) travelling less than two miles to the pharmacy on foot (43%) or by car, as a passenger or driver (54%).
- It was noted that only around 1% of the survey respondent are unable to get to a pharmacy of their choice due to mobility issues.
- The level of car ownership throughout the Bury area (76% of households own at least one car) is greater than both the regional (72%) and national average (74%).
- Home delivery services can help to provide medications to those who do not have access to a car or who are unable to use public transport.
- Bury with the exception of Besses Ward has good coverage in terms of their locations of pharmacies across the council in all areas of high population density.
- Five pharmacies have 100-hour contracts in the Bury area. They are centrally located and accessible by public transport, walking or own transportation.

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- It is considered maintaining the current availability and distribution of 100 hour/longer opening pharmacies is important to ensure high quality out-of-hour access for the population.
- Over two thirds of the pharmacy contractors in Bury are open on a Saturday and access can be found between the hours of 6am to midnight within Bury. This gives adequate cover for Bury (except in Besses Ward) on Saturdays both in terms of opening hours and number of locations.
- On Sunday only a quarter of pharmacy contractors in Bury are open. However, the public survey identified only 12% (n=10) of respondents were unsatisfied by the current pharmacy opening hours.
- 62% of respondents from the Prestwich Township postcode area would use pharmacies if open late at night and 47% would use pharmacies if open on a Sunday. There is currently one pharmacy in this area offering extended opening hours.
- The Wards, Radcliffe North and Besses have no pharmacies within their boundaries. However, the public survey did not identify concerns with accessing pharmaceutical services in both these areas.
- Representatives of the local community for Besses have highlighted to Bury's HWB and CCG the lack of easy access to pharmaceutical services. After due consideration it has been concluded that there is a need for greater provision of pharmaceutical services within the Besses Ward for the following reasons:
  - Besses Ward has three LSOAs which are ranked in the worst 10% for deprivation
  - There are a large number of households with no access to a car or van
  - Although there is reasonable access to public transport, the cost is a deterrent to its use
  - Besses Ward has high levels of teenage conception, smoking prevalence and known drug-use
- Besses Ward does have a need for additional pharmaceutical provision and this should be located within the Hillock Estate. Any new pharmacy contractor should deliver all locally commissioned services that will support this population.
- Due to changes in shopping habits a number of pharmacies now open on many Bank Holidays although they are not contractually obliged to do so. GMAT works with community pharmacies to ensure an adequate rota service is available for Christmas Day, Boxing Day, New Year's Day and Easter Sunday as these are days where pharmacies are traditionally closed.
- Bury CCG's successful bid of the Prime Minister's Challenge Fund (PMCF) to support the Easy-GP pilot project aims to increase patient access to practices and create an additional 150,000 appointments per year**.** Some existing pharmacies near the selected pilot sites may see a benefit in amending their opening hours to support this initiative.
- Bury West Township and Ramsbottom, Tottington and North Manor Township had less weekend access in comparison to other Bury townships.
- In the Bury West Township (Church and Elton Wards) there are a significant proportion of Bury's pharmacies in the neighbouring Bury East Township (East, Moorside and Redvales Wards) which are accessible to the population via public transport, walking or their own transportation
- Similar to Bury West, Ramsbottom, Tottington and North Manor Township have no pharmacies open on Sundays. However, such wards are considered predominately the least populated, least deprived within Bury and are likely to have access to transportation allowing patients to travel within the area to another location quite readily.
- The conclusion drawn in term of the access to pharmacies around Bury is that most wards (except Besses) have a satisfactory access to pharmacy services across the area. In time, if gaps in opening times are identified, these should be addressed initially through dialogue with existing specific contractors.

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6.2 Change in Number of Pharmacy Contractors from 2011

According the previous PNA and 2011 data, there was in total 38 pharmacies in Bury. At ward level there have been some changes in the number of community pharmacies and to date (30th June 2014) there are now a total of 41 community pharmacy contractors across the Bury HWB footprint. Of these five have 100 hour contracts and three are distance-selling pharmacies. There are no DACs in the Bury area (Figure 26).

Figure 26: Number of Pharmacy and GP contractor at Bury Ward/Township level

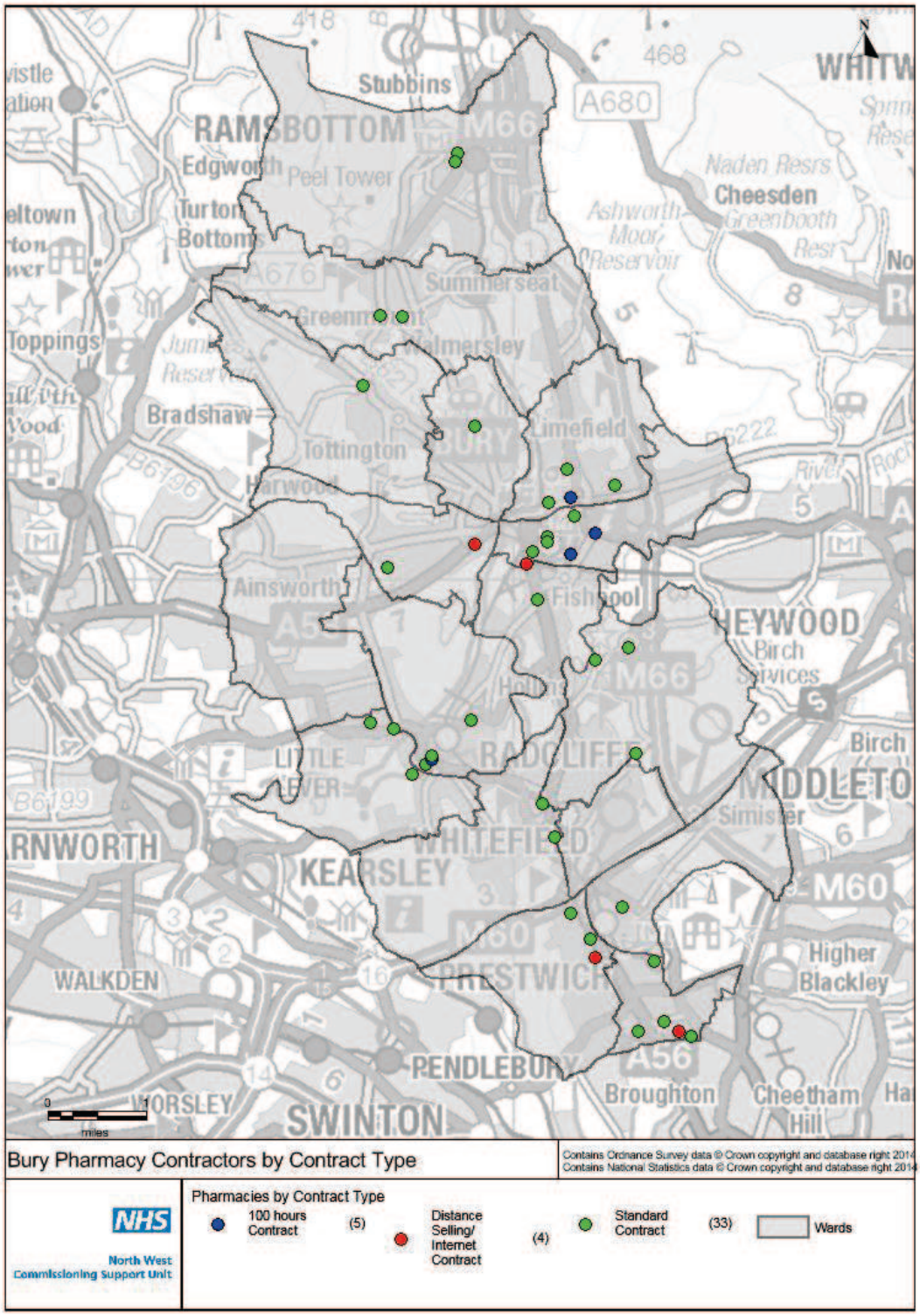
Bury Township	Ward	Population (2011 Census)	Number of pharmacies in 2011	Number of pharmacies in 2014	100 hour contract pharmacies in 2014	Number of GP surgeries in 2014
Bury East	East	10,636	5*	7*	2	10
	Moorside	12,013	4	5	2	2
	Redvales	11,529	1	1	0	0
		Total	10	13	4	12
Bury West	Church	10,345	2	2	0	1
	Elton	11,494	1	1	0	1
		Total	3	3	0	2
Prestwich	Holyrood	11,183	1	1	0	2
	Sedgley	13,021	4	6***	0	2
	St Mary's	10,175	2	1	0	2
		Total	7	8	0	6
Radcliffe	Radcliffe East	11,324	4	5	1	5
	Radcliffe West	11,185	3	2	0	0
	Radcliffe North	11,164	0	0	0	0
		Total	7	7	1	5
Ramsbottom, Tottington and North Manor	North Manor	9,842	2	2	0	2
	Ramsbottom	11,738	2	2	0	1
	Tottington	9,783	2	1	0	1
		Total	6	5	0	4
Whitefield and Unsworth	Pilkington Park	9,784	2	1	0	1
	Unsworth	9,490	3	4	0	3
	Besses	10,712	0	0	0	0
		Total	5	5	0	4
		Grand Total	38	41	5	33

**Figure includes the distance selling pharmacy known to be in Bury East Ward*
*** Figure includes the distance selling pharmacy known to be in Sedgley Ward*

6.3 Pharmacies Per Locality

There have been minimal changes in the number of pharmacy service providers at ward level in Bury (see Figure 26). The map below (Figure 27) shows the location of each community pharmacy service provider at ward level.

Figure 27: Bury Pharmacy contractor location with Ward boundaries (Dec 2014)



Of the 41 pharmacies in Bury, five are 100 hour contracted community pharmacies and three are distance-selling pharmacies. Patients have the right to access pharmaceutical services from any community pharmacy including mail order/wholly internet pharmacy of their choice and therefore can access any of the many distant selling pharmacies available nationwide.

There are no DACs within the Bury area. However, appliances are also available from community pharmacies and other DACs from outside the area. The dispensing of appliances has not been raised as an issue during the pre-consultation on the PNA. On the basis of this information it can be concluded that there is adequate access to these services in Bury.

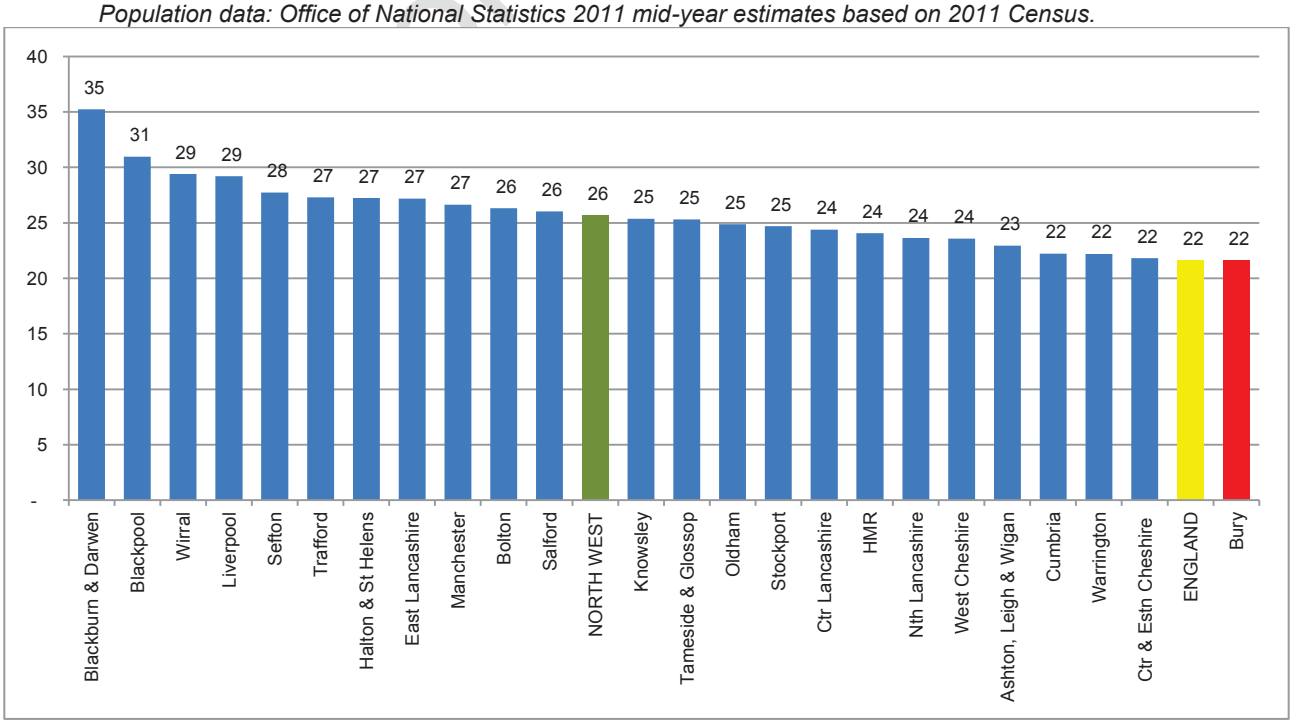
6.4 Pharmacies per Head of Population vs. National/ North West level and neighbouring former PCT (March 2013) [11]

Based on community pharmacy dispensing data of the 24 former North West PCTs Health and Social Care Information Centre (HSCIC) 2012-13 data, the following comparisons are made with the national and regional averages:

- There are 22 pharmaceutical service providers per 100,000 registered populations in Bury. This is less than the North West region average of 26 per 100,000 but equal to the national average.
- Bury had an average prescription items per month per pharmacy of 7264. Knowsley had the highest rate in the North West dispensing on average 8068 items per month compared to Blackburn with Darwen dispensing the lowest average items of 5,343 per month.
- Each month Bury pharmacies dispense on average more items than the monthly national and North West regional average items. However this does not take into account other DACs and distance-selling pharmacies outside the area.

Figure 28: Number of pharmacies per 100,000 population (31st March 2013)

Source: NHS Prescription Services of NHS Business Services Authority.
Population data: Office of National Statistics 2011 mid-year estimates based on 2011 Census.



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6.5 Dispensing Activity[11]

The Bury area is considered to have a higher than average monthly items per pharmacy compared to national and regional statistics. However, the current number of pharmacy contractors is considered sufficient for the higher than average prescription numbers. There could be a number of reasons for this including greater deprivation often increases the use of healthcare service rather than self-care and consequently increases prescribing. Another reason could be CCG encouragement to prescribers to supply fewer quantities but more frequently i.e. 28 day prescribing.

Community pharmacies could be used to move prescribing of common ailments away from general practice so that GPs can concentrate on the management of long-term conditions. This may also reduce the number of items per month prescribed.

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Figure 29: Number of Pharmacies per 100,000 Population, 2012-13

Source: NHS Prescription Services of NHS Business Services Authority.
Population data: ONS 2011 mid-year estimates based on 2011Census.

	Number of community pharmacies	Prescription items dispensed per month (000)s, 2012-13	Population (000)s Mid 2011 (1)	Pharmacies per 100,000 population, 2012-13	Average items per pharmacy per month 2012-13
England	**11,495**	**76,191**	**53,107**	**22**	**6,628**
North West	**1,812**	**12,334**	**7,056**	**26**	**6,807**
Ashton, Leigh and Wigan	73	523	318	23	7,159
Blackburn with Darwen Teaching	52	278	148	35	5,343
Blackpool	44	350	142	31	7,958
Bolton	73	494	277	26	6,766
Bury	**40***	**291**	**185**	**22**	**7,264**
Central & Eastern Cheshire	101	737	463	22	7,293
Central Lancashire	114	738	467	24	6,474
Cumbria	111	765	500	22	6,888
East Lancashire	104	646	383	27	6,210
Halton and St Helens	82	579	301	27	7,063
Heywood, Middleton & Rochdale	51	374	212	24	7,337
Knowsley	37	299	146	25	8,068
Liverpool	136	866	466	29	6,365
Manchester	134	817	503	27	6,100
North Lancashire	76	577	322	24	7,587
Oldham	56	394	225	25	7,044
Salford Teaching	61	461	234	26	7,561
Sefton	76	543	274	28	7,147
Stockport	70	504	283	25	7,199
Tameside and Glossop	64	455	253	25	7,104
Trafford	62	401	227	27	6,467
Warrington	45	316	203	22	7,023
Western Cheshire	56	358	237	24	6,400
Wirral	*94*	*570*	*320*	*29*	*6,062*

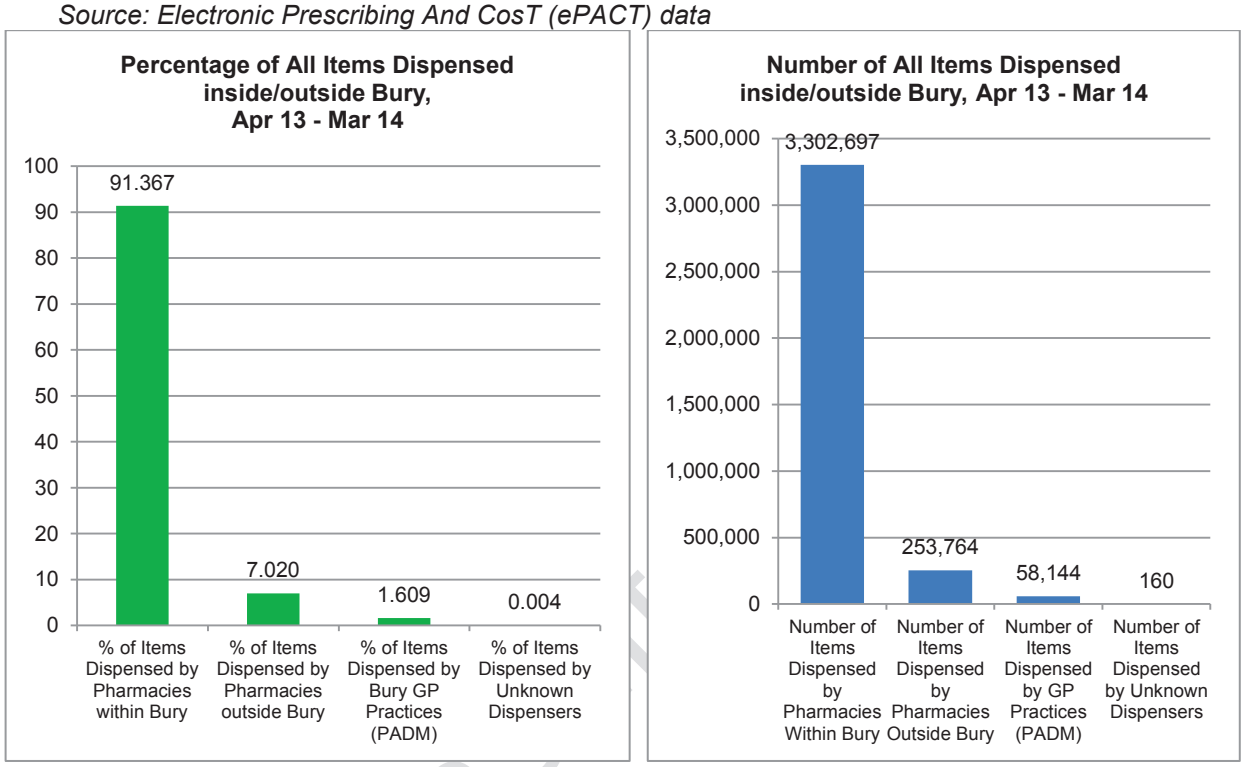
**According HSCIC 2012-13 data Bury has 40 pharmacies. To date (30th June 2014) Bury has 41 community pharmacy providers.*

6.5.1 Dispensing activity: Where are Bury Prescriptions Dispensed? [29]

Using data taken from electronic prescribing and cost (ePACT) tool for the year from April 2013 to March 2014 it can be seen that for all the items issued by Bury GPs that over 91% (3.3 million items) are dispensed within Bury pharmacies (Figure 30).

Figure 30: Percentage and Number of items issued by Bury prescribers which are dispensed within Bury pharmacies

Source: Electronic Prescribing And CosT (ePACT) data



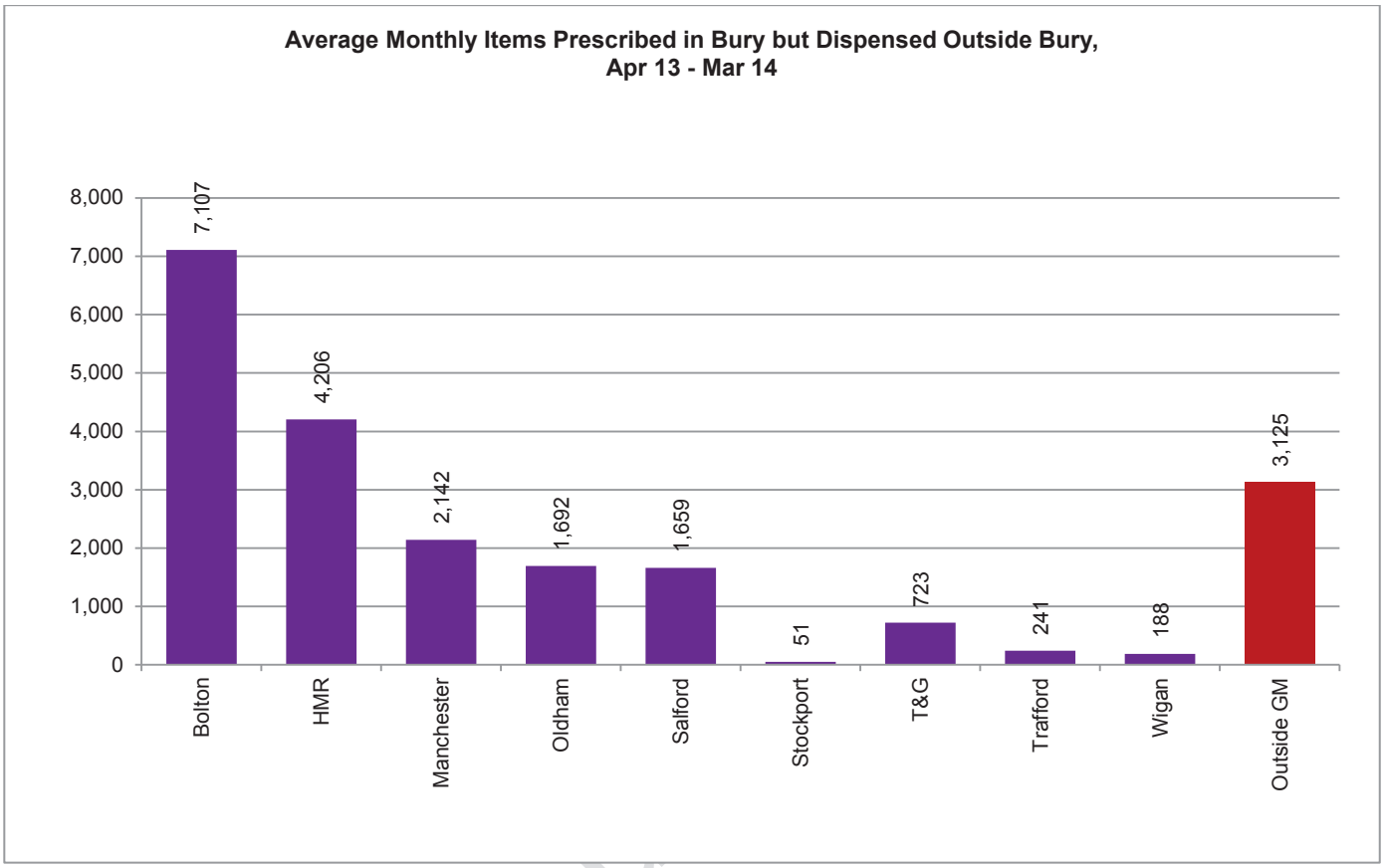
Of the 7% (250,000 items) which were dispensed by non-Bury pharmacies the majority (over 82%) was dispensed within Greater Manchester. The most (39%) being in the Bolton Local Authority area, where over 7000 items per month prescribed in Bury is dispensed in Bolton (see Figure 31). This could predominantly due to the fact that Bolton border covers a large area of Bury and potentially significant numbers of commuters travelling into Bolton to work.

Just over 1% of Bury prescribed items is dispensed outside of Greater Manchester region. This information leads us to the conclusion that for the prescriptions generated by Bury prescribers (i.e. predominately for Bury residents) the current number of dispensing pharmacy contractors within Bury is sufficient.

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Figure 31: Average number of monthly items issued by Bury prescribers but dispensed outside Bury HWB footprint

Source: ePACT



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6.6 Access to Pharmacies by Location

The 2008 White Paper Pharmacy in England: Building on strengths – delivering the future states that it is a strength of the current system that community pharmacies are easily accessible, and 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[28].

The public survey noted that over 85% of respondents were travelling less than two miles to their pharmacy and over 97% would either walk or use a car for transport. It was noted that 1% of the survey respondent are unable to get to a pharmacy of their choice due to mobility issues. Although, a very small percentage had mobility issues, barriers to accessing services are a key driver behind health inequalities and should be a key consideration in commissioning services.

The Wards, Radcliffe North and Besses have no pharmacies within their boundaries. The pre-consultation public survey did not identify concerns with accessing pharmaceutical services in both these areas. However, representatives of the local community from Besses have directly raised concerns to the HWB and CCG with regards to the lack of access to pharmacy services. After due consideration it has been concluded that there is a need for greater provision of pharmaceutical services within the Besses Ward for the following reasons:

- Besses Ward has three LSOAs which are ranked in the worst 10% for deprivation
- There are a large number of households with no access to a car or van
- Although there is reasonable access to public transport, the cost is a deterrent to its use
- Besses Ward has high levels of teenage conception, smoking prevalence and known drug-use

Whereas for Radcliffe North Ward it has:

- A relatively low population
- A high number of households with cars and therefore less affected by accessibility to pharmacies to neighbouring ward.
- Pharmacies accessible by walking, public transport or own transportation within neighbouring wards both inside and outside of Bury
- There has been no complaints or public representation concerning access to pharmaceutical services

Based on these finding it is considered that the population of Radcliffe North Ward are adequately served by other pharmacies within a mile distance or by pharmacies offering home delivery service.

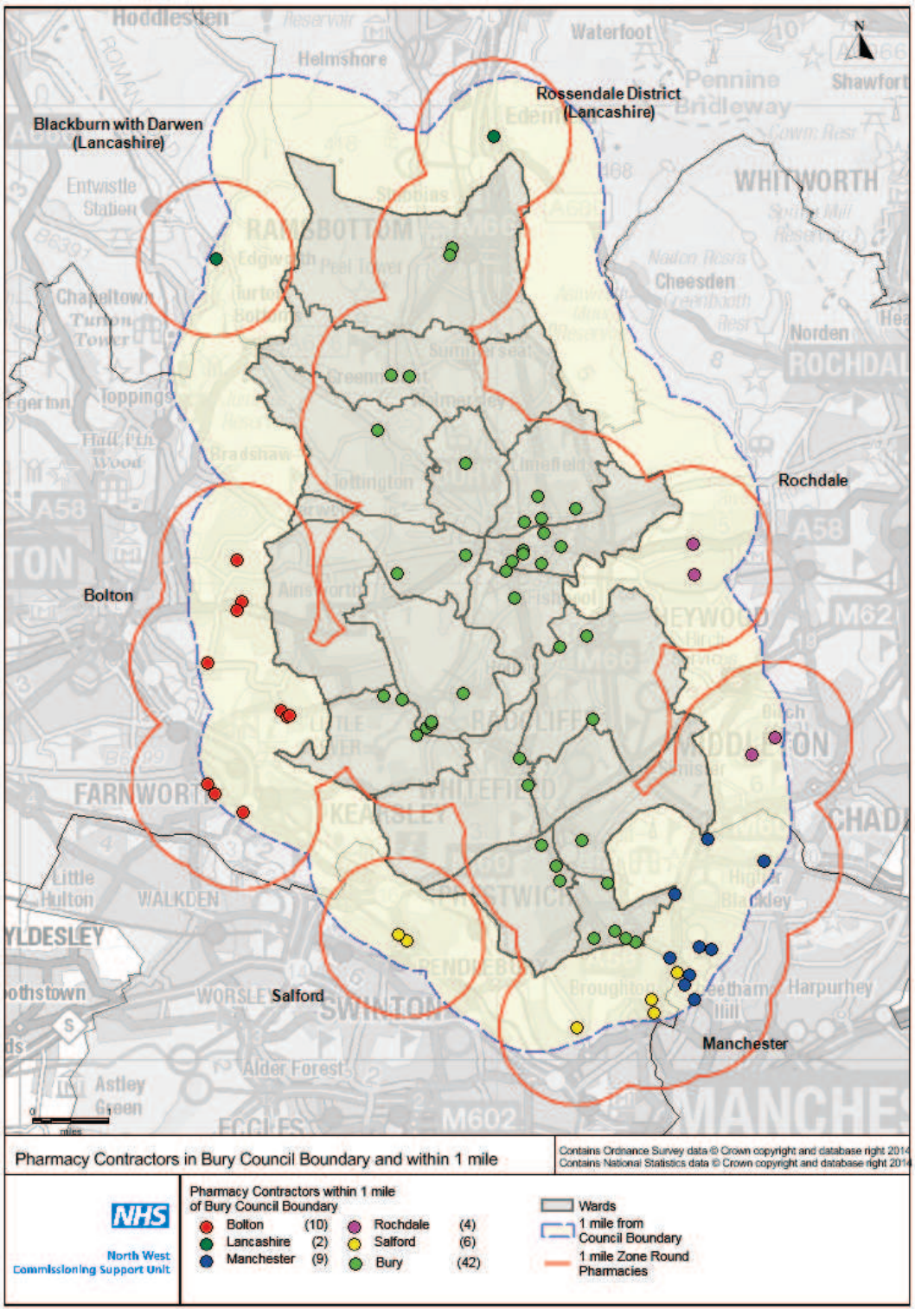
Besses Ward does have a need for additional pharmaceutical provision and this should be located within the Hillock Estate. Any new pharmacy contractor should deliver all locally commissioned services that will support this population. At the moment these locally commissioned services include smoking cessation support, chlamydia screening and treatment, minor ailments treatment, provision of EHC, needle exchange and observed consumption to support recovery of drug misuse. Any pharmacy contractor would be expected to deliver pharmaceutical services including all essential and at least two of the advanced services, MUR and NMS (subject to continuation of commissioning).

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In addition to the above recommendation, a need has been identified for the following hours of pharmaceutical service availability.

- Monday to Friday - a minimum of 40 hours between 08:30 and 18:00 hours daily;
- And Saturday - a minimum of 5 hours between 10:00 and 18:00 hours;
- And Sunday - a minimum of 2 hours between 11:00 and 15:00 hours.

Figure 32: Bury Pharmacies mapped against one mile buffer zone



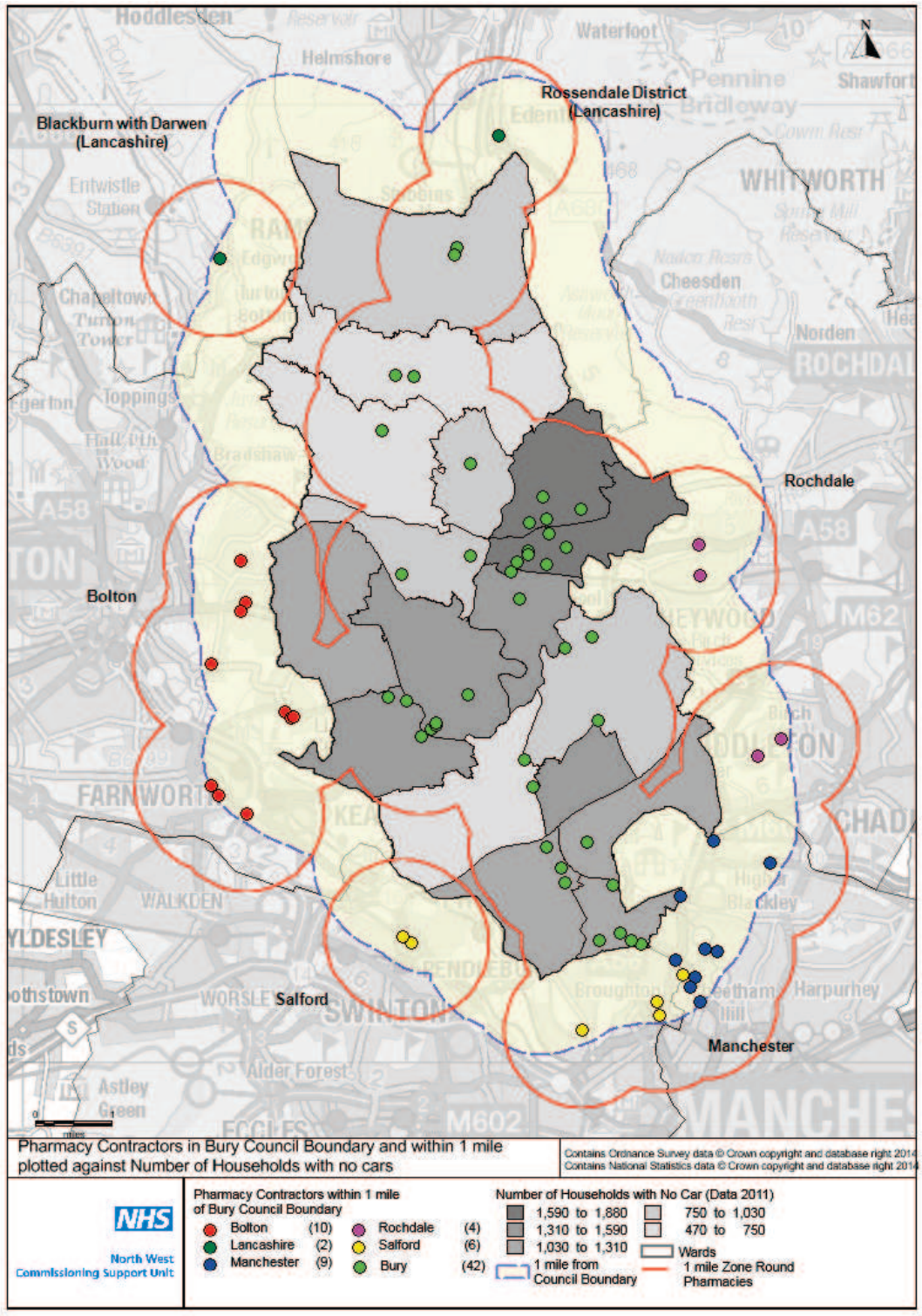
Having access to transport is an obvious important factor in considering accessibility of services for our population. However, it is extremely difficult to define the relative accessibility of a particular service without making some inevitable assumptions about the relevant population needing that service. For example, one could map walk or drive times, but that would assume that all in the relevant population are equally capable of making such journeys. Some people may have poor mobility, some may be frightened to go out and others may not have access to a car or bus. Data is available around number of households with no car ownership at ward level and this is detailed in Figure 33.

Both Bury East and Moorside Wards have the greatest number of households with no access to a car. However, as per Figure 33 there is good coverage in a one mile buffer zone of those pharmacies. In addition, most pharmacies offer the added value service of home delivery which can help to provide medications to those who do not have access to a car or who are unable to use public transport. Another support is also available from distant selling pharmacies (located within and outside of the Bury HWB footprint) that could make deliveries to individual homes.

The level of car ownership throughout Bury (76% of households own at least one car) is higher than both the regional and national average. It is recognised that not everyone has access to a car, and that those unable to access a car may be amongst the more vulnerable in society. NWCSU considered creating maps to illustrate access through public transport, but found that this information could not be easily presented due to complexity and constantly changing nature of public transport routes and service times.

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Figure 33: Thematic map of Bury and Wards with Households with No Car



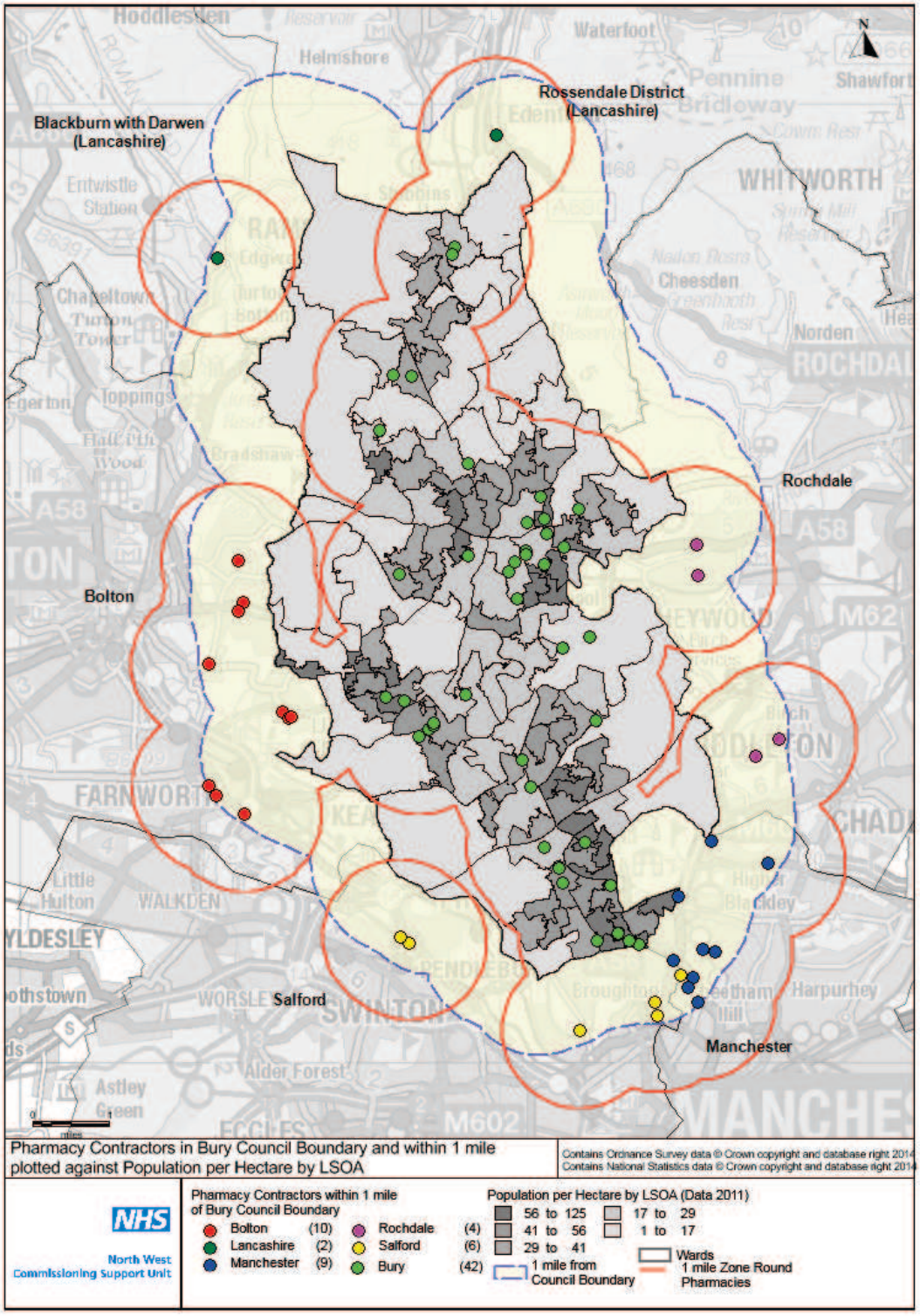
6.6.1 Unpopulated Areas

Figure 34 indicates that there are some areas in Bury where it is necessary to travel further than one mile to access a pharmacy. However, these areas e.g. Holcombe Moor and other surrounding Moors are considered rural and largely uninhabited.

It can be considered that Bury has satisfactory coverage in terms of their locations of pharmacies across the council in all areas of high population density, except Besses Ward. The pharmacy provision 'as the crow flies' is satisfactory, and apart from Besses Ward, there is no need for a pharmacy contract to be established to provide cover for the lack of a pharmacy within one mile of any lightly populated areas of Bury.

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Figure 34: Population per Hectare by LSOA and Pharmacy locations



6.6.2 Services provided Across the Border of Bury in Other Local Authority areas

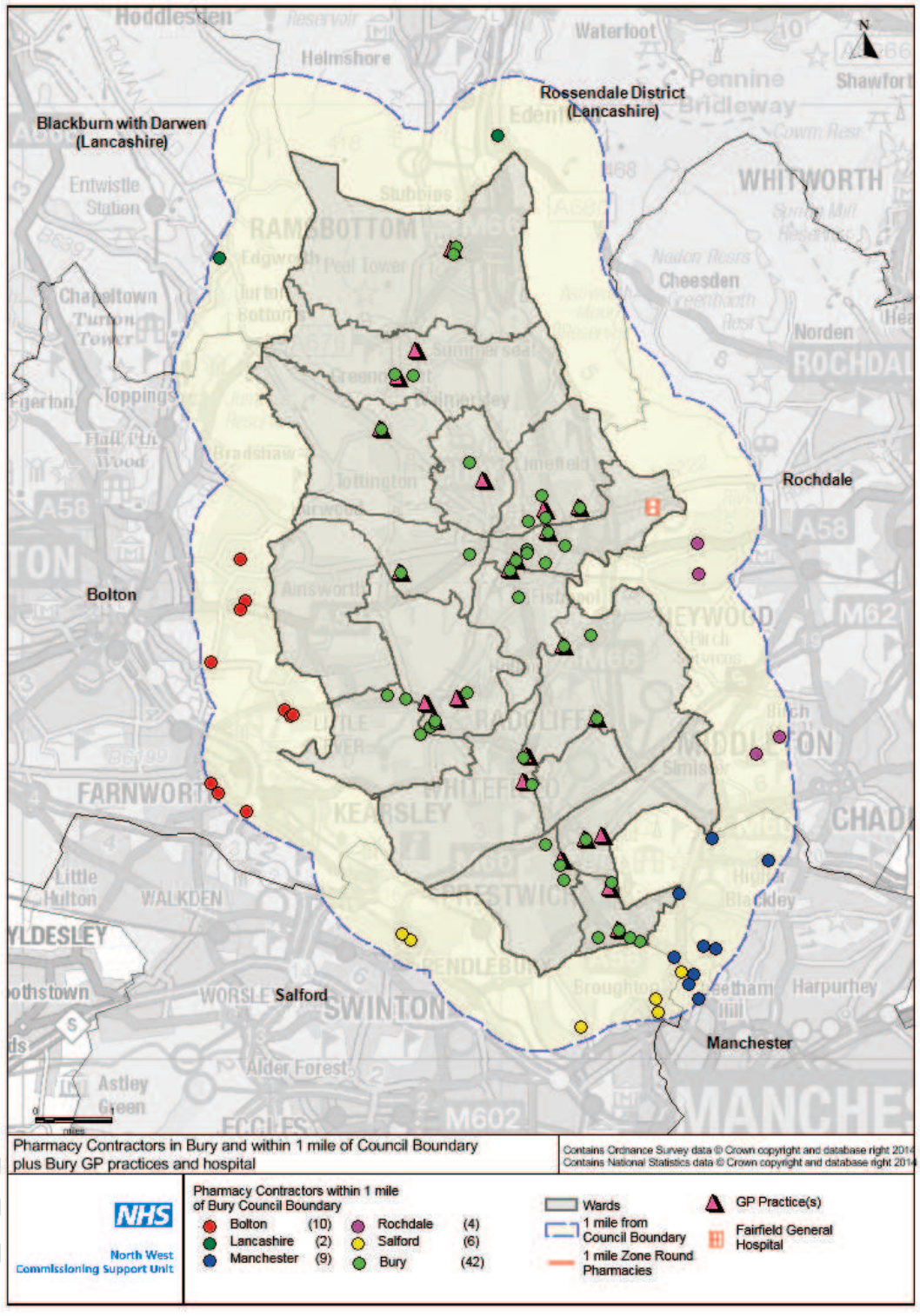
In making its assessment the HWB needs to take account of any services provided to its population which may affect the need for pharmaceutical services in its area. This could include services provided across a border to the population of Bury Council by pharmacy contractors outside their area, or by GPs, or other health service providers

Figure 35: Postcode boundary across Greater Manchester



During the development of this PNA the NWCSU evaluated the Local Authorities that border the Bury area (Blackburn and Darwen, Bolton, Lancashire County, Manchester City, Rochdale and Salford). The aim was to identify the access to, and provision of, pharmaceutical services to the Bury population who may access them along the borders of neighbouring localities. For example, a pharmacy in a neighbouring locality may be closer to a resident's home or place of work although they are registered for NHS services with Bury CCG. Figure 36 shows the locations of these cross border pharmacies and a list of the contractors is available in Appendix 4

Figure 36: Map of cross border non-Bury Community Pharmacies in a One Mile Buffer Zone



6.7 Access to Pharmacies by Opening Hours

For a map showing location of pharmacy opening hours see Figure 37 below. The pharmacies are colour coded to represent the hours they are open, the same coding is used in the table of opening hours in Appendix 8. A summary of community pharmacy opening hours on weekends can be seen in Figure 38.

There are currently five pharmacies contractually obliged to open for 100 hours per week due to the conditions on their application. This inevitably means that they are open until late at night and at weekend. There is a risk that if the regulations for these contracts were to change that they may reduce their hours. This could significantly reduce the area's network of late night and weekend pharmacies.

This will be of particular importance in respect of Bury CCG's successful bid in December 2013 to the PMCF. The aims of the PMCF are to improve access to GPs and test innovative ways of delivering GP services. In Quarter 3 2014/15 Bury will be begin a pilot of the Easy-GP Project which aims to help the population of Bury who might struggle to attend appointments during the day to access practices opening 8am to 8pm on weekdays, and 8am to 6pm at weekends and create an additional 150,000 appointments a year**.** Patients will also be able to use a new smartphone application to order prescriptions and book appointments direct.

At the time of writing this PNA, existing community pharmacy contractors are being consulted on the proposed pilot Easy-GP Project and the potential impact it could have on patient access to treatment. It is recognised that the provision of a prescription for dispensing at a pharmacy during out-of-hours is preferable to GPs stocking and supplying a restricted range of medicines. As a result some pharmacies near the selected pilot sites may be requested to extend their opening hours to support the Easy-GP Project. Any changes will then be monitored so that supplementary statements to the PNA can be produced, in accordance with regulations.

Since the introduction of the pharmaceutical contractual framework in 2005, community pharmacies do not need to participate in rota provision to provide access for weekends or during the evening. The need for such a service has been greatly reduced by the increased opening hours of a number of pharmacies including 100 hour pharmacies. In addition, due to changes in shopping habits a number of pharmacies now open on many Bank Holidays, although they are not contractually obliged to do so. GMAT works with community pharmacies to ensure an adequate rota service is available for Christmas Day, Boxing Day, New Year's Day and Easter Sunday as these are days where a majority of pharmacies are traditionally closed. The arrangements are renewed each year.

For a number of conditions there is also a range of general sales list medications that are available from a range of extended opening hour retailers such as garages and 24-hour supermarkets.

The public survey identified only 12% (n=10) of respondents were unsatisfied by the current pharmacy opening hours with the majority of those respondents living in the Whitefield and Unsworth Township postcode area. This Township includes Pilkington Park, Unsworth and Besses Wards.

With the exception of Besses Ward (see Section 6.6 above), the general consensus is that current pharmacy provision addresses the needs of people in Bury. It is considered maintaining the current availability and distribution of 100 hour/longer opening pharmacies is important to ensure high quality out-of -hours access for the population.

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Figure 37: Bury Pharmacy location and opening hours by Ward level

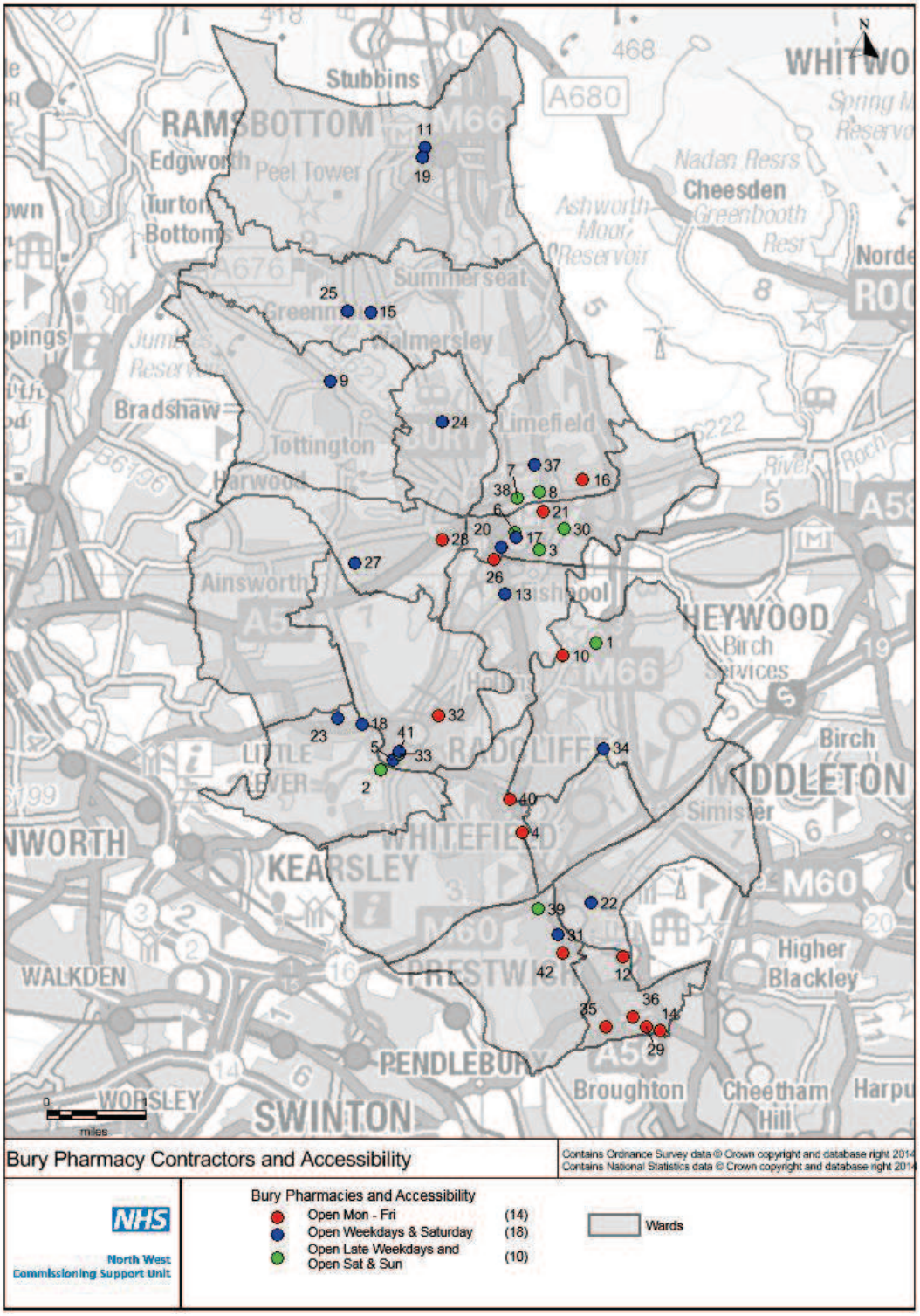


Figure 38: Number of Pharmacy at Bury Ward/Township level with Opening Times

Bury Township	Ward	Population (2011 Census)	Number of pharmacies in 2014	100 hour contract pharmacies in 2014	Number of pharmacies open on a Monday (earliest opening and latest closing times)	Number of pharmacies open on a Tuesday (earliest opening and latest closing times)	Number of pharmacies open on a Wednesday (earliest opening and latest closing times)	Number of pharmacies open on a Thursday (earliest opening and latest closing times)	Number of pharmacies open on a Friday (earliest opening and latest closing times)	Number of pharmacies open on a Saturday (earliest opening and latest closing times)	Number of pharmacies open on a Sunday (earliest opening and latest closing times)
Bury East	East	10,636	7*	2	7 (6am-11:59pm)	7 (6am-11:59pm)	7 (6am-10pm)	7 (6am-10pm)	7 (6am-10pm)	5 (6am-10pm)	3 (10am-6pm)
	Moorside	12,013	5	2	5 (8am-11:59pm)	5 (8am-11:59pm)	5 (8am-11:59pm)	5 (8am-11:59pm)	5 (8am-11:59pm)	4 (7am-11:59pm)	3 (12am-2am & 10am-5pm)
	Redvales	11,529	1	-	1 (9am-6pm)	1 (9am-6pm)	1 (9am-6pm)	1 (9am-6pm)	1 (9am-6pm)	1 (9am-1pm)	-
	Total		13	4	13	13	13	13	13	10	6
Bury West	Church	10,345	2	-	2 (9am-6pm)	2 (9am-6pm)	2 (9am-6pm)	2 (9am-6pm)	2 (9am-6pm)	1 (9am-1pm)	-
	Elton	11,494	1	-	1 (9am-1pm & 2pm-6pm)	1 (9am-1pm & 2pm-6pm)	1 (9am-1pm & 2pm-6pm)	1 (9am-1pm & 2pm-6pm)	1 (9am-1pm & 2pm-6pm)	1 (9am-1pm)	-
	Total		3	0	3	3	3	3	3	2	0
Prestwich	Holyrood	11,183	1	-	1 (9am-6pm)	1 (9am-6pm)	1 (9am-6pm)	1 (9am-6pm)	1 (9am-6pm)	1 (9am-5pm)	-
	Sedgley	13,021	6*	-	6 (8am-10pm)	6 (8am-10pm)	6 (8am-10pm)	6 (8am-10pm)	6 (8am-10pm)	1 (8am-10pm)	1 (10am-4pm)
	St Mary's	10,175	1	-	1 (8:30am-6:15pm)	1 (8:30am-6:15pm)	1 (8:30am-6:15pm)	1 (8:30am-6:15pm)	1 (8:30am-6:15pm)	1 (9am-2pm)	-
	Total		8	0	8	8	8	8	8	3	1
Radcliffe	Radcliffe East	11,324	5	1	5 (8am-10:30pm)	5 (8am-10:30pm)	5 (8am-10:30pm)	5 (8am-10:30pm)	5 (8am-11:59pm)	4 (12am-6pm)	1 (10am-6pm)
	Radcliffe West	11,185	2	-	2 (8:30am-10pm)	2 (8:30am-10pm)	2 (8:30am-10pm)	2 (8:30am-10pm)	2 (8:30am-10pm)	2 (8:30am-8pm)	1 (10:30am-4:30pm)
	Radcliffe North	11,164	0	-	-	-	-	-	-	-	-
	Total		7	1	7	7	7	7	7	6	2

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Ramsbottom Tottington and North Manor	North Manor	9,842	2	-	2 (9am-6pm)	2 (9am-6pm)	2 (9am-6pm)	2 (9am-6pm)	2 (9am-6pm)	2 (9am–1pm)	-
	Ramsbottom	11,738	2	-	2 (9am-6pm)	2 (9am-6pm)	2 (9am-6pm)	2 (9am-6pm)	2 (9am-6pm)	2 (9am–12:30pm)	-
	Tottington	9,783	1	-	1 (9am-6pm)	1 (9am-6pm)	1 (9am-6pm)	1 (9am-6pm)	1 (9am-6pm)	1 (9am–1pm)	-
		Total	5	0	5	5	5	5	5	5	0
Whitefield and Unsworth	Pilkington Park	9,784	1	-	1 (9am-6:15pm)	1 (9am-6:15pm)	1 (9am-6:15pm)	1 (9am-6:15pm)	1 (9am-6:15pm)	-	-
	Unsworth	9,490	4	-	4 (8:30am-10pm)	4 (8:30am-10pm)	4 (8:30am-10pm)	4 (8:30am-10pm)	4 (8:30am-10pm)	2 (8:30am–10pm)	1 (10:30am–4:30pm)
	Besses	10,712	0	-	-	-	-	-	-	-	-
		Total	5	0	5	5	5	5	5	2	1
		Grand Total	41	5	41	41	41	41	41	28	10

** Figure includes the distance selling pharmacy known to be in this ward*

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6.7.1 Saturday Opening

Over two thirds of the pharmacy contractors in Bury are open on a Saturday with at least one pharmacy open in each ward, except Radcliffe North, Besses and Pilkington Park. On Saturday's access to pharmaceutical services provided from a pharmacy can be found between the hours of 6am to midnight within Bury.

Although there is no access to pharmacies on Saturdays in Radcliffe North and Pilkington Park Wards, they are considered adequately served by other pharmacies within the one mile buffer zone. In contrast Besses Ward has no pharmacy, areas of high deprivation and a high proportion of household with no cars. Therefore, there is a gap in pharmaceutical provision in the Besses Ward.

In general, it is considered that in Bury with the exception of Besses Ward there is sufficient coverage on Saturdays both in terms of opening hours and number of locations.

6.7.2 Sunday Opening

On Sunday only a quarter of pharmacy contractors are accessible with opening hours ranging from midnight to 6pm within Bury. Although, nearly two thirds of Bury wards have no pharmacy contractors open on a Sunday (see Figure 38 of wards with no pharmacies open on Sundays), the public survey response identified only 12% (n=10) of respondents were unsatisfied by the current pharmacy opening hours.

Bury West Township and Ramsbottom, Tottington and North Manor Township are poorly served at weekends with access from 9am to 1pm on a Saturday and no cover of pharmacy services on a Sunday. Although there appears to be less access on Sundays in comparison to other Bury townships, it is felt that in the Bury West Township (Church and Elton Wards) there are a significant proportion of Bury's pharmacies in the neighbouring Bury East Township (East, Moorside and Redvales Wards). There are 12 pharmacies in the Bury East Township, of this, four have 100 hour contracts. The Bury East Township pharmacies offer extensive opening hours, weekend cover, within the one mile buffer zone of Church and Elton Wards and are accessible to the population via public transport, walking or their own transportation.

Similar to Bury West, Ramsbottom, Tottington and North Manor Township have no pharmacies open on Sundays. However, such wards are considered predominately the least populated, least deprived within Bury and are likely to have access to transportation allowing patients to travel within the borough to another location quite readily.

It is also worth noting that following the public survey, around two thirds of Prestwich township respondents would like to use a late night pharmacy and just under half would like to use a Sunday pharmacy. There is currently one pharmacy in the Prestwich Township offering extended opening hours and should be adequately meeting demand in Holyrood, Sedgley and St Mary's Wards.

The conclusion drawn in term of the opening hours for pharmacies around Bury is that all wards (except Besses) have a satisfactory access to pharmacy services. In time, if gaps in opening times are identified, these should be addressed initially through dialogue with existing specific contractors.

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7.0 Future Matters

7.1 Housing and Development

Bury Council has examined Bury's supply of housing in a document entitled 'Bury Five Year Supply of Deliverable Housing Land' (April 2014). This includes a housing trajectory which indicates that 3,195 dwellings are expected to be completed over the next five years. This equates to an average annual completion rate of 639 dwellings over this five year period. Over the longer term, the Council is planning for the delivery of a total of 6,800 dwellings between 2012 and 2029.

In terms of economic development, the Bury Employment Land Review has identified a potential supply of 69 hectares of land for future business, industrial and warehousing development up to 2029.

The PNA needs to be mindful of any dwelling construction that may affect the demand for pharmaceutical services, such as large housing developments, during its life. It is also important to capture any planned construction that may have an impact during the three year life of the PNA.

Bury Council currently have 36 planning applications for construction of dwellings of a size greater than 10 units, these are detailed in Figure 39 and mapped in Figure 40.

The majority of these sit within an area were pharmaceutical service provision will be satisfactory to meet any increase in population that may occur should these developments take place. However, there is one site (35) that sits outside the one mile distance from the nearest pharmacy with a planned development of 275 dwellings. This is intended to be a development of ‘executive’ homes and is likely to be occupied by residents with the availability of a car for transport and who will travel to access a range of services. This site is therefore not identified as a future need for additional pharmaceutical services.

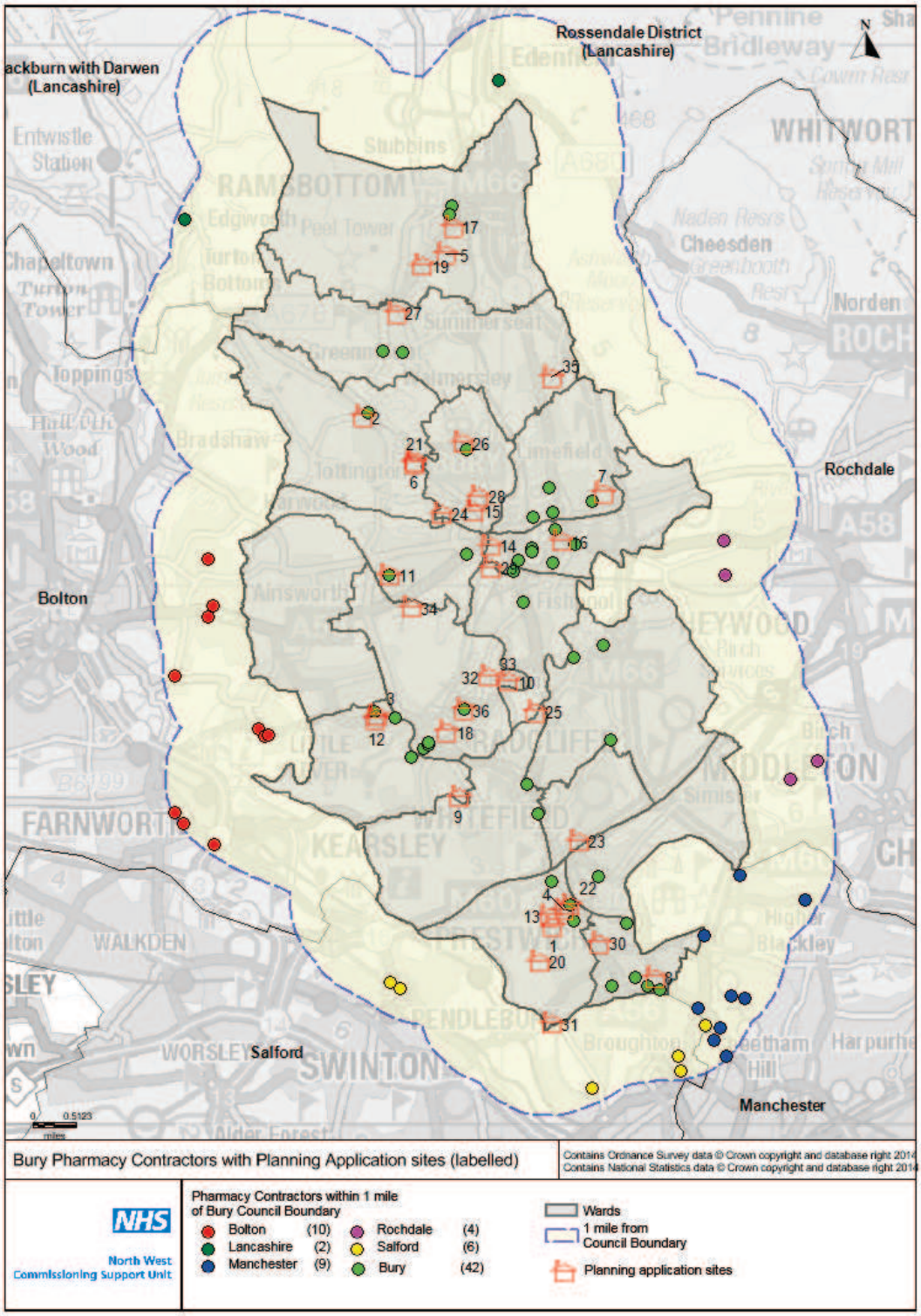
The Council has recently approved a food retail store of up to 10,227 square metres on the current leisure centre site in Bury town centre. The scheme also involves the relocation of the leisure centre to a vacant site on Knowsley Street. The Bury Retail Study shows that there is expenditure capacity for additional food retailing in Radcliffe town centre and for non-food retailing in Bury town centre although in the case of the latter the priority will be for this capacity to be absorbed by the reoccupation of existing vacant units rather than new development. Planning permission has also been granted for four restaurant units as an additional phase to the Rock development in Bury town centre.

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Figure 39: List of 36 Planning Application for Construction (Dwellings of a size greater than 10 units)

ID Number	Location	Postcode	Planning Status	Number of Dwellings in Application
1	Tulle Court, Ramsbottom Row, Prestwich	M25 3JL	Full planning permission	26
2	Wesley House, Wesley Street, Tottington, Bury	BL8 3NW	Full planning permission	12
3	Redbank Health Centre, Unsworth Street	M26 3GH	Full planning permission	11
4	Warwick Mill, Warwick Street, Prestwich	M25 3HN	Full planning permission	12
5	Ramsbottom Cottage Hospital, Nuttall Lane, Ramsbottom	BL0 9JZ	Full planning permission	13
6	Roach Packing, Scobell St, Tottington	BL8 3DT	Reserved matters	14
7	The Thrush Public House, Thrush Drive, Bury	BL9 6JD	Full planning permission	14
8	46-48 Bury Old Road, Prestwich	M25 0ER	Full planning permission	14
9	Bankside Mill, Chapelfield, Radcliffe	M26 1JH	Full planning permission	14
10	Land adjacent to SE of 11 Morris Street, Radcliffe, Manchester	M26 2HF	Full planning permission	14
11	Land off Mile Lane, Bury	BL8 2JR	Outline planning permission	14
12	Land opposite 9 to 21 Unsworth Street, Radcliffe	M26 3RN	Outline planning permission	17
13	Clough Saw Mill, Gardner Road, Prestwich	M25 3HU	Full planning permission	17
14	Former PJ Power Site, Millett Street, Bury	BL9 0JA	Full planning permission	21
15	Land between Tottington Road & Crostons Road, Bury	BL8 1LL	Full planning permission	34
16	York Street Mill, York Street, Bury	BL9 7AR	Full planning permission	24
17	Cobden Mill, Square Street, Ramsbottom	BL0 9AY	Full planning permission	31
18	Works off Brook Street, Radcliffe	M26 2PQ	Outline planning permission	30
19	Hazelhurst / Whittle Pike, Bolton Road West, Ramsbottom	BL0 9PJ	Full planning permission	46
20	Park Hotel - Off Lowther Road, Prestwich	M25 9GP	Full planning permission	30
21	Land to rear 353 and 365, including Beechwood Bungalow, Bury Road, Tottington, Bury	BL8 3DS	Outline planning permission	30
22	Longfield Suite, Prestwich	M25 1AY	Outline planning permission	36
23	Land Adj 15 Prestfield Road, Whitefield	M45 6BD	Outline planning permission	40
24	Former Elton Cop Dye Works, Walshaw Road, Bury	BL8 1NG	Full planning permission	111
25	Eagle Bleachworks, Manchester Road, Blackford Bridge, Bury	BL9 9TA	Other	50
26	Brandlesholme Pub, Brandlesholme Road, Bury	BL8 1HP	Full planning permission	50
27	Holcombe Brook Tennis/Sports Club, Longsight Road, Holcombe Brook, Ramsbottom	BL0 9TD	Full planning permission	55
28	Land to west of 149 Brandlesholme Road, Bury	BL8 1BA	Outline planning permission	57
29	(Openshaw Fold Road) Off Warth Road, Bury	BL9 0TZ	Outline planning permission	57
30	Former Claremont Elderly Persons Home, Bury New Road, Prestwich	M25 1FA	Full planning permission	62
31	Site of former Cussons Sons & Co Ltd, Kersal Vale Road, Prestwich	M7 0GL	Outline planning permission	122
32	Land bounded by York St, R.Irwell & Bealeys Goit, Radcliffe	M26 2QL	Outline planning permission	170
33	Land bounded by River Irwell to South of Dumers Lane, Morris Street, Radcliffe	M26 2HF	Full planning permission	239
34	Land at Spen Moor, Bury and Bolton Road, Radcliffe, Manchester	M26 0JZ	Outline planning permission	191
35	Tetrosyl Site, Bevis Green Works, Walmersley Old Road, Bury	BL9 6RE	Outline planning permission	275
36	East Lancs Paper Mill Site, Rectory Lane, Radcliffe	M26 2RF	Outline planning permission	490

Figure 40: Map of Planning Applications for Construction of Dwellings >10units and Pharmacies



7.2 Primary Care Developments

Following the NHS reform on the 1st April 2013, there have inevitably been changes in NHS structure and movement of commissioned services between the new NHS organisations and health partners.

Services will be re-designed and re-configured to fit into new integrated care pathways. Any potential change to services should be based on the population need of the local areas of which the PNA, along with the JSNA and JHWS, is an important document to inform such decisions.

7.3 Identification of the Gaps between Health Need and Current Services

Figure 41 below will discuss, according to the identified health priorities, what are the target populations or localities which current pharmacy services and other health care service providers are currently supporting this health need. We then discuss where gaps lie and how pharmacy provision may provide a solution to address those gaps.

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Figure 41: Gap Analysis between Health Needs and Commissioned Services

Identified Health Priorities	*Health Partners target/aims*	*Target Areas*	*Relevant Services currently delivered from community pharmacy*	*Services provided by other providers to address that need*	*Gap between need and current provision*	*How could pharmacy meet the needs in the future?*
Priority 1 ***Ensuring a positive start to life for children, young people and families***	-An increase in the number of children achieving a good level of development at age 5 -A reduction in the number of child protection plans -A reduction in the number of children in care -Increases in breastfeeding initiation and maintenance at 6-8 weeks after birth -A reduction in the number of mothers smoking during pregnancy -Improvements in differences in levels of educational attainment across the borough and between groups.	Challenges for Bury : -17% of mothers smoke at time of delivery -Breast fed babies at 6-8 weeks is significantly lower (41%) compared to England average (47%) -19% of children under 16 lives in poverty -Significant numbers of children with child protection plan or under care -Bury children is significantly worse than national average in achieving a good level of development at age 5	Essential services: Health Promotion and advisory service. Public Health promotion. Signposting. Dispensing Medicines or Appliances. Advanced services: MUR. NMS. Local Authority Commissioned services: Smoking cessation (for parents). CCG Commissioned Services: Minor ailment scheme.	Local Authority Commissioned Services: Ad hoc immunisations for at risk patients. GP service Health visitor and Midwife support. Smoking cessation.	Commissioners need to ensure that any austerity measures do not further disadvantage children and young people by identifying the groups of children who are most likely to be affected and intervene at the earliest opportunity.	Pharmacies are readily accessible health care locations within the communities that can support parents through pre-and post-pregnancy, early years and through to school, to give children the best start in life. Pharmacists could promote immunisations and are professionals who are able to administer immunisations. Schemes could be targeted at individuals who are identified as having missed out on the national immunisation programme. The pharmacies could be used as a point of contact for families to be signposted into relevant services/campaigns e.g. breastfeeding initiation/maintenance programmes and Change4Life schemes

Priority 2 ***Encouraging healthy lifestyle and behaviours in all actions and activities***	-Reductions in the levels of smoking, physical inactivity, excess weight and harmful alcohol consumption in adults, children and young people -A reduction in under 18s conception -An increase in life expectancy at age 75 -Reductions in the gap in life expectancy and healthy life expectancy between communities -Reductions in early deaths from cancer and cardiovascular, liver and respiratory diseases -A reduction in the level of long term conditions	Challenges for Bury : -22%of all adults in Bury are smokers compared to 20% across England -Bury has significant increase in levels of obesity between reception Year and Year 6 and in some wards levels of obesity are unacceptably high. -In Bury it is estimated that around half of adults are overweight and 23% of those are obese -Bury has higher levels of binge drinkers and alcohol related hospital admissions than national averages -Bury has higher regional and national under 18s conception -Bury has high cancer incidence rate -Early detection and presentation are critical in tackling premature deaths from cancer but there are known inequalities in cancer screening uptake in the most deprived and across ethnicities	<u>Essential services:</u> Health Promotion and advisory service. Public Health promotion. Signposting. Dispensing Medicines or Appliances. <u>Advanced services:</u> MUR. NMS. <u>Local Authority Commissioned services:</u> Smoking cessation. EHC. Chlamydia testing. Needle Exchange. Supervised administration. <u>CCG Commissioned Services:</u> Minor ailment scheme. Palliative Care. Out-of-Hours service.	<u>Local Authority Commissioned Services:</u> Ad hoc immunisations for at risk patients. <u>GP service</u> Health visitor and Midwife support. Smoking cessation.	Find ways to work with communities and individuals; help them to focus on seeing services as facilitating the change that people want to make for themselves rather than simply delivering the things that have always delivered. This will need service providers to think very differently about their roles and the way services are currently delivered.	Pharmacies are a central hub for healthcare where the majority of patients pass through for their medications. Therefore they could be used to undertake surveys or pilots for schemes. Commissioners could identify innovative ways of promoting healthy lifestyles via pharmacy locations within targeted neighbourhoods. For example, pharmacies could be commissioned to provide NHS Health Checks and/or address health priorities via Healthy Living Pharmacy services.

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Priority 3 ***Helping to build strong communities, wellbeing and mental health***	-An increase in the proportion of adults with mental illness who are in employment -An increase in the percentage of adults with mental illness living independently -An increase in self-reported wellbeing -A reduction in hospital admissions as a result of self-harm -A decrease in first time entrants to the youth justice system -A reduction in domestic violence -A reduction in homelessness. -A reduction in the length of stay of families in temporary accommodation	Challenges for Bury: -Significant mental health problem in Bury -Emotional disorders (including depression) affect around 3.7% of children in Bury -Over 21% of young people aged 17 and under in Bury would require some support from the Child and Adolescent Mental Health Services -Drug and alcohol related crimes remain high -2011/12 there was over 3400 incidents of domestic violence in Bury -In 2011/12 only 2.8% of adults in Bury who were in contact with secondary mental health services were in employment	<u>Essential services:</u> Health Promotion and advisory service. Public Health promotion. Signposting. Dispensing Medicines or Appliances. <u>Advanced services:</u> MUR. NMS. <u>Local Authority Commissioned services:</u> Smoking cessation (for parents). EHC. Chlamydia testing. Needle Exchange Supervised administration. <u>CCG Commissioned Services:</u> Minor ailment scheme. Palliative Care. Out-of-Hours service.	<u>Local Authority Commissioned Services:</u> Ad hoc immunisations for at risk patients. <u>GP service</u> Health visitor and Midwife support. Smoking cessation.	Maintenance of a stable mental health is vital and medication can play a huge role in achieving that. A coherent strategy for wellbeing which helps patients to remain mentally healthy is the goal. Included in this strategy access to mental health services should be addressed. There are very few services directed specifically at patients who have a mental health reason for not returning to work. Issues both from patients' own perceptions of mental health and a historical lack of mental health services have meant that many people have not been able to access the help they require. The shift calls for a radical reappraisal of current patterns of investment in mental health care if changing population needs are to be met effectively.	As pharmacies are regularly used by the majority of the public, they could be commissioned to provide services that identify target groups. Pharmacies already provide services to substance misusers, but commissioners could consider extending it to include extended mental health screening Pharmacies could carry out targeted MURs for people taking antidepressants to ensure they are using them correctly. This should enable patients to recover from their illness or maintain a standard of health which allows them a better chance of returning to employment. Train pharmacy contractors to promote recovery and self-care as an outcome for people with mental ill health issues. This will increase the access to advice and signposting for patients around the borough Health promotion campaigns designed to raise awareness of mental health issues and remove unhelpful preconceptions could be undertaken via pharmacy and other outlets.

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Priority 4 ***Promoting independence of people living with long term conditions and their carers***	-Reduced admissions of people with long term conditions -An increased number of adults and carers receiving self-directed support via a direct payment -An increased number of adults accessing a recognized self-care course -A reduction in proportion of long term sick	Challenges for Bury: -Significant mental health problem in Bury -Emotional disorders (including depression) affect around 3.7% of children in Bury -Over 21% of young people aged 17 and under in Bury would require some support from the Child and Adolescent Mental Health Services -Drug and alcohol related crimes remain high -2011/12 there was over 3400 incidents of domestic violence in Bury -In 2011/12 only 2.8% of adults in Bury who were in contact with secondary mental health services were in employment	<u>Essential services:</u> Health Promotion and advisory service. Public Health promotion. Signposting. Dispensing Medicines or Appliances. <u>Advanced services:</u> MUR. NMS. <u>Local Authority Commissioned services:</u> Smoking cessation (for parents). EHC. Chlamydia testing. Needle Exchange. Supervised administration. <u>CCG Commissioned Services:</u> Minor ailment scheme. Palliative Care. Out-of-Hours service.	<u>Local Authority Commissioned Services:</u> Ad hoc immunisations for at risk patients. <u>GP service</u> Health visitor and Midwife support. Smoking cessation.	The challenge to bridge the gap in providing more care for more people in the primary care or community setting will be around using the varied skills of the different health providers to their maximum effect. To do this, matrix working between the whole health and social care sector will be crucial. HWB are ideally placed to co-ordinate the reviews and changes required with the current services to enable a more cohesive system for providers to use their skills to the best advantage for patient outcomes.	Pharmacies themselves, as well as national pharmacy bodies and local commissioners, need to do more to promote the pharmacy as centres of excellence for supporting long term conditions, self-care and potentially be used as locations for NHS health checks. A pilot could be initiated using pharmacies (or other suitable professionals) to triage patients into the appropriate form of health care or social services. It is crucial that health and social care services plan these changes together, as changes to one part of the system are likely to have significant effects on the rest of it. We therefore need to be able to invest resources appropriately as a whole health and social care system to ensure that services are being provided in an integrated way

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Priority 5 ***Supporting older people to be safe, independent and well***	-A reduction in injuries and hip fractures due to falls in the over 65s -A reduction in permanent admissions to residential and nursing care homes -An increase in the number of over 65s who remain at home following support by reablement services -An increase in people feeling safe and secure as a result of adult care services -A reduction in excess winter deaths -An increase in early diagnosis of dementia -An increase in the number of people dying in their own home where they wish to do so -An increase in the number of people dying with an end of life plan	Challenges for Bury: -Significant projected increase in the patient group aged over 65 -Approximately 7000 over 75s are living alone in Bury and may be at increased risk of social isolation and loneliness -More than 2600 people aged 65 and over living in Bury are thought to have depression, including nearly 850 cases classed as severe -Around 700 people aged 65 and over in Bury had had a stroke or mini-stroke and have longstanding health condition caused by the stroke -It is predicted the number of falls in those aged 65 and over in Bury will increase by 50% between 2010 and 2030	<u>Essential services:</u> Health Promotion and advisory service. Public Health promotion. Signposting. Dispensing Medicines or Appliances. <u>Advanced services:</u> MUR. NMS. <u>Local Authority Commissioned services:</u> Smoking cessation (for parents). EHC. Chlamydia testing. Needle Exchange. Supervised administration. <u>CCG Commissioned Services:</u> Minor ailment scheme. Palliative Care. O**ut-of-H ours service.**	<u>Local Authority Commissioned Services:</u> Ad hoc immunisations for at risk patients. <u>GP service</u> Health visitor and Midwife support. Smoking cessation.	Many services, including those from pharmacies, are not directed to specific groups of people or are not targeted to an area of high need. Education around the reason for taking medicines and how they work can aid the patient's understanding of their condition and therefore improve the outcome. Multi skilled, multidisciplinary teams should be used to enable the best outcomes to be achieved for our older populations. To ensure patients are not imparting information about the same issue to various different health professionals a clear pathway and communication system needs to be set up to enable multidisciplinary teams to function effectively.	Most elderly patients who are unwell will use a pharmacy on a regular basis. Particularly if they have significant co-morbidities. Commissioners could consider using this accessible resource for screening, education, near patient testing, vaccine administration and any other innovative solutions the commissioners can identify to improve the health outcomes of the older population. Communication channels between health providers should be strengthened so that contractors are not working in isolation and health provision is more joined up. This will allow patient flow in and out of care settings e.g. clinics, hospitals or pharmacies to work more efficiently and save time for the patient and money for the NHS. Use pharmacists as part of a multidisciplinary team to help patients understand and manage their conditions more effectively e.g. via targeted MURs or other innovative mechanisms. This could include collaborative working with secondary and tertiary centres to reduce hospital admissions and support patients living independently.

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8.0 Summary and Recommendations

Bury HWB considers community pharmacies a key public health resource and recognises that they offer potential opportunities to commission health improvement initiatives and promote health and wellbeing and support in achieving the required outcomes identified in the Joint Health and Wellbeing Strategy (JHWS). They contribute to the health and wellbeing of the local population in a number of ways, including:

- Easily accessible – 99% of the UK population can get to a pharmacy within 20 minutes by car and 96% by walking or using public transport[26] and can help the Bury HWB footprint provide care to the population closer to home.
- Often first point of contact and are open for extended hours - most people can visit a pharmacy at time that is convenient to them and provide choice and access.
- Ideal for people seeking a less formal environment and those hard to reach groups who are less likely to visit their GP with health problems which will reduce health inequalities.
- Resourced with highly trained and experienced healthcare professionals that are able to offer a wide range of services including healthy life style advice, advice on medicines and long term conditions, health screening, support for the prevention of diseases and treatment of minor ailments, and signposting to other services.

Following the PNA, we can conclude on the following:

Provision of pharmaceutical services

Bury is well provided for by pharmaceutical service providers and almost all wards have not identified a current need for new NHS pharmaceutical service providers in the area. There are a number of reasons for this conclusion:

- There are 41 pharmacies across Bury, of which five have 100 hour contracts and three are distant selling pharmacies. This is an increase from 38 in the previous PNA in 2011.
- There is no DAC in the Bury area. However, appliances are available from community pharmacies and from DACs within and outside the borough. As a result, it is considered the dispensing of appliances is not an issue and has not been raised as such during the pre-consultation on the PNA.
- According to the HSCIC data 2012/13, Bury has 22 pharmaceutical service providers per 100,000 registered population, which is equal to the national average and considered sufficient to meet the dispensing demands of the area.
- Each month the Bury pharmacies dispense on average slightly more items than the monthly national and North West regional average items. However, overall, the majority of respondents (91%, n=70) were either satisfied or very satisfied with all aspects of service they receive from their pharmacy.
- 83% of the Bury public use a regular or preferred pharmacy and the most commonly selected reason for using one particular pharmacy was location and the proximity to the respondent's home or doctors.
- Items prescribed by the Bury CCG GPs - over 91% (3.3million items/year) are dispensed within the Bury area pharmacies.
- Approximately 7% annually (250K items) of items were dispensed by non-Bury Borough pharmacies however, the majority of which (over 82%) were dispensed within Greater Manchester.
- Patients have the right to access pharmaceutical services from any community pharmacy including mail order/wholly internet pharmacy of their choice and therefore can access any of the many distant selling pharmacies available nationwide.

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Access to pharmaceutical services

In general, the review of the locations, population density, access for patients and prescription numbers suggest there is satisfactory access to NHS Pharmaceutical Services in most of Bury HWB footprint. The conclusion drawn in terms of the opening hours for pharmacies around the Bury area is that most wards have a satisfactory access to pharmacy services. The reasons for such conclusions include:

- Bury pharmacies have good coverage in terms of locations across all areas of high population density and within their one mile buffer zones. Areas that are not covered in the one mile buffer zone are considered rural and largely uninhabited.
- The level of car ownership throughout the Bury area (76% of households own at least one car) is greater than both the regional (72%) and national average (74%).
- Pharmacies are easily accessible with the majority of respondents (85%) travelling less than two miles to the pharmacy on foot (43%) or by car, as a passenger or driver (54%).
- It was noted that only around 1% of the survey respondent are unable to get to a pharmacy of their choice due to mobility issues. To support patient pharmacy accessibility, pharmacies also offer a home delivery service which can help to provide medications to those who have poor mobility, do not have access to a car or who are unable to use public transport. In Bury, there are three distance-selling pharmacies that can support provide home delivery. Other distance-selling pharmacies in the country can provide the same.
- Five pharmacies have 100-hour contracts in the Bury area. They are centrally located and accessible by public transport, walking or own transportation.
- 62% of respondents from the Prestwich Township postcode area would use pharmacies if open late night and 47% would use pharmacies if open on a Sunday. There is currently one pharmacy in this area offering extended opening hours.
- Over two thirds of the pharmacy contractors in Bury are open on a Saturday and access can be found between the hours of 6am to midnight within Bury. The gives adequate cover for Bury (except in Besses Ward) on Saturdays both in terms of opening hours and number of locations.
- On Sunday only a quarter of pharmacy contractors in Bury are open. However, the public survey identified only 12% (n=10) of respondents were unsatisfied by the current pharmacy opening hours.
- Due to changes in shopping habits a number of pharmacies now open on many Bank Holidays although they are not contractually obliged to do so. GMAT works with community pharmacies to ensure an adequate rota service is available for Christmas Day, Boxing Day, New Year's Day and Easter Sunday as these are days where pharmacies are traditionally closed.
- Bury West Township has less access at weekends in comparison to other Bury townships. However, there are 12 pharmacies in the neighbouring Bury East Township. Of these, four have 100 hour contracts which are accessible to a large population (including the Bury West Township) via public transport, walking or their own transportation.
- Similar to Bury West; Ramsbottom, Tottington and North Manor Township have no pharmacies open on Sundays. However, such wards are considered predominately the least populated, least deprived within Bury and are likely to have access to transportation allowing patients to travel within the borough to another location quite readily.

However, the Radcliffe North and Besses Wards did raise some concerns as there are no pharmacies and potentially could be identified as gaps in service provision. Although the public survey did not identify this finding and no negative comments were made about pharmacy access in those wards, representatives of the local community from Besses Ward have highlighted to the Bury HWB and the CCG that there is a lack of easy access to pharmaceutical services.

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After due consideration it has been concluded that there is a need for pharmaceutical service provision within the Besses Ward for the following reasons:

- Besses Ward has three LSOAs which are ranked in the worst 10% for deprivation
- There are a large number of households with no access to a car or van
- Although there is reasonable access to public transport, the cost is a deterrent to its use
- Besses Ward has high levels of teenage conception, smoking prevalence and known drug-use

Whereas for Radcliffe North Ward it has:

- A relatively low population
- A high number of households with cars and therefore less affected by accessibility to pharmacies to neighbouring ward
- Pharmacies accessible by walking, public transport or own transportation within neighbouring wards both inside and outside of Bury
- There has been no complaints or public representation concerning access to pharmaceutical services

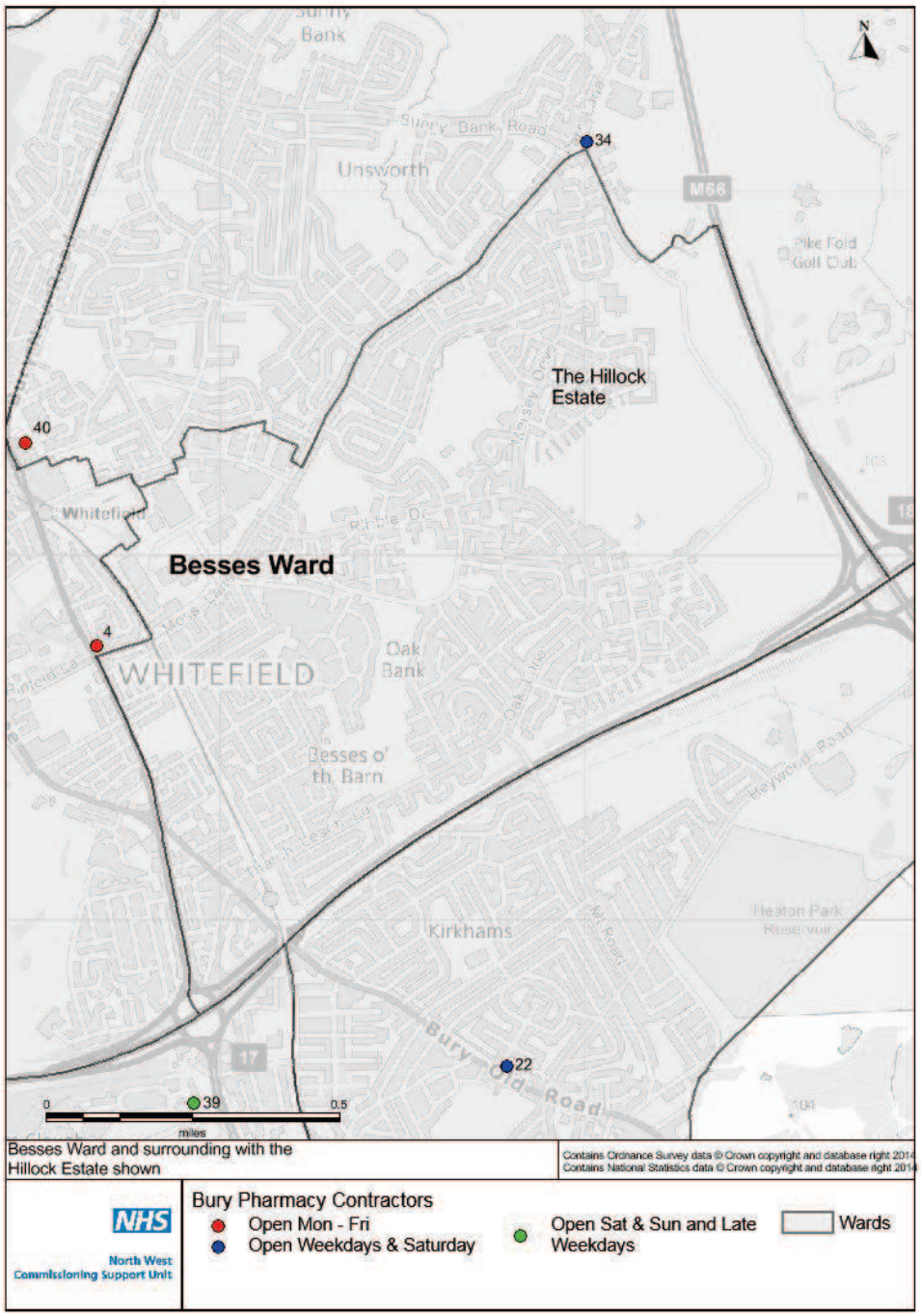
Based on these finding it is considered that the population of Radcliffe North Ward are adequately served by other pharmacies within a mile distance or by pharmacies offering home delivery service. However, for Besses Ward, it is recommended that an additional pharmaceutical provider is established within the Hillock Estate area (Figure 42). Any new pharmacy contractor in this area should deliver all locally commissioned services that will support this population. At the moment these locally commissioned services include smoking cessation support, chlamydia screening and treatment, minor ailment treatment, provision of EHC, needle exchange and observed consumption to support recovery of drug misuse. Any pharmacy contractor would be expected to deliver pharmaceutical services including all essential and at least two of the advanced services, MUR and NMS.

In addition to the above recommendation, a need has been identified for the following hours of pharmaceutical service availability.

- Monday to Friday - a minimum of 40 hours between 08:30 and 18:00 hours daily;
- And Saturday - a minimum of 5 hours between 10:00 and 18:00 hours;
- And Sunday - a minimum of 2 hours between 11:00 and 15:00 hours.

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Figure 42: Map of Besses Ward and the Hillock Estate



Community Pharmacy role in local health needs

Over the coming years the population in Bury is expected to both age and grow substantially in numbers. Housing and commercial developments are in progress and it will be a collective number of factors that may influence the potential need for any additional pharmaceutical service providers. To facilitate commissioning of pharmaceutical service providers responsive to the potential population changes the Health and Wellbeing Board and partners will monitor those changes and development, and produce supplementary statements to the PNA if deemed necessary, in accordance with regulations.

The current pharmacy services commissioned from Bury pharmacies, in addition to their NHS contract, supports Bury's HWB in achieving the required health priorities and outcomes outlined in their strategy. Overall 91% of the respondents in the public survey were either satisfied or very satisfied with the service they received from their pharmacy. However, there is also a need for ensuring that those additional services that are commissioned by Bury Council and CCG from Bury pharmacies are promoted to the local population so as to improve their uptake. The patient survey indicated that on average a 77% of respondents have not used services already on offer. There may be a number of reasons for this including, lack of awareness and/or the service in community pharmacy does not meet their needs.

It is important that commissioners continue to review the currently commissioned pharmaceutical services and assess service delivery and health outcomes achieved. Review should include whether all pharmacy contractors should be engaged in commissioned additional services or whether targeted delivery by a small number of contractors would be preferential. It is important that any review includes possible or actual service delivery by other providers where they also meet specific pharmaceutical needs.

At the time of writing the PNA (June 2014), some commissioning arrangements are awaiting clarification. However, following the current assessment of Bury pharmacies locally commissioned services, the following recommendations were noted:

1. Smoking cessation activities in community pharmacies in Bury have increased, but there are still many community pharmacies that do not provide a smoking cessation service. Bury Council has commissioned smoking cessation services in just over half of the pharmacies (24 of the 41 contractors) and although existing contracted pharmacies are covering areas of high prevalence there are still other areas that maybe beneficial for further development. For example, although lower prevalence the Northern area of Bury e.g. Ramsbottom have no commissioned smoking cessation service. This can additionally complement other medical services provisions and educate patients in self-care, thereby reducing the impact on GP consultations.

2. Only two pharmacies in Bury have signed up to the Chlamydia Screening and Treatment programme so there is opportunity to expand this across Bury. Areas with high population of 15- 24 year olds such as Radcliffe West, Redvales, Ramsbottom and Besses should be considered. In addition, chlamydia screening could be offered when EHC is provided, since those requiring such contraception may also be at risk of infection. The extent to which local services signpost to services or carry out testing when EHC is provided could be examined in an audit, to stimulate best practice in this area.

3. Needle exchange service is commissioned from seven pharmacies in Bury and there are 15 pharmacies providing supervised consumption of methadone/ buprenorphine. There is limited access to both services during extended hours on weekdays, Saturdays and on Sundays. The key priorities are to ensure adequate access and monitor the quality, service outcomes and client experience; and to work with existing pharmacy contractors to address any issues identified.

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4. Opportunistic alcohol screening and provision of brief advice is another area where pharmacies could potentially contribute to improving the health of the local population. One public health campaign theme 2014/15 planned for Bury pharmacists by NHS England include alcohol awareness and this could, for example, potentially be integrated into agreements around medication checks.

The Royal Pharmaceutical Society (RPS) recommends that pharmacists collaborate with each other and with other healthcare professions, to develop models of care which enable commissioners to deliver integrated patient pathways, and ensure patients have consistent access to support with medicines use as they move between care settings. This could be particularly relevant to those at risk groups identified in this PNA and Bury JHWS.

Community pharmacies are ideally placed to offer:

- ✓ Signposting to services and providing on-going support towards achieving healthy weight, alcohol awareness and other public health checks
- ✓ Promoting awareness of good mental health, for example signposting to information about local support networks, mental health help lines etc.
- ✓ Early detection of some cancers
- ✓ Target patient groups for medication reviews including older people, falls prevention, care home residents, people on four or more medications, people receiving medications from different sources (e.g. General Practice (GP) and hospital), people recently discharged from hospital on complex medicines
- ✓ Support in medication compliance, therapeutic monitoring and in self-care where appropriate, as well as referring back to the GP service or signposting patients to other appropriate services to reduce emergency admissions

In the future, community pharmacists could become more involved in more targeted pharmaceutical care, for example, domiciliary visiting for those on complex medicine regimes, and also within the multidisciplinary care and case management teams, working closely with district nurses, care co-ordinators and the medicines optimisation team within the CCG.

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9.0 Equality Impact Assessment

The HWB has a statutory duty to tackle and reduce health inequalities in health and wellbeing and consequently these have informed the JHWS priorities set out in Section 5. See Appendix 10 for HWB Equality Analysis.

10.0 Appendices

APPENDIX 1 - Pharmacy Service Descriptions
APPENDIX 2 - PNA 60 day Consultation plan
APPENDIX 3 - 60 day Consultation Analysis
APPENDIX 4 - Cross Boundary Pharmacies
APPENDIX 5 - Pharmacy Survey 2014
APPENDIX 6 - Locally Commissioned Services
APPENDIX 7 - Public Survey 2014
APPENDIX 8 - Pharmacy Contractor Opening Hours
APPENDIX 9 - List of Acronyms
APPENDIX 10 - Maps
APPENDIX 11 - Equality Analysis

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Appendix 1 – Service Descriptions

Essential Service	Service Description
Dispensing Medicines or Appliances	Pharmacies are required to maintain a record of all medicines dispensed, and also keep records of any interventions made which they judge to be significant. Whilst the terms of service requires a pharmacist to dispense any (non-blacklisted) medicine 'with reasonable promptness', for appliances the obligation to dispense arises only if the pharmacist supplies such products 'in the normal course of his business'. The Electronic Prescription Service (EPS) is also being implemented as part of the dispensing service. Prescription-linked interventions can be identified during the dispensing process. Pharmacists could identify patients with specified health needs which should be addressed. The health needs that the HWB wish to be targeted could be agreed with the GM AT and the Local Pharmaceutical Committee (LPC).
Repeat Dispensing	Pharmacies will dispense repeat prescriptions and store the documentation if required by the patient. They will ensure that each repeat supply is required and seek to ascertain that there is no reason why the patient should be referred back to their General Practitioner. This service is aimed at patients with long term conditions who have a stable medication routine and hence may have less opportunity to discuss any health issues with their GP or nurse. Pharmacists are required to check if a patient is using their medication. This gives them an opportunity to identify if a patient is not using his mediation as intended and hence may not be giving the desired health outcomes for which they were prescribed.
Disposal of unwanted medicines	Pharmacies are obliged to accept back unwanted medicines from patients. The pharmacy will, if required by NHS England or the waste contractor, sort them into solids (including ampoules and vials), liquids and aerosols, and the NHS England's Area Team will make arrangements for a waste contractor to collect the medicines from pharmacies at regular intervals. Additional segregation is also required under the Hazardous Waste Regulations. Pharmacy staff have the opportunity to identify patients who have not taken the medicines they were prescribed. This can initiate a discussion and problems such as side effects or dosage regimes can be addressed to help improve the patients' health outcomes. Also CCGs would be interested in knowing whether issued medicines are not being used correctly. A significant amount of wasted NHS resource is attributed to medications being used incorrectly or not at all.
Public Health (promotion of Healthy Lifestyles)	Each year pharmacies are required participate in up to six campaigns at the request of NHS England. This involves the display and distribution of leaflets provided by NHS England. In addition, pharmacies are required undertake prescription-linked interventions on major areas of public health concern, such as encouraging smoking cessation.
Signposting	NHS England will provide pharmacies with lists of sources of care and support in the area. Pharmacies will be expected to help people who ask for assistance by directing them to the most appropriate source of help.

Support for Self Care	Pharmacies will help manage minor ailments and common conditions, by the provision of advice and where appropriate, the sale of medicines, including dealing with referrals from NHS Direct/NHS 111. Records will be kept where the pharmacist considers it relevant to the care of the patient.

Advanced Service	Service Description
Medicines Use Review (MUR)	The Medicines Use Review (MUR) and Prescription Intervention Service consists of accredited pharmacists undertaking structured adherence-centred reviews with patients on multiple medicines, particularly those receiving medicines for long term conditions. National target groups have been agreed in order to guide the selection of patients to whom the service will be offered. The MUR process attempts to establish a picture of the patient's use of their medicines – both prescribed and non-prescribed. The review helps patients understand their therapy and it will identify any problems they are experiencing along with possible solutions. An MUR Feedback Form will be provided to the patient's GP where there is an issue for them to consider.
New Medicine Service (NMS)	The service provides support for people with long-term conditions newly prescribed a medicine to help improve medicines adherence; it is initially focused on particular patient groups and conditions. Since the introduction of the NMS in October 2011, more than 90% of community pharmacies in England have provided it to their patients. Initial funding for the service was agreed until March 2013, and since then funding has been extended pending a decision on the long-term future of the service. An academic review was completed in August 2014, the findings from the evaluation were overwhelmingly positive, with the researchers concluding that as the NMS delivered better patient outcomes for a reduced cost to the NHS, it should be continued. This was the basis for NHS England's firm decision to continue commissioning the service throughout 2014/15. NHS England has agreed to continuation of the NMS during 2014/15. The service specification remains unchanged meaning contractors can continue to provide the service and will be paid for it as previously.

Appliance Use Reviews (AUR)	Appliance Use Review (AUR) is the second Advanced service to be introduced into the NHS community pharmacy contract. AURs can be carried out by a pharmacist or a specialist nurse in the pharmacy or at the patient's home. AURs should improve the patient's knowledge and use of any 'specified appliance' by: • Establishing the way the patient uses the appliance and the patient's experience of such use; • Identifying, discussing and assisting in the resolution of poor or ineffective use of the appliance by the patient; • Advising the patient on the safe and appropriate storage of the appliance; and • Advising the patient on the safe and proper disposal of the appliances that are used or unwanted.
Stoma Appliance Customisation Service (SAC)	Stoma Appliance Customisation (SAC) is the third Advanced service in the NHS community pharmacy contract. The service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste. The stoma appliances that can be customised are listed in Part IXC of the Drug Tariff.

NHS England - Enhanced Services	Service Description
Inflenza vaccination	This service allows the provision of influenza vaccination to at risk individuals aged 18 to 64 years on an opportunistic basis during the influenza season. This service is intended to increase the numbers of this group of patients being vaccinated.

Local Authority (LA) – Locally Commissioned Service	Service Description
Emergency Hormonal Contraception	This service involves supply of Levonorgestrel Emergency Hormonal Contraception (EHC) when appropriate to clients in line with the requirements of the Patient Group Direction (PGD). Under 16s must be competent to consent to the treatment.
Stop Smoking Intermediate Advice and Nicotine Replacement Therapy	A Stop Smoking service is one in which pharmacies will provide one to one support and advice to people who want to give up smoking. When commissioned, the service will help to increase choice and improve access to NHS Stop Smoking Services, especially for 'hard to reach' groups, such as pregnant mothers and young people. The pharmacy will provide one to one support and advice to the user and referral to specialist services if necessary. The pharmacy will help facilitate access to, and where appropriate supply, appropriate stop smoking drugs and aids.

Chlamydia Screening and Treatment	This service involves the provision of chlamydia screening postal kits to 15-24 year olds as part of the national screening programme. Pharmacy contractors should ensure that screening is offered to all persons attending for emergency hormonal contraception and as part of the promotion of healthy lifestyles etc. under the essential services. The service also involves the provision of treatment for chlamydia positive patients and their contacts as identified by the chlamydia screening service. Persons will be referred to the pharmacy to obtain treatment.
Supervised Methadone/Buprenorphine	This service provides a pharmacist and suitably qualified staff to supervise the consumption of prescribed medicines at the point of dispensing in the pharmacy, ensuring that the dose has been administered to the patient. Pharmacies will offer a user-friendly, non-judgmental, client-centered and confidential service. The pharmacy will provide support and advice to the patient, including referral to primary care or specialist centre where appropriate.
Needle Exchange	Pharmacies will provide access to sterile needles and syringes, and sharps containers for return of used equipment. Associated materials, for example condoms, citric acid and swabs, to promote safe injecting practice and reduce transmission of infections by substance misusers, will also be provided. Pharmacies will offer a user-friendly, non-judgmental, client-centered and confidential service. Used equipment is normally returned by the service user for safe disposal. The service user will be provided with appropriate health promotion materials. The pharmacy will provide support and advice to the user, including referral to other health and social care professionals and specialist drug and alcohol treatment services where appropriate. The pharmacy will promote safe practice to the user, including advice on sexual health and STIs, HIV and Hepatitis C transmission and Hepatitis A and B immunisation.

Clinical Commissioning Group (CCG) – Locally Commissioned Service	Service Description
Minor Ailment Scheme	This involves the provision of advice and support to people on the management of minor ailments, such as colds and flu, including where necessary, the supply of medicines for the treatment of the minor ailment, for those people who would have otherwise gone to their GP for a prescription or A & E Department.
Palliative Care	The service requires a pharmacist to stock and supply an agreed list of specialist medicines for use in palliative care and in addition to ensure there is prompt access and availability to these medicines at all times the pharmacy is open.

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NHS

North West Commissioning Support Unit

Appendix 2 – PNA 60 Day Consultation Plan

Author: Rebecca Carnegie
Version: 1.0
Date: 05/03/2014



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1. Background and current context

The Pharmaceutical Needs Assessment (PNA) is a legal document which details services which would be desirable and necessary in a locality based on the local health needs and population demographics.

The Health and Social Care Act 2012 transferred the responsibility for developing and updating the PNAs to the LA Health and Wellbeing Boards (HWBs).

The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating PNAs and can be found at: http://www.dh.gov.uk/health/2013/02/pharmaceutical-services-regulations/.

There is a legal requirement for the HWB boards to publish the PNA before 31 March 2015
PNAs will inform commissioning decisions by local authorities (public health services from community pharmacies) and by NHS England and clinical commissioning groups (CCGs).

2. Communications context and scope

This document details the scope of formal consultation and the proposed methods that will be used to engage different stakeholders and ensure patient and public involvement within this PNA.

There is a need for the local authority to understand;

- Local people and their representatives affected by the new service;
- Existing Pharmacy Services/Community based providers;
- Patients affected by possible new services in the area;
- Patient Services and Formal Complaints; and
- Other key stakeholders

Details of these issues can be gathered by public and pharmacy service provider surveys. The information from these can then be used to inform the final PNA document.

Prior to publication of the final document a draft version should be available for interested stakeholders to be able to comment on its content. This is called the formal consultation.

The formal consultation programme will commence on **1st September 2014** and will run for a period of 61 days. Therefore, the consultation will formally close on **31st October 2014.**

3. Key outcomes

- To encourage constructive feedback from a variety of stakeholders between 1st September 2014 and 31st October 2014.
- To ensure a wide range of primary care health professionals provide opinions and views on what is contained within the PNA

4. Key Audiences

The regulations state that:

When making an assessment for the purposes of publishing a pharmaceutical needs assessment, each HWB must consult the following about the contents of the assessment it is making—

(a)any Local Pharmaceutical Committee for its area (including any Local Pharmaceutical Committee for part of its area or for its area and that of all or part of the area of one or more other HWBs); .
(b)any Local Medical Committee for its area (including any Local Medical Committee for part of its area or for its area and that of all or part of the area of one or more other HWBs); .
(c)any persons on the pharmaceutical lists and any dispensing doctors list for its area; .
(d)any LPS chemist in its area with whom the NHSCB has made arrangements for the provision of any local pharmaceutical services; .
(e)any Local Healthwatch organisation for its area, and any other patient, consumer or community group in its area which in the opinion of HWB1 has an interest in the provision of pharmaceutical services in its area; and .
(f)any NHS trust or NHS foundation trust in its area; .
(g)the NHSCB; and .
(h)any neighbouring HWB.

The consultation must be for a minimum of 60 days.

The following groups of people could be formally consulted on the draft PNA asked to comment on the assessment and the assumptions that it makes. A local decision needs to be made whether these groups are going to be contacted.

- General public
- Patient Participation Groups in primary care
- Community Pharmacy Contractor Superintendent Offices
- Local Authority area CCGs
- Local Authorities employees
- Neighbouring CCGs
- Local Voluntary Groups
- Overview and Scrutiny Committee

- Social services

5. Consultation engagement

Although the timescale for the consultation to begin (**1st September 2014**) and end (**31st October 2014**) is a standard date, the period of consultation between can be locally agreed based on work load. However you do need to ensure that everyone who participates in the consultation has enough time to complete the response forms by 31st October 2014.

Any paper copies of the response forms can be sent back to GMCSU who will electronically input the responses into the survey – they need to be returned to GMCSU by Monday 3rd November 2014 to be included in the analysis.

The advert on homepage of council's website and the link on other relevant pages need to be done on 29th August 2014 to ensure the consultation begins on time. Everything that follows this should be done within the first month to allow time for responses and targeted work where returns have been low.

All the stakeholders listed below who are preceded by a C are in the compulsory list of people who must be consulted on the draft PNA.

You may feel that you do not need to undertake engagement with all the other stakeholders listed below, or that you will do more, which is a decision for your local teams to decide on.

When each section has/has not been attempted we need the two last columns completing to say how many people you engaged with for each element before this is sent back at the end of the consultation period.

	Stakeholder	Channel	Detail	Cost	Responsibility	Complete	Reach
	General population	Advert on homepage of council's website	Large advert on the carousel with a link to the consultation document and survey monkey for responses.	No cost	Comms team at LA	*e.g. yes or no*	***e.g. 2,100 people***
	General population	Links to survey on relevant webpages on council's website	Identify relevant webpages and add a couple of sentences about the consultation document/survey along with a link	No cost	Comms team at LA		
C	H&WB Board	Health and Wellbeing Board secretary	Send out an electronic link to the electronic copy of the consultation document with a link to the online response form.	No cost	LA		
C	Neighbouring H&WB boards	Health and Wellbeing Board	Send out an electronic link to the electronic copy of the consultation document with a link to the online response form.	No cost	LA		
C	NHS Commissioning Board	Email consultation document to GM local area team	Send out an electronic link to the electronic copy of the consultation document with a link to the online response form.	No cost	LA		
	General population	Face to face surveys at local events – could be where the LA is already in attendance	Attendance at local events in targeted communities and complete paper surveys face to face with members of the public.	No cost	Comms team at LA		
	General population	Advert in local newspapers	Quarter page, black and white advert in local newspaper to direct people to the online survey would be advised	Various cost	Comms team at LA		

	Stakeholder	Channel	Detail	Cost	Responsibility	Complete	Reach
	General population	Press release	Short news piece with link to the survey.	No cost	council's press office		
	General population	Electronic Flyers	Produce and distribute A5 flyers to pharmacies to promote the survey and give the online address.	No cost	GMCSU & LPC to email		
	Local HOSC	Email consultation document	Send out an electronic link to the consultation document with a link to the online response form.	No cost	Comms team at LA		
	Local PH Committees	Email consultation document	Send out an electronic link to the electronic copy of the consultation document with a link to the online response form.	No cost	Comms team at LA		
C	Pharmacy contractors (including appliance and distance selling pharmacies)	Email consultation document to pharmacy superintendent	Send out an electronic link to the electronic copy of the consultation document with a link to the online response form.	No cost	GMCSU / LPC		
C	LPS pharmacy contractors	Email consultation document	Send out an electronic link to the electronic copy of the consultation document with a link to the online response form.	No cost	GMCSU / LPC		
C	Local Pharmaceutical Committee	Email consultation document to LPC secretary	Send out an electronic link to the electronic copy of the consultation document with a link to the online response form.	No cost	GMCSU / LPC		
C	Local Medical Committee	Email consultation document to LMC secretary	Send out an electronic link to the electronic copy of the consultation document with a link to the online response form.	No cost	Comms team at LA		

	Stakeholder	Channel	Detail	Cost	Responsibility	Complete	Reach
	Local Authority Staff	Council internal communications campaign	Desktop wallpaper and Intranet homepage story to encourage staff to complete the online survey.	No cost	Comms team at LA		
	General population	Council social media Twitter Facebook	Post regular tweets with a link to the survey and submit content for Facebook	No cost	Comms team at LA		
C	Healthwatch	Email Healthwatch	Contact Health Watch to ask for support to encourage Link users to complete the survey	No cost	Comms team at LA		
C	NHS Acute Trusts	Send link to head of pharmacy	Send out an electronic link to the electronic copy of the consultation document with a link to the online response form.	No cost	Comms team at LA		
C	NHS Mental Health Trusts	Send link to head of pharmacy	Send out an electronic link to the electronic copy of the consultation document with a link to the online response form.	No cost	Comms team at LA		
	Local Commissioners	Patient groups at the local CCG	M&C to contact to ask for support for PPI group to complete the survey	No cost	Comms team at CCG/LA		
	MPs and Local councilor's	Email MP and Councilor's	Email sent to all MPs and councillors to make them aware of the survey and give more information about it.	No cost	Comms team at LA		

	Stakeholder	Channel	Detail	Cost	Responsibility	Complete	Reach
	Local Voluntary, Health and community Faith Groups	Email to other relevant groups and organisations to give information about the survey and ask for participation	Below is an example of some groups this could be sent to: • *Prison Pharmacy's* • *Care UK* • *Asylum seekers* • *Schools* • *Colleges* • *Older People's Forum* • *Adult Safeguarding Board* • *Men's Action Group* • *Women's Centre* • *BME Forum* • *Interfaith Network* • *Community Committees* • *Carers Centre* • *MIND* • *Breathe Easy*	No cost	Comms team at LA		

6. Budget

It is advised that a budget is agreed with Public Health at a local level to be used to promote the consultation and to cover costs for printing out response forms, consultation documents and postage of forms back to NWCSU if needed.

7. Evaluation

A consultation report and an evaluation report will be provided by NWCSU. The Consultation report will analyse the feedback received and will also be used to update the final PNA. The evaluation report will be used to analyse the level of participants and the number of people engaged with.

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APPENDIX 3 - ANALYSIS OF PNA CONSULTATION

The formal consultation period of this Pharmaceutical Needs Assessment (PNA) ran from 1st September 2014 until 24th November 2014. The draft PNA and consultation response form were issued to all of the stakeholders listed in appendix 2.

-The number of responses received totalled 88.
- From the 88 responses, 76 were received from the general public.
- 81 thought that the explanation of the PNA was sufficient.
- 70 thought that the PNA provided an adequate assessment of pharmaceutical services in the Bury area.
- 71 thought that the PNA provided a satisfactory overview of the current and future pharmaceutical needs of the Bury population.
- 40 thought that current pharmacy provision and services in Bury is adequate.
- 65 out of 87 agreed with the conclusion of the PNA.

The consultation responses were collated and analysed, and PNA amended as necessary. This detailed in the table below.

Responder Number	Organisation/Member of Public	Section of PNA	Actual Response	Comment from PNA Steering group	Decisional of the steering group to amend the PNA? (Y/N)	Date amendment made
1	Member of the public	General comment	The review also probably reflects the position re availability of GP access in Besses	The PNA does not look at GP provision in Bury.	No	
3	Member of the public	General comment	There is, apparently, a further need in Radcliffe and Besses Areas	The PNA states there is no need for additional pharmaceutical services identified in the Radcliffe Ward for the reasons stated, but there is a need in Besses Ward.	No	
4	Member of the public	General comment	Unable to see this part of the document due to the way in which it was downloaded on the accompanying email, therefore I can't respond. The information I received let me see to the point of referring to Besses as being under supplied.....	Difficulties accessing the document should have been raised with Bury Council who posted out paper copies when necessary.	No	
4	Member of the public	General comment	Not able to see conclusion! Due to reasons given in answer to Question No 4 above.	The only options available to the council due to the size of the PNA was to provide a link to the website or send out paper copies.	No	
4	Member of the public	General comment	Please resend email with a pdf link to the document referred to rather than an extract put inside the email, which then doesn't allow you to read the whole document. Kind regards	The only options available to the council due to the size of the PNA was to provide a link to the website or send out paper copies.	No	
6	Member of the public	General comment	What do they offer	N/A	No	
6	Member of the public	General comment	More details about pharmacies	This comment has been noted.	No	
6	Member of the public	General comment	Need to say how many independent or large companies. where to obtain emergency drugs that are classed as dangerous e.g. morphine for terminally ill and end of life drugs	A list of pharmacies which are commissioned to provide palliative care drugs is included with Appendix 6.	No	
6	Member of the public	General comment	As above . unable to get prescribed drugs from Tesco when needed	Any complaints should be made directly to the pharmacy or to the Patient Advice and Liaison Service (PALS) at NHS England' Greater Manchester Area Team.	No	
7	Member of the public	General comment	Obviously the fact that we haven't got a local Pharmacy makes me think the PNA needs to Improve. The public should not have to fight for this right .	This comment has been noted.	No	
7	Member of the public	General comment	If we succeed in getting a pharmacy perhaps I could change my opinion .	This comment has been noted.	No	
7	Member of the public	General comment	Lots of elderly and young parents living in Besses need access to a local pharmacy .	This PNA clearly identifies a need for pharmaceutical services within the Besses Ward. It will be a commercial decision for pharmacists and pharmacy companies whether they apply for an NHS contract and NHS England whether they approve any application	No	
7	Member of the public	General comment	don't know enough to comment	N/A	No	
8	Member of the public	General comment	None in Besses area. Difficult to get to late pharmacy without use of car.	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
9	Member of the public	General comment	Provided a cross section of all communities takes part	N/A	No	
9	Member of the public	General comment	With the same proviso as in question 2	N/A	No	
9	Member of the public	General comment	For my own purposes	N/A	No	
13	Organisation - Councillor Bury MBC	General comment	yes, I believe we need local pharmacies and we should look to stop local ones closing and supermarkets taking over this service	Pharmacies are run by individual pharmacists, small, medium and large companies. Each pharmacy should deliver services to the same high standard to their locality (and nationally for distance selling pharmacies) regardless of owner. Any failings should be reported to the appropriate body.	No	
14	Member of the public	General comment	Besses needs a pharmacy	This PNA clearly identifies a need for pharmaceutical services within the Besses Ward. It will be a commercial decision for pharmacists and pharmacy companies whether they apply for an NHS contract and NHS England whether they approve any application	No	
15	Member of the public	General comment	Besses Ward did originally have a pharmacy over 20 years ago	This comment has been noted.	No	
16	Member of the public	General comment	For anyone who does not have access to the internet or get out and about due to immobility etc they would not be able to partake in any consultation, and those are exactly the people who need the local service.	This comment has been noted.	No	
16	Member of the public	General comment	where would we find it and how would people know where to find it?	N/A	No	
16	Member of the public	General comment	Thinking locally, there are no pharmacies within walking distance or even 1, 2 bus stops. There are two within 1/2 mile o each other up at Pilsworth, and two or three in Whitefield but none in the Hillock/Besses area. For those with ailments who just need otc chemist medicines/supplies or advice you would have to get a taxi, a car or travel to get to one - ridiculous. There are perfectly good local shops in a new shopping precinct which would benefit from a pharmacy, also taking the burden off GP's where a Chemist/Pharmacist advice may all that is needed.	This PNA identifies a need for pharmaceutical services within the Besses Ward. It will be a commercial decision for pharmacists and pharmacy companies whether they apply for an NHS contract and NHS England whether they approve any application	No	
17	Member of the public	General comment	We do not have a chemist/pharmacy anywhere near us, its a real issue.	This PNA identifies a need for pharmaceutical services within the Besses Ward. It will be a commercial decision for pharmacists and pharmacy companies whether they apply for an NHS contract and NHS England whether they approve any application	No	

17	Member of the public	General comment	The sooner the better we get something in Besses, ideally on the Hillock	This PNA identifies a need for pharmaceutical services within the Besses Ward. It will be a commercial decision for pharmacists and pharmacy companies whether they apply for an NHS contract and NHS England whether they approve any application	No	
18	Member of the public	General comment	There is no provision in Besses	This PNA clearly a need for pharmaceutical services within the Besses Ward. It will be a commercial decision for pharmacists and pharmacy companies whether they apply for an NHS contract and NHS England whether they approve any application	No	
19	Member of the public	General comment	There is no need for a pharmacy in Besses ward. We have plenty nearby	The PNA for the reasons stated within it identifies a need.	No	
26	Member of the public	General comment	too far for the elderly people to walk	This comment has been noted.	No	
27	Member of the public	General comment	No pharmacy in Besses ward	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
28	Member of the public	General comment	no pharmacies in the Prestwich clough area , have to go to sedgley , or Prestwich centre	This comment has been noted. No need was identified in the Prestwich clough area.	No	
30	Member of the public	General comment	I have to travel roughly 1 mile to the nearest pharmacy	This comment has been noted.	No	
31	Member of the public	General comment	Don't want to answer this	Response to this consultation were optional.	No	
32	Member of the public	General comment	no pharmacies in the Hillock area	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
32	Member of the public	General comment	No, see question 2	This comment has been noted.	No	
34	Member of the public	General comment	Because there is no pharmacy in Besses ward. Nearest is either Unsworth or on Bury New Road.	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
35	Member of the public	General comment	In the Besses Ward there is no Pharmacy. Our nearest one is in Unsworth - easily reached by car for us, but difficult for those who do not drive. This Pharmacy is also extremely busy and there are long queues for people collecting medication.	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
36	Member of the public	General comment	There is no provision in Besses Ward	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
37	Member of the public	General comment	This is needed in this area 6.0	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
37	Member of the public	General comment	we have campaigned for a while now to get a Pharmacy in the area there are quite a few pensioners on our estate who can not travel to other areas to get there prescription I personally have mine on repeats at the chemist near the doctors but not every one has this facility	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
38	Member of the public	General comment	Besses does not have the same access to a chemist as other areas do	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
38	Member of the public	General comment	See above. I am concerned that elderly people without transport are not being catered for in terms of their needs	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
39	Member of the public	General comment	I drive so it isn't as much of an issue but for my elderly mum who also lives in Besses there are no pharmacies in close walking distance	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
40	Member of the public	General comment	Prior to the letter arriving from my MP I was unaware of the PNA or it's purpose.	This comment has been noted.	No	
40	Member of the public	General comment	Besses ward has no provision	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
41	Organisation - Boots UK Limited	Appendix 4 & 8	Appendices 4 & 8 – clarity is needed on the key to the appendices for the orange line Yellow – Opens later on weekdays and open Saturdays and Sundays Blue – Pharmacy opens weekdays and on Saturdays Orange – Open standard core hours Monday – Friday (over 40 hours per week) Green – Internet pharmacies Purple – Appliance suppliers Orange - says standard core hours. Does this mean opening times or does it mean in NHS contractual terms their core hours? They have contractually different timings. The hours listed in both appendices are opening hours. If the orange line is relating to NHS core hours then the hours for the Boots UK Limited stores are incorrect – please contact us for the NHS contractual core hours.	In the key, the orange line has been changed to 'pharmacy opens weekdays only' as the appendix was not intend to highlight the type of contract the pharmacy had but their opening hours.	Yes	17/12/2014
41	Organisation - Boots UK Limited	Appendix 6	Appendix 6 The heading is for opening hours; yet the text is for services – needs changing. For pharmacy ref 6 Boots 32-36 The Mall BL9 0QQ this store does provide the smoking intermediate advice service (SIA) – please change. For pharmacy ref 7 Boots Unit 1 Woodfields Retail Park – this 100 hour pharmacy provides an in- hours palliative care service – missing from the table. Please include	The heading has been amended. Information around commissioned services were provided by commissioners. Service reviews to begin April 2015.	Yes	17/12/2014
41	Organisation - Boots UK Limited	Appendix 6	What is service CS? It is not listed in the key to the table	Column heading CS should actually be CTT. This will be amended.	Yes	17/12/2014
41	Organisation - Boots UK Limited	Section 6.5, Page 65, Figure 29	Corrections in the draft PNA itself Page 65 the table heading “Average items per pharmacy 2012-13” – should specify per month	This will be amended.	Yes	17/12/2014
42	Member of the public	General comment	Insufficient, if any information provided that explains what has already been assessed or how	It appears that responder 42 could not access the PNA document. This has been noted for future reference.	No	
42	Member of the public	General comment	impossible to comment as there is no information of anything the PNA has reported	It appears that responder 42 could not access the PNA document. This has been noted for future reference.	No	
42	Member of the public	General comment	where is this superposed PNA report ? could it be at the end of this survey that you cant get to until all the questions have already been answered ?	It appears that responder 42 could not access the PNA document. This has been noted for future reference.	No	
42	Member of the public	General comment	This survey is yet another waste of public funds, there's chemists all over the borough that collect prescriptions and deliver them to your door	This comment has been noted.	No	
43	Member of the public	General comment	not many open late and at weekends none within a mile of my house. i have a car but not everyone does and if i was ill i would not want to walk much further to get a prescription or help	This comment has been noted.	No	
43	Member of the public	General comment	in an area where there are deprivation issues there should be a 100 hours pharmacy available	The PNA did not identify a need for an additional 100 hour pharmacy in the Bury area.	No	
44	Member of the public	General comment	i need medication regular and there are not near enough.	This comment has been noted.	No	
45	Member of the public	General comment	I agree that there is a need for a chemist on the hillock estate.	This comment has been noted.	No	
46	Member of the public	General comment	I live in Besses Ward area and there is a definitely a need for a pharmacy on Hillock Estate	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
47	Member of the public	General comment	No chemist on Hillock Estate. Have to go to Bury New Rd, Prestwich or Unsworth	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
47	Member of the public	General comment	As per above - Hillock Estate used to have a chemist many years ago but was closed down	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
47	Member of the public	General comment	again Besses Ward does not have many chemists	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
47	Member of the public	General comment	more local chemists	This comment has been noted.	No	
47	Member of the public	General comment	Elderly residents have to travel far for a chemist or ask other people to pick up medication etc for them	This comment has been noted.	No	

48	Organisation - Rowlands Pharmacy	General comment	The PNA recommends that a further pharmacy is needed in Besses ward. there have been numerous applications in this area in recent years and all have been rejected by the NHS Litigation Authority at the appeal stage as the evidence was not available to suggest that current services were not meeting need. this view is supported by the statement, in the PNA, that "the Wards, Radcliffe North and Besses have no pharmacies within their boundaries. However, the public survey did not identify concerns with accessing pharmaceutical services in both these areas". To suggest that another pharmacy is needed in the light of this is od in the extreme. Reference is made to representatives of the local community suggesting that a pharmacy is needed. However, no detail is given regarding the authority these individuals have to make such assertions nor is there adequate explanation of why the short distances to pharmacies in neighbouring wards and the services that they offer is inadequate. It is common knowledge that when asked whether resident would like a pharmacy 'on their doorstep' they will say yes. however the PNA is a document that can have profound consequences on the viability of existing pharmacies and to treat these services with such apparent disdain is unworthy of the document. We question whether the absence of a proper, detailed assessment of need for the Besses ward (rather than the hearsay which has apparently occurred) leaves the PNA document open to judicial review.	There has been concerns raised on a number of ocassions with regards to lack of pharmacuetical provision in Besses wards. This has been noted in the minutes of the Health and Wellbeing Board minutes in April 2014, where residents of Besses presented a need to the Board. Residents have also met with Stuart North, Chief Finance Officer, Bury CCG and Dr Patel, Chair of Bury CCG where it was agreed that a local pharmacy presence was required within the ward. The reason for this is highlighted in Section 1.0, Page 5 of the PNA. In addition, the formal consultation has received 76 public responses . Most of these responses have identified the need for a pharmacy in the Besses area. Unfortunately, a lot of residents in Besses struggled to access the public survey in April and May and therefore, their concerns were not captured at this time.	No	
48	Organisation - Rowlands Pharmacy	General comment	See response to question 2 above	As above.	No	
48	Organisation - Rowlands Pharmacy	General comment	We do not agree with the assertion that another pharmacy is required in Besses ward - see response to question 2.	As above.	No	
48	Organisation - Rowlands Pharmacy	General comment	Another pharmacy is not required in Besses ward - see response to question 2	As above.	No	
49	Member of the public	General comment	Some areas are without easy access to a pharmacy. This presents a major problem to elderly people without their own transport or those on their own with nobody to assist.	This comment has been noted.	No	
50	Member of the public	General comment	Those wards without a pharmacy need that provision. A mile to the nearest pharmacy is a long way if you are elderly with no transport and no help to get there. Not everybody has a phone to arrange delivery either. The PNA identifies 2 wards without pharmacies and this issue should be rectified.	This comment has been noted however, there has been no need identified in Radcliffe North Ward.	No	
50	Member of the public	General comment	In that the wards without pharmacies should have that provision made available.	This comment has been noted however, there has been no need identified in Radcliffe North Ward.	No	
51	Member of the public	General comment	Because no summary provided from a 95 page document	An executive summary is included at the start of the PNA	No	
51	Member of the public	General comment	No Summary of Conclusions from the PNA provided with the survey request letter	An executive summary is included at the start of the PNA	No	
51	Member of the public	General comment	No Summary of Conclusions from the PNA provided with the survey request letter	An executive summary is included at the start of the PNA	No	
51	Member of the public	General comment	No Pharmacies in the Besses Ward	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
51	Member of the public	General comment	No Summary of Conclusions from the PNA provided with the survey request letter	An executive summary is included at the start of the PNA	No	
51	Member of the public	General comment	yes How do you expect people to wade through a 95 page document without providing more advice and summaries with the survey letter.	The only options available to the council due to the size of the PNA was to provide a link to the website or send out paper copies.	No	
52	Organisation - Pharmacy Care Plus Ltd, t/a Barash Pharmacy	General comment	There is no need for a further pharmacy in the Besses ward. Electoral wards do not constitute the best view of pharmaceutical neighbourhoods, they are artificial constructs. There are THREE (3) pharmacies on the borders of the Besses ward, which is more than adequate. What is needed is a range of commissioned services to the existing pharmacies.	There has been concerns raised on a number of ocassions with regards to lack of pharmacuetical provision in Besses wards. This has been noted in the minutes of the Health and Wellbeing Board minutes in April 2014, where residents of Besses presented a need to the Board. Residents have also met with Stuart North, Chief Finance Officer, Bury CCG and Dr Patel, Chair of Bury CCG where it was agreed that a local pharmacy presence was required within the ward. The reason for this is highlighted in Section 1.0, Page 5 of the PNA. In addition, the formal consultation has received 76 public responses . Most of these responses have identified the need for a pharmacy in the Besses area. Unfortunately, a lot of residents in Besses struggled to access the public survey in April and May and therefore, their concerns were not captured at this time.	No	
52	Organisation - Pharmacy Care Plus Ltd, t/a Barash Pharmacy	General comment	The PNA states that there is need of a further pharmacy in Besses ward, but there are three pharmacies already lying on the boundary of Besses Ward and there is actually no need. People when asked, "Would you like a pharmacy here?" will often automatically reply, 'Yes' and politicians would like something to talk about, but to make the decision one needs to know that it comes at a high cost, that the network of surrounding pharmacies is already close by, and that that network's business will be severely disrupted by yet another pharmacy. Bury is in need of MORE COMMISSIONED PHARMACY SERVICES not more pharmacies that are still unfunded to provide the extra services! As yet these have not been delivered through lack of money. This money would be wasted on the establishment and practice fees for a new pharmacy and not a single extra service in the gaps known would be delivered.	There has been concerns raised on a number of ocassions with regards to lack of pharmacuetical provision in Besses wards. This has been noted in the minutes of the Health and Wellbeing Board minutes in April 2014, where residents of Besses presented a need to the Board. Residents have also met with Stuart North, Chief Finance Officer, Bury CCG and Dr Patel, Chair of Bury CCG where it was agreed that a local pharmacy presence was required within the ward. The reason for this is highlighted in Section 1.0, Page 5 of the PNA. In addition, the formal consultation has received 76 public responses . Most of these responses have identified the need for a pharmacy in the Besses area. Unfortunately, a lot of residents in Besses struggled to access the public survey in April and May and therefore, their concerns were not captured at this time.	No	
52	Organisation - Pharmacy Care Plus Ltd, t/a Barash Pharmacy	General comment	Completely adequate and in line with national standards.	This comment has been noted.	No	

52	Organisation - Pharmacy Care Plus Ltd, t/a Barash Pharmacy	General comment	There is no need for an additional pharmacy at huge expense to the public purse in Besses ward. What is needed is more funded pharmacy services through the existing network of pharmacies, that are needed. An additional pharmacy at Besses would also financially destabilise the existing network.	There has been concerns raised on a number of ocassions with regards to lack of pharmacuetical provision in Besses wards. This has been noted in the minutes of the Health and Wellbeing Board minutes in April 2014, where residents of Besses presented a need to the Board. Residents have also met with Stuart North, Chief Finance Officer, Bury CCG and Dr Patel, Chair of Bury CCG where it was agreed that a local pharmacy presence was required within the ward. The reason for this is highlighted in Section 1.0, Page 5 of the PNA. In addition, the formal consultation has received 76 public responses . Most of these responses have identified the need for a pharmacy in the Besses area. Unfortunately, a lot of residents in Besses struggled to access the public survey in April and May and therefore, their concerns were not captured at this time.	No	
52	Organisation - Pharmacy Care Plus Ltd, t/a Barash Pharmacy	General comment	No need for any more pharmacies. We must, instead, improve the services through the existing network.	This comment has been noted.	No	
53	Organisation Pharmacy Care Plus	General comment	There are sufficient pharmacies in place in Besses, but we need instead more enhanced services funding through the existing pharmacy network.	There has been concerns raised on a number of ocassions with regards to lack of pharmacuetical provision in Besses wards. This has been noted in the minutes of the Health and Wellbeing Board minutes in April 2014, where residents of Besses presented a need to the Board. Residents have also met with Stuart North, Chief Finance Officer, Bury CCG and Dr Patel, Chair of Bury CCG where it was agreed that a local pharmacy presence was required within the ward. The reason for this is highlighted in Section 1.0, Page 5 of the PNA. In addition, the formal consultation has received 76 public responses . Most of these responses have identified the need for a pharmacy in the Besses area. Unfortunately, a lot of residents in Besses struggled to access the public survey in April and May and therefore, their concerns were not captured at this time.	No	
54	Member of the public	General comment	I feel we need a pharmacy in Besses Ward Whitefield. We used to have one in Hillock shops when I first came to Whitefield in 1980s. Then it closed down. Not having a car inconvenient as have to pay for public Transport or walk to nearest pharmacy.	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
54	Member of the public	General comment	Areas such as Besses ward need a pharmacy within easy reach particularly for the elderly.	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
55	Organisation - Bury & Rochdale LPC	Section 1.0, Page 5, bullet 3	"(except in Besses Ward)" should be deleted, as Besses ward residents have easy access to four pharmacies immediately across the border with adjacent wards, two of which are open on Saturdays and one is open on Sundays.	There has been concerns raised on a number of ocassions with regards to lack of pharmacuetical provision in Besses wards. This has been noted in the minutes of the Health and Wellbeing Board minutes in April 2014, where residents of Besses presented a need to the Board. Residents have also met with Stuart North, Chief Finance Officer, Bury CCG and Dr Patel, Chair of Bury CCG where it was agreed that a local pharmacy presence was required within the ward. The reason for this is highlighted in Section 1.0, Page 5 of the PNA. In addition, the formal consultation has received 76 public responses . Most of these responses have identified the need for a pharmacy in the Besses area. Unfortunately, a lot of residents in Besses struggled to access the public survey in April and May and therefore, their concerns were not captured at this time.	No	
55	Organisation - Bury & Rochdale LPC	Section 1.0, Page 5, bullet 3 & 4	The comparators should be consistent: either % of pharmacies open on Saturdays and Sundays, or the % of wards with no pharmacies open on Saturdays and Sundays. The use of 'in contrast' suggests a different conclusion from the bullet above, yet the fact that only 12% of the public were concerned indicates that there is sufficient Sunday cover as well.	The PNA will be amended in line with this comment.	Yes	17/12/2014
55	Organisation - Bury & Rochdale LPC	Section 1.0, Page 5, bullet 4	There is an inconsistency in references to the public survey, which is used as evidence in some parts of the PNA, yet referred to as unreliable due to a low response rate in other parts of the same document. This might leave the document open to challenge.	The PNA will be amended in line with this comment.	Yes	17/12/2014
55	Organisation - Bury & Rochdale LPC	Section 1.0, Page 5, bullet 5	'financially viable' would be preferred to 'commercially viable' as this document focuses on NHS clinical services	In line with comments received from NHS England's Greater Manchester Area Team, all reference to commercial viability will be removed from the PNA	Yes	17/12/2014
55	Organisation - Bury & Rochdale LPC	Section 1.0, Page 5, bullet 6	The Area Team does not organise a rota service as such, but it does work with LPCs and community pharmacies to ensure there is cover where and when there is a perceived need.	We have sought clarity from NHS England's Greater Manchester Area Team who have advised they do co-ordinate a rota service.	No	
55	Organisation - Bury & Rochdale LPC	Section 1.0, Page 5, bullet 7	Bury West has two pharmacies (out of three) open on Saturdays so "weekends" should be changed to "within the ward on Sundays". Bury West residents have easy access to five pharmacies immediately across the border in Bury East, four of which are open on Saturdays and three are open on Sundays.	The PNA will be amended to read 'within the ward on Sundays' however, the PNA already clearly states that there are alternative pharmacies available in the neighbouring townships on weekends.	Yes	17/12/2014

55	Organisation - Bury & Rochdale LPC	Section 1.0, Page 5, Besses Ward	The LPC does not agree that there is “a need for [additional] pharmaceutical service provision within Besses ward” for the following reasons: • Applications in this area have been repeatedly rejected, precisely because there is no need for an additional pharmacy in this area. This has been confirmed independently on appeal • Opening a community pharmacy in Besses would cost the NHS in the region of £40k per year in establishment payments • There are four pharmacies on the immediate boundary of the ward, all of which provide collection an delivery services • These pharmacies also all provide additional and enhanced services and are all prepared to provide any further enhanced services that might be commissioned in future • Tesco pharmacy in Prestwich is probably the main supermarket in the area, and provides extended opening hours. The other pharmacies adjacent to Besses would consider extending their hours if a particular need is identified • There is no GP practice in Besses, so patients will travel to adjacent wards for medical treatment, where there is adequate and convenient pharmacy cover near their GP practice. The absence of a nearby GP practice would make it difficult for a pharmacy in Besses to thrive. • Cost should not be a deterrent to the use of public transport – if it genuinely is, then consideration should be given to subsidising the bus service if it isn't already.	There has been concerns raised on a number of ocassions with regards to lack of pharmacuetical provision in Besses wards. This has been noted in the minutes of the Health and Wellbeing Board minutes in April 2014, where residents of Besses presented a need to the Board. Residents have also met with Stuart North, Chief Finance Officer, Bury CCG and Dr Patel, Chair of Bury CCG where it was agreed that a local pharmacy presence was required within the ward. The reason for this is highlighted in Section 1.0, Page 5 of the PNA. In addition, the formal consultation has received 76 public responses . Most of these responses have identified the need for a pharmacy in the Besses area. Unfortunately, a lot of residents in Besses struggled to access the public survey in April and May and therefore, their concerns were not captured at this time.	No	
55	Organisation - Bury & Rochdale LPC	Section 1.0, Page 7, Bullet number 1	LPC is aware that some pharmacies wish to provide this service but are not yet commissioned to do so. This service is currently under review and hopefully more pharmacies will soon be able to provide it. All pharmacies also provide Nicotine Replacement Therapy over the counter.	This comment has been noted and a statement will be included to advise that NRT can be bought over the counter however it should be noted that cost may be a deterrent for the public to use this service outside of NHS provision.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 1.0, Page 7, Bullet number 2	We believe this figure may now be inaccurate following recent recommissioning of the sexual health service.	Information around commissioned services were provided by commissioners. Service reviews to begin April 2015.	No	
55	Organisation - Bury & Rochdale LPC	Section 1.0, Page 7, Bullet number 2	This section should also refer to Pharmacy Needle Exchange, Supervised Consumption and Flu Vaccination, all of which are commissioned in Bury	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 1.0, Page 7	Should read “Community pharmacies are ideally placed…” as services are often provided by the wider pharmacy team	The PNA will be amended in line with this comment.	Yes	17/12/2014
55	Organisation - Bury & Rochdale LPC	Section 1.0, Page 7, tick list	This tick list is very limited and should also include: Public health advice (e.g. through Healthy Living Pharmacies) NHS Health Checks Compliance support Emergency supplies of repeat medication Therapeutic monitoring Support for long term conditions and expert patients Pharmacist prescribers (supplementary and independent) Medication support following hospital discharge	The PNA will be amended in line with this comment. Statement remains in Section 8 only. Reduced duplication.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 3.2.1, Page 11, Figure 1	This map is confusing. It is hard to differentiate between green and blue stars. It would also help if it clearly indicated population density and major transport routes	The map will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 3.2.1, Page 11&12	The sections on LPS, Dispensing Doctors and DACs are potentially confusing. We suggest they should include the heading, a statement that we have none in Bury and need none in Bury, and a reference to the regulations where a definition can be found if required.	This format request will be noted for future PNAs however, this PNA will not be amended.	No	
55	Organisation - Bury & Rochdale LPC	Section 3.2.1, Page 12, Other independent contractors	This section could include reference to domiciliary oxygen services	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 3.2.2, Page 13, NMS	This note is no longer necessary following the DH announcement in August 2014 http://psnc.org.uk/our-news/official-nms-evaluation-confirms-value-of- the-service/	The PNA will be amended in line with this comment.	Yes	17/12/2014
55	Organisation - Bury & Rochdale LPC	Section 3.2.3, Page 14, Public Health Services	This section should include reference to vaccination (e.g. seasonal flu), which is also a service commissioned by NHSE Area Team.	The PNA will be amended in line with this comment.	Yes	17/12/2014
55	Organisation - Bury & Rochdale LPC	Section 3.3, Page 15	We are pleased that this section has been included, but since the recent contract settlement includes reference to a delivery service for certain patients, perhaps another example could be cited such as compliance support for non-DDA patients	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 4.4, Page 23, Final sentence	This might be misconstrued as recruitment advice, which is not appropriate in a PNA. A better way of making this point would be “Pharmacy contractors recruit staff from their local community, which helps them to ensure that local cultural and language diversity is respected”	The PNA will be amended in line with this comment.	Yes	17/12/2015
55	Organisation - Bury & Rochdale LPC	Section 4.6, Page 31, Figure 14	This map is very unclear. The horizontal scale is compressed, and the choice of red stars for pharmacies when the most deprived wards are also in red is unfortunate.	The map will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 5.1, Page 32	Paragraphs 3, 4 and 5 (“However, commissioners…” to “…provide extended hours”) provide advice to commissioners, are not appropriate to an assessment of need, and should therefore be deleted.	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 5.1, Page 33	Many of these are statements of service provision, not health need	The PNA will be amended in line with this comment.	Yes	17/12/2014
55	Organisation - Bury & Rochdale LPC	Section 5.1, Page 33, bullet 7	How many of the pharmacies providing supervised consumption are formally commissioned to do so? LPC is aware of a significant number providing this service unofficially for no payment. This situation is currently under review by the commissioner.	Information around commissioned services were provided by commissioners. Service reviews to begin April 2015.	No	
55	Organisation - Bury & Rochdale LPC	Section 5.1, Page 33, final bullet	Historically, enhanced services have not been promoted to the public. This is partly due to targeted commissioning that means messages can't be a simple 'go to your pharmacy for this service'. The need to restrain demand was another factor.	This comment has been noted.	No	
55	Organisation - Bury & Rochdale LPC	Section 5.2, Page 34	The references to the JSNA would be better placed in section 5.1	A sentence will be included in section 5.1 to advise that the JSNA will be explained in detail in section 5.2.	Yes	07/01/2015

55	Organisation - Bury & Rochdale LPC	Section 5.3, Page 35	We would like to insert a paragraph after paragraph 1 "As well as the pharmacists and dispensing technicians referred to above, pharmacies also employ medicines counter assistants, trained to at least NVQ level 2. Many are trained to provide Brief Interventions, and some act as Healthy Living Champions, Dementia Friends, Carers Champions and more. They add significantly to the skill mix available in pharmacy teams."	The PNA will be amended in line with this comment.	Yes	17/12/2015
55	Organisation - Bury & Rochdale LPC	Section 5.3, Page 35 & 36	Please add to the end of the penultimate paragraph "Allowing pharmacists to take professional responsibility for assessing and declaring their own competence to provide a service is expected to significantly improve service continuity."	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 5.3.3, Page 36	The NHSE flu service example needs updating to 2014-15 "At the time of writing the PNA the GMAT had commissioned an influenza vaccination community pharmacy Enhanced Service from pharmacies across the GM area, including Bury. This pilot service has been commissioned from pharmacies from November 2014 to February 2015, and targets under 65 at risk individuals. Over 200 accredited community pharmacies in Greater Manchester (10 community pharmacies in Bury) have been commissioned to provide the service. The pilot will be evaluated to inform commissioning of subsequent influenza vaccinations programmes."	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 5.3.4, Page 37	To avoid the implication that pharmacies are somehow responsible for gaps in locally commissioned services… and that there is thus a need for additional pharmacies to provide those services… it should be clearly noted here that: 1. The range of NHS services provided is crucially affected by the will and ability of commissioning bodies to commission them 2. Existing pharmacies are willing and able to provide any local service that is commissioned from them 3. To maximise value for public money, any service to meet a local need will be offered to existing community pharmacy contractors in the first instance	This comment will be included in the PNA however, this may need to be re-worded.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Page 38-42, Figure 16	All sections need cross-referencing to appropriate parts of the PNA that give more detail	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Page 38-42, Figure 16, Dispensing of Medicines	"Explanation of medicines prescribed at the time of dispensing has been shown to increase the understanding…" A possibly more relevant example for this service would be the provision of emergency supplies of repeat medication, which avoids calls to Out of Hours GP service, WIC and A&E	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Page 38-42, Figure 16, Repeat Dispensing	The Note is somewhat surprising since Bury has one of the highest uptake and usage levels of EPS2 in the country. Roll out is virtually complete. More appropriate wording might be: "the uptake of the RD service in Bury is low, but is expected to rise now Release 2 of the Electronic Prescription Service is established in the Borough"	The PNA will be amended in line with this comment	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Page 38-42, Figure 16, Disposal of unwanted medicines	"Example:" needs inserting before the second paragraph, which should be amended to include a statement that "… community pharmacies would be willing and able to provide such a service, if commissioned"	The PNA will be amended in line with this comment. This statement will be included within a footnote and referenced throughout the document.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Page 38-42, Figure 16, Public health	Community pharmacies in Bury are not usually provided with leaflets and posters to support these campaigns, which can limit their effectiveness.	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Page 38-42, Figure 16, Signposting	This section needs a definition of the service (perhaps a link to the appropriate page on PSNC's website or cross-reference to Appendix 1 would be sufficient). The example could be referral to Brook Advisory Service for routine contraception. Regrettably, the specific example given is probably one of the few services that pharmacists do not get asked about.	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Page 38-42, Figure 16, Support for Self Care	This section needs a definition of the service (perhaps a link to the appropriate page on PSNC's website or cross-reference to Appendix 1 would be sufficient). The example should read "If patients used pharmacies for advice and treatment on a more frequent basis…"	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Page 38-42, Figure 16, Medicines Use Review	This section needs a definition of the service (perhaps a link to the appropriate page on PSNC's website or cross-reference to Appendix 1 would be sufficient). Targeted MURs are now required to make up 70% of the service. A better example would be an MUR+ service such as inhaler technique support.	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Page 38-42, Figure 16, New Medicines Service	The NMS increases patient engagement with their condition and medicines, supporting patients in making decisions about their treatment and self-management. It focuses on patients' understanding of their new medicine, not just on which have been started or stopped.	The PNA will be amended in line with this comment	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Page 38-42, Figure 16, Locally Commissioned Services	These sections all need definitions and cross-referencing	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Page 38-42, Figure 16, EHC	This example should recognise that community pharmacies can be commissioned to provide routine oral and barrier contraceptive services	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Page 38-42, Figure 16, Sexual Health	Pharmacies can also be an integral part of a comprehensive sexual health service for the general public – perhaps this section should be combined with the Chlamydia section above, to avoid duplication	This section will be combined with the above.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Page 38-42, Figure 16, Supervised consumption	This section needs a definition and cross-referencing Further examples would be supervised consumption of benzodiazepines to aid recovery from prescriber-induced dependence, and of anti-tubercular drugs to aid compliance with complex treatment regimens.	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Page 38-42, Figure 16, Smoking cessation	Typo: "Pharmacist provision of stop smoking…"	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Page 38-42, Figure 16, Palliative Care	The description on p57 is much clearer wording and should be referenced here.	This comment has been noted. The PNA will be amended.	Yes	07/01/2015

55	Organisation - Bury & Rochdale LPC	Section 5.4.1, Page 43	This section, and the map at Figure 18, understates the provision of this service. LPC is aware that some pharmacies wish to provide this service but are not yet commissioned to do so. This service is currently under review and hopefully more pharmacies will soon be able to provide it. All pharmacies also provide Nicotine Replacement Therapy over the counter.	This comment has been noted and a statement will be included. Over the counter NRT has not been included as the provision of retail sales in community pharmacy is not part of this needs assessment since it is not contracted by the NHS.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 5.4.2, Page 44	Community pharmacy can refer directly to the BEATS 'exercise on prescription' service. It is also possible to commission a comprehensive weight management service through pharmacy. Please include a statement that "… community pharmacies in Bury would be willing and able to provide such a service, if commissioned"	The PNA will be amended in line with this comment. This statement will be included within a footnote and referenced throughout the document.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 5.4.3, Page 45	Please include a statement that "… community pharmacies in Bury would be willing and able to provide such a service, if commissioned"	This statement will be included within a footnote and referenced throughout the document.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 5.4.4, Page 45	Community pharmacy can also be commissioned to provide routine oral contraception as part of a comprehensive sexual health service.	This comment has been noted.	No	
55	Organisation - Bury & Rochdale LPC	Section 5.4.4, Page 46, Figure 19	This map is unclear, using green and red stars on a green and red map	The map will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 5.4.5, Page 47	PCT training requirements, coupled with budget cuts, meant that when trained pharmacists left the area incoming pharmacists could not get accreditation to provide the service. Allowing pharmacists to take professional responsibility for assessing and declaring their own competence to provide the service is expected to significantly improve service continuity. This section should acknowledge that all community pharmacies can supply EHC over the counter.	This comment has been noted and a statement will be included. Over the counter EHC has not been included as the provision of retail sales in community pharmacy is not part of this needs assessment since it is not contracted by the NHS.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 5.4.6, Page 49	This is not simply an opportunity for other services to use pharmacy consultation rooms. Please include a statement that "… community pharmacies in Bury would be willing and able to provide such a service themselves, if commissioned"	This comment has been noted. This statement will be included within a footnote and referenced throughout the document.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 5.4.7, Page 49	Community pharmacies are able to offer relatively anonymous support to this cohort of individuals, which is an opportunity to provide support to the 'missing 50%' of OC Users, and can sometimes result in them accessing specialist services.	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 5.4.7a, Page 50	The relative anonymity of this service is essential in order to maximise the uptake of clean equipment and so minimise the spread of blood-borne diseases. More pharmacies are willing and able to provide this service, if commissioned	This comment has been noted. This statement about pharmacies willingness to provide services will be included within a footnote and referenced throughout the document.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 5.4.7b, Page 52	How many of the pharmacies providing supervised consumption are formally commissioned to do so? LPC is aware of a significant number providing this service unofficially for no payment. This situation is currently under review by the commissioner. Community pharmacies do offer a non-judgemental etc service (borne out by the customer satisfaction figures quoted elsewhere in the PNA)	Information around commissioned services were provided by commissioners. Service reviews to begin April 2015. The PNA will be amended in line with this comment.	No	
55	Organisation - Bury & Rochdale LPC	Section 5.4.7b, Page 53, Figure 25	This map doesn't appear to reflect recent commissioning changes to this service	Information around commissioned services were provided by commissioners. Service reviews to begin April 2015. The map to be amended	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 5.4.8, Page 54	This section should be amended to include a statement that "… community pharmacies would be willing and able to provide such services, if commissioned"	This statement will be included within a footnote and referenced throughout the document.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 5.4.9, Page 55	This section should be amended to include therapeutic monitoring services and a statement that "… community pharmacies would be willing and able to provide such services, if commissioned"	This statement will be included within a footnote and referenced throughout the document.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 5.4.13, Page 56	Work is under way to commission a 'Common Ailment Service' in Bury – minor ailments are not 'minor' to the people that are suffering from them at the time!	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 5.4.14, Page 57	To avoid misunderstandings, it is important to note here that all pharmacies carry stock of palliative care drugs regularly prescribed in their area, and can obtain stock of other items quickly when needed. The enhanced service is to ensure access to urgently required items outside normal opening hours.	The PNA will amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 5.4	There is no mention of HLP in the document. It is a pharmacy-led development programme, with 16 pharmacies working towards HLP status in Bury. The HLP programme will drive up the quality of public health provision through community pharmacy, and provide commissioners with quality assurance for services they choose to commission from HLPs.	The PNA will amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 5.5.1, Page 57, Paragraph 3	The final sentence is unclear. Perhaps better wording might be: "Friendly and knowledgeable staff is the most frequent service-related factor selected."	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 5.5.1, Page 57, Paragraph 6	Blood pressure checks are not commissioned under the NHS in Bury, and it is inappropriate to quote awareness of non-NHS services in the PNA, or to comment on the advertising thereof. However, "… community pharmacies would be willing and able to provide such services, if commissioned" Commissioned services should include a publicity and promotion plan, which should be costed in to the business case. Wherever possible services should be commissioned from all pharmacies in the area so a clear message can be given to the public that the service is available from their regular pharmacy.	Comment noted however, this is just an example of a response received from the public survey which has been included for information,	No	
55	Organisation - Bury & Rochdale LPC	Section 5.5.1, Page 58, Note	There is an inconsistency in references to the public survey, which is used as evidence in some parts of the PNA, yet referred to as unreliable due to a low response rate in other parts of the same document. This might leave the document open to challenge.	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 6.1, Page 59	Please delete 'can' in the first sentence. "Pharmacists have an impact…"	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 6.1, Page 59, Penultimate bullet	LPC does not agree that Besses is an exception (see note above re p5)	The statement with regards to the need for an additional pharmacy in Besses stands.	No	
55	Organisation - Bury & Rochdale LPC	Section 6.1, Page 60, bullet 2	'financially viable' would be preferred to 'commercially viable' as this document focuses on NHS clinical services	In line with comments received from NHS England's Greater Manchester Area Team, all reference to commercial viability will be removed from the PNA	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 6.1, Page 60, bullet 3	LPC does not agree that Besses is an exception (see note above re p5)	The statement with regards to the need for an additional pharmacy in Besses stands.	No	

55	Organisation - Bury & Rochdale LPC	Section 6.1, Page 60, bullet 3 & 4	The comparators should be consistent: either % of pharmacies open on Saturdays and Sundays, or the % of wards with no pharmacies open on Saturdays and Sundays. The use of 'in contrast' suggests a different conclusion from the bullet above, yet the fact that only 12% of the public were concerned indicates that there is sufficient Sunday cover as well.	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 6.1, Page 60, bullet 7 & 8	LPC does not agree that Besses lacks access to pharmaceutical services, and believes that these bullet points should be deleted (see note above re p5)	The statement with regards to the need for an additional pharmacy in Besses stands.	No	
55	Organisation - Bury & Rochdale LPC	Section 6.1, Page 60, bullet 9	The Area Team does not organise a rota service as such, but it does work with LPCs and community pharmacies to ensure there is cover where and when there is a perceived need.	We have sought clarity from NHS England's Greater Manchester Area Team who have advised they do co-ordinate a rota service.	No	
55	Organisation - Bury & Rochdale LPC	Section 6.1, Page 60, bullet 11	'required' should be amended to read 'requested' or 'commissioned'	This will be amended to 'requested'.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 6.1, Page 60, bullet 12	This point should include a statement that existing contractors will asked to consider extending their hours if there is a genuine local need	Further to comment below, this will be included on page 61.	No	
55	Organisation - Bury & Rochdale LPC	Section 6.1, Page 61, bullet 2	This should be amended to read: "There is currently satisfactory access to pharmaceutical services in the Borough. In time, if gaps in opening times are identified, these will be addressed initially through dialogue with existing contractors"	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 6.3, Page 63, Figure 27	It is difficult to differentiate between the blue and green stars	The map will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 6.5, Page 65, Paragraph 2	Typo: '…prescribing for common ailments…'	The PNA will be amended in line with this comment	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 6.5, Page 65, Figure 29	Right hand column is Average items per pharmacy per month 2012-13	The PNA will be amended in line with this comment	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 6.6, Page 67-68	The comments relating to Radcliffe North apply equally to Besses and in the view of LPC it is perverse to draw different conclusions for each ward, neither of which needs a new pharmacy.	There has been concerns raised on a number of ocassions with regards to lack of pharmacuetical provision in Besses wards. This has been noted in the minutes of the Health and Wellbeing Board minutes in April 2014, where residents of Besses presented a need to the Board. Residents have also met with Stuart North, Chief Finance Officer, Bury CCG and Dr Patel, Chair of Bury CCG where it was agreed that a local pharmacy presence was required within the ward. The reason for this is highlighted in Section 1.0, Page 5 of the PNA. In addition, the formal consultation has received 76 public responses . Most of these responses have identified the need for a pharmacy in the Besses area. Unfortunately, a lot of residents in Besses struggled to access the public survey in April and May and therefore, their concerns were not captured at this time.	No	
55	Organisation - Bury & Rochdale LPC	Section 6.6, Page 69, Figure 32	This map would be clearer if the horizontal scale was not compressed	The map will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 6.6.1, Page 71	Delete 'except for Besses ward' (see comment re p5)	The statement with regards to the need for an additional pharmacy in Besses stands and therefore, 'except for Besses' will not be removed from this sentence.	No	
55	Organisation - Bury & Rochdale LPC	Section 6.6.1, Page 72, Figure 34	This map is very hard to read. Most pharmacies are located in more densely populated areas, coloured red or orange… and are represented by red stars	The map will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 6.7, Page 74	Currently there is no risk that 100hr pharmacies will be permitted to apply to reduce their hours. They would need to close, then re-apply for a new contract, which would be a major risk to them.	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 6.7, Page 75, Paragraph 2	'required' should be amended to read 'requested' or 'commissioned'	This will be amended to 'requested'.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 6.7, Page 75, Paragraph 3	The Area Team does not organise a rota service as such, but it does work with LPCs and community pharmacies to ensure there is cover where and when there is a perceived need.	We have sought clarity from NHS England's Greater Manchester Area Team who have advised they do co-ordinate a rota service.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 6.7, Page 75, Paragraph 5	'financially viable' would be preferred to 'commercially viable' as this document focuses on NHS clinical services	In line with comments received from NHS England's Greater Manchester Area Team, all reference to commercial viability will be removed from the PNA	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 6.7, Page 75, Paragraph 6	LPC does not agree that Besses is an exception (see note above re p5)	Based on evidence provided, the statement with regards to the need for an additional pharmacy in Besses remains.	No	
55	Organisation - Bury & Rochdale LPC	Section 6.7, Page 77, Figure 38	For completeness and clarity this table should also include weekday opening hours	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 6.7.1 & 6.7.2, Page 78	The comparators should be consistent: either % of pharmacies open on Saturdays and Sundays, or the % of wards with no pharmacies open on Saturdays and Sundays.	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 6.7.1 & 6.7.2, Page 78	LPC does not agree that Besses is an exception (see note above re p5)	Based on evidence provided, the statement with regards to the need for an additional pharmacy in Besses remains.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 7.2, Page 82	Services will be re-designed and re-configured to fit into the new integrated care pathways.	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 7.3, Page 83, Figure 41, Column 7, Paragraph 2	Pharmacists are not 'potential professionals'! "Pharmacists are professionals who are able to administer immunisations…"	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 7.3, Page 84, Figure 41, Column 7, Paragraph 3	Ample evidence exists that community pharmacy is an appropriate venue for Health Checks. This does not need to be trialled. "Pharmacies could be commissioned to provide NHS Health Checks" Healthy Living Pharmacies also address this priority area	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 7.3, Page 85, Figure 41, Column 7, Paragraph 1	"they could be commissioned to provide services that identify the target groups"	The PNA will be amended in line with this comment.	Yes	07/01/2015

55	Organisation - Bury & Rochdale LPC	Section 8.0, Page 88	Delete 'almost' in the first sentence	The statement with regards to the need for an additional pharmacy in Besses stands and therefore, 'almost' will not be removed from this sentence.	No	
55	Organisation - Bury & Rochdale LPC	Section 8.0, Page 89, Access Paragraph 1	Delete 'In general' and 'most' (of Bury) from the first sentence, and 'most' (wards) from the second sentence	The statement with regards to the need for an additional pharmacy in Besses stands and therefore, 'in general' and 'most' will not be removed from this sentence.	No	
55	Organisation - Bury & Rochdale LPC	Section 8.0, Page 89, Access bullet 7 & 8	The comparators should be consistent: either % of pharmacies open on Saturdays and Sundays, or the % of wards with no pharmacies open on Saturdays and Sundays. The use of 'in contrast' suggests a different conclusion from the bullet above, yet the fact that only 4% of the public were concerned indicates that there is sufficient Sunday cover as well.	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 8.0, Page 89, Access bullet 9	'financially viable' would be preferred to 'commercially viable' as this document focuses on NHS clinical services	In line with comments received from NHS England's Greater Manchester Area Team, all reference to commercial viability will be removed from the PNA	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 8.0, Page 89, Access bullet 10	The Area Team does not organise a rota service as such, but it does work with LPCs and community pharmacies to ensure there is cover where and when there is a perceived need.	We have sought clarity from NHS England's Greater Manchester Area Team who have advised they do co-ordinate a rota service.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 8.0, Page 90, Besses Ward	LPC does not agree that Besses requires [additional] pharmaceutical service provision (see note above re p5) The comments relating to Radcliffe North apply equally to Besses and in the view of LPC it is perverse to draw different conclusions for each ward, neither of which needs a new pharmacy.	There has been concerns raised on a number of ocassions with regards to lack of pharmacuetical provision in Besses wards. This has been noted in the minutes of the Health and Wellbeing Board minutes in April 2014, where residents of Besses presented a need to the Board. Residents have also met with Stuart North, Chief Finance Officer, Bury CCG and Dr Patel, Chair of Bury CCG where it was agreed that a local pharmacy presence was required within the ward. The reason for this is highlighted in Section 1.0, Page 5 of the PNA. In addition, the formal consultation has received 76 public responses . Most of these responses have identified the need for a pharmacy in the Besses area. Unfortunately, a lot of residents in Besses struggled to access the public survey in April and May and therefore, their concerns were not captured at this time.	No	
55	Organisation - Bury & Rochdale LPC	Section 8.0, Page 91, Role Paragraph 3 & 4	The idea of targeted delivery by a small number of contractors contradicts the need identified in the previous paragraph that services provided should be promoted to the local population. Experience shows that promotional messages are unclear and ineffective when not all pharmacies provide the service.	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 8.0, Page 91, Role bullet number 1	The paragraph should include a statement that "… community pharmacies would be willing and able to provide such a service, if commissioned"	This statement will be included within a footnote and referenced throughout the document.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 8.0, Page 91, Role bullet number 2	We believe this figure is now inaccurate following recent recommissioning of the sexual health service.	Information around commissioned services were provided by commissioners. Service reviews to begin April 2015.	No	
55	Organisation - Bury & Rochdale LPC	Section 8.0, Page 91, Role bullet number 3	The paragraph should be amended to include a statement that "… community pharmacies would be willing and able to provide alcohol screening and brief advice service, if commissioned"	This statement will be included within a footnote and referenced throughout the document.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Section 8.0, Page 92, tick list	This tick list is very limited and should also include: Public health advice (e.g. through Healthy Living Pharmacies) NHS Health Checks Compliance support Emergency supplies of repeat medication Therapeutic monitoring Support for long term conditions and expert patients Pharmacist prescribers (supplementary and independent) Medication support following hospital discharge	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Appendix 1	Cross references should be made to this appendix at appropriate points in the main document	The PNA will be amended in line with this comment.	Yes	07/01/2015
55	Organisation - Bury & Rochdale LPC	Appendix 8	IMPORTANT: There is a need for clarity around 'Core hours' in this table. With very few exceptions, a pharmacy has 40 core contractual hours (or 100 for those that have opened under the former exemption from the control of entry test), which cannot be amended without the consent of NHS England, together with supplementary hours, which are all the additional opening hours, and which can be amended by the pharmacy subject to giving 90 days notice (or less if NHS England consents). The LPC notes that many of the opening hours quoted in Appendix 8 include supplementary hours, and the treatment of lunchtime closing is inconsistent. We acknowledge that the PNA needs to include the actual physical opening hours of each pharmacy, but the distinction between contractual core hours and voluntary supplementary hours must be clearly identified. The LPC strongly urges the Council to double-check all the pharmacy opening hours against the contractual core hours registered by NHS England and to identify all additional opening hours correctly as supplementary hours.	In the key, the orange line has been changed to 'pharmacy opens weekdays only' as the appendix was not intend to highlight the type of contract the pharmacy had but their opening hours.	Yes	07/01/2015
56	Member of the public	General comment	Need one in Besses	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
56	Member of the public	General comment	Nearest one are in Prestwich (2) and Whitefield near Morrisons	This comment has been noted.	No	
56	Member of the public	General comment	No interest in internet pharmacies. Doesn't count.	As per regulations, internet pharmacies are included with the scope of the PNA due to the services they provide.	No	
61	Member of the public	General comment	No -There are lots of provision throughout Bury - nevertheless there is no provision in Besses ward.	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
62	Member of the public	General comment	In M45 we have no pharmacy - it's 20 minutes walk to nearest from my house, which isn't good enough.	This comment has been noted.	No	
62	Member of the public	General comment	In general - however could do with a pharmacy in our local area - see above.	This comment has been noted.	No	
62	Member of the public	General comment	Open a new Dr surgery with pharmacy attached in M45 as both services are too far away.	The review of general practitioner services fall outside of the scope of the PNA.	No	
64	Member of the public	General comment	Elms is my nearest pharmacy	This comment has been noted.	No	

70	Member of the public	General comment	Yes for Bury. No for Besses - need more services within community to enable achievements to co-inside with the rest of Bury levels of service.	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
72	Member of the public	General comment	Too far away	This comment has been noted.	No	
73	Member of the public	General comment	Urgent need for a local pharmacy. Unsworth pharmacy is running at a capacity . It can't operate for and people are waiting 2 weeks for items on their prescription.	This comment has been noted.	No	
73	Member of the public	General comment	As stated above local pharmacy in Unsworth is providing poor service due to the capacity of people it serves.	This comment has been noted. Any complaints with regards to poor service should be made directly to the pharmacy or to the Patient Advice and Liaison Service (PALS) at NHS England' Greater Manchester Area Team.	No	
73	Member of the public	General comment	Pharmacy is urgently required in Besses Ward	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
74	Member of the public	General comment	Not enough in area	This comment has been noted.	No	
74	Member of the public	General comment	No not enough in area.	This comment has been noted.	No	
74	Member of the public	General comment	Needed in Besses Ward area.	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
74	Member of the public	General comment	Pharmacy urgently needed Besses Ward	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
77	Member of the public	General comment	None in Whitefield	This comment has been noted however, the PNA does identify two pharmacies Whitefield.	No	
78	Member of the public	General comment	There is not enough local pharmacies	This comment has been noted.	No	
80	Member of the public	General comment	Besses had a pharmacy for over 20 years - this was a huge facility to our community. It was of use in the past, surely it is a need now. There are 7 new housing estates in the vicinity of where that chemist was located and where we would like a chemist locating now.	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
82	Member of the public	General comment	More needed/waiting time at most pharmacies is too long	This comment has been noted.	No	
83	Member of the public	General comment	Besses Ward does not posses a pharmacy	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
84	Member of the public	General comment	Need another pharmacy in Besses area.	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
84	Member of the public	General comment	That it needs to be discussed about a Besses Chemist	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
86	Member of the public	General comment	I think one is needed in the Besses area.	This comment has been noted. The PNA has already identified a need in the Besses ward.	No	
86	Member of the public	General comment	Pharmacy needed more local	This comment has been noted.	No	
86	Member of the public	General comment	There is a lack of easy access pharmacy	This comment has been noted.	No	
88	Organisation - Bury Health Scrutiny		The Committee broadly support the assessment of need detailed within the PNA, namely that; • all wards in Bury with the exception of Besses Ward are well provided for by pharmaceutical service providers • more pharmacies need to offer extended opening hours • that there is a need for pharmaceutical service provision within the Besses Ward • More work needs to be done to ensure that those additional services commissioned by Bury Local Authority and CCG from Bury pharmacies are promoted to the local population so as to improve their uptake.	This comment has been noted.	No	
88	Organisation - Bury Health Scrutiny		The Scrutiny committee discussed the need to ensure that pharmacies collaborate with each other and with other healthcare professionals, to develop models of care which enable commissioners to deliver integrated patient pathways, and ensure patients have consistent access to support.	This comment will be included in the PNA's Executive Summary.	Yes	07/01/2015
88	Organisation - Bury Health Scrutiny		Members of the Committee expressed concern that members of the public are n	This comment has been noted and will be fedback to commissioners of these services.	No	
89	Organisation - NHS England - Greater Manchester Area Team	P4, then through	"(as amended)" needs to be added in after any reference to the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, for completeness	The PNA will be amended in line with this comment.	Yes	07/01/2015
89	Organisation - NHS England - Greater Manchester Area Team	P5, P60	Statement says:- "Although it would be ideal to have more pharmacies offering extended opening hours seven days a week, realistically this could be an expensive and underused service which is not commercially viable for contractors." As this is a needs assessment document, would query the appropriateness of including a statement which isn't needs based and is entirely cost related. Finance isn't a determining factor when approving or refusing applications for new pharmacies.	This comment has been noted and all reference to commercial viability will be removed from the PNA.	Yes	07/01/2015
89	Organisation - NHS England - Greater Manchester Area Team	P5, then throughout the document P90	Relating to the "need" identified in Besses ward:- Some of the statements are slightly vague regarding this. If a need has been identified, then the wording should reflect this, i.e. Paragraph 2, P6 "… However, for Besses ward, it is recommended that an additional pharmaceutical provider is established in the Hillock estate area". Suggest this should say " …However, for Besses ward, a need has been identified for pharmacy provision". Also think "the Hillock estate area" needs clarifying as it was a struggle to locate anything called "Hillock Estate" on the map – might be helpful to specify exactly whereabouts in the Besses ward it is, for anyone not familiar with this part of Bury. In paragraph 2, P6 "In addition to the above recommendation, any new pharmacy contractor should be accessible during the following times." I would suggest this should say "In addition to the above recommendation, a need has been identified for the following hours of pharmaceutical service availability." (Thus expressly stating the needs). The recommended hours of accessibility stated for Besses on P90 appear to state a requirement for the 40 core hours to be between Monday and Friday. Pharmacies can declare any 40 hours as core throughout Monday to Sunday, so this statement sounds like any incoming provider is being directed to specifically provide core hours during the week, but not at weekends.	The PNA will be amended in line with this comment. The recommended hours of accessibility stated for Besses Ward is expected to be a minimum of 47 core hours over 7 days (40 of those hours are expected as a minimum, to be delivered on weekdays)	Yes	07/01/2015
89	Organisation - NHS England - Greater Manchester Area Team	P36, 5.3.1, then throughout the document	Reference made to "GMAT" without explaining that this is NHS England's Greater Manchester Area Team. Other parts of the document refer to "NHS England Area Team" – the Area Team should be described either as one or the other, to avoid confusion.	The PNA will be amended in line with these comments.	Yes	07/01/2015
89	Organisation - NHS England - Greater Manchester Area Team	P60	Bullet point beginning "There is a gap in pharmacy contracted hours to cover statutory holidays". This looks like the PNA is determining a need, when the rest of the statement confirms there is no need identified. There generally isn't a "gap" in provision, as the Area Team ensures adequate provision on statutory holidays. Therefore suggest removing this sentence entirely, then beginning the next sentence "Due …." as it then goes on to state that many pharmacies are actually open on these days.	The PNA will be amended in line with these comments.	Yes	07/01/2015

89	Organisation - NHS England - Greater Manchester Area Team	P61	States “Bury CCG’s successful bid of the Prime Minister’s Challenge Fund to support the Easy GP pilot project aims to increase patient access to practices and create an additional 150,000 appointments per year. Some existing pharmacies may be required to extend their opening hours to support the Easy GP project. Additional funding may be required if the extra business generated for those pharmacies does not produce sufficient commercial return”. Use of the phrase “may be required to” indicates the intention is to impose extended opening hours on some pharmacies local to the GP pilot sites. If this is the case, there are several pharmacies across Bury already offering extended hours or 100 hours access - has consideration been given to these ?	The PNA will be amended in line with these comments.	Yes	07/01/2015
89	Organisation - NHS England - Greater Manchester Area Team	P60, P78	Making reference to “reduced access” to pharmacy services in Bury West, Ramsbottom, Tottington and North Manor Townships implies that there was once more access, and that access has in some way decreased. Would suggest amended wording to say these townships “… have less weekend access in comparison to other Bury townships.” Under 6.7.2 there is a statement that these townships are “poorly served at weekends” which again implies there is a need – if this is the case, the need should be explicitly specified. If there is no identified need, would suggest rewording this just to state the actual coverage rather than highlighting a perceived lack of coverage i.e. “… townships are served at weekends with access from …” etc.	The PNA will be amended in line with these comments.	Yes	07/01/2015
89	Organisation - NHS England - Greater Manchester Area Team	P89	Under “access to pharmaceutical services”, bullet point beginning “Bury West Township has reduced at weekends” doesn’t make sense – has reduced *what* at weekends ? If this is similar to the statement regarding “reduced access” above, suggest similar amended wording.	The PNA will be amended in line with this comment.	Yes	07/01/2015
90	Organisation - Lloyds Pharmacy	Appendix 6 & 8	I have gathered the following information regarding correct opening times and services offered. Could you please correct this info on the PNA. Branch 6401 2 Knowsley Place, Knowsley St, Bury Mon – Fri 8am to 6.30pm Sat – 9am to 12pm Services: BP, Smoking Cessation, Diabetes, EHC, MURS, Minor Ailments Branch 6402 Moorgate, 22 Derby Way, Bury Mon – Fri 8am to 6.30pm Sat – Closed Services: Diabetes, BP, EHC, Flu Vac, MUR’s, Minor Ailments Branch 7140 474 Bury Old Rd Prestwich Mon – Fri 8.30am to 6.15pm Sat – 9am – 5pm Services: Diabetes, BP, Stop Smoking, Pru Health, Mur’s, NMS, EHC, Care in the Chemist Branch 7360 6 Bolton St, Ramsbottom Mon - Tues 8.30am to 8pm Wed – Fri 8.30am to 6.30pm Sat – 9am to 12.30pm Services: Minor Ailments, Repeat Prescription, Substances miss use / methadone, Diabetes, BP, NMS and MUR	The opening hours listed does not match the opening hours provided by NHS England's Greater Manchester Area Team. It is therefore requested that the responder advises the Area Team of the changes and the Area Team will advise the LA, CCGs and CSU as appropriate.	No	

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Appendix 4 – Cross Boundary Pharmacies (Figure 29)

Yellow – Pharmacy opens later on weekdays and open Saturdays and Sundays
Blue – Pharmacy opens weekdays and on Saturdays
Orange – Pharmacy opens weekdays only
Green – Internet pharmacies
Purple – Appliance suppliers

Local Authority	Pharmacy Trading Name	Address	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Bolton	A1 Pharmacy	491 Radcliffe Road, Darcy Lever	BL3 1SX	8.30am - 1pm 2pm - 5.30pm	8.30am - 1pm 2pm - 5.30pm	8.30am - 1pm 2pm - 5.30pm	8.30am - 1pm 2pm - 5.30pm	8.30am - 1pm 2pm - 5.30pm	9.00am - 12.30pm	Closed
Bolton	Cohens Chemist	31 Kentmere Road, Breightmet	BL2 5JG	9am - 1pm 2pm - 5.30pm	9am - 1pm 2pm - 5.30pm	9am - 1pm 2pm - 5.30pm	9am - 1pm 2pm - 5.30pm	9am - 1pm 2pm - 5.30pm	9am - 12.00pm	Closed
Bolton	Cohens Chemist	Breightmet Health Centre, Breightmet Fold Lane	BL2 6NT	8am - 11pm	8am - 11pm	8am - 11pm	8am - 11pm	8am - 11pm	9am - 10pm	10am - 10pm
Bolton	Cohens Chemist	1 Market Street, Little Lever	BL3 1HH	9am - 6.30pm	9am - 6.30pm	9am - 6.30pm	9am - 6.30pm	9am - 6.30pm	9am - 1pm	Closed
Bolton	Gordon Leonard	193-195 Bolton Road, Kearsley	BL4 9BX	8am - 6pm	8am - 6pm	8am - 5pm	8am - 6pm	8am - 6pm	Closed	Closed
Bolton	Market Pharmacy	34 Brackley Street, Farnworth	BL4 9DR	9am - 5.30pm	9am - 5.30pm	9am - 5.00pm	9am - 5.30pm	9am - 5.30pm	9am - 5.00pm	Closed
Bolton	Maxwell's Chemist	830 Bury Road	BL2 6PA	9am - 1.15pm 2.15pm - 6pm	9am - 1.15pm 2.15pm - 6pm	9am - 2pm	9am - 1.15pm 2.15pm - 6pm	9am - 1.15pm 2.15pm - 6pm	9am - 1pm	Closed
Bolton	Springview Pharmacy	Springview Health Centre, Mytham Road	BL3 1HQ	8.45am - 1pm 2pm - 6.30pm	8.45am - 1pm 2pm - 6.30pm	8.45am - 1.30pm	8.45am - 1pm 2pm - 6.30pm	8.45am - 1pm 2pm - 6.30pm	Closed	Closed

Local Authority	Pharmacy Trading Name	Address	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Bolton	The Co-Operative Pharmacy	118 High Street, Little Lever	BL3 1LR	9am - 7pm	9am - 7pm	9am - 5pm	9am - 7pm	9am - 7pm	9am - 1pm	Closed
Bolton	The Co-Operative Pharmacy	Farnworth Health Centre, Frederick Street	BL4 9AL	8.30am - 6pm	8.30am - 6pm	8.30am - 5.30pm	8.30am - 6pm	8.30am - 6pm	Closed	Closed
Lancashire	Village Pharmacy	365 Bolton Road, Edgworth	BL7 0AZ	9am-1pm 2pm-6pm	9am-1pm 2pm-6pm	9am-1pm 2pm-6pm	9am-1pm 2pm-6pm	9am-1pm 2pm-6pm	Closed	Closed
Manchester	Boots The Chemist	3 Delaunays Road, Higher Crumpsall	M8 4QS	9am-6pm	9am-6pm	9am-6pm	9am-6pm	9am-6pm	9am-1pm	Closed
Manchester	Boots The Chemist	103 Crumpsall Lane, Crumpsall	M8 5SR	9am-6pm	9am-6pm	9am-6pm	9am-6pm	9am-5.30pm	Closed	Closed
Manchester	Cheetham Hill Internet Pharmacy	460b Cheetham Hill Road, Cheetham Hill	M8 9JW	9am - 1pm 2pm - 6pm	9am - 1pm 2pm - 6pm	9am - 1pm 2pm - 6pm	9am - 1pm 2pm - 6pm	9am - 1pm 2pm - 6pm	Closed	Closed
Manchester	Lloyds Pharmacy	Wellfield Medical Centre, 53-55 Crescent Road, Crumpsall	M8 9JT	8.30-6.30pm	8.30-6.30pm	8.30-6.30pm	8.30-6.30pm	8.30-6.30pm	Closed	Closed
Manchester	Sainsbury's Pharmacy	170 Heaton Park Road West, Higher Blackley	M9 0QS	7am - 11pm	7am - 11pm	7am - 11pm	7am - 11pm	8am-10pm	7am - 10pm	10am - 4pm
Manchester	Tesco Pharmacy	Cheetham Hill Road, Cheetham	M8 5DP	8am-10.30pm	6.30am-10.30pm	6.30am-10.30pm	6.30am-10.30pm	6.30am-10.30pm	6.30am-10pm	10am-4pm
Manchester	The Co-Operative Pharmacy	183-187 Victoria Avenue, Blackley	M9 0RB	9am-6.30pm	9am-6.30pm	9am-5.30pm	9am-6.30pm	9am-6.30pm	Closed	Closed
Manchester	Wise Pharmacy	376 Cheetham Hill Road, Cheetham Hill	M8 9LS	9am-9pm	9am-9pm	9am-9pm	9am-9pm	9am-9pm	9am-9pm	Closed
Rochdale	Bowness Pharmacy	26 Bowness Road, Langley	M24 4WT	8.45am-6pm	8.45am-6pm	8.45am-6pm	8.45am-6pm	8.45am-6pm	8.45am-1pm	Closed
Rochdale	Internet Pharmacy	120 Bury New Road, Heywood	OL104RG	9am-6pm	9am-6pm	9am-6pm	9am-6pm	9am-6pm	Closed	Closed
Rochdale	Lloyds Pharmacy	7 Argyle Parade, Darnhill	OL103RY	8.30am-6pm	8.30am-6pm	8.30am-6pm	8.30am-6pm	8.30am-6pm	Closed	Closed
Rochdale	Rowlands Pharmacy	3a Lakeland Court, Wood Street	M24 3QJ	9am - 1pm 2pm - 6.15pm	9am - 1pm 2pm - 6.15pm	9am - 1pm 2pm - 6.15pm	9am - 1pm 2pm - 6.15pm	9am - 1pm 2pm - 6.15pm	9am-1pm	Closed
Salford	Boots The Chemist	1-2 St Margaret's Building, Bury Old Road	M7 4PF	9am-5.30pm	9am-5.30pm	9am-5.30pm	9am-5.30pm	9am-5.30pm	9am -5pm	Closed
Salford	Rosenhead Pharmacy	49 Leicester Road	M7 4AS	9am-6.30pm	9am-6.30pm	9am-6.30pm	9am-6.30pm	9am-6pm	Closed	9.30am-1pm
Salford	Rowlands Pharmacy	92 Littleton Road	M7 3SE	9am -1pm 2pm - 6.15pm	9am -1pm 2pm - 6.15pm	9am -1pm 2pm - 6.15pm	9am -1pm 2pm - 6.15pm	9am -1pm 2pm - 6.15pm	Closed	Closed

Local Authority	Pharmacy Trading Name	Address	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Salford	SMS Pharmacy	86 Devonshire Street	M7 4AE	7am - 10pm	7am - 10pm	7am - 10pm	7am - 10pm	7am - 10pm	7am - 8pm	7am - 7pm
Salford	Tims & Parker	The Health Centre, 659 Bolton Road, Pendlebury	M27 8HP	8.30am - 6pm	8.30am - 6pm	8.30am - 6pm	8.30am - 6pm	8.30am - 6pm	Closed	Closed
Salford	Tims & Parker	716 Bolton Road, Pendlebury	M27 6EW	9am - 6.30pm	9am - 6.30pm	9am - 6.30pm	9am - 6.30pm	9am - 6.30pm	9am - 1pm	Closed

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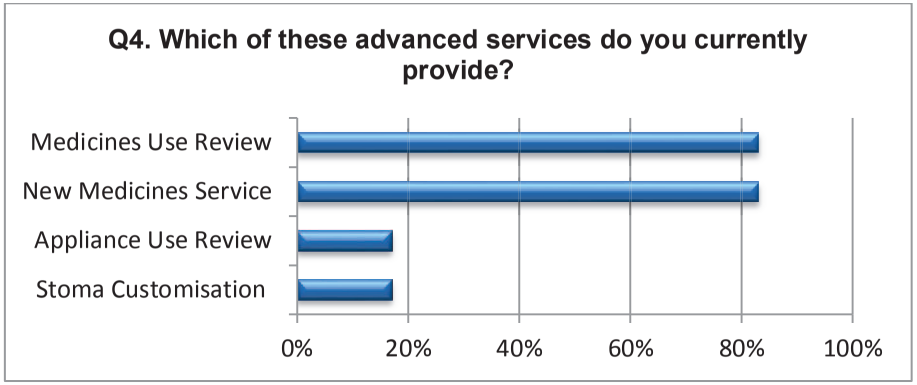
Appendix 5 – Pharmacy Survey

A survey was created and ran from the 7th April 2014 until the 25th May 2014 to gather information from pharmacies with regards to the services they provide to the public.

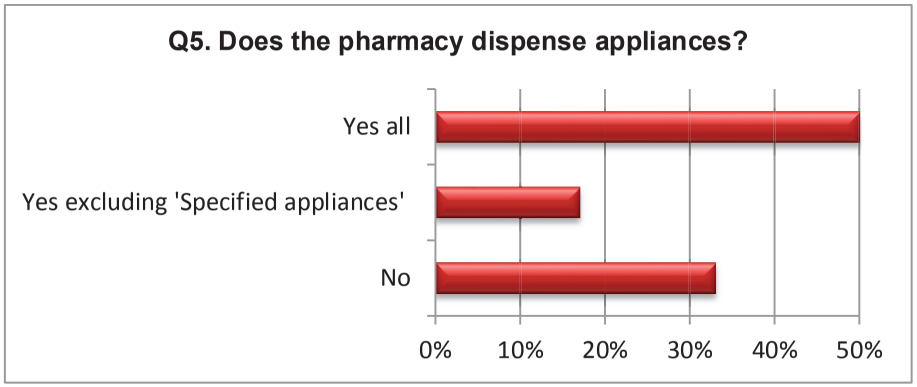
The survey received responses from 6 out of 39 community pharmacies in Bury.

Where analysis does not meet 6 responses, this is due to pharmacies omitting to answer certain questions.

The response to questions 1, 2 and 3 with regards to the pharmacy's contact details and opening hours have been incorporated in **appendix 8.**

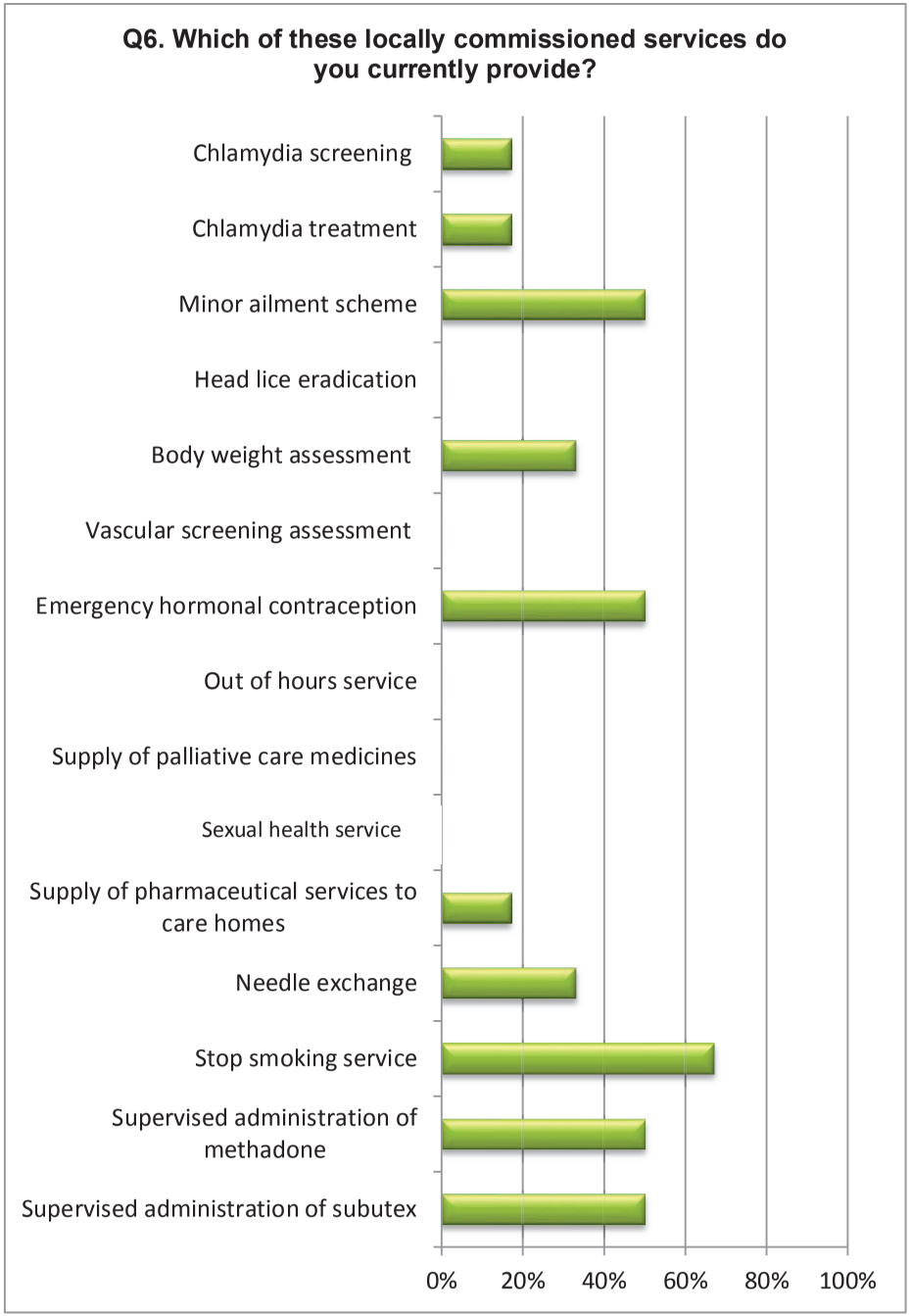


Which of these advanced services do you currently provide?		
Stoma Customisation	17%	1
Appliance Use Review	17%	1
New Medicines Service	83%	5
Medicines Use Review	83%	5

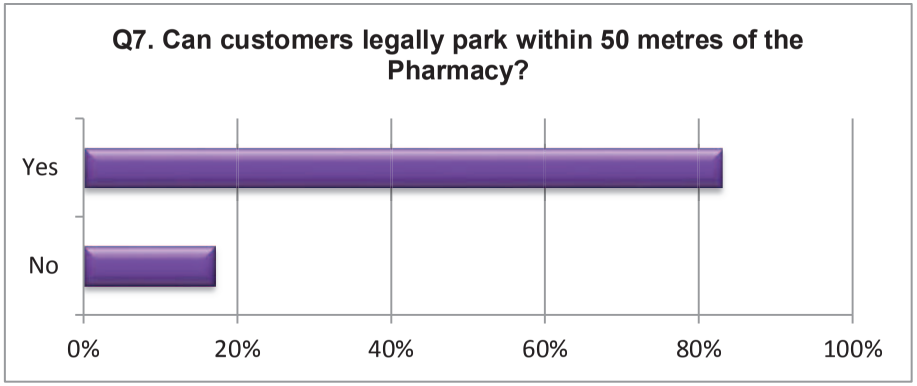


Does the pharmacy dispense appliances?		
No	33%	2
Yes excluding 'Specified appliances'	17%	1
Yes all	50%	3

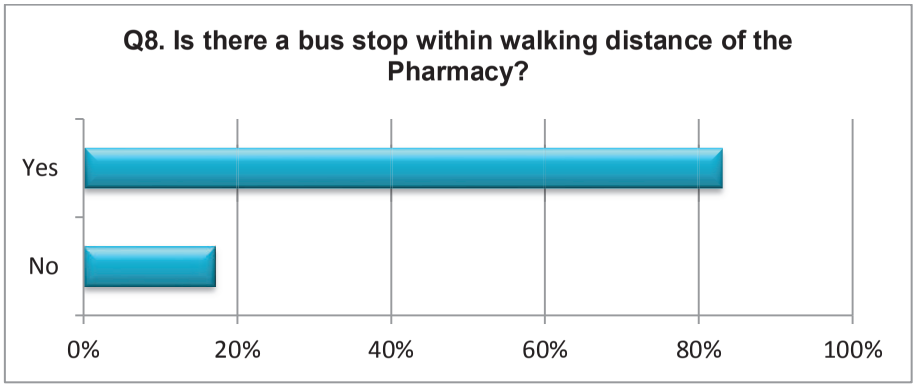
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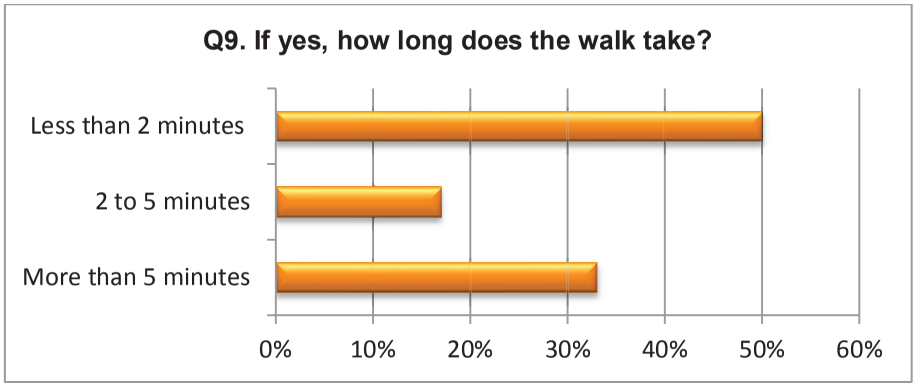
Which of these locally commissioned services do you currently provide?		
Supervised administration of subutex	50%	3
Supervised administration of methadone	50%	3
Stop smoking service	67%	4
Needle exchange	33%	2
Supply of pharmaceutical services to care homes	17%	1
Sexual health service including supply of contraception under patient group direction	0%	0
Supply of palliative care medicines	0%	0
Out of hours service	0%	0
Emergency hormonal contraception	50%	3
Vascular screening assessment	0%	0
Body weight assessment	33%	2
Head lice eradication	0%	0
Minor ailment scheme	50%	3
Chlamydia treatment	17%	1
Chlamydia screening	17%	1



Can customers legally park within 50 metres of the Pharmacy?		
No	17%	1
Yes	83%	5

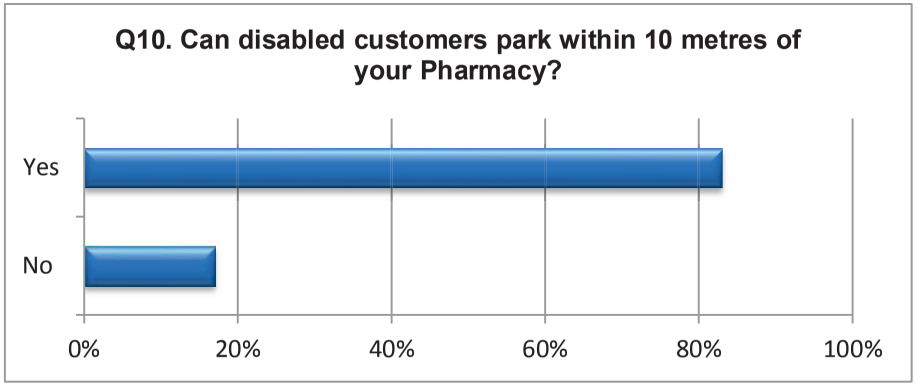


Is there a bus stop within walking distance of the Pharmacy?		
No	17%	1
Yes	83%	5

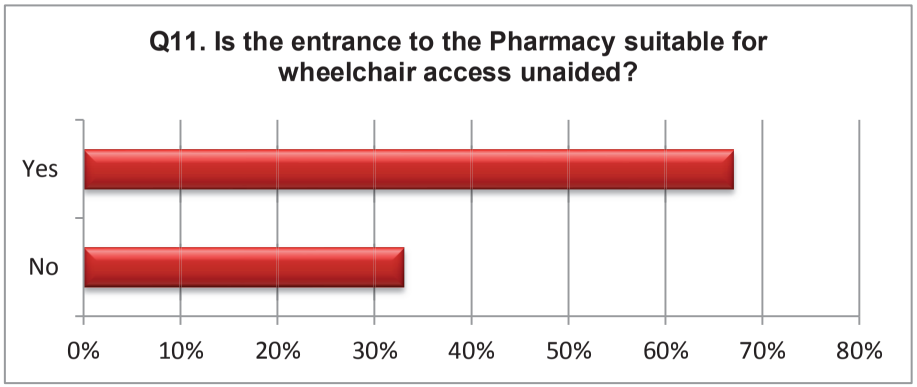


If yes, how long does the walk take?		
More than 5 minutes	33%	2
2 to 5 minutes	17%	1
Less than 2 minutes	50%	3

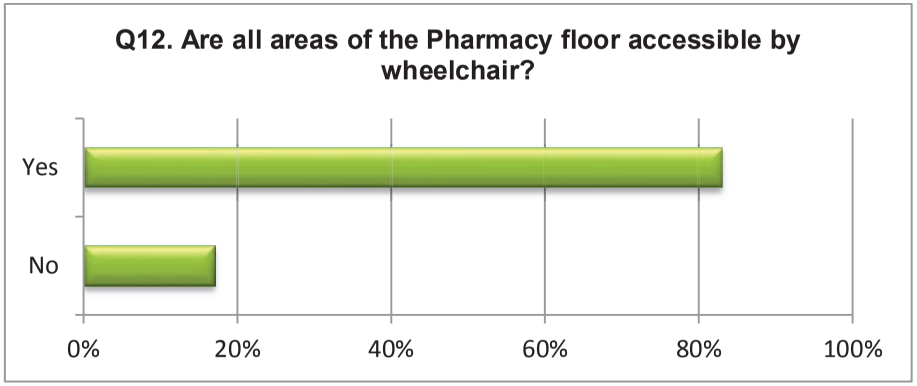
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Can disabled customers park within 10 metres of your Pharmacy?		
No	17%	1
Yes	83%	5

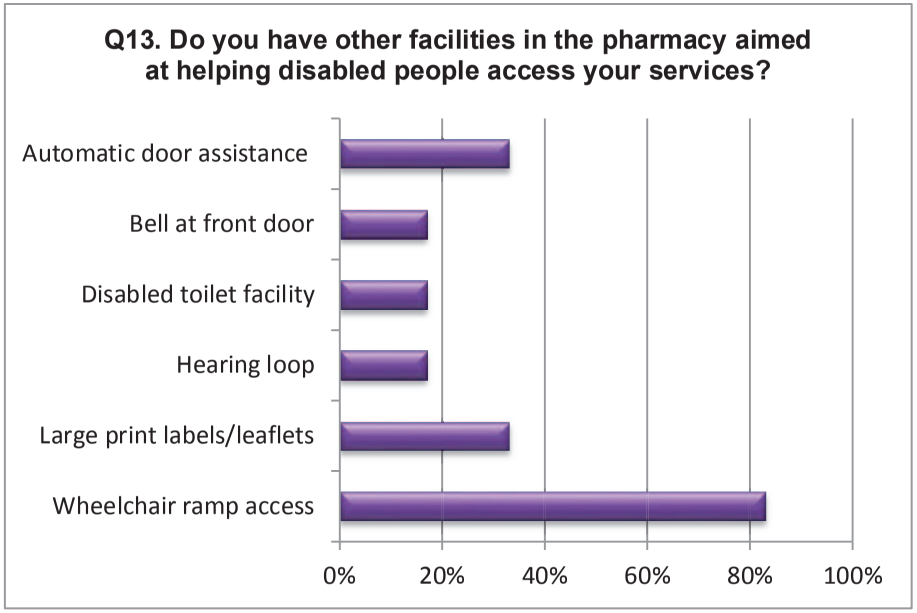


Is the entrance to the Pharmacy suitable for wheelchair access unaided?		
No	33%	2
Yes	67%	4

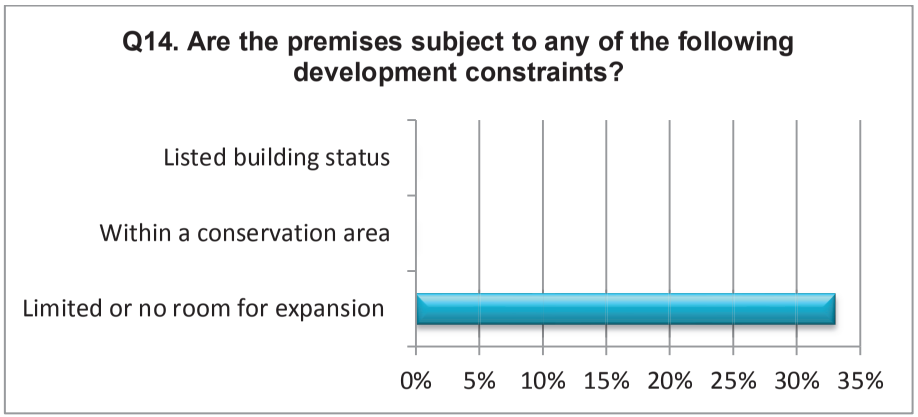


Are all areas of the Pharmacy floor accessible by wheelchair?		
No	17%	1
Yes	83%	5

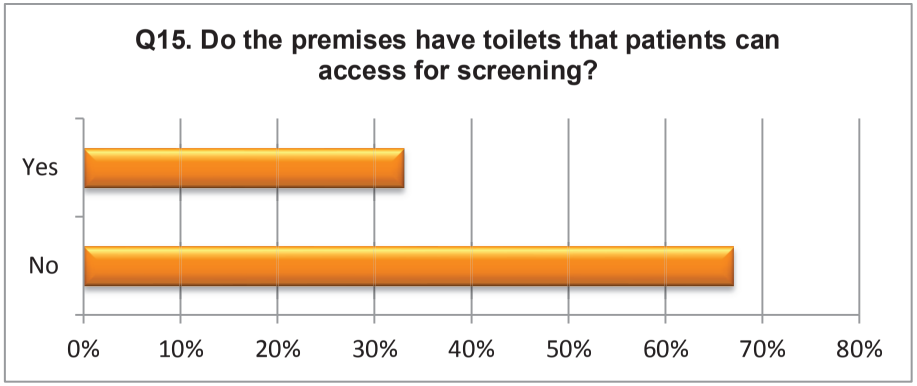
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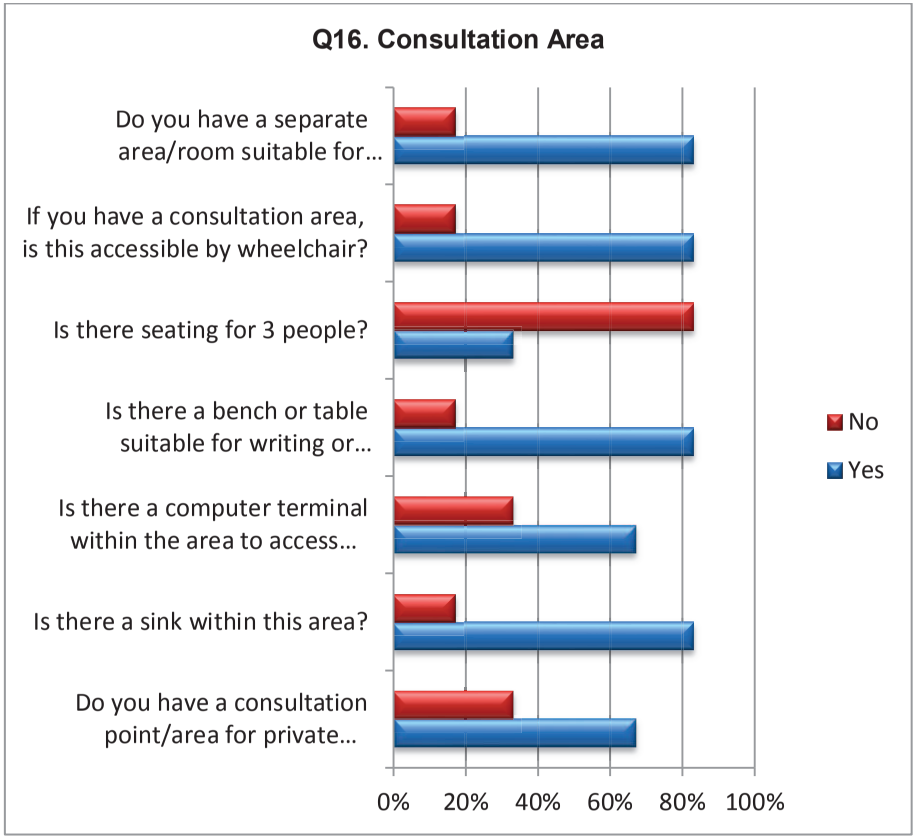
Do you have other facilities in the pharmacy aimed at helping disabled people access your services?		
Wheelchair ramp access	83%	5
Large print labels/leaflets	33%	2
Hearing loop	17%	1
Disabled toilet facility	17%	1
Bell at front door	17%	1
Automatic door assistance	33%	2



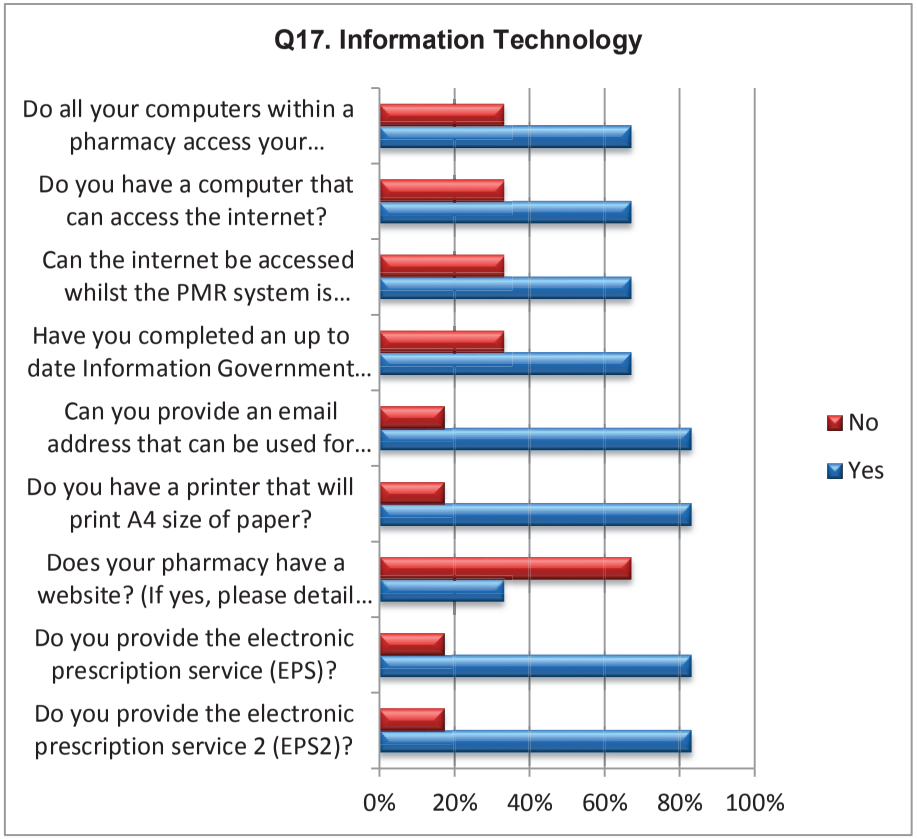
Are the premises subject to any of the following development constraints?		
Limited or no room for expansion	33%	2
Within a conservation area	0%	0
Listed building status	0%	0



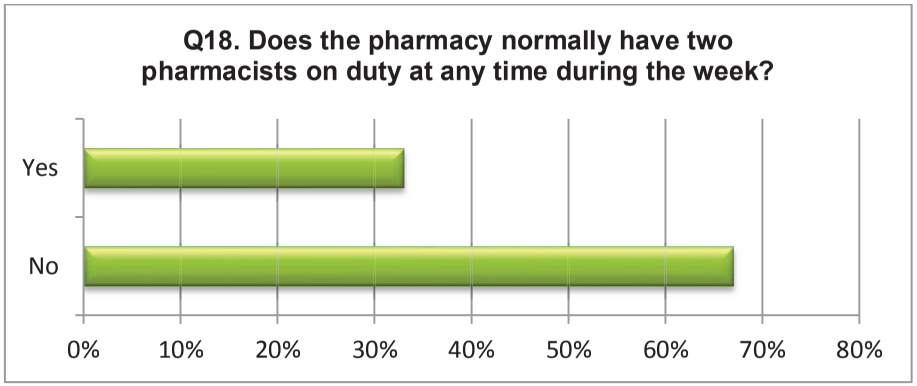
Do the premises have toilets that patients can access for screening?		
No	67%	4
Yes	33%	2



Consultation Area		
	Yes	**No**
Do you have a consultation point/area for private discussions?	67%	33%
Is there a sink within this area?	83%	17%
Is there a computer terminal within the area to access patient's records or complete audit data?	67%	33%
Is there a bench or table suitable for writing or examining medicines/products?	83%	17%
Is there seating for 3 people?	33%	83%
If you have a consultation area, is this accessible by wheelchair?	83%	17%
Do you have a separate area/room suitable for advanced services for consultations with customers?	83%	17%

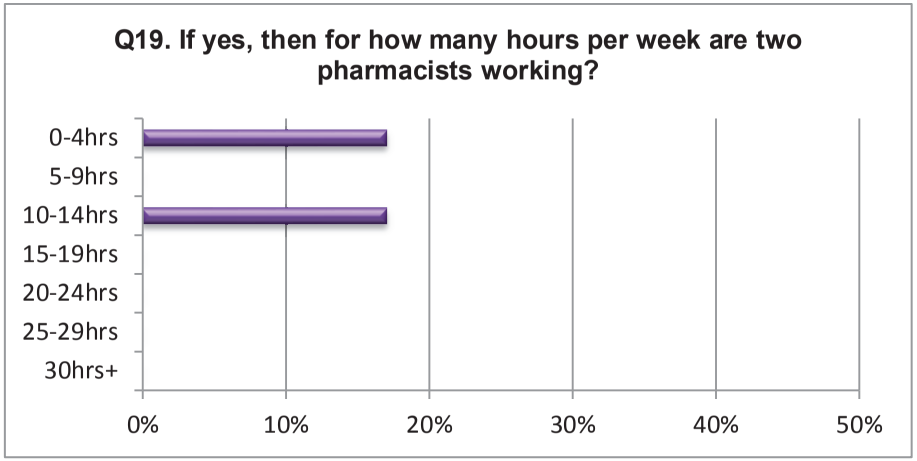


Information Technology		
	Yes	No
Do you provide the electronic prescription service 2 (EPS2)?	83%	17%
Do you provide the electronic prescription service (EPS)?	83%	17%
Does your pharmacy have a website? (If yes, please detail below)	33%	67%
Do you have a printer that will print A4 size of paper?	83%	17%
Can you provide an email address that can be used for official communications? (If yes, please detail below)	83%	17%
Have you completed an up to date Information Government assessment?	67%	33%
Can the internet be accessed whilst the PMR system is running?	67%	33%
Do you have a computer that can access the internet?	67%	33%
Do all your computers within a pharmacy access your dispensary software?	67%	33%

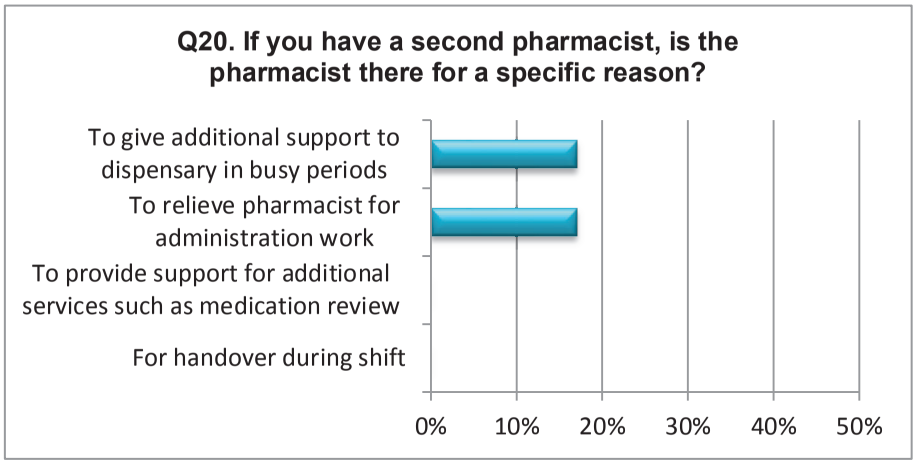


Does the pharmacy normally have two pharmacists on duty at any time during the week?		
No	67%	4
Yes	33%	2

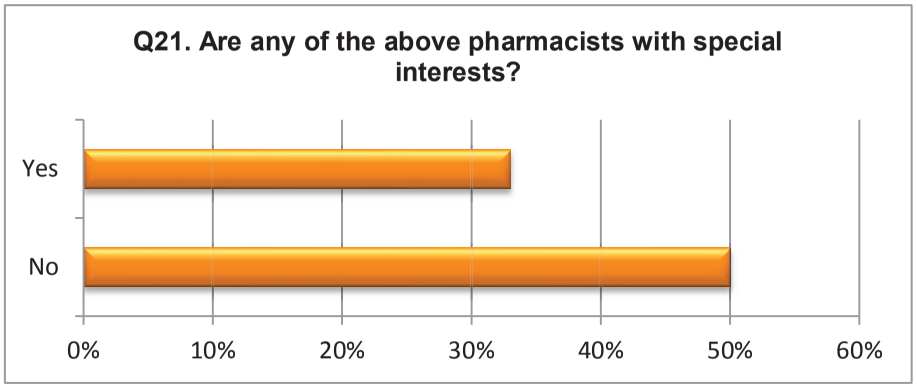
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If yes, then for how many hours per week are two pharmacists working?		
30hrs+	0%	0
25-29hrs	0%	0
20-24hrs	0%	0
15-19hrs	0%	0
10-14hrs	17%	1
5-9hrs	0%	0
0-4hrs	17%	1

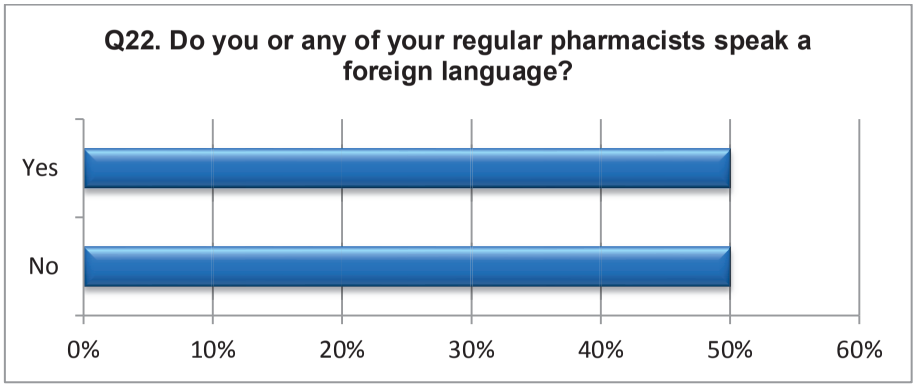


If you have a second pharmacist, is the pharmacist there for a specific reason?		
For handover during shift	0%	0
To provide support for additional services such as medication review	0%	0
To relieve pharmacist for administration work	17%	1
To give additional support to dispensary in busy periods	17%	1

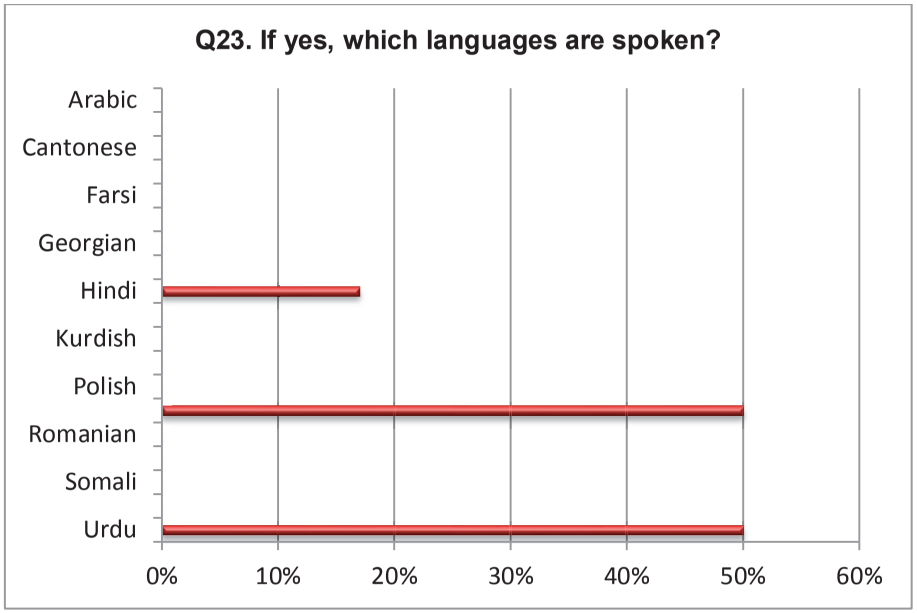


Are any of the above pharmacists with special interests?		
No	50%	3
Yes	33%	2

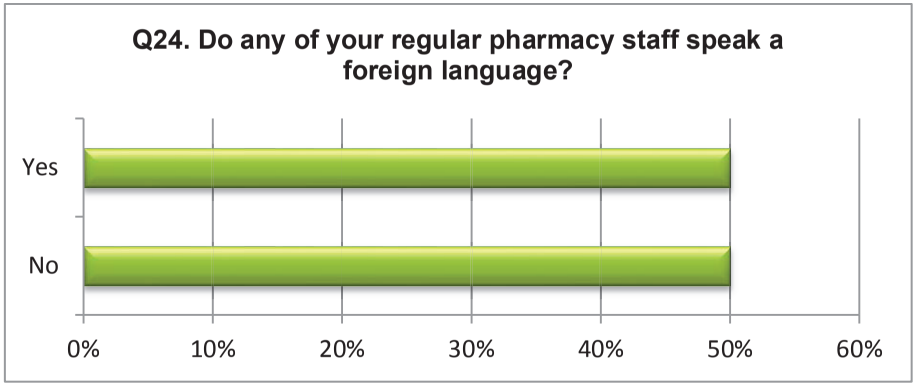
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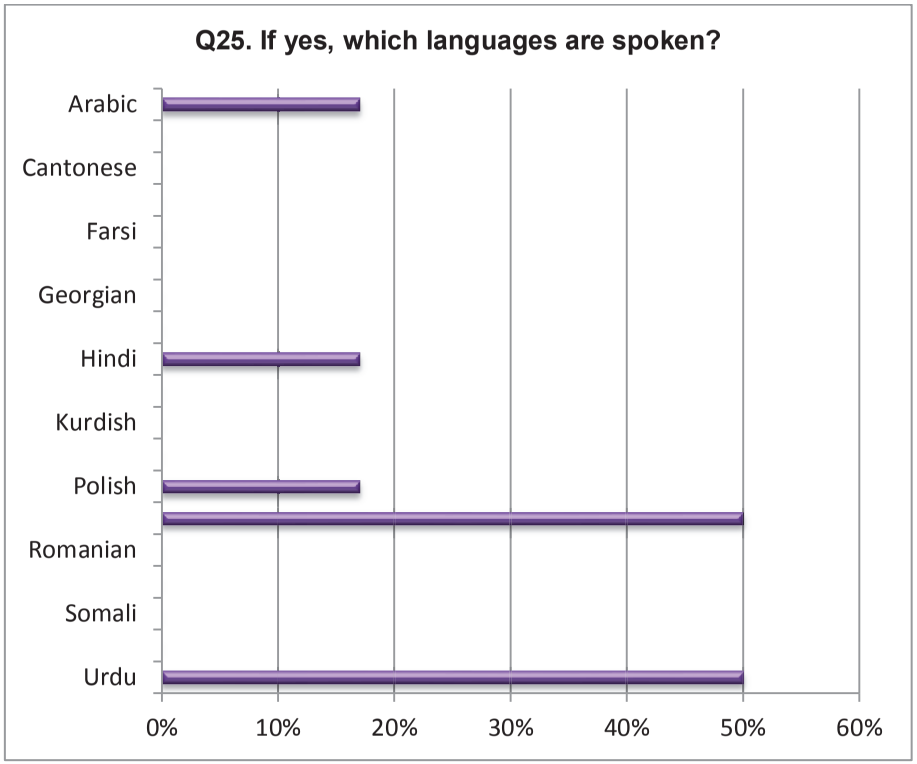
Do you or any of your regular pharmacists speak a foreign language?		
No	50%	3
Yes	50%	3



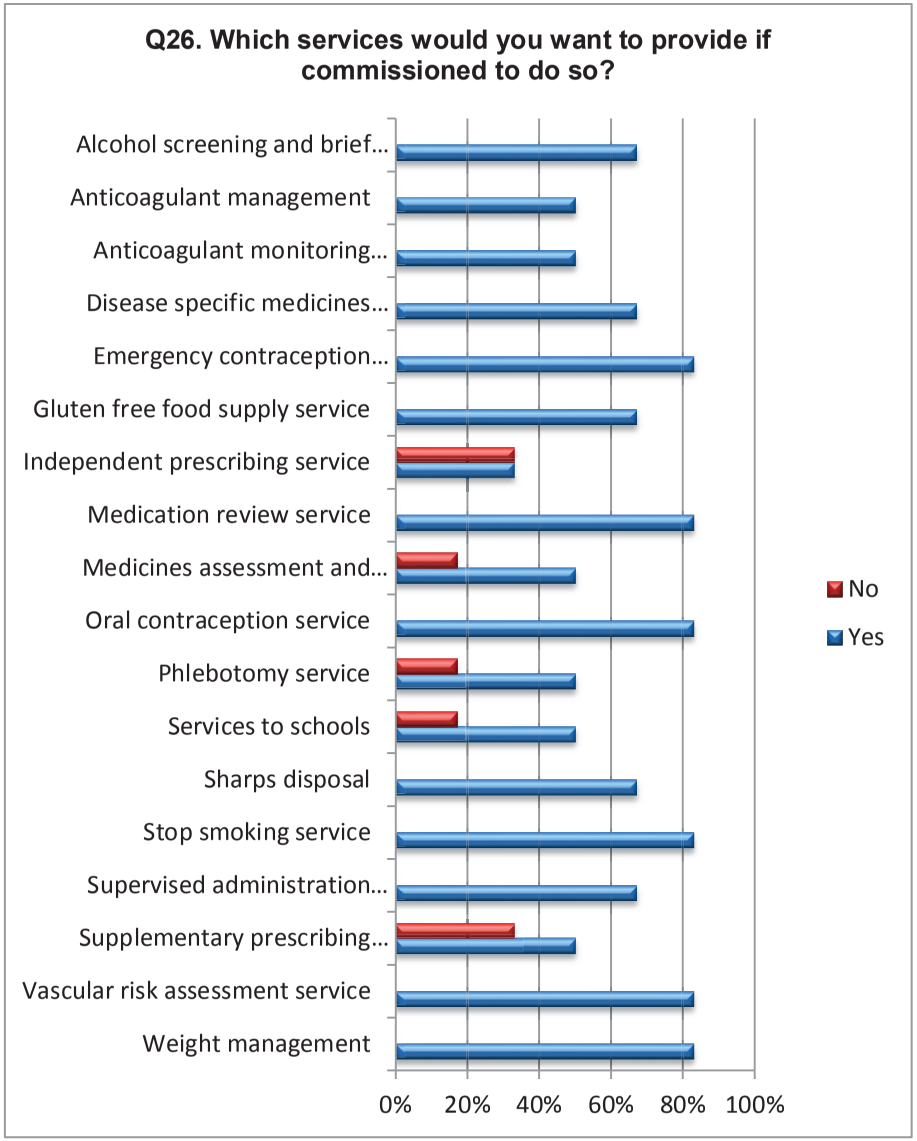
If yes, which languages are spoken?		
Urdu	50%	3
Spanish	0%	0
Somali	0%	0
Russian	0%	0
Romanian	0%	0
Punjabi	50%	3
Polish	0%	0
Mandarin	0%	0
Kurdish	0%	0
Japanese	0%	0
Hindi	17%	1
Gujarati	0%	0
Georgian	0%	0
French	0%	0
Farsi	0%	0
Czech	0%	0
Cantonese	0%	0
Bengali	0%	0
Arabic	0%	0



Do any of your regular pharmacy staff speak a foreign language?		
No	50%	3
Yes	50%	3



If yes, which languages are spoken?		
Urdu	50%	3
Spanish	0%	0
Somali	0%	0
Russian	0%	0
Romanian	0%	0
Punjabi	50%	3
Polish	17%	1
Mandarin	0%	0
Kurdish	0%	0
Japanese	0%	0
Hindi	17%	1
Gujarati	0%	0
Georgian	0%	0
French	0%	0
Farsi	0%	0
Czech	0%	0
Cantonese	0%	0
Bengali	0%	0
Arabic	17%	1



Which services would you want to provide if commissioned to do so?		
	Yes	No
Weight management	83%	0%
Vascular risk assessment service	83%	0%
Supplementary prescribing service	50%	33%
Supervised administration service	67%	0%
Stop smoking service	83%	0%
Sharps disposal	67%	0%
Services to schools	50%	17%
Phlebotomy service	50%	17%
Oral contraception service	83%	0%
Medicines assessment and compliance support	50%	17%
Medication review service	83%	0%
Independent prescribing service	33%	33%
Gluten free food supply service	67%	0%
Emergency contraception service	83%	0%
Disease specific medicines management	67%	0%
Anticoagulant monitoring service	50%	0%
Anticoagulant management	50%	0%
Alcohol screening and brief intervention	67%	0%

Other
The flu vaccination service

Q27. All pharmacies are required to conduct an annual community pharmacy patient questionnaire (CPPQ, formerly referred to as the Patient Satisfaction Questionnaire). Using the results from your most recent CPPQ please identify the most frequent requests from patients as either improvements or additions to services.
Smoking cessation.
EHC as we have 2 colleges nearby and also stop smoking service
Seating space and comfort.
None

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Appendix 6 – Locally Commissioned Services

Services commissioned by the Local Authority (LA)	Services commissioned by the Clinical Commissioning Group (CCG)
CTT – Chlamydia Testing and Treatment	**PC** – Palliative Care Out of Hours
EHC – Emergency Hormonal Contraception	**MA** – Minor Ailments
SIA – Smoking Intermediate Advice	
NRT – Nicotine Replacement Therapy	
NE – Needle Exchange	
SM – Supervised Methadone/Buprenorphine	

BURY EAST TOWNSHIP

Ward	Ref	Pharmacy Trading Name	Address	Postcode	LA						CCG	
					CTT	EHC	SIA	NRT	NE	SM	PC	MA
East	3	Asda Pharmacy **(100hr)**	Spring Street, Bury	BL9 0RN		Y	Y	Y				Y
	6	Boots the Chemist	32-36 The Mall, Bury	BL9 0QQ		Y	Y	Y		Y		Y
	18	Imaan Pharmacy	14 Princess Parade, Bury	BL9 0QL			Y	Y				
	22	Lloyds Pharmacy	Moorgate PPC, 22 Derby Way, Bury	BL9 ONJ		Y	Y	Y		Y		Y
	21	Lloyds Pharmacy	Townside PCC, 2 Knowsley Place, Bury	BL9 0SN		Y	Y	Y		Y		Y
	27	Medical Specialists Pharmacy	Westminster House, 49 Knowsley Street, Bury	BL9 0ST								
	30	Pimhole Pharmacy **(100hr)**	185 Rochdale Road, Bury	BL9 7BB		Y						Y

Ward	Ref	Pharmacy Trading Name	Address	Postcode	LA						CCG	
					CTT	EHC	SIA	NRT	NE	SM	PC	MA
Moorside	7	Boots the Chemist **(100hr)**	Unit 1 Woodfields Retail Park, Peel Way, Bury	BL9 5BY		Y	Y	Y		Y		Y
	8	Bury Healthcare Pharmacy **(100hr)**	28 Walmersley Road, Bury	BL9 6DP		Y	Y	Y				Y
	17	Huntley Mount Pharmacy	Huntley Mount Road	BL9 6JA	Y	Y			Y	Y		Y
	37	Strachan's Chemist	Chesham Precinct, 166a Walmersley Road, Bury	BL9 6LL			Y	Y		Y		Y
	38	Tesco Pharmacy	Woodfields Retail Park, Peel Way, Bury	BL9 5BY			Y	Y				Y
Redvales	13	Fishpool Pharmacy	14 Parkhills Road, Bury	BL9 9AX								Y

BURY WEST TOWNSHIP

Ward	Ref	Pharmacy Trading Name	Address	Postcode	LA						CCG	
					CTT	EHC	SIA	NRT	NE	SM	PC	MA
Church	28	Mile Lane Pharmacy	66 Mile Lane, Bury	BL8 2JR		Y	Y	Y				Y
	29	Netchem Pharmacy	107 Bolton Road, Bury	BL8 2NW								
Elton	25	Manor Pharmacy	367 Brandlesholme Road, Bury	BL8 1HS								Y

PRESTWICH TOWNSHIP

Ward	Ref	Pharmacy Trading Name	Address	Postcode	LA						CCG	
					CTT	EHC	SIA	NRT	NE	SM	PC	MA
Holyrood	23	Lloyds Pharmacy	474 Bury Old Road, Prestwich	M25 1NL			Y	Y	Y	Y		Y
Sedgley	12	Dennis Gore Chemists	26 Whittaker Lane, Prestwich	M25 1FX		Y	Y	Y				Y
	14	Formans Chemist	12 Park Hill, Bury Old Road, Prestwich	M25 0FX								Y
	16	Pharmacykwik	Rear Unit, 56 Parksway, Manchester	M25 0HB								
	35	Sedgley Park Pharmacy	33 Bury New Road, Prestwich	M25 9JY								Y
	36	St Gabriel's Medical Centre Pharmacy	4 Bishop's Road, Prestwich	M25 0HT		Y						Y
	39	Tesco Pharmacy	Bury New Road, Prestwich	M25 3TG			Y	Y				Y
St Mary's	31	Prestwich Pharmacy	40 Longfield Centre, Prestwich	M25 1AY	Y	Y			Y	Y	Y	Y

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Radcliffe Township

Ward	Ref	Pharmacy Trading Name	Address	Postcode	LA						CCG	
					CTT	EHC	SIA	NRT	NE	SM	PC	MA
Radcliffe East	5	Boots the Chemist	11 Blackburn Street, Radcliffe	M26 1NN		Y	Y	Y		Y		Y
	32	Radcliffe Pharmacy	62 Cross Lane, Radcliffe	M26 2RF						Y		Y
	41	The Co-operative Pharmacy	Radcliffe PCC, Church Street West, Radcliffe	M26 2SP		Y	Y	Y		Y		Y
	33	Radcliffe Pharmacy **(100hr)**	47 Church Street West, Radcliffe	M26 2SQ					Y	Y		
	19	JT Smith & Son	8-8a Ainsworth Road, Radcliffe	M26 4DJ		Y	Y	Y				Y
Radcliffe West	2	Asda Pharmacy	Riverside Retail Park, Pilkington Way, Radcliffe	M26 3DA								
	24	Manor Pharmacy	Unsworth Street, Radcliffe	M26 3RF			Y	Y	Y	Y		Y

**There are no pharmacies in the Radcliffe North Ward.*

Ramsbottom, Totttington and North Manor Township

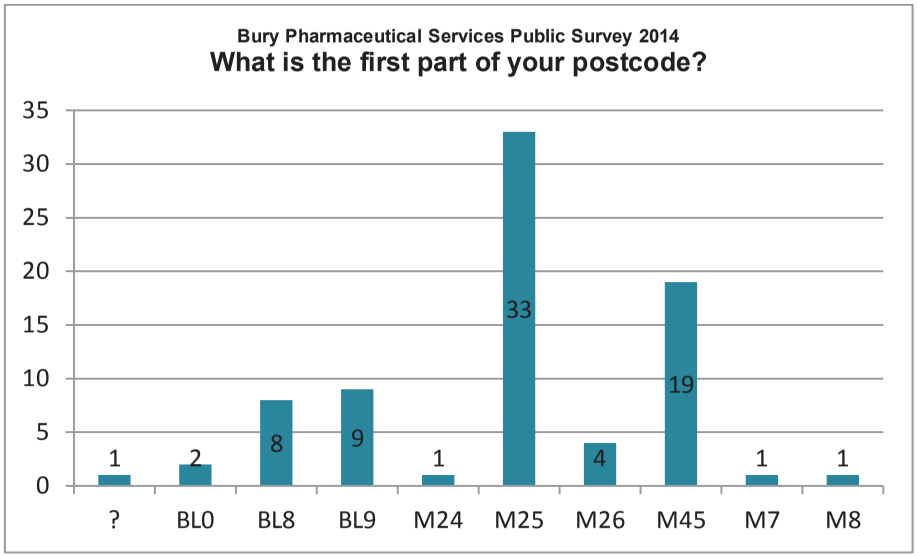
Ward	Ref	Pharmacy Trading Name	Address	Postcode	LA						CCG	
					CTT	EHC	SIA	NRT	NE	SM	PC	MA
North Manor	15	Gardners Chemist	6 Vernon Road, Greenmount	BL8 4DD								Y
	26	Manor Pharmacy	1 Brandlesholme Road, Greenmount	BL8 4DS			Y	Y	Y			Y
Ramsbottom	11	Cohens Chemist	7 Market Place, Ramsbottom	BL0 9AJ		Y	Y	Y				Y
	20	Lloyds Pharmacy	6 Bolton Street, Ramsbottom	BL0 9HX			Y	Y		Y		Y
Tottington	9	Cohens Chemist	12-14 Market Street, Tottington	BL8 4AD			Y	Y	Y	Y		Y

Whitefield and Unsworth

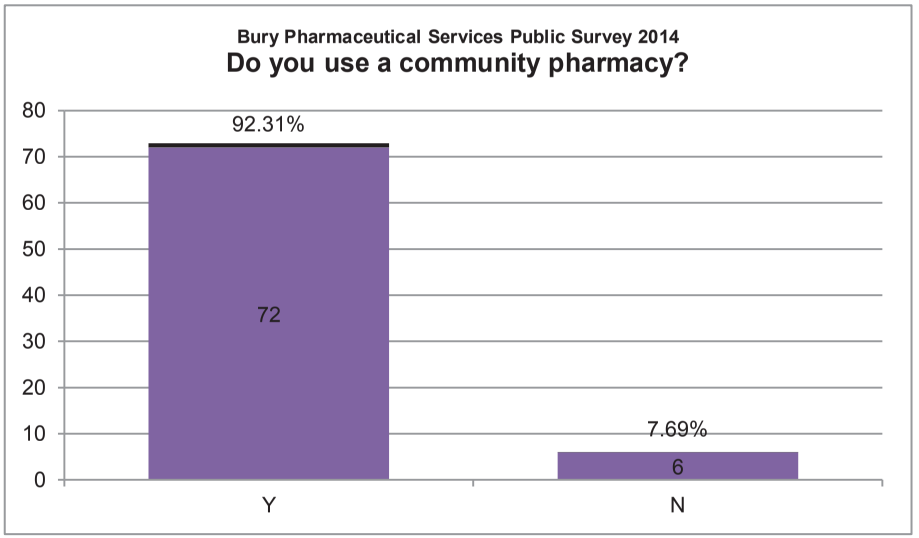
Ward	Ref	Pharmacy Trading Name	Address	Postcode	LA						CCG	
					CTT	EHC	SIA	NRT	NE	SM	PC	MA
Pilkington Park	4	Barash Pharmacy	166 Bury New Road, Whitefield	M45 6QJ								Y
Unsworth	1	Asda Pharmacy	Pilsworth Road, Pilsworth, Bury	BL9 8RS			Y	Y				
	10	Cohens Chemist	135 Croft Lane, Bury	BL9 8QA		Y						Y
	34	Rowlands Pharmacy	59 Parr Lane, Unsworth	BL9 8JR			Y	Y				Y
	40	The Co-operative Pharmacy	Unit 1 Elms Square, Whitefield	M45 7TA			Y	Y				Y

**There are no pharmacies in the Besses Ward.*

Appendix 7 – Public Survey

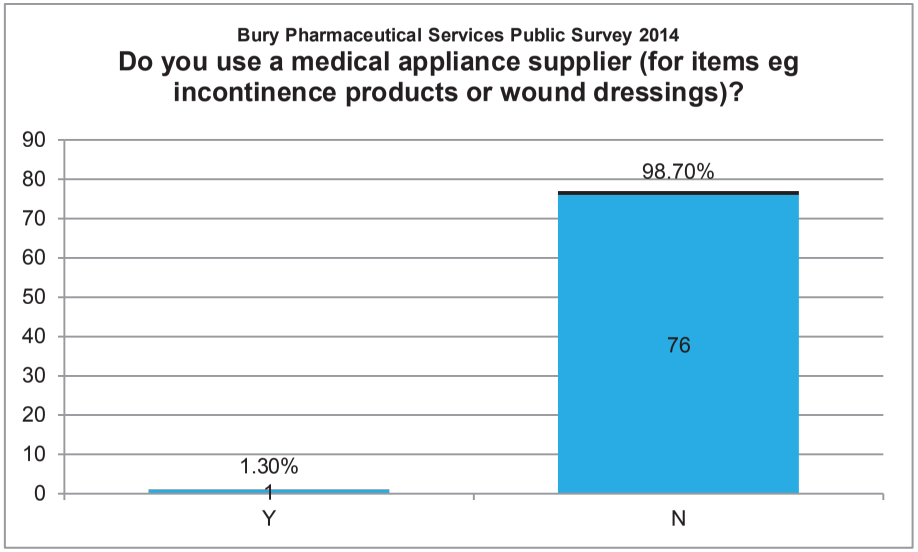


What is the first part of your postcode?	
?	1
BL0	2
BL8	8
BL9	9
M24	1
M25	33
M26	4
M45	19
M7	1
M8	1

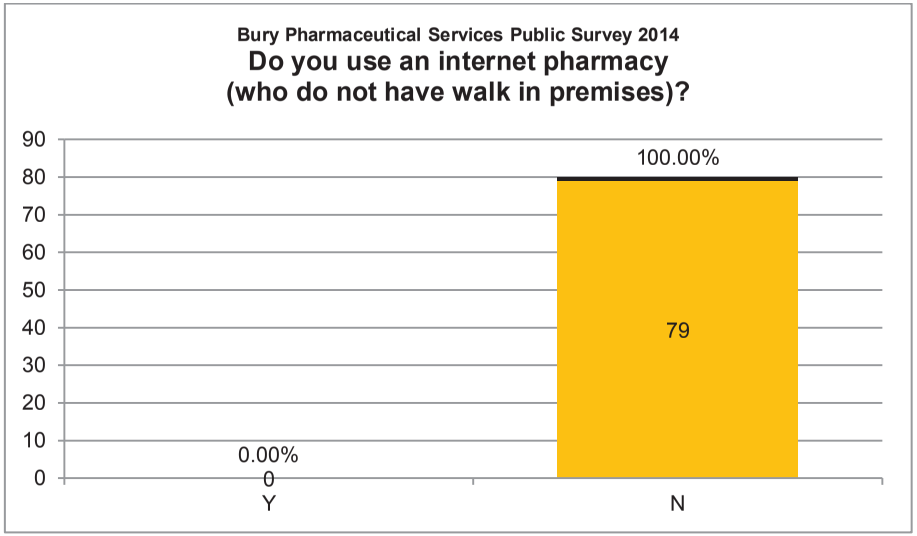


Do you use a community pharmacy?	Y	N
	72	6
	92.31%	7.69%
Skipped 1		

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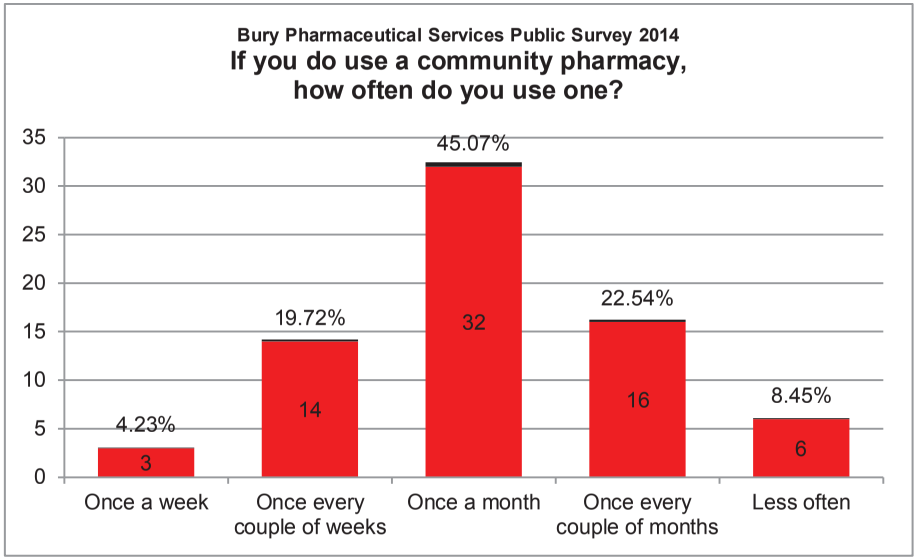


Do you use a medical appliance supplier (for items such as incontinence products or wound dressings)?	Y	N
	1	76
	1.30%	98.70%
Skipped 2		

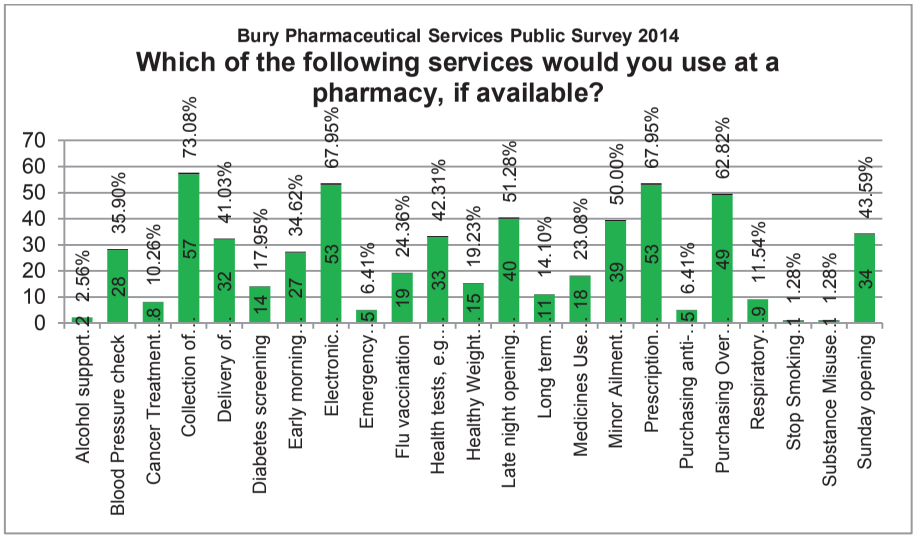


Do you use an internet pharmacy (who do not have walk in premises)?	Y	N
	0	79
	0.00%	100.00%
Skipped 0		

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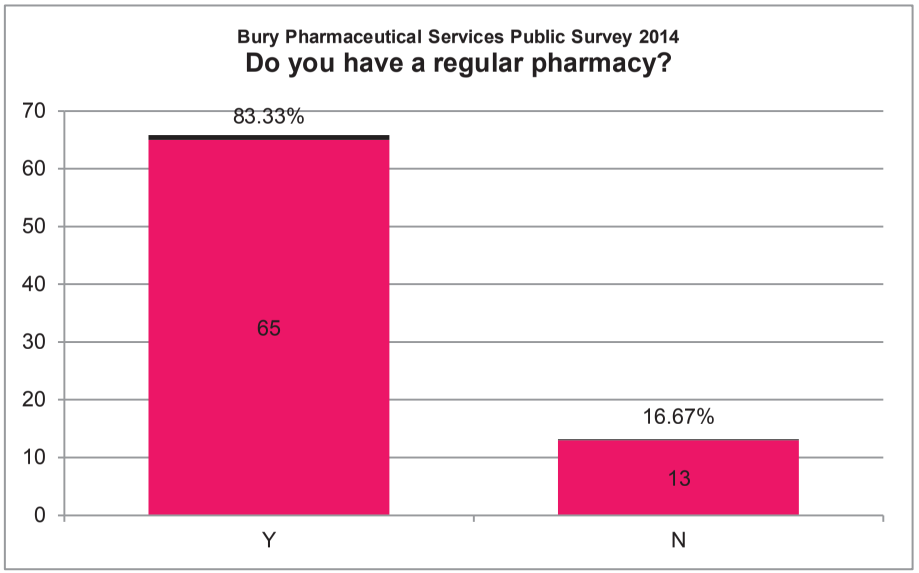
If you do use a community pharmacy, how often would you say you used one?	Once a week	Once every couple of weeks	Once a month	Once every couple of months	Less often
	3	14	32	16	6
	4.23%	19.72%	45.07%	22.54%	8.45%



Which of the following services would you use at a pharmacy, if available? Please tick as many answers as appropriate		
Alcohol support services	2	2.56%
Blood Pressure check	28	35.90%
Cancer Treatment support services	8	10.26%
Collection of prescription from your GP surgery	57	73.08%
Delivery of medicines to your home	32	41.03%
Diabetes screening	14	17.95%
Early morning opening (before 9am)	27	34.62%
Electronic Prescription Service	53	67.95%
Emergency Hormonal Contraception (morning after pill)	5	6.41%
Flu vaccination	19	24.36%
Health tests, e.g. cholesterol, blood pressure	33	42.31%
Healthy Weight advice	15	19.23%
Late night opening (after 7pm)	40	51.28%
Long term condition advice	11	14.10%
Medicines Use Review (MUR)	18	23.08%
Minor Ailment Scheme (Access to certain subsidised over the counter medicines to avoid a GP visit)	39	50.00%
Prescription dispensing	53	67.95%
Purchasing anti-malarials	5	6.41%
Purchasing Over the Counter medicines	49	62.82%
Respiratory Services e.g. inhaler technique	9	11.54%
Stop Smoking Service	1	1.28%
Substance Misuse Service	1	1.28%
Sunday opening	34	43.59%

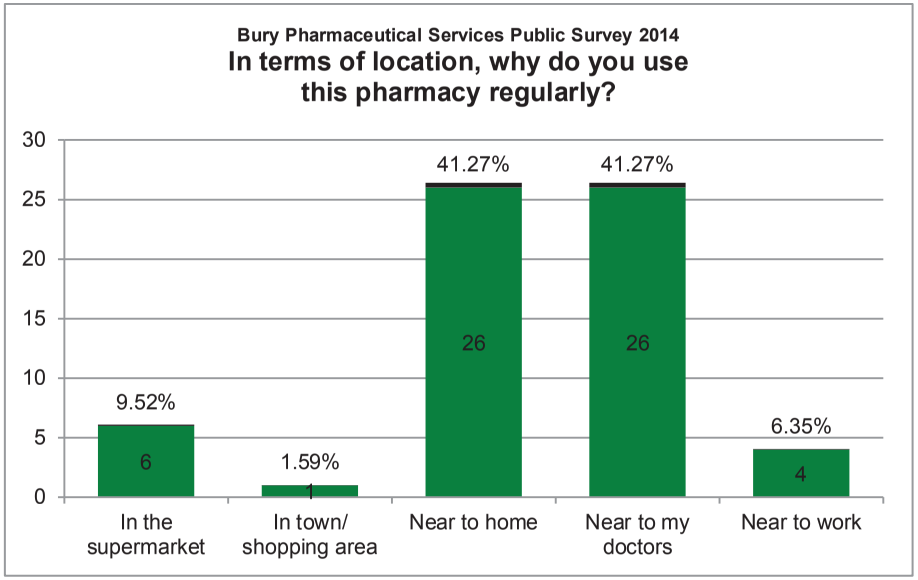
Skipped 1		

Other (please specify) 4
Advice on health issues
Cancer Treatment support services would be particularly welcomed as physically accessing cancer care at Christies (e.g. counselling) has been difficult (problems parking in particular as counselling sessions run at the same time as chemo sessions so it's always difficult to park which I found quite distressing when I was struggling with my diagnosis).
Drop in clinics for Dementia awareness advice like Purple Angel scheme 1st in UK started in Torbay this week. Mental health drop ins using health service community based staff. Carer support advice.
I do not want a pharmacist to replace a doctor. I do not have confidence in a pharmacist to diagnose. Also there is a privacy issue. I assume a doctor is qualified and there is some sort of register I can refer to. In a chemist how can I verify the integrity or competence of the person dealing with me. Also data security.



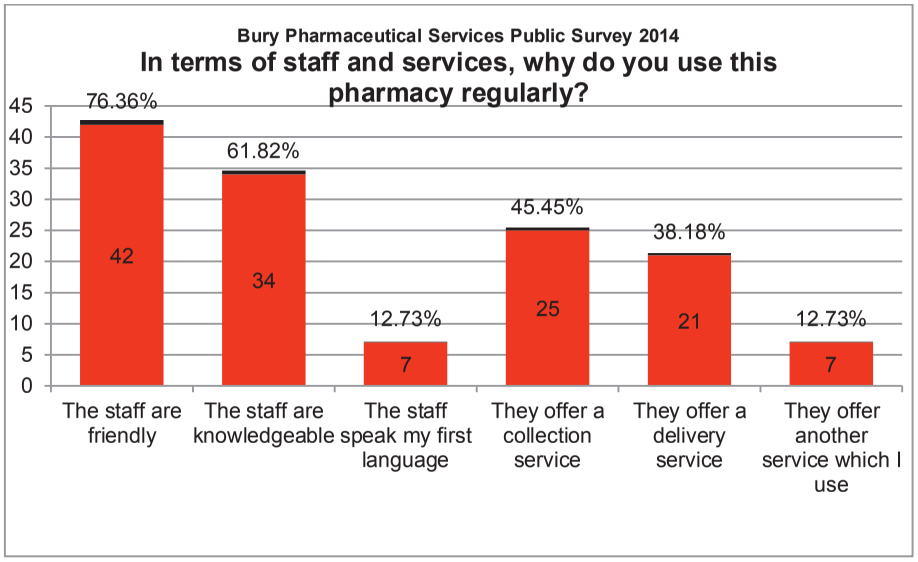
Do you have a regular pharmacy? Please tick one box only.	**Y**	**N**
	65	13
	83.33%	16.67%
Skipped 1		

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In terms of location, why do you use this pharmacy regularly? Please tick one box only.	In the super-market	In town/ shopping area	Near to home	Near to my doctors	Near to work
	6	1	26	26	4
	9.52%	1.59%	41.27%	41.27%	6.35%
Skipped 16					

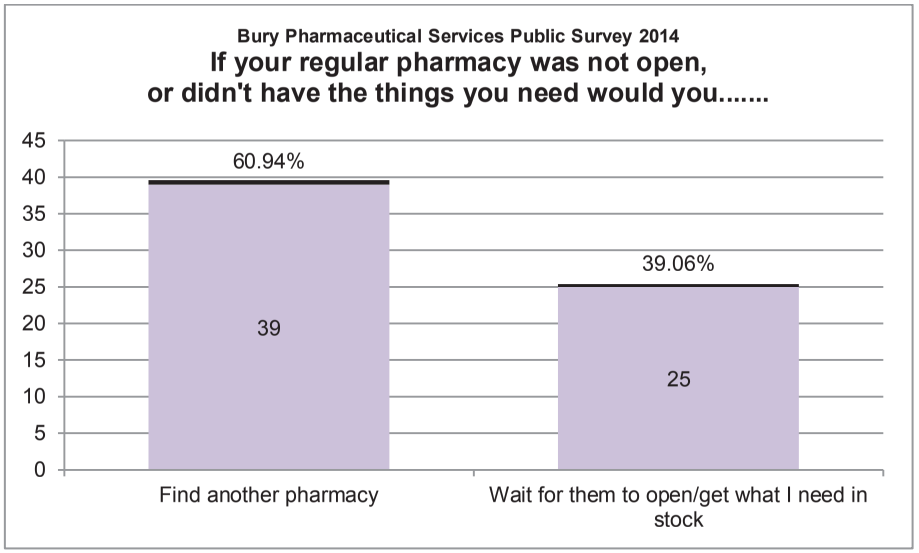
Others
Electronic prescription
And near to my home
Free parking available!
excellent service
Opening hours and speed of service
I use the pharmacy within Tesco Prestwich; 99% of the time my medication is available, or they will order for next day collection. even on a Sunday.
I use more than one pharmacy according to convenience of location or need. I am mainly well and therefore I am a frequent user of a pharmacy.
Parking close-by



In terms of staff and services, why do you use this pharmacy regularly? Please tick as many answers as appropriate.	The staff are friendly	The staff are knowledge able	The staff speak my first language	They offer a collection service	They offer a delivery service	They offer another service which I use
	42	34	7	25	21	7
	76.36%	61.82%	12.73%	45.45%	38.18%	12.73%
Skipped 24						

Other (please specify)
order repeat prescriptions online and collect from pharmacy
See above
They always have my medication in stock.
Prescriptions go direct from the GP so if I have a telephone appointment, I only need to make one trip to collect the prescription.
No convenient pharmacy
they know if I am compromised with asthma they deliver.
They get my prescriptions electronically from the doctor

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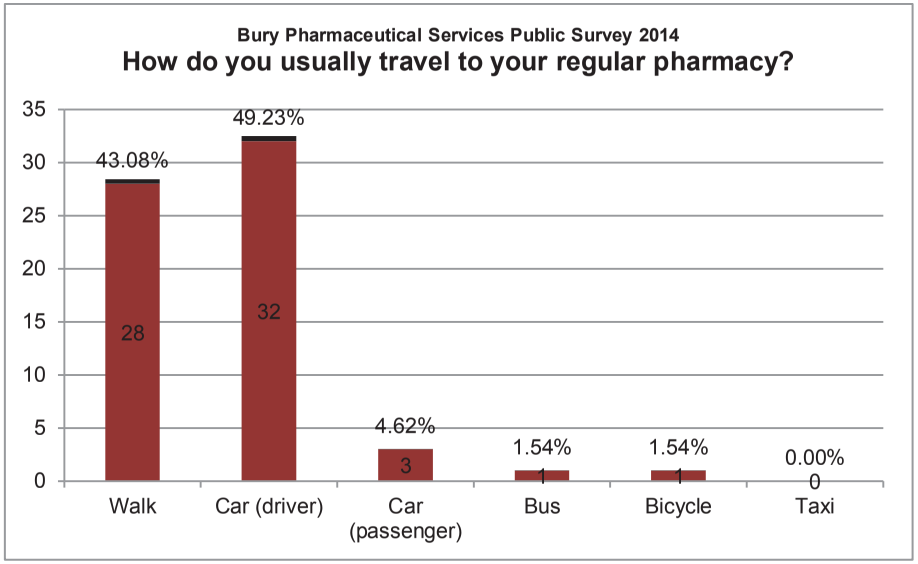


They don't close early like the one in the village
They are rubbish but I have to get a prescription from somewhere and all the others I have tried are just as bad.
Prescriptions go straight to the pharmacy from the surgery
They offer a very poor service but are close to the GP surgery and home therefore convenient.
I just use a pharmacy to obtain prescription drugs from the doctor or to buy the odd medical cure/plaster etc. I sometimes ask about minor symptoms or seek advice about child symptoms.
Near to the doctors
Electronic prescription
close to home not the best service but for convenience
Electronic PS
It's near to my doctors.

Languages (please specify)
English
My first language is English

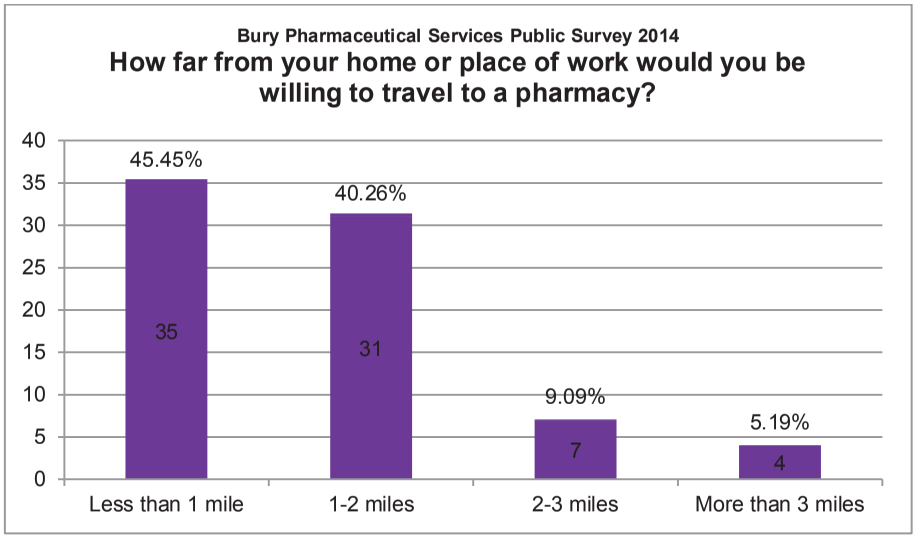
If your regular pharmacy was not open, or didn't have the things you need would you... Please tick one box only.	**Find another pharmacy**	**Wait for them to open/get what I need in stock**
	39	25
	60.94%	39.06%
Skipped 15		

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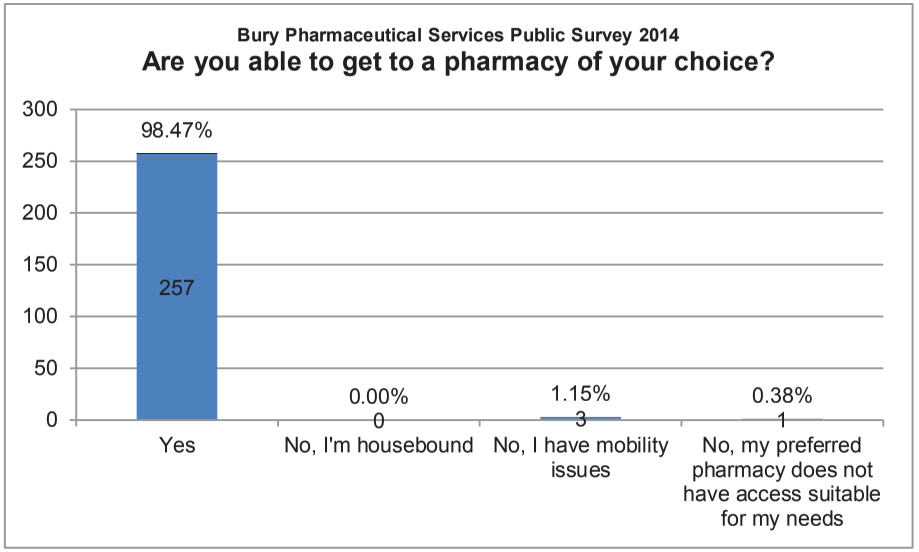
How do you usually travel to your regular pharmacy? Please tick one box only.	Walk	Car (driver)	Car (passenger)	Bus	Bicycle	Taxi
	28	32	3	1	1	0
	43.08%	49.23%	4.62%	1.54%	1.54%	0.00%
Skipped 14						

Other
as it is next door to our GP
I mostly use the pharmacy near my doctor's but that is a car ride away. Also it is only open when the doctor's is open. It is not really convenient, so I tend to go to other pharmacies when I am out and about.



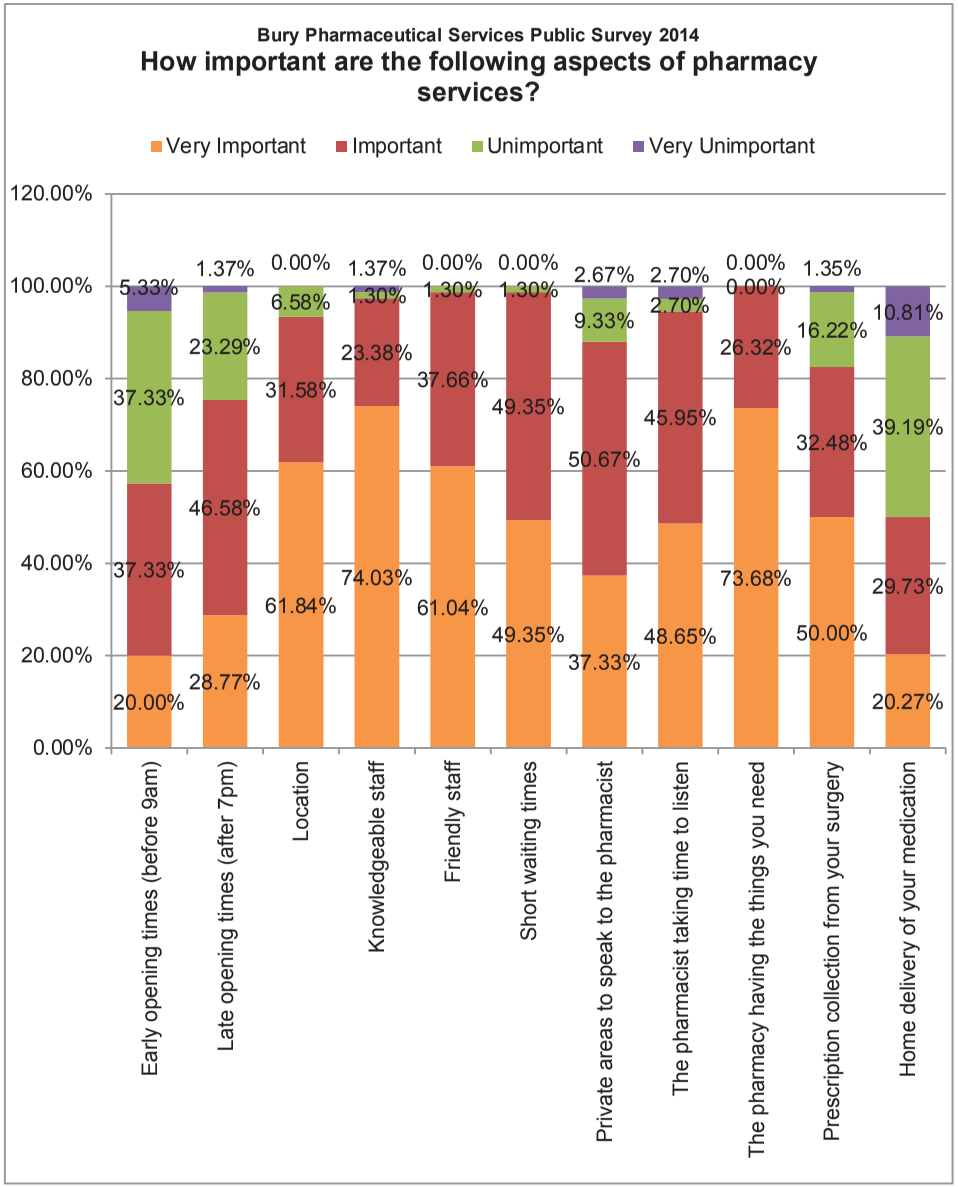
How far from your home or place of work would you be willing to travel to a pharmacy? Please tick one box only.	Less than 1 mile	1-2 miles	2-3 miles	More than 3 miles
	35	31	7	4
	45.45%	40.26%	9.09%	5.19%
Skipped 2				

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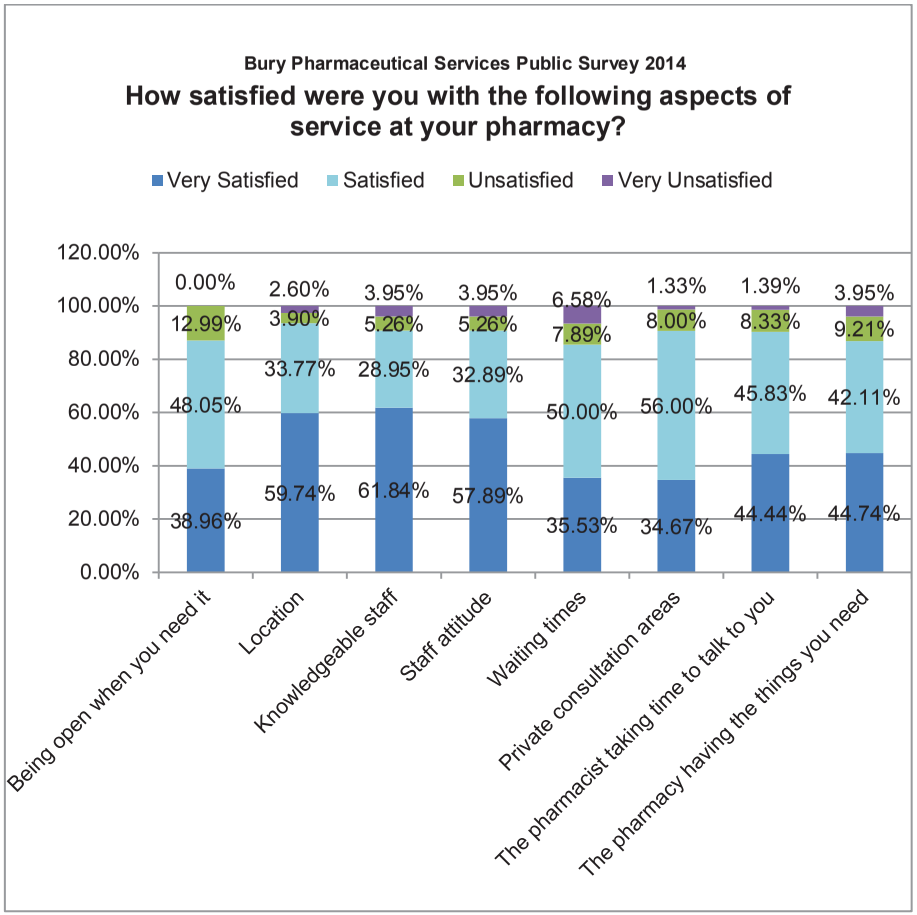
Are you able to get to a pharmacy of your choice? Please tick one box only.	Yes	No, I'm housebound	No, I have mobility issues	No, my preferred pharmacy does not have access suitable for my needs
	257	0	3	1
	98.47%	0.00%	1.15%	0.38%
Skipped 2				

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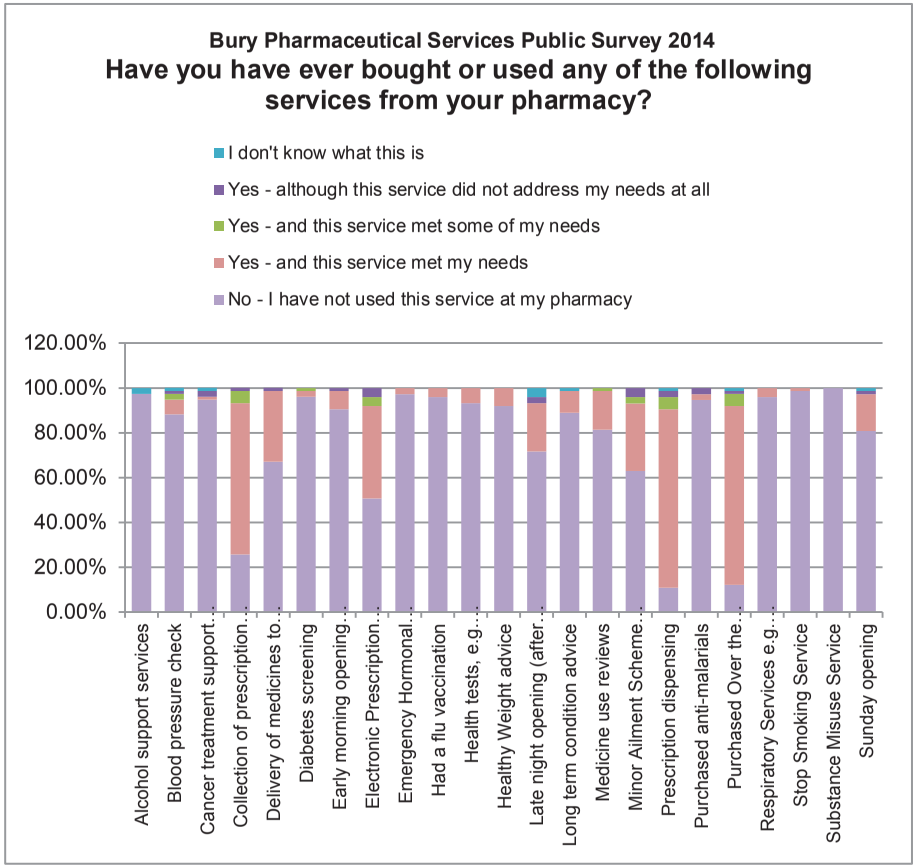


How important are the following aspects of pharmacy services?	Very Important	Important	Unimportant	Very Unimportant
Early opening times (before 9am)	20.00%	37.33%	37.33%	5.33%
Late opening times (after 7pm)	28.77%	46.58%	23.29%	1.37%
Location	61.84%	31.58%	6.58%	0.00%
Knowledgeable staff	74.03%	23.38%	1.30%	1.37%
Friendly staff	61.04%	37.66%	1.30%	0.00%
Short waiting times	49.35%	49.35%	1.30%	0.00%
Private areas to speak to the pharmacist	37.33%	50.67%	9.33%	2.67%
The pharmacist taking time to listen	48.65%	45.95%	2.70%	2.70%
The pharmacy having the things you need	73.68%	26.32%	0.00%	0.00%
Prescription collection from your surgery	50.00%	32.48%	16.22%	1.35%
Home delivery of your medication	20.27%	29.73%	39.19%	10.81%
Skipped 22				

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How satisfied were you with the following aspects of service at your pharmacy?	Very Satisfied	Satisfied	Unsatisfied	Very Unsatisfied
Being open when you need it	38.96%	48.05%	12.99%	0.00%
Location	59.74%	33.77%	3.90%	2.60%
Knowledgeable staff	61.84%	28.95%	5.26%	3.95%
Staff attitude	57.89%	32.89%	5.26%	3.95%
Waiting times	35.53%	50.00%	7.89%	6.58%
Private consultation areas	34.67%	56.00%	8.00%	1.33%
The pharmacist taking time to talk to you	44.44%	45.83%	8.33%	1.39%
The pharmacy having the things you need	44.74%	42.11%	9.21%	3.95%

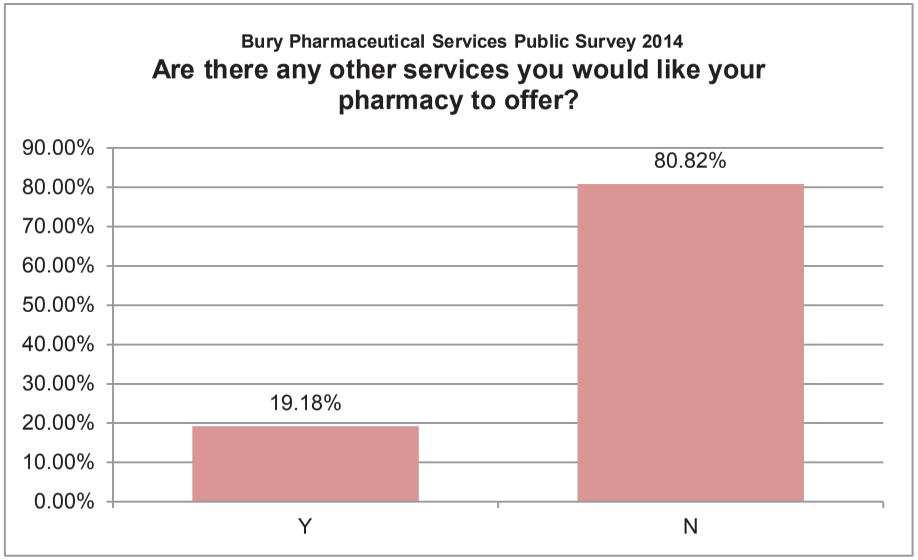


Have you have ever bought or used any of the following services from your pharmacy?	No - I have not used this service at my pharmacy	Yes - and this service met my needs	Yes - and this service met some of my needs	Yes - although this service did not address my needs at all	I don't know what this is	Total
Alcohol support services	97.37%	0.00%	0.00%	0.00%	2.63%	76
Blood pressure check	88.16%	6.58%	2.63%	1.32%	1.32%	76
Cancer treatment support services	94.74%	1.32%	0.00%	2.63%	1.32%	76
Collection of prescription from my surgery	25.68%	67.57%	5.41%	1.35%	0.00%	74
Delivery of medicines to my home	67.11%	31.58%	0.00%	1.32%	0.00%	76
Diabetes screening	96.05%	2.63%	1.32%	0.00%	0.00%	76
Early morning opening (before 9am)	90.54%	8.11%	0.00%	1.35%	0.00%	74
Electronic Prescription Service	50.67%	41.33%	4.00%	4.00%	0.00%	75
Emergency Hormonal Contraception (morning after pill)	97.26%	2.74%	0.00%	0.00%	0.00%	73
Had a flu vaccination	95.95%	4.05%	0.00%	0.00%	0.00%	74
Health tests, e.g. cholesterol, blood pressure	93.24%	6.76%	0.00%	0.00%	0.00%	74
Healthy Weight advice	91.89%	8.11%	0.00%	0.00%	0.00%	74
Late night opening (after 7pm)	71.62%	21.62%	0.00%	2.70%	4.05%	74
Long term condition advice	88.89%	9.72%	0.00%	0.00%	1.39%	72
Medicine use reviews	81.33%	17.33%	1.33%	0.00%	0.00%	75

Minor Ailment Scheme (Access to certain subsidised over the counter medicines to avoid a GP visits)	63.01%	30.14%	2.74%	4.11%	0.00%	73
Prescription dispensing	10.81%	79.73%	5.41%	2.70%	1.35%	74
Purchased anti-malarials	94.59%	2.70%	0.00%	2.70%	0.00%	74
Purchased Over the Counter medicines	12.16%	79.73%	5.41%	1.35%	1.35%	74
Respiratory Services e.g. inhaler technique	95.95%	4.05%	0.00%	0.00%	0.00%	74
Stop Smoking Service	98.65%	1.35%	0.00%	0.00%	0.00%	74
Substance Misuse Service	100.00%	0.00%	0.00%	0.00%	0.00%	73
Sunday opening	80.82%	16.44%	0.00%	1.37%	1.37%	73

Other (please specify)
I'd get a flu vax at the chemist's to avoid having to go to the drop-in at the GP. If you work, a dropin isn't much use
A more efficient electronic prescription service to avoid having to visit the doctors, then the pharmacy and then having to come back later for the medicine when you've got a sick child with you
Please don't open on Sundays. It is damaging our community to have everything open all the time, we need a day of 'down time' a week for spiritual and family renewal. It's important for health.
Chemist does not open before 9am or stay open late or open on a Sunday
I would like some of these services but they are not available
I only use this pharmacy when I visit the doctor's

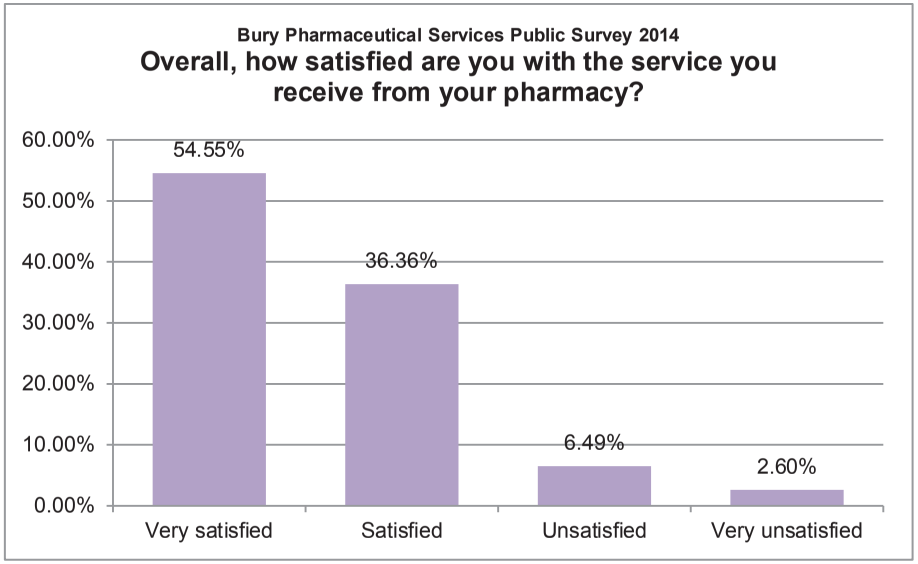
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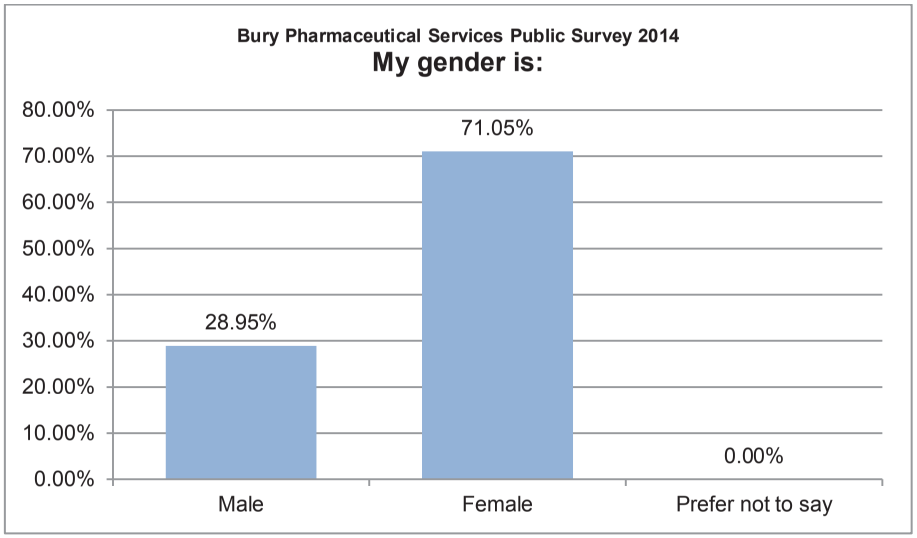
Are there any other services you would like your pharmacy to offer? Please tick one box only	Y	N
	19.18%	80.82%
Skipped 6		

Other
Sunday opening times
Helpful staff
Automated prescription ordering, dispensing and delivery of regular items without having to arrange via GP system
electronic prescriptions
Stop smoking service
This is a hard question, because sometimes you don't know what you'd use until it's there. I'd really like shorter waiting times for on-the-spot dispensing. I also like that my local chemist in Prestwich is co-located with a photo shop. It's amazing how much I use them both because they're both there.
Sunday opening - within a health centre and closes at 6pm
to arrange particular drop in clinics with trained mental health staff re dementia, depression, anxiety management to those needing signposting etc
To provide the best products available
Automatic reordering of prescriptions
I'd like it to offer the health screening services detailed above - e.g. BP, diabetes, cholesterol, 'flu vaccs
I would like to know if there are any pharmacies which can prescribe some drugs
I've started using this service
Efficiency
Eczema advice and support for children

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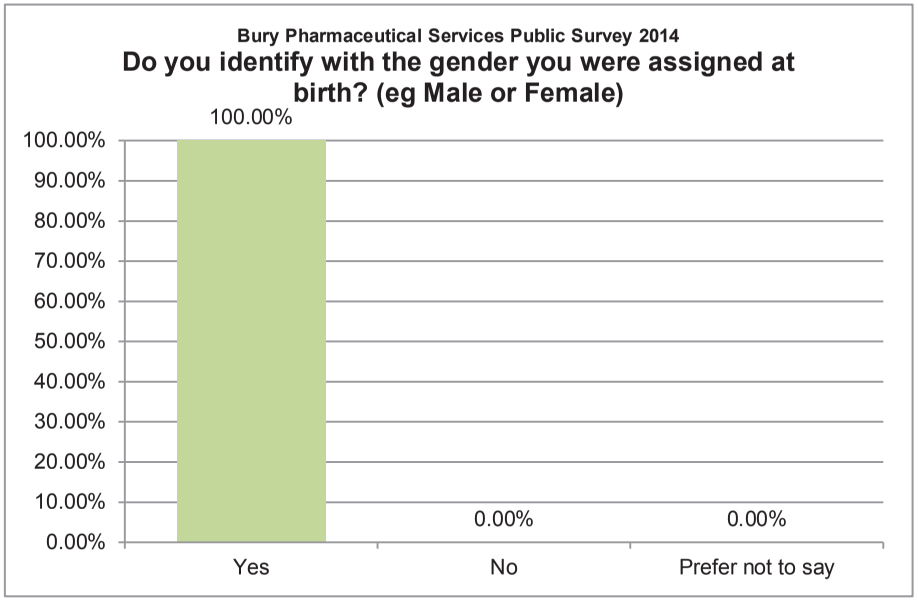


Overall, how satisfied are you with the service you receive from your pharmacy?	%	Number
Very satisfied	54.55%	42
Satisfied	36.36%	28
Unsatisfied	6.49%	5
Very unsatisfied	2.60%	2
Skipped 2		

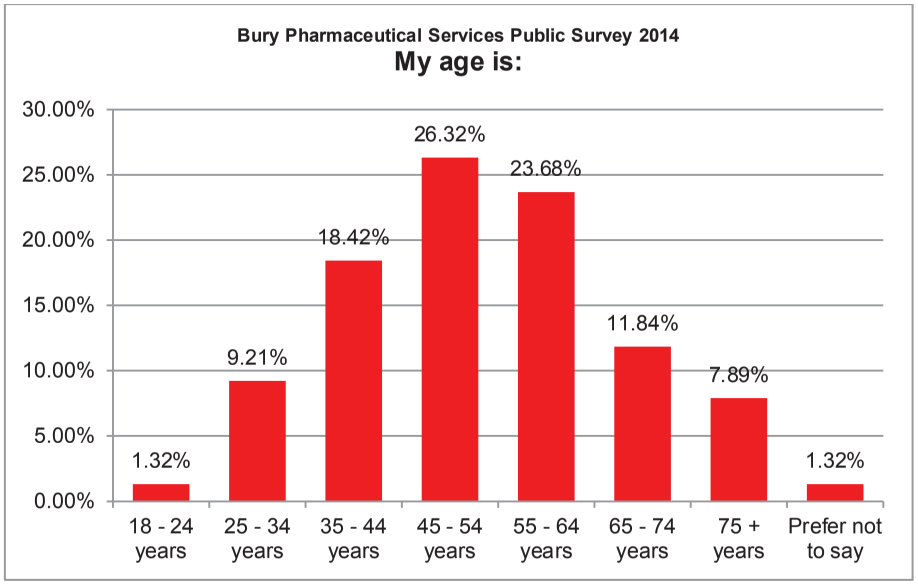


My gender is:	%	Number
Male	28.95%	22
Female	71.05%	54
Prefer not to say	0.00%	0
Skipped 3		

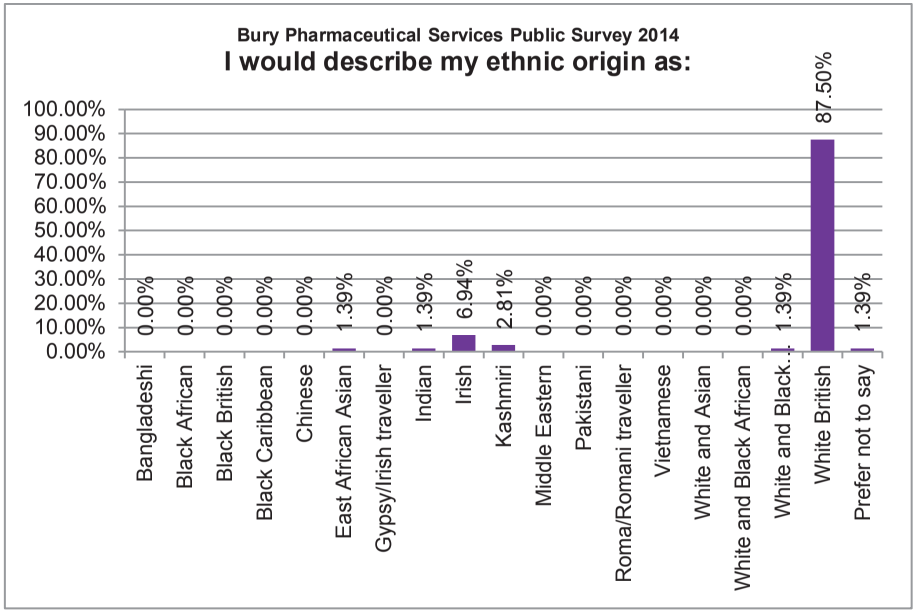
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Do you identify with the gender you were assigned at birth? (e.g. Male or Female)	%	Number
Yes	100.00%	75
No	0.00%	0
Prefer not to say	0.00%	0
Skipped 4		

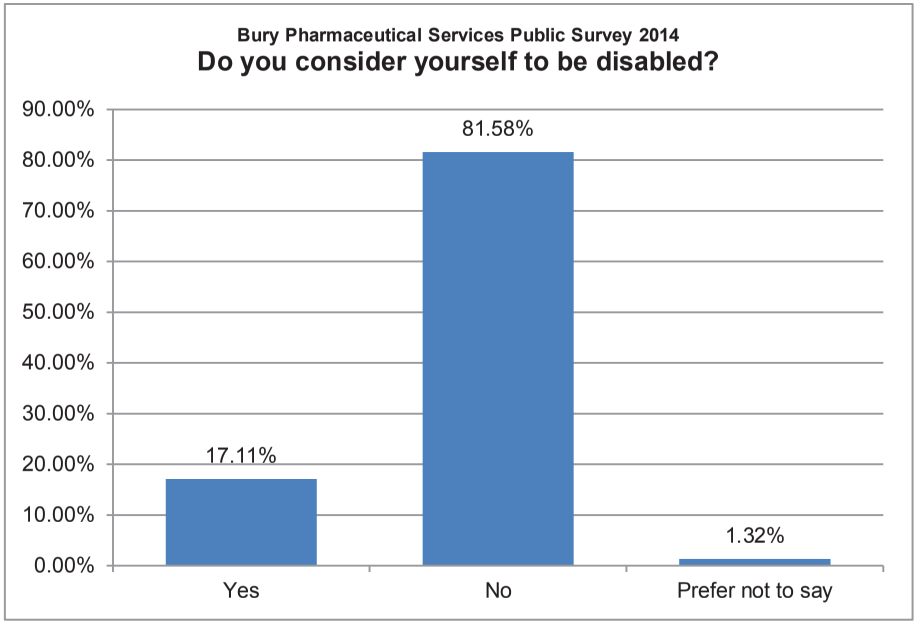


My age is:	%	Number
18 - 24 years	1.32%	1
25 - 34 years	9.21%	7
35 - 44 years	18.42%	14
45 - 54 years	26.32%	20
55 - 64 years	23.68%	18
65 - 74 years	11.84%	9
75 + years	7.89%	6
Prefer not to say	1.32%	1
Skipped 3		



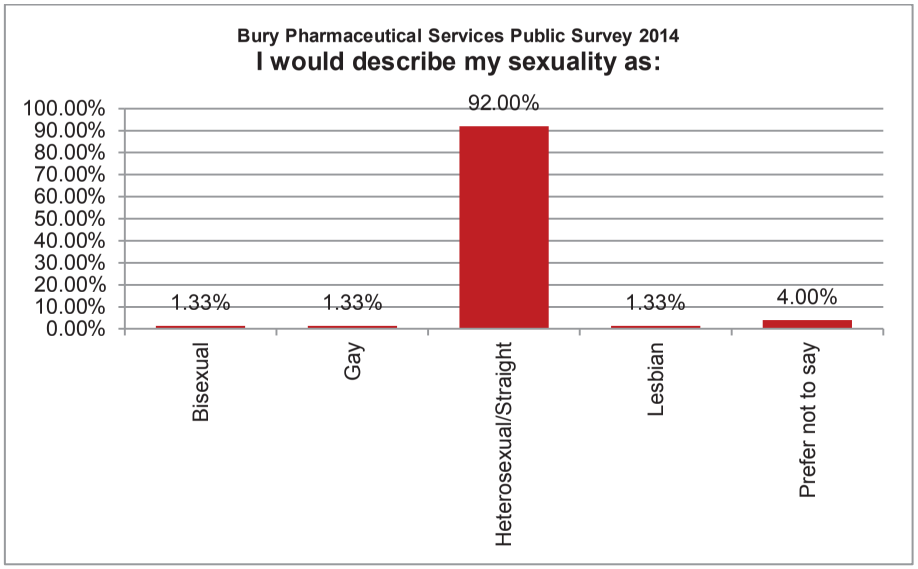
I would describe my ethnic origin as:	%	Number
Bangladeshi	0.00%	0
Black African	0.00%	0
Black British	0.00%	0
Black Caribbean	0.00%	0
Chinese	0.00%	0
East African Asian	1.39%	1
Gypsy/Irish traveller	0.00%	0
Indian	1.39%	1
Irish	6.94%	5
Kashmiri	2.81%	7
Middle Eastern	0.00%	0
Pakistani	0.00%	0
Roma/Romani traveller	0.00%	0
Vietnamese	0.00%	0
White and Asian	0.00%	0
White and Black African	0.00%	0
White and Black Caribbean	1.39%	1
White British	87.50%	63
Prefer not to say	1.39%	1
Skipped 7		

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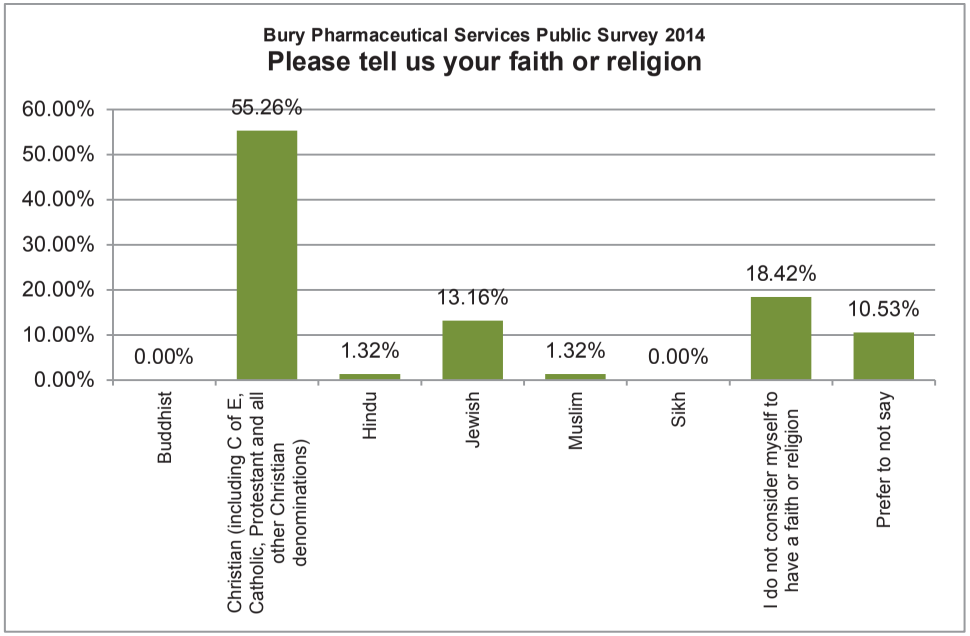


Do you consider yourself to be disabled?	%	Number
Yes	17.11%	13
No	81.58%	62
Prefer not to say	1.32%	1
Skipped 3		

Would like to give more information?
ushers syndrome
only in past few years but yes.
Long term neck/back injury

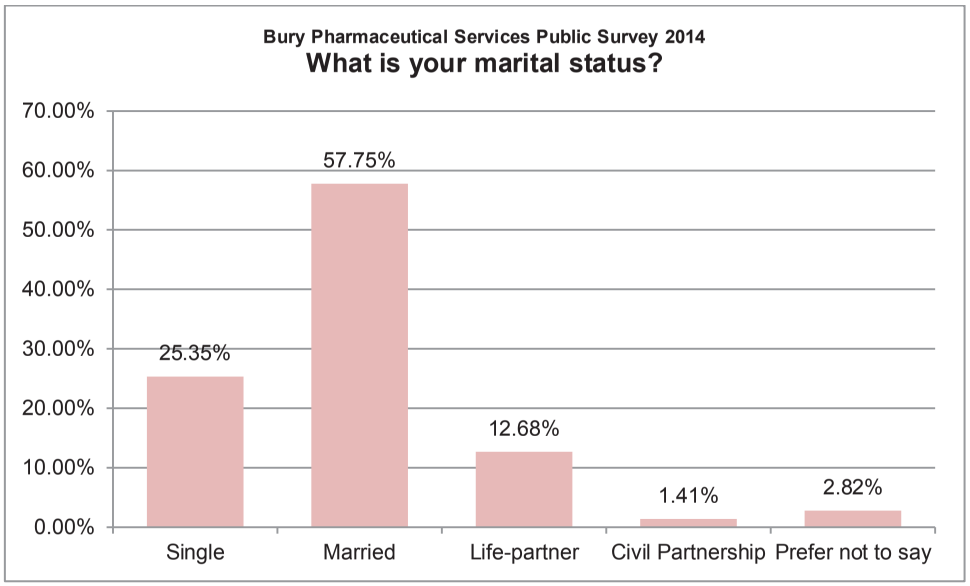


I would describe my sexuality as:	%	Number
Bisexual	1.33%	1
Gay	1.33%	1
Heterosexual/Straight	92.00%	69
Lesbian	1.33%	1
Prefer not to say	4.00%	3
Skipped 4		



Please tell us your faith or religion	%	Number
Buddhist	0.00%	0
Christian (including C of E, Catholic, Protestant and all other Christian denominations)	55.26%	42
Hindu	1.32%	1
Jewish	13.16%	10
Muslim	1.32%	1
Sikh	0.00%	0
I do not consider myself to have a faith or religion	18.42%	14
Prefer to not say	10.53%	8
Skipped 3		

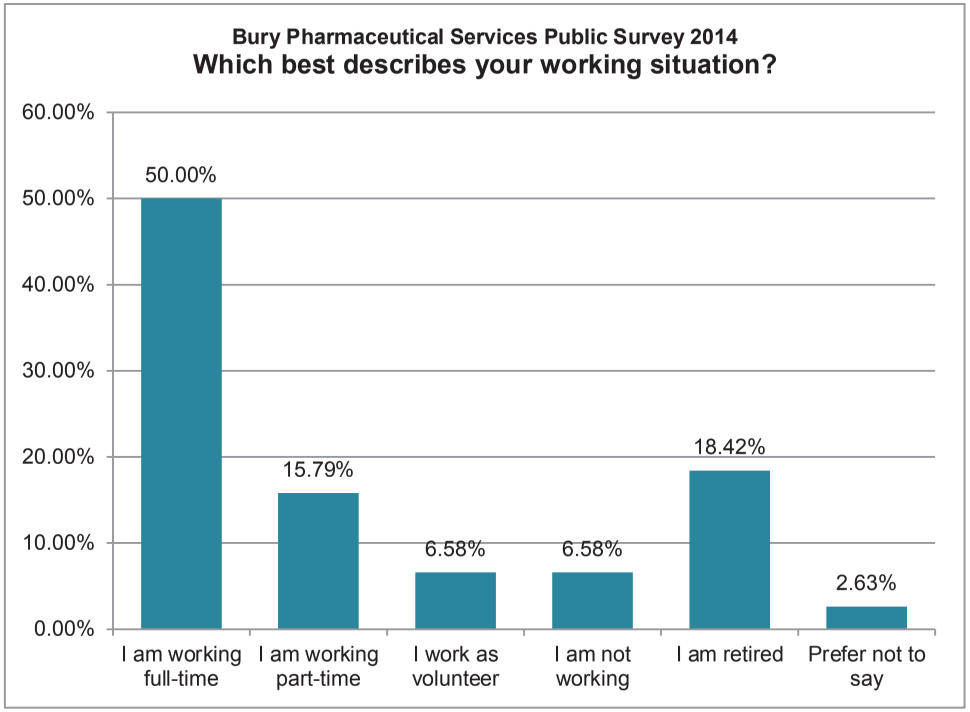
Others
Atheist



What is your marital status?	%	Number
Single	25.35%	18
Married	57.75%	41
Life-partner	12.68%	9
Civil Partnership	1.41%	1
Prefer not to say	2.82%	2
Skipped 8		

Others
Widowed
Divorced
Separated
Divorced

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Which of the following best describes your working situation?	%	Number
I am working full-time	50.00%	38
I am working part-time	15.79%	12
I work as volunteer	6.58%	5
I am not working	6.58%	5
I am retired	18.42%	14
Prefer not to say	2.63%	2

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Appendix 8 – Pharmacy Opening Hours

Yellow – Pharmacy opens later on weekdays and open Saturdays and Sundays
Blue – Pharmacy opens weekdays and on Saturdays
Orange – Pharmacy opens weekdays only
Green – Internet pharmacies
Purple – Appliance suppliers

BURY EAST TOWNSHIP

Ward	Ref	Pharmacy Trading Name	Address	Postcode	Phone Number	Mon	Tue	Wed	Thur	Fri	Sat	Sun
East	3	Asda Pharmacy **(100hr)**	Spring Street, Bury	BL9 0RN	0161 447 8219	6am - 9pm	6am - 9pm	6am - 10pm	6am - 10pm	6am - 10pm	6am - 10pm	11am - 5pm
	6	Boots the Chemist	32-36 The Mall, Bury	BL9 0QQ	0161 763 7537	8.45am-5.30pm	8.45am-5.30pm	8.45am-5.30pm	8.45am-5.30pm	8.45am-5.30pm	8.45am-5.30pm	10.30am-4.30pm
	18	Imaan Pharmacy	14 Princess Parade, Bury	BL9 0QL	0161 764 1489	9am-6pm	9am-6pm	9am-6pm	9am-6pm	9am-6pm	9am-5.30pm	closed
	22	Lloyds Pharmacy	Moorgate PPC, 22 Derby Way, Bury	BL9 ONJ	0161 764 4573	8.30am-6pm	8.30am-6pm	8.30am-6pm	8.30am-6pm	8.30am-6pm	closed	closed
	21	Lloyds Pharmacy	Townside PCC, 2 Knowsley Place, Bury	BL9 0SN	0161 764 5010	8am - 6.30pm	8am - 6.30pm	8am - 6.30pm	8am - 6.30pm	8am - 6.30pm	9am-12noon	closed
	27	Medical Specialists Pharmacy	Westminster House, 49 Knowsley Street, Bury	BL9 0ST	0161 762 9108	9am-5pm	9am-5pm	9am-5pm	9am-5pm	9am-5pm	closed	closed
	30	Pimhole Pharmacy **(100hr)**	185 Rochdale Road, Bury	BL9 7BB	0161 761 1011	7am-23.59	7am-23.59	7am-9.30pm	7am-9.30pm	7am-9.30pm	7am-9.30pm	10am-6pm

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Ward	Ref	Pharmacy Trading Name	Address	Postcode	Phone Number	Mon	Tue	Wed	Thur	Fri	Sat	Sun
Moorside	7	Boots the Chemist **(100hr)**	Unit 1 Woodfields Retail Park, Peel Way, Bury	BL9 5BY	0161 705 2845	8am-23.59pm	8am-23.59pm	8am-23.59pm	8am-23.59pm	8am-23.59pm	8am-10pm	11am - 5pm
	8	Bury Healthcare Pharmacy **(100hr)**	28 Walmersley Road, Bury	BL9 6DP	0161 222 1024	8am-10.30pm	8am-10.30pm	8am-10.30pm	8am-10.30pm	8am-10.30pm	7am-23.59pm	00-2am-10am-4pm
	17	Huntley Mount Pharmacy	Huntley Mount Road	BL9 6JA	0161 761 6662	8.45am-6pm	8.45am-6pm	8.45am-6pm	8.45am-6pm	8.45am-6pm	closed	closed
	37	Strachan's Chemist	Chesham Precinct, 166a Walmersley Road, Bury	BL9 6LL	0161 705 1829	8.45am-6.30pm	8.45am-6.30pm	8.45am-6.30pm	8.45am-6.30pm	8.45am-6.30pm	9am-1pm	closed
	38	Tesco Pharmacy	Woodfields Retail Park, Peel Way, Bury	BL9 5BY	0161 951 6047	8am-9pm	8am-9pm	8am-9pm	8am-9pm	8am-9pm	8am-9pm	11am-5pm
Redvales	13	Fishpool Pharmacy	14 Parkhills Road, Bury	BL9 9AX	0161 764 3535	9am-6pm	9am-6pm	9am-6pm	9am-6pm	9am-6pm	9am-1pm	closed

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BURY WEST TOWNSHIP

Ward	Ref	Pharmacy Trading Name	Address	Postcode	Phone Number	Mon	Tue	Wed	Thur	Fri	Sat	Sun
Church	28	Mile Lane Pharmacy	66 Mile Lane, Bury	BL8 2JR	0161 764 5054	9am-6pm	9am-6pm	9am-6pm	9am-6pm	9am-6pm	9am-1pm	closed
	29	Netchem Pharmacy	107 Bolton Road, Bury	BL8 2NW	0161 764 4401	9am-5pm	9am-5pm	9am-5pm	9am-5pm	9am-5pm	closed	closed
Elton	25	Manor Pharmacy	367 Brandlesholme Road, Bury	BL8 1HS	0161 764 4249	9am - 1pm 2pm - 6pm	9am - 1pm 2pm - 6pm	9am - 1pm 2pm - 6pm	9am - 1pm 2pm - 6pm	9am - 1pm 2pm - 6pm	9am-1pm	closed

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PRESTWICH TOWNSHIP

Ward	Ref	Pharmacy Trading Name	Address	Postcode	Phone Number	Mon	Tue	Wed	Thur	Fri	Sat	Sun
Holyrood	23	Lloyds Pharmacy	474 Bury Old Road, Prestwich	M25 1NL	0161 773 2786	9am-6pm	9am-6pm	9am-6pm	9am-6pm	9am-6pm	9am-5pm	closed
Sedgley	12	Dennis Gore Chemists	26 Whittaker Lane, Prestwich	M25 1FX	0161 773 1994	9am - 7pm	9am - 7pm	9am - 7pm	9am - 7pm	9am - 7pm	closed	closed
	14	Formans Chemist	12 Park Hill, Bury Old Road, Prestwich	M25 0FX	0161 740 3438	9am-7pm	9am-7pm	9am-7pm	9am-7pm	9am-7pm	closed	closed
	16	Pharmacykwik	Rear Unit, 56 Parksway, Manchester	M25 0HB	0161 773 1456	9am-7pm	9am-7pm	9am-7pm	9am-7pm	9am-7pm	9am-7pm	closed
	35	Sedgley Park Pharmacy	33 Bury New Road, Prestwich	M25 9JY	0161 773 2750	9am-6pm	9am-6pm	9am-6pm	9am-6pm	9am-6pm	closed	closed
	36	St Gabriel's Medical Centre Pharmacy	4 Bishop's Road, Prestwich	M25 0HT	0161 773 5665	8.30am-6pm	8.30am-6pm	8.30am-6pm	8.30am-6pm	8.30am-6pm	closed	closed
	39	Tesco Pharmacy	Bury New Road, Prestwich	M25 3TG	0161 951 5447	8am-10pm	8am-10pm	8am-10pm	8am-10pm	8am-10pm	8am-10pm	10am-4pm
St Mary's	31	Prestwich Pharmacy	40 Longfield Centre, Prestwich	M25 1AY	0161 798 9932	8.30am-6.15pm	8.30am-6.15pm	8.30am-6.15pm	8.30am-6.15pm	8.30am-6.15pm	9am-2pm	closed

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Radcliffe Township

Ward	Ref	Pharmacy Trading Name	Address	Postcode	Phone Number	Mon	Tue	Wed	Thur	Fri	Sat	Sun
Radcliffe East	5	Boots the Chemist	11 Blackburn Street, Radcliffe	M26 1NN	0161 723 2221	9am-5.30pm	9am-5.30pm	9am-5.30pm	9am-5.30pm	9am-5.30pm	9am-5pm	closed
	32	Radcliffe Pharmacy	62 Cross Lane, Radcliffe	M26 2RF	0161 725 9111	8.45am-6.15pm	8.45am-6.15pm	8.45am-5pm	8.45am-6.15pm	8.45am-6.15pm	closed	closed
	41	The Co-operative Pharmacy	Radcliffe PCC, Church Street West, Radcliffe	M26 2SP	0161 724 7687	8am-8pm	8am-8pm	8am-8pm	8am-8pm	8am-8pm	8am-12noon	closed
	33	Radcliffe Pharmacy **(100hr)**	47 Church Street West, Radcliffe	M26 2SQ	0161 723 0005	8am-10.30pm	8am-10.30pm	8am-10.30pm	8am-10.30pm	8am-23.59pm	00-6pm	10am-6pm
	19	JT Smith & Son	8-8a Ainsworth Road, Radcliffe	M26 4DJ	0161 723 2519	9am - 1pm 2pm - 6pm	9am - 1pm 2pm - 6pm	9am - 1pm	9am - 1pm 2pm - 6pm	9am - 1pm 2pm - 6pm	9am-1pm	closed
Radcliffe West	2	Asda Pharmacy	Riverside Retail Park, Pilkington Way, Radcliffe	M26 3DA	0161 724 2510	8.30am-10pm	8.30am-10pm	8.30am-10pm	8.30am-10pm	8.30am-10pm	8.30am - 8pm	10.30am-4.30pm
	24	Manor Pharmacy	Unsworth Street, Radcliffe	M26 3RF	0161 723 2128	9am - 1pm 2pm - 6pm	9am - 1pm 2pm - 6pm	9am - 1pm 2pm - 6pm	9am - 1pm 2pm - 6pm	9am - 1pm 2pm - 6pm	9am-1pm	closed

**There are no pharmacies in the Radcliffe North Ward.*

Ramsbottom, Totttington and North Manor Township

Ward	Ref	Pharmacy Trading Name	Address	Postcode	Phone Number	Mon	Tue	Wed	Thur	Fri	Sat	Sun
North Manor	15	Gardners Chemist	6 Vernon Road, Greenmount	BL8 4DD	01204 883220	9am-6pm	9am-6pm	9am-5.30pm	9am-6pm	9am-6pm	9am-1pm	closed
	26	Manor Pharmacy	1 Brandlesholme Road, Greenmount	BL8 4DS	01204 884266	9am-1pm 2pm-6pm	9am-1pm 2pm-6pm	9am-1pm 2pm-6pm	9am-1pm 2pm-6pm	9am-1pm 2pm-6pm	9am-1pm	closed
Ramsbottom	11	Cohens Chemist	7 Market Place, Ramsbottom	BL0 9AJ	01706 822206	9am-1pm 2pm-6pm	9am-1pm 2pm-6pm	9am-1pm 2pm-6pm	9am-1pm 2pm-6pm	9am-1pm 2pm-6pm	9am-12.30pm	closed
	20	Lloyds Pharmacy	6 Bolton Street, Ramsbottom	BL0 9HX	01706 823155	9am-6pm	9am-6pm	9am-5pm	9am-6pm	9am-6pm	9am-12.30pm	closed
Tottington	9	Cohens Chemist	12-14 Market Street, Tottington	BL8 4AD	01204 882928	9am-6pm	9am-6pm	9am-6pm	9am-6pm	9am-6pm	9am-1pm	closed

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Whitefield and Unsworth

Ward	Ref	Pharmacy Trading Name	Address	Postcode	Phone Number	Mon	Tue	Wed	Thur	Fri	Sat	Sun
Pilkington Park	4	Barash Pharmacy	166 Bury New Road, Whitefield	M45 6QJ	0161 766 4242	9am-6.15pm	9am-6.15pm	9am-6.15pm	9am-6.15pm	9am-6.15pm	closed	closed
Unsworth	1	Asda Pharmacy	Pilsworth Road, Pilsworth, Bury	BL9 8RS	0161 351 2510	8.30am - 10pm	8.30am - 10pm	8.30am - 10pm	8.30am - 10pm	8.30am - 10pm	8.30am - 10pm	10.30am-4.30pm
	10	Cohens Chemist	135 Croft Lane, Bury	BL9 8QA	0161 766 2161	8.30am-12.30pm 1.30pm - 6pm	8.30am-12.30pm 1.30pm - 6pm	8.30am-12.30pm 1.30pm - 6pm	8.30am-12.30pm 1.30pm - 6pm	8.30am-12.30pm 1.30pm - 6pm	closed	closed
	34	Rowlands Pharmacy	59 Parr Lane, Unsworth	BL9 8JR	0161 766 3595	9am - 12.30pm 1.30pm - 6pm	9am - 12.30pm 1.30pm - 6pm	9am - 12.30pm 1.30pm - 6pm	9am - 12.30pm 1.30pm - 6pm	9am - 12.30pm 1.30pm - 6pm	9am-1pm	closed
	40	The Co-operative Pharmacy	Unit 1 Elms Square, Whitefield	M45 7TA	0161 767 9334	9am-6pm	9am-6pm	9am-6pm	9am-6pm	9am-6pm	closed	closed

**There are no pharmacies in the Besses Ward.*

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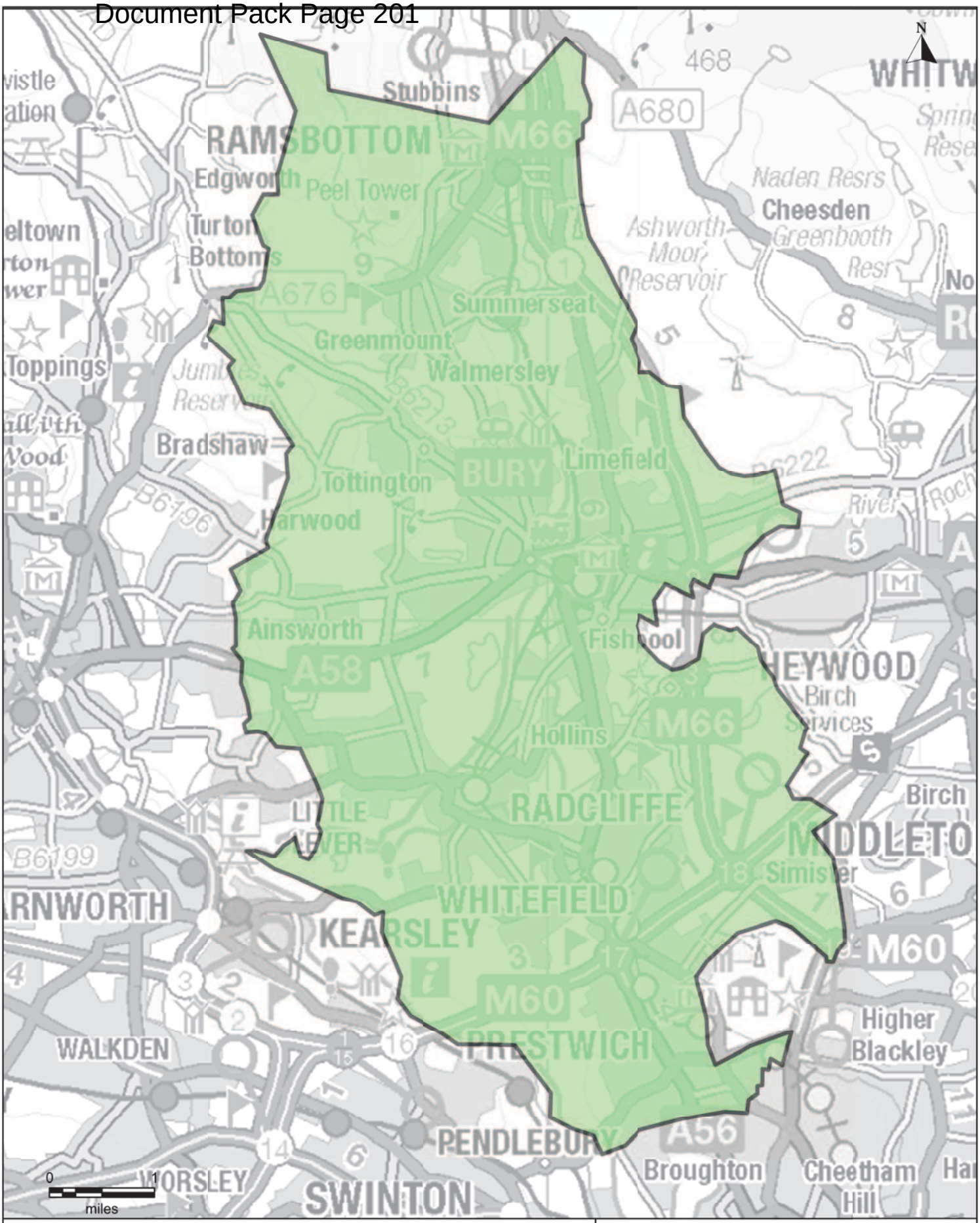
Appendix 9 – Acronyms

AAACM	All age all cause mortality
AUR	Appliance Use Review
BME	Black and Minority Ethnic
CCG	Clinical Commissioning Group
CMO	Chief Medical Officer
COPD	Chronic Obstructive Pulmonary Disease
CPCF	Community Pharmacy Contractual Framework
CPPE	Centre Pharmacy Postgraduate Education
CVD	Cardiovascular Disease
DAC	Dispensing Appliance Contractors
DDA	Disability Discrimination Act
DH	Department of Health
EHC	Emergency Hormonal Contraception
ePACT	Electronic Prescribing and CosT tool
EPS	Electronic Prescription Service
GMAT	NHS England's Greater Manchester Area Team
GP	General Practice
GUM	Genitourinary Medicine

HCAI	Health Care Acquired Infections
HSCIC	Health and Social Care Information Centre
HWB	Health and Wellbeing Board
IMD	Index of Multiple Deprivation
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LAT	Local Area Team
LCS	Locally Commissioned Services
LPC	Local Pharmaceutical Committee
LPS	Local Pharmaceutical Service
LSOA	Lower Layer Super Output Area
LTC	Long Term Conditions
MSOA	Middle Layer Super Output Area
MUR	Medicines Use Review
NWCSU	North West Commissioning Support Unit
NICE	National Institute for Health and Clinical Excellence
NHS	National Health Service

NMS	New Medicines Service
NPSA	National Patient Safety Agency
NVQ	National Vocational Qualification
OCU	Opiate or Crack Users
ONS	Office of National Statistics
OOH	Out of Hours
PCT	Primary Care Trust
PGD	Patient Group Direction
PID	Pelvic Inflammatory Disease
PMCF	Prime Minister's Challenge Fund
PNA	Pharmaceutical Needs Assessment
PSNC	Pharmaceutical Services Negotiating Committee
RPS	Royal Pharmaceutical Society
SAC	Stoma Appliance Customisation Service
SOA	Super Output Area
STI	Sexually Transmitted Infection

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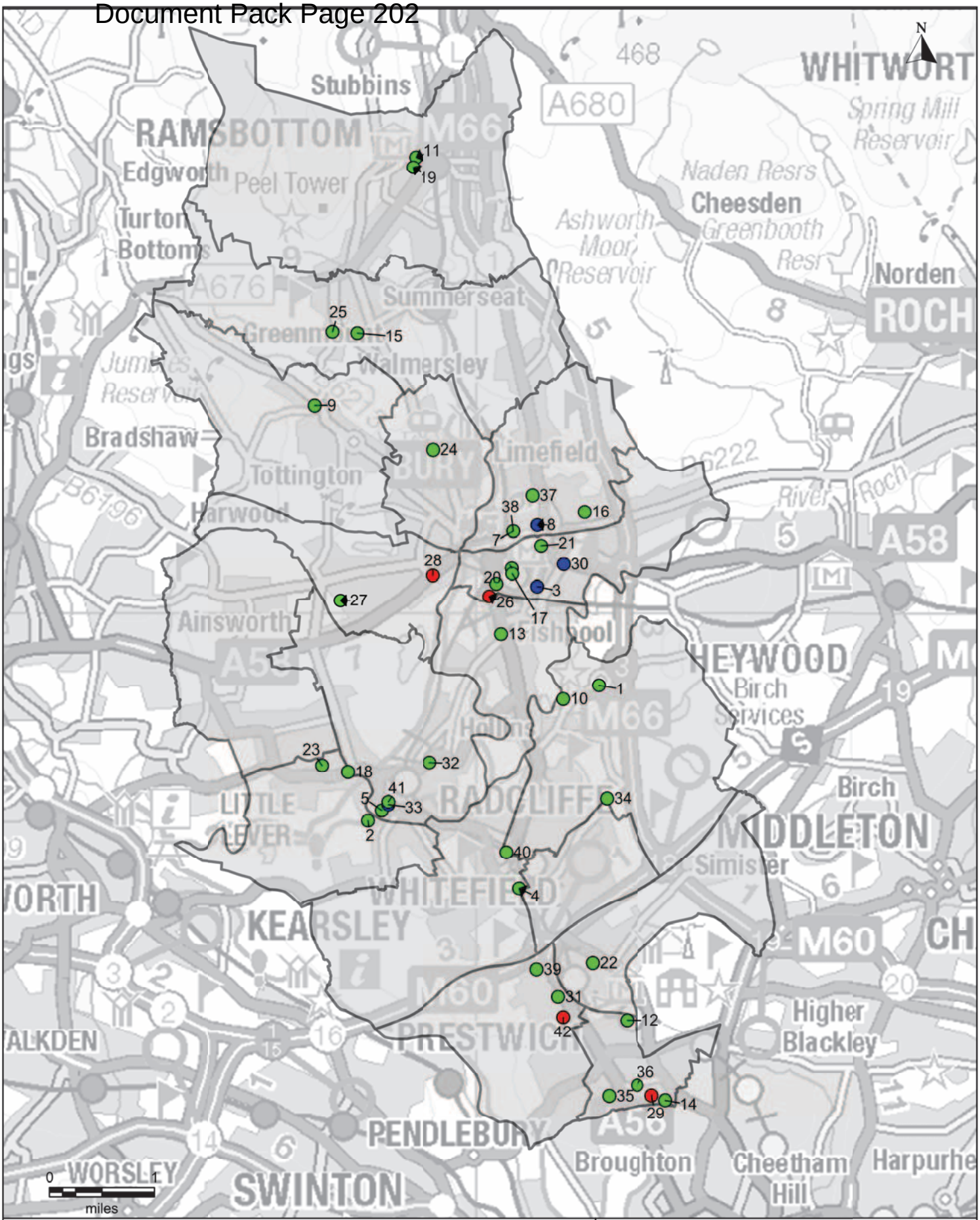


Bury Council Boundary

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All maps within this document produced by:
Medicines Optimisation Team (GM), NHS North West Commissioning Support Unit
St James's House, Pendleton Way, Salford M6 5FW
Telephone: 0161 212 5680
Email: gmcsu.medsman@nhs.net



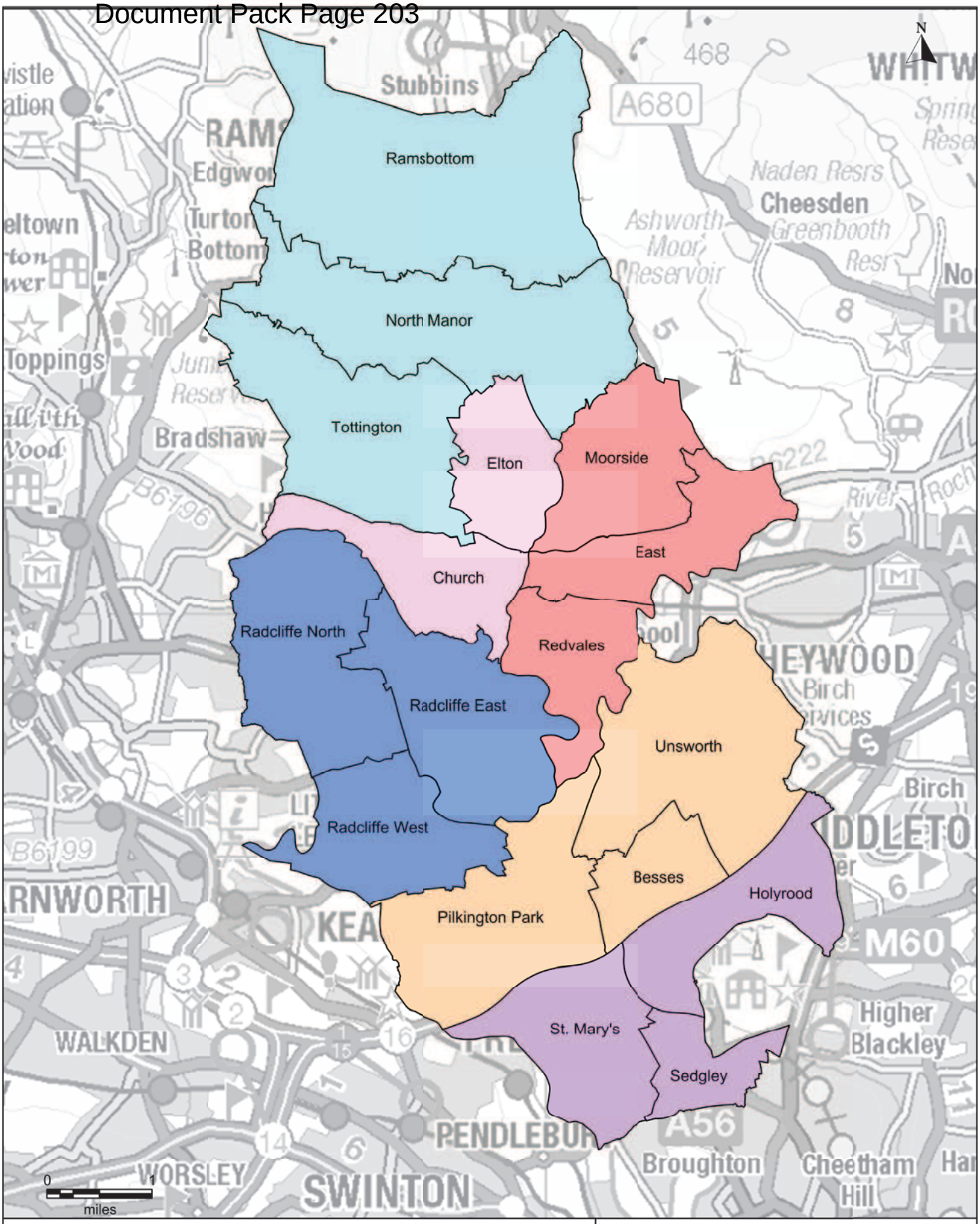
Bury Pharmacy Contractors by Contract Type
(with reference number)

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Pharmacies by Contract Type

- 100 hours Contract (5)
- Distance Selling/ Internet Contract (4)
- Standard Contract (33)
- Wards



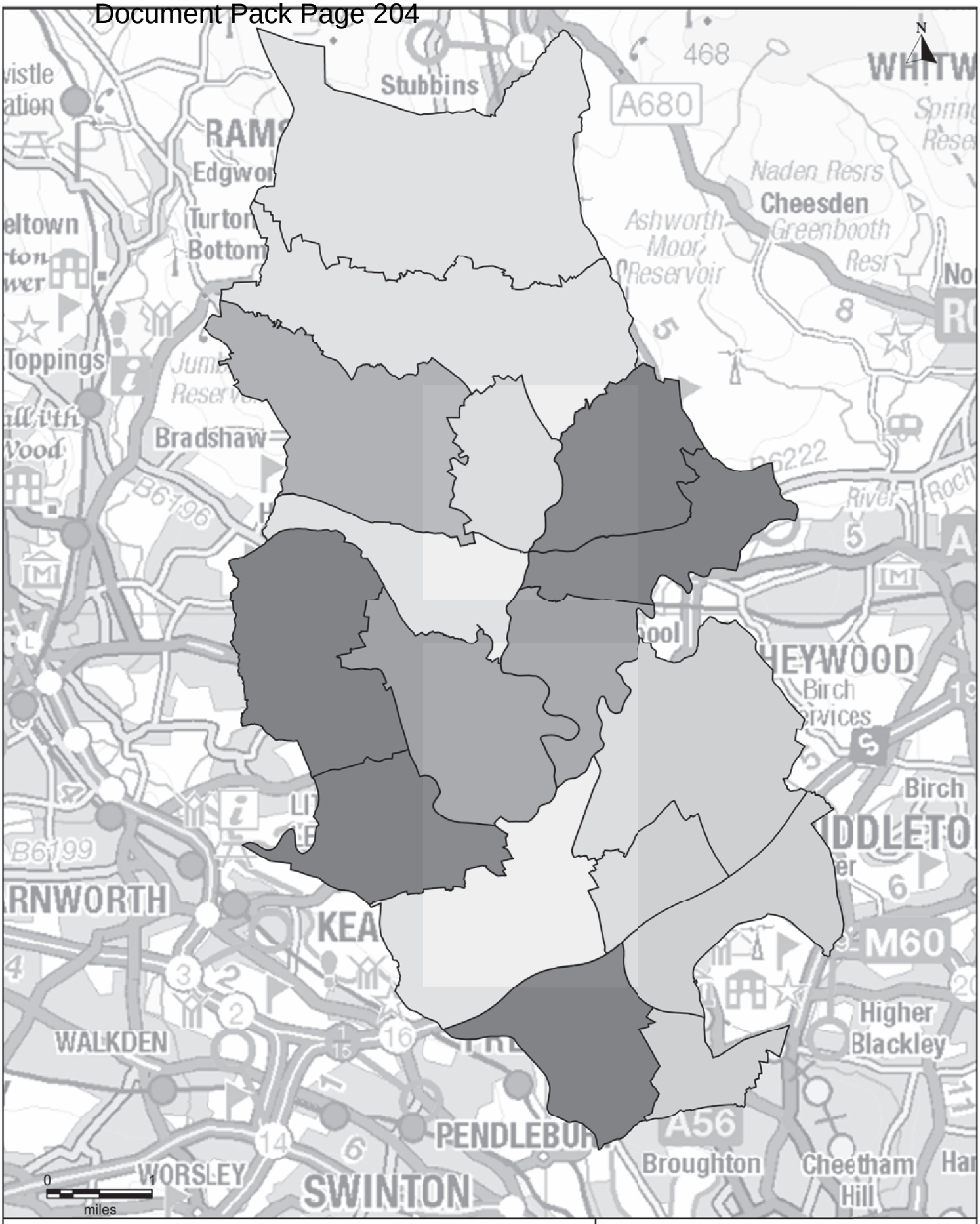
Electoral Ward and Township boundaries in Bury

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Bury Wards and Township Boundaries

- Bury East
- Bury West
- Prestwich
- Radcliffe
- Ramsbottom, Tottington and North Manor
- Whitefield and Unsworth



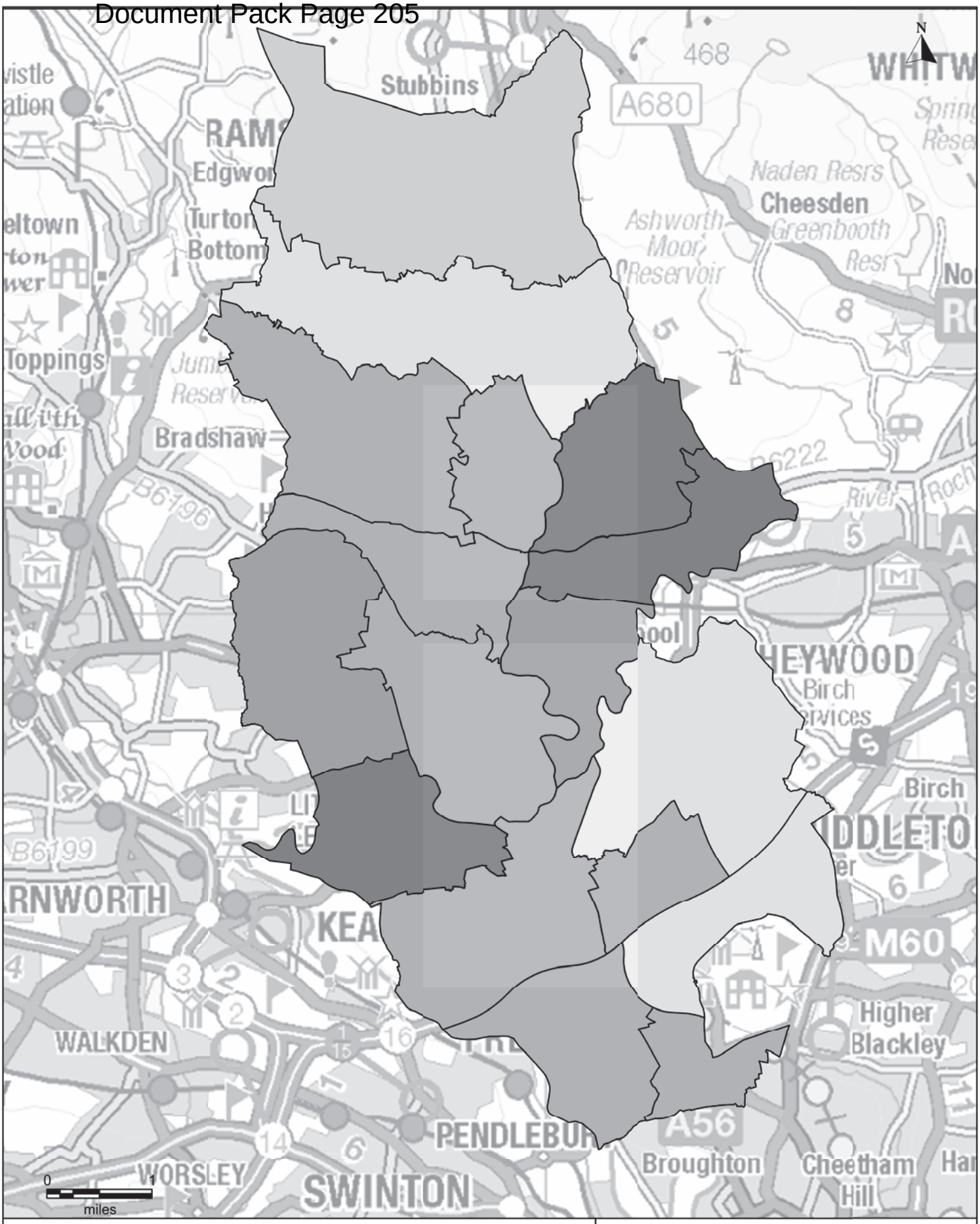
Electoral Ward and Life Expectancy from birth for males

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Life Expectancy at Birth by Ward
(Male - PHE, Local Health 2012)

- 79.9 to 81.2 (4)
- 78.5 to 79.9 (5)
- 77.1 to 78.5 (1)
- 75.7 to 77.1 (2)
- 74.3 to 75.7 (5)
- Wards



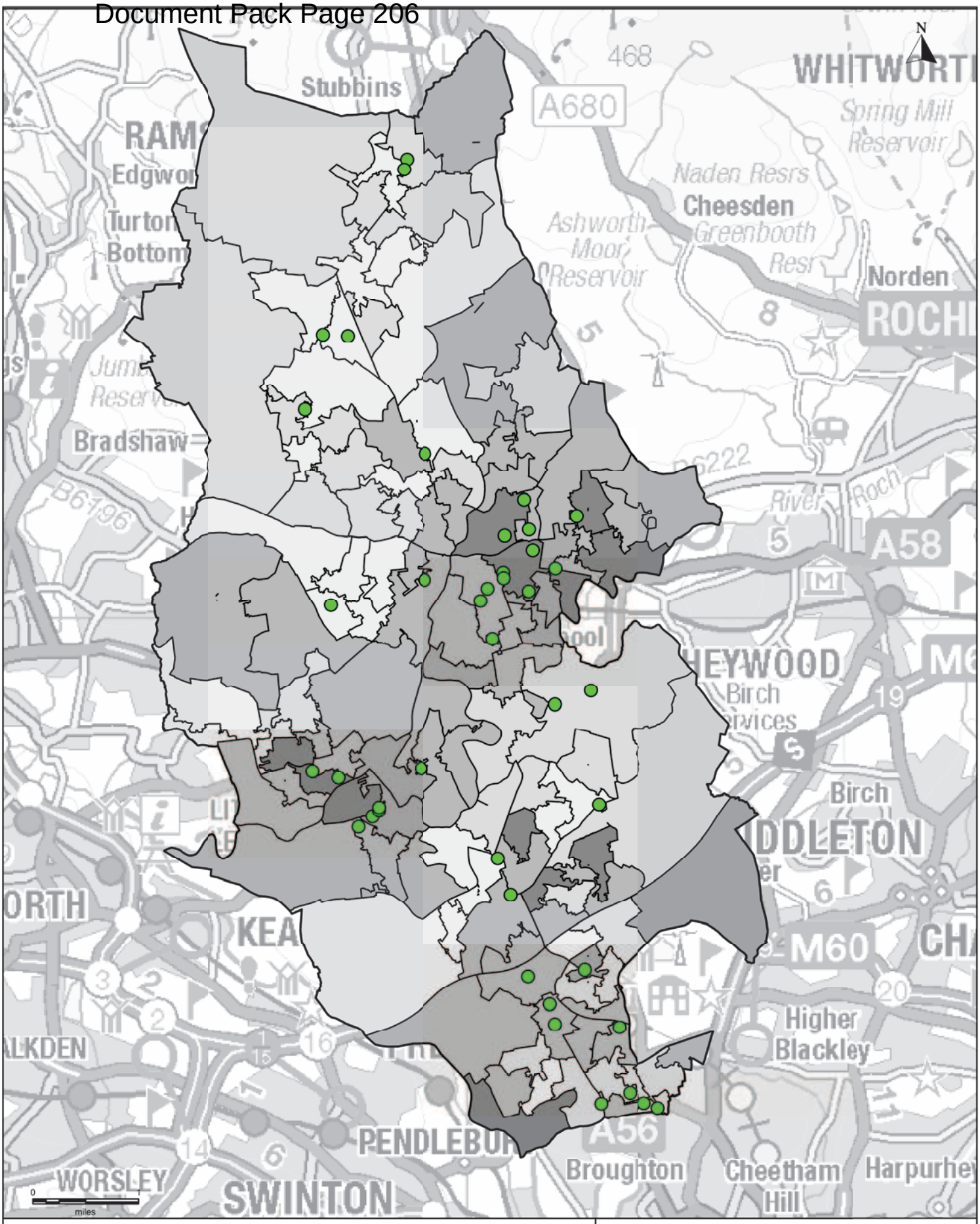
Electoral Ward and Life Expectancy from birth for females

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Life Expectancy at Birth by Ward
(Female - PHE, Local Health 2012)

84 to 85.6 (3)	80.8 to 82.4 (8)	77.6 to 79.2 (3)	Wards
82.4 to 84 (1)	79.2 to 80.8 (2)		



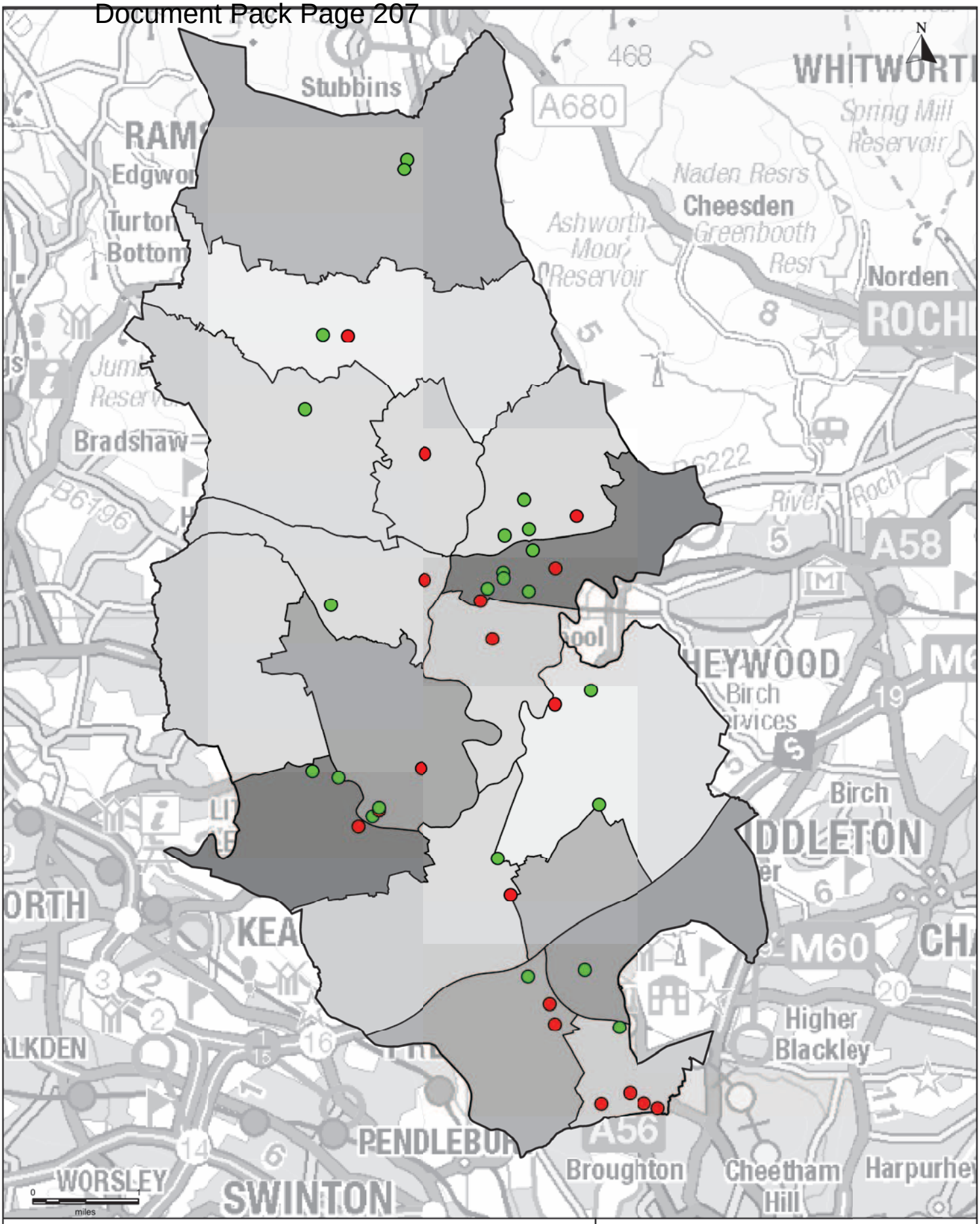
Deprivation in Bury (IMD 2010) ranking for England by LSOA

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Bury's IMD Ranking for England by LSOA
(A ranking of 1 indicates the most deprived area)

24,363 to 32,300 (25)	6,122 to 16,241 (46)	293 to 3,248 (11)	Wards
16,242 to 24,362 (30)	3,249 to 6,121 (8)		



Stop Smoking Support by Pharmacy Contractors in Bury

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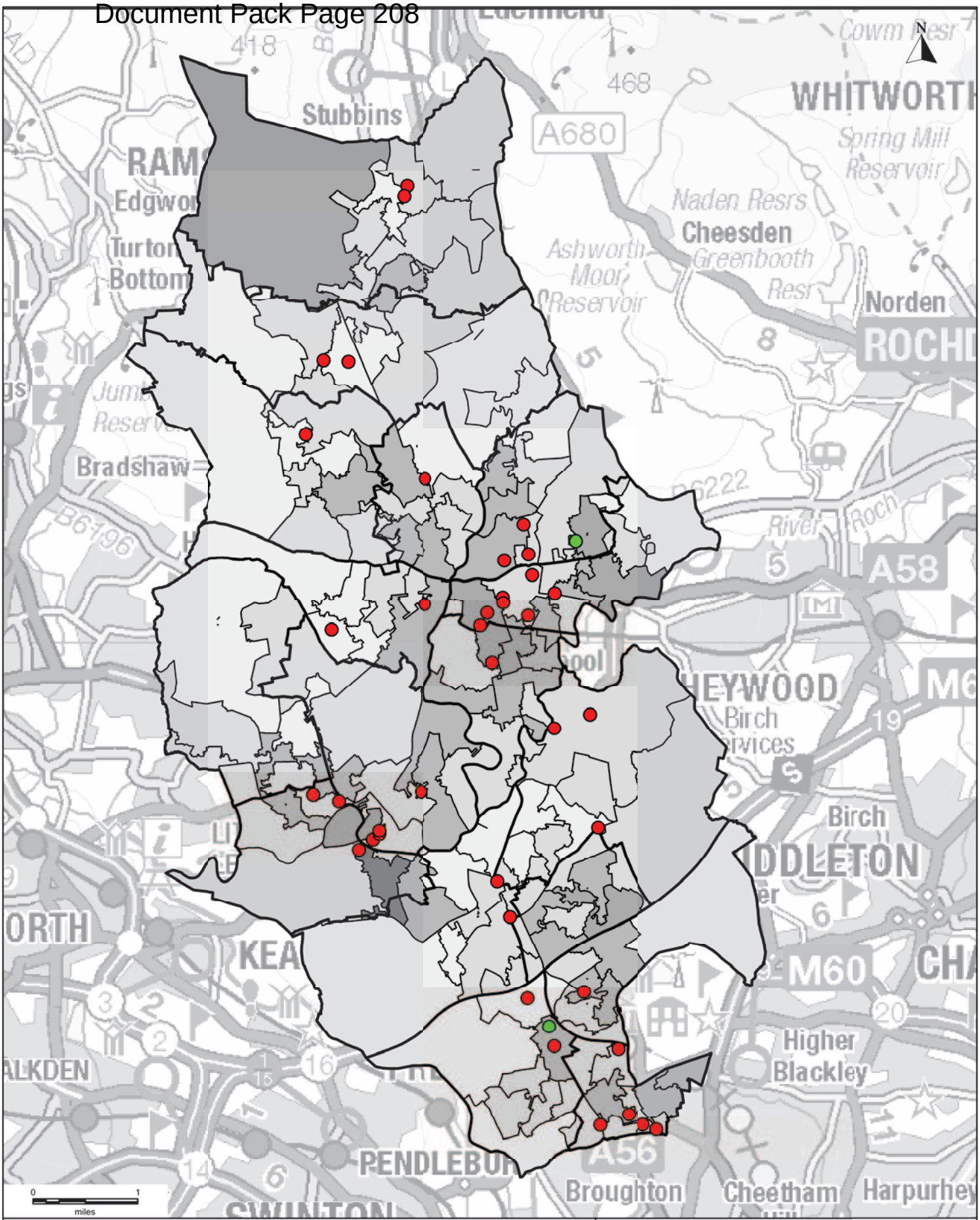
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North West Commissioning Support Unit

Bury Pharmacy Contractors and Smoking Cessation services provision

- Pharmacy Contractors commissioned to provide Stop Smoking Support (24)
- Pharmacy Contractors not commissioned to provide Stop Smoking Support (18)

Bury Percentage of Smokers by Ward (Bury Health Survey 2010 data)

- 24 to 27
- 21 to 24
- 18 to 21
- 15 to 18
- 12 to 15
- Wards



Bury Pharmacy Contractors providing Chlamydia Testing and Treatment

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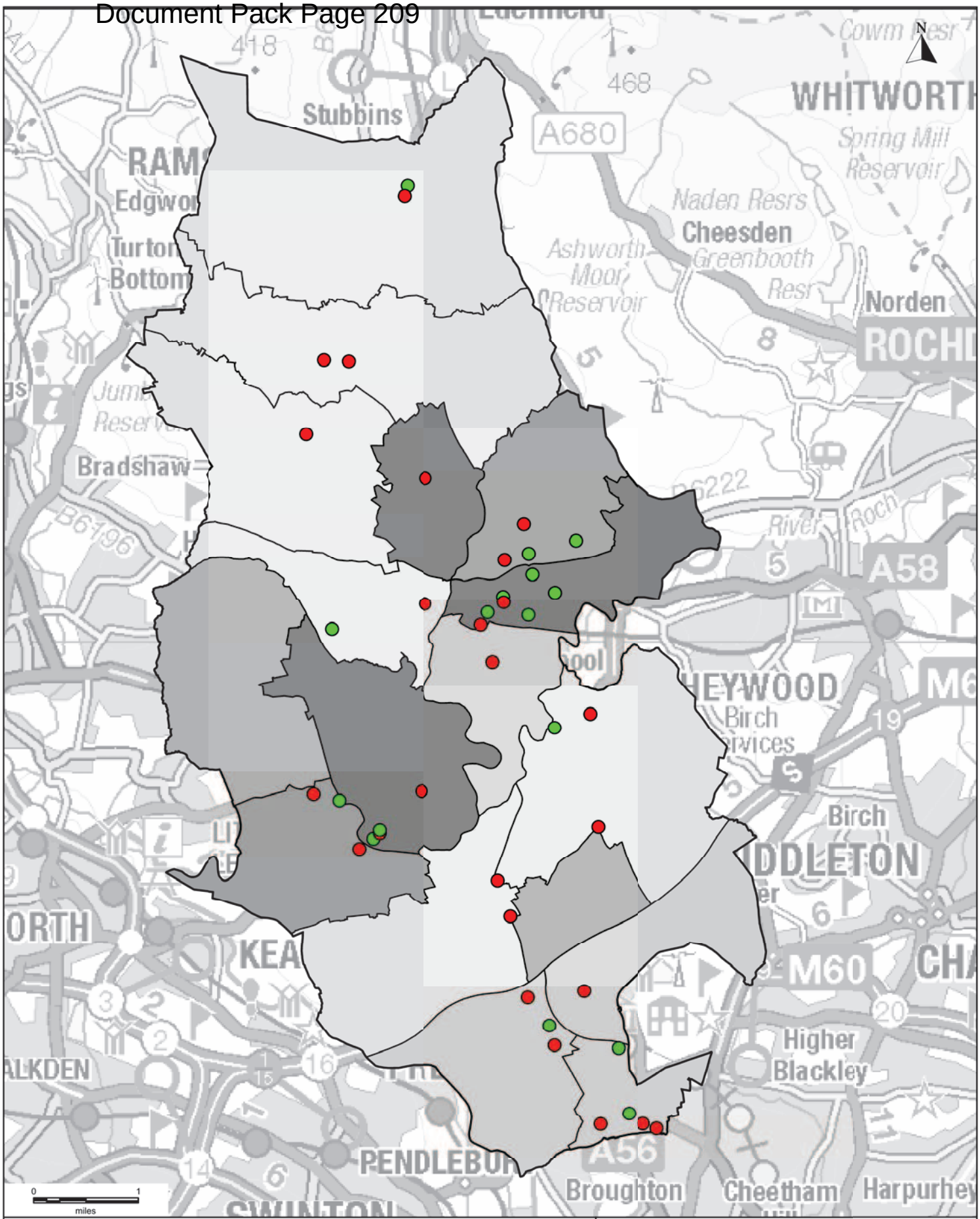
Pharmacy Contractors and provision of Chlamydia Testing and Treatment

Pharmacy Contractor commissioned to provide (2)

Pharmacy Contractor not commissioned to provide (40)

Population by LSOA for 15-24 year olds

302 to 354 (1)
252 to 302 (7)
202 to 252 (31)
152 to 202 (55)
102 to 152 (26)
Wards



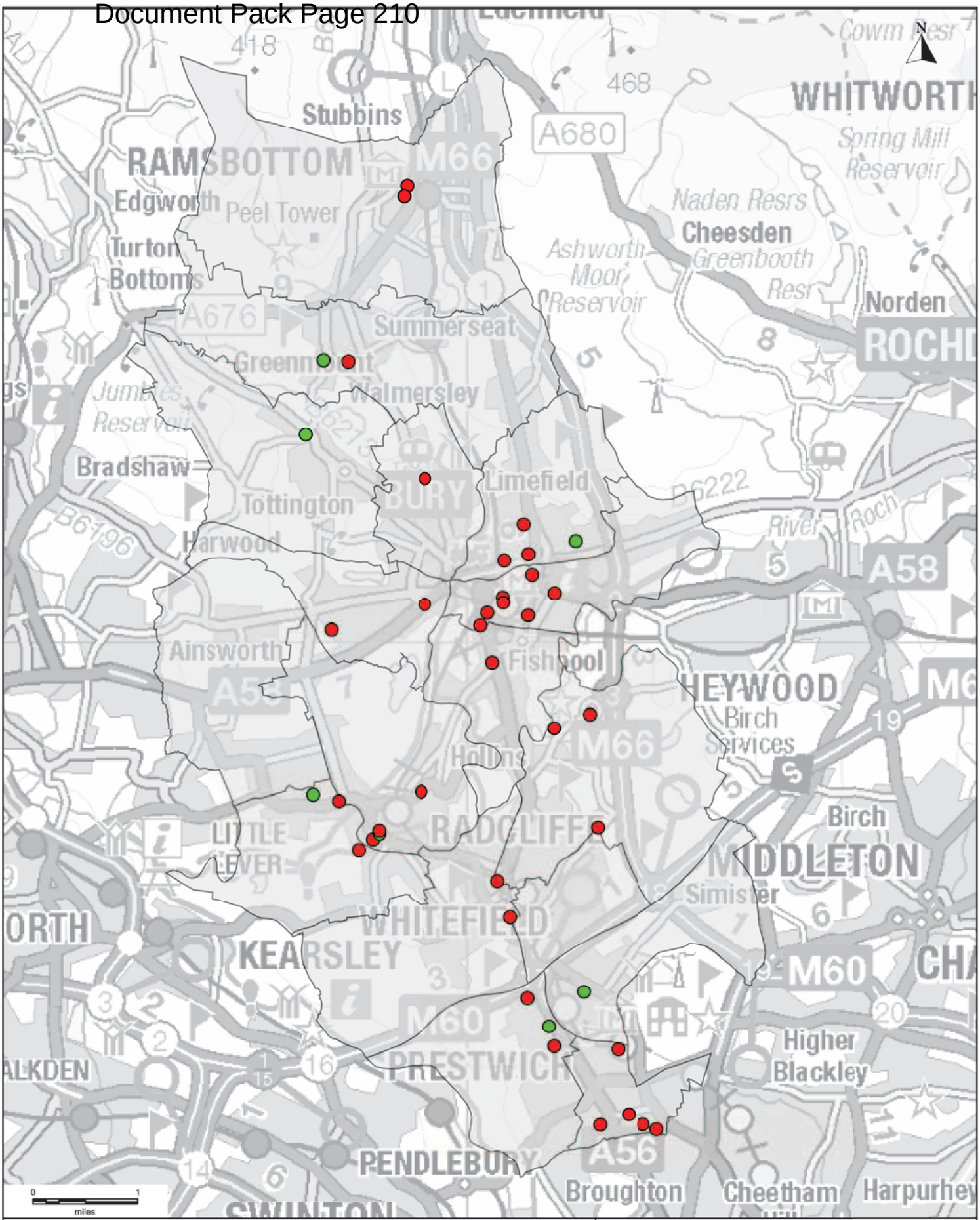
Bury Pharmacy Contractors providing Emergency Hormonal Contraception

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Pharmacy Contractors and provision of EHC
Commissioned to provide (17)
Not commissioned to (25)

Bury Conception rates per 1000 females age 13 to 17 years by Ward
61 to 71
49 to 61
37 to 49
25 to 37
13 to 25
Wards



Bury Pharmacy Contractors and Needle Exchange provision

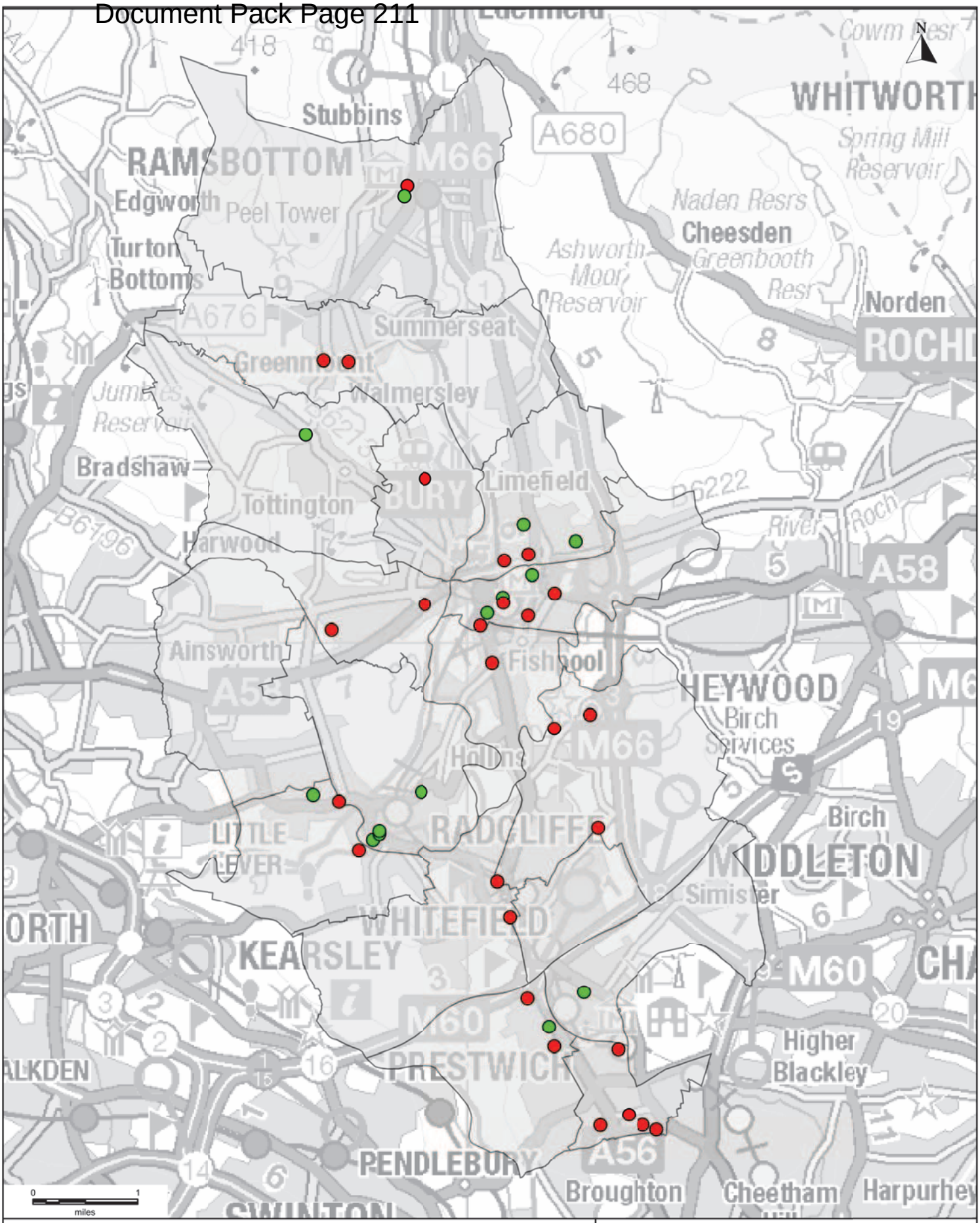
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Bury Pharmacy Contractors and Needle Exchange provision

- Pharmacy Contractors commissioned to provide Needle Excharge (7)
- Pharmacy Contractors not commissioned to provide Needle (35)

Wards



Bury Pharmacy Contractors and Supervised Consumption provision

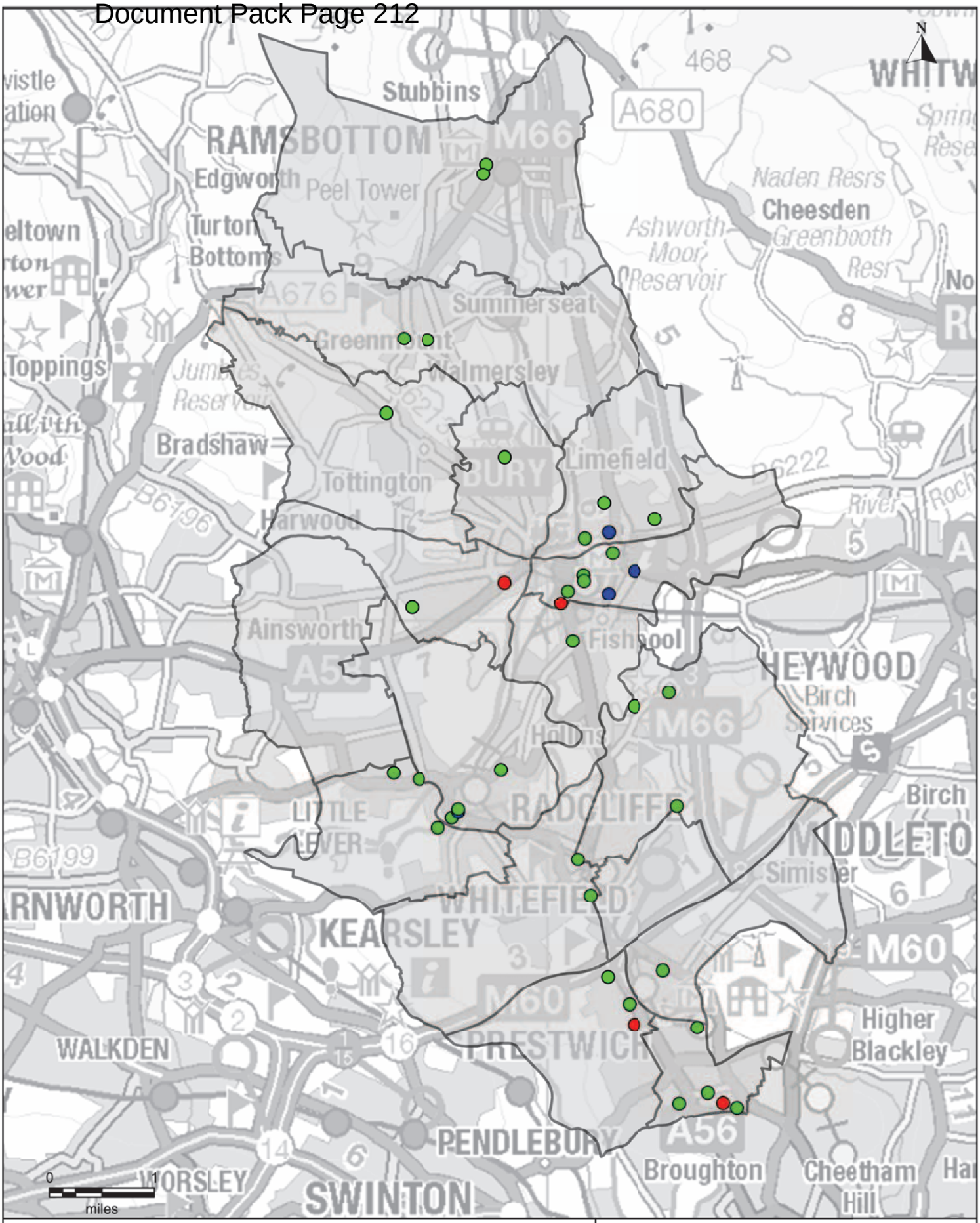
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Bury pharmacy contractors and Supervised Consumption provision

- Pharmacy Contractors not commissioned to provide Supervised Consumtpion (27)
- Pharmacy Contractors commissioned to provide Supervised Consumtpion (15)

Wards



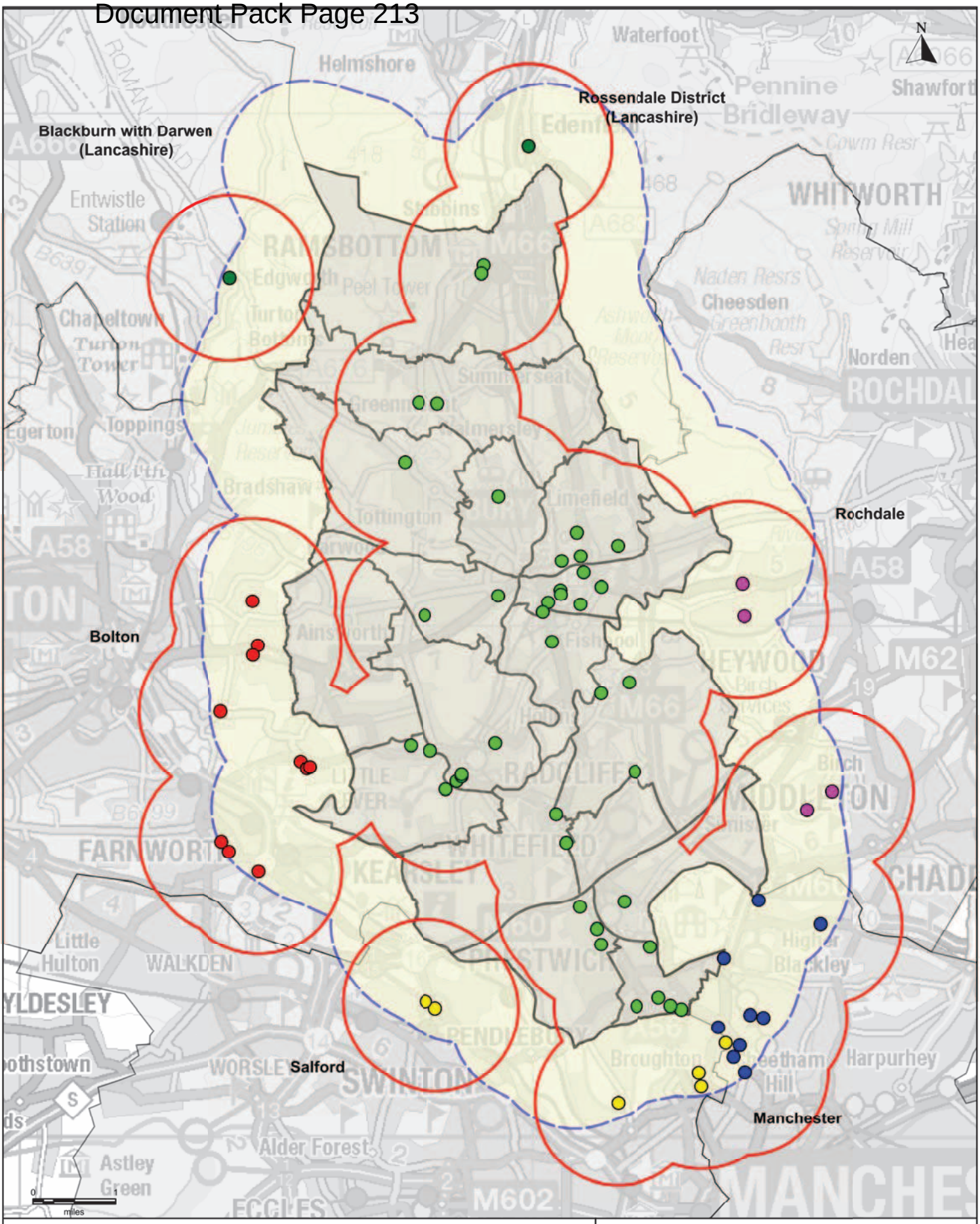
Bury Pharmacy Contractors by Contract Type

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Pharmacies by Contract Type

- 100 hours Contract (5)
- Distance Selling/ Internet Contract (4)
- Standard Contract (33)
- Wards



Pharmacy Contractors in Bury Council Boundary and within 1 mile

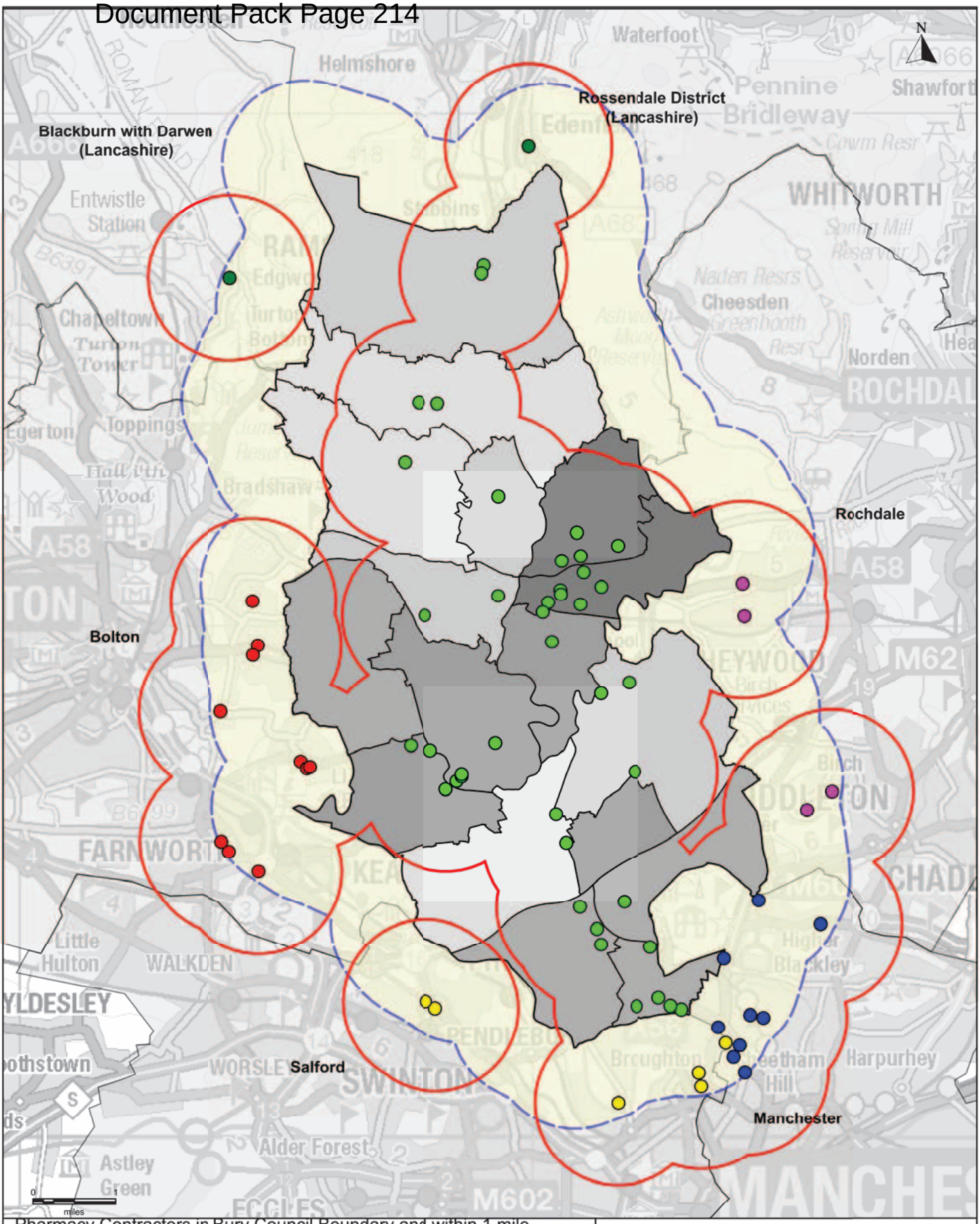
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Pharmacy Contractors within 1 mile of Bury Council Boundary

Bolton	(10)	Rochdale	(4)
Lancashire	(2)	Salford	(6)
Mancheste	(9)	Bury	(42)

Wards
1 mile from Council Boundary
1 mile Zone Round Pharmacies



Pharmacy Contractors in Bury Council Boundary and within 1 mile plotted against Number of Households with no cars

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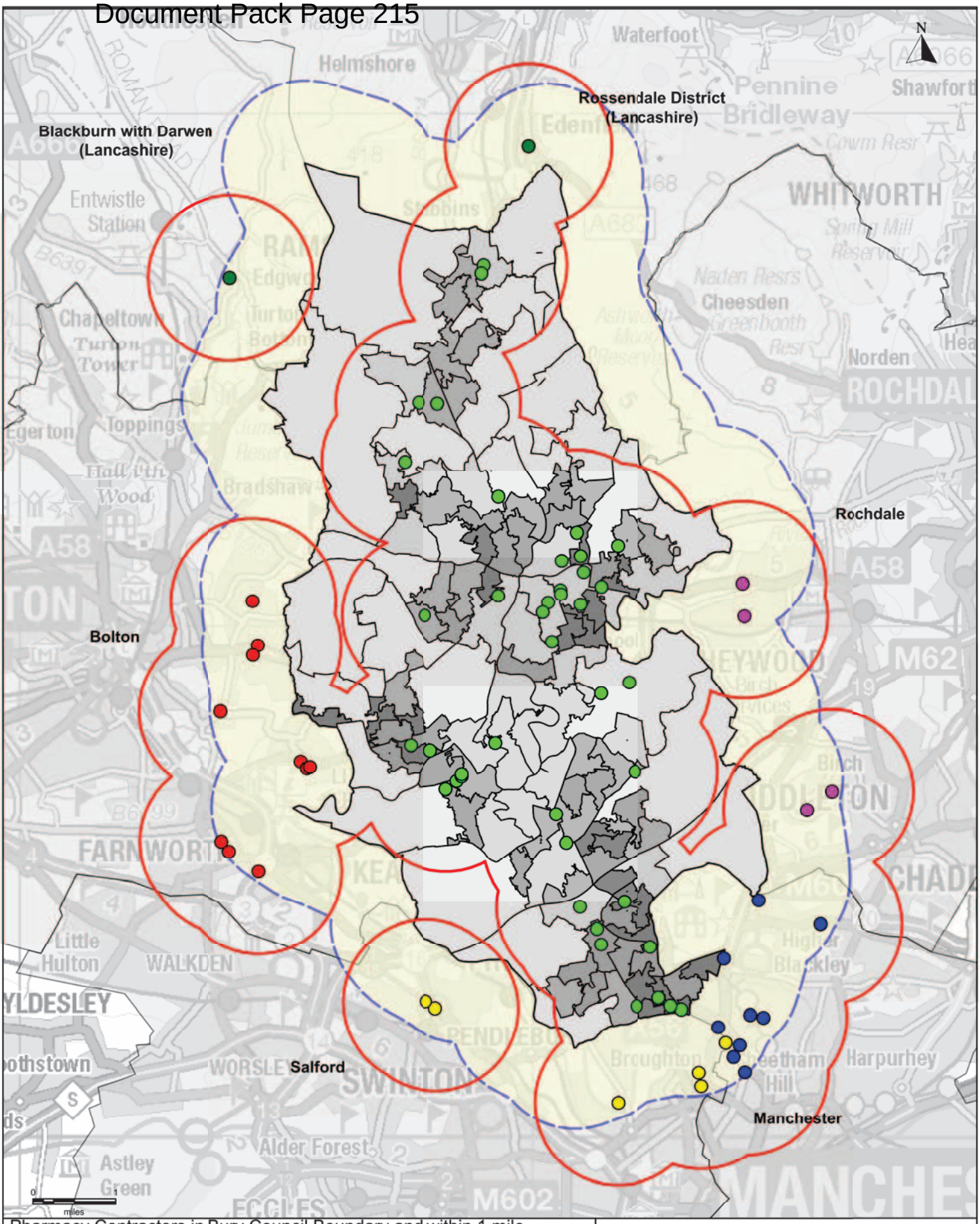
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North West Commissioning Support Unit

Pharmacy Contractors within 1 mile of Bury Council Boundary

Bolton	(10)	Rochdale	(4)		
Lancashire	(2)	Salford	(6)		
Manchester	(9)	Bury	(42)		

Number of Households with No Car (Data 2011)

1,590 to 1,880	750 to 1,030
1,310 to 1,590	470 to 750
1,030 to 1,310	Wards
1 mile from Council Boundary	1 mile Zone Round Pharmacies



Pharmacy Contractors in Bury Council Boundary and within 1 mile plotted against Population per Hectare by LSOA

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Pharmacy Contractors within 1 mile of Bury Council Boundary

Bolton	(10)	Rochdale	(4)
Lancashire	(2)	Salford	(6)
Manchester	(9)	Bury	(42)

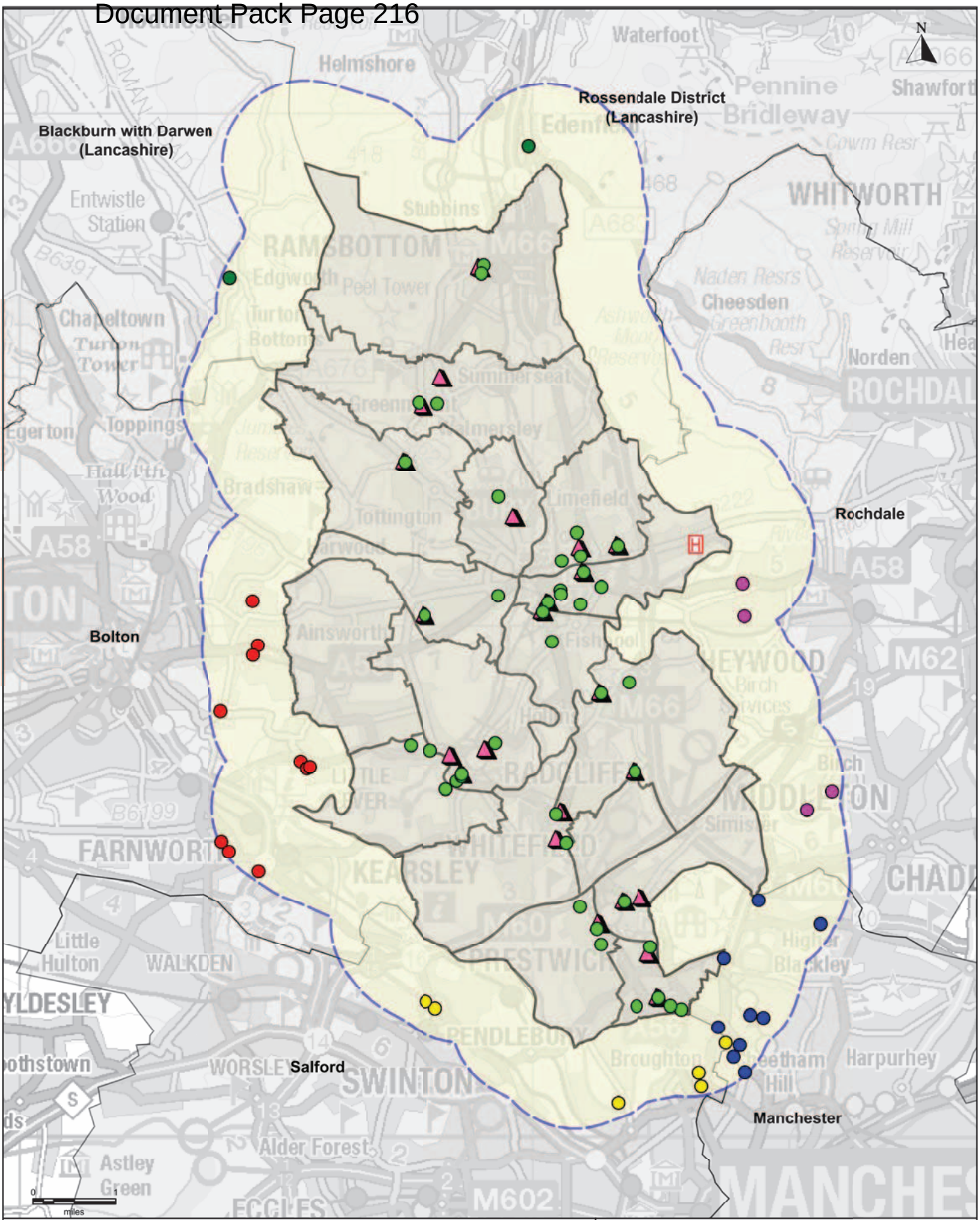
Population per Hectare by LSOA (Data 2011)

56 to 125	17 to 29
41 to 56	1 to 17
29 to 41	

1 mile from Council Boundary

Wards

1 mile Zone Round Pharmacies



Pharmacy Contractors in Bury and within 1 mile of Council Boundary plus Bury GP practices and hospital

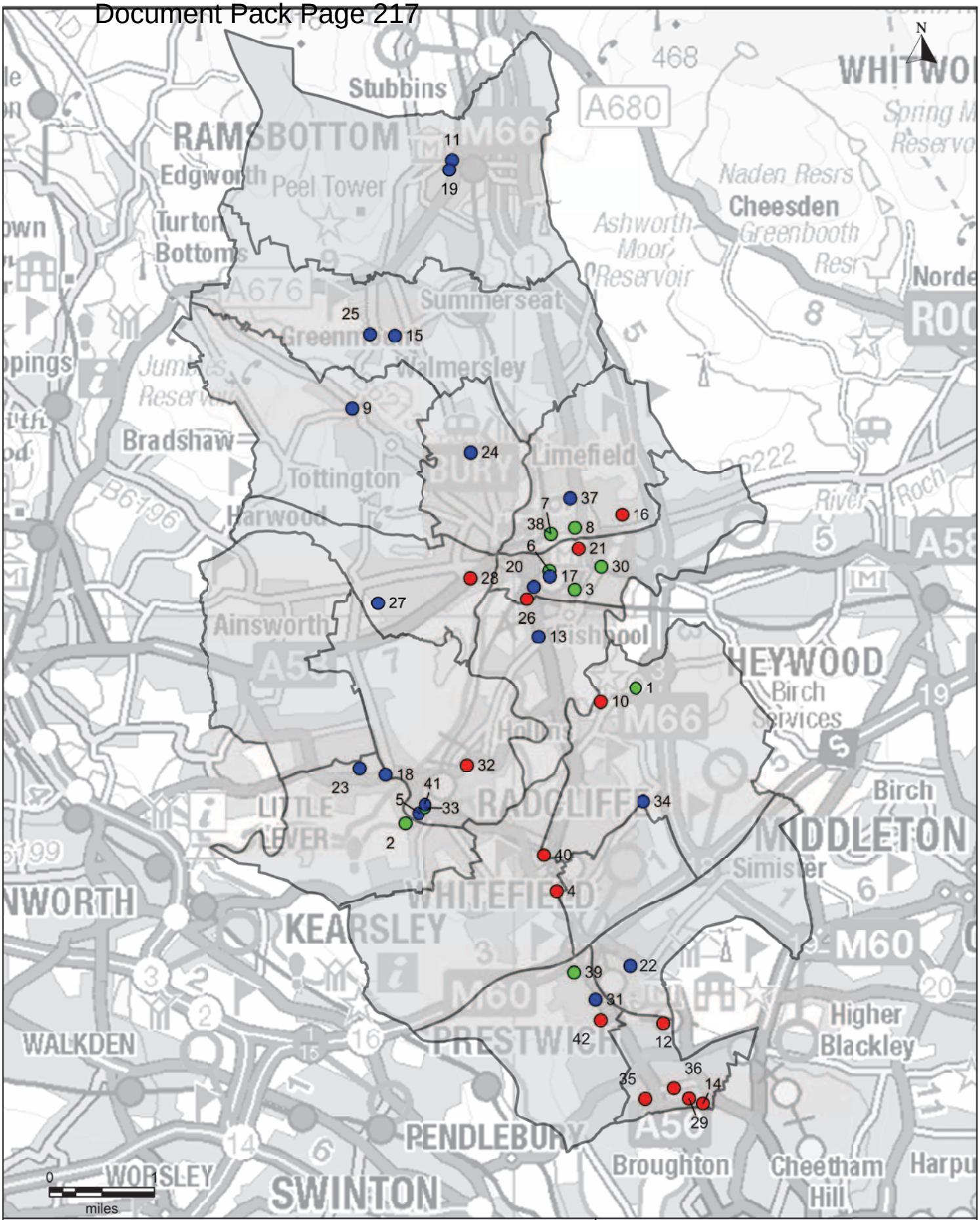
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North West Commissioning Support Unit

Pharmacy Contractors within 1 mile of Bury Council Boundary

Bolton	(10)	Rochdale	(4)
Lancashire	(2)	Salford	(6)
Manchester	(9)	Bury	(42)

Wards
1 mile from Council Boundary
1 mile Zone Round Pharmacies
GP Practice(s)
Fairfield General Hospital



Bury Pharmacy Contractors and Accessibility

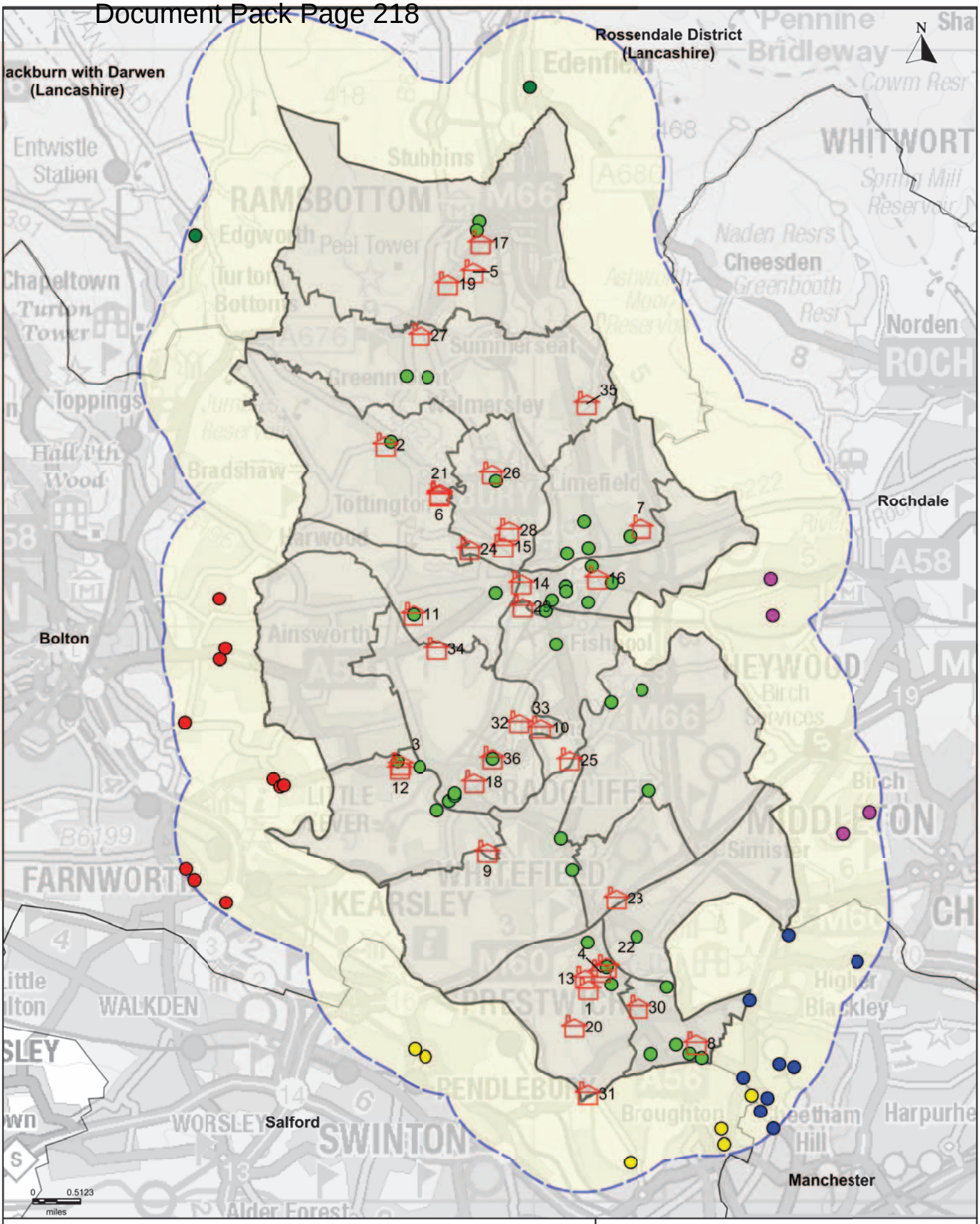
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NHS
North West
Commissioning Support Unit

Bury Pharmacies and Accessibility

Open Mon - Fri	(14)	
Open Weekdays & Saturday	(18)	
Open Late Weekdays and Open Sat & Sun	(10)	

Wards



Bury Pharmacy Contractors with Planning Application sites (labelled)

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NHS North West Commissioning Support Unit

Pharmacy Contractors within 1 mile of Bury Council Boundary

Bolton	(10)	Rochdale	(4)
Lancashire	(2)	Salford	(6)
Manchester	(9)	Bury	(42)

Wards
1 mile from Council Boundary
Planning application sites

Health & Wellbeing Board Report template

Bury Health and Wellbeing Board

Title of the Report	Revised Better Care Fund Plan
Date	15th January 2015
Contact Officer	Lorraine Tatlock Integration Programme Manager Bury Council & Bury CCG
HWB Lead in this area	

1. Executive Summary

Is this report for?	Information ☐	Discussion ☐	Decision ☐
Why is this report being brought to the Board?	To share the revised Better Care Fund plan and to seek ratification		
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	all		
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	all		
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 Board is asked to note and ratify the revised Better Care Fund Plan that was submitted to the national Better Care Fund Taskforce on 14th January 2015		
What requirement is there for internal or external communication around this area?	There is a requirement for comprehensive engagement and communication with all stakeholders		
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	No as the revised plan has been in draft format and will now be shared at other meetings		

provide details.	

2. Introduction / Background

The Better Care Fund (BCF) plan was agreed by the Health and Wellbeing Board on the 18th September 2014 and submitted to the national Better Care Fund Taskforce on 19th September 2014. The plan was then evaluated as part of a national assurance process and approved subject to conditions. There was then a requirement to resubmit revised aspects of the plan in order to address outstanding financial and analytical risks.

The resubmission process was outlined at the last Health and Wellbeing Board meeting in relation to providing clarification and further evidence around:

- Data sharing and the use of the NHS number in social care
- Provider engagement
- Risk share agreement
- A revised risk log
- A review of the metrics
- Financial plan

Assistance has been provided with the plan revision process by the national Better Care Fund Taskforce in the form of financial and analytical consultancy support.

3. key issues for the Board to Consider

Due to the tight timescales involved, it was agreed at the last Board meeting that the sign off of the Better Care Fund Plan should be delegated to Councillor Shori, the Chair of the Board. The revised version of the plan was then signed off by Councillor Shori and submitted to the national Better Care Fund Taskforce on 14th January 2015.

It was also agreed that the final version of the revised Better Care Fund Plan would be shared with the Board and this is now attached for information and ratification. The plan is in several parts as follows:

- Part 1 – Better Care Fund
- Part 1 – annexe 1 - descriptions of Better Care Fund schemes
- Milestone plan associated with Better Care Fund schemes
- Part 2 – finance, metrics and activity spreadsheets

The Better Care Fund Plan has not changed. More information has been provided in parts of the plan and these are still highlighted in red in the attached Part 1 document for ease of review.

The plan will now be subjected to a further national assurance process and assuming the conditions have now been met, it will either be approved or approved with support from either the national Better Care Fund Taskforce or the Local Area Team. The outcome of this process should be known by early February 2015 in order to have the Better Care Fund set up by April 2015. The national Better Care Fund Taskforce has booked a conference call to clarify any issues with the revised plan on Friday 23rd January 2015 and the outcome of this call can be shared verbally at the Board meeting.

4. Recommendations for action

The Board is asked to note and ratify the revised Better Care Fund Plan.

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).

6. Equality/Diversity Implications

CONTACT DETAILS:

Contact Officer: Lorraine Tatlock

Telephone number: 0161 762 3153

E-mail address: Lorraine.Tatlock@nhs.net

Date: 16.1.15

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Better Care Fund Planning template – Part 1

Bury CCG
Bury Council

October 2014

Resubmission of revised version January 2015

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Updated July 2014

Better Care Fund planning template – Part 1

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

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

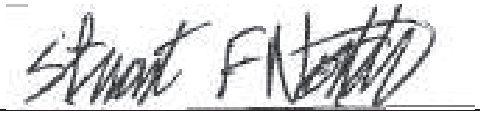
To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

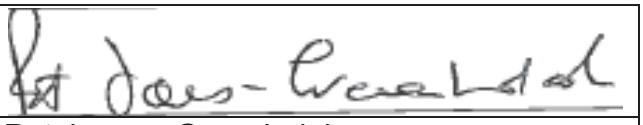
a) Summary of Plan

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

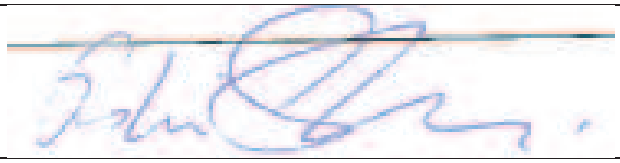
b) Authorisation and signoff

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

<Insert extra rows for additional CCGs as required>

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

<Insert extra rows for additional Councils as required>

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

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

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

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

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

2) VISION FOR HEALTH AND CARE SERVICES

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

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

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

The vision is that:-

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

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

Joint Strategic Need Assessment

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

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

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

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

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

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

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

Health and Wellbeing Strategy

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

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

The strategy focuses on five priorities:

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

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

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

The wider Greater Manchester vision for integrated health and social care

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

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

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

Shared design principles

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

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

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

Integration programmes to deliver the vision

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

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

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

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

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

Ageing Well

Better Together

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

Integrated Wellness Services

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

Staying Well

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

Self Care Programme

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

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

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

Active Ageing

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

Bone Health & Falls Prevention

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

Affordable Warmth

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

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

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

Seasonal Flu Jab Uptake

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

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

Dementia Awareness

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

Disabled Facilities Grant (DFG's)

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

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

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

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

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

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

Person Centred Coordinated Care

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

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

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

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

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

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

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

Healthy

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

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

Delivery against the Better Care Fund Metrics

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

Table 1

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

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

- Patient Experience
- Falls
- Delayed Transfers of Care

Patient/service user experience

Outcome sought

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

allowing any improvements to be demonstrated.

Use of an existing national metric

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

Newly Developed Local Metrics

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

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

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

Consultation on Newly Developed Local Metrics

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

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

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

Selection of the Patient User Experience Metric

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

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

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

Implementation of inclusion of additional questions

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

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

Baselines and Milestones

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

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

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

The answers to the questions are:

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

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

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

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

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

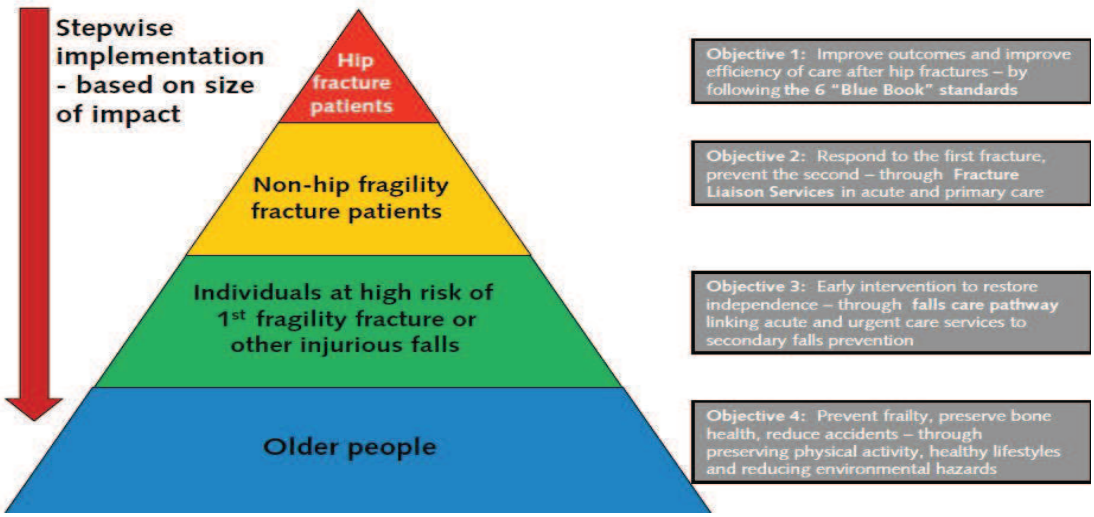
Falls

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

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

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

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



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

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

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

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

management.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Delayed Transfers of Care

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

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

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

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

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

Reduction in reportable DTOC

Total of delayed discharge days by responsible organisation for Bury

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

Patient snapshot by responsible organisation for Bury

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

Metrics Mapping – Impact of Schemes

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

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

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

Figure 1

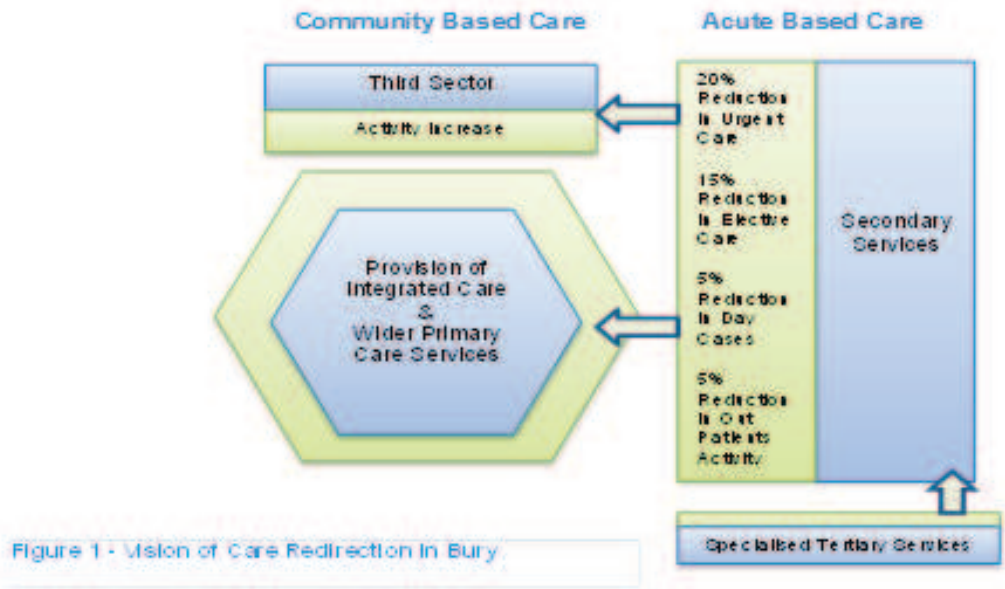


Figure 1 - Vision of Care Redirection in Bury

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

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

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

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

inevitably require trade-offs.

Our communities

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

Primary Care

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

Community and Mental Health

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

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

Secondary care

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

Social Care

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

How will the Better Care Fund plan deliver this vision

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

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

Table 2

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

3) CASE FOR CHANGE

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

In the Case for Change section we demonstrate:

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

Population Projections for Bury

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

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

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

Financial Context for Health and Social Care in Bury

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

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

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

financial settlements are currently unknown.

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

Life Expectancy in Bury

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

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

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

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

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

Table 3

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

Numbers in () indicate no concerns for that gender

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

Falls

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

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

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

Dementia

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

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

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

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

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

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

Table 4

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

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

Vaccinations

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

Alcohol Misuse

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

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

Social Isolation

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

Poverty

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

Excess Winter Deaths

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

Housing

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

Carers

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

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

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

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

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

Safeguarding

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

Acute Services Utilisation

Use of services by the over 65 population

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

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

and for the remaining age bands was 2.55 days.

Figure 2

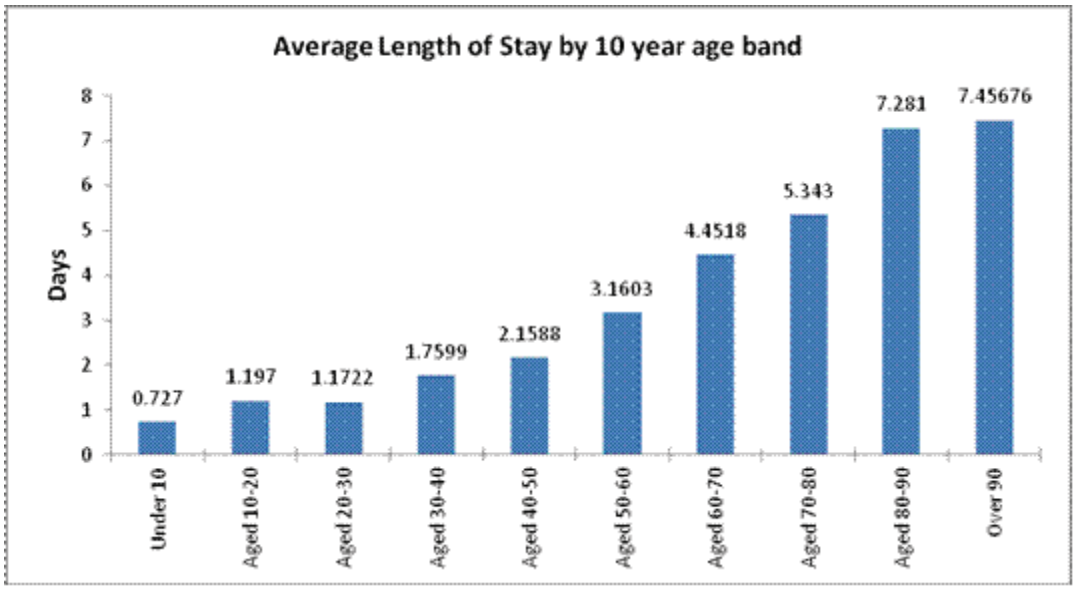


Figure 3 shows, there were 2,500 readmissions which equates to 16% of all admissions. Of these 45% were over the age of 70.

Figure 3

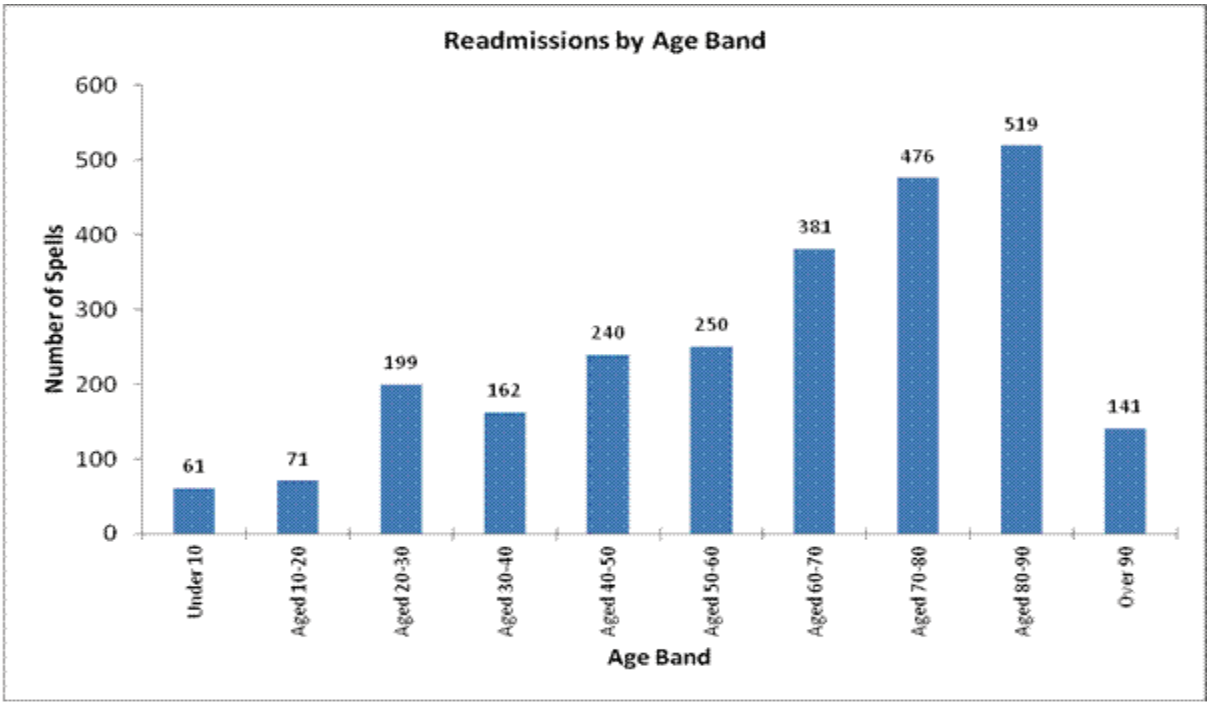
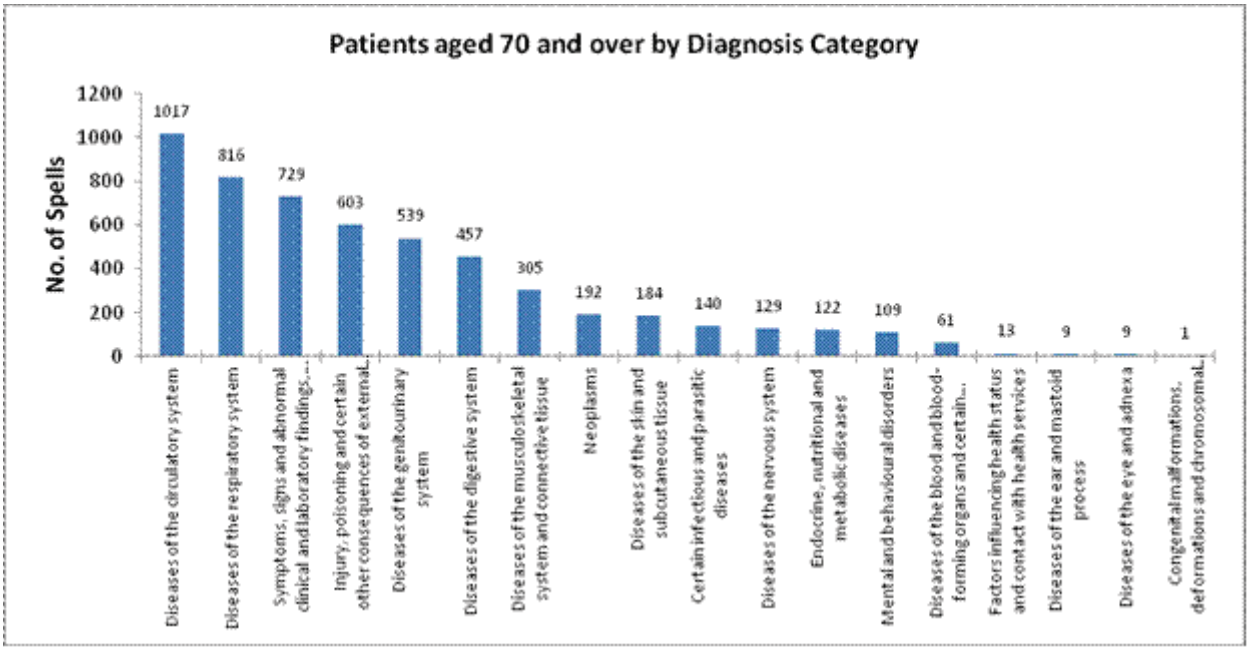


Figure 4 below shows that for patients aged 70, over 19% of these admissions are for diseases of the circulatory system and 15% for respiratory disease.

Figure 4



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

Admissions below 12 hours

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

Figure 5

All Ages

Nov-13 to Jun-14 Data

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

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

Over 65

Nov-13 to Jun-14 Data

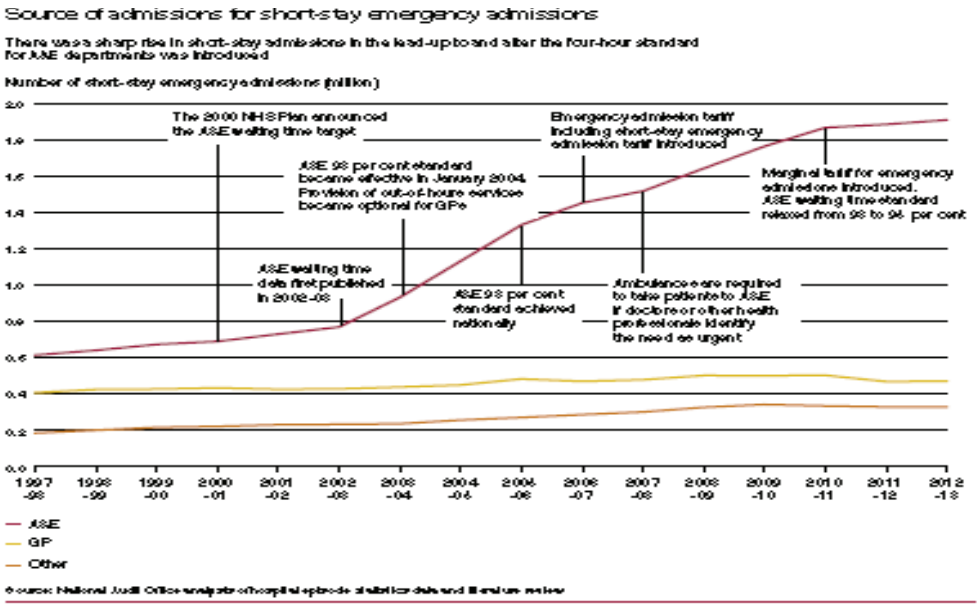
Data source: BI Tools - Urgent Care - (emergency admissions only)

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

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

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

Figure 6



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

Benchmarking

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

Figure 7

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

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

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

Figure 8

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

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

Population segmentation

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

Figure 9

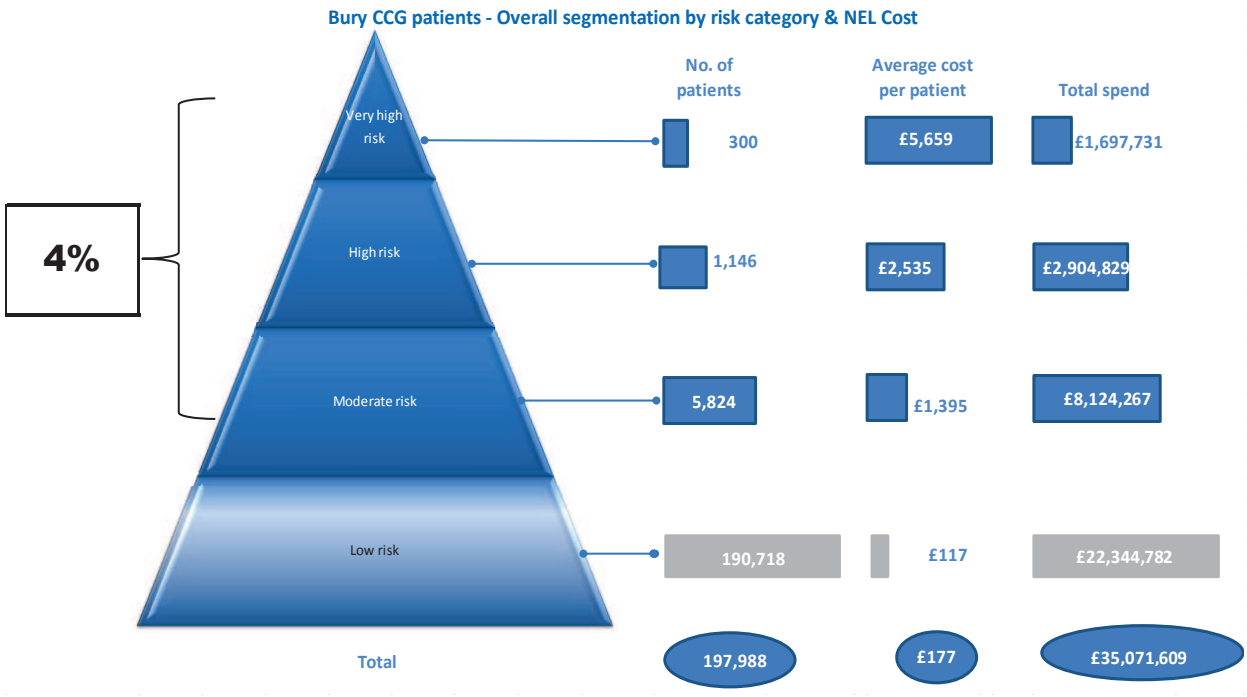


Figure 9 illustrates the population of Bury segmented across the different risk categories. The average cost and total spend per patient is profiled across the segmentation areas and is calculated based on the diagnosis and procedure tariffs for A&E visits, Outpatient Appointments and Non Elective Inpatient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

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

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

Conclusions

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

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

population is higher compared to other areas

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

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

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

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

Figure 10

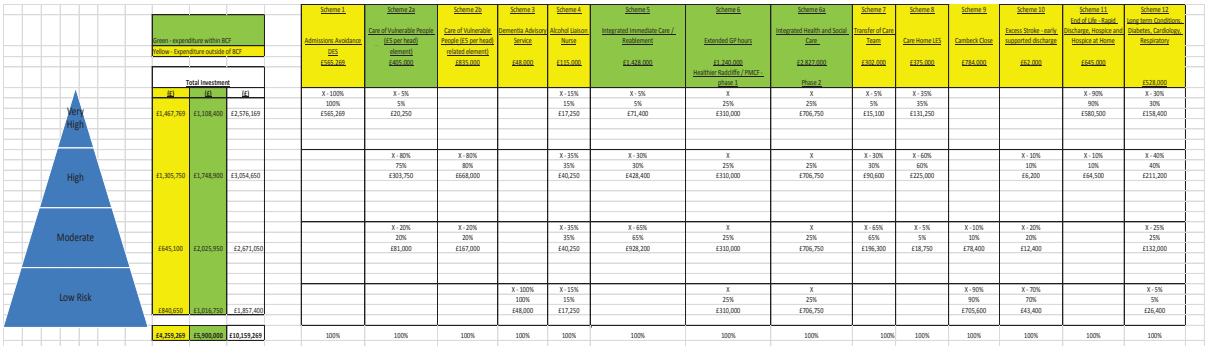
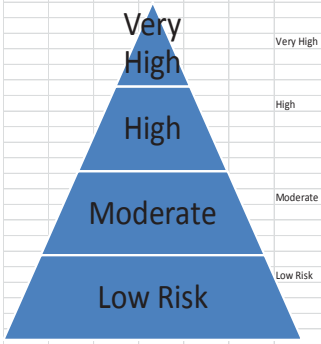


Figure 11 illustrates the risk stratification category breakdown for non-elective admissions for our population and the average cost for each of the segments. It is estimated that 300 people with Long Term Conditions are at a very high risk of a readmission, costing on average £5,649.00 each and 1146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

Figure 11



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

4) PLAN OF ACTION

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

Key milestones

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

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

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

Governance arrangements

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

Integrated Health & Social Care Partnership Board

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

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

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

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

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

Joint Commissioning Group

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

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

Integration Programme Office

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

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

Co-ordinated Community Based Care Group

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

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

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

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

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

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

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

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

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

The Joint Commissioning Group

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

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

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

Management of any remedial actions should plans go off track

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

BCF metrics

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

Quality Indicators

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

Financial

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

Risks

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

Bury Health & Wellbeing Board

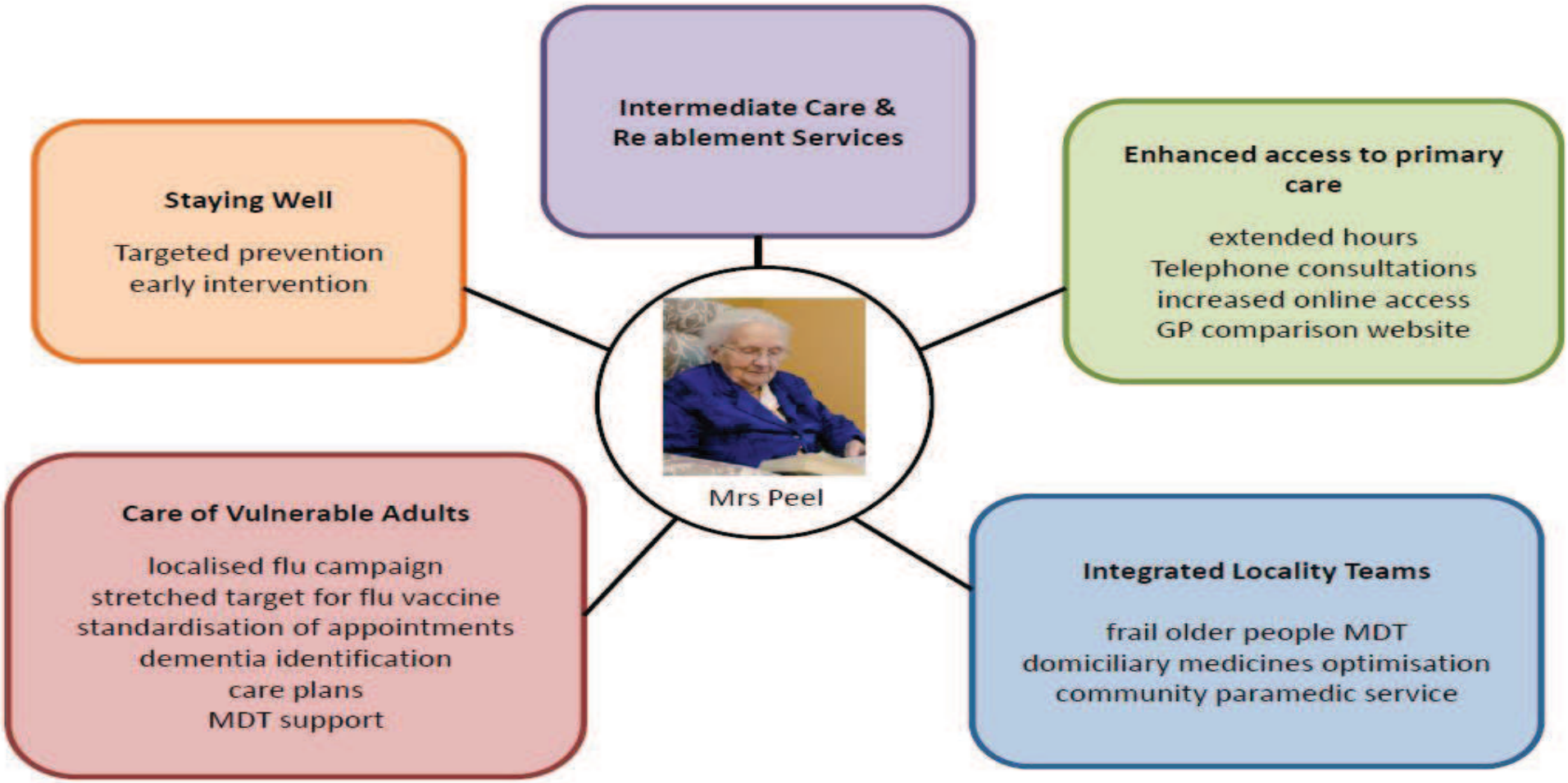
The importance of the Health & Wellbeing Board in overseeing the Better Care Fund is acknowledged. A Policy Lead has been identified from Bury Council to work in partnership with Democratic Services, the Chair and members of the board to support the development and work of the Bury Health & Wellbeing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

d) List of planned BCF schemes

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

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

Model of Integrated Care in Bury & Better Care Fund Schemes



5) RISKS AND CONTINGENCY

a) Risk log

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

Risk log in appendix 3.

b) Contingency plan and risk sharing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6) ALIGNMENT

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

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

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

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

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

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

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

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

Other initiatives underway are as follows:

Provision of information advice and guidance - The Bury Directory

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

voluntary sector.

The system has:

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

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

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

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

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

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

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

Links with Housing

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

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

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

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

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

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

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

Pooled budget arrangements for complex care for children and adults

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

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

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

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

Operational Resilience plans for Bury

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

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

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

Primary Co commissioning

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

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

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

- Collaborative Prevention, Wellness and Life Support Programmes

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

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

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

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

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

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

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

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

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

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

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

The CCG has involved the following stakeholders in the decision:

- Patients Cabinet
- GP Members
- Health and Wellbeing Board

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

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

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

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

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

7) NATIONAL CONDITIONS

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

a) Protecting social care services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Resources for Carer Specific Support

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

Carers strategy and implementation

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

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

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

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

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

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

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

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

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

b) 7 day services to support discharge

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

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

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

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

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

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

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

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

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

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

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

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

Mental Health

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

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

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

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

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

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

Pennine Acute Trust

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

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

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

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

Pennine Care NHS Foundation Trust

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

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

Service offering 6 day working:

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

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

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

Pharmacy Services

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

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

Operational Resilience

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

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

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

c) Data sharing

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

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

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

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

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

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

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

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

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

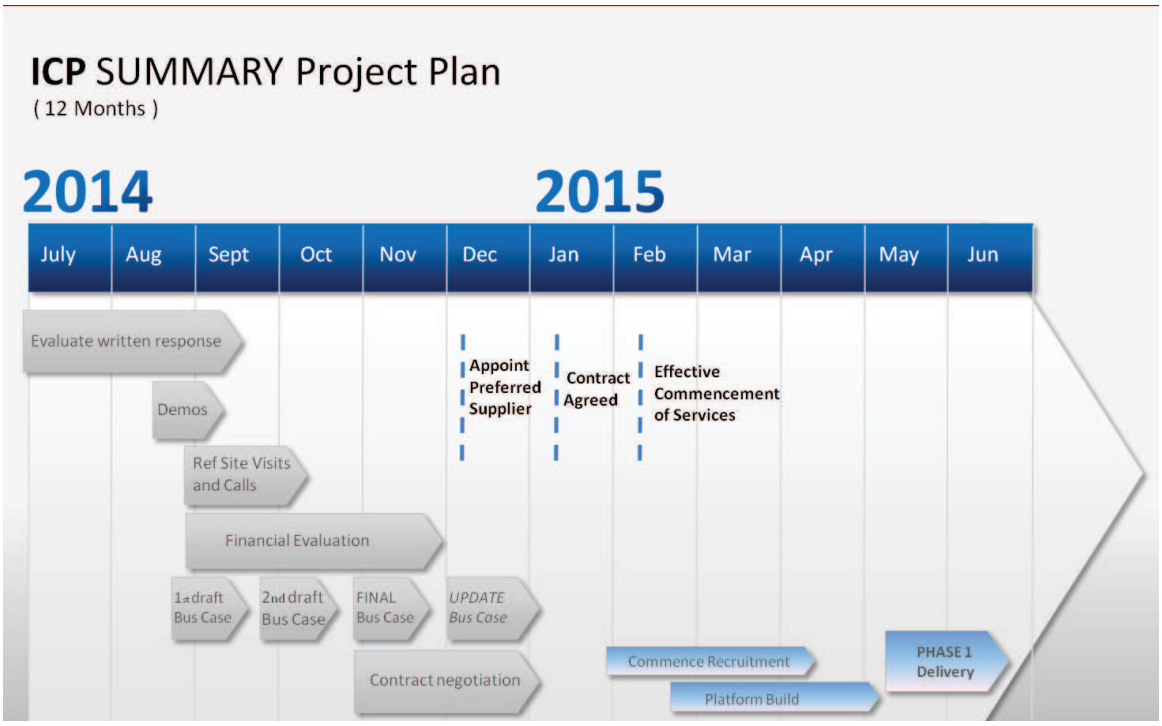
ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 children at high risk of admissions due to asthma

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

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

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

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

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

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

Action being taken to remove barriers to joint assessments and planning

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In order to achieve this Bury CCG is working to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8) ENGAGEMENT

a) Patient, service user and public engagement

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

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

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

Our objectives are:

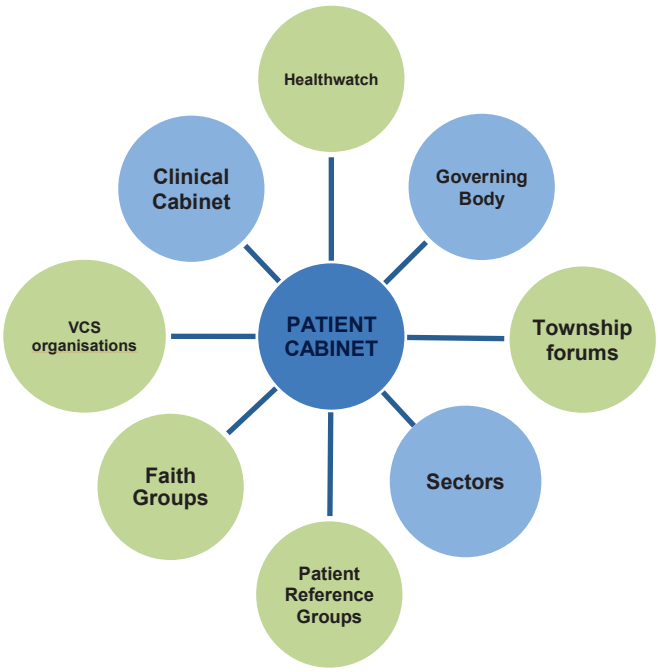
- Local people understand the need for change and own the plans to transform local health and care services
- Community Champions harness the views of local people to shape strategies and plans
- Services are designed with local people
- Local people can manage their own health on a day to day basis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

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

CCG Patient Cabinet

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

Figure 13



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

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

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

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

In the longer term respondents identified priorities including:

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

Respondents were critical about:

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

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

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

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

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

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

Adult Social Care Customer Task Force

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

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

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

Examples include:

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

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

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

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

Township Forum

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

Healthier Radcliffe Demonstrator Community

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

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

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

Health & Wellbeing Strategy Consultation

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

Healthier Together Consultation Events

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

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

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

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

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

CCG Engagement on its 5 year strategy

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

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

Our Place

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

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

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

Our **objectives** are that local people:

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

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

Future Developments

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

Table 6

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

b) Service provider engagement

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

i) NHS Foundation Trusts and NHS Trusts

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

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

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

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

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

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

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

Provider Partnership

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

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

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

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

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

The discussion at the workshop then considered:

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

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

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

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


Bury Provider Partnership Worksho


Bury Provider Partnership Worksho


Action Plan.doc

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

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

ii) primary care providers

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

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

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

Extended hours - longer opening hours including:

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

Tele consultations

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

Increased Online Access

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

Development of a "GP-Comparison" website

- To enable patients to make better choices about GP services

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

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

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

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

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

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

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

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

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

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

c) Implications for acute providers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The significant risks are:

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

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

Bury Health & Social Care Workforce

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

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

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

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

The workforce group aim to:

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

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

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



Primary Care Workforce report Bur

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

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

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

Appendix 1 - Impact of schemes Metrics Mapping

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

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

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

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

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

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

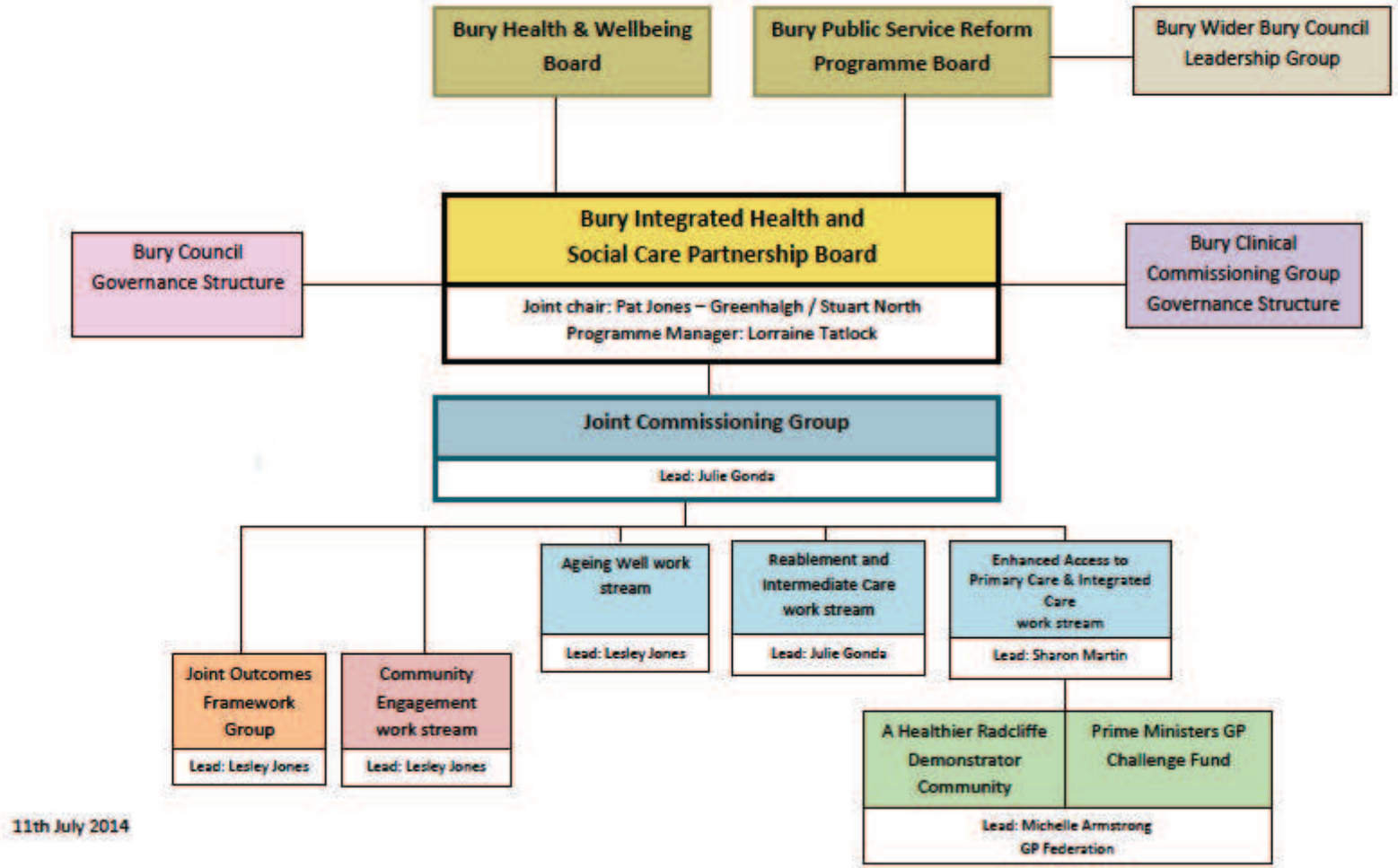
2015-16 change (from 2014-15)

Low = up to and including 10%

Moderate = 11-20%

Significant = greater than 20%

Appendix 2 - Bury Integrated Health & Social Care Governance Structure



11th July 2014

Appendix 3 – Risk Log

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

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

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

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

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

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

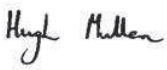


ANNEX 1 – Detailed Scheme Description

See separate attachment.

ANNEX 2 – Provider commentary

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

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

For HWB to populate:

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

For Provider to populate:

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

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

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Better Care Fund
ANNEX 1 – Detailed Scheme Description

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

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

ANNEX 1 – Detailed Scheme Description

SCHEME 1

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

people to maintain their health, wellbeing and independence.

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

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

.

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

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

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

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

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The Staying Well intervention comprises the following elements:

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

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

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

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

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

The Staying Well Check Tool consists of:

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

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

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

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

There are two potential models for delivery:

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

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

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

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

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

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

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

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

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

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

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

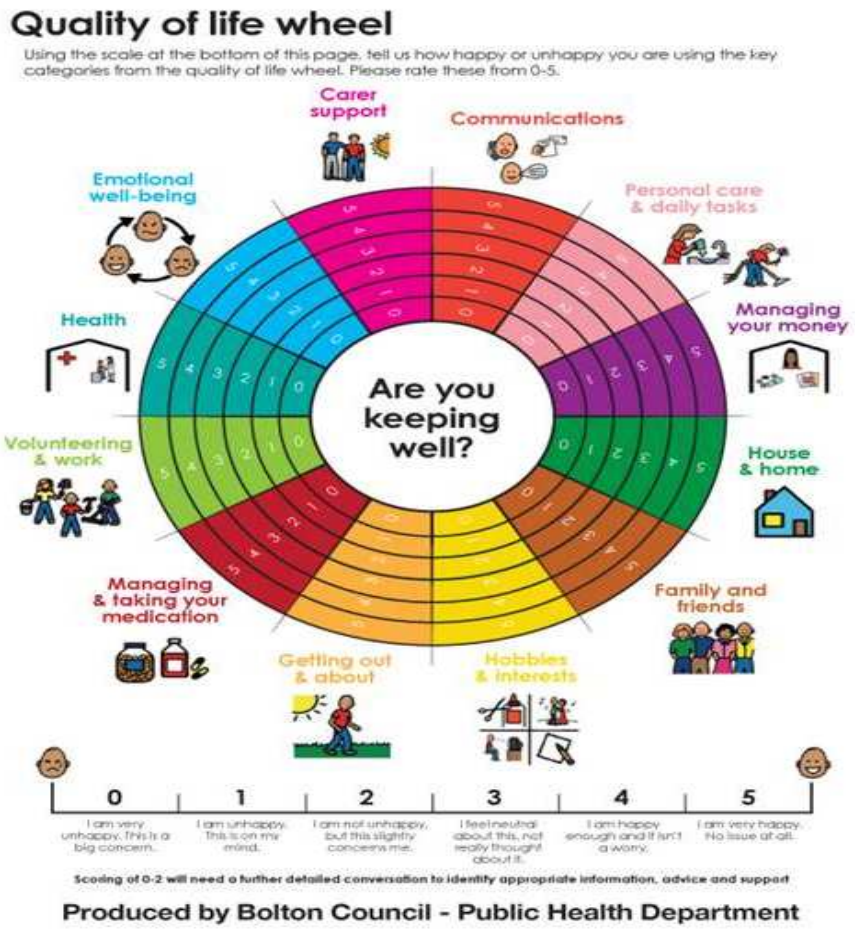
This scheme focuses on wellness and the factors that our residents value.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

Further likely impacts include:

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

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

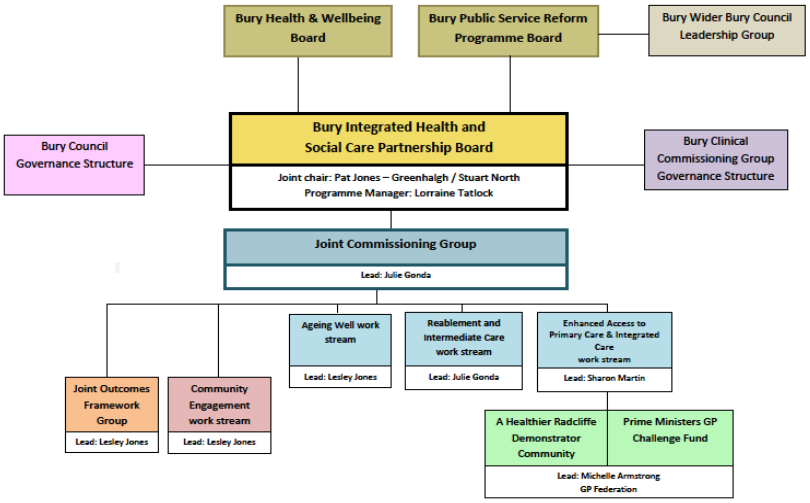
Feedback loop

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

Governance Structure

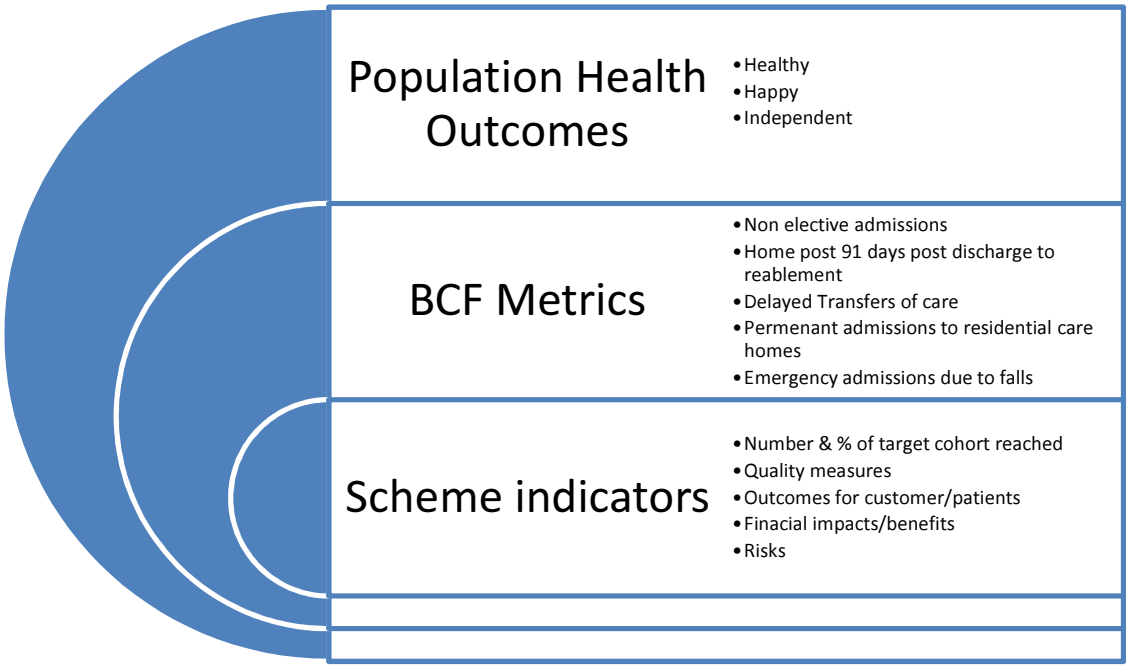
This Better Care Fund scheme is project managed by a scheme lead who reports to the Joint Commissioning Group via the ageing well workstream. The Joint Commissioning Group reports to the Integrated Health and Social Care Partnership Board and subsequently to the Health and Wellbeing Board as shown in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

Bury Integrated Health & Social Care Governance Structure



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

The Outcomes Framework



Population Outcome measures

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

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

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

JOF overarching indicators June 14 v2

Better Care Fund Metrics

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

As an interim whilst the dashboard is developed, we will be collating current performance reports on the different metrics to create a single monthly report provided to the Joint Commissioning Group, Provider Partnership Group and Health & Social Care Integration Partnership Board.


NEL.xls

Scheme indicators
The indicators for this scheme are set out below. The key indicators on progress will be incorporated into the above dashboard in time. Meanwhile monthly progress reports will be collated and provided to the Joint Commissioning Group and Provider Partnership with exception reporting to the Health & Social Care Integration Partnership Board. This robust governance structure is described in part 1 section 4b.

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

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

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

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

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

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

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

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

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

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

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

ANNEX 1 – Detailed Scheme Description

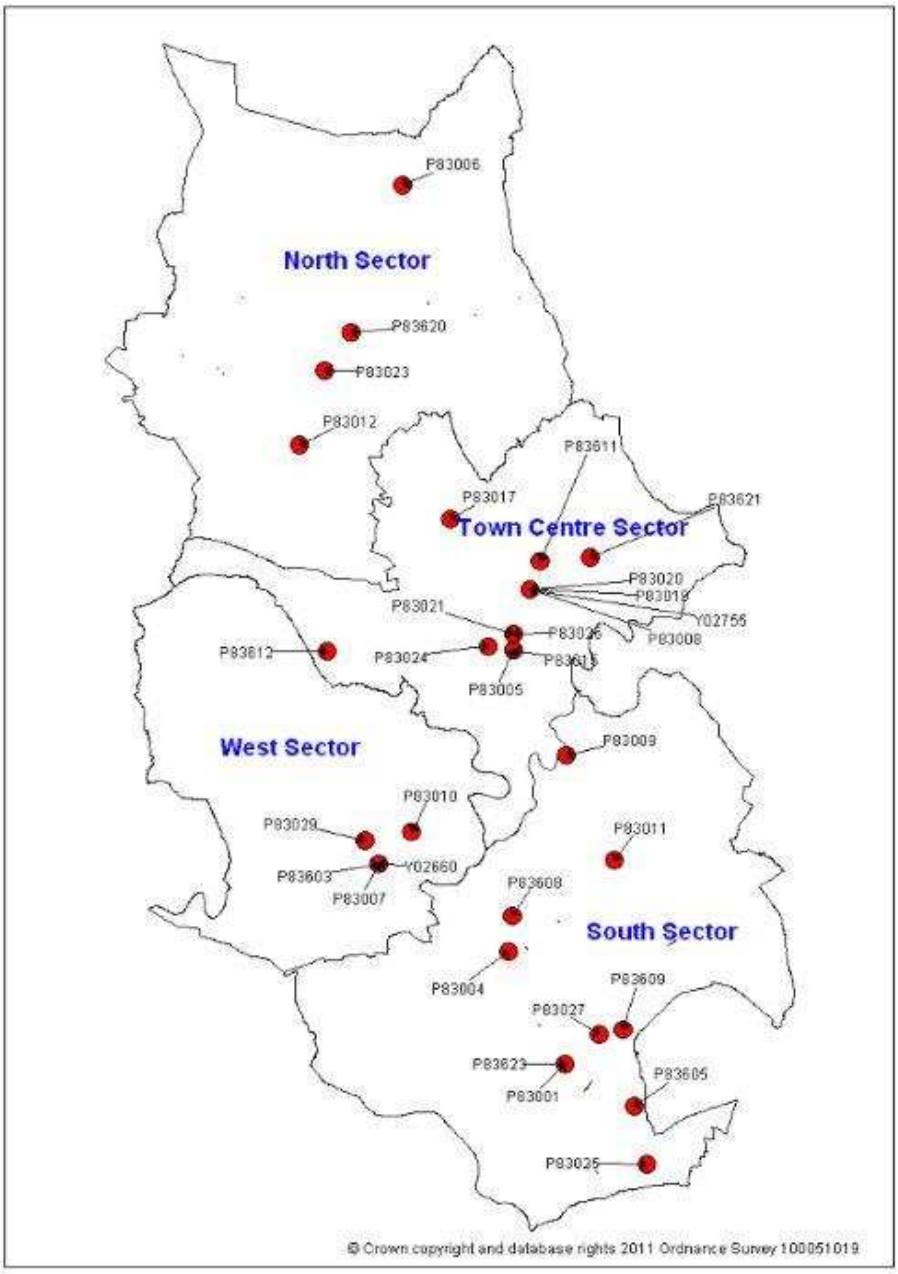
SCHEME 2

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

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

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

Please also see sector map on the next page.



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

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

Project 2 - Tele-consultations

The Tele-consultation project will:

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

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

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

Project 3 - Increased Online Access

The increase online access project will:

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

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

Project 4 - GP Comparison Website

The GP comparison website project will deliver:

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

The delivery chain

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

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

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

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

The Evidence Base

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

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

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

It also sets key primary care commitments to:

- the production of transparent, publicly available benchmarking data

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

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

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

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

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

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

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

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

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

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

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

Investment requirements

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

Impact of scheme

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

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

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

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

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

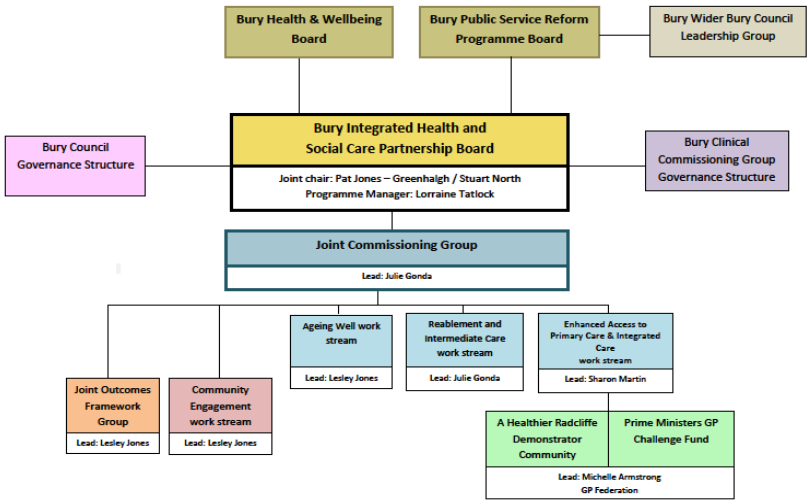
As extended access will be supported by a number of wrap around schemes via the Integrated Health and Social Care Teams scheme it is expected that this will also significantly help to deliver against the reablement metric

Feedback loop

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

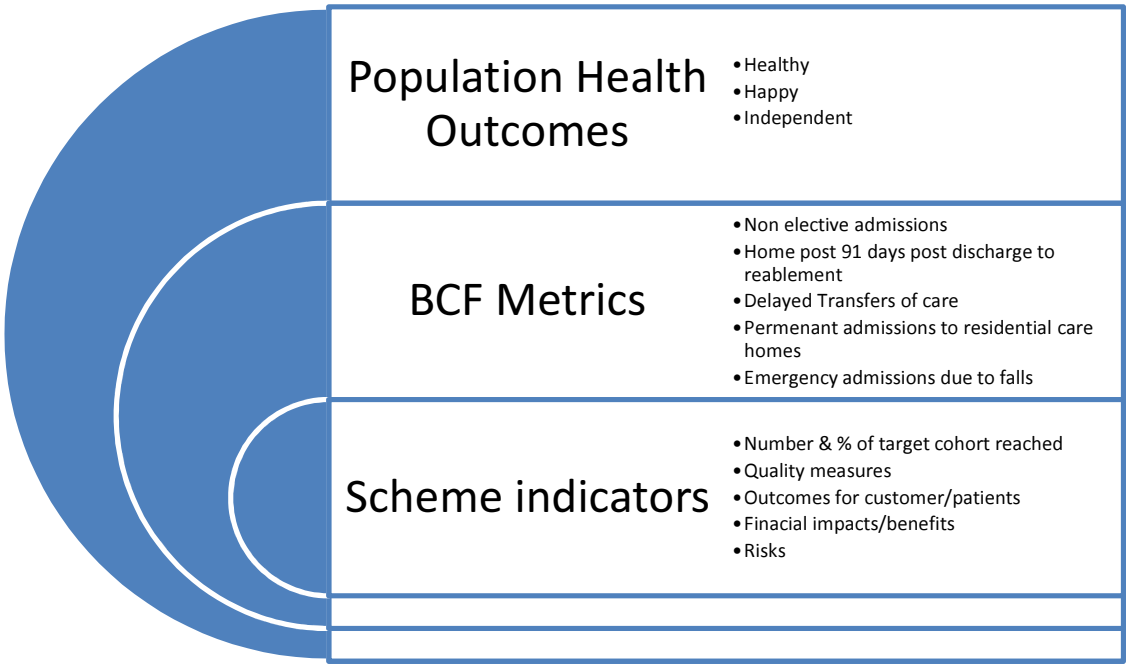
workstream. The Joint Commissioning Group reports to the Integrated Health and Social Care Partnership Board and subsequently to the Health and Wellbeing Board as shown in the structure below.

Bury Integrated Health & Social Care Governance Structure



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

The Outcomes Framework



Population Outcome measures

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

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

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

JOF overarching indicators June 14 v2

Better Care Fund Metrics

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

As an interim whilst the dashboard is developed, we will be collating current performance reports on the different metrics to create a single monthly report provided to the Joint Commissioning Group, Provider Partnership Group with exception reporting to the Health & Social care Integration Partnership Board.


Healthier Radcliffe Pilot Dashboard - as a


NEL.xls

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

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

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

Prime Minister's Challenge Fund Contract Board Meeting

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

Bury Integration Group – A Healthier Radcliffe

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

Bury GP Sector Meetings

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

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

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

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

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

ANNEX 1 – Detailed Scheme Description

SCHEME 3

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

Scheme 4 - Domiciliary medicines optimisation service

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

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

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

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

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

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

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

Some of the proposed operational arrangements are as follow:

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

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

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

Scheme 3 - Community Paramedic Service

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

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

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

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

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

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

Scheme 4 - Domiciliary medicines optimisation service

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

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

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

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

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

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

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

The delivery chain

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

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

There is an robust infrastructure of reporting and meetings to support delivery which is described in part 1 section 4b.

The governance structure includes The Bury Integrated Partnership Board, The Bury Joint Commissioning Group and The Health and Wellbeing Board for this particular scheme it also includes:

Prime Minister's Challenge Fund Contract Board Meeting

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

Bury Integration Group – A Healthier Radcliffe

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

Bury GP Sector Meetings

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

The other key components in the delivery chain for this scheme are the other schemes detailed in this plan, in particular, Extended Access and Care of Vulnerable adults.

The evidence base

Bury CCG is currently designing a set of measurement with the GP Federation for the four pilots in Radcliffe. Each scheme will have a defined set of metrics. As schemes only became operational in November 2014 and January 2015 there is no actual, directly reportable, evidence to date.

Once developed these metrics for Radcliffe will be added to the local dashboard already developed and inserted below in the feedback loop section. Similar measurement will be developed for the other three Bury sectors to track the impact of Integrated Health and Social Care as implemented.

There is a lot of wider evidence detailed below to indicate the value of pursuing the schemes detailed above.

The evidence around individual care plans

A care plan is a document owned by the person receiving care and their general practice. It should be co-created with them and set out their agreed year of care. For long-term conditions or for people whose conditions need regular management, having a proactive care plan is vital. The care plan should be wellness focused and should cover a comprehensive and up-to-date understanding of the persons' needs and circumstances[1].

[1] North West London – Whole systems integrated care toolkit, 2014

North West London Integrated care toolkit highlights the following key principles of an individualised care plan[2]:

- Focus on patients most at risk of hospitalisation
- Patients and carers own care plans with agreed goals
- Access to single electronic health record
- Information sharing across health and social care
- 7 of 11 published reviews which were analysed found a positive impact of assessing care plans[3]. Other studies have shown a reduction in hospitalisations by ~23%3.

Further evidence on individualised care plans:

- Graffyetal, Primary Health Care Research & Development, 2009,10(3), 210-222
- NHS England, Transforming participation in health and care 2013, http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc- guid1.pdf

The evidence around care coordination

Care co-ordination is the practice of having someone (not necessarily a clinician) co-ordinate the care received by an individual that has been designated as needing additional support. Typically, these are older people and those with chronic conditions who often represent 10-20% of the population and 30-70% of costs in the health and care system. There are several essential steps that are required to implement care co-ordination including the identification of individuals who would benefit from care co-ordination, the enrolment of those individuals into a programme, the development of care plans for those individuals and then on- going follow-up in line with the plan.

The evidence base highlights the following techniques:

- A holistic focus supporting self-care at home
- Single entry point to provide continuity
- Shared electronic health records
- Coordinating care at the neighbourhood level with engagement of local community
- Prioritising engagement with GPs and links with secondary care

8 out of 13 reviews, which were analysed, assessed care co-ordination and found a positive impact. Other reviews of literature have concluded that hospitalisations may be reduced by approximately 37%[4] Interventions involving care co- ordination have shown to reduce HbA1c (in patients with diabetes) by 22% more than interventions without care co-ordination[5]

[2] Ibid.

[3] North West London – Whole systems integrated care toolkit, 2014, pooled estimate only reported in 2 relevant reviews

[4] North West London – Whole systems integrated care toolkit, 2014, pooled estimate only reported in 2 relevant reviews

[5] Shojana et al, JAMA, 2006, 296(4), 427-440

Further evidence on care co-ordination:

- 'Case management: what it is and how it can be best implemented'
- 'South Devon & Torbay: Proactive case management using the community
- Virtual ward and the Devon predictive model'
- Goodwin N, SonolaL,Thie IV, Kodner D (2013).Co-ordinated care for people with complex chronic conditions. London: The King's Fund.

The evidence around case management
Case management focuses on the small proportion of the population (e.g. <5%) with much more intense needs than the population addressed by care co- ordination. Given these needs, a case manager is required who can help to actively manage the condition of a person. The evidence base highlights the following techniques:

- A focus on early action and prevention, targeted at particular communities to mobilise local people
- Community-based multi-professional teams based around general practices or groups of practices that promote close working and communication between staff in different organisations, for example, through co-location
- A single point of access, single assessment and shared clinical records
- Targeting individuals who are at high risk of future emergency admission to hospital, before they deteriorate, which requires access to good quality health and social care data
- The evidence base for case management is "promising but mixed' (Purdy, 2010). This is in part due to difficulty in attributing any positive changes to case management when there are multiple factors at play (for example, how to disentangle the effect of case management from any specific interventions that might be planned e.g. falls prevention, reablement, self-care)

Further evidence on case management:

- Ross S, Curry N, Goodwin N (2011). Case management: what it is and how it can best be implemented. London: The King's Fund.
- Challis D, Hughes J (2011) Intensive care / case management, PSSRU, Manchester
- Graffy J, Grande M, Campbell J(2008).' Case management for elderly patients at risk of hospital admission: a team approach'. Primary Health Care Research and Development, vol 9, no 1, pp 7–13

The evidence around multidisciplinary teams
Multidisciplinary teams (MDTs) bring together the relevant professionals needed to care for someone with complex needs. MDTs should include everyone required to look after the physical, mental and social health and care needs of the individuals they serve. The aim is to manage the complexity of individual cases and facilitate the delivery of the best possible care.

The evidence base highlights the following techniques:

- Multi-disciplinary teams
- MDT meetings about every person admitted to hospital
- Hire specialists to work in community settings rather than hospitals
- Expanded hours for GPs and coordinators
- Dedicated housing workers for SEMI/vulnerable groups
- Allow nurses or nurse practitioners to prescribe certain drugs
- Mental health liaison teams
- Direct phone/email access from GPs to Mental Health experts

Further evidence on MDTs:

- Hollandetal,Heart,2005,91,899-906
- Proactive care partnership
- http://www.sussexcommunity.nhs.uk/Downloads/services/proactive_care/proactivecare_coastal_leaflet.pdf
- Case study examples: NHS North West London, Torbay, Towers Hamlets

The evidence around community paramedic service
NWAS alongside Clinical Commissioning Groups (CCGs) has spent time putting provisions in place to safely manage patients in their home environment. These include Paramedic Pathfinder pathways, GP referral schemes and Community Care Pathways. In spite of this the average A&E attendance to admission ratio in urban areas across the North West is higher than the national average (Information from Ambulance CQI Data). The challenge is to reduce A&E attendances for those patients appropriate for treatment by alternative services.

Across Greater Manchester the team have identified 286 frequent caller patients since its inception in November 2013. 23 of those identified are resident in the Bury CCG yet due to the team's capacity only 10 of those patients are receiving interventions to support their needs. The success associated with those receiving interventions has been really positive, in both improving the patient's quality and reducing ambulance & A&E attendances. Data relating to April identify 10 identified Frequent Callers in the Bury catchment area that generated seventy-nine 999 calls in the preceding 28 days. Following intervention from the team the same group of patients generated twenty nine 999 calls, a 63% reduction in 999 calls.

The evidence around domiciliary medicines optimisation service
Medicines remain the most common treatment offered to patients, and dispensing prescriptions and supplying medicines safely is at the heart of what community pharmacy does and what patients expect.

The NHS spends over £13 billion on medicines with 80% of this in primary care. However, avoidable medicines wastage in primary care is estimated to be in the region of £150 million annually, an unacceptable situation that needs to be addressed.

- A partnership for Older People Project (POPP) financed by Dept of Health provided a reduction in overnight hospital stays by 47% and reduced A&E usage by 29% amongst the target group

- A US PACE (Programme for all inclusive care of the elderly) targeting frail older people and involving a multidisciplinary team , found a 50% decrease in hospital use, 20% decrease in nursing admission, patients used 16 fewer bed days. Patients took ownership of their health with 43% reporting good health and 72% a more satisfying life
- A pharmacy Domiciliary Review Service in Croydon conducted 2012/13 involving Medicine Use Reviews to 230 patients resulted in the avoidance of 130 emergency admissions. The cost avoidance cost was calculated at over 400k
- NICE reports that 30-50% of medicines are not taken as the prescriber intended, which means the patient does not get the full benefit of the treatment and the NHS does not get the full value of its investment

Apart from medicines wastage, not taking medicines correctly can have serious consequences for patients, as studies have found that up to 15.4% of hospital admissions were drug related and preventable; the commonest causes were prescribing and monitoring problems (53%) and non-adherence (33%). Waste medicines result predominantly from patients not taking medicines as intended (non-adherence).

Investment requirements

Integrated Health & Social Care - £2,372k per annum across all four sectors.

Impact of scheme

The Integrated Health Social Care scheme will help to deliver against each of the six Better Care Fund Metrics. This scheme will have a significant impact on residential admissions, reablement and avoidable admissions as detailed in the table below. The metrics mapping exercise that relates to all of the schemes is available in part 1, appendix 1.

		Metric 1 - Residential Admissions		Metric 2 - Reablement		Metric 3 - Delayed Transfers of Care		Metric 4 - Avoidable Emergency Admissions		Metric 5 - Patient experience	Metric 6 - Local metric - Falls	
Scheme ID	**Scheme Description**	%	Nos of people	%	Nos of people	%	Nos of people	%	Nos of people	%	%	Nos of people
BCF03	Integrated Health & Social Care	35%	2	30%	2	15%	39	30%	296	20%	20%	8

Bury CCG is currently designing a set of measurement with the GP Federation for the four pilots in Radcliffe. Similar measurement will be developed for the other three sectors to track the impact of Integrated Health and Social Care as implemented.

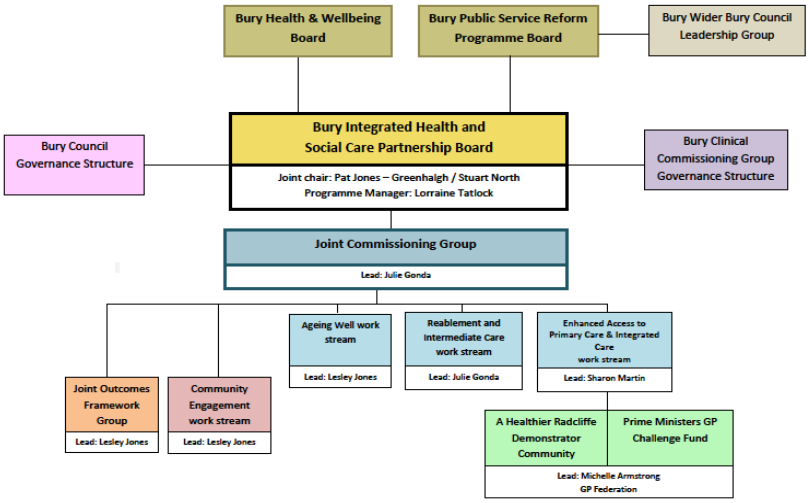
There is an expected significant impact on residential admissions as patients in Bury become increasingly supported by the additional services in the community. Equally as schemes begin to mobilise around extended access there is expected to be significant improvements against the reablement measure and reductions in avoidable admissions.

Feedback loop

Governance Structure

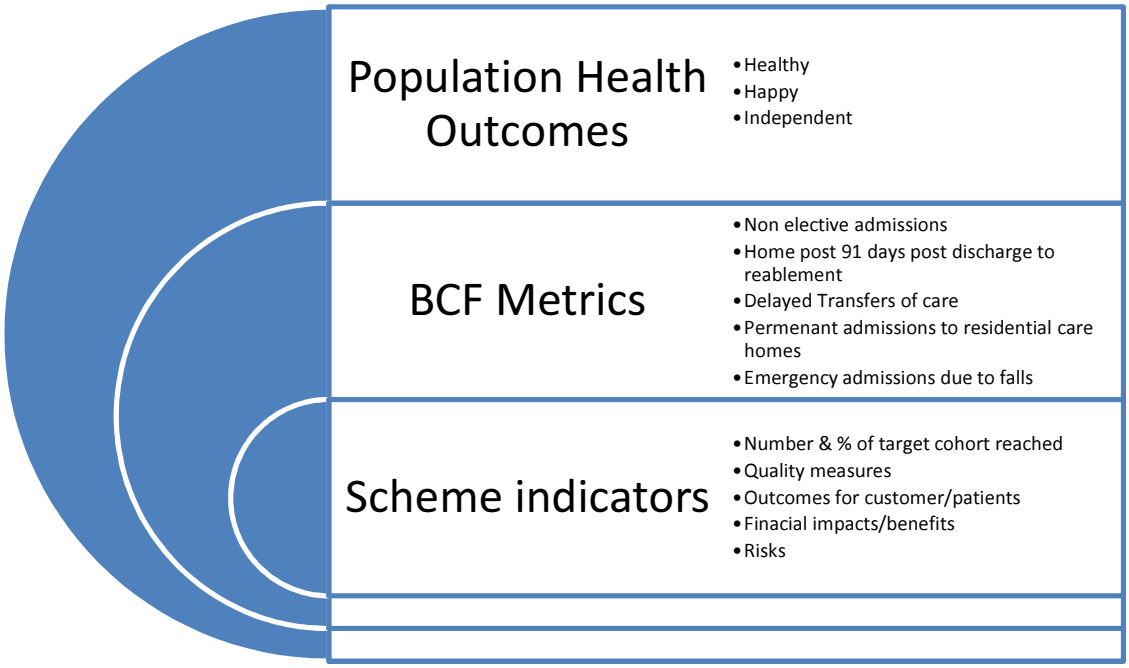
This Better Care Fund scheme is project managed by a scheme lead who reports to the Joint Commissioning Group via the Enhanced access to primary care and integrated care workstream. The Joint Commissioning Group reports to the Integrated Health and Social Care Partnership Board and subsequently to the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

Bury Integrated Health & Social Care Governance Structure



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

The Outcomes Framework



Population Outcome measures

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

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

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

JOF overarching indicators June 14 v2

Better Care Fund Metrics

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

As an interim whilst the dashboard is developed, we will be collating current performance reports on the different metrics to create a single monthly report provided to the Joint Commissioning Group, Provider Partnership Group with exception reporting to the Health & Social Care Integration Partnership Board.


Healthier Radcliffe Pilot Dashboard - as a


NEL.xls

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

A specific set of measurements has been developed for Healthier Radcliffe, as detailed in the above attachments, and is currently being used to measure the impact of extended hours in Radcliffe. This model will be further developed to include measurement for the four integrated Health and Social Care Schemes.

As identified in part 1 section 4b, there is then robust project level governance structure in place to receive reports and updates and the develop mitigation plans where required. The governance structure includes The Bury Integrated Partnership Board, The Bury Joint Commissioning Group and The Health and Wellbeing Board for this particular scheme it also includes:

Prime Minister's Challenge Fund Contract Board Meeting

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

Bury Integration Group – A Healthier Radcliffe

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

Bury GP Sector Meetings

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

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

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

Joint Commissioning Group as part of the regular reporting of the performance of the scheme. Mitigating actions will be undertaken to reduce the likelihood of the risk arising or to address the risk. If this is not possible and potentially means that plans could go off track, then this will be escalated to the Integrated Health & Social Care Partnership Board.
What are the key success factors for implementation of this scheme?
The delivery of an Integrated Health and Social Care system in Bury is being driven by all the local stakeholders. The key success factors are: • Stakeholder engagement • Releasing capacity across stakeholders to support delivery • Delivery of extended access to GP Services over 7 days a week • Robust governance in place as schemes cut across the whole health and social care economy • GP engagement • Patient awareness • Changes in traditional behaviour patterns • Management of risk via risk register and regular contact with schemes in-between meetings

ANNEX 1 – Detailed Scheme Description

SCHEME 4

Scheme ref no.
Bury BCF 04
Scheme name
Care of Vulnerable Adults
What is the strategic objective of this scheme?
To reduce the number of avoidable admissions within secondary care by improving the coordination and quality of care for those who need it most. The scheme aligns with the core principles underpinning Bury's Health & Wellbeing Strategy: • Promoting prevention, early intervention and self-care • Reducing inequalities in health and wellbeing • Developing person-centred services • Planning for future demands
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
All 33 practices have signed up to deliver the following modules of care: **Module 1 – Increased Awareness/Administration of Flu Vaccinations** This module has two components that are targeted at over 65s: 1. Localised flu campaign • All patients over the age of 65 to be invited to receive their flu vaccination 2. Increased vaccination levels • Targeted payment rewards based on a higher level of achievement (80%, 85%, 87.5% and 90%) **Module 2 - Quality Improvements via Coordinated Care** This module has three key components which by the nature of their remit will cover all ages (197,376 registered population) but in particular those aged 65 and over (33,751) (as of June 2014). 1. Comprehensive care plans to be offered to the following cohorts of patients: • All patients within a residential establishment (Nursing/Residential (est no. 1,297),

Mental Health & Temporary residences) and registered with a Bury GP
- All patients on the practice's dementia register (currently 1,490)
- Any other patients as identified using local intelligence (e.g. those with co-morbidities or multiple A&E attendances/admissions). All care plans will be uploaded to the patients Summary Care Record (SCR) and Electronic Referral and Information Sharing System (ERISS) which is web-based application, designed to enhance information sharing and collaborative working between the North West Ambulance Service (NWAS) and its key stakeholders.

2. Increasing access to General Practice (general enabler supporting all ages):
   - All patients cohorts will benefit from practices delivering a minimum threshold of appointments per 1000 patients based on the average from benchmarking data (5.4 per 1000 patients)
   - Measured/monitored using bespoke software

3. Delivery of Multi-Disciplinary Teams for those who need one (all ages)
   - Coordination of appropriate attendance
   - Ensuring actions are documented and acted upon
   - Monitoring of outcomes/evaluation

Module 3 - Dementia identification and management
- Named dementia lead in every practice
- Localised training on dementia identification/assessment/investigation and management
- Increased prevalence recording (68% of predicted being the target)
- Implementation of a practice based pathway for dementia and alzheimer's disease
- Patients on the practices dementia register to be offered a comprehensive care plan (under Module 2)

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

The services described will be delivered by the 33 practices within Bury through the use of a Locally Commissioned Service (LCS) contract which has been funded under the BCF. How general practice deliver the core expectations of this contract within their own practices will be for them to determine (i.e. staffing/skill mix) although cross stakeholder working will be required if the overall scheme is to be successful as illustrated on the next page.



Within the LCS Contract is the requirement for practices to deliver against a specific set of key performance indicators (KPIs) which will be measured and reported against on a monthly basis as shown in the table below:

Performance Indicator	Threshold	Read Code	Method of Measurement	Frequency
Delivery of a stretched target for flu (age 65 and over)	=>80% =>85% =>87.5% =90%		Extracted via vision by Sector Analyst	Monthly
Equitable access to appointments across the CCG to be achieved by 31 March 2015 (all ages) Practices should be able to demonstrate that they have sufficient capacity to match demand	By 31st October 2014 practices will have undertaken the initial run of software By 12 November 2014 the CCG will present an initial benchmarking analysis and agree a minimum threshold per 1000 patients By Jan 2015 practices will re-run the appointment software to validate any increase needed has been implemented	N/A	The use of agreed appointment software (Monitoring will continue to ensure any required increase is maintained) Practices will not be penalised where deadlines have not been met due to CCG capacity	Once as per deadlines
Increased identification and management of patients with dementia (all	68% of the practices estimated prevalence identified		Extracted by vision by Sector Analyst	Monthly
	A named dementia lead has been identified	N/A	Practices must be able to demonstrate compliance	On request
	Dementia lead has attended	N/A		

ages)	training on identification, assessment, investigation and management of dementia			
	A practice based pathway for identification, assessment, investigation and management of dementia and Alzheimer's Disease has been implemented	N/A	Practices must be able to demonstrate compliance on request (see Dementia Resource Pack)	On request
Care Plans (all ages)	100% of dementia diagnosed patients to have been offered 90% received a standardised care plan	13F6 "nursing / other home"	Practice Search / submission	Monthly
	100% of patients within Nursing/Residential Establishments including other care facility settings/respite settings (this includes temp residents) and mental health establishments to be offered, 90% received a standardised care plan	13F6 "nursing / other home"	Practice Search / submission Consideration for 13F6 – which is "nursing / other home"	Monthly
	100% of Quarterly reviews have been conducted	8CMG.00	Practice Search / submission	Monthly
	Where patients may be suitable but do not fall into the above categories (for example => 75 or on 4+ medications and 4 GP appointments /admissions in the last 12mths or local intelligence)	13F6 "nursing / other home"	Practice Search / submission	Monthly
MDTs (all ages)	Appropriate patients to receive the benefit of an MDT attended by relevant Health and Social Care professionals, the outcomes of which are clearly documented and acted on.	#3876 multidisciplinary assessment #6AE multidisciplinary review	Practice Search / submission Standardised MDT outcome template submitted to CCG	Monthly
Quality assurance	undertake/submit a random sample of care plans as part of a quality assurance process	N/A	Random sample of care plans by CCG (No. dependent on findings)	as requested
Overall Measure Performance Indicator	**Threshold**	**Read Code**	**Method of Measurement**	**Frequency**
A combined reduction which against (all ages) • NEL Admissions • A&E attendances	Baseline achievement against plan Further 5% reduction against plan	N/A	Practice/Sector and CCG reductions will be monitored through SUS/SLAM by the sector analyst and presented to Sectors and PMO on a monthly basis.	Monthly

This will not only give assurance to the Health & Social Care Governance Structure that measureable outcomes are being achieved but will also support general practices to have peer to peer discussions around the implementation of each module in order to share any good

practice and identify areas were further additional support may be required at the earliest opportunity.

Key milestones:

Vulnerable Adults	Start Date	End Date
Overall Project	**10/2/2014**	**30/9/2015**
Stakeholder Engagement	10/2/2014	19/6/2014
Specification Development	18/4/2014	1/10/2014
Financial modelling	14/3/2014	15/8/2014
Performance/Outcome Monitoring	15/7/2014	30/9/2015
Ongoing Support	1/10/2014	30/9/2015

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Local evidence

General overview of local intelligence

The Joint Strategic Needs Assessment for Bury states that, by 2022 the population in every 5-year age band over 50 years old is expected to increase by at least 20% :

- The over 65 year olds population is expected to increase by 29% (9,000 more)
- The over 85 year olds population is expected to increase by 54%. (2,000 more)

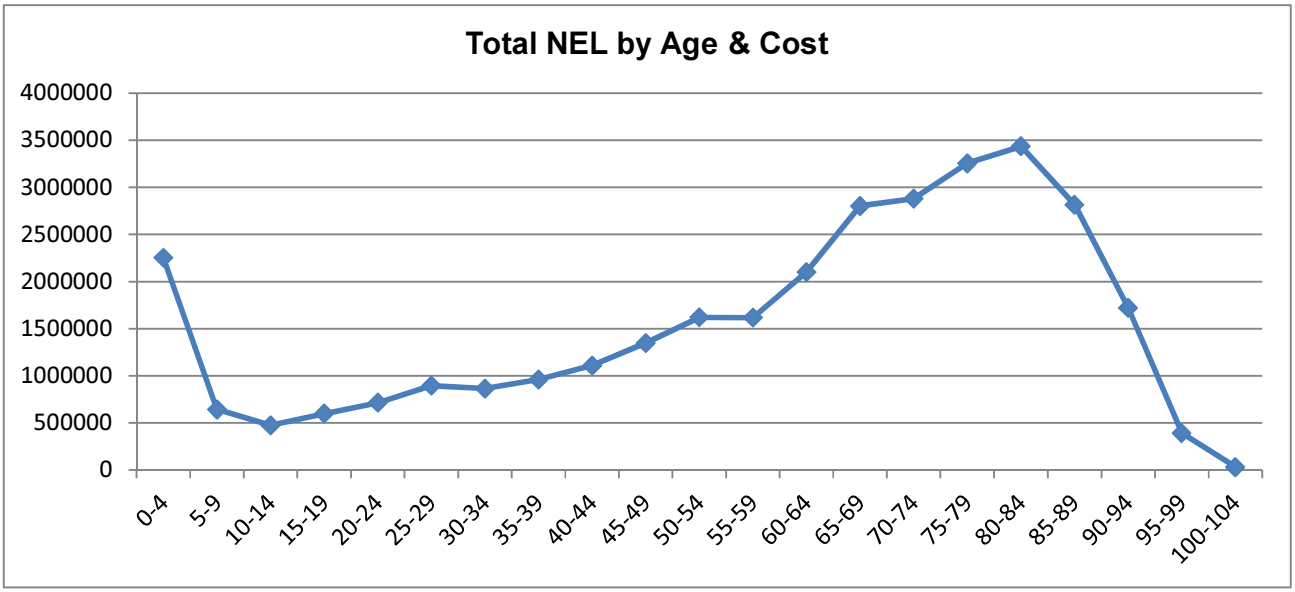
The demographic data in the report gives a clear indication of the ageing nature of the population with an estimated 10,000 more people over the age of 65 by 2025 (a 35% increase on 2010 levels). In addition, these people will be living longer. Females will continue to live longer than males although this gap is set to close due to increased life expectancy of males over the age of 80. In the next 15 years, there will be 79% more very elderly men compared to only 38% more females. The combined effect equates to 55% more over 80s by 2025.

Current projections suggest that by 2025:

- 5,000 more people will have long term limiting conditions (+35%)
- 10,000 people are likely to have some form of continence problem
- 8,500 will have some problem getting around (+40% on current levels)
- Some 10,000 older people will be classed as obese with almost 5,000 people suffering from diabetes
- There will be 1,000-1,500 more people with dementia
- Other limiting condition such as visual and hearing impairment are also expected to rise by between 35% and 45%

Of particular concern is the number of falls amongst older people. In Bury admission rates for fractured femurs are already higher than average and with falls predicted to increase by up to 3,000 (+38%) by 2025, this could result in around 1,000 people per annum (10% of the total)

being admitted to hospital.
On looking at the total spend of non-elective admissions against all ages it is clear to see that this age band of patients are the most resource intense population; it is therefore imperative that any schemes delivered must be aimed at this cohort of patients.



Module 1 – Increased Awareness/Administration of Flu Vaccinations
Bury historically underperforms against a 75% target for the administration of Flu vaccinations for those aged 65 and over:

Year	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14
% uptake	71.9	72.3	72.2	71.4	72.1	74.5	72.3	72.6

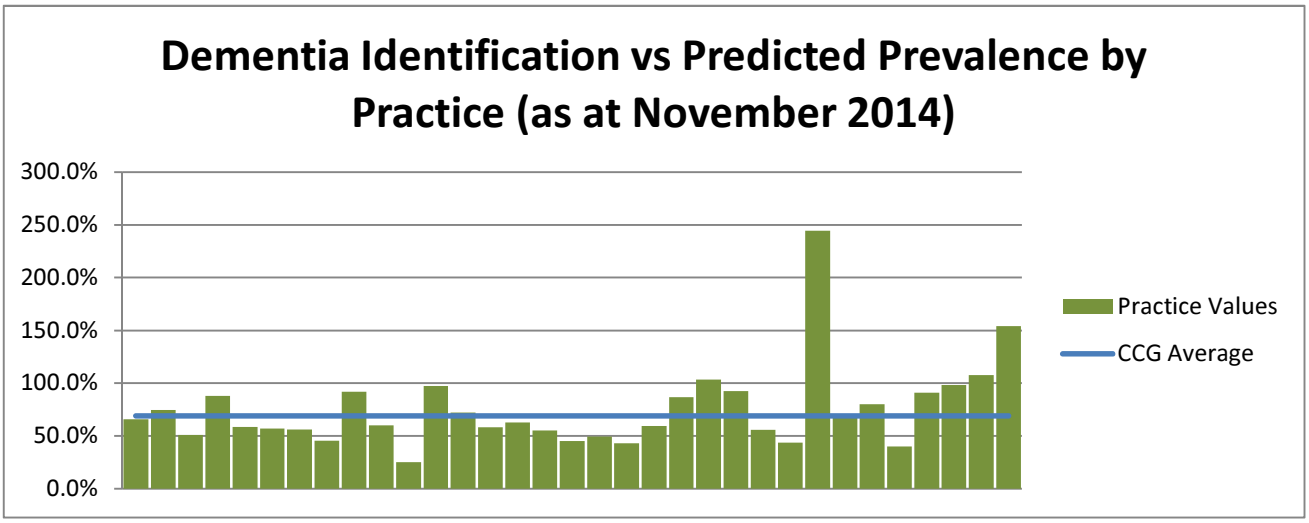
Module 2 – Quality Improvements via Coordinated Care

Local Schemes Already in Delivery - Care Home LCS
Proactive coordinated care planning is already in place for a specific cohort of patients through the Care Home LCS which has 18 out of 33 practices providing a dedicated GP role to specific homes within the borough. It hoped that by expanding the ethos of this model we will replicate the positive outcomes already seen which include:

- 22 out of a possible 30 homes covered (although not all patients within the homes have chosen to change GPs)
- Improved patient/carer experience
- Improved quality of care
- Reduction and prevention of non-elective admissions -86 compared to a 22 rise in those homes not covered (2012/13 verses 2013/14)
- Reduction in A&E attendances -30 verses a 39 increase in homes not covered by the LCS (2012/13 verses 2013/14)
- Promotes self-care and carer confidence

- Up-skilling of existing care home staff
- Alleviate pressure within Primary Care services
- An EOL evaluation and ADASS data indicates that Bury has moved from a national regional position of 42, to the third best performing region for death in usual place of residence (DiUPR.) Between 2009 and 2012, the proportion of people in Bury dying in their usual place of residence improved from 36% to 44%

Module 3 - Dementia Identification and Management
There is significant clinical variation across practices in terms of prevalence identification (Predicted versus actual, current highest 244%, lowest 25%)



National Evidence

Module 1 – Increased Awareness/Administration of Flu Vaccinations

- http://www.evidence.nhs.uk/search?q=flu+jabs

Module 2 – Quality Improvements via Coordinated Care

- Admission Avoidance Direct Enhanced Service (DES) http://www.nhsemployers.org/~/media/Employers/Publications/Avoiding%20unplanned%20admissions%20guidance%202014-15.pdf
- Delivering better services for people with long-term conditions - Building the house of care the Kings Fund 2013 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf
- A collaborative process of personalised care between the clinician, patient and if applicable the patient's carer(s).“My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes.” (National Voices)
- Health policy has consistently advocated personalised care and care planning, emphasised within ‘Our health, our care, our say’ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/272238/6737.pdf

- Personalised Care Plans for long term conditions - Quality and Productivity http://www.evidence.nhs.uk/qipp
- Shared Decision Making - http://sdm.rightcare.nhs.uk/
- NHS England, Transforming participation in health and care 2013, http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf
- Graffy et al, Primary Health Care Research & Development, 2009, 10(3),210-222
- Graffy J, Grande M, Campbell J. (2008) Case management for elderly patients at risk of hospital admission: a team approach. Primary Health Care Research and Development, 2008: 9 (1): 7-13.
- Care Planning "Putting Patients first." http://www.england.nhs.uk/wp-content/uploads/2013/04/ppf-1314-1516.pdf

Increasing Access To General Practice (General Enabler):

- GP Survey Results http://www.gp-patient.co.uk/results
- Improving General Practice – a call to action http://www.england.nhs.uk/wp-content/uploads/2013/09/igp-cta-evid.pdf
- Daly JM, Buckwalter K, Maas M. Written and computerized care plans. Organizational processes and effect on patient outcomes. J Gerontol Nurs 2002;28(9):14-23.

Module 3 - Dementia Identification and Management

- Dementia CG42: http://www.nice.org.uk/guidance/CG42/chapter/1-Guidance
- Improving the identification and care of patients with dementia has been prioritised by the Department of Health through its mandate to NHS England and by NHS England through its planning guidance for clinical commissioning groups (CCGs) .The commitment to improving patient care and early diagnosis in primary care is in the NHS England business plan "Putting Patients first." http://www.england.nhs.uk/wp-content/uploads/2013/04/ppf-1314-1516.pdf

How We Used National and Local Evidence

A series of events were held and 100% of Practices were represented (clinicians and managerial staff). A number of evidence based interventions (provided by the Kings Fund) were presented under the following broad headers:

- Healthy active ageing and supporting independence
- Living well with simple or stable long-term conditions
- Living well with complex comorbidities, dementia and frailty
- Rapid support close to home in crisis
- Good acute hospital care when (and only when) needed
- Good discharge planning and post-discharge support
- Good rehabilitation and reablement after acute illness or injury
- High-quality nursing and residential care for those who truly need it
- Choice, control and support towards the end of life

(King's Fund, 2013)

Practices were asked to pick their top four initiatives under these headers likely to achieve the desired outcome (to reduce NEL admissions) which were:

1. Influenza and pneumococcal pneumonia vaccination

2. An identified key worker who acts as a case manager and coordinator of care across the system
3. Expert decision makers are available at the front door of the acute hospital from 8am to 8pm, seven days a week. Specialist assessment should be available within 12 hours of admission, seven days per week
4. There should be a multi-disciplinary team located at the front door of the hospital integrated with the community team focused on the facilitation of discharge

Through a further series of meetings all initiatives where scoped into a project initiation document which took into account:

- Ease of implementation
- Delivery model (including potential financial envelope needed)
- Enablers
- Likely timescales for delivery and key milestones (by when and by who)
- KPIs for success
- Local/National Evidence
- Stakeholders
- Risks and possible mitigating actions
- Commissioned Provider (i.e. from practice/alternate provider)
- Outcomes / incentive payments for achievement of KPI's

This enabled a rationalisation exercise to take place and the main areas for implementation then agreed as:

Module 1 – Increased Awareness/Administration of Flu Vaccinations
Module 2 – Quality Improvements via Coordinated Care
Module 3 – Dementia identification and management

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

A budget allocation of £1,215,620 has been made available to the practices. This figure includes the national recommendation of £5 per head as well as an additional sum of funding to ensure 100% coverage of registered patients within care facilities (such as Nursing/Care Homes, respite facilities, mental health establishments etc. The following table explains how this investment will be deployed. It should be noted that only the performance element of the scheme is being funded through the BFC pool (in green) and that the remaining elements are funded by the CCG (in yellow).

Area	Target	Financial Reward
Module 1 – Increased Awareness/Administration of Flu Vaccinations (Incremental increases up to a total of 140K achievable)	Advertisement	£10,000
	80%	£77,000
	85%	£7,000
	87.5%	£14,000
	90%	£42,000
Module 2 - Co-ordinated Care (expectation that practices deliver all KPIs i.e. care plans/appointment software MDTs etc.)	KPIs	£397,029
Module 3 - Dementia Identification and Management	68%	£60,781
Overall Reward Payment (based on a financial saving against a planned practice budget)	Baseline	£486,248
	5% Reduction on baseline	£121,562
Total Budget		**£1,215,620**

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

The main impact of this scheme is to reduce the number of non-elective (NEL) admissions, as shown in the table below and in part 1, appendix 1, both general and acute (estimated as a reduction of 328 with an average spell cost of £1,765).

		Metric 1 - Residential Admissions		Metric 2 - Reablement		Metric 3 - Delayed Transfers of Care		Metric 4 - Avoidable Emergency Admissions		Metric 5 - Patient experience	Metric 6 - Local metric - Falls	
Scheme ID	Scheme Description	%	Nos of people	%	Nos of people	%	Nos of people	%	Nos of people	%	%	Nos of people
BCF04	Care of Vulnerable Adults	35%	2	5%	1	15 %	39	30%	296	20%	20 %	8

The wider impact of the scheme will include:

Module 1 – Increased Awareness/Administration of Flu Vaccinations

- Reduced clinical variation for the administration of flu vaccines (89% highest practice, lowest practice 55.9%)
- Increased administration of flu vaccinations for over 65s (baseline 13/14 72.6%)
- Reduction in the number of respiratory classified admissions

Module 2 – Quality Improvements via Coordinated Care

- Reduced NEL admissions, general and acute
- Reduced length of stay
- Reduced Excess bed days
- Encourage collaborative working across the whole health care system (including other primary care providers, secondary care, community care, social care, third sector, out of hours medical services, ambulance, and 111 services) in order to ensure patient care is delivered in a 'joined up' manner
- Emergency re-admissions within 30 days of discharge from hospital
- Amenable/preventable mortality
- Improving people's experience of integrated care
- Health-related quality of life for carers/carer-reported quality of life
- Health-related quality of life for people with long-term conditions/social care related quality of life
- Reduce the number of minor A&E attendances
- Increased (equitable) access provision within General Practice (5.4 appointments per 1000 patients across all practices)
- Enhance the patient experience in terms of responsiveness and improved access

Module 3 - Dementia identification and management

- Reduced clinical variation across providers for the identification of Dementia (Predicted versus actual with 68% being the target – current highest 244%, lowest 25%)
- Dementia effectiveness of post-diagnosis care in sustaining independence and improving quality of life
- Provide clinicians with the skills and knowledge to detect assess and manage patients at potential risk of dementia

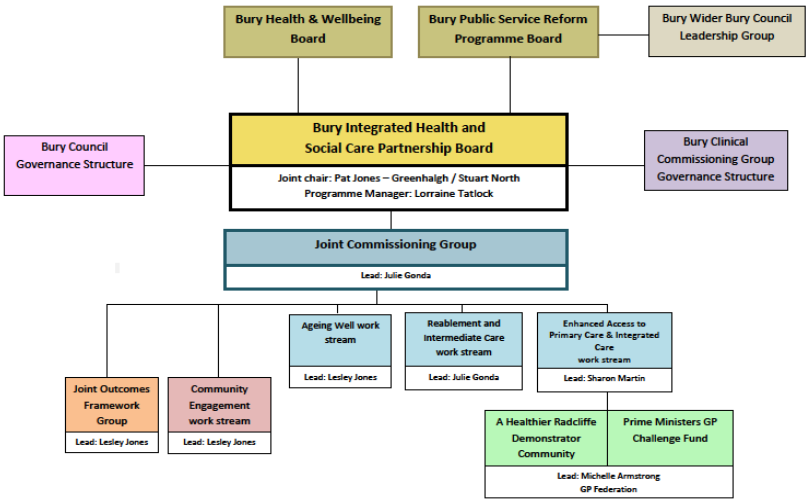
Feedback loop

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

Governance Structure

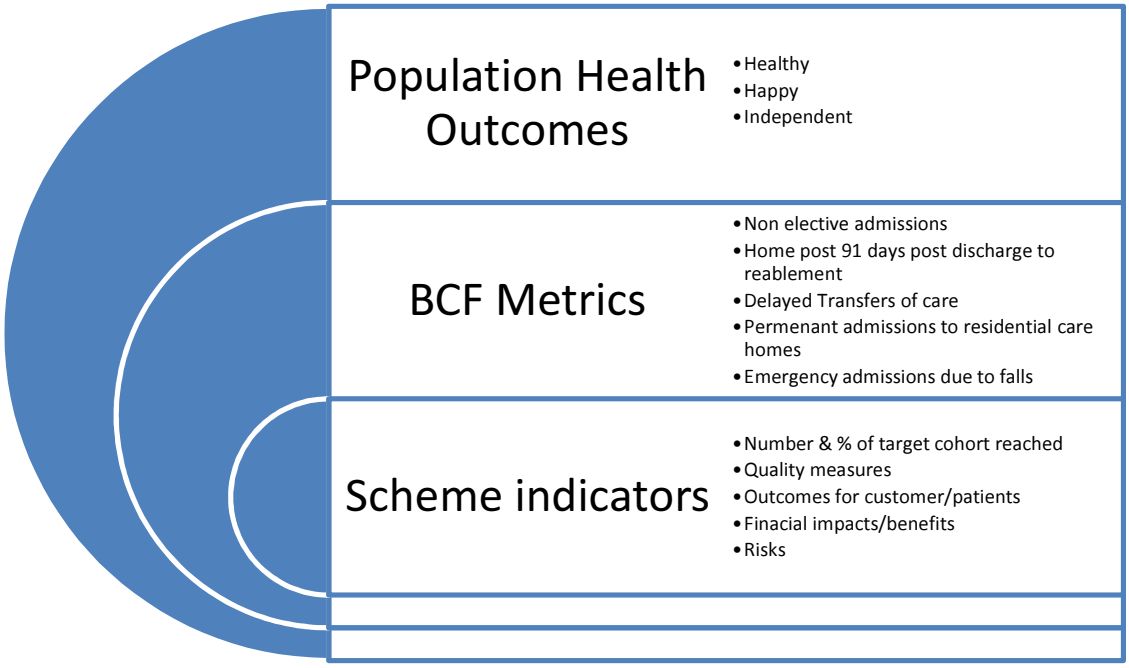
This Better Care Fund scheme is project managed by a scheme lead who reports to the Joint Commissioning Group via the Enhanced access to primary care and integrated care workstream. The Joint Commissioning Group reports to the Integrated Health and Social Care Partnership Board and subsequently to the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

Bury Integrated Health & Social Care Governance Structure



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

The Outcomes Framework



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

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

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


JOF overarching indicators June 14 v2

Better Care Fund Metrics
The Better Care Fund metrics provide us with more immediate feedback on whether the work we are doing is delivering the system changes that we are driving towards. We are building on work undertaken by Greater Manchester CSU on developing a Performance dashboard for the Healthier Radcliffe Demonstrator and the Non Elective Story Board (see embedded document) to develop a single whole Borough, whole system dashboard incorporating the BCF metrics using software recently purchased by the Local Authority.
As an interim whilst the dashboard is developed, we will be collating current performance reports on the different metrics to create a single monthly report provided to the Joint Commissioning Group, Provider Partnership Group with exception reporting to the Health & Social Care Integration Partnership Board.


NEL.xls

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

- Avoidable emergency admissions
- Permanent admissions of older people to residential and nursing care
- Effectiveness of Reablement for people 65 and over
- Delayed transfers of care
- Patient/service user experience
- Falls

A project dashboard which pulls together all of the key outcomes/KPIs intended to be delivered is reported to practices on a monthly basis in order for them to assess the impact of schemes and address any concerns at an early stage in the project via the Sector Support Groups which meet on a monthly basis.


Vulnerable Adults

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

Any risks that may affect the delivery of the Better Care Fund will be raised with the Joint Commissioning Group as part of the regular reporting of the performance of the scheme.

Mitigating actions will be undertaken to reduce the likelihood of the risk arising or to address the risk. If this is not possible and potentially means that plans could go off track, then this will be escalated to the Integrated Health & Social Care Partnership Board.

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

- Clinical leadership
- 100% sign up to the Locally Commissioned Service Contract
- Clear targets/objectives for the provider
- A coordinated approach to care delivery across providers
- Effective communication across wider system stakeholders
- Utilisation of all resources available within the community
- Regular reporting/monitoring of outcomes

As a result of this achievement of the specific targets referred to above which will ultimately lead to improved care for vulnerable people.

ANNEX 1 – Detailed Scheme Description

SCHEME 5

Scheme ref no.
Bury BCF 05
Scheme name
Review Programme - Integrated Intermediate Care , Reablement and other related services
What is the strategic objective of this scheme?
The vision for health and social care services in Bury is one of self-support, self-care, prevention and early intervention. Our plans cover not only service integration for those with existing health and social care need and their carers, but also feature a strong health improvement and prevention element to prevent people needing services in the first place.    AQUA ADASS Locality benchmarking Despite being the best performing area according to AQuA data as recently as September 2014, as illustrated in the document embedded above, to achieve even better use of resources, we will need to maximise the capacity of existing services, making sure they are 'fit for purpose' for the future, avoid duplication, are outcome focussed and fit to meet market demand. The success of this programme of reviews will be assessed by measuring its contribution to the following performance measures within the BCF; it is expected that the scheme will have most impact on Reablement, Delayed Transfers of Care and Falls metrics, whilst indirectly supporting Residential Care and Non Elective admissions. The capital elements of the BCF, relating to Disabled Facilities Grants (DFGs) and the social care capital allocation are linked to this scheme in terms of prevention and intermediate care services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
NHS Bury CCG and Bury Councils Adult Social Care Services have agreed to undertake a joint commissioning review of a number of services within Bury which have a direct influence on the numbers of patients being admitted to hospital and which support effective and early discharge.

Some of these services, but not all, form part of a cluster of services currently delivered by both health and social care providers that already support patients and customers in line with Better Care Fund outcomes, hence they have been aligned with the Better Care Fund. The objective of the review is to explore the feasibility and impact of integrating these services to provide a pathway which reduces system blockages and referral points. This means that elements of these services may be de-commissioned, re-commissioned or re-designed for example brought under single line management of one agency.

The significant majority of customers within these services are older people, latest reports (at Q2, September 2014) showing in Reablement 75% of customers are aged 75 or over, in Crisis Response 80% and in Intermediate Care 82%. It is expected that this demographic will continue for the foreseeable future.

The services also deal with a significant proportion of people who are referred into services due to falls/mobility issues, again with September 2014 reports showing Reablement at 68%, Crisis Response at 32% and Intermediate Care at 44%.

Outcomes from current operation of the schemes are expected to continue until the review is completed; At Quarter 2 (Sept 2014) some of the successful outcomes are:

Reablement – 50% of customers completed reablement and were discharged without a care package; 19% received a reduced (are package)

Crisis Response – 39% of customers were discharged and supported at home with a social care package; 19% of customers were discharged with no further actions; 27% of customers were transferred to short term residential or nursing care, indicating their need could not be met at home in the short term.

Intermediate Care – 72% of customers were discharged home, but 14% were discharged to hospital, indicating a deterioration in condition during the Intermediate Care episode of care

The services in scope and current investment levels are shown in the table below; those highlighted in green will form part of the Better Care Fund from 2015/16 whilst those in yellow complement the BCF schemes and are therefore included in the wider review, but not at this point in the BCF. Once the review is complete, the wider schemes may also be included within the BCF in future.

Service Name	Commissioned by	2015/16 £000
BCF schemes		
Integrated intermediate care	CCG	820
Integrated intermediate care	LA	315
Crisis response	LA	254
Crisis response	CCG	400
Discharge liaison	CCG	354
Reablement Service	LA	2,300
Total - included in BCF		**4,443**
Related schemes		
Bealeys - bed	CCG	
Access to beds (crisis response)	CCG	
Access to beds (50:50 beds)	CCG	
Access to beds (50:50 beds)	LA	
Access to beds (spot purchase)	CCG	
Access to beds (assessment)	CCG	
Schemes currently outside BCF but to be reviewed		

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

These services sit within the current patient / customer pathway as illustrated in the diagram below, with the discharge liaison service being a key referral point into service hence the inclusion of this team within the review.

IMC & REABLEMENT services.pdf

The current delivery chain in respect of the scheme is detailed below; changes to this will be identified clearly as part of the review programme. However, the main providers of Intermediate Care, Reablement and other related services in Bury are Pennine Care Foundation Trust and the Local Authority.

Intermediate Care Residential Service - a 36 bed service, social care rather than clinical model.	Provided by the Local Authority, majority commissioned by CCG
Crisis response – a joint service comprising social workers	Provided jointly by LA and Pennine Care Foundation Trust (PCFT) under line management from the LA; commissioned by CCG and LA
Discharge Liaison Team	Provided by PCFT but under line management from the LA Commissioned by the CCG
Reablement – this is a service that is both provided and funded by the Local Authority, under the same senior line management as IMC. It works closely with the hospital social work team, and with Domiciliary Care Brokerage Team in respect of on-going placements.	Provided by the LA; funded in full by the LA
• Assessment beds • crisis response • 50/50 beds • assessment beds • spot purchase beds	Commissioned directly from independent providers by the CCG
Bealeys Community Hospital	Provided by PCFT, commissioned by CCG

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Strong national evidence exists to show that intermediate care and reablement services are a significant part of the Government's agenda around prevention, aimed at keeping people independent and free from long term support for as long as possible; research demonstrates that a reablement approach also has a positive impact on people's own perception of quality of life.

SCIE (Social Care Institute for Excellence) have published a number of research items, including Social Care TV videos, between 2011 and 2013, ranging from cost effectiveness of such services to engagement with families and carers around reablement.

http://www.scie.org.uk/topic/careservices/preventionreablement/reablement

Section 2 of the Care Act provides a statutory framework for focussing on 'Preventing, reducing or delaying needs'. It outlines the duty for local authorities to 'identify and target those individuals who may benefit from particular types of preventative support'. The expectation of building strong links with health professionals such as GPs and community nurses to undertake some of the identification is clear, and there are projects underway in Bury to support this approach , such as Staying Well, which is part of the BCF programme.

Intermediate Care has been evidenced by the King's Fund as a positive way of supporting people moving through the health and wider care system
http://www.kingsfund.org.uk/publications/intermediate-care

and more recent King's Fund evidence pertinent to this cluster of services indicates that reablement forms a key component of effective integrated care which focuses on effective co-ordinated care and reduced delays for patients moving around the care system.

http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population

However, it should be noted that this BCF scheme is not only about reviewing and reshaping the Reablement Service and the Intermediate Care Service, but wider services which provide short interventions to support people's recovery on discharge from hospital, as well as shifting the emphasis to a 'step up' model of prevention. The case for change is strong – whilst Intermediate Care Services are a good example of collaborative working across the NHS and social care in Bury and the positive contribution that these services have made to the health and social care economy is positively acknowledged, both Local Authority and CCG commissioners' vision for services is a better integrated one, albeit with the recognition that the range of services may continue to be run by different partner agencies.

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

Service Name	Commissioned by	2015/16 £000
BCF schemes		
Integrated intermediate care	CCG	820
Integrated intermediate care	LA	315
Crisis response	LA	254
Crisis response	CCG	400
Discharge liasion	CCG	354
Reablement Service	LA	2,300
Total - included in BCF		**4,443**

As outlined above, the funding from BCF is £4.443m currently spent on these schemes, it is expected that this will continue until the review is completed.
The capital element of the BCF totals:

Capital element of BCF	£
Disabled Facilities Grants	781,000
Social Care Capital	455,000
Total Capital	1,236,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Specific targets have not yet been identified in terms of the reviewed services, but the following outcomes will be delivered by the review: • Service model which ensures self-care and self-support – the aim of these services is to bring people up to baseline ability, then either discharge with no further support or minimal long term support. The review will assess how well do services meet that objective, how could they be improved, and measurements for success • Delivery of the Better Care Fund measures – Four of the key measures within the Better Care Fund are: o Avoidance of emergency admissions to hospital; o Reduction in admissions into permanent residential care o Maintenance of an individual at home 90 days after discharge. o Delayed Transfers of Care It is expected that this review will provide a series of recommendations that are evidence based as to how the services in scope could be re-designed to contribute more effectively to the measures, in particular prevention of hospital admission • Delivery of the CCG Commissioning Intentions 15/16, it is expected that the services in scope form Stage 4 of a procurement exercise in which decommissioning notice is served in October 2015, with new services live from October 2016. The outcomes from this review will develop the specification which the CCG will use to tender or re-design • Support to the Integrated Health & Social Care model– the CCG and Council want to commission community based services supporting people in their own home, linked to primary care and other community based services to promote better wellbeing for the residents of Bury. The review will assess how well do services meet that objective now, how could they be improved, measurements for success against this objective • Efficiencies - The review will identify potential savings through avoidance of duplication, system wide efficiencies and reduction in hospital admissions which will be outlined in a Business Case • In addition, without going into detailed operational re-design, the review is expected to provide an overview of changes needed in respect of referral points in and out of these services to ensure that we adopt a ‘tell us once’ approach for the patient / customer, identify potential blockages within the customer journey and provide proposals on how providers can work together to resolve any issues. This scheme will contribute towards the following metrics and financial benefits realisation as detailed in the table below and also in part 1 appendix 1

		Metric 1 - Residential Admissions		Metric 2 - Reablement		Metric 3 - Delayed Transfers of Care		Metric 4 - Avoidable Emergency Admissions		Metric 5 - Patient experience	Metric 6 - Local metric - Falls	
Scheme ID	Scheme Description	%	Nos of people	%	Nos of people	%	Nos of people	%	Nos of people	%	%	Nos of people
BCF05	Integrated Intermediate Care, Reablement and other related services	10%	1	40%	2	65%	167	5%	49	20%	50%	21

Action Plan

The high level action plan for this scheme is as follows:

Workstream	Activity	Key Milestone	Start Date	End Date	Owner	Status
A	**Review of Services**		**01/08/2014**	**30/09/2015**		**On Target**
1	Development of key material to support review process (prioritisation matrix/ joint processes/review template)		01/08/2014	31/12/2014	**Tracy Minshull**	**On Target**
2	Review to be completed and clusters of services identified	**Y**	31/12/2014	31/12/2014	**Tracy Minshull**	**On Target**
3	Data analysis (identification of trends/gaps ion services) Risk log maintained and existing metric reviewed.		31/12/2014	31/03/2015	**Liz Hodgkinson**	**On Target**
4	Review of existing practice and research around innovative models		31/12/2014	31/03/2015	**Zena Shuttleworth**	**On Target**
5	Emerging models developed for discussion		01/03/2015	30/04/2015	**Review Team**	**Not Started**
6	Options appraisal developed (where appropriate) Future metrics finalised.		01/04/2015	30/04/2015	**Review Team**	**Not Started**
7	Future service design to be finalised	**Y**	30/04/2015	31/05/2015	**Review Team**	**Not Started**
8	Implement findings of IMC review		01/06/2015	30/09/2015	**Review Team**	**Not Started**

The review team is a joint team made up of staff from both the CCG and the LA. The team members are:

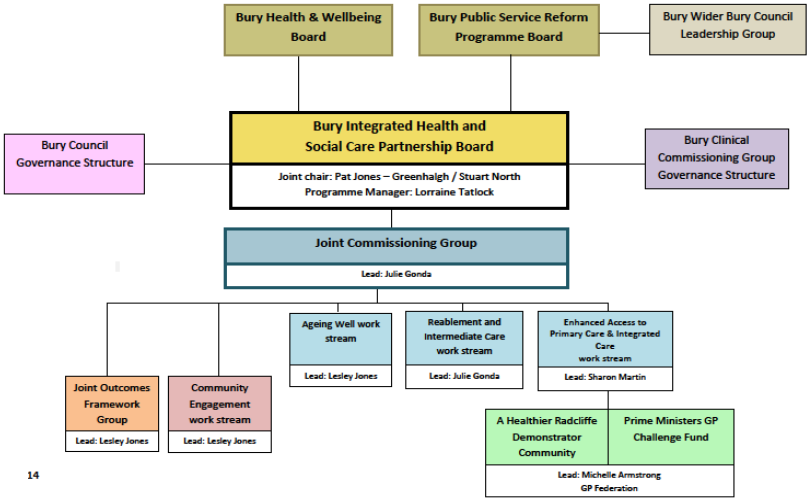
Tracy Minshull – Strategic Project Lead, Head of Commissioning & Strategy, Bury Council
Zena Shuttleworth – Strategic Planning Officer, Bury Council
Liz Hodgkinson – Economist, Bury Council

Sally Deaville – Deputy Head of Commissioning - Bury CCG
David Latham – Programme Manager, Bury CCG

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

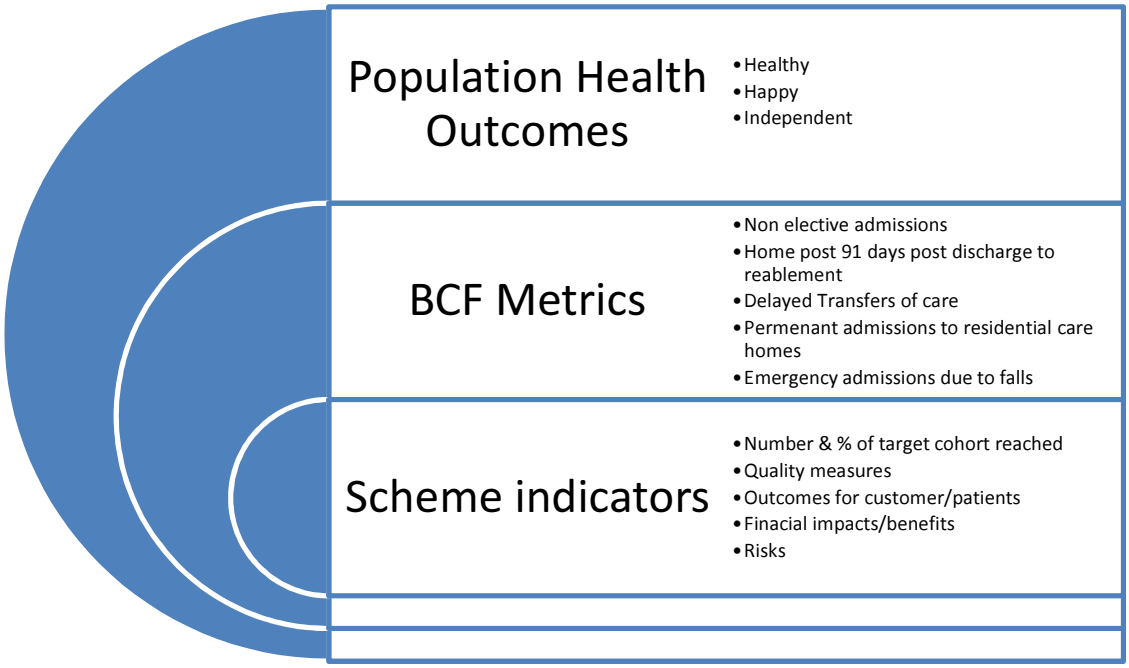
Governance Structure
This Better Care Fund scheme is project managed by a scheme lead who reports to the Joint Commissioning Group via the reablement and intermediate care workstream. The Joint Commissioning Group reports to the Integrated Health and Social Care Partnership Board and subsequently to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

Bury Integrated Health & Social Care Governance Structure



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

The Outcomes Framework



Population Outcome measures

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

We have therefore agreed a set of indicators through which we can determine whether our work has a positive impact on people's health, wellbeing and independence.
The embedded document outlines the measures agreed and associated data sources and gives the current picture for Bury against each indicator.

JOF overarching indicators June 14 v2

Better Care Fund Metrics

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

As an interim whilst the dashboard is developed, we will be collating current performance reports on the different metrics to create a single monthly report provided to the Joint Commissioning Group, Provider Partnership Group with exception reporting to the Health & Social Care Integration Partnership Board.


NEL.xls

Scheme indicators
The key indicators on progress will be incorporated into the above dashboard in time. Meanwhile monthly progress reports will be collated and provided to the Joint Commissioning Group and Provider Partnership with exception reporting to the Health & Social Care Integration Partnership Board.

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

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

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

- Integrated pathway
- Improved patient journey
- Effective Navigation service in the Acute Trust both in A&E and Discharge
- Robust pathway development
- Efficient collection and analysis of data
- Buy-in of external stakeholders

Appendix 1 - Impact of schemes Metrics Mapping

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

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

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

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

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

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

2015-16 change (from 2014-15)

Low = up to and including 10%

Moderate = 11-20%

Significant = greater than 20%

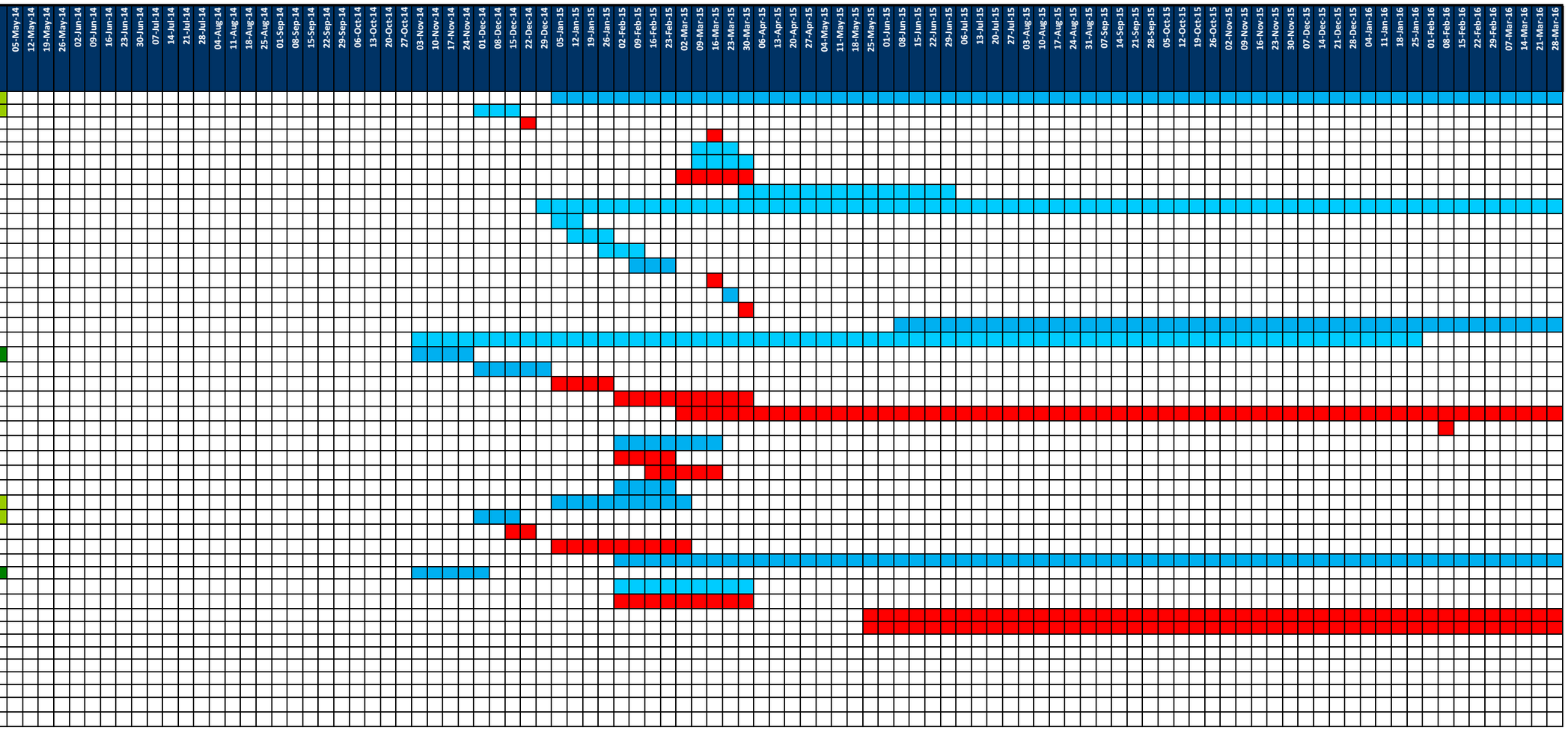
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[Back to BCF Programme Plan](#)

Current period

Start Date	End Date	Status
05/01/15	**30/04/16**	On Target
08/12/14	17/12/14	On Target
24/12/14	24/12/14	Not Started
14/03/15	14/03/15	Not Started
14/03/15	28/03/15	Not Started
14/03/15	04/04/15	Not Started
01/03/15	31/03/15	Not Started
01/04/15	30/06/15	Not Started
05/01/15	**30/04/16**	Not Started
05/01/15	14/01/15	Not Started
14/01/15	31/01/15	Not Started
01/02/15	14/02/15	Not Started
14/02/15	01/03/15	Not Started
14/03/15	14/03/15	Not Started
21/03/15	21/03/15	Not Started
01/04/15	01/04/15	Not Started
01/06/15	30/04/16	Not Started
01/11/14	**31/01/16**	Not Started
01/11/14	30/11/14	Completed On Time
01/12/14	31/12/14	Not Started
05/01/15	31/01/15	Not Started
01/02/15	31/03/15	Not Started
01/03/15	Ongoing	Not Started
31/01/16	31/01/16	Not Started
01/02/15	**14/03/15**	Not Started
01/02/15	28/02/15	Not Started
14/02/15	14/03/15	Not Started
01/02/15	28/02/15	Not Started
05/01/15	**28/02/15**	On Target
01/12/14	15/12/14	On Target
16/12/14	24/12/14	Not Started
01/01/15	28/02/15	Not Started
01/02/15	**Ongoing**	Not Started
01/11/14	30/11/14	Completed On Time
01/02/15	30/03/15	Not Started
01/02/15	30/03/15	Not Started
31/05/15	Monthly	Not Started
31/05/15	Monthly	Not Started



Project Implementation Plan
2 Enhanced Access to Primary Care

Back to BCF Programme Plan

Gantt Chart Key

Workstream
Activity
Milestone

Current period

Workstream	Activity	Key Milestone	Start Date	End Date	Status
A1	**Enhanced Access to PC**		**01/12/13**	**01/12/15**	**On Target**
1	Development Healthier Radcliffe (extended hours one borough) (GP Fed Lead)		01/12/13	01/12/14	On Target
2	Extended access role out to all GP practices to commence (GP Fed Lead)		05/05/14	01/12/15	Completed On Time
3	Deliver Borough wide communications campaign (linked to SRG, GP Fe Lead)		01/09/14	01/12/15	Completed On Time
4	Review other services and identify any duplication and synergise pathways (GP Fed Lead)		01/09/14	17/12/14	Completed Late
5	Agree local evaluation process (CCG Lead)		01/12/15	09/03/15	Behind Schedule
6	GP Federationation application for additional funding and notification from NHS E (GP Fed Lead)		01/12/15	12/01/15	On Target
A2	**EA - Telephone Consultations (Copied directly from the NHS E Performance Report)**				
	Delivery of stakeholder workshops		07/07/14	07/07/14	Completed On Time
	Define list of services to be offered under telephone consultation		24/07/14	31/08/14	Completed On Time
	Demand profile established		21/08/14	21/08/14	Completed On Time
	Sign off service model		05/05/14	1710/14	Completed On Time
A3	**EA - Increased Online Access (Copied directly from the NHS E Performance Report)**				
	Deliver workshop to understand barriers and streamlining opportunities		05/05/14	18/06/14	Completed On Time
	Patient smartphone app released		05/05/14	04/08/14	Completed Late
	Pilot 'how to guides', VOS process and targeted initiatives in one practice		10/10/14	10/10/14	Completed On Time
	Review pilot interim findings and agree roll out plan for each practice		05/05/14	19/11/14	Completed Late
	Update 28-10-14 Easy GP Patient Services smartphone app delivered by INPS		05/05/14	31/01/15	Behind Schedule
	Update 28-10-14 Targeted initiatives complete for all practices		05/05/14	31/03/15	Behind Schedule
A4	**EA - GP Comparison Website (Copied directly from the NHS E Performance Report)**				
	Delivery of patient engagement workshops to capture design		30/06/14	31/08/14	Completed Late
	Initial design of website		08/08/15	30/09/14	Completed Late
	Submit technical solution to Programme Board for go/no go decision based on affordability.		29/08/14	30/09/14	Completed Late

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ect Implementation Plan
Integrated Health and Social Care

Back to BCF Program

t Chart Key

Workstream
Activity
Milestone

				Current period
Activity	**Key Milestone**	**Start Date**	**End Date**	**Status**
Intergrated Health and Social Care Teams				
Mobilise the Prevention and Early intervention Task Team Scheme (GP FED & LA)				
Mobilise scheme in Radcliffe in Novemeber		04/08/14	01/12/14	**Completed On Time**
Establish monitoring and KPIs		01/11/14	31/01/15	**On Target**
Establish Bury wide role out and finacial model		01/11/14	31/03/15	**On Target**
Mobilise the Targeted Frail Elederly MDT with care co-ordination and re-ablement Scheme (GP FED & LA)				
Mobilise scheme in Radcliffe in Novemeber		04/08/14	01/12/14	**Completed On Time**
Establish monitoring and KPIs		01/11/14	31/01/15	**On Target**
Establish Bury wide role out and finacial model		01/11/14	31/03/15	**On Target**
Mobilise the Community Paramedic Scheme (GP FED & LPC)	**Y**	05/01/15	05/07/15	**On Target**
Mobilise scheme in Radcliffe in January		04/08/14	01/01/15	**On Target**
Establish monitoring and KPIs		01/11/14	31/01/15	**On Target**
200 review to be completed		01/01/15	31/03/15	**On Target**
Establish Bury wide role out and finacial model		01/11/14	31/03/15	**On Target**
Domiciliary medicines optimisation service (GP FED & NWAS)	**Y**	05/01/15	31/03/15	**On Target**
Mobilise scheme in Radcliffe in January		04/08/14	01/01/15	**On Target**
Establish monitoring and KPIs		01/11/14	31/01/15	**On Target**
Establish Bury wide role out and finacial model		01/11/14	31/03/15	**On Target**
Developing the Alcohol Liaison Role within the RAID (Rapid Access, Interface and Discharge) Model				
Review Alcohol Liaison linked to RAID		01/09/14	01/04/15	**On Target**
Review Dementia Advisor Service		01/09/14	01/04/15	**On Target**
Finalise serrvice specification with HMR		01/08/14	31/03/15	**On Target**
Agree KPIs to reflect outcome data from PAHT		01/08/14	15/02/15	**On Target**
Meet with TPM to confirm contract changes requiresd		01/08/14	28/02/15	**On Target**

ect Implementation Plan
Care of Vulnerable Adults

Back to BCF Programme Plan

tt Chart Key

Workstream
Activity
Milestone

Current period

Activity	Key Milestone	Start Date	End Date	Status
Stakeholder Engagement		**10/02/14**	**19/06/14**	**Completed On Time**
Set up initial meeting with General Practice		10/02/14	14/03/14	Completed On Time
Prepare background/evidence material to support potential schemes		14/03/14	14/03/14	Completed On Time
Initial Discussions		14/03/14	14/03/14	Completed On Time
£5 per head workshop feedback collation		14/03/14	28/03/14	Completed On Time
Set up 2 additional workshops to process the £5 per head interventions 1 in 3weeks and 1 in 6		14/03/14	04/04/14	Completed On Time
Prepare options based on outputs from initial meeting		31/03/14	31/03/14	Completed On Time
Workshop 1		03/04/14	03/04/14	Completed On Time
Rework options based on outputs of workshop 1		18/04/14	18/04/14	Completed On Time
Workshop 2		01/05/14	01/05/14	Completed On Time
Rework options based on outputs of workshop 2		16/05/14	16/05/14	Completed On Time
Smaller Task and Finish Group		19/05/14	19/05/14	Completed On Time
Rework options based on outputs of T&F Group		06/06/14	06/06/14	Completed On Time
Final Workshop 3		19/06/14	19/06/14	Completed On Time
Specification Development		**18/04/14**	**01/10/14**	**Completed On Time**
Draft initial specification based on workshop feedback		18/04/14	30/06/14	Completed On Time
Circulate to practices for comment		30/06/14	30/06/14	Completed On Time
Summarise practice comments received and review drafted spec accordingly		31/07/14	31/07/14	Completed On Time
Meet with Practice Managers to review intended KPIs		13/08/14	13/08/14	Completed On Time
Complete EIA and gain sign off from E&D lead		18/04/14	06/06/14	Completed On Time
Present draft proposals to Clinical Cabinet	Y	02/07/14	02/07/14	Completed On Time
All practices requested to submit final feedback on £5 schemes		04/07/14	04/07/14	Completed On Time
Prepare final specification/paper for clinical cabinet		15/08/14	24/08/14	Completed On Time
Present final specification for sign off	Y	03/09/14	03/09/14	Completed On Time
Final Spec to be shared with General Practices for sign up		15/09/14	15/09/14	Completed On Time
Go live	Y	01/10/14	01/10/14	Completed On Time
Financial modelling		**14/03/14**	**15/08/14**	**Completed Late**
Ascertain level of investment required under national guidelines		14/03/14	14/03/14	Completed On Time
Consider any additional investment needed		19/06/14	19/06/14	Completed On Time
Model potential upfront and reward based payments based on agreed outputs from workshops		14/03/14	14/03/14	Completed On Time
Include proposals within draft for clinical cabinet		02/07/14	02/07/14	Completed Late
Rework financial modelling to allow for 12mths Oct - Sep (providing assurance that max cost does not exceed potential saving and include a high cost patient contingency)		18/07/14	15/08/14	Completed Late
Performance/Outcome Monitoring		**15/07/14**	**30/09/15**	**On Target**
Create vision searched, test with practices throughout September ready for October 'GO LIVE'		15/07/14	31/10/14	On Target
Create an easy to understand monitoring proforma for any returns which may be needed including a reporting performance dashboard which will go through PMO		15/07/14	30/09/14	Behind Schedule
Ongoing reporting of performance against work programme to PMO and sectors		13/11/14	30/09/15	Not Started
Formal review of performance against plan to be presented to PMO	Y	08/01/15	08/01/15	Not Started
Formal review of performance against plan to be presented to Sector Meetings	Y	06/01/15	27/01/15	Not Started
Review of performance/specification report back to Clinical Cabinet	Y	04/02/15	04/02/15	Not Started
Ongoing Support		**01/10/14**	**30/09/15**	**On Target**
Put on an educational event to support the development of good care plans through the use of a standardised guideline	Y	15/10/14	15/10/14	Completed On Time
Outcomes from event circulated to all pratices		15/10/14	15/10/14	Completed Late
Certificates of attendance to be sent to all attendees		31/10/14	31/10/14	On Target
Ensure practices understand how to implement guideline including summary care record up load and flagging on ERISS		15/10/14	30/11/14	On Target
Regular discussions at Sector Meetings		01/10/14	30/09/15	On Target
Future event based on outputs of monitoring if needed		01/02/15	01/02/15	Not Started

Project Implementation Plan

5 Intermediate Care and Reablement

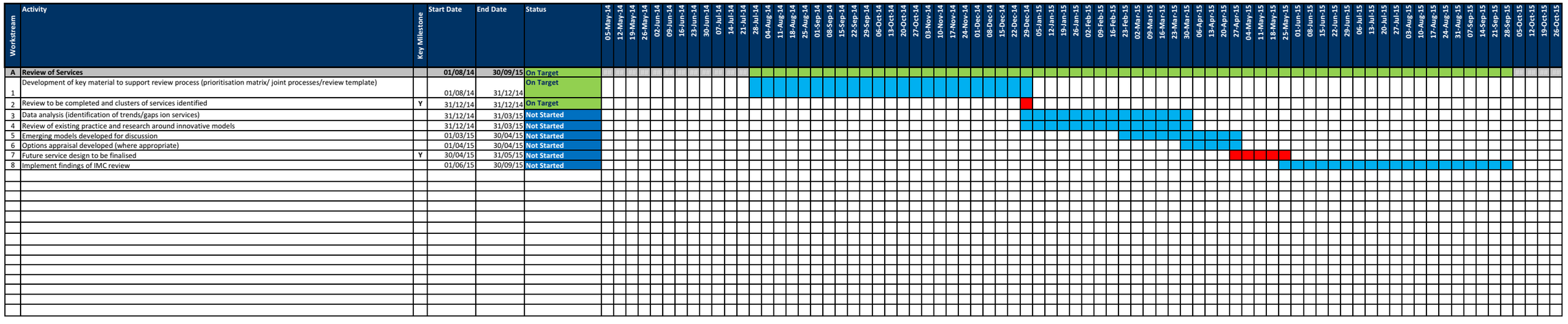
Back to BCF Programme Plan

Gantt Chart Key

Workstream
Activity
Milestone

Current period

Workstream	Activity	Key Milestone	Start Date	End Date	Status
A	**Review of Services**		01/08/14	30/09/15	On Target
1	Development of key material to support review process (prioritisation matrix/ joint processes/review template)		01/08/14	31/12/14	On Target
2	Review to be completed and clusters of services identified	Y	31/12/14	31/12/14	On Target
3	Data analysis (identification of trends/gaps ion services)		31/12/14	31/03/15	Not Started
4	Review of existing practice and research around innovative models		31/12/14	31/03/15	Not Started
5	Emerging models developed for discussion		01/03/15	30/04/15	Not Started
6	Options appraisal developed (where appropriate)		01/04/15	30/04/15	Not Started
7	Future service design to be finalised	Y	30/04/15	31/05/15	Not Started
8	Implement findings of IMC review		01/06/15	30/09/15	Not Started



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Project Implementation Plan

Reduction in the rate of injurious falls in 65+ population

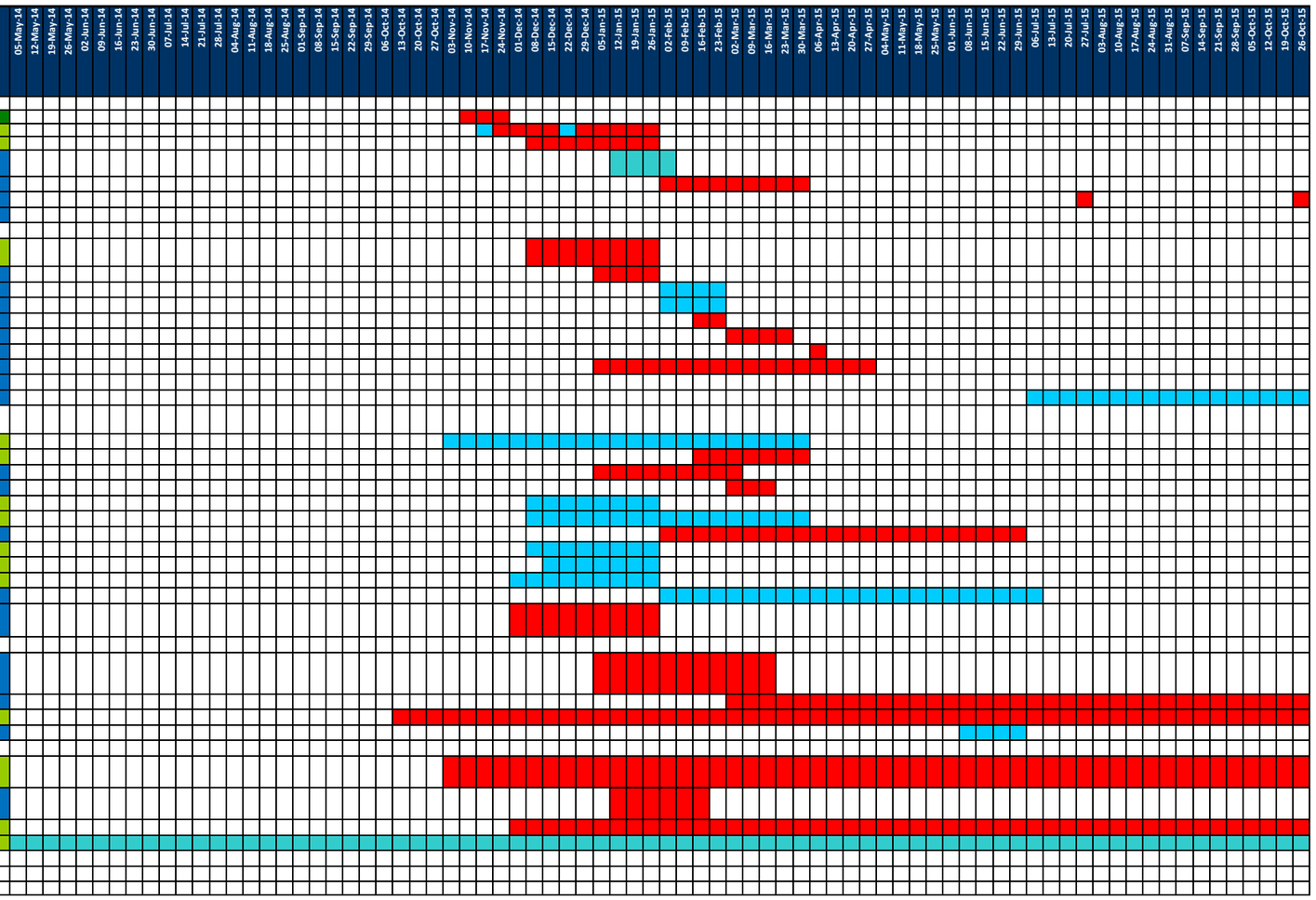
Back to BCF Programme Plan

Gantt Chart Key

Workstream
Activity
Milestone

Current period

Workstream		Activity	Key Milestone	Start Date	End Date	Status
A	**Improve Patient Outcomes and improve efficiency of care after hip fractures**			**10/11/14**	**31/03/16**	
1	Analyse findings of Royal College of Physician's Falls and Fragility Fracture Clinical Audit		Y	10/11/14	28/11/14	Completed On Time
2	Commissioners to utilise findings to drive any service improvements where indicated			24/11/14	30/01/15	On Target
3	Review current falls and fragility fracture care in acute setting			08/12/15	30/01/15	On Target
4	Identify opportunities for improvement in falls and fragility fracture care with Orthogeriatrican in acute setting, in turn supporting achievement of Best Practice Tariff			12/01/15	06/02/15	Not Started
5	Develop and implement improvement plan		Y	09/02/15	31/03/15	Not Started
6	Monitor and evaluate delivery of improvement plan			01/07/15	31/03/16	Not Started
7	Analyse findings of next Falls and Fragility Fracture Audit and recommence cycle		Y	01/12/15	31/12/15	Not Started
B	**Respond to a first fracture and prevent the second through fracture liaison type services**			**05/01/15**	**30/04/16**	
8	Review current fragility fracture care in Acute setting to ensure systematic FLS type approach to secondary fracture prevention		Y	08/12/15	30/01/15	On Target
9	Review Community Falls Service			01/01/15	31/01/15	Not Started
10	Develop Business Case for a Falls and Fracture Liaison Service as a redesign			01/02/15	28/02/15	Not Started
11	Develop Falls Service and FLS Specification			01/02/15	28/02/15	Not Started
12	Agreement to proceed from Joint Commissioning Group		Y	14/02/15	28/02/15	Not Started
13	Agree spec with provider		Y	01/03/15	21/03/15	Not Started
14	Commence Delivery		Y	01/04/15	01/04/15	Not Started
15	Develop infrastructure to undertake risk stratification around osteoporosis (audit and Qfracture facilities)		Y	01/01/15	30/04/15	Not Started
16	Contract Monitoring Meetings			01/07/15	20/04/16	Not Started
17	Include osteoporosis in primary care quality dashboard and monitor accordingly			01/12/14	31/02/2015	Not Started
C	**Early intervention to restore independence through falls care pathway linking acute and urgent services to secondary falls prevention**			**01/11/14**	**31/01/16**	
18	Review falls care pathway across health and social care sectors to optimise patient outcomes and system efficiency			01/11/14	31/03/15	On Target
19	Incorporate review of falls care within intermediate care review		Y	15/02/14	31/03/15	On Target
20	Redesign pathway where necessary		Y	01/01/15	28/02/15	Not Started
21	Joint commissioning of falls care pathway by health and social care through Joint Commissioning Group		Y	01/03/15	21/03/15	Not Started
22	Incorporate review of falls care within physiotherapy review			08/12/14	31/01/15	On Target
23	Review falls care within other relevant services e.g. OT, Postural Stability etc.			08/12/14	31/03/15	On Target
24	Redesign provision where necessary to deliver optimal falls care, maximising skills mix and resource		Y	01/02/15	31/06/2015	Not Started
25	Review GP Exercise Referal Scheme (BEATS)			08/12/14	31/01/15	On Target
26	Include osteoporosis, risk of fracture, risk of falls, history of falls as key criteria within revised BEATS scheme			15/12/14	31/01/15	On Target
27	Map all relevant physical activity assets			01/12/14	31/01/15	On Target
28	Develop capacity and capability within existing assets to work with relevant cohorts			01/02/15	30/06/15	Not Started
29	Develop new sustainable physical activity model and pathway offering evidence based interventions to sit alongside falls care pathway.		Y	01/12/14	28/02/15	Not Started
D	**Prevent frailty, promote bone health and reduce accidents**			**01/02/15**	**14/03/15**	
30	Implement NICE CG161 on Assessment and Prevention of Falls: Routine identification through health and social care contacts, interventions to improve strength and balance; offer of multifactorial assessment from community falls service		Y	01/01/15	14/03/15	Not Started
31	New Community Falls and Fracture Liaision Service to offer dedicated programme for care homes		Y	01/03/15	Ongoing	Not Started
32	Develop and implement Active Ageing programme (primary prevention), utilising opportunities through the I Will if You Will		Y	01/10/14	Ongoing	On Target
33	Incorporate bone health in Bury's proposed new Healthy Schools programme			01/06/15	30/06/15	Not Started
	Supportive Actions					
34	To continually assess need through maintenance of an up to date data profile around falls, related injuries including fragility fractures and osteoporosis		Y	01/11/14	Ongoing	On Target
35	Present data profile to Provider Partnership to mobilise the whole system around reducing injurious falls		Y	14/01/15	14/02/15	Not Started
36	To participate in PHE's Falls and Fragility Fractures Audit Programme (FFFAP), subject to resource decision by GM DPHs.		Y	01/12/14	31/03/16	On Target
37	To lead a GM Collaborative around falls and bone health			01/04/14	Ongoing	On Target



Date	Sheet	Cells
28/07/14	Payment for Performance	B23
28/07/14	1. HWB Funding Sources	C27
28/07/14	HWB ID	J2
28/07/14	a	Various
29/07/14	a	AP1:AP348
28/07/14	All sheets	Columns
30/07/14	8. Non elective admissions - CCG	
30/07/14	6. HWB supporting metrics	D18
30/07/14	6. HWB supporting metrics	D19
30/07/14	7. Metric trends	K11:O11, G43:H43,G66:H66
30/07/14	Data	Various
30/07/14	5. HWB P4P metric	H14
31/07/14	1. HWB Funding Sources	A48:C54
01/08/14	5. HWB P4P metric	G10:K10
01/08/14	5. HWB P4P metric	H13
01/08/14	5. HWB P4P metric	H13
01/08/14	5. HWB P4P metric	H14
01/08/14	4. HWB Benefits Plan	J69:J118
01/08/14	4. HWB Benefits Plan	B11:B60, B69:B118
Version 2		
13/08/14	4. HWB Benefits Plan	I61, I119, J61, J119
13/08/14	4. HWB Benefits Plan	rows 119:168
13/08/14	4. HWB Benefits Plan	rows 59:108
13/08/14	3. HWB Expenditure Plan	rows 59:108
13/08/14	a	M8
13/08/14	HWB ID	J2
13/08/14	6. HWB supporting metrics	C11, I32, M32
13/08/14	6. HWB supporting metrics	C12, I33, M33
13/08/14	6. HWB supporting metrics	C21
13/08/14	6. HWB supporting metrics	C22

13/08/14	6. HWB supporting metrics	D21
13/08/14	6. HWB supporting metrics	D21
13/08/14	6. HWB supporting metrics	E21
13/08/14	6. HWB supporting metrics	E21
13/08/14	6. HWB supporting metrics	D22
13/08/14	6. HWB supporting metrics	E22
13/08/14	5. HWB P4P metric	J14
13/08/14	5. HWB P4P metric	N9:AL9
13/08/14	4. HWB Benefits Plan	H11:H110, H119:H218
13/08/14	2. Summary	G44:M44

Description
formula modified to *=IF(B21-B19<0,0,B21-B19)*
formula modified to *=SUM(C20:C26)*
Changed to Version 2
Data mapped correctly for Bournemouth & Poole
Allocation updated for changes
Allowed to modify column width if required
Updated CCG plans for Wolverhampton, Ashford and Canterbury CCGs
Updated conditional formatting to not show green if baseline is 0
Comment added
Updated forecast formulas
Changed a couple of 'dashes' to zeros
Removed rounding
Unprotect cells and allow entry
Updated conditional formatting
formula modified to *=IF(OR(G10<0,H10<0,I10<0,J10<0),"",IF(OR(ISTEXT(G10),ISTEXT(H10),ISTEXT(I10),ISTEXT(J10)),"",IF(SUM(G10:J10)=0,"",(SUM(G10:J10)/SUM(C10:F10))-1)))*
Apply conditional formatting
formula modified to *=if(H13="","",-H12*J14)*
Remove formula
Texted modified
Delete formula
Additional 50 rows added to 14-15 table for orgaanisations that need it. Please unhide to use
Additional 50 rows added to 15-16 table for orgaanisations that need it. Please unhide to use
Additional 50 rows added to table for orgaanisations that need it. Please unhide to use
Add Primary Care to drop down list in column I on sheet '*3. HWB Expenditure Plan*'
Changed to Version 3
Change text to *'Annual change in admissions '*
Change text to *'Annual change in admissions %'*
Change text to *'Annual change in proportion '*
Change text to *'Annual change in proportion %'*

Change formula to *=if(D19=0,0,D 18 -C 18)*
Change format to 1.dec. place
Change formula to *= if(E19=0,0,E 18 -D 18)*
Change format to 1.dec. place
Change formula to *=if(D19=0,0,D 18 /C 18 -1)*
Change formula to *=if(E19=0,0,E 18 /D 18 -1)*
Cell can now be modified - £1,490 in as a placeholder
Test box for an explanation of why different to £1,490 if it is.
Change formula to eg. *=H11*G11*

Test box for an explanation for the difference between the calculated NEL saving on the metrics tab and the benefits tab

Agenda Item 8

Health & Wellbeing Board Report template

Bury Health and Wellbeing Board

Title of the Report	Quarterly report on Health & Wellbeing Strategy Measures for the refreshed Priority 1 & 4
Date	29th January 2015
Contact Officer	Anna Barclay
HWB Lead in this area	Lesley Jones

1. Executive Summary

Is this report for?	Information X	Discussion	Decision
Why is this report being brought to the Board?	This report is being brought to the Health & Wellbeing Board to inform the board of the refreshed Health & Wellbeing Strategy Measures for Priority 1 & 4		
Please detail which, if any, of the Joint Health and Wellbeing Strategy priorities the report relates to. (See attached Strategy)	Priority 1 & 4		
Please detail which, if any, of the Joint Strategic Needs Assessment priorities the report relates to. (See attached JSNA)	ALL		
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 note the contents of this report		
What requirement is there for internal or external communication around this area?	N/A		
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.	No this report is specific to the Health & Wellbeing Board		

2. Introduction / Background

In July 2014, the Health & Wellbeing Board entered into a commitment to refresh the Heath & Wellbeing Strategy priority by priority at each board meeting. However, to ensure that the Health & Wellbeing Board were kept informed of performance against each measure whilst the refresh of the strategy was taking place, a data Dashboard was produced and agreed alongside the refresh of the strategy at the July meeting. Where possible, the data included on the dashboard is sourced from the three national outcomes frameworks as these provide robust data and enable comparisons with other areas.

- Public Health Outcomes Framework
- NHS Outcomes Framework
- Adult Social Care Outcomes Framework

Data from nationally-published sources (such as the outcomes frameworks) can often have a lag between the reporting period the data refers to and when it becomes publically available however the dashboard is updated every quarter to reflect any new data that becomes available.

To date, the actions, measures and indicators for priority 1 & 4 of the strategy have been refreshed and agreed as:

Refreshed Priority 1

ACTIONS	MEASURES OF SUCCESS	INDICATORS	Responsible Group
Improve health and developmental outcomes for Under 5s.	Improved health outcomes for under 5s	Number of mothers who smoking during pregnancy	Starting Well Sub Group
		Breastfeeding initiation and maintenance at 6-8 weeks after birth	
		Infant mortality	
		Tooth decay in children aged 5	
		Childhood obesity	
	A higher proportion of children will be school ready	Children achieve a good level of development by the end of Reception	
		Children with free school meal status achieve a good level of development at the end of reception	

		Year 1 pupils will achieve the expected level in the phonics screening check	
		Year 1 pupils with free school meal status will achieve the expected level in the phonics screening check.	
Develop integrated services across education, health and social care which focus on the needs of the child especially those with the most complex needs	Implementation of SEND reforms	Number of EHC plans in place	Learning Difficulties and Disabilities Strategy Group
		Number of families accessing personal budgets	
Support positive and resilient parenting, especially for families in challenging circumstances	Fewer children making repeat entry to social care system	A reduction in the number of repeat child protection plans	Bury Safeguarding Children's Board
	Children move from care into high quality permanence	Number of children moving out of care into permanence through adoption or Special Guardianship Orders	
	Children in care in stable placements	Long term placement stability for CYPIC	
Narrow the attainment gap amongst the vulnerable groups.	vements in the differences in levels of educational attainment across the borough and between groups	Narrowing the gap indicators	Children, Young People and Culture Management Team

Refreshed Priority 4

ACTIONS	MEASURES OF SUCCESS	INDICATORS	Responsible Group
Ensure people with long term conditions (including mental health) are supported to live as well as possible with their condition.	An improved quality of life for people living with long term conditions	Health related quality of life for people with long term conditions	Health & Social Care Integration Board (Joint Commissioning Group)
		Percentage of adults with a learning disability living in stable and appropriate accommodation	
		Percentage of adults in contact with secondary mental health services who live in stable and appropriate accommodation	
	A reduction in hospital admissions for people with long term conditions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions	
	Improved health and wellbeing of carers	Percentage of adult carers who have as much social contact as they would like	
		Health related quality of life for carers	
Support people with long term conditions (including mental health) to achieve and maintain sustainable employment.	Increased number of people with long term conditions in sustainable employment.	Employment of people with long term conditions	Health & Social Care Integration Board (Economic Growth employment group)
		Gap in the employment rate between those with a long term health condition and the overall employment rate	
		Gap in the employment rate between those with a learning disability and the overall employment rate	
		Gap in the employment rate between those in contact with secondary mental health services and the overall employment rate	

To enable us to get a real picture of how Bury is doing, the dashboard compares Bury's data to that from the other Local Authorities that are most like Bury. These are called 'statistical neighbours' and have been identified using an online tool, and their data added to the dashboard. (For more information please see p16 of Appendix 1.)

Bury's ten closest statistical neighbours are:

- Bolton
- Calderdale
- Darlington
- Kirklees
- Rochdale
- Medway

- St. Helens
- Tameside
- Telford & Wrekin
- Wigan

Targets for Bury would be set depending upon the comparison to our statistical neighbours. This would be either:

1) To be better than our statistical neighbour average
2) To be the best in statistical neighbour group
3) To be the best in England

3. Key issues for the Board to Consider

Priority 1

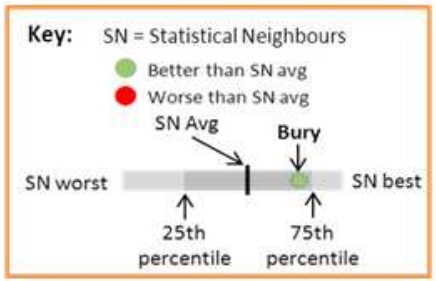
The dashboard showing the indicators for Priority 1 can be found below:

Health & Wellbeing Strategy Measures Dashboard - January 2015

Priority 1 - Ensuring a positive start to life for children, young people and families

Measures:

1. a) Improved health outcomes for under 5s
   b) A higher proportion of children will be school ready
2. Implemented the SEND reforms
3. a) Fewer children making repeat entry to social care system
   b) Children move from care into high quality permanence
   c) Children in care in stable placements
4. Improvements in the differences in levels of educational attainment across the borough and between groups



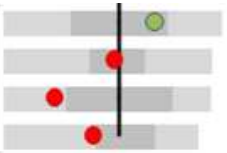
The data below are nationally-published indicators that can be matched to the Strategy measures shown above. Where data is available, they show how Bury is doing in relation to similar Local Authorities, and over time.

More indicators will be added following discussions and development.

= Bury is in lowest quartile (of SN)

NB: No significance implied

Strategy Measure Number and Indicator	Bury	SN Avg	SN Best	Statistical Neighbours range	Bury Trend	Trend - which is better?	Target
1a i) Smoking status at time of delivery	**13.6**	17.2	13.2			↓	**Best in SN**
1a ii) Breastfeeding initiation	**69.7**	65.7	78.9			↑	**Best in SN**
* 1a iii) Breastfeeding prevalence at 6-8 weeks after birth	**36.1**	37.6	46.3			↑	**?**
1a iv) Infant Mortality	**4.6**	4.3	3.0			↓	Better than SN avg
1a v) Tooth decay in Children aged 5	**1.3**	1.3	0.6			↓	**Best in SN**
1b i) % achieving good level of development at end of reception	**51.2**	48.0	57.1			↑	**Best in SN**
1b ii) % with FSM status achieving good level of development at the end of reception	**31.7**	32.2	42.5			↑	Better than SN avg
1b iii) % of Y1 achieving the expected level in phonics screening check	**65.7**	69.8	75.8			↑	Better than SN avg
1b iv) % of Y1 with FSM status achieving expected level in phonics screening check	**53.6**	55.8	62.8			↑	Better than SN avg

	Strategy Measure Number and Indicator	Bury	SN Avg	SN Best	Statistical Neighbours range	Bury Trend	Trend - which is better?	Target
1b i)	% achieving good level of development at end of reception	51.2	48.0	57.1			↑	Best in SN
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1b iv)	% of Y1 with FSM status achieving expected level in phonics screening check	53.6	55.8	62.8			↑	Better than SN avg
2 i)	Number of EHC plans in place	In development						
2 ii)	Number of families accessing personal budgets							
3 a)	A reduction in repeat child protection plans	19.7	16.5	10.1	In development		↓	Better than SN avg
3 b i)	Percentage of children moving out of care into permanence - adoption	16.5	19.3	26.0			↑	Better than SN avg
3 b ii)	Percentage of children moving out of care into permanence - special guardianship orders	15.0	12.1	19.0			↑	Best in SN
3 c)	Long term placement stability for children and young people in care	55.0	68.6	73.0			↑	Better than SN avg
4 a i)	Gap between pupils eligible for FSM and their peers achieving the expected level - KS 2	-19.2	In development				↓	
4 a ii)	Gap between pupils eligible for FSM and their peers achieving the expected level - KS 4	-19.6					↓	
4 b)	The SEN/non SEN gap achieving 5 A*-C GCSE inc. English and Maths	-47.5					↓	
4 c i)	Educational progress of CYPIC KS2-KS4 (English)	28.0					↑	
4 c ii)	Educational progress of CYPIC KS2-KS4 (Maths)	17.0					↑	
4 d i)	Educational progress of children with English as an additional language KS2-KS4 (English)	72.0					↑	
4 d ii)	Educational progress of children with English as an additional language KS2-KS4 (Maths)	72.0					↑	

*Not available as values for 4 SNs were not published on PHOF for data quality reasons

The reporting process for some of the indicators is currently under development – the dashboard will be updated as soon as more data is available.

The dashboard shows that Bury is currently BETTER than the statistical neighbour average for:

- Smoking at time of delivery
- Breastfeeding initiation
- Children achieving a good level of development at end of Reception
- Special guardianship orders

Bury is CLOSE TO the statistical neighbour average for:

- Tooth decay in children aged 5 (Bury is slightly better)

- Children with free school meal status achieving a good level of development at the end of reception (Bury is slightly worse)

Bury is WORSE than the statistical neighbour average for:

- Infant mortality
- Children in Year 1 achieving the expected level in phonics screening check
- Children in Year 1 with free school meal status achieving the expected level in phonics screening check
- Repeat child protection plans
- Adoption
- Long term placement of children in care

Full details of these indicators, including definitions and trend comparisons where available can be found in Appendix 1 'Priority 1 Measures – Details and Definitions'.

Document Pack Page 404

Priority 4

The dashboard can be found below:

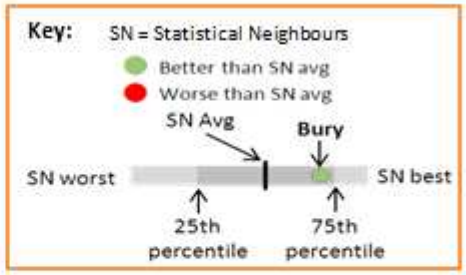
Priority 4 - Promoting independence of people living with long term conditions and their carers.

Measures from Strategy:

4.1 a) An improved quality of life for people living with long term conditions
b) A reduction in hospital admissions for people with long term conditions

4.2 Improved health and wellbeing of carers

4.3 Increased number of people with long term conditions in sustainable employment.



The data below are nationally-published indicators that can be matched to the Strategy measures shown above. Where data is available, they show how Bury is doing in relation to similar Local Authorities, and over time.

= Bury is in lowest quartile

NB: No significance implied

Strategy Measure Number and Indicator	Bury	SN Avg	SN Best	Statistical Neighbours range	Bury Trend	Trend - which is better?	Target
4.1ai Health-related quality of life for people with long-term conditions	**0.73**	0.72	0.75			↑	Best in SN
4.1aii Adults with LD who live in stable and appropriate accommodation	**86.3**	82.7	95.8			↑	Best in SN
4.1aii Adults in contact with 2ry MH services who live in stable and appropriate accomm	**50.9**	66.0	87.9			↑	Better than SN av
4.1b Unplanned adms for chronic ambulatory care sensitive conditions	**1017**	1057	861			↓	Best in SN
4.2ai % of adult carers who have as much social contact as they would like	**46.5**	44.8	51.1			↑	Best in SN
4.2aii Health-related quality of life for carers	**0.79**	0.78	0.82			↑	Best in SN
4.3ai Employment gap - people with LTCs	**10.0**	9.7	4.9			↓	Better than SN av
4.3aii Employment gap - people with a learning disability	**64.3**	64.5	59.4			↓	Best in SN
4.3aii Employment gap - people in contact with secondary MH services	**75.1**	61.6	55.7			↓	Better than SN av

The dashboard shows that Bury is currently BETTER than the statistical neighbour average for:

- Health-related quality of life for people with long term conditions
- Adults with a learning disability who live in stable and appropriate accommodation
- Adult carers who have as much social contact as they would like

Bury is CLOSE TO the statistical neighbour average for:

- Unplanned admissions for chronic ambulatory care sensitive conditions (Bury is slightly better)
- Health-related quality of life for carers (Bury is slightly better)
- Employment gap – people with long-term conditions (Bury is slightly worse)
- Employment gap – people with a learning disability (Bury is slightly better)

Bury is WORSE than the statistical neighbour average for:

- Adults in contact with secondary mental health services who live in stable and appropriate accommodation
- Employment gap – people in contact with secondary mental health services

4. Recommendations for action

To note Bury's position in comparison to our statistical neighbours. This information will be used to inform the work programme for sub groups and monitor performance.

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).

There are no financial or legal implications.

6. Equality/Diversity Implications

There are no equality or diversity implications.

CONTACT DETAILS:

Contact Officer: Anna Barclay

Telephone number: 0161 253 6910

E-mail address: anna.barclay@bury.gov.uk

Date: 09/01/2015

Appendix 1



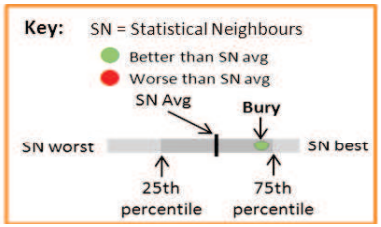
Priority 1 Details Definitions HWB 29 Ja

Health & Wellbeing Strategy Measures Dashboard - January 2015

Priority 1 - Ensuring a positive start to life for children, young people and families

Measures:

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	3 a) A reduction in repeat child protection plans	**19.7**	16.5	10.1	In development		↓	Better than SN avg
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	3 b ii) Percentage of children moving out of care into permanence - special guardianship orders	**15.0**	12.1	19.0			↑	**Best in SN**
	3 c) Long term placement stability for children and young people in care	**55.0**	68.6	73.0			↑	Better than SN avg
	4 a i) Gap between pupils eligible for FSM and their peers achieving the expected level - KS 2	**-19.2**	In development				↓	
	4 a ii) Gap between pupils eligible for FSM and their peers achieving the expected level - KS 4	**-19.6**					↓	
	4 b) The SEN/non SEN gap achieving 5 A*-C GCSE inc. English and Maths	**-47.5**					↓	
	4 c i) Educational progress of CYPIC KS2-KS4 (English)	**28.0**					↑	
	4 c ii) Educational progress of CYPIC KS2-KS4 (Maths)	**17.0**					↑	
	4 d i) Educational progress of children with English as an additional language KS2-KS4 (English)	**72.0**					↑	
	4 d ii) Educational progress of children with English as an additional language KS2-KS4 (Maths)	**72.0**					↑	

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Health & Wellbeing Strategy Measures Dashboard - January 2015

Priority 1 - Ensuring a positive start to life for children, young pe

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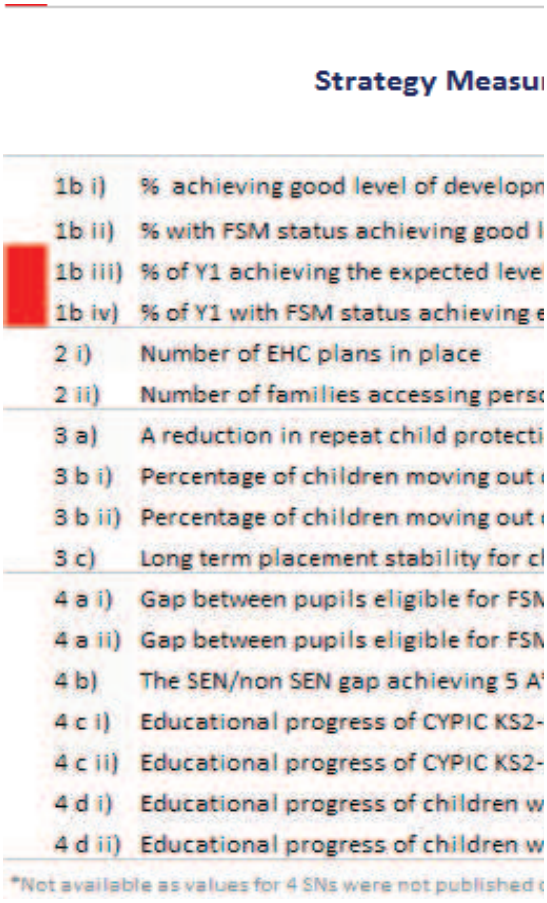
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1a ii)	Breastfeeding initiation
1a iii)	Breastfeeding prevalence at 6-8 weeks after birth

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1a v)	Tooth decay in Children aged 5
1b i)	% achieving good level of development at end of reception
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1b ii)	% with FSM status achieving good level of development at the end of re
1b iii)	% of Y1 achieving the expected level in phonics screening check
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2 ii)	Number of families accessing personal budgets
3 a)	A reduction in repeat child protection plans
3 b i)	Percentage of children moving out of care into permanence - adoption
3 b ii)	Percentage of children moving out of care into permanence - special gu
3 c)	Long term placement stability for children and young people in care
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4 c i)	Educational progress of CYPIC KS2-KS4 (English)
4 c ii)	Educational progress of CYPIC KS2-KS4 (Maths)
4 d i)	Educational progress of children with English as an additional langua
4 d ii)	Educational progress of children with English as an additional langua

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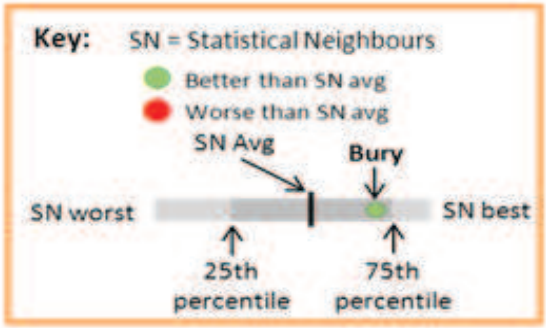
Strategy Measu

1b i)	% achieving good level of developn
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2 i)	Number of EHC plans in place
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3 a)	A reduction in repeat child protecti
3 b i)	Percentage of children moving out
3 b ii)	Percentage of children moving out
3 c)	Long term placement stability for cl
4 a i)	Gap between pupils eligible for FSM
4 a ii)	Gap between pupils eligible for FSM
4 b)	The SEN/non SEN gap achieving 5 A*
4 c i)	Educational progress of CYPIC KS2-
4 c ii)	Educational progress of CYPIC KS2-
4 d i)	Educational progress of children w
4 d ii)	Educational progress of children w

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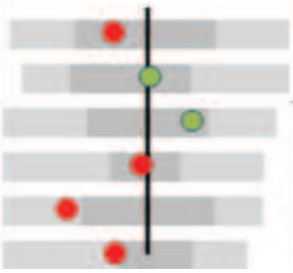
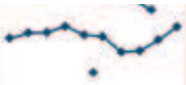
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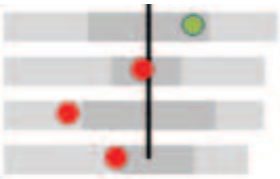


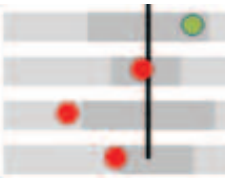
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	Bury	SN Avg	SN Best	Statistical Neighbours range	Bury Trend	Trend - which is better?	Target
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	In development					
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	-47.5					↓
	28.0					↑
	17.0					↑
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Health & Wellbeing Strategy Measures Dashboard - Janu
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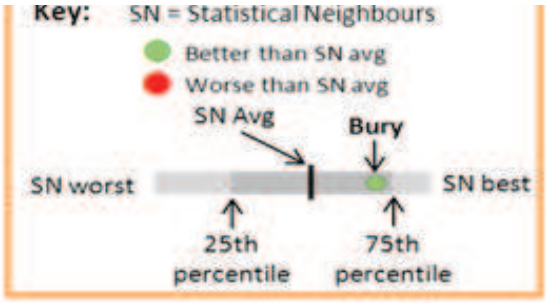
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nge	Bury Trend	Trend - which is better?	Target
		↑	Best in SN
		↑	Better than SN avg
		↑	Better than SN avg
		↑	Better than SN avg
		↓	Better than SN avg
elopment		↑	Better than SN avg
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the end of reception	31.7	32.2	42.5		
check	65.7	69.8	75.8		
s screening check	53.6	55.8	62.8		

Trend - which is better?	Target
↓	Best in SN
↑	Best in SN
↑	?
↓	Better than SN avg
↓	Best in SN
↑	Best in SN
↑	Better than SN avg
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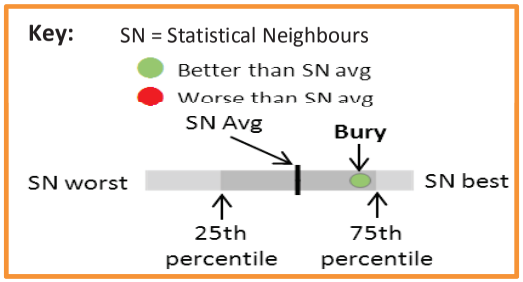
Priority 4 - Promoting independence of people living with long term conditions and their carers.

Measures from Strategy:

4.1 a) An improved quality of life for people living with long term conditions
b) A reduction in hospital admissions for people with long term conditions

4.2 Improved health and wellbeing of carers

4.3 Increased number of people with long term conditions in sustainable employment.



The data below are nationally-published indicators that can be matched to the Strategy measures shown above. Where data is available, they show how Bury is doing in relation to similar Local Authorities, and over time.

= Bury is in lowest quartile

NB: No significance implied

	Strategy Measure Number and Indicator	Bury	SN Avg	SN Best	Statistical Neighbours range	Bury Trend	Trend - which is better?	Target
	4.1ai Health-related quality of life for people with long-term conditions	**0.73**	0.72	0.75			↑	**Best in SN**
	4.1aii Adults with LD who live in stable and appropriate accommodation	**86.3**	82.7	95.8			↑	**Best in SN**
■	4.1aiii Adults in contact with 2ry MH services who live in stable and appropriate accommodation	**50.9**	66.0	87.9			↑	Better than SN avg
	4.1b Unplanned adms for chronic ambulatory care sensitive conditions	**1017**	1057	861			↓	**Best in SN**
	4.2ai % of adult carers who have as much social contact as they would like	**46.5**	44.8	51.1			↑	**Best in SN**
	4.2aii Health-related quality of life for carers	**0.79**	0.78	0.82			↑	**Best in SN**
	4.3ai Employment gap - people with LTCs	**10.0**	9.7	4.9			↓	Better than SN avg
	4.3aii Employment gap - people with a learning disability	**64.3**	64.5	59.4			↓	**Best in SN**
■	4.3aiii Employment gap - people in contact with secondary MH services	**75.1**	61.6	55.7			↓	Better than SN avg

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Bury Health and Wellbeing Board

Title of the Report	Children & Young People's Plan 2015 – 18
Date	29 January 2015
Contact Officer	Lindsay Dennis, Children's Trust Development Officer
HWB Lead in this area	Mark Carriline

1. Executive Summary

Is this report for?	Information ☐	Discussion ☐	Decision x
Why is this report being brought to the Board?	For signing off		
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	Priorities 1, 2 and 3 • Positive start to life • Healthy lifestyles • Strong communities, wellbeing and mental health		
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	Priorities 1, 2, 3, 4, 5 • Pregnancy & Early Years • Children & Young People • Lifestyle and Living Environment • Work and Welfare • Vulnerability		
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 Children & Young People's Plan has been signed up to by the Children's Trust Board, and the H&WB is now asked to formally approve and sign if off. The H&WB is asked to support the Children's Trust Board in joining up existing work and new developments more effectively to meet the Priorities in the CYPP.		
What requirement is there for internal or external communication around this area?	Significant internal and external communication via the Children's Trust Network. CYPP is not subject to statutory requirements.		
Assurance and tracking process – Has	CYPP is a Partnership Strategy, signed		

the report been considered at any other committee meeting of the Council/meeting of the CCG Board/other stakeholders....please provide details.	up to by all Partner Agencies of the Children's Trust and subject to their own internal processes. The Children's Trust is part of the Team Bury structure, governance is via the Health & Wellbeing Board. The Children & Young People's Plan forms part of the Team Bury governance arrangements. The report has not been considered by any other committee meeting of the Council or the CCG Board.

2. Introduction / Background

The requirement for partners to work together to improve the lives of children and young people through Children's Trusts is set out in the Children Act 2004, Section 10 'Duty to Cooperate'.

Children & Young People's Plan 2015-18 sets out Bury Children's Trust working arrangements, its Ambitions for children and young people, and the Priorities which partners will work together to address over the next 3 years.

The Children's Trust Board sets and drives the Children & Young People's Plan and is supported by the Children's Trust Operational Group. The Children's Trust Network involves the wider workforce in developing and delivering the Priorities and the Participation Strategy ensures the active participation of children and young people at all levels of the work.

Aligned to the CYPP 2015-18 are 2 supporting documents, the Early Help Strategy and the Strategy & Guidance for the Active Participation of Children & Young People. These Strategies are not being brought to the H&WB today, but are noted here for information.

3. key issues for the Board to Consider

The CYPP sets out overarching Ambitions which encapsulate the vision of the Children's Trust for all children and young people, ie, Right Help Right Time and Life Ready. Over the next 3 years, the Children's Trust Priorities will be:

- Children and Young People will have access to early help: right help, right time, right person

- Developing Resilience and Improving Emotional Health & Wellbeing in children and young people
- Preventing Alcohol and Substance Misuse

The focus of the Children's Trust is on services working together more effectively so that problems are identified early and the necessary support in place when and where it is needed. The Health & Wellbeing Board has an oversight of many areas of work and developments that can help to meet the Priorities and is asked to have this in mind, especially in the development of new initiatives which could be joined up with existing work through the Children's Trust.

The Children's Trust is committed to a culture of participation by children and young people, recognising and building on their strengths, and this is reflected in its approach to developing and delivering the CYPP. The Health & Wellbeing Board is asked to assist the Trust Board in developing a participation culture and recommends that the Participation Strategy is brought to a future H&WB Board meeting.

4. Recommendations for action

Health & Wellbeing Board is asked to approve and sign off the Children & Young People's Plan.

Children's Trust Board to provide update reports to Health & Wellbeing Board at agreed intervals (six-monthly).

Children's Trust Board brings the Participation Strategy to a future Health & Wellbeing Board for information and discussion.

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).

Currently there are no financial and legal implications. However, meeting the Priorities in the Children & Young People's Plan is a key component of the need to address the escalating cost of statutory and specialist interventions and the pressure on Services.

6. Equality/Diversity Implications

No equality/diversity implications.

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Date: 08-01-15

BURY CHILDREN'S TRUST

CHILDREN & YOUNG PEOPLE'S PLAN 2015 - 18

Right Help Right Time
Life Ready

Team Bury
Working Together For A Better Bury

BURY CHILDREN & YOUNG PEOPLE'S PLAN 2015-18

1. Foreword

Welcome to the Bury Children and Young People's Plan for 2015 to 2018. This document sets out how the partners within the Children's Trust will work together towards our agreed priorities and what we hope to achieve.

Our starting point is our shared desire of ensuring that all children and young people in Bury should be the best they can be – that remains our shared vision and the overarching principle which drives our work both together, through the Trust, and as individual agencies, teams and workers. As a Trust we also recognise that the vast majority of children and young people flourish in Bury, are well parented and supported by excellent universal services and go on to achieve great things both as children and young people and ultimately adults – Bury is a great place to grow up.

We have therefore agreed to focus our shared actions on three key priorities which we believe will have a substantial impact on those who are not currently achieving the outcomes they might. This is not to say that other things aren't important – simply that if we get Early Help right, enable young people to be emotionally healthy and resilient and tackling the issues of alcohol and substance misuse we will make a huge impact.

We hope this will prove to be a useful framework for colleagues to think about their work. We believe that if we all work together we can achieve great things.

Mark Carriline
Executive Director of Children, Young People and Culture – Bury Council
Chair of Bury Children's Trust Board

2. Introduction

Bury Children's Trust brings together partners from a wide range of agencies with a shared commitment to helping children and young people be the best that they can, in particular those, who for many different reasons face more barriers than their peers. The Children & Young People's Plan 2015-18 sets out Bury Children's Trust working arrangements, its Ambitions for children and young people, and the Priorities which partners will work together to address over the next 3 years.

Aligned to the Children & Young People's Plan are two important supporting Strategies. The first of these is the Participation Strategy, which has been reviewed and refreshed. Children & young people's participation is a key principle of the Children's Trust and the Participation Strategy sets out what this means for all agencies working with children and young people.

Also aligned to the Children & Young People's Plan is the new Early Help Strategy. The focus of the Children's Trust is on establishing arrangements and practice that provide an early response to problems so that the negative impact upon the lives of children and young people is minimised. The Early Help Strategy sets out principles and key actions for partners to develop a culture of early help.

These three documents will form the basis of the work of the Children's Trust over the next three years.

3. Children's Trust arrangements

The requirement for partners to work together to improve the lives of children and young people through Children's Trusts is set out in the Children Act 2004 Section 10 ' Duty to Cooperate'. In 2010 the Department for Education withdrew much of the heavily prescribed statutory guidance on Children's Trusts, giving Children's Trust Boards much more freedom to establish their own local arrangements.

An underpinning premise of Bury Children's Trust is that there are some important issues that can't be resolved unless partners work together, and effective Children's Trust arrangements will ensure that partners are able to plan and deliver joined up services to address those issues.

Bury's working arrangements have been reviewed and refreshed over recent years, reflecting national requirements and local need. Always central to Bury Children's Trust arrangements are the Children's Trust Board which sets and drives the Children & Young People's Plan, the Network which involves

the workforce in developing and delivering the Priorities, and ensuring the participation of children and young people at all levels of the work.

Prior to 2010, there was also a range of multi-agency sub groups responsible for the outcomes in the Children & Young People's Plan. The working relationships built in the sub groups led to some good improvements for children and young people, but the overlaps between groups and the level of bureaucracy outweighed the positive benefits. Therefore in 2011 the Board abolished the sub groups and instead Board members took individual responsibility for the actions in the Children & Young People's Plan and set up time-limited task & finish groups to support the work where necessary.

As part of the development of the 2015-18 Plan, the Board reviewed the Children's Trust arrangements to ensure they remain fit for purpose. As a result, the Board has established an operational sub group to support it in driving the work in the Children & Young People's Plan. The Children's Trust Operational Group will have responsibility for developing and delivering action plans to meet the Priorities, which will be overseen by the Board. It replaces the pre-existing Early Intervention Partnership Group, building on the good work of that group.

The Children's Trust is part of the Team Bury governance structure and supports the delivery of the Team Bury priorities, with immediate responsibility to the Health & Wellbeing Board.

4. Achievements 2011-14

The Children & Young People's Plan 2011-14 initiated and drove forward lots of good work to improve the lives of children and young people.

This work included the development of a set of Transition Principles to improve transition between services. These are being used to benchmark and improve transition for example for Care Leavers and in the System Reforms for children and young people with special education needs and disabilities (SEND). The work to roll out and embed the Transition Principles continues in the new Children & Young People's Plan.

There was some excellent progress in understanding of the needs of young people who are at risk of and/or become homeless with services working together more effectively to address these. Examples include the development of a joint protocol between Children's and Adults Services and the development of a young people's Housing, Employment & New Opportunities (HEN) project.

The strength of partnership working within the Children's Trust was demonstrated in the ability to mobilise partnership action to set up the Multi-

agency Safeguarding Hub (MASH), Early Help Panel and Team. The rapid rate of progress in a short space of time was recognised by Ofsted. The Children's Trust Board continue to oversee and develop work to develop a culture of Early Help across all services.

The Trust Board set up young people's peer mentoring and peer education projects to support young people to build on their strengths to support their peers. Pilot projects to support young people to continue their education and to reduce smoking and alcohol misuse led to many positive outcomes for all involved and the Board is committed to building on this approach in the new Plan.

The Circles of Influence events bringing together young people and decision-makers have been held for a number of years. Over the last two years the Board have extended this good practice to ensure that primary school age children also have a strong voice in Children's Trust work.

At both a strategic and operational level, the Board have made links with groups and work programmes which can help to meet the Priorities. For example, strategic links between the Children's Trust Board, Health & Wellbeing Board and Bury Safeguarding Children's Board have been clarified and formalised; and operationally links were made between the 'I will if you will' campaign to increase physical activity amongst girls and and work in schools to strengthen emotional well-being. This resulted in the development and delivery of a joint project for young people. Building strategic and operational links to benefit children and young people continues to be a key activity for the Children's Trust.

The Network has continued to develop in order to ensure that the workforce has a better understanding of each other's work and experience and build working relationships that lead to better outcomes for children and young people. In addition to network events, information sharing workshops and the newsletter, the lunchtime briefings introduced in 2013 have proved an extremely popular and beneficial way for the workforce to improve their awareness of other services and make appropriate links.

These and many other examples of progress demonstrate the strengths of the Children's Trust in Bury and form the foundations for continued good practice in the new Children & Young People's Plan.

5. CYPP Ambitions

Two overarching Ambitions encapsulate the vision of the Children's Trust for all children and young people.

Right Help Right Time
Life Ready

These ambitions encompass within them responsibility upon all those who work with and care for children and young people to support them to:

- be able to recognise and articulate when they need help
- know what help is available and how to access it
- to develop the necessary skills and personal attributes to lead safe and fulfilling lives

6. The Priorities

The Priorities in the Children & Young People's Plan form the basis of all Children's Trust activity for the next 3 years in order to make progress towards the overarching Ambitions.

The Board agrees that the best progress is made when the focus is on a small number of shared priorities. These priorities have been agreed by all partners in the Children's Trust, as being significant issues where only by agencies working together can there be real and lasting improvements. The risk of not meeting the priorities carries a significant 'cost' whether this be to those children, young people and families directly affected; services who will come under increasing pressure as resources are stretched ever more; or the wider society.

As well as drawing upon local and national data, the Board brings together the expertise, experience and knowledge of the workforce and of children, young people and families to assist in identifying the Priorities. Their continued involvement in developing and delivering actions to meet the Priorities will be key to progress over the next three years.

There are strong links between the Priorities and much of the work will be to identify and address the underlying causes, and build on the work of the past three years to ensure that children, young people, families and the wider community are seen positively as part of the solution. The work of the Children's Trust to meet the priorities in the Children & Young People's Plan will also support the Team Bury Priorities, Health & Wellbeing, a Stronger Economy and Stronger, Safer Community.

PRIORITY 1:
Children and young people will have access to early help: right help, right time, right person

RATIONALE – Why is this important

Early Help includes both interventions early in life (with young children, including prenatal interventions) and interventions early in the development of a problem (with children or young people of any age).

Early Help empowers people to regain control of their circumstances and can help transform the lives of vulnerable children and young people. Where Early Help does not exist and problems escalate the effect can be devastating for children, young people and families, and can impact on a child/young persons' health, education, social and emotional development.

For local authorities and their partners, providing Early Help is a crucial component of the need to address the escalating cost of statutory and specialist interventions and the pressure on services.

OUTCOMES

- Children live in safe homes with nurturing families
- Young people recognise when they need help and know how to access it
- Children and young people have a sense of responsibility to themselves and others
- Children and young people feel in control and at the centre of their own lives
- Children and young people experience good physical, emotional and mental health and recognise positive health and lifestyle choices
- Children and young people have aspirations/increased opportunity for the future
- Children and young people feel happy, confident and self-aware

POPULATION

Universal: The need for Early Help can happen at any time and at any age.

Year 1 Objectives

- Scope and evaluate existing interventions to identify whether there can be an earlier response to domestic violence incidents
- Scope and evaluate opportunities for peer-led support – improve/expand current projects
- Make Local Offer more accessible
- Develop a young person's version of the Local Offer
- Scope possibility of One Stop Shop – counselling/advice in school with non-teaching staff (ref Youth Cabinet October 2014)
- Young people link-workers to help develop projects/offer advice to staff
- Develop restorative approaches for community issues

PRIORITY 2:
Developing Resilience and Improving Emotional Health & Wellbeing in children and young people

RATIONALE – Why is this important

In Bury, we are seeing increasing pressure on our services for children & young people. Nationally, 1 in 10 children and young people fulfil criteria for a diagnosis of a clinical mental health disorder. These include concerns with the number who present with anxiety and depression with an estimated 1 in 12 having thought to have self-harmed. Schools, colleges and other services are highlighting concerns about the emotional health and wellbeing of children and young people and their ability to cope with the stresses of life (resilience).

Poor mental health is closely related to many other health and social concerns, including educational achievement, employment, offending behaviour, poor relationships, substance misuse and adult mental health problems. 50% of lifetime mental illness starts by the age of 14 years!

Promoting and sustaining good mental health thus preventing mental health problems is an issue of considerable significance both in terms of public health and social wellbeing.

OUTCOME

- Children and young people have early safe, secure and consistent attachments
- Children and young people have support networks
- Children and young people have good emotional health & wellbeing and mental health
- Children and young people are happy
- Children and young people are e-safe
- Children and young people receive 'good enough' parenting

POPULATION

- Children and young people with complex needs
- Children and young people with communication difficulties
- Children and young people who are more vulnerable to poor emotional health

Year 1 Objectives:

- Establish a minimum standard of training, mandatory for workforce
- Stepped training to teachers
- Identify groups of children/young people who are more vulnerable than others to poor emotional health/wellbeing (eg, due to background/due to lack of access to support)
- Establish key stage interventions
- Pull together what we already know
- Increase workforce awareness of each other's services

PRIORITY 3:
Preventing Alcohol & Substance Misuse

RATIONALE – Why is this important

Local and national evidence highlights the detrimental result of alcohol and substance misuse on individuals, families and communities and the significant financial burden to services.

Bury has high levels of binge drinking amongst young people age 16+ (25.1% compared to 20.1% nationally) with 24% claiming to binge drink at least once a week. Nearly half of young people who are assessed by Bury Youth Offending Service have a substance misuse issue.

Children who live in families affected by drugs and alcohol are more likely to become looked after and in Bury approx half the adults in treatment for drugs/alcohol are parents.

For children and young people, the impact of alcohol and substance misuse can be significant across all aspects of their current and future lives.

OUTCOMES

- Children and young people will be protected from harm
- Children and young people and families will be aware of risks associated with alcohol and substance misuse
- Children, young people and families have access to a well-trained workforce
- Children and young people are emotionally resilient

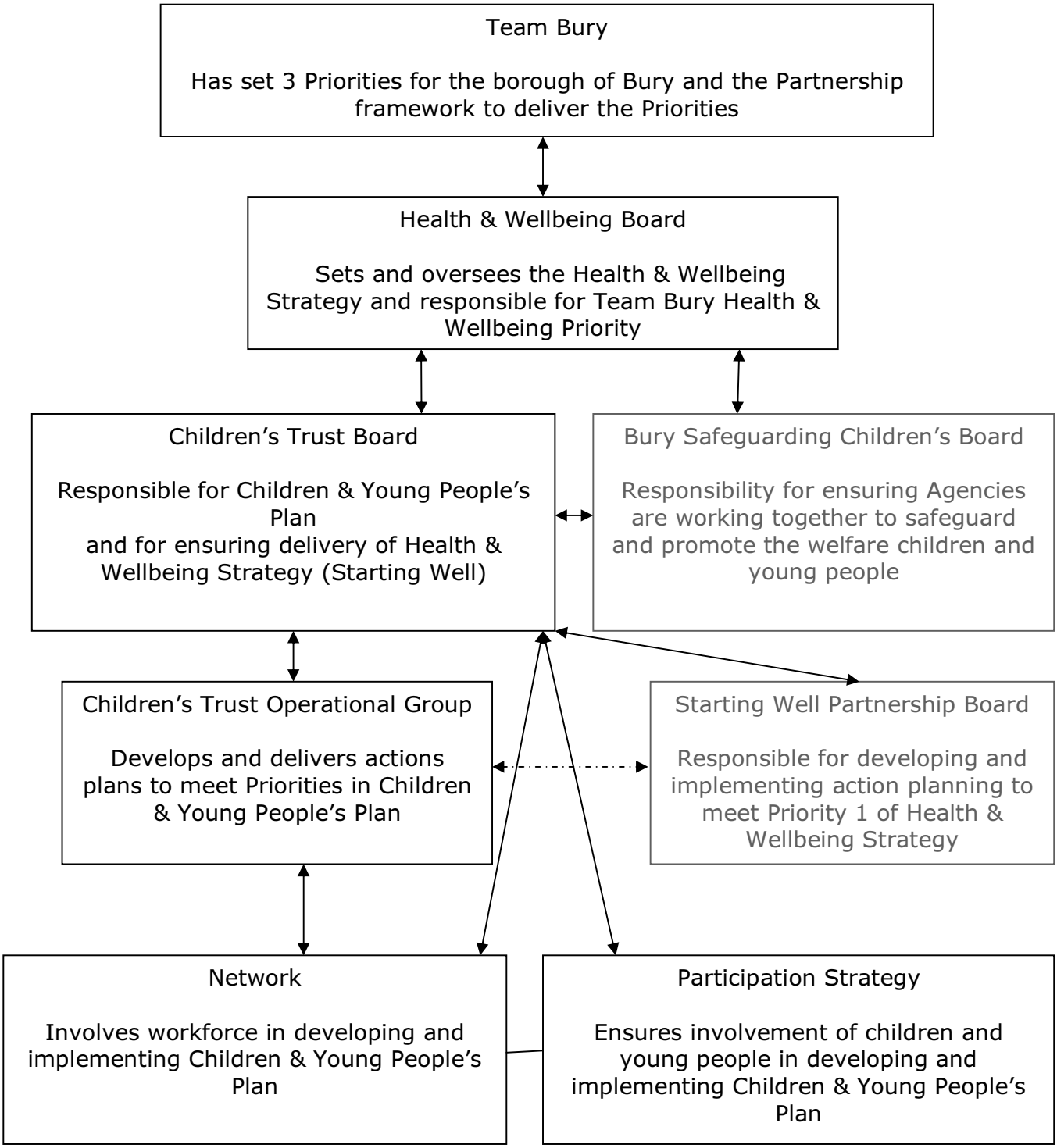
POPULATION

- Children affected by parental substance misuse or where parenting capacity is reduced.
- Children and young people questioning their sexuality and/or facing potential additional complexities including learning difficulties, mental health, family breakdown, domestic violence
- During exams and other stressful times (stress related substance use)
- The wider populations during seasonal peaks such as Christmas

Year 1 Objectives:

- A strong strategy and vision on how substance misuse will be addressed within the borough and identified resources
- Awareness raising and training for appropriate stakeholders
- Safe night out campaign (underway)
- Reduction in child protection where substance misuse is an issue

7. Governance Framework for the Children & Young People's Plan



8. Conclusion

Thank you for taking the time and trouble to read the Plan – we hope you find it useful. It doesn't however exist in isolation but is part of our broader framework of working. We will, in particular, continue to produce our regular newsletters updating you on our work and areas of good practice across the Borough – contributions welcome. We will seek every opportunity to innovate and improve our services in these very challenging circumstances. We will actively engage with the Greater Manchester Devolution agenda and Public Service Reform.

We will also continue to arrange a number of regular Network Events, Information Sharing Workshops, lunchtime briefings and other events to ensure as broad a range of people as possible can contribute to the development of our work – we look forward to working with you.

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NHS England

Lancashire and Greater Manchester.

Direct Commissioning Report for Bury Health and Wellbeing Board

Document Title: Direct Commissioning

Subtitle - January 2015

Version number: 1

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Prepared by: Kate Kinsey

Classification: OFFICIAL

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1 Executive summary

This report follows the NHS England, Greater Manchester Area Team Direct Commissioning report to Bury Health and Wellbeing Board in September 2014 and is focussed on the commissioning and provision of Dental Service, together with an update for the Bury Prime Minister's challenge fund bid site. There is further additional information for GP Medical Practice, Community Pharmacy and Optometry Practices.

The work of Direct Commissioning continues to be significantly supported by the clinical leadership and engagement of the Greater Manchester Professional Networks. Aspects of Local Professional Networks (LPN) service development, improvement and innovation across Eye Care, Pharmacy and Dental care and are having not only a local impact but in some cases receiving national recognition.

Innovation and developments within Greater Manchester primary care were showcased through two large events. The 3rd Primary Care Summit, "Transforming at Pace" was hosted by the Transformation team and the Dental Professional Network launched the "Healthy Gums DO Matter" toolkit.

The approach to equity and consistency in GP contracting continued to be applied under Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) contract review arrangements. In accordance with national guidance, PMS review arrangements have progressed through joint working between the GP contracts and finance teams. Also CCGs have continued to be engaged in the APMS contract review process and preparations for procurement

Having successfully delivered against this year's Quality Innovation Planning and Prevention Programme (QIPP), there has been the opportunity to invest non-recurrently in ensuring delivery of organisational responsibilities, achieving organisational objectives and supporting transformational change.

National clarity of arrangements was published regarding proposed Co-Commissioning arrangements during Quarter Three. The Direct Commissioning team has worked closely with the Greater Manchester Clinical Commissioning Groups to develop arrangements to support Co-Commissioning, under the oversight of the established Steering Group. Operational and financial arrangements continue to be developed to support all levels of co-commissioning arrangements.

Similar to the rest of NHS England teams and functions, the Greater Manchester the Direct Commissioning Team has been subject to the Organisational Alignment and Capability Programme during Quarter Three.

2 Dental

2.1 Commissioning Responsibility

From April 2013, the NHS Commissioning Board assumed 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.

The responsibility for commissioning Oral Health Improvement sits with the Local Authorities.

2.2 Dental Survey of Five year olds 2012

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:

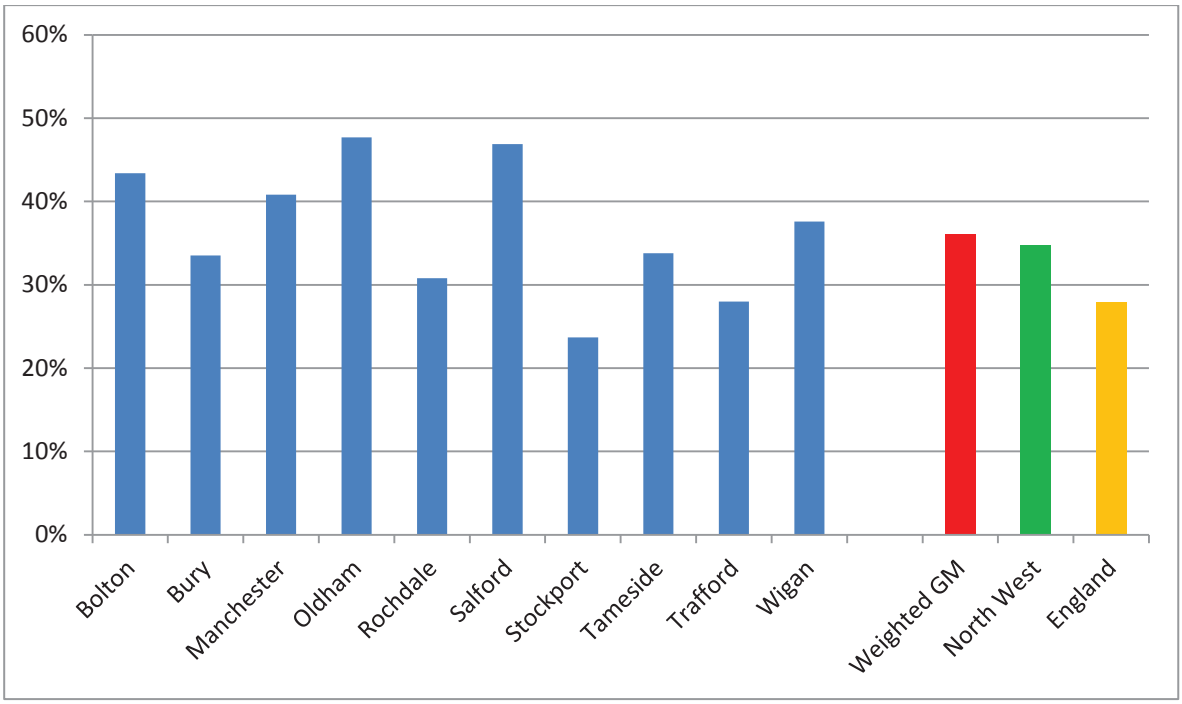
- Overall the proportion of five year old children with any tooth decay has reduced from 30.9% to 27.9%
- The proportion of children with untreated decay has reduced from 27.5% to 24.5%
- Children with sepsis in their mouths has reduced from 2.3% to 1.7% since 2008
- 72.1% of five year olds are free 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.

2.3 Summary of findings for Greater Manchester local authorities 2012/13

Public Health England (PHE) Dental Public Health has undertaken a survey of caries among three-year-old children that has shown that 12% of children in England overall had one or more teeth affected by decay. In Bury this figure was 18%. The average number of teeth affected among children with any decay was 3.1 in England and 3.3 in Bury. This, together with the information for five-year-olds, shows that more children in Bury suffer from decay than in other parts of the country but have similar average numbers of teeth affected. There are likely to be variations between different communities across the local authority area.

2.4 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 completed.

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.

2.5 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	28	378
General and Orthodontic	2	17
Orthodontic	1	36
Pilot (Type 1)*	0	2
Pilot (Type 2)**	0	2
Pilot (Type 3)***	1	3
Community (PDS)	1	4
Total	**33**	**442**

In total there are 16 secondary care contracts across Greater Manchester.

*Pilot Type 1 - guaranteed contract value remuneration for guaranteed NHS commitment

**Pilot Type 2 – based on weighted capitation (age, gender & social deprivation) and quality within contract value covering all care

***Pilot Type 3 – based on weighted capitation (age, gender & social deprivation) and quality with capitation payment covering only routine care with the remaining contract value attributed to complex care

All pilots are based on oral health assessments and reviews which follow a clinical pathway.

2.6 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

2.7 GP Patient Survey of Dental Provision

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 July – September 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?

Locality	% Yes	% No	% Can't remember
England	93%	5%	2%
Greater Manchester	92%	6%	2%
Bury	89%	9%	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?

Locality	% 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	47%	36%	8%	4%	5%

According to the above data Greater Manchester has a slightly higher percentage of patients who stated their experience of NHS Dental Services was very good.

Bury also has a slightly lower percentage of patients who stated their experience of NHS Dental Services was very good.

2.8 Dental 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 December 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	Patients seen in previous 24 months at end of September 2014	Patients seen in previous 24 months at end of December 2014
Greater Manchester	1,553,258	1,658,990	1,664,335	1,665,267	1,664,929	1,667,372
North of England Commissioning Region	8,751,351	9,231,335	9,249,297	9,244,868	9,242,438	9,261,393
England	28,144,599	29,775,762	29,915,994	29,915,895	29,931,166	30,005,435

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	% of Access levels Sept 2014 compared to end of March 2006	% of Access levels Dec 2014 compared to end of March 2006
Greater Manchester	100.0%	106.81%	107.15%	107.21%	107.19%	107.35%
North of England Commissioning Region	100.0%	105.48%	105.69%	105.64%	105.61%	105.83%
England	100.0%	105.80%	106.29%	106.29%	106.35%	106.61%

Bury Dental Access – December 2013 to December 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)	Patients seen in previous 24 months at end of Sept 2014 (total adults and children)	Patients seen in previous 24 months at end of Dec 2014 (total adults and children)
Bury	108,586	107,455	106,650	106,303	106,695

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	% of Access levels Sept 2014 compared to end of December 2013	% of Access levels Dec 2014 compared to end of December 2013
Bury	100.0%	99.0%	98.2%	97.9%	98.3%

Practices are responsible for monitoring their delivery month by month to ensure they deliver 100% of their contracted activity over the 12 month period. This results in variance from quarter to quarter. This variance may be due to a number of factors ranging from seasonal variation to economic reason.

This may explain the slight drop in access in Bury between December 2013 and December 2014.

2.9 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:

a) <u>Healthy Gums DO Matter Pilot 2014 / 2015</u>

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.

b) <u>Baby Teeth DO Matter 2014 / 2015</u>

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.

2.10 Non- Recurrent New Patient Access Scheme

In December 2014 a total of £1,046,010.00 was invested in non-recurrent activity, providing access to approximately 10,600 additional patients. This funding was primarily for children aged 0-5 years, in order to build on the work of the Baby Teeth DO Matter scheme. Patients outside of this age range may also be seen under this scheme as long as they are new patients that have not been seen in the previous 24 months.

Seven practices in Bury expressed an interest and met the criteria for the non-recurrent scheme, providing access to approximately 840 additional patients.

NHS England has since received a further £1.3m for non-recurrent activity and we are currently collating Expressions of Interest from practices across Greater Manchester with a view to allocate these additional non recurrent by 25th January 2015.

2.11 Orthodontic Non Recurrent Funding

In December 2014 / January 2015 £1,3m was made available for orthodontic assessments & case starts for 2014 / 2015. Practices that hold an Orthodontic PDS Agreement were asked to submit expressions of interest and a total of 14 practices met the criteria and received funding.

As result there will be 1071 additional new orthodontic case starts during 2014 / 2015.

2.12 Dental Assurance Framework (DAF)

The DAF UDA Framework has 14 clinical and non-clinical indicators (see below) which the Area Team uses 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.

The Dental Assurance Framework is reviewed on a quarterly basis by the Dental Team. Any practices with more than 4 flags are reviewed in more detail by the Dental Team and Dental Advisors. Practices may then be contracted to arrange a meeting to discuss the findings.

Flags for Bury as of December 2014 are:

Contract Type	Number of Flags
GDS General	1x practice with 6 flags 1 x practice with 5 flags 1 x practice with 4 flags 7 x practices with 3 flags 6 x practices with 2 flags 5 x practices with 1 flag 7 x practices with 0 flags
General and Orthodontic	1 x practice with 4 flags UDAs & 3 flags UOAs 1 x practice with 1 flag UDAs & 0 flags UOAs
Orthodontic	1 x practice with 1 flags

2.13 Dental 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 December 2015.

2.14 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

2.15 Contact Details

For the public:
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 colleagues 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.

3 General Medical Practice

The number of GP practices within the Health and Wellbeing Board has remained the same as previously reported at 33 practices and with no contract sanctions being placed against Bury practices.

Locality	Total Practices (as at 31.12.14)	Details of change
Bury	33	0
Total	**494**	

The medical team seeks assurance of the quality of service provision in general practice through the triangulation of data available via the (Medical) Assurance Framework comprising 42 high level clinical indicators and annual electronic declaration ("E-dec"), the Quality and Outcomes Framework comprising 81 clinical indicators and intelligence gained from CQC reports.

3.1 Key Achievements in Q3

- **Dementia Identification Scheme.** This new enhanced service is designed to reward practices for undertaking a proactive approach to identify patients with Dementia and work with CCGs to develop services and care packages for patients on their Dementia register. 409 (83%) of practices have signed up to participate.

- **Friends and Family Test (FFT).** Successful role out and implementation of FFT was facilitated by 1st December 2014 in line with contractual requirements. In partnership with NHS England North, a series of launch events were held across Greater Manchester and in early December all practices were provided with the 'FFT in a box' resource pack which contained promotional materials to support practices.

- **GP Choice.** Implementation of the GP out of area registration by 5th January was facilitated in line with contract changes. In October 2014 all practices were asked as part of the annual electronic declaration (e-DEC) to indicate their general position on accepting out of area registrations. 197 (40%) practices indicated that they would be accepting patients under these terms. An enhanced service to provide out of area registered patients with in hours urgent care e.g., home visits has been offered to all practices. To date 87 (18%) practices have signed up to participate.

- **Annual electronic declaration (e-DEC).** Successful facilitated implementation of the national requirement to complete the 2014/15 annual e-DEC by 7th November 2014. 494 (99.8%) of practices submitted the e-DEC within the required timeframe. The one remaining practice, which was not in Bury, submitted manually after the deadline.

4 Ophthalmic Practice

The number of Ophthalmic practices within the Health and Wellbeing Board has remained the same as previously reported at 18 practices and with no contract sanctions being placed against Bury practices. The additional contracts relate to domiciliary provision and 9 ophthalmic practices also hold such contracts in an addition to the mandatory contract.

H&W Board Area	Mandatory Contracts	Mandatory and Additional Contracts	Additional Only Contract
Bury	18	9	
GM Wide Total	299	83	30

4.1 Key Achievements in Q3

- First phase of (Quality in Optometry) QiO contract assurance has been completed – all priority "red" and "amber" rated contractors have now been visited, together with a small number of contractors who self- assessed as a "green" but were subsequently re-rated as either red or amber through the review process. 2015/16 will see the commencement of "routine" contract assurance visits to "green" rated contractors.
- Commencement of the GOS contract data audit collection has been completed; in preparation for reissuing GOS contracts as NHS England Commissioning Board contracts to replace the previous PCT contracts.
- Annual GOS Complaints Returns 2013/14 work completed - 92% of returns have been received by the Area Team, and contractors will be reminded to prepare to submit their 2014/15 return by end of April 2015.
- Agreed collaborative work with Action for Blind on improving uptake of sight tests and diabetic retinopathy screening – starting with analysis of areas and populations to target.
- LEHN – Eye Health Call to action stakeholder event held and filming included within the national LPN video.
- Submitted Eye Health Call to action response from GM Local Eye Health Network.
- Submitted 400,000 pieces of GOS data for analysis by University of Leeds Ophthalmic Public Health Team.

4.2 Priorities for 2014/15

- Auditing contractor data in preparation for re-issuing GOS contracts;
- Further mapping of glaucoma and macular services;
- Development of low vision strategy;
- Implementation of the glaucoma repeat readings and cataract pathways;
- LEHN proceeding to facilitate with CCG collaborative Minor Eye Conditions Service Procurement and implementation;
- Implement optometry and pharmacy collaborative medicines access service following minor eye condition service assessment;

- LEHN to facilitate review of costs of delivery of Wet AMD treatment across CCGs to enable effective use of resources;
- LEHN to deliver public health message campaign regarding vision and smoking and vision and dementia;
- LEHN to provide ongoing Support for Action for Blind project (funded by National Lottery funding);
- LEHN to explore extension of NHS IT infrastructure (N3, IG Toolkit, NHS mail, E-referrals) to Optical practices to enable greater communications between primary optical practice and secondary care;
- LEHN to work with HEENW on developing appropriate training and development programme for optometrists and associated healthcare professionals including a non-medical prescribers programme in conjunction with University of Manchester.

5 Community Pharmacy

The number of Community Pharmacies within the Health and Wellbeing Board has remained the same as previously reported at 41 pharmacies. Of these , five are pharmacies that are open for 100 hours or more per week, three of the pharmacies are Distant Selling Pharmacies. The remaining pharmacies are open during normal retails hours.

Pharmacies:	Bury	Greater Manchester
Standard (40 hours)	33	567
100 hours	5	97
****DSP***	3	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.

There were no contractual sanctions issued to pharmaceutical service providers in Quarter Three across Greater Manchester.

The Pharmaceutical Needs assessment for is soon to be published by Bury Health and Wellbeing board by April 2015.

5.1 Key Achievements in Q3

- Improving Inhaler Technique through Community Pharmacy service developed ready for launch;
- Festive period pharmaceutical coverage co-ordinated with a rota produced and distributed to key stakeholders;

- Agreement with Greater Manchester LPCs on a framework for local dispute resolution;
- Minor Ailments Scheme launched in a fourth CCG area. The most recent data has demonstrated that approximately 962 GP appointments have been freed up. This allow more time for GP practice to prioritise care for patients with long term conditions.

5.2 Priorities for 2014/15

- Implementation of the 2014/15 contract assurance process;
- Development of a Healthy Living Pharmacy ready framework;
- Dementia Friends training to be organised and delivered together with the development of a Dementia Friendly Pharmacy Framework;
- Completion of contract database audit;
- Working with the Local Pharmaceutical Committee to develop a framework for local dispute resolution for contractor concerns;
- Patient safety around medicines (considering acute kidney injury as a focus);
- Transfer of care – developing simple process to identify and signpost patients requiring support with medicines following discharge from hospital to community pharmacies;
- Medicines optimisation – supporting patients to achieve the best outcomes from their medicines;
- Developing leadership within the pharmacy profession to drive the medicines optimisation agenda forward;
- Supporting patients to self-care for minor ailments and long term conditions;
- Co-ordinating training for community pharmacists across Greater Manchester to link with LPN priorities.

6 Primary Care Transformation Enablers

There is a detailed action plan in place for all five Strategic Commitment Areas. There is continued work in scope for additional strategic areas, namely:

6.1 Resourcing Proactive Primary Care

- The Association of Governing Groups (AGG) agreed for the PC Transformation Team to continue to facilitate the development of GM wide primary medical care Standards to reduce unwarranted variation across primary care.

- Three workshops have been held to date and have had representation from most CCGs. The output of the workshops has resulted in the proposal of 9 sentinel standards for GM. These will now be further developed over Quarter 4 for implementation by CCGs during 2015/16.

6.2 GM IM&T Digital Strategy

- The development continues at pace with the aim of presenting the GM Digital Strategy to AGG on 3rd March for comment/approval. To this

end, principles for the strategy have been agreed at the GM Clinical Reference Group and the high level scope agreed.

- Meetings to discuss the proposed principles have also been held with AHSN, GM (provider) Directors of IT, Manchester and Wigan CCGs, Stockport HSCI Group, CSU IT Director as well as attendance at CCG leads meeting to brief IT leads.
- Further engagement will continue throughout the development of the strategy with the aim of ensuring when received AGG; it is widely recognised and owned.

6.3 Workforce

- CPD funding from HENW was allocated to 11 of the 12 CCGs where GP practices completed the workforce return. Named CPD leads are now identified within each of the 12 CCGs
- Investment Plan for 2015/16 in development including; increased CPD cash allocation; adoption of YH Advanced Training Practice model; roll out of national Care Certificate to HCAs in primary care etc.

6.4 Organisational Development

A follow up OD workshop for GPs and their teams to understand the legal framework for federations has been delivered and we have disseminated a checklist of considerations as a result of this workshop.

7 Prime Minsters Challenge Fund Update

The Bury Easy GP Extended Working Hours (EWH) project initiated its 'soft launch' on 1 December 2014. The service will run from 4 sectors across the Bury CCG conurbation, operating from 5 locations. Once fully live, the EWH will provide an additional 1425 appointments per week across the 4 sectors. The project has encountered a number of implementation issues which they are working through however remain confident for the formal launch on the 5th January 2015. The pilot has initiated an extensive public awareness campaign of the new services available which will inform the public of access to telephone consultations as an alternative to face to consultations as well as the new arrangements for extended hours over 7 days. Early feedback from patients accessing the service has been positive.

Area Teams, on behalf of wave 1 pilots had the opportunity to apply for additional funding to support an extension for extended access to demonstrate sustainability. An application for £600k to support a 6 month extension was submitted in December. This would enable the pilot to continue until November 2015, providing 11 months activity data which can support both the national and a local evaluation to inform Bury CCG's future commissioning intentions of the service. The Shadow Contract Board involving the Area Team, CCG and provider continues to meet monthly to monitor the pilot and oversee any transition arrangements.

On 30 September 2014 the Prime Minister announced a new second wave of access pilots, with further funding of £100m for 2015/16. This has been communicated to all General Practices in Greater Manchester and CCG leads. The closing date for

applications is 16 January 2015. Several areas within Greater Manchester have indicated their intention to submit an expression of interest in the second wave.

7.1 Key tasks for Quarter 4 include:

- Formal launch of Extended Working Hours component for Bury Easy GP Project, which will offer extended access to all 195,000 registered patients in Bury (8am to 8pm, Monday to Friday and 8am to 6pm at weekends/Bank Holidays)
- Notification of outcome of Area Team application for 6 month extension of wave 1 pilots
- Assessment of PMCF wave 2 bids and prioritisation of strongest 2 bids
- Announcement of successful wave 2 pilots

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Agenda Item 11

Bury Health and Wellbeing Board

Title of the Report	Co-Commissioning Primary Care
Date	
Contact Officer	Stuart North, Chief Officer, Bury CCG
HWB Lead in this area	

1. Executive Summary

Is this report for?	Information X	Discussion ☐	Decision ☐
Why is this report being brought to the Board?	To update the H&W Board on the implications of Bury CCG Co-Commissioning primary care with NHS England from April 2015.		
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.	This paper is for information, however the H&W Board will need to identify a representative to be a member of the CCG/NHs England Joint Committee by April 2015.		
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	Bury CCG Governing Body		

Council/meeting of the CCG Board/other stakeholders....please provide details.	

2. Introduction / Background

NHS England has offered the opportunity for Clinical Commissioning Groups (CCG) to Co-Commission Primary Care with NHS England from 1st April 2015.

NHS England has issued the attached guidance on conflicts of interest and governance of such matters.

The guidance indicates that in order for a joint committee between NHS England and the local CCG to appropriately address conflicts of interest issues, a member of the H&W Board and a member of the local Healthwatch should be on the committee.

3. key issues for the Board to Consider

The Board need to consider and identify before the end of March 2015 an appropriate H&W Board representative to be on the joint committee for co-commissioning Primary Care in Bury.

4. Recommendations for action

It is recommended that the march H&W Board approves a representative to be a member of the joint committee above.

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

6. Equality/Diversity Implications

None

CONTACT DETAILS:

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Date: 19th January 2015

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Gateway reference: 02776

Commissioning Strategy Directorate
NHS England
Quarry House
Quarry Hill
Leeds
LS2 7UE

E-mail: england.co-commissioning@nhs.net

18 December 2014

To Local Authority CEOs and Health and Wellbeing Board Chairs
cc. CCG Clinical Leads

RE: Update on primary care co-commissioning

A. Background and context

NHS England recently invited clinical commissioning groups (CCGs) to take on an increased role in the commissioning of primary care services. The intention is to empower and enable CCGs to improve primary care services locally for the benefit of patients and local communities.

On 10 November 2014, we published Next steps towards primary care co-commissioning. This document sets out three possible models for primary care co-commissioning (greater involvement, joint commissioning and delegated commissioning) and the next steps towards implementation. The approach has been developed by the joint CCG and NHS England primary care co-commissioning programme oversight group, which includes two local authority representatives: Ged Curran (Chief Executive, Merton Council) and Merran McRae (Chief Executive, Calderdale Council). The group is co-chaired by Dr Amanda Doyle, Co-chair of NHS Clinical Commissioners and Chief Clinical Officer of NHS Blackpool CCG, and Ian Dodge, National Director: Commissioning Strategy, NHS England.

We want to encourage Health and Wellbeing Boards to have a conversation with their local commissioners of primary care, both CCGs and NHS England - and we have made the same recommendation to NHS commissioners. The

effectiveness of co-commissioning arrangements will be reliant upon the development of strong local relationships and effective approaches to collaborative working.

In this context, CCGs have an obligation to consult with each relevant Health and Wellbeing Board in preparing or revising their commissioning plan, as set out in annex A.

B. Invitation to participate in joint and delegated commissioning committees

In both joint and delegated commissioning arrangements, CCGs must issue a standing invitation to the local Health and Wellbeing Board to appoint representatives to attend commissioning committee meetings, including, where appropriate, for items where the public is excluded from a particular item or meeting for reasons of confidentiality. These representatives would not form part of the membership of the committee.

Where there is more than one local Health and Wellbeing Board for a CCG's area, the CCG should agree with them which should be invited to attend the committee.

Health and Wellbeing Boards are under no obligation to nominate a representative, but we believe there would be significant mutual benefits from their involvement. For example, it would support alignment in decision making across the local health and social care system.

If you have any queries or would like to find out more about the primary care co-commissioning programme, please email: england.co-commissioning@nhs.net

With best wishes,





Ian Dodge
National Director: Commissioning Strategy
NHS England

Dr Amanda Doyle
Chief Clinical Officer
NHS Blackpool CCG

Annex A: CCG statutory requirements in relation to CCG commissioning plans and Health and Wellbeing Boards

Under the National Health Service Act 2006 (as amended by the Health and Social Act 2012):

- CCGs must give each relevant Health and Wellbeing Board a draft of the plan and consult each such Board on whether the draft takes proper account of each joint health and wellbeing strategy published by it, which relates to the period that the plan relates to (section 14Z13(4)).

- Where a Health and Wellbeing Board is consulted, it must give the CCG its opinion on whether the plan takes proper account of each relevant joint health and wellbeing strategy.

- CCGs must include a statement of the final opinion of each relevant Health and Wellbeing Board consulted in relation to the commissioning plan in the final plan as published (section 14Z13(8)).

- Where a significant revision is made to an existing commissioning plan, CCGs must consult with the Health and Wellbeing Board as per section 14Z13, before finalising the revised plan (section 14Z12). They must also give a copy of the document to each relevant Health and Wellbeing Board.

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