AGENDA FOR

HEALTH SCRUTINY COMMITTEE

Contact: Julie Gallagher
Direct Line: 0161 2536640
E-mail: Julie.gallagher@bury.gov.uk
Web Site: www.bury.gov.uk

To: All Members of Health Scrutiny Committee

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

Dear Member/Colleague

Health Scrutiny Committee

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

Date:	Tuesday, 26 January 2016
Place:	Meeting Rooms A&B Bury Town Hall Knowsley Street Bury
Time:	7.00 pm
Briefing Facilities:	If Opposition Members and Co-opted Members require briefing on any particular item on the Agenda, the appropriate Director/Senior Officer originating the related report should be contacted.
Notes:	***** Please note there will be a pre-meeting briefing for elected members only commencing at 6pm in meeting rooms A&B.**

AGENDA

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTEREST

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

3 PUBLIC QUESTION TIME

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

4 MINUTES *(Pages 1 - 8)*

The minutes of the last meeting held on the 8th December 2015 are attached.

5 MATTERS ARISING

- Gluten free prescribing – Chief Operating Officer, Bury Clinical Commissioning Group to update

6 DELAYED DISCHARGE *(Pages 9 - 20)*

The Assistant Director, Communities and Wellbeing will report at the meeting. Report attached.

7 QUALITY ASSURANCE ANNUAL REPORT *(Pages 21 - 50)*

The Assistant Director, Strategy Procurement and Finance Julie Gonda and Lesley Molloy will report at the meeting. Report attached.

8 LOCALITY PLAN AND DEVOLUTION MANCHESTER UPDATE *(Pages 51 - 108)*

The Assistant Director, Strategy, Procurement and Finance and the Chief Operating Officer, Bury CCG will report at the meeting. Reports attached.

9 URGENT BUSINESS

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

10 FOR INFORMATION *PHYSIOTHERAPY OVERVIEW PROJECT GROUP MINUTES* *(Pages 109 - 112)*

Agenda Item 4

Minutes of: **HEALTH SCRUTINY COMMITTEE**

Date of Meeting: 8 December 2015

Present: Councillor S Kerrison (in the Chair)
Councillors E FitzGerald, J Grimshaw, S Haroon, K Hussain, J Mallon, R Skillen, T Pickstone and R Walker

Also in attendance: Councillor Andrea Simpson, Cabinet Member, Health and Wellbeing
Julie Gonda, Assistant Director, Strategy, Procurement and Finance
Michelle Stott, Housing Development and Policy Officer, Bury MBC
Ann Norleigh Noi, Strategic Planning and Development Lead
Pam Livesey Service Delivery Director, Bury, One Recovery
Julie Gallagher, Democratic Services Officer

Public Attendance: Three members of the public were present at the meeting.

Apologies for Absence: Councillor S Smith(clash) L Fitzwalter and P Adams

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HSC.532 DECLARATIONS OF INTEREST

Councillor Tim Pickstone declared a personal interest in respect of all items under consideration as his partner is employed by the NHS.

Councillor Joan Grimshaw declared a personal interest in respect of all items under consideration as a member of the Patient Cabinet.

HSC.533 PUBLIC QUESTION TIME

There were no questions from members of the public present at the meeting

HSC.534 MINUTES OF THE LAST MEETING

It was agreed:

The minutes of the meetings held on 20th October 2015 be approved as a correct record.

HSC.535 MATTERS ARISING

In respect of minute number HSC.338 Public Question Time; Physiotherapy Project Overview Group. The Democratic Services Officer reported that a meeting of the group had taken place with representatives from the Clinical Commissioning Group and Douglas Galvin, Patient Advocate. Members considered the proposals and sought assurances in relation to transitional arrangements, waiting times, communication and consultation. Members resolved to meet again in six months to monitor the impact of the proposals as well as the attendance rates.

In respect of minute number HSC.223 non-emergency transport service, the Principal Democratic Services Officer reported that a communication had been received from Blackpool Clinical Commissioning Group confirming Arriva's decision not to re-tender for the contract. The decision not to re-tender was as a result of:

"A level of management failure with the reporting of performance against its contract in Greater Manchester.... this means they had previously provided incorrect information, which shows a higher level of performance than is the case. These reports are one of the sources of intelligence used to assess ATSL's performance against the contract."

Members discussed the proposals and the attendance of Arriva representatives at a previous meeting of the Committee. Member's expressed concern that the Committee had received assurances from Arriva representatives and that information presented to the Committee had been inaccurate and misleading.

With regards to a larger number of contracts being allocated to private sector companies; Members discussed the need to be assured that there are proper and sufficient audit processes in place to monitor performance.

It was agreed

Once the announcement has been made in respect of a new provider of the Non-emergency transport service, their representatives as well as representatives from Blackpool CCG would be invited to attend a future meeting of the Health Overview and Scrutiny Committee.

HSC.536 FUEL POVERTY UPDATE

Michelle Stott, Housing Development and Policy Officer, Bury MBC attended the meeting and provided members with an overview of the work undertaken within the Borough to tackle fuel poverty. The presentation contained the following information:

- Improving housing efficiency
- Health consequence of fuel poverty
- Temperature effects on health
- Costs to the health service
- Fuel poverty strategy for Bury

The Housing Development and Policy Officer, reported that inadequate room temperatures can cause or exacerbate; cardiovascular problems; respiratory infections; mobility problems and mental health conditions.

Fuel poverty and living in a cold home can lead to excess winter death.
In Bury there were 130 Excess Winter Deaths in 2012/13.

There can be significant costs to the NHS for cold related illness e.g. repeat GP visits, A&E admissions due to stroke, heart attack, respiratory and falls, extra bed days and repeat admissions.

Total cost to the health service for A&E admissions attributable to cold related illness, based on the Department of Health reference costs for this time period is £11,247,990.

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

The Housing Development and Policy Officer reported that funding to assist residents in making houses more fuel efficient is means tested, however fuel efficiency advice from members of the team is available to all.

The Council has targeted seven wards most likely to have vulnerable residents advising them of schemes and assistance available to help make their properties more energy efficient.

The Housing Development and Policy Officer reported that the Greater Manchester Collective Switch initiative had now ended.

It was agreed:

The Housing Development and Policy Officer would provide democratic services with comparative data for all the Greater Manchester authorities regarding energy works including: Green Deal Communication installs and Greater Manchester collective switch auctions.

HSC.537 BURY'S IN-HOUSE INFECTION CONTROL SERVICE

Lorraine Chamberlain, Head of Health and Environmental Protection attended the meeting to provide members with an update in respect of the infection prevention and control service. The presentation contained the following information:

- From June 2014 to May 2015 Intrahealth provided the infection control service managed by the Bury Council's Health and Environmental Protection team
- Their work included root cause analysis of all C difficile cases, post infection reviews of all MRSA cases, serious untoward incidents, outbreak management. Lessons learned from the investigative work undertaken was fed back via Bury CCG Quality and Risk Committee.
- A business case was subsequently prepared for a wholly in-house service, comprising a lead health protection nurse and health protection nurse – recruitment to the post has proved difficult.
- In October 2015 the Bury Tattoo Hygiene Rating scheme was launched.

- A Greater Manchester wide sector improvement review led by the Public health network across the 10 local authority areas has been concluded and the review outcomes are currently being addressed.

Members reviewed an anonymised performance report on the type of work undertaken to date.

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

In response to a Member's question, the Head of Health and Environmental Protection reported that Councils across Greater Manchester did consider establishing one infection control service across the ten local authorities. This however was not feasible; the Council therefore took the decision to provide the service in-house.

The Head of Health and Environmental Protection reported that concerns raised in relation to Tattoo premises could emanate from a variety of sources including GPs, and concerns raised by customers.

In response to a Member's question the Head of Health and Environmental Protection reported that if antibiotics are required and the care home operates a single GP unit then the GP can prescribe for all staff and patients affected. This is a model (one prescribing unit) within care homes that the Head of Health and Environmental Protection would want to see across the Borough to prevent the spread of contagious diseases/illnesses.

The Head of Health and Environmental Protection reported that the in-house Council run infection control service would work with the infection control staff in the Acute sector, share advice and best practice.

It was agreed:

The performance of the In-house Infection Control Service will be reviewed in 12 months.

HSC.538 ORAL HEALTH STRATEGY

Members of the Committee considered the Oral Health Strategy. Steph Mitchell, the Health Improvement Specialist reported that improving oral health is both a priority and challenge in Bury.

Bury rate for teeth that are decayed, missing or filled in children at age 5, although similar to the North West average, it is significantly worse than the national average, with many young children facing dental extractions under anaesthetic as a result of poor dental health. In addition to this, Bury has wide in-borough oral health inequalities, with those living in more deprived wards more likely to have poor oral health.

- Bury has a higher rate of decayed, missing or filled teeth and Early childhood carriers in three year olds – 18%, compared to a national average of 12% and a regional average of 14%

- At 5 the figure is 33.4% compared to a national average of 27.9%
- In 2012/13 484 children in Bury aged 19 or under had dental extraction under general anaesthetic.

As a result of poor dental health, many young Bury children face dental extractions under general anaesthetic.

The action plan will focus on preventative efforts for the first 12 months and instil positive oral health. The Health Improvement Specialist reported that increasing preventative activities and promoting healthy behaviours and healthy relationships in the early years has been evidenced to have a lasting affect into adulthood.

Members considered a table of current practice against the range of interventions for primary care teams across the Borough of Bury.

In response to Members comments, the Health Improvement Specialist reported that the children centres will be the main driver for much of the preventative work. The Health Improvement Specialist reported that the Council are looking to re-introduce the Healthy Schools Programme.

In response to a Member's question, the Health Improvement Specialist reported that there was no additional money available to support the delivery of the action plan. Some actions will be achieved via collaborative work across Greater Manchester and making best use of current resources.

In response to a Member's query, the Health Improvement Specialist reported that she is able to provide Members with oral health work already undertaken in specific schools.

It was agreed:

A further update in respect of the Borough's Oral Health will be provided at a future meeting of the Health Overview and Scrutiny Committee.

HSC.539 DRUG AND ALCOHOL UPDATE

Members considered a verbal presentation from Ann Norleigh Noi, Strategic Planning and Development Lead, Pam Livesey Service Delivery Director, Bury, One Recovery and a current service user in respect of Bury's drug and alcohol service. An accompanying report had been circulated prior to the meeting which contained the following information:

A comprehensive review of the new service was undertaken and as a result it was necessary to systematically transform the way drug and alcohol services were provided. The transformation aimed to break the service users cycle of dependency. Key to this transformation was the new service model which was significantly different and based on a recovery care pathway. The new provider was tasked with carrying out a full caseload audit.

Success so far:

- The recovery hub
- Benzodiazepine workers role
- Gateway programme

- Key lifestyle Outcomes
- STRIVE team
- Task and finish group established to develop a response to the increasing use of new psychoactive substances NPSs

Members considered the performance data provided by One Recovery, Bury. The completions for opiates have remained steady; non-opiate use continues to rise. Alcohol and opiate use showed a decrease in successful completions but performance is now starting to increase.

Bury are currently operating at mid-point within the Greater Manchester in terms of completions. The Strategic Development and Planning Lead reported that in taking into account that the service has undergone a period of significant change, including a change in provider as well as a different operating model, performance continues to improve.

Members of the Committee received evidence from a current service user, a recovering alcoholic. The service user explained the support and assistance he had received from One Recovery and commended in particular, the holistic approach he had received via the "bridging the gap" project.

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

In response to a Member's question, the Strategic Development and Planning Lead reported that the caseload audit has highlighted circumstances in which the package of support offered to service users had been over medicalised, the new approach is to offer a holistic recovery approach.

In response to a member query in respect of the make up of users of the service; the Service Director reported that the majority suffer with mental health problems and misuse substances to disguise the problem.

The Strategic Development and Planning Lead reported that there is a high level of recreational cocaine use in Bury, predominately at the weekend by people who do not think they have a problem with substance misuse.

In response to a Member query; the Service Director reported that there has been an increase in the numbers of drug related deaths, across the Borough.

It was agreed:

1. The officers and in particular the One Recovery service user be thanked for their attendance.
2. A further update in respect of the Drug and Alcohol service be provided in 12 months and will include information relating to the demographic make-up of the service users.

HSC.540 URGENT BUSINESS

There was no urgent business reported.

COUNCILLOR SARAH KERRISON
Chair

(Note: The meeting started at 7pm and ended at 9.10pm)

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Delayed transfers of care update for Bury

Joanne Moore &Linda Jackson

26th January 2016

Team Bury
Working Together For A Better Bury

Definition of DTOC

The following definition of a DTOC is taken from the recently revised guidance from NHS England, Monthly Delayed Transfer of Care Situation Reports Definitions and Guidance version 1.09, section 3, October 2015 (publications Gateway Reference 04122)

A SitRep delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed.

A patient is ready for transfer when:

A clinical decision has been made that patient is ready for transfer

AND

A multi-disciplinary team decision has been made that patient is ready for transfer

AND

c. The patient is safe to discharge/transfer.

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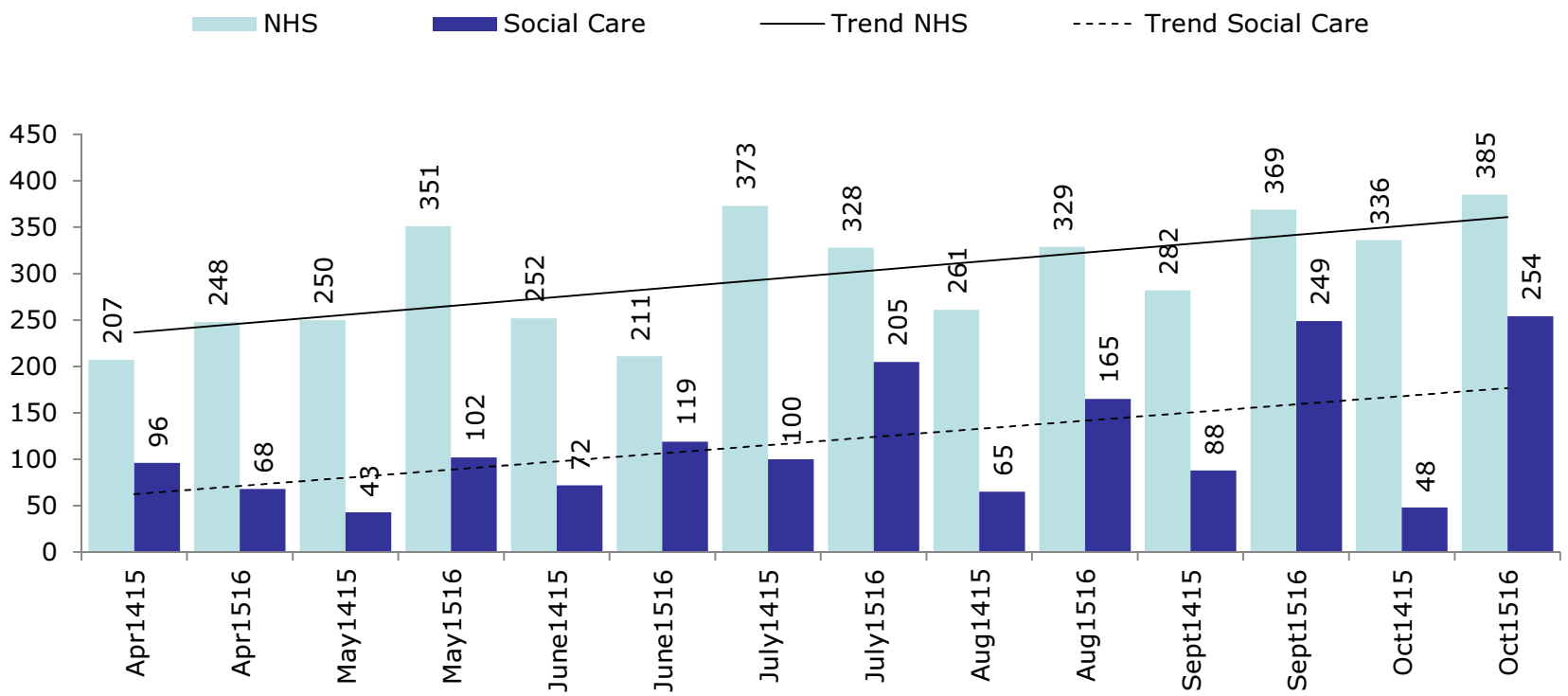
DTOC 14/15 & 15/16

Delays by Responsible Organisation



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- **Summary**

- **639 Bed Days were lost due to delays in October for Bury LA Patients. This is the 4th highest in GM and a 66.4% increase**
- **when compared to last October and a 3.4% increase from last month.**
- **Delayed days are increasing month on month, whereas 14/15 to M7 was fairly static**
- **The following reasons are the main contributors to the delayed days and have seen an increase in trend:**

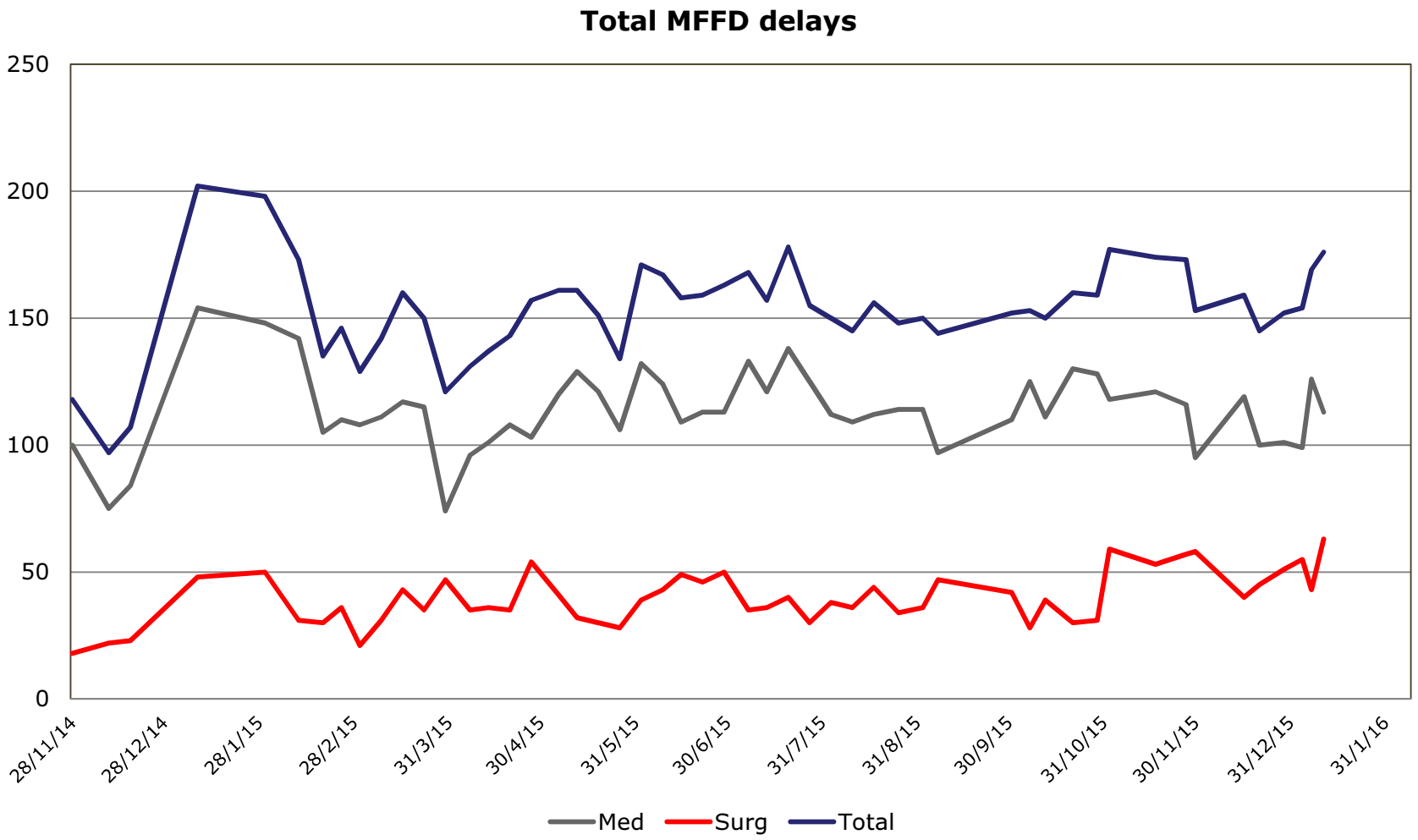
- **222 days we lost due to delays for Awaiting Care Package in Own Home**
- **197 days we lost due to delays in Waiting for Further NHS Non Acute Care**

Medically fit for discharge

A patient that is medically fit for discharge is where a clinical decision has been made that the patient is ready to transfer. This is from a medical perspective only (usually the consultant or team that the patient is under). The patient therefore has not had a MDT decision at this point, and the patient may require further therapy or social care input prior to an MDT agreement and therefore not a reportable Delayed Transfer of Care delay. (TDA, 2015)

Within the currently local health economy PAHT produce a daily list of patients deemed as Medically Fit For Discharge (MFFD). The MFFD list of patients is not the DTOC list of patients, this can cause some confusion in the system. Many patients on the MFFD list are within the normal discharge process, awaiting assessments, MDTs, family arrangements, pharmacy etc……

MFFD for Pennine Acute



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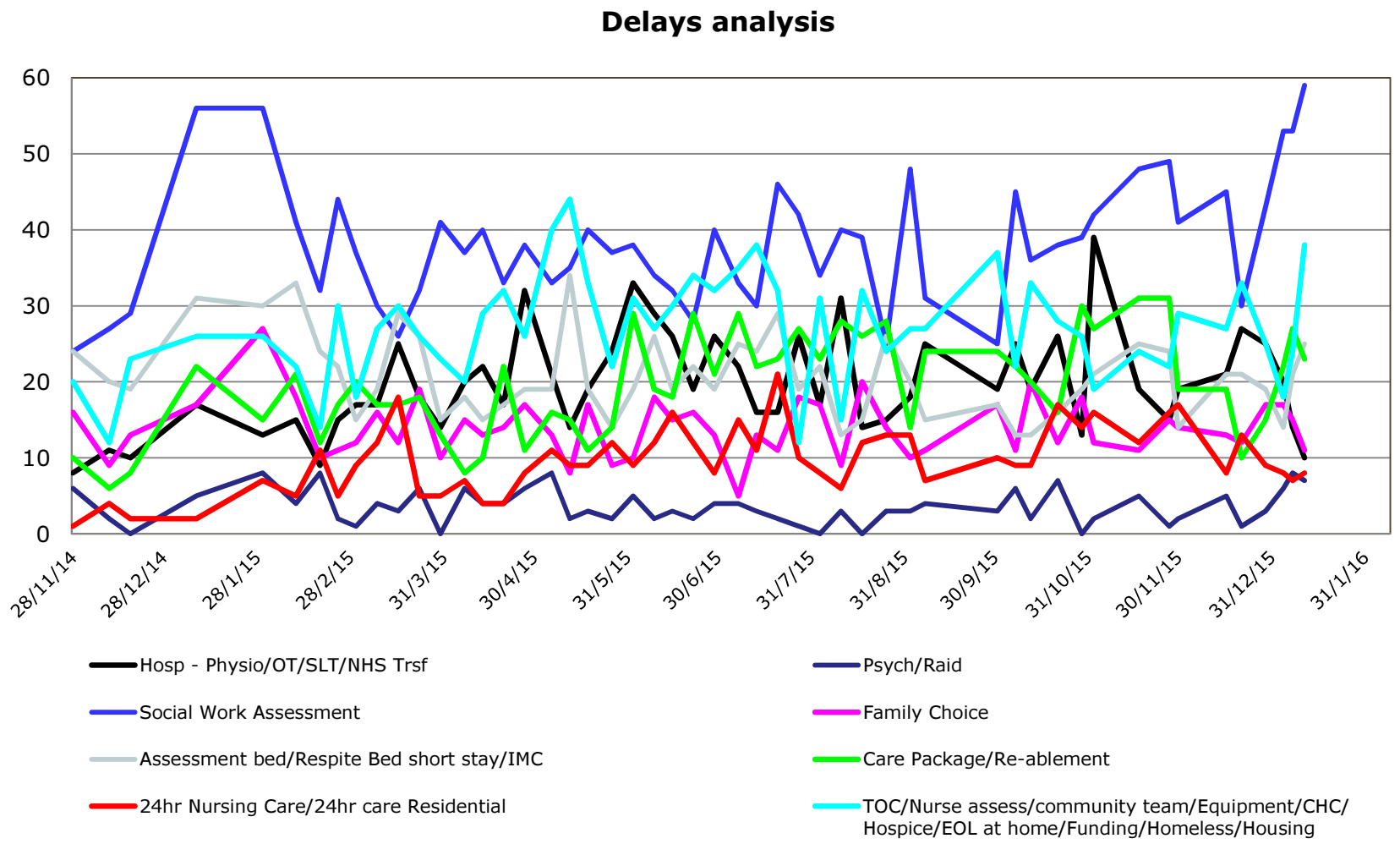
Reasons for MFFD delays



MFFD Reasons

- Over the Christmas period there has been an increase in patients reported to be waiting for social work assessment, as stated previously this can be patients' who have had their assessments started but are waiting information from other disciplines.
- Increase in the number of people awaiting continuing Health care screening and transfer to community teams
- Those people waiting to go into residential and nursing care has reduced.
- The Mental Capacity Act can also delay MFFD patients, when a individual is deemed not to have capacity it is unlawful for us to arrange them to be moved without a best interest meeting. This can sometimes add to delays for people.

Recovery Plan

- There is no one single project designed to improve this situation for Bury but rather a range of initiatives which are described below. The actions required to improve this situation cut across a range of organisations, systems and processes. The following summarises current and planned actions:

- **Bury Urgent Care Partnership Group**

  Despite DTOC not being a high priority for other NES CCGs the recently redesigned Bury Urgent Care Partnership has agreed that DTOC needs to be one for the priority areas for focus. As such this report and other supporting information will be discussed at the meeting of the group. The group will receive monthly monitoring data and review/recommend possible further solutions.
- **Further Data Collection Review**

  There is to be a further review of data collection at FGH and an exploration of the delayed discharge days reported for Bury patients on the North Manchester site.
- **Deeper Local Dive into the National Data Categories**

  The Bury Urgent Care Partnership Group will perform a deep dive with providers into the 10 recorded categories for delayed discharge days
- **Discharge Tracker**

  PAHT, BARDOC and the Local Authority are piloting a discharge tracker system for a few wards on the FGH site. The aim being to develop a method of patient stratification that all agencies can agree on, generating a real time tracking system.
- **The NES Discharge Group** is co-ordinating a range of 'Discharge To Assess' (D2A) measures at each PAHT to improve and speed up discharge processes. From a hospital/Bury perspective all Bury and HMR patients whose projected delay in discharge is more than 2 days will be transferred from Oldham and North Manchester to Fairfield.

Additional System Capacity

- A range of schemes supported funded through SRG monies to increase capacity, speed up discharge processes and reduce NELs admissions as well as seeking to improve performance on 'Awaiting Care Package In Own Home'. Most of these schemes became operational in September/November 2015. These include:
-
  - Additional medical staffing
  - Additional re-ablement capacity
  - Additional packages of care
  - Additional IMC capacity
  - Additional social work capacity

- **PAHT internal actions following finding from the Perfect Week Exercise**
- Reviewing Bed Man./Site Man/Escal
- Enhancing Ambulatory Care
- Redesigning Ward Rounds
- Training ward staff on discharge processes
- Reviewing A&E Consultant cover
- Continuing recruitment drive
- Reviewing inter-site transfers
- Reviewing A&E front and Ambulatory Care models to try and reduce the number of NEL admission and create capacity.
-

System recovery plan

- **Community IV**
- NHS Bury CCG are running a 12 month pilot which commenced on 1st December 2015 with the current provider of the IV therapy service. The aim is to better understand the level of demand for IV antibiotics within the community. The pilot will enable clinically stable patients who do not require on-going monitoring to be **stepped down** into the community service.
- **Extended Working Hours**
- Bury CCG has committed to extending current EWHs arrangements until 31.3.16 and is in the process of designing an EWHs model for 2016/17 and beyond. It is believed that EHWs in bury has contributed towards the reductions being seen in A&E and attendances and Non Elective Admissions. The correlation is that more Non Elective Admissions are likely to lead DTOCs in a system under pressure.
- **Seven day working for social care**
- The social work service at FGH have commenced seven day working from 17th January 2016, this will also facilitate discharges at the weekend.

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Bury Council
Communities & Wellbeing Procurement Service

Adult Social Care Quality Assurance Report

2014 -2015

Lesley Molloy

Senior Quality Assurance and Development Officer

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1. Background

Communities & Wellbeing is a department of Bury Council which is responsible for commissioning social care services for Adults and Older People in the borough.

Communities & Wellbeing recognises that it is of vital importance that the services we commission provide high quality care, which meets the needs and outcomes of our customers, to ensure that the department fulfils its statutory duty of care, serves the residents of the borough as effectively as possible and ensures that council resources are used for value for money services. This report therefore provides:

- An outline of the Quality Assurance Team and the Quality Assurance Framework;
- A summary of the Social Care Market Quality Assurance activity that Communities & Wellbeing Services has undertaken between October 2013 and March 2015;
- The current quality of social care services we commission including any specific quality issues that are being addressed to improve the quality of the services to our customers.

The Quality Assurance Team focuses on the quality of the two main areas of social care delivery: care in people's homes (domiciliary care and supported living) and residential care. A brief description of these services is provided below:

Care in People's Homes

Care in people's homes (known as home care, supported living or domiciliary care) is the term used for the care and support service provided by trained professionals to vulnerable people within their own home.

Care in people's own homes is provided with the aim of enabling people to remain independent in their home and maintain a good quality of life.

Some of the tasks that care workers perform are detailed below;

- Assistance with personal care
- Assistance with meal preparation
- Assistance with getting in and out of bed
- Assistance with toileting
- Assistance with medication
- Assistance with prescription collection

Residential and Nursing Care

Residential Care helps people who can no longer manage at home. There are two types of care home:

Residential Care Homes - where care is provided all day and all night but there does not need to be a qualified nurse present.

Residential and Nursing Care Homes - where there needs to be constant involvement of, or supervision by, a qualified nurse.

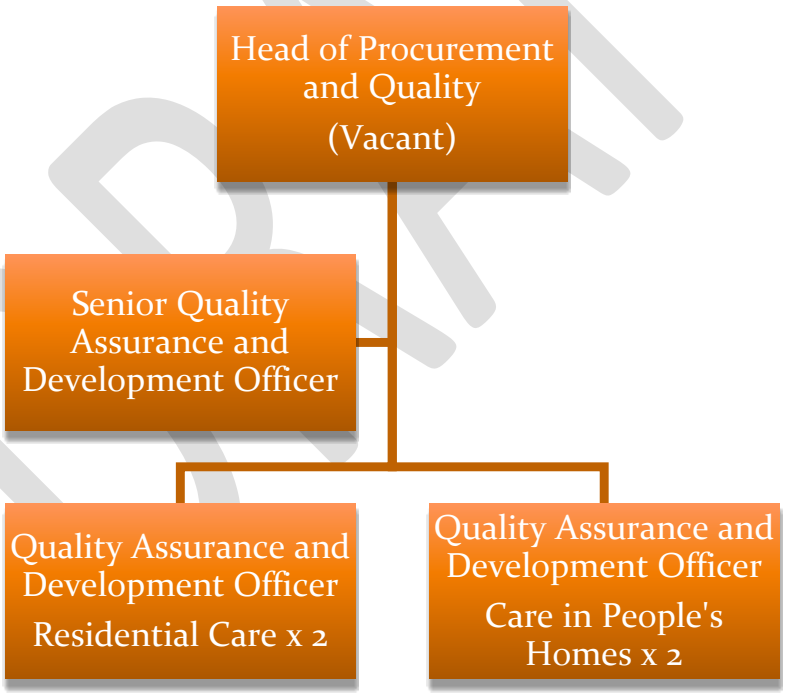
Residential and Nursing Care Homes services can differ but they often include most of the services that a care service in someone's own home can offer plus the following:

- Provision of accommodation
- Provision of all meals
- Social and recreational activities
- 24 hour emergency care
- Medical care (Nursing Homes)

2. Quality Assurance and Development Team

In order to assess, support and develop the quality of care services that we commission, both in a person's own home and in residential care, The Department of Communities & Wellbeing (DCW) employs a Quality Assurance and Development Team (QA team) which is part of the Communities & Wellbeing Procurement Service.

Quality Assurance Team Structure



The team undertake annual reviews of the quality of all our commissioned providers (both internal and external) who are registered with The Care Quality Commission (CQC) using a framework based on the Essential Standards of Quality and Safety developed by CQC (see Appendix 2).

The QA team provides support and advice to providers to enable them to develop their service, provide high quality care and support to our customers and to meet the requirements of CQC. Where required, providers who are failing to comply with the Council's or CQC's standards receive intensive support to rectify any issues in relation to the quality of support they provide. Examples of such support include regular monitoring visits by officers and

onsite guidance and support for staff. This ensures that DCW manages the market to ensure that there are sufficient providers within the borough to meet the needs of adults with social care needs.

The team also investigates concerns, complaints and safeguarding issues raised by customers, families and professionals in relation to the quality of services delivered by the Council's commissioned service providers in line with the department's policies and procedures. Customers can raise any concerns regarding quality of service with the QA team, who will then act upon these concerns as quickly as possible with the aim of resolving any concerns within 10 days of receipt. This reassures the customer that any issues they have are taken seriously and also prevents small incidents of potential poor practice, such as a late visit being undertaken by a provider, escalating into established poor quality.

Some issues of a more serious nature may become formal complaints or safeguarding referrals. The QA team form part of the multi-disciplinary response to such matters through the formal processes the department has in place.

3. Quality Assurance Framework

The QA framework has been developed to take account of the outcomes identified by the CQC in their published document 'Guidance about compliance: Essential Standards of quality and safety'. There are separate frameworks in place for each type of provision: Domiciliary Care; Supported Living and Residential Care.
The framework takes account of the core outcomes identified by CQC including :

- Respecting and involving people who use services
- Care and welfare including meeting nutritional needs
- Consent to care and treatment
- Cooperating with other providers
- Safeguarding
- Cleanliness and Infection Control
- Management of medicines
- Safety and suitability of premises and equipment
- Requirements relating to workers including staffing and supporting workers
- Assessing and monitoring the quality of service provision including complaints
- Records

The QA framework currently used by the Council comprises 9 primary outcomes and 4 supporting outcomes as detailed below:

Primary	**Supporting**
Outcome 1 – Care Planning	Outcome 2 – Shared Care
Outcome 3 – Consent	Outcome 5 - Equipment
Outcome 4 – Nutrition	Outcome 12 - Environment
Outcome 6 – Medication	Outcome 13 - Records
Outcome 7 – Dignity & Respect	
Outcome 8 – Safeguarding	
Outcome 9 – Quality Assurance & Complaints	
Outcome 10 – Staffing	
Outcome 11 – Infection Control	

Quality Assurance Process

All contracted providers undergo an annual QA review which takes approximately six months from start to completion.

The quality assurance process described below is followed in order to assess the quality of services. The time frame in brackets below shows the maximum amount of time allowed for each step of the process.

- A self assessment document for completion by the provider is made available via the Council's web based Quality Assurance system.

- The Quality Assurance Officer (QA Officer) schedules an annual site visit and review to each of their allocated providers throughout the year.

- The provider is notified of the final date for completing the self assessment, which is at least two weeks before the scheduled visit (Start of process).

- Whilst the provider is completing the self assessment the QA Officer contacts customers and their relatives to gather feedback on the quality of the service.

- The site visit is undertaken to validate the accuracy of the provider's self assessment. The site visit will not in all cases be announced but usually 24 hours notice will be given to providers. The visit will usually take place within two to four weeks of the given date for completing the self assessment. (Start + 8 weeks)

- During the site visit the QA Officer will check relevant records, policies and procedures, observe practice, speak to staff and customers, where appropriate.

- Following the site visit, an action plan may be produced. A follow-up visit is then arranged to discuss the findings of the review and agree a date for completion of any identified actions. (Start + 14 weeks)

- Only evidence observed and logged by the QA Officer at the time of the review visit may be used for any discussion regarding amendments to the action plan and resulting rating.

- Once the action plan is agreed, a maximum of three action plan reviews are carried out. During this time, the QA Officer will offer support and guidance as required to enable the provider to meet the identified actions.

- The provider has a maximum of 12 weeks to complete the actions before the provider is referred to the Contract Officer for contractual action as necessary. (Start + 26 weeks)

- Any actions warranting immediate action, for example, issues affecting the health and safety of customers, are brought to the attention of the provider and the Contract Officer as they arise. Visits to providers for reasons of complaint or safeguarding are usually undertaken unannounced depending on the urgency or risk arising as a result of concerns raised.

- On achieving full compliance, a written report is produced.

4. Quality Ratings

The Council have developed a quality rating for providers based upon the following criteria:

- **Level A** - Full compliance with all 13 Primary and Supporting Outcomes.
- **Level B** - Full compliance with all 9 Primary Outcomes and compliance with at least 3 of the 4 Supporting Outcomes.
- **Level C** - Full compliance with all 9 Primary Outcomes and compliance with at least 2 of the 4 Supporting Outcomes.
- **Level D** - Not meeting requirements for Level C.

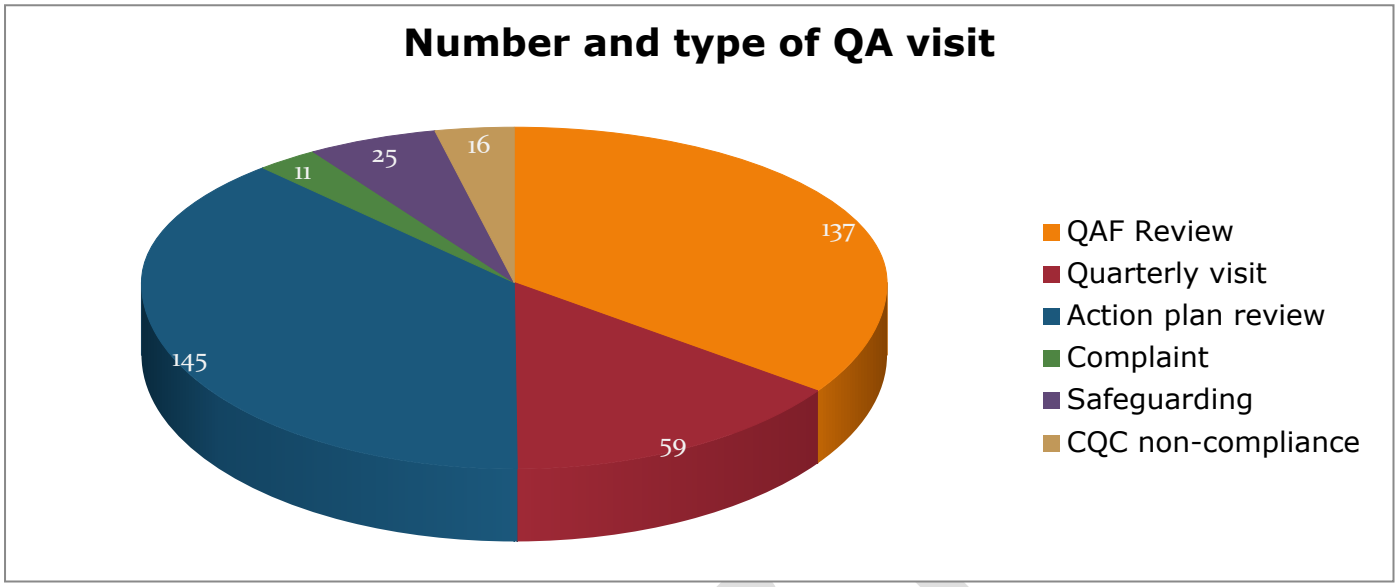
The quality rating enables a comparison to be made of the performance of providers across the social care sector. At the end of the 2nd QA cycle, all providers have received either an 'A' rating (compliant) or a 'D' rating (non-compliant).

Customer feedback

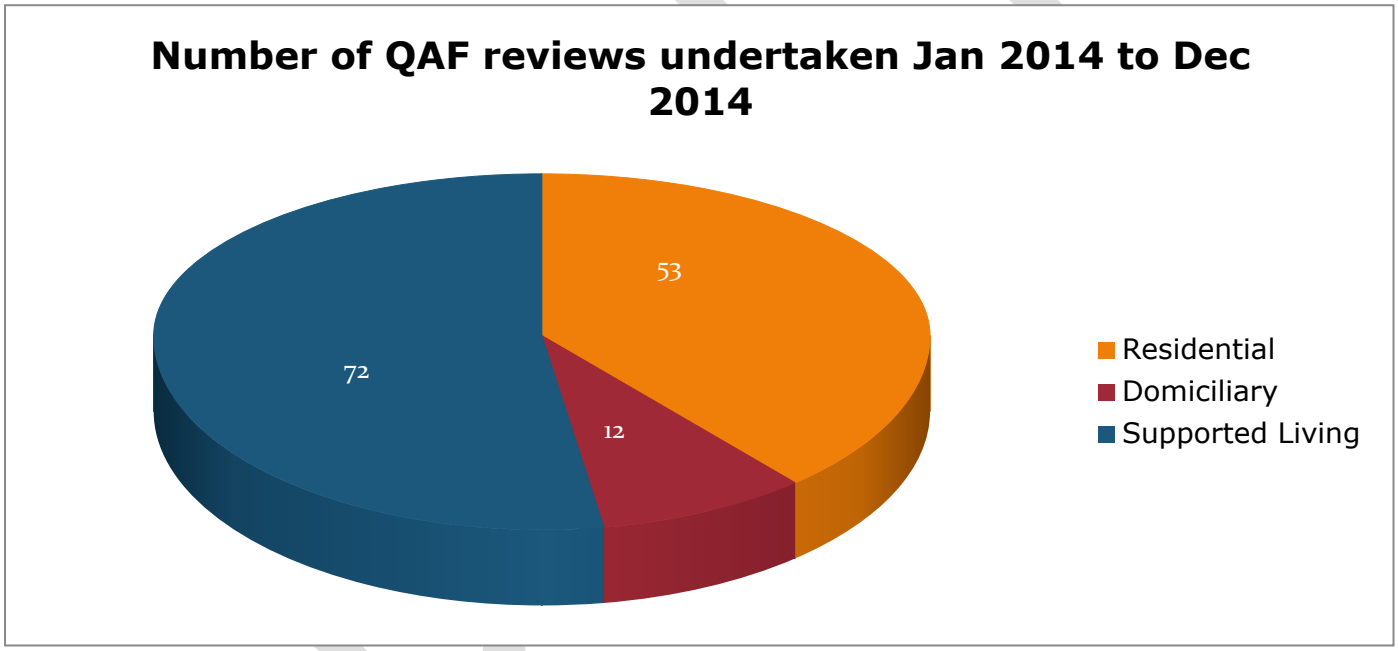
Customer and relatives feedback is collected, collated and reported back to the provider. Where issues are identified, these are brought to the provider's attention and relevant action requested. Customers and their families are involved in resolving any issues where appropriate and feedback given on issues raised.

5. Quality Assurance Activity

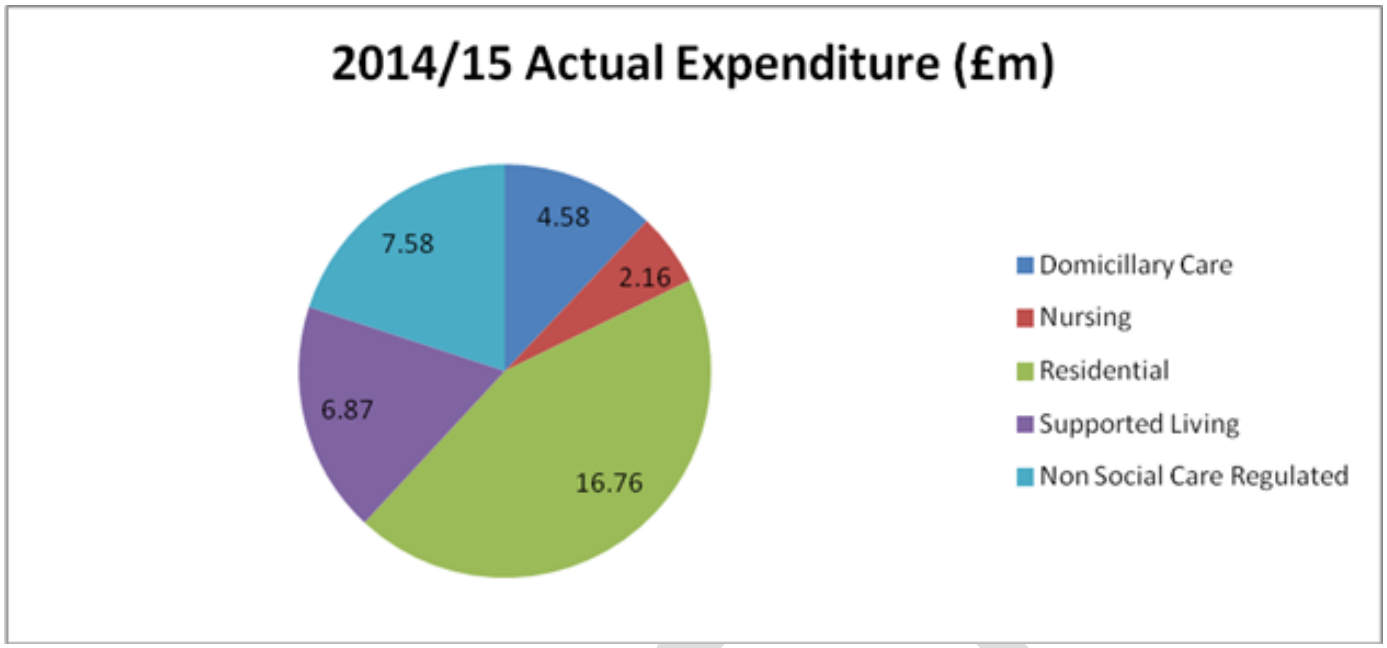
The chart below provides a summary of the key activities that were undertaken by the Quality Assurance and Development Team between October 2013 and March 2015. Approximately two thirds of activity undertaken relates to QAF Reviews and Action Plan Reviews, as would be expected. The remaining one third of activity relates to unexpected occurrences such as safeguarding, complaints and visits relating to providers who have been assessed by CQC as non-compliant.



The table below categorises QAF reviews according to type of provision.

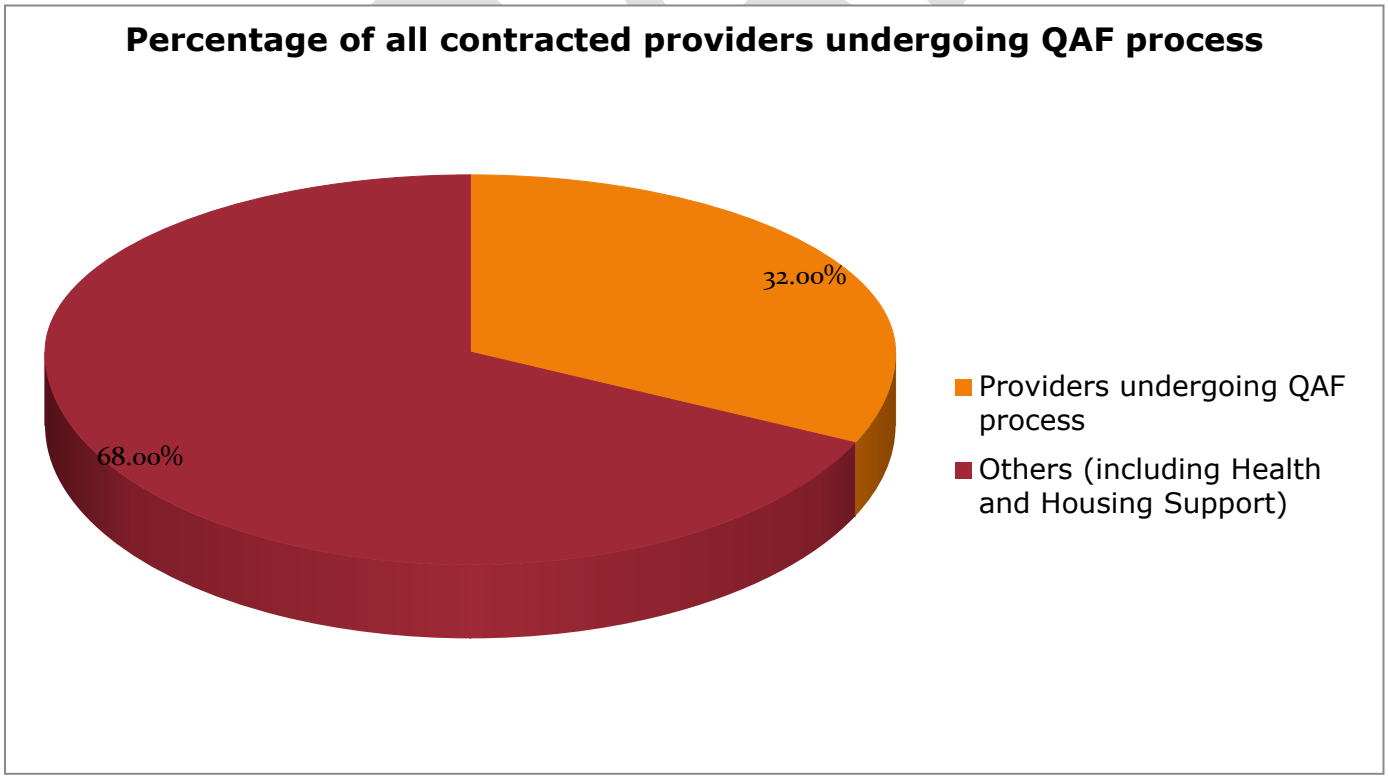


DCW holds contracts with 432 providers many of whom are not regulated by the CQC, for example, housing support or public health contracts such as smoking cessation. The chart below shows the actual expenditure across all contracts held by DCW in relation to health and social care contracts.

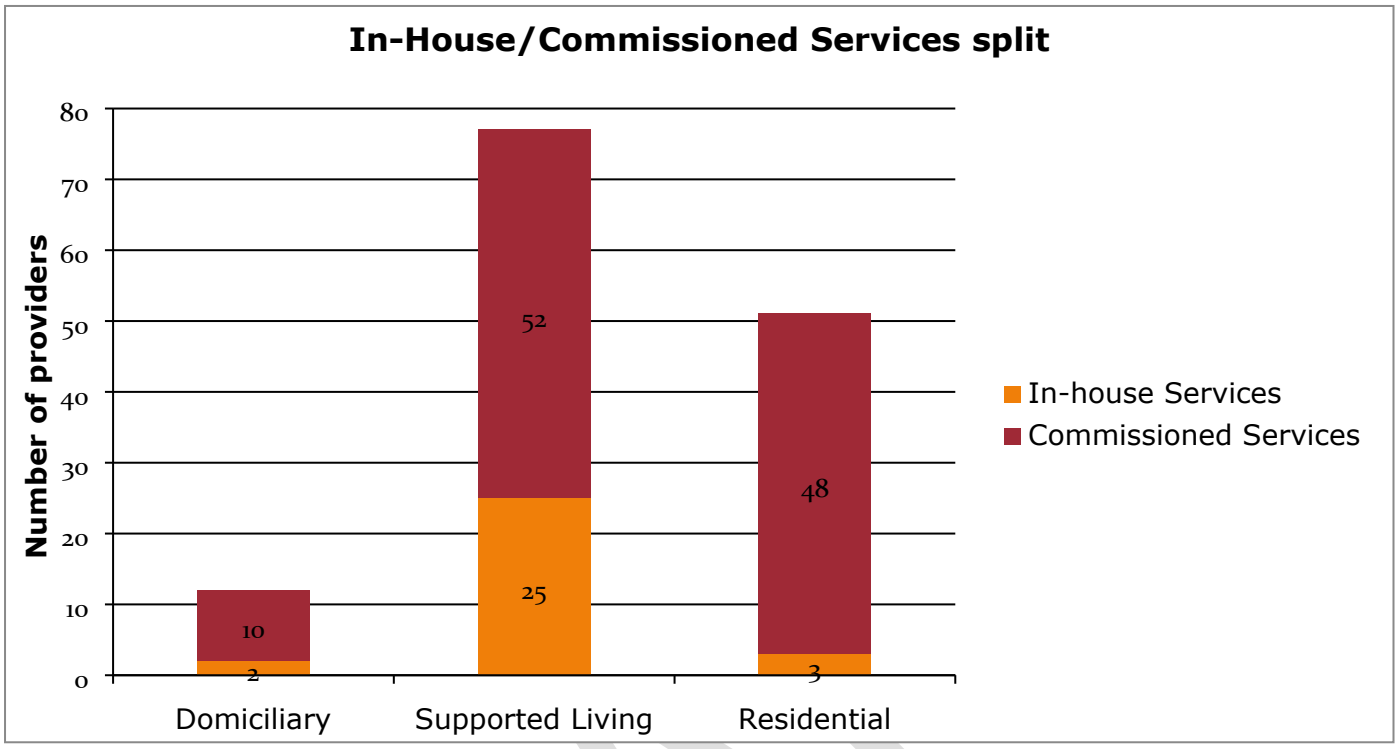


Some of these contracts are regulated by CQC but outside the scope of the QAF, for example, sexual health clinics as the QAF process is linked to Social Care contracts or those involving the personal care of vulnerable people.

The chart below shows the proportion of all contracted providers who have undergone the QAF process.



The majority of care services are provided by external services with in-house services accounting for approximately 20% of all services.



6. Localities Report

Care in the community has recently been reorganised into Localities. Social work teams now undertake care management according to the area in which people live.

LT1 covers people living in Prestwich and Whitefield (also Bolton and Manchester which are outside the scope of this report).

LT2 covers people living in Ramsbottom and Bury East (also Blackburn, Oldham and other Out of Borough placements which are outside the scope of this report).

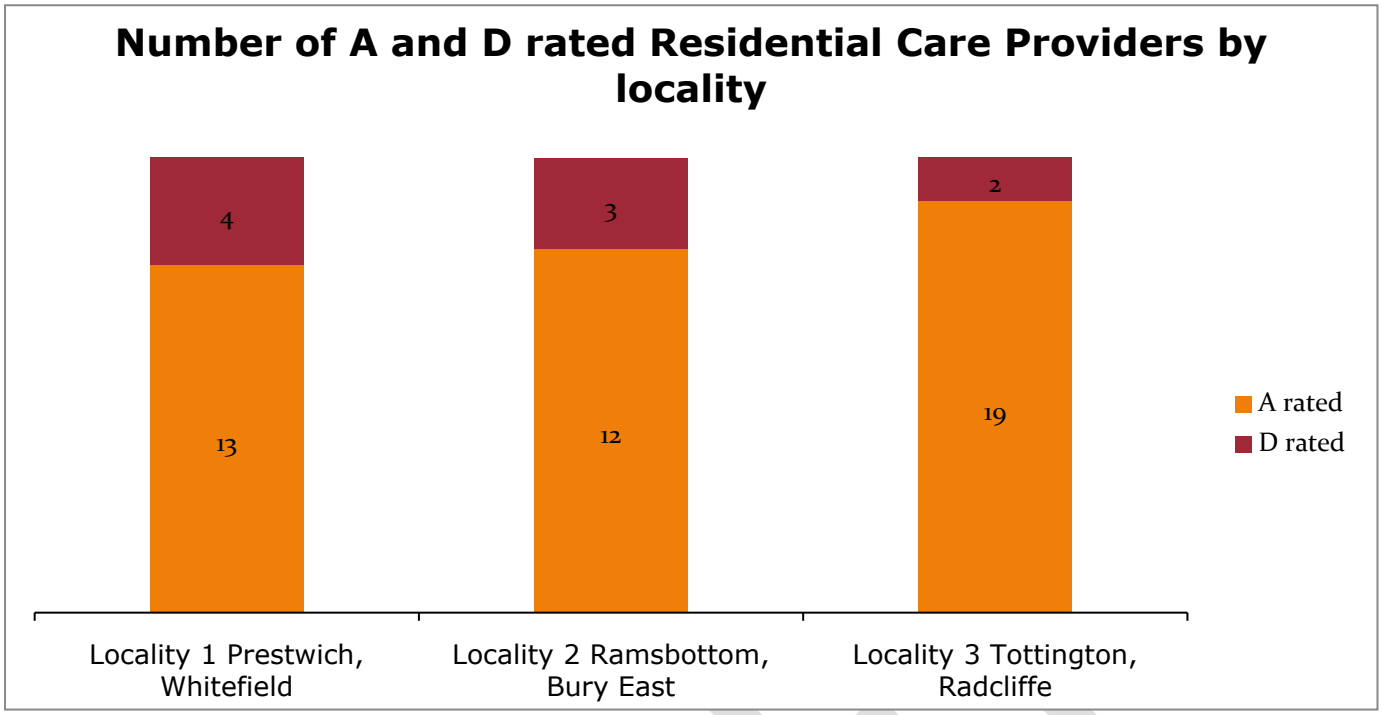
LT3 covers people living in Radcliffe, Tottington and Bury West.

See Appendix 1 for map of designated localities.

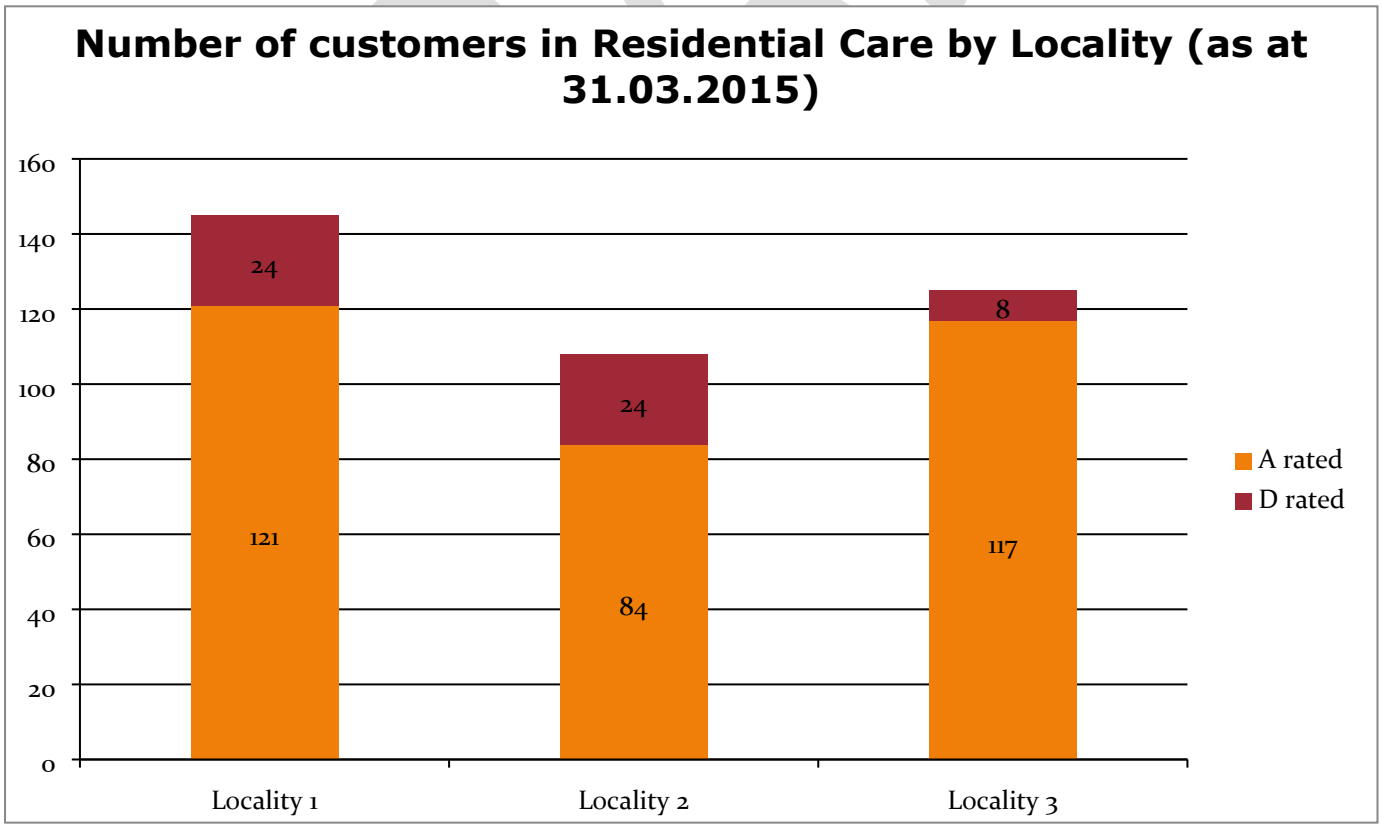
The following section analyses the standard of care across localities for all service provision.

Residential Care

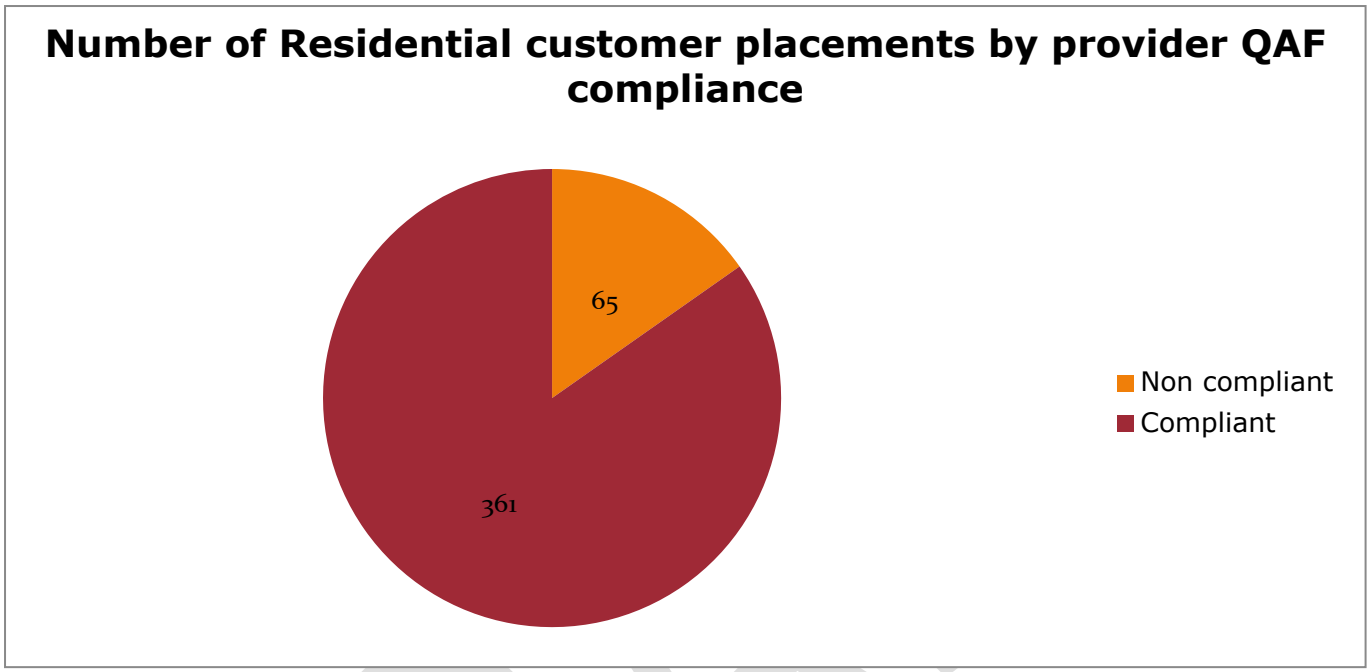
The chart below shows the number of A and D-rated Residential Care providers by locality followed by the number of customers living in those services.



The chart below shows the number of Bury funded customers living in A and D rated services by locality. It can be seen that the majority of customers are living in A-rated homes. Contract Officers are undertaking appropriate action on those services in receipt of a D-rating.

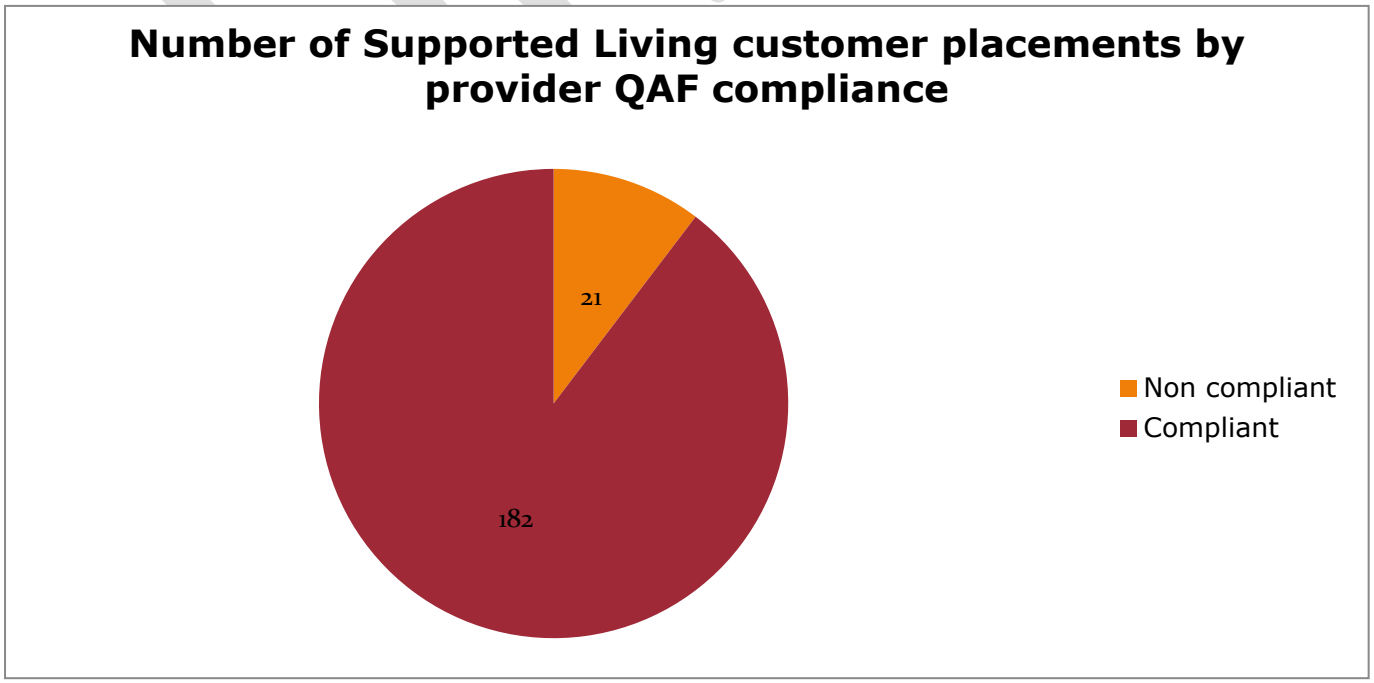


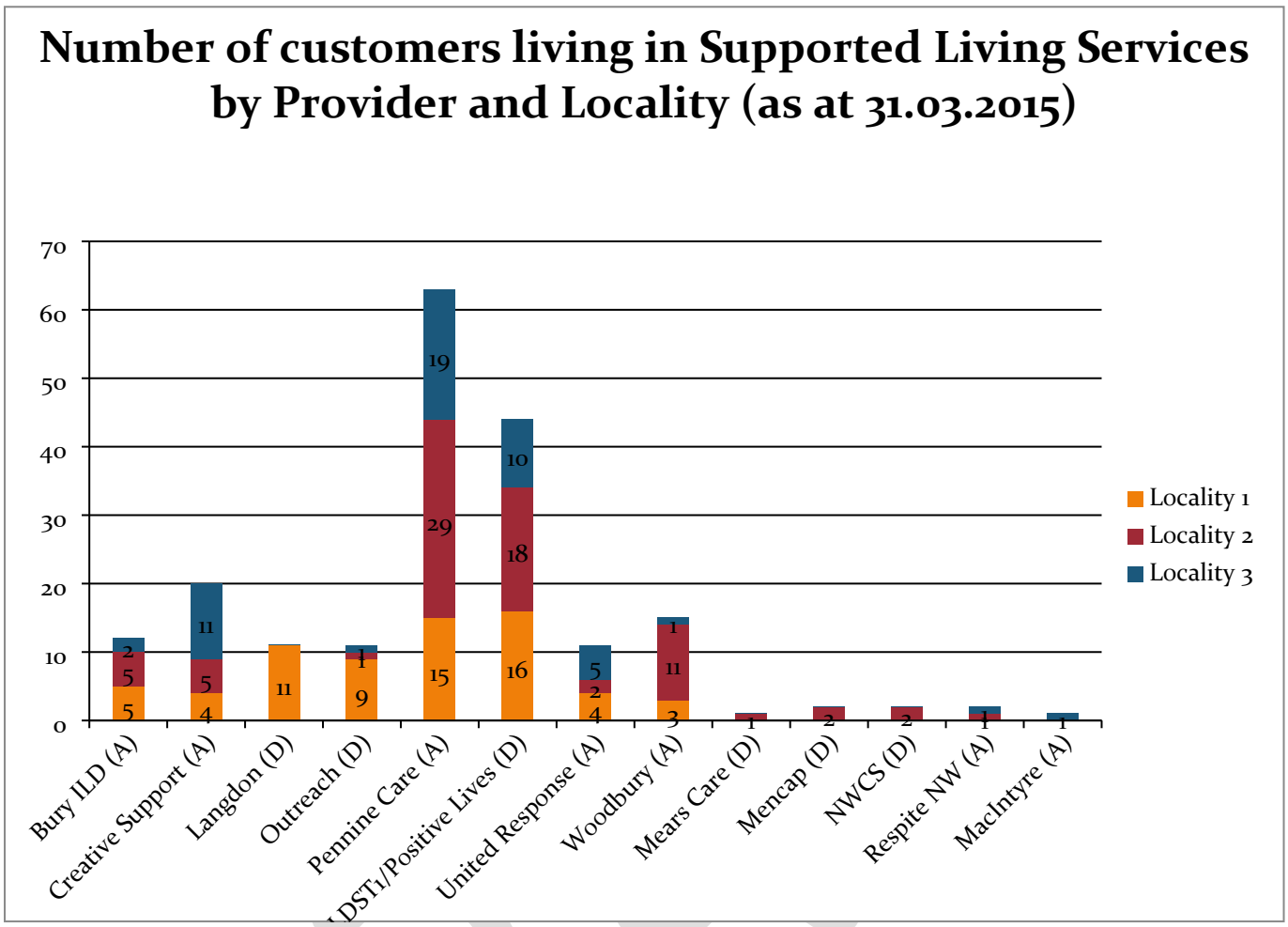
The chart below gives an indication of the number of customers living in services rated as non-complaint under the Council's QAF process. The reasons for non-compliance are detailed in Section 7 Outcomes Analysis.



Supported Living

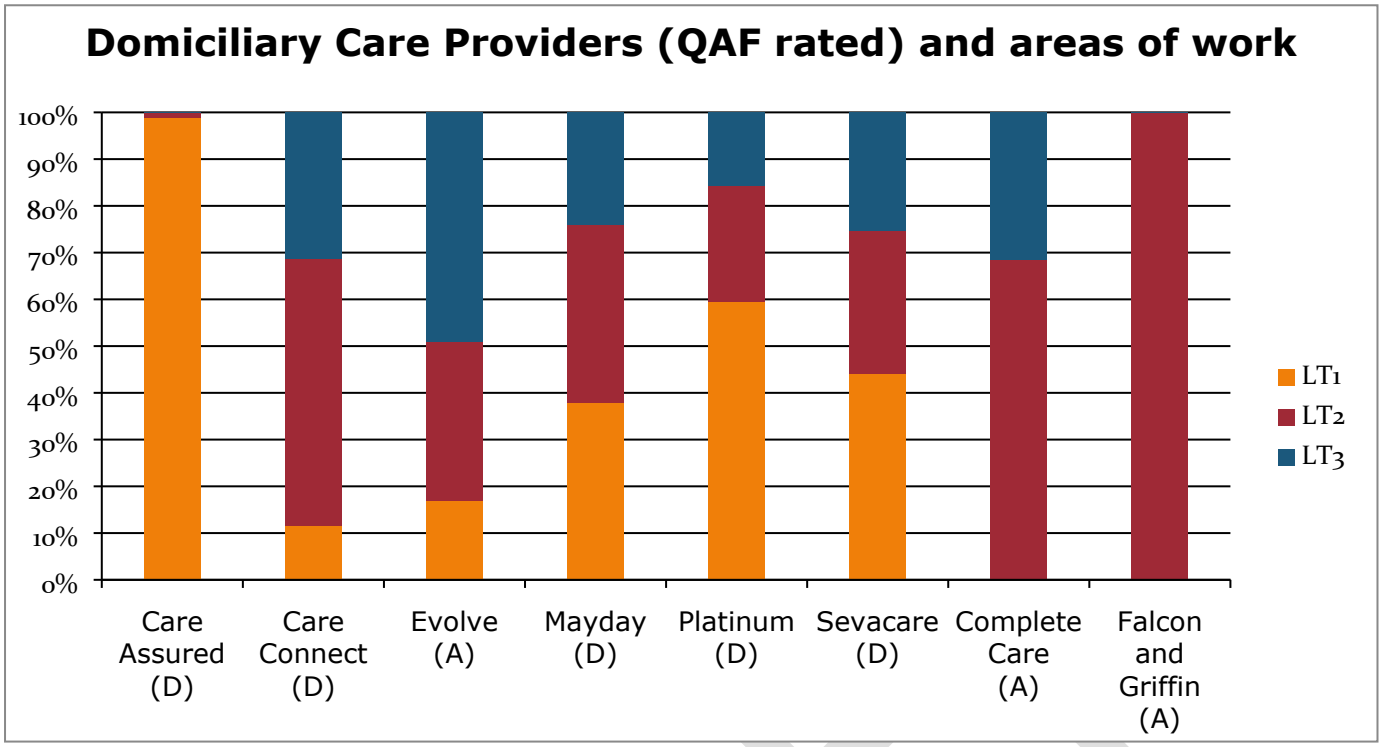
The chart below shows the number of Bury funded customers in receipt of Supported Living services and the rating of the service given by the Quality Assurance Officer. Again, the reasons for non-compliance can be seen in the Outcomes Analysis at Section 7.





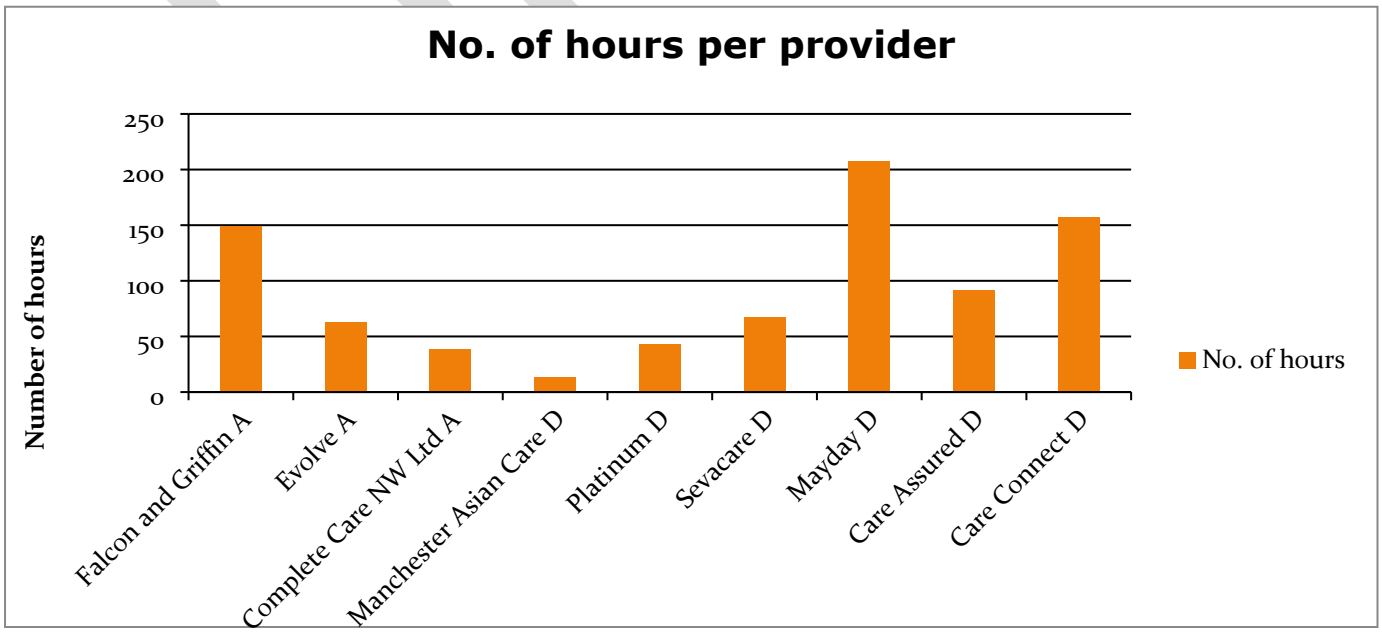
Domiciliary Care

It is not possible to classify Domiciliary Care providers in the same way as providers of these services tend to work across localities. The chart below shows the allocation of commissioned hours across each locality.

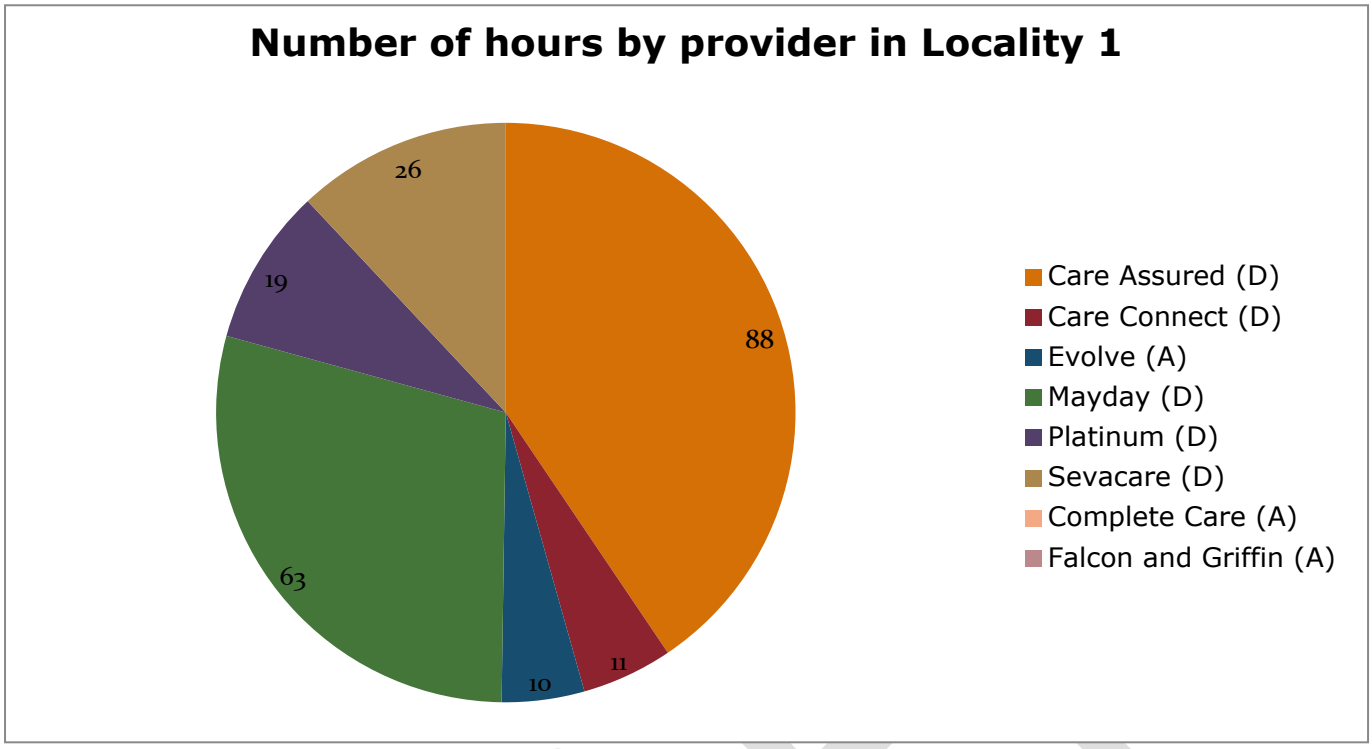


The chart below shows the number of hours commissioned by provider. The chart shows that Care Assured undertakes the majority of their work in one particular localities. The remaining providers undertake work across all three localities with the exception of Complete Care who concentrate their work in Localities 2 and 3. Falcon and Griffin is an exceptional case as they only provide care services to those who live within the Extra Care Scheme.

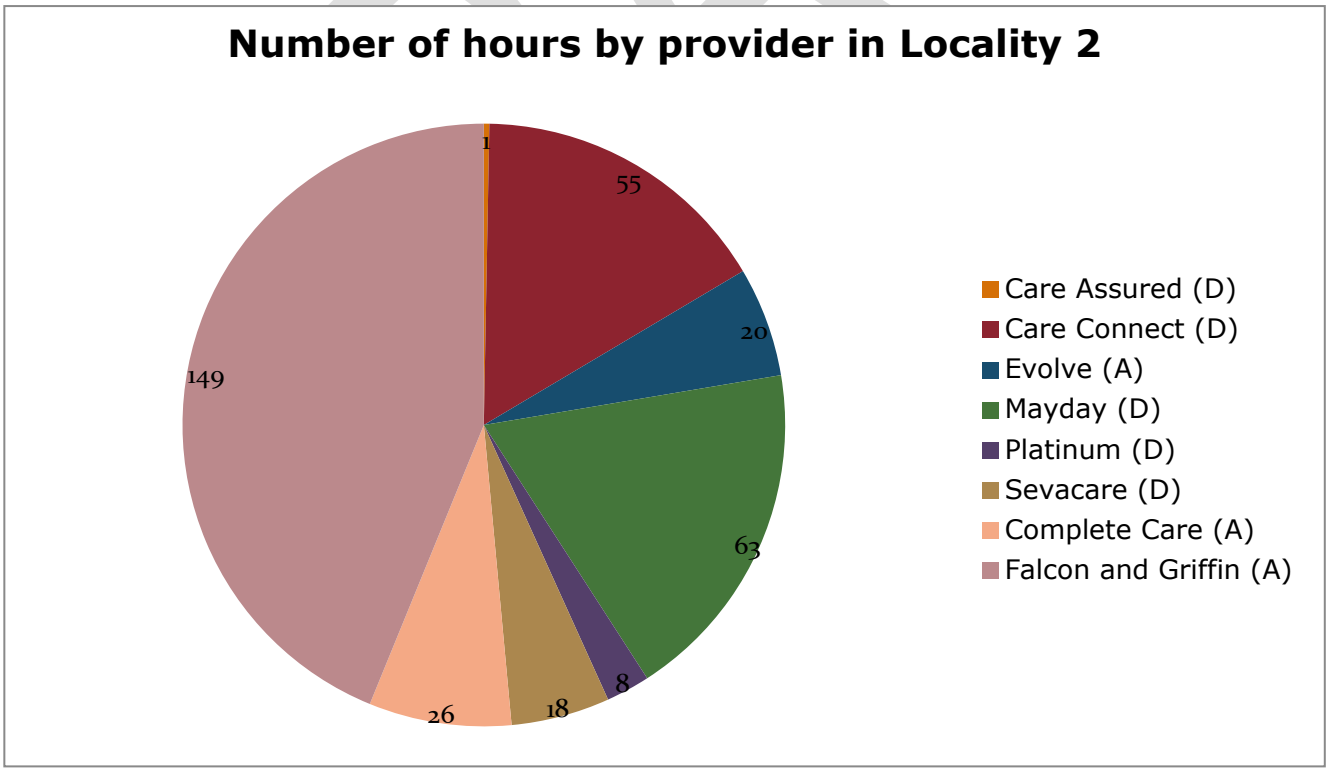
The chart below shows that, amongst external providers, Mayday is the largest provider of services with Manchester Asian Care being the smallest.



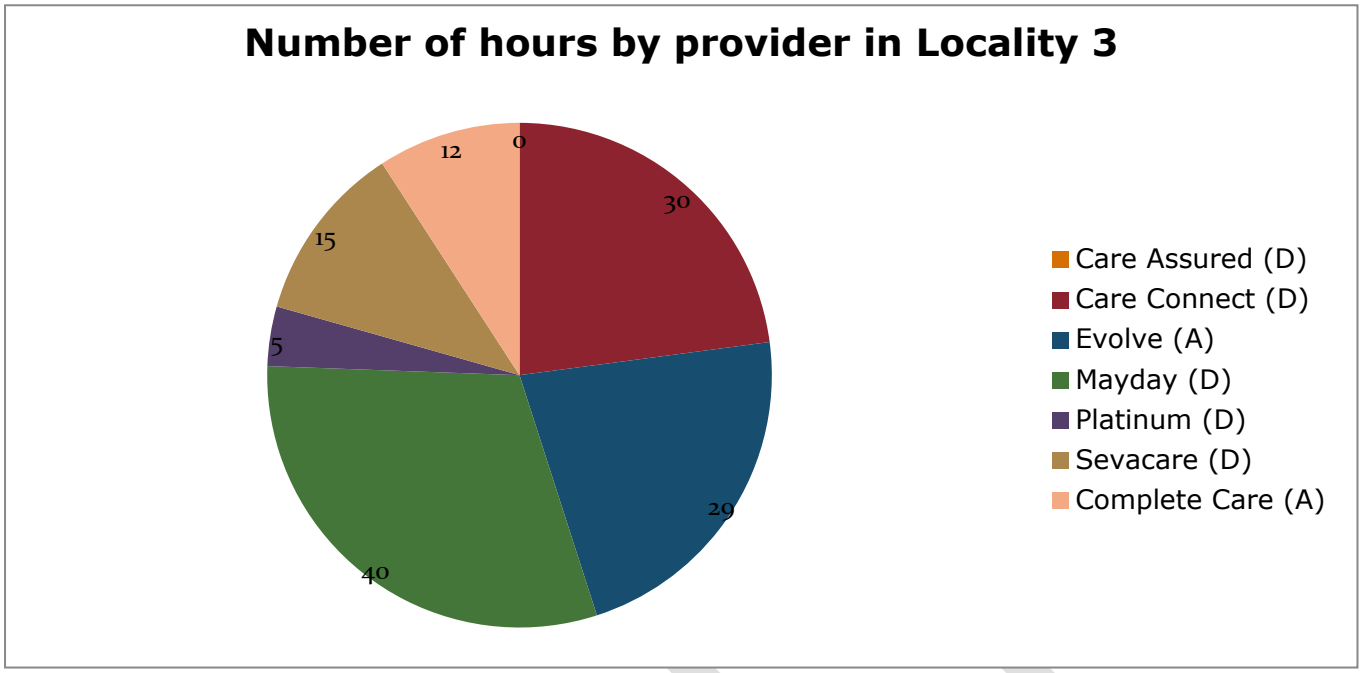
The following three charts show the number of commissioned hours delivered by providers across the borough by Locality.



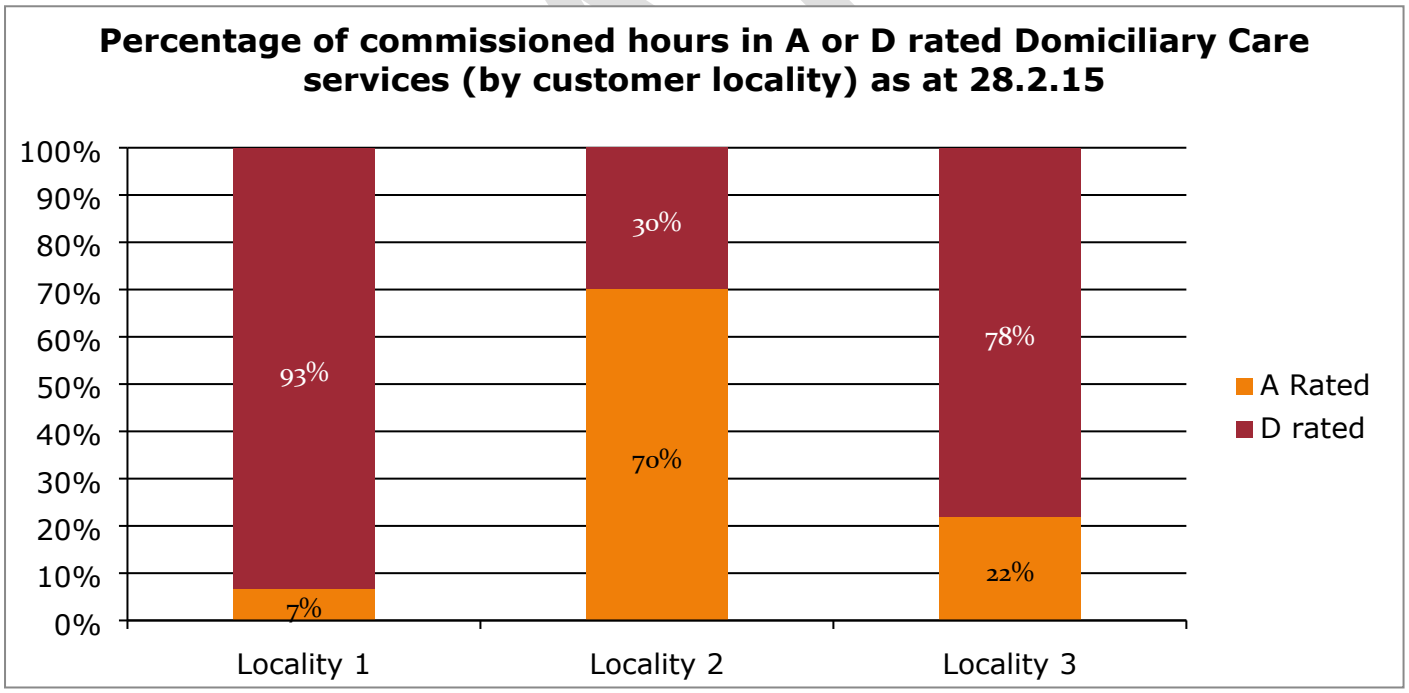
As can be seen in the chart above, Care Assured (with a D rating) conduct most of their service delivery in Locality 1 and are the biggest provider of services in this locality. Evolve is the only provider operating in this locality to have achieved an A rating. Evolve provide only ten hours of care in this area which is the minority share of commissioned hours.



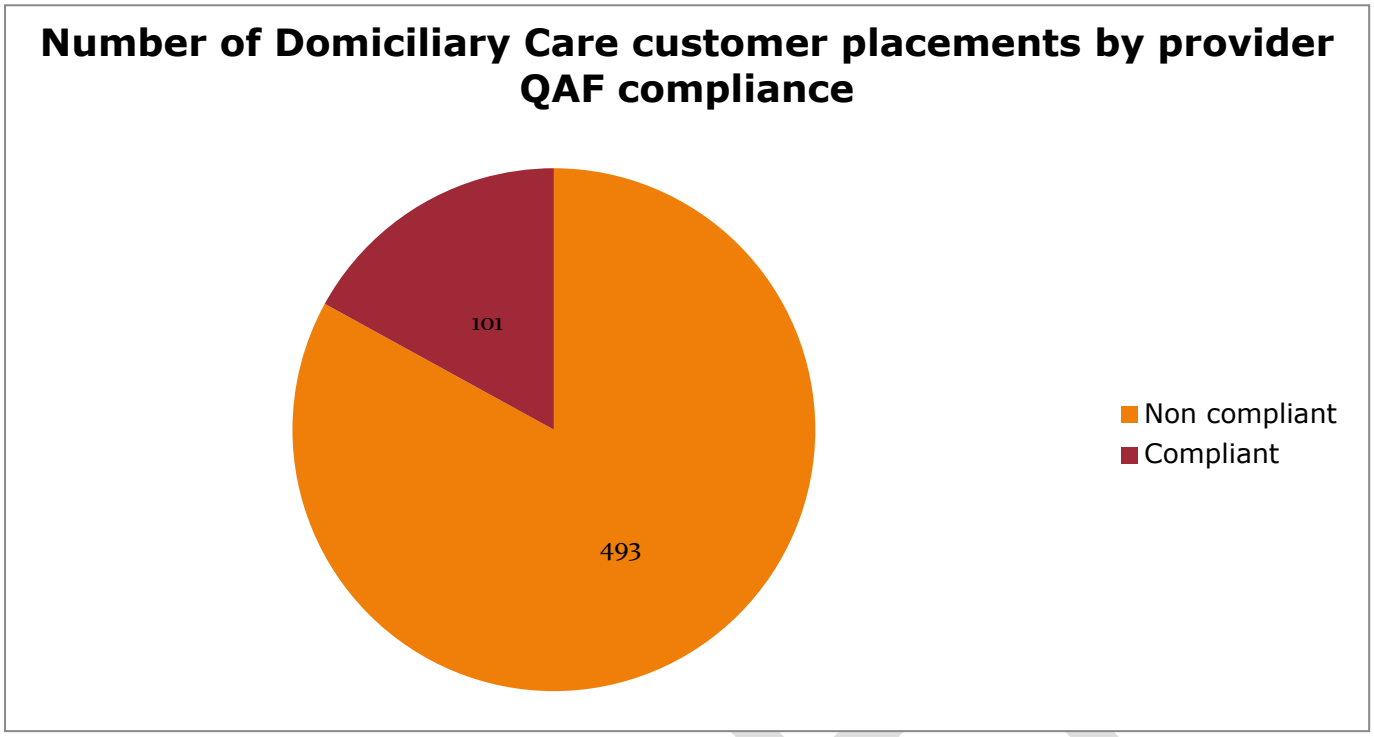
Falcon and Griffin (A rated), an in-house Extra Care Scheme, is based in Locality 2. Falcon and Griffin provides personal care to tenants in the scheme exclusively. Evolve and Complete Care combined (both A rated) deliver approximately one third of the remaining commissioned hours in the community.



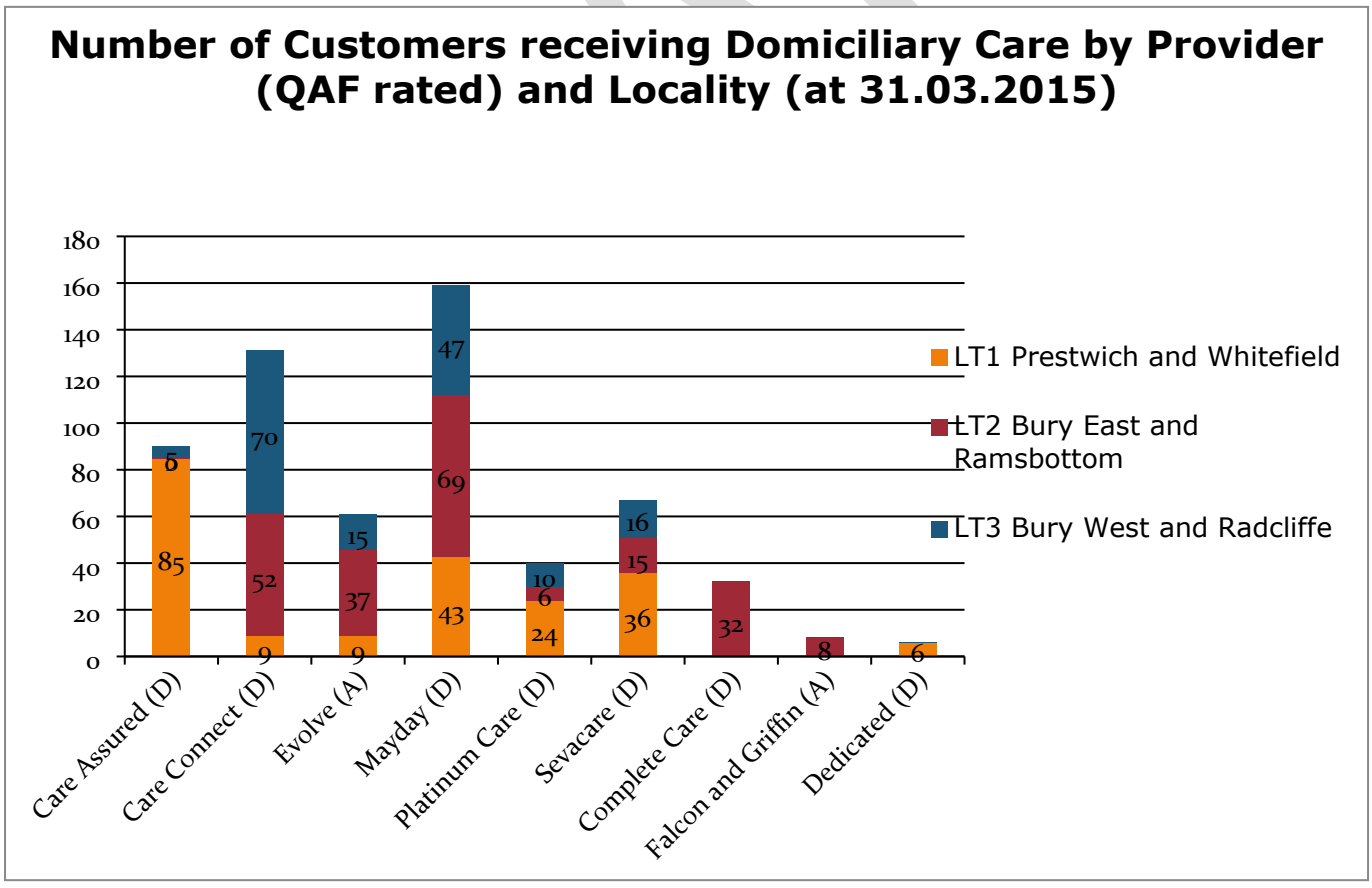
In Locality 3, Evolve and Complete Care jointly have the majority share of the commissioned hours.



The chart below gives an overall view of the number of customers in receipt of domiciliary care services from D-rated providers.



The chart below is a snapshot of the number of customers receiving services from each Domiciliary Care provider in each locality as at 31st March 2015.



On the face of it, customers receiving care services in their own home are receiving a poor quality service in Localities 1 and 3. This is partly due to the distribution of hours as discussed above. The main reason, however, is that 2014-2015 was the first QAF review undertaken for the majority of Domiciliary Care services due to the original QAF documentation proving to be

not fit for purpose. The first review framework contained over 600 individual questions, many of which were found not to be relevant to the services provided by a domiciliary care service and the QAF was redesigned as a result (see Appendix 2) to the benefit of both the QA team and all service providers.

As happened with Residential and Supported Living services in the first cycle of reviews almost all providers were non-compliant at the first review but with support from the QA team all services will be brought to a satisfactory performance level or relevant action taken.

This doesn't mean, however, that the Domiciliary Care providers were left to their own devices. The nature of this type of service provision means that there is much more interaction between the Procurement Service and Domiciliary Care providers on a day to day basis with issues being dealt with as and when they arise. This support in itself enables providers to highlight areas of improvement and raise the standards of service delivery.

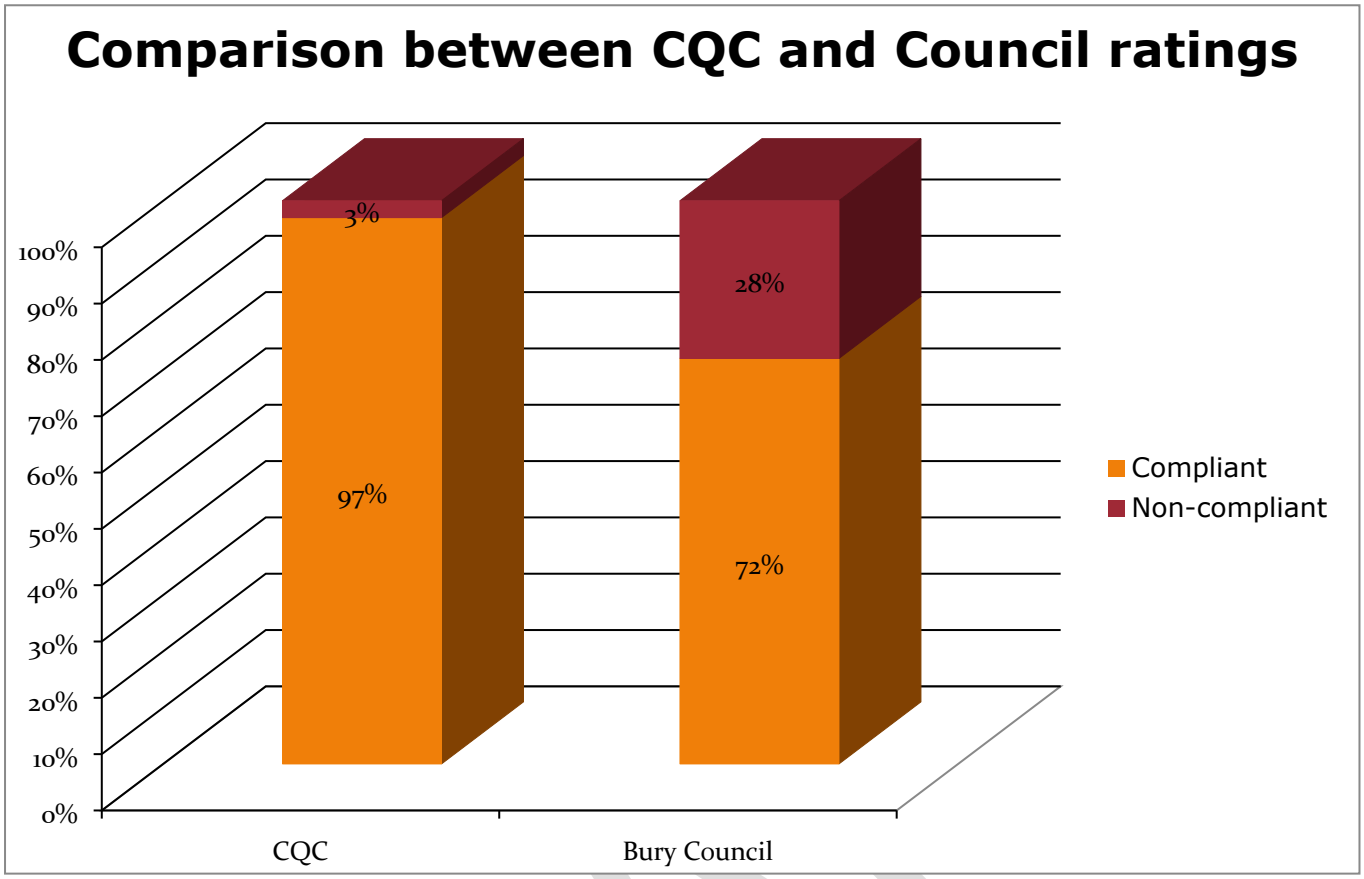
7. Quality and Compliance Ratings Analysis

7.1 Comparison of CQC and Bury Council Provider Quality and Compliance

CQC is the regulator for those services providing personal care to adults. CQC aims to ensure that all registered services are safe, effective, caring, responsive and well-led.

The chart below provides a comparison of the current percentage of all domiciliary and residential services that have been assessed as either compliant or non-compliant by both the Council and CQC.

For the period April 2014 to March 2015 approximately 97% of providers were assessed by CQC as being compliant with the Essential Standards of Quality and Safety under their inspection regime. For this same period, 72% of services have been assessed as fully compliant against Bury Council's QAF. The main reason for the difference in the percentage of compliant services is due to the Council assessing a provider's compliance against every outcome area whilst CQC focus on 3-5 outcome areas, which makes it more difficult for providers to achieve full compliance with the Council's framework. Whilst this approach is more stringent, the Council believes that it is important to assess each outcome area for compliance as this will support providers to deliver a higher quality service and give the QA team a more complete view of the quality of service provision.



CQC changed the way they inspect in April 2015. Ratings currently being allocated (since April 2015) seem to more closely reflect the findings of the QA team.

CQC now initially inspects all services based on intelligence-based risk factors. Five standards (safe, effective, caring, responsive, well-led) are judged to be outstanding, good, requiring improvement or inadequate and those ratings averaged out to provide an overall rating of 'Outstanding', 'Good', 'Requires improvement' or 'Inadequate'.

Those in receipt of an inadequate rating are deemed to be in 'special measures', which means they are given six months to put things right otherwise CQC will take steps to stop the service operating. A rating of 'Requires Improvement' will result in a further visit being made within six months. Those services receiving 'Good' or 'Outstanding' ratings will be inspected on a less frequent basis.

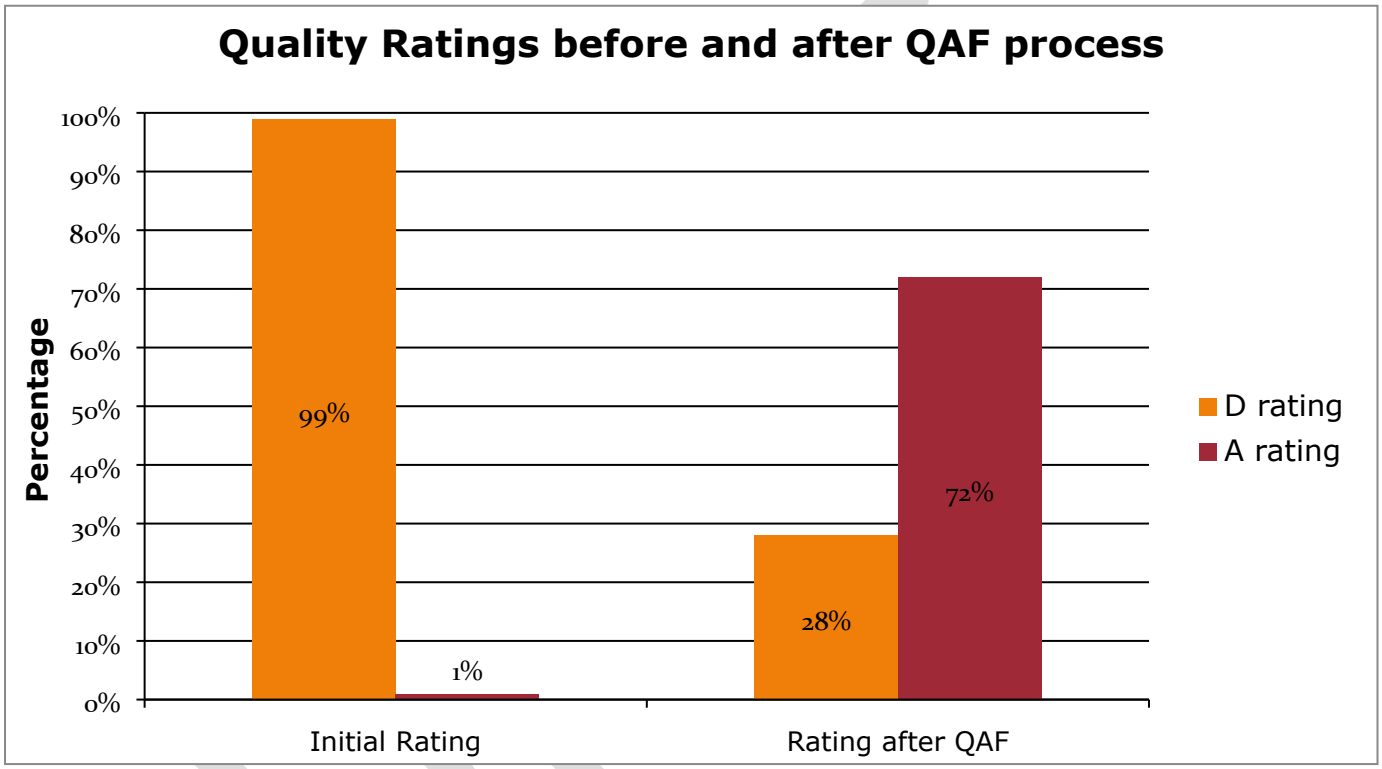
In some instances, CQC may return a rating of 'Requires improvement' where the Council have rated the service as being fully compliant. This could be for a number of reasons including CQC inspectors choosing to examine support plans relating to customers from outside the borough (whose files are not considered as part of the Council QAF process due to issues of confidentiality and Data Protection) and CQC inspectors observing particular incidents or behaviours on the day of their inspection.

Where ratings differ, the QA will draw up an action plan based on issues raised in the CQC report. The QA officer will then work with the provider to ensure all identified issues are addressed at the earliest opportunity.

7.2 Initial Quality Rating

The chart below provides a summary of the quality ratings that were awarded after the initial quality assessment was completed and the resulting improvement on completion of the QAF process. 99% of services had been initially assessed as Level D meaning that services were non-compliant with the Council's framework, which may result in a lower quality service being delivered to customers.

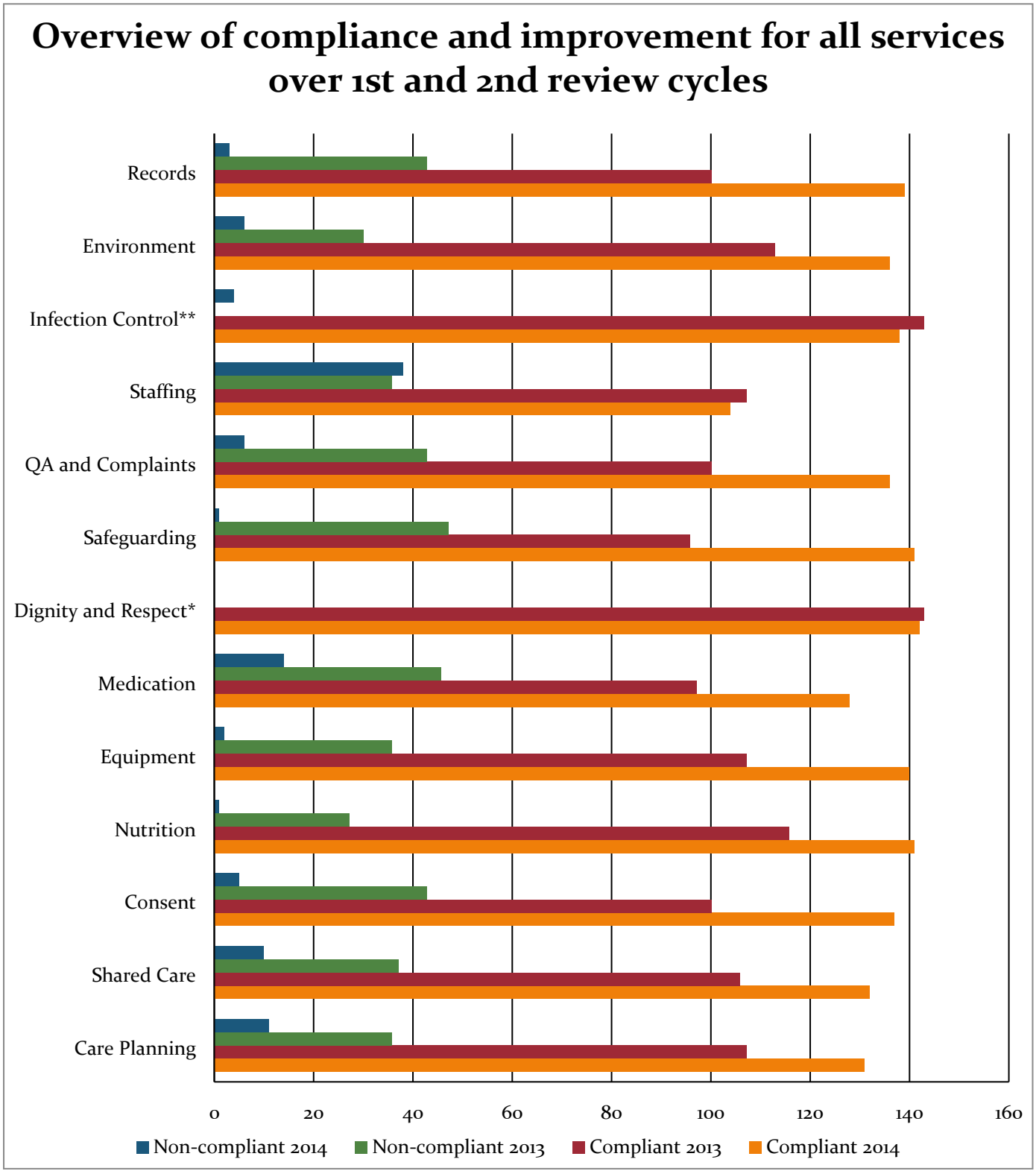
At the end of the QAF process, the percentage of services assessed as being Level A (fully compliant) increased from 1% to 72%. This is good news for the department and its customers as it demonstrates that providers are working with us to improve their service.



8. Outcomes Analysis

8.1 Percentage of all services compliant and non-compliant

The chart below provides an analysis of the percentage of all services that have been assessed as compliant and non-compliant by the Council in relation to each specific outcome of the Quality Assurance Framework.



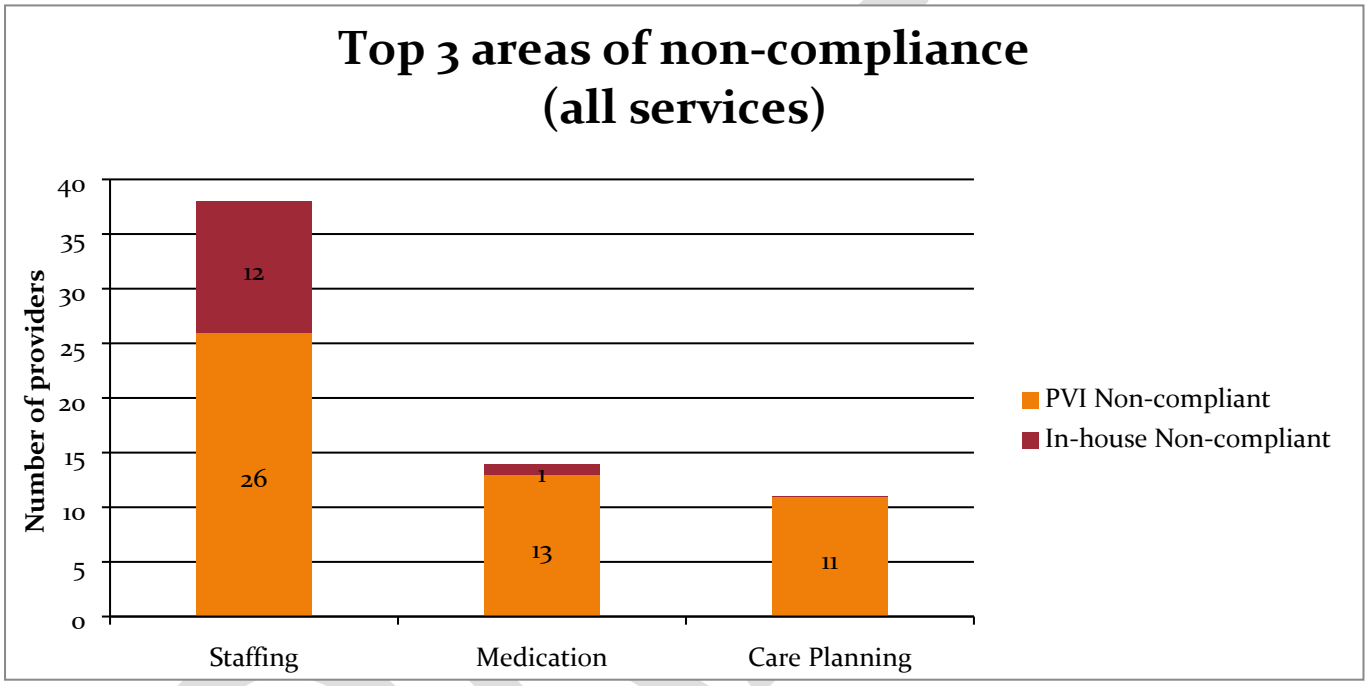
The green bar shows percentage of non-compliance with each outcome in the first cycle of the QAF review (2013-2014). As illustrated by the blue bar, all outcomes with the exception of Staffing showed a significant reduction in non-compliance in the latest QAF review (2014-2015).

8.2 Main Areas of Non-compliance - All Services

The following charts outline the top three outcomes currently assessed as being non-compliant across all service areas.

As illustrated below, the top three areas of non-compliance are Staffing (38 non-compliant); Medication (14 non-compliant) and Care Planning (11 non-compliant).

The graph below shows the split on non-compliance between PVI (Private, voluntary and independent) and in-house provision.



The top 3 outcome areas and reasons for non-compliance are:

- Outcome 10 Staffing
  - Staff had not undertaken the training or refresher training necessary for their role.
  - Staff had not been supported through a regular system of supervisions and annual appraisals.
- Outcome 6 Medication
  - MAR sheets had not been completed correctly and those errors were not reported and acted on immediately.
  - Protocols for PRN "as required" and variable dose medications were not in place.
- Outcome 1 Care Planning
  - Support plans including risk assessments not reviewed

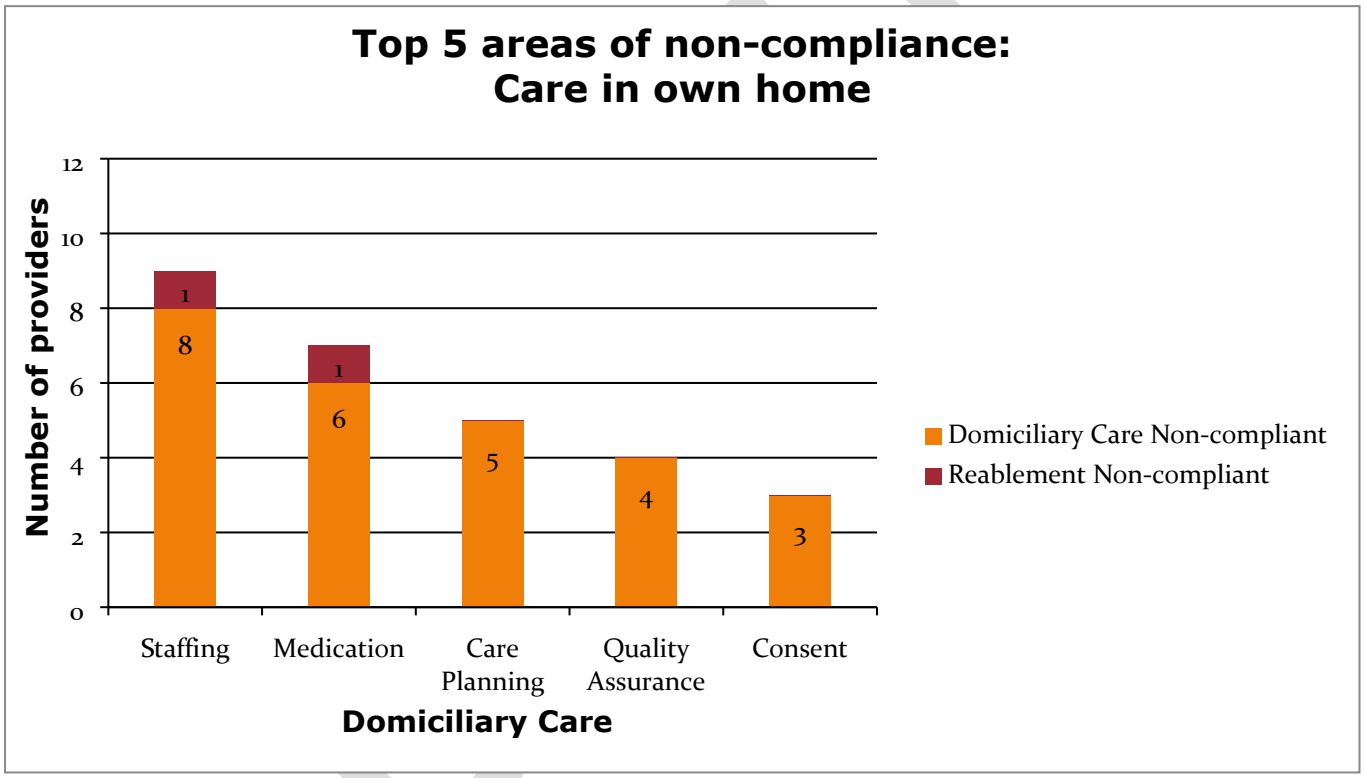
The Quality Assurance and Development Team have delivered best practice workshops on Medication Management, Consent and Quality Assurance in addition to undertaking individual on-site support sessions and regular reviews of actions plans.

The increase in non-compliance with the Staffing outcome is a result of a themed drive to raise standards in this area. Issues relating to staff training have been brought to the attention of the relevant Contract Officer.

It is anticipated that through these interventions providers will be fully supported and better able to achieve compliance at the earliest opportunity.

8.3 Top 5 Areas of Non-compliance – Care in own home

The charts below details the top areas of non-compliance for care services delivered in people's own homes:

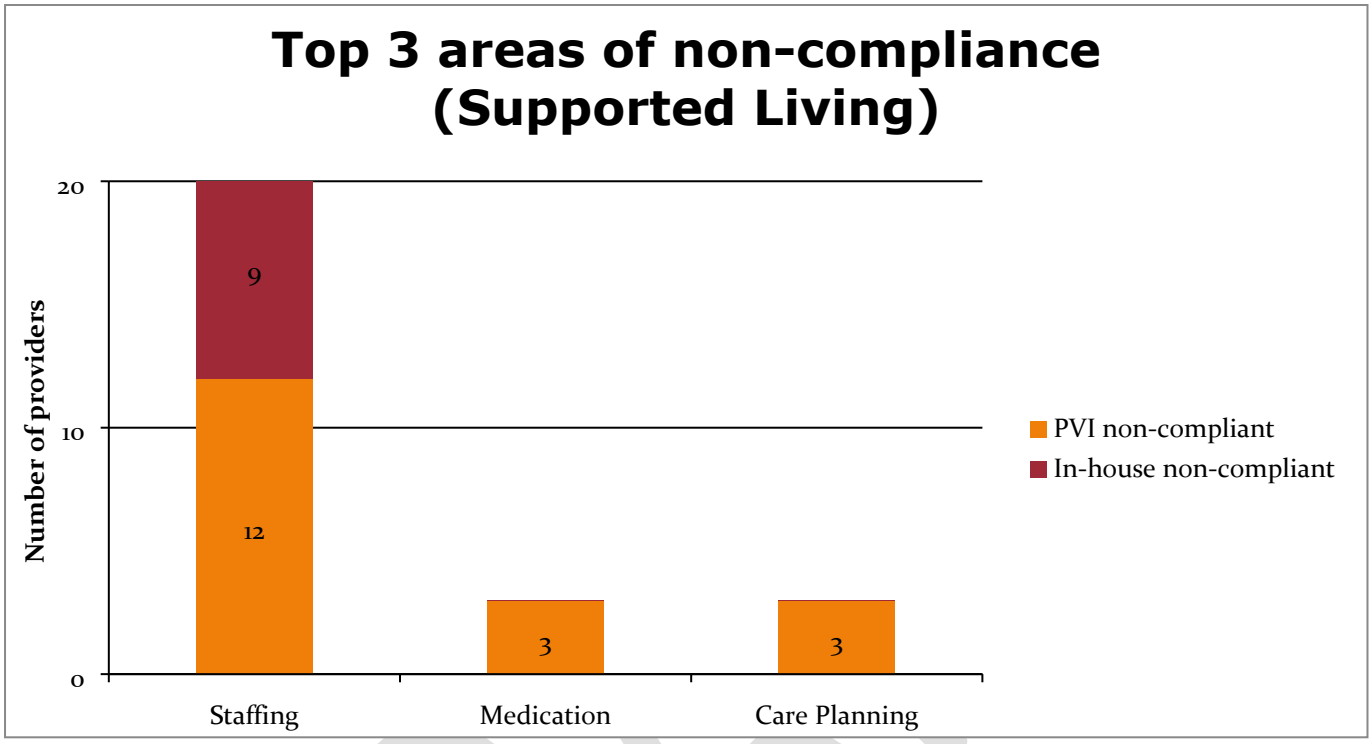


The top 5 areas of non-compliance are shown for Domiciliary Care services as this was the first time Domiciliary Care providers were reviewed under the QAF system. The top 5 outcomes and reasons for non-compliance are as follows:

- Staffing
  - Staff have not undertaken the training necessary for their role.
- Medication
  - PRN protocols not in place
  - Staff not following procedures, for example, not completing paperwork in accordance with policy
- Care planning
  - Support plans, including risk assessments, not reviewed appropriately
- Quality Assurance
  - Not undertaking appropriate audits

- Consent
    - Not obtaining or documenting consent appropriately

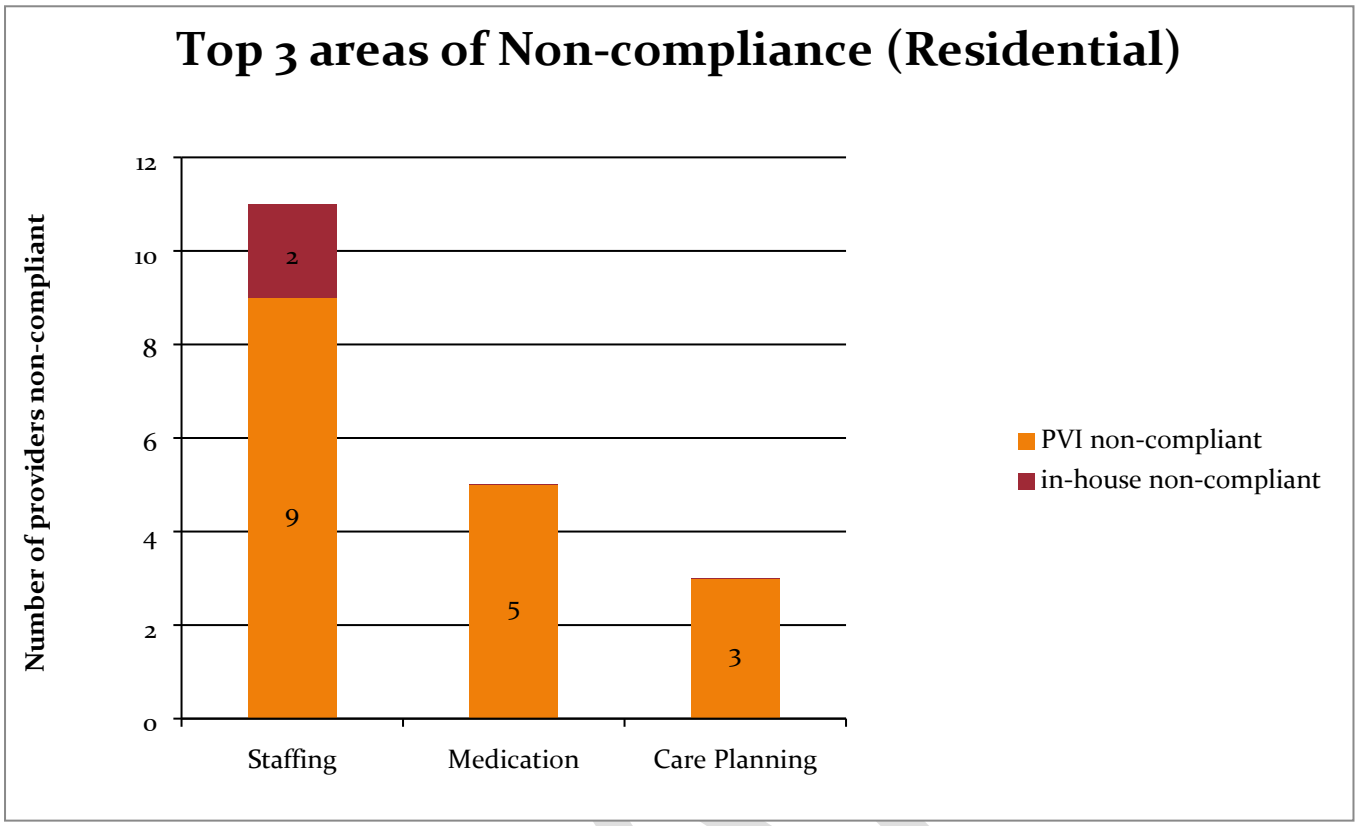
8.4 Top 3 areas of non-compliance comparison – Supported Living Services



The top 3 outcomes and reasons for non-compliance are as follows:

- Training
    - Staff have not undertaken the training necessary to perform their role.
- Medication
    - Paperwork errors resulting from not following procedures
- Care planning
    - Support plans including risk assessments not reviewed

8.5 Top 3 Areas of Non-compliance - Residential Care



The top 3 areas of non-compliance in residential care are:

- Staffing
  - Staff have not undertaken the training necessary for their role
- Medication
  - Staff not following procedures
- Care Planning
  - Care plans including risk assessments not reviewed

9. Conclusion

The 2nd cycle of the QAF process has now been completed for Supported Living Services and Residential Services. This report shows that although there are again areas of non-compliance these are much fewer than last year and providers can easily be brought back to compliance.

As mentioned in Section 6, the majority of Domiciliary Care agencies have undergone the QAF process for the first time, due to the original framework proving to be not fit for purpose for this type of service provision, which accounts for the greater number of non-compliant outcomes and is line with the results achieved by Residential and Supported Living providers in their first cycle.

Since the implementation of the Council's revised Quality Assurance Framework in September 2013 it has been evidenced that the quality of services has significantly improved with an increase of 72% of services becoming fully compliant and being awarded a Level A Quality Rating.

It should be noted that whilst there has been a positive shift to the quality of services, work continues to be undertaken with providers to improve the overall quality of the social care market and also maintain the high standards that are being achieved. The QA team operate a supportive approach which includes telephone support, quarterly visits and invitations to attend workshops developed in response to the areas of non-compliance found.

Provider surveys are undertaken to gauge the response of providers to the support offered. The survey carried out in August 2014 (correlating to this cycle of reviews) showed that 81% of respondents thought the QAF process was useful in helping to achieve a quality service and CQC compliance. 89% of respondents thought the guidance, advice and direction offered by the QA team was good or better with only one provider stating the service offered was poor.

It should also be noted that CQC changed the way they inspect and report in April 2015 following the introduction of the Fundamental Standards and associated regulations. Their inspection process has become much more robust and has resulted in a higher number of non-compliant providers or, since new ratings introduced, providers whose service is deemed to be inadequate or requiring improvement. In some cases, the Council's QAF process results in a fully compliant rating but CQC have returned a "Requires improvement" rating, which will trigger a return visit in 6 months, or an "Inadequate" rating which would put the provider in "Special Measures" (see Appendix 3). The basis for these ratings could be as a result of a variety of indicators including practice observed on the day; the records looked at and, in some cases, CQC having access to the action plan issued by the Council. In many cases, the CQC inspector contacts the team in advance of an inspection to ask if we have any concerns.

The results presented in this report show that the Quality Assurance and Development Team continue to be highly effective in improving the quality of the services the Council commissions on behalf of our customers.

APPENDIX 1 – Map of designated localities

APPENDIX 2 - Quality Assurance Framework

As mentioned in Section 6, the QAF was redesigned in 2013. The original framework comprised more than 600 questions over 28 outcomes taken directly from CQC's Essential Standards of Quality and Safety. The 28 outcomes were found to contain a lot of duplication and some of the outcomes related to regulatory practice which neither ourselves or the providers had any control over.

When this framework was put into operation, it was found to be too onerous for providers to complete meaningfully and for QA officers to assess. As a result, the framework was redesigned by removing questions which didn't apply to the types of services we commission and amalgamating and recategorising others to make them more meaningful in everyday practice. The number of questions was reduced to approximately 140 over 13 outcomes which was more manageable for both providers and QA officers yet still produced the same results. The introduction of the QAF was also acknowledged as being a great improvement by providers.

The redeveloped QAF comprised 13 outcomes. Shortly after the redesigned QAF was put into action, CQC announced the introduction of the Fundamental Standards which closely resembled the Outcomes identified by the new QAF.

CQC and Special Measures

The extract below is from the CQC website and briefly identifies the process to be followed when a provider is deemed to be "Inadequate".

We want to ensure that services found to be providing inadequate care do not continue to do so. Therefore we have introduced special measures. The purpose of special measures is to:

- *Ensure that providers found to be providing inadequate care significantly improve.*
- *Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.*
- *Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example to cancel their registration.*

Further information can be found via the link below:

http://www.cqc.org.uk/sites/default/files/20150401_special_measures_guidance_ASC.pdf

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Team Bury
Working Together For A Better Bury

Executive Summary

Bury Locality Plan

'Bolder, Braver Bury – Towards GM Devolution'

2016 - 2021

Version – Final (Updated)
Published – 25 November 2015

OUR APPROACH

Our vision is to ensure our population is as healthy, happy and independent as possible, living with minimal intervention in their lives. This will be achieved through targeted strategies of self help, prevention and early intervention, reablement and rehabilitation. When needed, formal care and support will be designed to create a coordinated and seamless health and care system. All services will be person-centred and will build on and develop local community assets.

This will be achieved through targeted strategies of self help, prevention and early intervention, reablement and rehabilitation, which will support reductions in activity in acute services – supporting financial sustainability. When needed, formal care and support will be designed to create a coordinated and seamless health and care system. All services will be person-centred and will build on and develop local community assets.

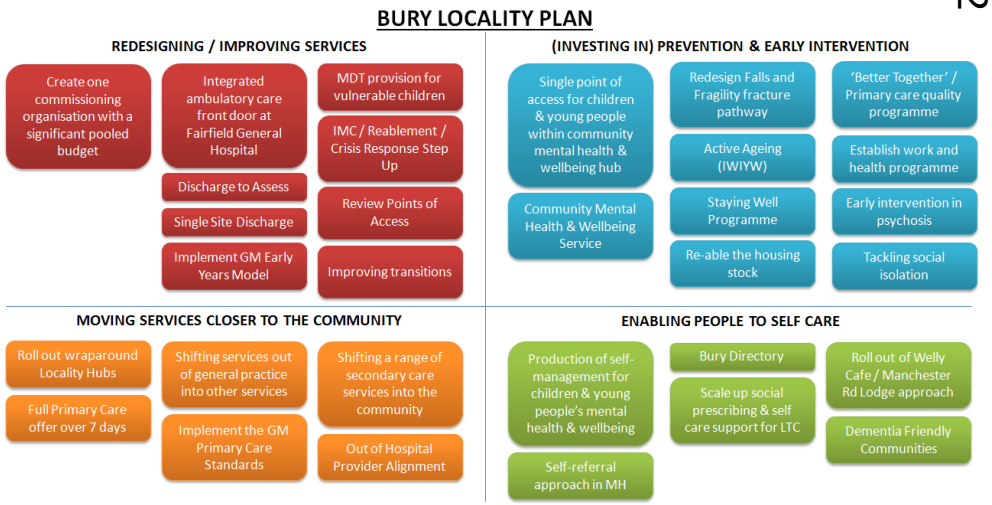
Our approach is a simple one - in order to achieve a narrowing of the potential financial gap at the same time as delivering consistent or improved outcomes for our population, there will be four key themes to our work locally:

1. **Redesigning & Improving Services**: Our intention is to maximise the use of the Bury pound to support the citizens of Bury to live longer, happier lives, ensuring that everything we do is fit for purpose and as efficient and effective as it can be. We will quickly develop and upscale a number of services/projects in order to save money and to create an investment fund for our longer term work, whilst maintaining or improving outcomes for the people of Bury. We will also be changing the way we commission services and from whom. Health and Social Care will work together as if one commissioning organisation with aligned commissioning intentions, a significant pooled budget and shared back office functions.

3. **Moving Services Closer to the Community**: Here we will start to move services out of acute settings and into appropriate community ones. Some of this will require investment / pump-priming.

4. **Investing in Early Intervention & Prevention**: We will invest in evidence led interventions which will be designed to reduce the prevalence and severity of health conditions over the short, medium and longer term.

5. **Enabling People to Self Care**: Here we will work to engage people in being part of the solution and ensuring they take a significant and active part in living longer and more healthily.



Vision

Our vision is to ensure our population is as healthy, happy and independent as possible, living with minimal intervention in their lives. This will be achieved through targeted strategies of self help, prevention and early intervention, reablement and rehabilitation. When needed, formal care and support will be designed to create a coordinated and seamless health and care system. All services will be person-centred and will build on and develop local community assets

Key issues

- Increasing the proportion of adults in contact with secondary MH services who live in stable and appropriate accommodation
- Decreasing the under 75 mortality rate from cancer, cardiovascular, respiratory and liver disease
- Reducing male early deaths from all causes (& inequalities between most & least deprived areas)
- Reducing the number of emergency admissions for acute conditions that should not usually require hospital admission
- Increasing the health-related quality of life for people with long term conditions

GM Devo Themes

- COMMISSIONER REFORM / SHARING BACK OFFICE
- BETTER CARE
- PREVENTION

Bury Themes

- COMMISSIONER ALIGNMENT
- REDESIGNING & IMPROVING SERVICES
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Bury Locality Plan Projects

- Create One Commissioning Organisation with a significant pooled budget
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  - Integrated ambulatory care front door at Fairfield General Hospital
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- Production of self-management for children & young people's mental health & wellbeing
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- Scale up social prescribing & self-care support for LTC
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- Active Ageing (IWIYW)
- Staying Well Programme
- 'Better Together' / Primary care quality programme
- Establish Work & Health Programme
- Early Intervention in Psychosis
- Re-able the housing stock

Enablers

- Making best use of our estate & physical assets
- Transformation of our workforce
- Joint governance of our system
- Developing our local contracting mechanisms
- Ensuring health is all of our business
- Developing an assets based approach
- Ensuring people know, understand & are more motivated to act upon the messages
- Developing & stimulating the Third Sector
- Personal ownership & accountability
- Understanding our people better
- Integrated assessment & recording
- System leadership

CONTEXT

We will also need to work in close synergy with the wider thematic work being undertaken at a Greater Manchester level. These include:

- Key Greater Manchester wide devolution programmes
- Wider work around public service reform
- Public Health Memorandum of Understanding programme
- plans developed by providers to deliver better care with higher levels of productivity and more effective use of their combined estates
- work delivered locally and regionally by the 'Transformation Prospectus'
- The impact of the Healthier Together programme
- The transformation plans of Pennine Acute Hospitals Trust
- Local and regional responses to the NHS 5 Year Plan

Most of the ill health suffered by our local population is not inevitable but can be seen as a consequence of how we organise and manage our society. Devolution offers a massive opportunity to gain more control over these wider determinants of health and re-create a system and society that does more to promote and enhance health and well-being.

PRIORITIES

Five consistent themes are shown throughout the Joint Strategic Needs Assessment:

- The consequences of the growth and profile of our population will increase demand for services, particularly from older people
- The effect of social deprivation on poorer health outcomes for some of our population compared to others
- Social exclusion is both a cause and consequence of poor health outcomes and often results from limited rights, resources and opportunities
- The impact of lifestyle choices which are increasing the demand on services, increasing inequalities and will result in higher levels of ill-health and lower levels of wellbeing
- Premature mortality is higher than expected given our levels of deprivation

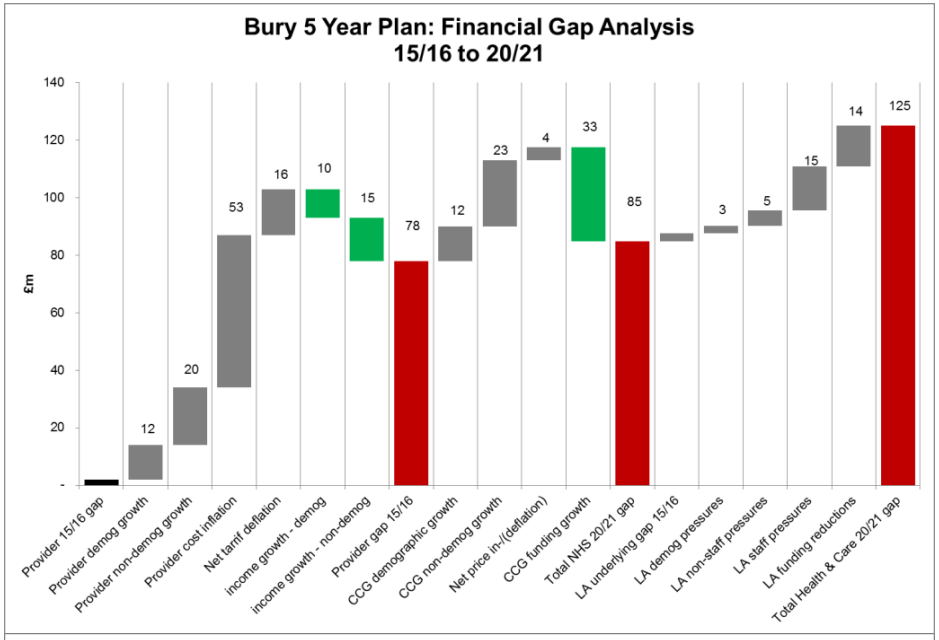
THE FINANCIAL CHALLENGE

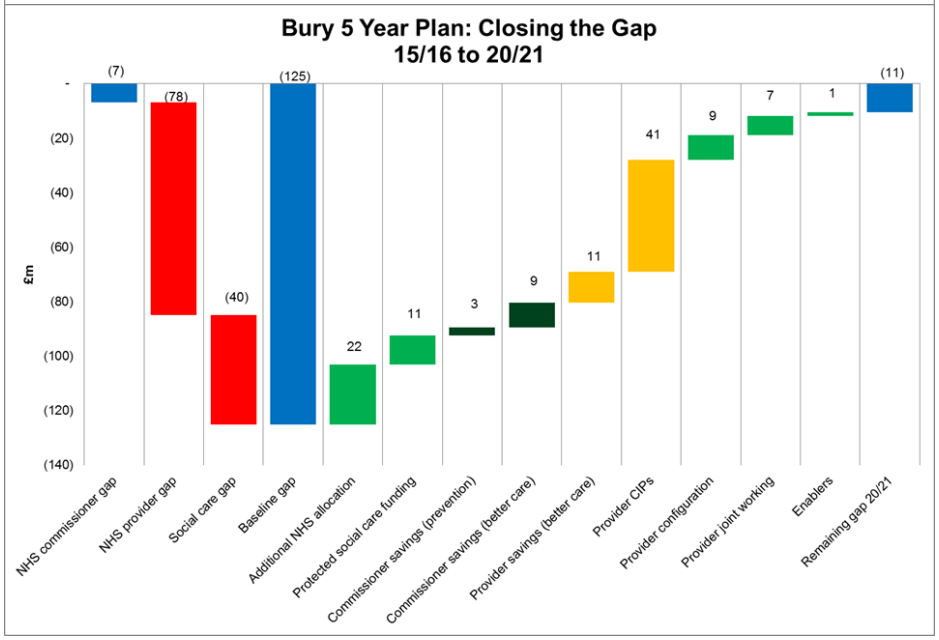
- Bury CCG, and its predecessor, Bury PCT, have experienced significant financial challenges over the last 5 years and were in formal financial turnaround until 2012/13.
- Bury CCG's revenue allocations in 2014/15 are £17m behind the calculated target for the size and need of its population and it is expected to be significantly behind target for the foreseeable future.
- The local authority has been equally challenged, with council wide savings of £16m required for the financial year 2015/16, of which adult social care's share is £4.2m, some 9% of net budget.
- Bury also suffers from underfunding in primary care, which equates to an annual shortfall of around £5 million.

Financial modelling has been undertaken at a local level in order to assess the financial challenge facing the locality over the next 5 years. This shows:

- Commissioning resources are projected to be £379.3m p.a. by 2020/21
- Without reform, commissioners would need to spend £426.1m p.a. by 2020/21 to meet health and care requirements.
- This leaves a **joint financial challenge for commissioners of £47m p.a.**
- **NHS providers face a financial pressure building up to £78m p.a.** without any further cost improvement and transformational changes.
- As a result the **total financial challenge** facing the health and care system in Bury by 2020/21 **is forecast to be £125m per annum**.

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 reductions in acute activity, but also in terms of capacity within both organisations to review, reshape or decommission existing services.





EXEMPLAR PROJECT

Key to the delivery of our plans is the creation of one Commissioning Organisation with a significant pooled budget. This will operate in shadow form initially from April 2016 and will bring together council and CCG commissioners as one organisation. This will ensure that there is joined up commissioning of health, social care and wellbeing services across the whole pathway from asset based early intervention to acute hospital services. This will reduce duplication and facilitate holistic, person-centred approaches to service design and development, supporting financial sustainability of the health and care economy in the longer term. We see it as being key to driving a variety of forms of provider alignment.

For this to be successful there are also a number of other linked areas of work that need to happen:

- We need to foster a more collaborative approach to working with providers, as well as fostering collaboration between providers across all sectors
- We need to encourage innovation, by and having a system that is responsive to new opportunities and that can change quickly without being hindered by bureaucracy
- We must adopt a whole population approach to commissioning and service delivery, rather than commissioning for an age group or a particular disease

As part of this commissioner alignment, we will undertake a risk based, programme managed review of all commissioned/delivered services to understand if they are efficient, effective and focused on delivery of the new vision. This will lead to a programme of service review/redesign/ (de)commissioning activity that will deliver savings and better outcomes in the short (Yrs 1 & 2), medium (Yrs 3 to 5) and longer term (Yrs 6+).

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Team Bury
Working Together For A Better Bury

Bury Locality Plan

'Bolder, Braver Bury – Towards GM Devolution'

2016 - 2021

Version – Final (Updated)
Published – 25 November 2015

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OUR APPROACH

Bury's Locality Plan recognises the need to promote the prevention agenda, getting people to take more ownership for their own health and wellbeing. As well as requiring a behaviour change from people, providers will be required by commissioners to change what they deliver and the ways in which they deliver it. Reviews of existing services will have to demonstrate whether they are still relevant, new ways of working will be developed and providers too will be required to sell this message of change to both their staff and the people they serve. As well as an organisational cultural shift and acceptance of change by staff, there is a need for investment in training and skills development in order to meet these objectives.

Our approach is a simple one (See Appendix 3 for a graphical representation) - in order to achieve a narrowing of the potential financial gap at the same time as delivering consistent or improved outcomes for our population, there will be four key themes to our work locally:

1. **Redesigning & Improving Services**: Our intention is to maximise the use of the Bury pound to support the citizens of Bury to live longer, happier lives, ensuring that everything we do is fit for purpose and as efficient and effective as it can be. We will quickly develop and upscale a number of services/projects in order to save money and to create an investment fund for our longer term work, whilst maintaining or improving outcomes for the people of Bury. We will also be changing the way we commission services and from whom. Health and Social Care will work together as if one commissioning organisation with aligned commissioning intentions, a significant pooled budget and shared back office functions.

2. **Moving Services Closer to the Community**: Here we will start to move services out of acute settings and into appropriate community ones. Some of this will require investment / pump-priming.

3. **Investing in Early Intervention & Prevention**: We will invest in evidence led interventions which will be designed to reduce the prevalence and severity of health conditions over the short, medium and longer term.

4. **Enabling People to Self Care**: Here we will work to engage people in being part of the solution and ensuring they take a significant and active part in living longer and more healthily.

This can be represented diagrammatically as shown over the page, including how these link to the Greater Manchester thematic work and our local vision.

Vision

Our vision is to ensure our population is as healthy, happy and independent as possible, living with minimal intervention in their lives. This will be achieved through targeted strategies of self help, prevention and early intervention, reablement and rehabilitation. When needed, formal care and support will be designed to create a coordinated and seamless health and care system. All services will be person-centred and will build on and develop local community assets

Key issues

- Increasing the proportion of adults in contact with secondary MH services who live in stable and appropriate accommodation
- Decreasing the under 75 mortality rate from cancer, cardiovascular, respiratory and liver disease
- Reducing male early deaths from all causes (& inequalities between most & least deprived areas)
- Reducing the number of emergency admissions for acute conditions that should not usually require hospital admission
- Increasing the health-related quality of life for people with long term conditions

GM Devo Themes

- COMMISSIONER REFORM / SHARING BACK OFFICE
- BETTER CARE
- PREVENTION

Bury Themes

- COMMISSIONER ALIGNMENT
- REDESIGNING & IMPROVING SERVICES
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- System leadership

We share the Greater Manchester ambition to drive the greatest and fastest possible improvements to the health of our local population and reduce health inequalities both within Bury and between Bury and the England average.

Our locality plan also supports the delivery of our previously agreed overarching strategic plans including:

- Bury Council's Vision, Purpose & Values 2015-20 priority to 'Drive forward, through effective marketing and information, proactive engagement with the people of Bury to take ownership of their own health and wellbeing'
- NHS Bury Clinical Commissioning Group (CCG) vision from the 2014-19 Strategy 'That people will live well, stay well, remain active and have better outcomes and experiences' and the 'Staying Well' agenda to promote early intervention, prevention and self ownership for personal health for older people
- Delivery of Public Health's strategic framework which aims to improve health and reduce health inequalities across the life-course through action at population, community and individual levels
- Greater Manchester's goal to 'Reduce the Net Cost of Health and Social Care' though the clinical and financial sustainability plan

We will also need to work in close synergy with the wider thematic work being undertaken at a Greater Manchester level. These include:

- Key Greater Manchester wide devolution programmes focussed on mental health, primary & social care transformation, prevention & early intervention, IM&T, public estate, workforce, organisational development (see Appendix 1)
- Wider work around public service reform
- The Public Health Memorandum of Understanding programme
- The plans developed by providers to take account of opportunities to deliver better care with higher levels of productivity and more effective use of their combined estates
- The work delivered locally and regionally by the 'Transformation Prospectus'
- The impact of the Healthier Together programme, reorganising and improving the care delivered by hospitals in the Greater Manchester area and changing the way in which Bury residents are treated across the sub-region
- The transformation plans of Pennine Acute Hospitals Trust
- Local and regional responses to the NHS 5 Year Plan

We recognise that acute hospital services provide a key component of the care pathway for patients experiencing acute illness and / or whose condition cannot be managed safely in the community. Bury patients attend a range of hospitals for their secondary care and each of these have transformation proposals; however most of our patients receive their hospital care from Pennine Acute hospitals.

Pennine Acute Hospital NHS Trust provides a range of hospital, specialist, integrated and community services to the localities of Oldham, Bury, Heywood, Middleton and Rochdale and North Manchester (covering a population of around 820,000). Services are delivered from four major sites: Royal Oldham Hospital, North Manchester General Hospital, Fairfield General Hospital in Bury and Rochdale Infirmary, together with the Floyd Unit.

Services are operated using a single service model which balances locally based services, close to the patient's home, with a range of consolidated services eg: Stroke services for the north east locality are consolidated at Fairfield General Hospital, Gastroenterology at Royal Oldham, etc. Consolidated services have higher volumes, standardised approaches and

less variation, which in turn offers better outcomes for patients and economies of scale in terms of delivery.

The Royal Oldham has been designated as a specialist hospital under Healthier Together, supported by North Manchester and Fairfield General Hospital as local hospitals. Healthier Together changes enhance the current single service model with Acute Surgery and Acute Medicine at the Royal Oldham.

Building on Healthier Together and working in partnership with commissioners, the Trust has commenced a clinical service transformation programme that covers its full range of services and aims to deliver clinical and financial sustainability by 2019/20.

Most of the ill health suffered by our local population is not inevitable but can be seen as a consequence of how we organise and manage our society. The local health profile is shaped not only by our local actions but also by regional, national and global influences beyond our direct control. However, devolution offers a massive opportunity for us to gain more control locally over some of these wider determinants of health and to attempt to re-create a system and society that does more to promote and enhance health and well-being.

We already recognise, through the wider public services reform work, that creating investment in jobs and housing will not only improve the infrastructure of the town, but will also create better prospects for the population through increased wealth and opportunity for individuals and localities; with this comes greater wellbeing and better health.

Much of the demand for health and social care is driven by the wider determinants of health: economic security, housing, and criminal justice manifesting themselves in complex needs and poor health and well-being - for example mental ill-health, substance misuse and multiple long term conditions. The health & social care system cannot therefore act in isolation – if we are to secure good wellbeing for our citizen's than many other agencies and teams have an active role to play.

Lifestyle Choices (eg: smoking, alcohol, drugs, diet & exercise)

- Continuation of the multi-agency working to tackle incidents of domestic violence which will help to reduce the number of emergency admissions and episodes of acute care, as well as reducing issues related to mental health
- The Early Years Services changing the current model of early help support (moving from targeted interventions to a self help approach and empowerment model, using the assets within the community of its people and resources) to continue their work on improving the quality of life of the youngest members of society, so that they can grow up healthily, have better health in later life, have better educational achievement and improve their future life chances
- Continuation of the multi-agency Supporting Communities, Improving Lives (SCIL) (Troubled Families) programme, targeting those families requiring the greatest levels of intervention from public services, helping to stabilise chaotic lifestyles and improve the health of those affected, such as through tackling dependency on alcohol or drugs
- Continue the work with sport and leisure providers to expand the reach of their programmes, such as I Will If You Will, and facilities are utilised to ensure that people are kept active and enabled to interact with a wider community

Social & Community Networks (eg: family, friends, wider social circles)

- Maximise the socialisation opportunities presented by physical activity programmes such as I Will If You Will
- Support for Third Sector will help support the development & maintenance of groups for people to attend or volunteer

Education

- Work with Adult education to ensure courses on self care and health lifestyles are on offer and targeted at those most in need of support
- Work with education providers to offer services via social prescribing
- Develop self-care offer at Children's Centres, Youth Service, Connexions, within schools, within Fostering Services and within providers such as Pennine Care, Pennine Acute, Persona and Six Town Housing

Training & Employment

- Investment in projects such as 'Working Well', Backing Young Bury (apprenticeships) and access to adult learning for people with mental health issues is all geared to enable people to move people closer to the jobs market. Finding stable employment will also allow people the means to enjoy better quality housing and lifestyles

Welfare

- Maximising the impact of affordable warmth initiatives by targeting 'hot spots' to raise awareness and that schemes are targeted at those most in need, seeking to reduce excess winter deaths, and that take up is maximised
- Work with a range of agencies to see if assessment process can include welfare / benefits and debt
- Link debt advice & welfare services to Children's Centres

Housing

- Strategic Housing Services, housing providers and Six Town Housing utilising 'troubled families' principles to address the needs of complex individuals, increase homeless preventions and reduce the health impacts of rough sleeping
- Continue to work with housing providers to establish new models of housing which support self care which will inevitably involve the use of technology such as telecare and telehealth
- Working with house builders and housing providers to develop communities by ensuring that people can have 'homes for life' and can be enabled to remain in their own homes for as long as possible
- Working with house builders and housing providers to ensure housing is dementia friendly
- Working with the Fire Service to improve the quality and safety of properties

Transport

- Working with Transport for Greater Manchester to develop the transportation infrastructure in a way that promotes the use of walking, cycling and public transport use
- Working with Transport for Greater Manchester to ensure that public transport access to localities and facilities is good, especially during evenings and weekends
- Working with Transport for Greater Manchester to ensure no communities become isolated through lack of access to public transport
- Work with Transport for Greater Manchester to support uptake of subsidised and specialised travel (eg: travel cards, ring & ride)

Amenities

- Working with the Planning function of the council to ensure that our outside spaces are inclusive to all, conducive to health and are designed to take into account the needs of all of our population
- Working with council departments such as Licensing & Planning to ensure that town centre environments are safe and usable by all throughout the day and night and that they help to create an 'environment' that nurtures health
- Working with Planning and Building Control to ensure that dementia friendly environments are created wherever and whenever possible

General Socioeconomic, Cultural & Environmental Factors (eg: wages, income, availability of work, taxation, prices, food, clothing, etc)

- Work with welfare and debt support agencies to ensure people's income is maximised
- Work with Bury Third Sector Development Agency (B3SDA)to develop a volunteering offer to support third sector groups / agencies and to support people to connect with communities / form support networks
- Maximise use of volunteering opportunities by Museums, Libraries, Children's Centres, Youth Services, Connexions, Adult Education, Parks & Countryside & social inclusion services
- Explore use of spare land and food recycling schemes to get people growing their own food and eating healthily

Justice

- Continue to take a more preventative focus on reducing first time entrants to the criminal justice system and reducing re-offending, as this will not only improve the life chances of offenders and potential offenders but also improves the lives of victims of crime and the wider community, though improved perceptions of safety and cohesiveness in communities

FINANCIAL CONTEXT

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 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, recent investment in the Better Care Fund also requires corresponding reductions in expenditure elsewhere eg: non elective admissions.

The local authority has been equally challenged, with council wide savings of £16m required for the financial year 2015/16, of which adult social care's share is £4.2m, some 9% of net budget. This scale of saving may well be similar in coming years, although future financial settlements are currently unknown.

Bury also suffers from underfunding in primary care, which is at an average of £109 per head of population, compared to £136 nationally - using the Mid-2013 population estimate of 187,000 people in Bury, this equates to an annual shortfall of around £5 million.

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 reductions in acute activity, but also in terms of capacity within both organisations to review, reshape or decommission existing services.

Reducing resources, coupled with the rising demand for services, means that standing still is not an option for Bury; in order to ensure the future sustainability of the system, our principles of change must be underpinned by an approach to self care, leading to changes in the behaviour of both staff and the population of Bury, and ensuring that people have access to information and advice and can use community assets to help to keep themselves happy and healthy.

The Council's budget setting process is well underway, with engagement from Executive Directors and Elected Members over possible savings proposals. There remains considerable uncertainty of the level of cuts given the lack of funding detail from the Government, however we hope this to be firmed up by the Comprehensive Spending Review on 25th November and, ultimately, the Settlement itself in December. We feel we have been cautious in our estimates as to Government funding levels.

The next step will be public consultation, due to commence early December 2015 where budget options will be outlined.

The budget will be formally set at the Council Budget Meeting on 24th February 2016.

SNAPSHOT OF THE LOCALITY

There are a number of factors which contribute to health and ill health, some of which are chosen but many of which are due to individual and community circumstances. For example, we know that if a child in Bury is born to a mother who smoked and drank alcohol during their pregnancy, grows up living in poor housing, receives little interaction at home, is poorly educated and lives in a home where parents are either out of work or on low income, then the child is much more likely to have poorer health behaviours and outcomes. For example, when growing up this child is more likely to smoke, misuse alcohol and drugs, have a poor diet and do little physical activity and become a teenage parent. All of which contributes to significantly reduced life expectancy.

There are also significant inequalities in health behaviours between wards in Bury. For example some wards have smoking rates as high as 26.3% (Bury East); in contrast some of the most affluent wards have rates as low as 12.1% (North Manor). These inequalities are further reflected in levels of obesity between wards (28.2% vs 16.1%), and alcohol related admissions (32% vs 12.6%).

Five consistent themes are shown throughout the Joint Strategic Needs Assessment (JSNA) which still hold true in light of more up to date information:

- The consequences of the growth and profile of our population will increase demand for services, particularly from older people
- The effect of social deprivation on poorer health outcomes for some of our population compared to others
- Social exclusion is both a cause and consequence of poor health outcomes and often results from limited rights, resources and opportunities
- The impact of lifestyle choices which are increasing the demand on services, increasing inequalities and will result in higher levels of ill-health and lower levels of wellbeing
- Premature mortality is higher than expected given our levels of deprivation

An essential part of improving the health of a population is by reducing inequalities. To do this effectively targeted prevention and early intervention is essential, via a multi-agency approach is required which addresses all the factors highlighted above which contribute to inequalities.

While older people are generally recognised as being more active and health conscious than their counterparts of thirty or forty years ago, health issues associated with older age, such as dementia, increased life expectancy and falls will continue to represent a significant demand on service budgets and so are key considerations when designing services that are fit for the future.

Our vision is to ensure our population is as healthy, happy and independent as possible, living with minimal intervention in their lives. This will be achieved through targeted strategies of self help, prevention and early intervention, reablement and rehabilitation. When needed, formal care and support will be designed to create a coordinated and seamless health and care system. All services will be person-centred and will build on and develop local community assets.

This will be achieved through targeted strategies of self help, prevention and early intervention, reablement and rehabilitation, which will support reductions in activity in acute services – supporting financial sustainability. When needed, formal care and support will be designed to create a coordinated and seamless health and care system. All services will be person-centred and will build on and develop local community assets.

As well as ensuring that the health and social care economy in Bury moves towards a more financially sustainable position, we also expect the Locality Plan to deliver improvements in a number of key areas - whilst not a definitive/complete list, we are looking to focus on the following outcomes:

- Increasing the proportion of adults in contact with secondary MH services who live in stable and appropriate accommodation
- Decreasing the under 75 mortality rate from cancer, cardiovascular, respiratory and liver disease
- Reducing male early deaths from all causes (and the inequalities between the most and least deprived areas)
- Reducing the number of emergency admissions for acute conditions that should not usually require hospital admission
- Increasing the health-related quality of life for people with long term conditions

In order to achieve a narrowing of the potential financial gap at the same time as delivering improved outcomes, there are four key themes to our work:

1. **Redesigning & Improving Services**: Our intention is to maximise the use of the Bury pound to support the citizens of Bury to live longer, happier lives, ensuring that everything we do is fit for purpose and as efficient and effective as it can be. We will quickly develop and upscale a number of services/projects in order to save money and to create an investment fund for our longer term work, whilst maintaining or improving outcomes for the people of Bury. We will also be changing the way we commission services and from whom. Health and Social Care will work together as if one commissioning organisation with aligned commissioning intentions, a significant pooled budget and shared back office functions.
2. **Moving Services Closer to the Community**: Here we will start to move services out of acute settings and into appropriate community ones. Some of this will require investment / pump-priming.
3. **Investing in Early Intervention & Prevention**: We will invest in evidence led interventions which will be designed to reduce the prevalence and severity of health conditions over the short, medium and longer term.
4. **Enabling People to Self Care**: Here we will work to engage people in being part of the solution and ensuring they take a significant and active part in living longer and more healthily.

All of our Locality Plan work will need to reference and take account of the wide range of workstreams that are being led at and delivered by Greater Manchester wide thematic groups (See Appendix 2) – eg: Estates; Primary Care Transformation; Mental Health and Children & Young People's Mental Health; Information Management & Technology; Learning Disability; Early Years; Housing; Dementia; GM Leadership within New Society; and GM Specialised Services Transformation Programme.

REDESIGNING & IMPROVING SERVICES

In order to obtain maximum value for the poor levels of funding that Bury receives and in order to close the financial gap as much as is safely possible, we need to ensure that all of our services are fit for purpose and as efficient as possible. With the provision of excellent outcomes at the heart of what we will do, there are also a number of short term gains that can be made in terms of known projects or service redesigns that we can get on with immediately. This will not only contribute to the closure of the financial gap, but will also help us to create an investment fund for use to further develop / implement this area or to progress work in the other three areas.

WHERE ARE WE NOW?

- An uncoordinated arrangement of services and programmes which needs rationalisation
- Very little funding available for investment
- Services commissioned in isolation / silos
- Services provided in isolation / silos
- Multiple hand-offs for service users

WHERE DO WE WANT TO BE?

- Aligned / Integrated commissioning of services across both the health & social care economy, as well as wider wellbeing services
- Greater alignment amongst providers and more partnership working across public, private and third sectors, for health and social care provision.
- A deeper and broader set of integrated services
- Service users treated for the minimal amount of time in the most appropriate place
- Reduce the number of excess bed days
- Increased capacity within the intermediate care and reablement services

WHAT WILL WE DO TO GET THERE?

- Create one Commissioning Organisation with a significant pooled budget, in shadow form initially from April 2016, bringing council and CCG commissioners together as one organisation is to ensure that joined up commissioning of health, social care and wellbeing services is undertaken, through the whole pathway from asset based early intervention to acute hospital services. This will reduce duplication and facilitate holistic, person-centred approaches to service design and development, supporting financial sustainability of the health and care economy in the longer term. It will also help to drive a variety of forms of provider alignment. For this to be successful there are a number of other linked areas of work that need to happen:
  - Fostering a more collaborative approach to working with providers as well as fostering collaboration between providers across all sectors
  - Fostering innovation and having a system that is responsive to opportunities and that can change quickly without being hindered by bureaucracy
  - Adopting a whole population approach rather than commissioning for an age group or a particular disease
- Undertake a risk based, programme managed review of all commissioned / delivered services to understand if they are efficient, effective and focused on delivery of the new vision. This will lead to a programme of service review / redesign / (de)commissioning activity that will deliver savings and better outcomes in the short (Yrs 1 & 2), medium (Yrs 3 to 5) and longer term (Yrs 6+).
- Develop an integrated ambulatory care model, which acts as a primary care front end at Fairfield General Hospital Accident & Emergency Department. This will ensure that people are cared for in the right place at the right time. Services will include GP services, all age Crisis

Response services and palliative care provision which will be provided on the hospital site, as this is where people are attending to access help and support. The service will reduce the number of non-elective admissions and inappropriate attendance at A&E.

- Leading on behalf of the North East Sector, establish a single discharge service at the Fairfield General Hospital site to support improved performance around this key acute target, by freeing up beds within the hospital in a timely manner for people who are medically fit for discharge (MFFD). We will work towards a 'trusted assessor' model making most effective use of limited health & social care resources within the locality and across localities.
- Develop a ward-based 'Discharge to Assess' model within the hospital environment that cohorts MFFD patients and supports the in-reach of community services in support of discharge arrangements. Over time, we will look to move this into a community setting.
- Merge the Intermediate Care and Reablement Services across health and social care to have one clear pathway for intermediate care provision and ensure that specifications and admission criteria are aligned with hospital sub-acute rehabilitation services to ensure that there are no service gaps. The redesign of the intermediate care pathway will include Crisis Response services to improve the flow of service users through these services. In addition to streamlining the 'step down' intermediate care provision, we will also look to develop the service as a 'step up' one to reduce hospital admissions and ensure that people are cared for in the right place at the right time.
- Implement the Greater Manchester Early years New Delivery Model - A new model of integrated provision for 0-5s across healthcare, children's services and early years education providers. It is an eight stage assessment model supported by evidence based universal and targeted interventions to improve health outcomes and school readiness for children. This will lead to reduced complications of pregnancy, reduced demand on GP Practices and reduced childhood admissions to hospital.
- Merge the services focused on vulnerable children into a single multi-disciplinary team, rationalising processes and systems, where possible, and improving capacity within the service. We will explore the possibility of making this an 'all age' service, further improving efficiency and addressing issues around transition
- Review and make clear the access points to the health and social care system across Bury, rationalising where possible and streamlining to common processes where possible. We will also explore the role of Third Sector organisations in this, which is linked to our work on locality hubs, the primary care front door at Fairfield General Hospital and our proposed work around alignment of out of hours hospital provision.
- Undertake a review of points of transition, either between health and social care or between children's and adult or between services to understand and address any common points of failure. This will improve transition as a process and potentially stop service breakdowns and the need for high cost interventions at a later stage.

HOW WILL WE KNOW WE HAVE BEEN SUCCESSFUL?

- Reduction in the number of emergency admissions for acute conditions that should not usually require hospital admission
- Reduction in the length of acute stay by patients who are medically fit for discharge
- Reduction in readmission rates
- Reduction in the level of excess bed days
- Reduction in the level of acute bed stock
- Increased numbers of service users seen by the IMC / Reablement services
- More effective use of commissioning funds, especially where services are joint commissioned or have singly been commissioned in the past.

MOVING SERVICES CLOSER TO THE COMMUNITY

To support the closure of the financial gap, we will look to develop community based/community focused services which support the movement of care out of an acute setting and into a community one. In order to do this, there may be an element of investment required to cover capital costs, pump priming or double running.

WHERE ARE WE NOW?

- Large numbers of services are delivered from an acute setting, using high cost medical models
- Traditional service models
- Fragmented services delivered across a range of sectors and locations

WHERE DO WE WANT TO BE?

- Larger proportion of services delivered in the community
- Greater horizontal and vertical integration of services

WHAT WILL WE DO TO GET THERE?

- Roll out wraparound locality hubs, which build upon the successes of the Healthy Radcliffe project and provide a full range of primary and non-specialist healthcare services alongside social care and voluntary, community and third sector services. This will allow for a holistic, locality-specific wraparound service offering to be developed which will include appropriate secondary care services. Our ambition is for them to be a 'one stop shop for care'.
- Push for greater provider alignment, using our new aligned commissioning arrangements, across all sectors, for out of hospital provision. If providers engage in effective partnership, then we can genuinely make shared budgets a reality. For this approach to be successful, new accountability and joint working arrangements will be essential elements of delivering our local vision. This will include alignment of local authority social care provision with Pennine Care's community provision. This work will mean that there are more seamless services from a customer perspective and efficiency savings for commissioners
- Fully implement the Greater Manchester Primary Care Standards, ensuring consistent quality delivery offer
- Expand the seven day GP offer to include a wider primary care offer, such as diagnostics and pharmacy to ensure that people receive seamless care and treatment regardless of the day of the week.
- Encouraging groups of GP practices to work together to offer some specialisms within communities and shifting some services out of general practice into other services - this will free up capacity within the general practice sector, make best use of the skills in general practice and the wider primary care sector and ensure that primary care services work in partnership (rather than in competition)
- Take a range of secondary care services out into the community, using a range of different providers and delivery models. This will mean that services can be provided in a more seamless manner at a venue closer to the patient. Whilst this list will grow and change over time, initial areas to explore include:
  - Secondary mental health services
  - Children & Young People's Mental Health (CAMHS) services
  - Eating Disorder services
  - Some diagnostic services
  - Pain management services
  - Cardiology services
  - Audiology services
  - Routine outpatient appointments
  - Paediatric services

HOW WILL WE KNOW WE HAVE BEEN SUCCESSFUL?

- Reduction in acute sector spend
- Reduction in admission rates
- Reduction in the level of excess bed days
- Reduction in the level of acute bed stock

INVESTING IN PREVENTION AND EARLY INTERVENTION

In order to reduce demand upon acute and high costs services, we will invest in evidence led interventions which will be designed to reduce the prevalence and severity of health conditions over the short, medium and longer term.

WHERE ARE WE NOW?

- An uncoordinated arrangement of small-scale services and programmes which needs rationalisation
- Very little funding available for investment
- Services commissioned in isolation / silos
- Services provided in isolation / silos
- Traditional approach by organisations within the third sector, in general
- Lack of appropriate infrastructure and capacity within the system
- System oriented towards 'see & treat' rather than 'detect & prevent'

WHERE DO WE WANT TO BE?

- Joint commissioning of services across wellbeing and preventative services
- Integration of services to address a common set of service users
- Greater focus on prevention and early intervention in services
- Creation of a whole system, place based approach to improving health and wellbeing

WHAT WILL WE DO TO GET THERE?

- Implement a community mental health wellbeing service for adults.
- Implement a single point of access for Children & Young People's services within a community based emotional health & wellbeing hub.
- Develop a range of interventions that tackle issues of social isolation amongst older people, ensuring people understand and can access the support networks in their own communities and that the community looks out for people who are at risk of social isolation. This will keep people engaged with their own local community, support them to remain well and to remain in their own homes for longer.
- Redesign our Falls and Fragility fracture pathway and commission a primary care and acute fracture liaison service. We will also look to embed physical activity support across the pathway and provide a greater focus on prevention, ensuring appropriate interfaces with relevant services and maximising all opportunities for falls prevention across the system. This will lead to reduced outpatient appointments, reduced hospital admissions, reduced complications from surgery and reduced demand for community services, social care, IMC & reablement services.
- Implement an 'Active Ageing' strand of the I Will If You Will programme, our nationally significant work to create a social movement for health and physical activity. This will focus on keeping people in later life active and support their continued mobility and social engagement.
- Implement a 'Staying Well' service across Bury, 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. Evidence suggests that this form of early intervention will have a significant impact of health and social care demand in the medium to long term - reducing social care costs, reducing nursing and residential care costs, reducing hospital admissions and reducing demand on primary care.
- Re-able the housing stock – aligning new build schemes to local needs, streamlining access to adapted properties, working with energy suppliers to reduce fuel poverty, working with private landlords to reduce hazards and develop housing options to increase the number of homeless preventions and minimise the need for rough sleeping.

- Scale up and expand the 'Better Together' / Primary care quality programme (LTC health checks) with an emphasis on CVD, Diabetes, COPD, Asthma, Blood Pressure, Cancer, Arterial Fibrillation & Osteoporosis, the physical health of those with mental illness and those with learning disabilities. This is an incentive & support programme to drive up identification of the missing thousands from high risk and disease registers in primary care and ensure systematic best care for all patients. Currently there are a significant proportion of population with unidentified and therefore unmanaged disease; identification and effective management in primary care will reduce the progression of these diseases and reduce costs of more complex, expensive treatment and hospital admissions. It will include a range of medical and healthy lifestyle interventions where appropriate. This will help to find and treat people earlier, will prevent future prescribing costs by intervening with those at high risk CVD and pre-diabetes, reduce hospital admissions, reduce hospital outpatient appointments and mean there are fewer complications from surgery.
- Establish a work and health programme in Bury to support those at risk of falling out of employment due to ill-health to remain in work. This will build upon the pilot undertaken by Greater Manchester Public Health Network and will ensure access to assets such as employment, decent housing and social support in order to help reduce recovery times and prevent increased in co-morbidity. This will lead to reduced demand on primary, community, social and secondary care services and reduced demand on mental health and substance misuse services.
- Ensure that adults experiencing a first episode of psychosis start treatment in early intervention in psychosis services within 2 weeks of referral. Early intervention in psychosis services are multi disciplinary community mental health teams that aim to provide a full range of pharmacological, psychological, social occupation and educational interventions for people with psychosis. This will support the prevention of relapses and reduce long term impacts.

HOW WILL WE KNOW WE HAVE BEEN SUCCESSFUL?

- Improved health behaviours
- Shift in balance of resources between acute and community based services
- Increased health related quality of life for people with long term conditions
- Reduction in admission rates
- Reduction in relapses for people with a first episode of psychosis
- Reduction in referral to treatment times

ENABLING PEOPLE TO SELF CARE

In order to embed a longer term reduction in demand for services and to support a change in behaviour by people around health and care, we will work to engage people in being part of the solution and ensuring they take a significant and active part in living longer and more healthily. We will also need to review what we are going to stop doing in order to enable people to take individual ownership for their health and wellbeing.

WHERE ARE WE NOW?

- Historically an area that has been under-funded / neglected
- Previously, no strategic approach to developing this area - it has emerged piecemeal up until now

WHERE DO WE WANT TO BE?

- People take responsibility for their own health and social care
- We recognise that there should be a 'peer to peer' relationship between people and professionals, rather than a 'parent-child' relationship
- People recognise they have an integral role to play in supporting their own health, care and wellbeing and can bring their own assets and resources to be part of the solution

WHAT WILL WE DO TO GET THERE?

- Further develop our dementia friendly communities initiative. Broadly, we want a society where the public thinks and feels differently about dementia, where there is less fear, stigma and discrimination, more awareness of how to live a healthy life to reduce the risk of developing dementia in later years; and more understanding of people living with dementia in the community. A society where every person diagnosed with dementia and those around them:
  - Has access to meaningful care following their diagnosis, which supports them and those around them
  - Receives information on what post-diagnosis services are available locally and how these can be accessed
  - Has access to relevant advice and support to help and advise on what happens after a diagnosis and the support available through the journey
  - Is given the opportunity for advanced care planning early in the course of their illness, including plans for end of life.
  - Is given the opportunity to access relevant assistive technology to enable then to continue to live well

  We will continue to raise awareness of dementia by ensuring all of our staff receive the appropriate level of training required to carry out their responsibilities and by working with schools and within communities. Our aim is for Bury organisations to achieve the BSI standard for recognition as a Dementia Friendly Community. To achieve this we will work towards developing dementia friendly environments in hospitals, GP surgeries, public buildings, dentists, pharmacists, opticians, care homes, local businesses and dementia friendly public transport and taxis. We will continue to engage in regional and national initiatives to enhance local services.
- Develop a self referral process in mental health services for children and young people to align with the self referral process that has been successfully implemented within adult mental health services
- Production of self management materials for mental health and wellbeing, funded through the Children & Young People Local Transformation monies.
- Optimise use of the Bury Directory, expanding it to cover the wider health and wellbeing economy. The Bury Directory is a key tool to support people to make people aware of and so access local services. The Bury Directory lists the community assets and support networks available across the borough, together with details of how these services can be accessed.

- Scale up social prescribing and self-care support for people with long term conditions. This will put patients in the driving seat of their own care and could reduce demand upon primary, community, social and secondary care services.
- Roll out of the Welly Cafe / Manchester Road Lodge approach to providing support for people with disabilities wishing to enter / re-enter the employment market.

HOW WILL WE KNOW WE HAVE BEEN SUCCESSFUL?

- Asset based approach embedded across health and social care
- People recognise and value their role in their own health and wellbeing
- Improvement in user satisfaction rates re: access to advice and information

There are a number of local enablers that underpin this work and support the delivery of this change. These include:

- **Use of the estate and other physical assets**
  - Over the last few years public sector organisations within Bury have been working successfully to remodel and achieve efficiencies from their estates. However it is recognised that a more collaborative and innovative approach is now required to be able to break down historic barriers and to pool resources more effectively for the wider system benefit. This approach aligns fully with the Greater Manchester 'one public estate' initiative. Bury has formed a Strategic Estates Group (SEG) which will play a critical role in ensuring the public estate can support the delivery of commissioning and service redesign plans for the benefit of patients, staff and the taxpayer.
  - Bury's SEG will maintain a 'service led' rather than 'asset led' approach that fits with the 'Place' agenda for local services and supports partner organisations to remodel their estate more effectively at a central and local level. In general terms, the vision is for partners to effectively collaborate in relation to strategic asset management and to rationalise the property estate currently used leaving one that is:
    - In the right place, in the right condition, at the right time
    - Flexible and sustainable in use now and in the future
    - Able to deliver value for money in terms of service benefit, operating costs and financial return
    - Able to contribute to the reduction in the combined carbon footprint of Bury
  - Our approach will encompass primary care alongside the broader health and social care system, linking also to the Healthier Together programme and the Greater Manchester Devolution Programme.
  - The proposal is to pilot the service led approach to Estates through the new Whitefield Health centre development. This NHS England funded integrated health and social care facility will open in 2017.
  - Areas to explore which can complement our current proposals or act as a catalyst for change include: looking at using buildings as 'hubs' for multi-agency teams to work from; use of buildings as a single 'front door' to a variety of services or agencies; and the potential for community ownership.
- **Transformation of our workforce**
  - In developing the integration agenda we need to reshape the workforce to one that is able to deliver coordinated care in new ways, focusing on the person as an equal partner in their care and support and promoting self-management to improve community resilience. The key implication is that more of the health and care workforce will also have to work more within the community.
  - Whilst having a clear values-based driver, the self-management support agenda is also identified as a pragmatic enabler for services to manage an increasing demand on services, with an ageing and increasingly complex population. With people supported to manage their health and wellbeing, this creates capacity to target resource to areas of greatest need.
  - A critical barrier to this is eliciting behavioural change across the workforce to support better self-management. It has been recognised nationally that services are traditionally delivered in a paternalistic culture, which creates dependency on services/practitioners, and limits the extent to which people are supported to be empowered to take responsibility for their own health and wellbeing. Shifting towards a much more enabling, co-produced, person-centred culture is the aspiration for Bury. The challenge for us in Bury is how we do this on a system wide basis ensuring effective workforce leadership to support behavioural change so that we can deliver the right care in the right place at the right time.
  - We will need to explore how staff can be facilitated to work in multi-disciplinary teams, exploring and addressing issues around single

line management, governance and professional support, breaking down barriers between the traditional tasks undertaken by certain roles, the changing training and development needs of this new breed of staff and issues around seven day extended working.
    - We will also need wider considerations around the implementation of the living wage, the skills availability within the labour market, the labour market's vibrancy, the fee rates paid to contractors and our payment mechanisms.
    - We have a number of very distinct organisational cultures within the health and social care economy and so, as we integrate a number of organisations, services, functions and teams, we should celebrate that diversity and ensure that the best of each culture is retained and given prominence in the new world.
- **Joint governance of our system**
    - We currently have 3 separate governance systems for the health and social care economy - political, clinical and operational/ organisational. Whilst we have joint governance arrangements in place across the locality, this will need to build in a further level of 'locality' governance and so we need to review our current arrangements and ensure that they are fit for the future.
- **Developing our local contracting mechanisms**
    - We need to ensure that our contracting mechanisms allow us to develop and embed the range of services and skills that we require from providers in the future. Whilst not an exhaustive list, there are several key enablers that we feel need addressing in the short term if change is to be both rapid and sustainable. These include:
        - Allowing the flexibility to move away from set nationally driven tariff rates to something that rewards innovation and delivery of our local key outcomes
        - Having contracting mechanisms that support and reward partnership; rather than ensuring providers are in strict competition with each other
        - Moving to a contracting for outcomes basis as opposed to one that rewards activity as well as having flexibility within contracts that allows for innovation at pace in order to take advantage of opportunities as they present themselves
        - Having a contracting system that does not place any unnecessary barriers in the way of third sector organisations being able to win contracts
        - Adopting a wider, more holistic definition of 'value'
- **Ensuring that health is all of our business**
    - This is an understanding that the key players are many and diverse, from the individual's role in maintaining their own health to non-traditional partners' contribution to health and wellbeing. There is a separate work stream planned around engaging individuals in their own health and wellbeing, but there also needs to be a another work stream around some of the wider determinants of heath and the active role they can play to create an 'environment' that nurtures health (eg: planning, roads and infrastructure, licensing, procurement, etc).
    - We will also look to develop a 'health in all policies' approach to strategy and policy making which can help to stimulate and maintain some of this change.
- **Developing an asset based approach**
    - We have identified the need to roll out an asset based community development approach as part of our locality place-based approach to service provision. We have also identified some of the mechanisms that will make this possible - expansion of the Bury Directory; mobilising personal (skills, knowledge) and social (connections and relationships) assets among staff and their customers/ service users; establishing community development programmes in our most deprived neighbourhoods; and developing our neighbourhood assets (eg: parks, leisure centres etc) as resources for community wellbeing.

- Staff who undertake 'assessments' of individuals will need to take an asset or strengths based approach to these, linking people to the skills, physical assets, communities and connections that they already have, ensuring these work in harmony with any planned health & social care interventions or services.
- This co-production approach also needs to be embedded within all of the major agencies that work within the health and wellbeing sector.

- **Ensuring people know, understand and are more motivated to act upon the messages**
  - For people to understand how the new health and social care system hangs together, what services are provided by whom and where, what our expectations of them are in terms of self-care, keeping well and using personal assets and what assets there are out in the community, we need to be able to get effective messages to people, in a manner that ensures they are heard and understood and using a delivery method they will engage with. We will develop a structured programme of marketing and communications alongside this programme of change and a social marketing approach to making sure key messages are targeted at those people we need to target them at.
- **Developing and stimulating the third sector**
  - There is a large element of using personal and community assets to stay healthy and to use self-care and preventative services to maintain your health or condition. At the same time, professionals need to think differently about how to address health conditions in a non-traditional manner (eg: social prescribing) and so it is vital that we have a vibrant and entrepreneurial third sector and that we stimulate volunteering activity in support of this.
  - We are also looking for a far more diverse range of health and social care provision within the market if we are to be able to reduce the levels of activity within the acute sector and to reduce the cost of services - one potential area to explore is provision of a larger array of services, either by third sector organisations or in partnership with them.
  - We therefore need to rethink the way in which we engage with the third sector in general and also with individual organisations. We also need to rethink how we support this sector to be 'match fit' to take on some of the opportunities that may present themselves and how some of our processes can act as barriers to this happening.
  - The use of volunteers is key to the delivery of community / social networks and also provision of many third sector services. We will work closely with the sector to stimulate and harness the volunteering capacity in a coordinated way locally
  - We need to signal clearly to the Third Sector what the size and makeup of the sector needs to be in the future in order to deliver on the local aspirations and ambitions. This will help the Third Sector to self organise and mobilise to deliver on this agenda and will allow us to work collaboratively with the Sector to ensure that organisations and services are developed in areas of most need, recognising that there is a risk to organisations at present from the lack of funding available to them.
- **Personal ownership and accountability**
  - Part of the new 'health deal' for Bury has to be that people recognise their own key role in living healthy lifestyles, remaining healthy and returning to good health as soon as they can. At the same time, they have a key role to play in solutions to their own ill health when it comes to the skills, experiences and assets that they can bring to bear in support of efforts by health and social care services.
  - This will need to be enforced at an individual level by the way in which assessments and conversations are undertaken; at a community level by engaging with groups and organisations to explain the approach and to reinforce this individual level messaging; and at a population level by marketing and communications activity.

- **Understanding our people better**
  - We currently have a whole host of person, community and population level data, with some key information that allows for this to be brought together in a more cohesive picture, which is reflective of the inconsistent level of intelligence within the JSNA. Individually, we have been good at leveraging the intelligence we each hold, but have been less successful as a health and social care economy. If you then add the wider intelligence available across other public services and agencies, there is a clear opportunity to produce a step change in the intelligence that all partners produce and how this intelligence is used to stratify risks within our communities and deploy our resources more effectively.
  - Whilst sharing and combining our data and sharing the skills and resources we have within our data / intelligence teams is one potential benefit, having a shared view of the world and the issues that need to be addressed means that all of the combined resources of the various agencies, and teams involved can be brought to bear on it in a more coordinated and effective way. This will also support the strategic development of both the third sector in general and particular provider organisations or sectors.
  - The Joint Strategic Needs Assessment (JSNA) for Bury is being redeveloped and has recently been through a phase of consultation and engagement. An operational group is being brought together to support the delivery of intelligence and insight to partners and agencies across Bury. The agreed purpose of the JSNA is to provide a centralised, valid and reliable data source which offers key information, analysis and interpretation to provide a detailed overview of the health, wellbeing and social care situation in Bury. The vision is for the JSNA to be a web based dynamic document used by a range of key stakeholders for the following reasons:
    - Developing policies and strategies
    - Commissioning services
    - Redesigning pathways/services
    - Putting in bids for services
    - More effectively focusing / targeting services
    - Working together with our partners in a more integrated way
  - As part of the development of the JSNA there is a workstream which is scoping out the availability and appropriateness of various customer insight and intelligence software and tools. It is recognised that we now need to explore, further than using standard segmentation, the characteristics of our residents and cohorts of residents to understand and target services effectively. For example looking at the geo-demographics of the non-elective admission cohort to understand what people are being admitted for and length of stay. Such research can only be possible by utilising the established relationship between the CCG and the council. Further work is underway to explore options on how both the intelligence functions within the council and the CCG can work in a more integrated way, share resources, tools and software and access to data.
  - If we are to truly address common issues in an integrated way then we also need to be bold about having integrated health and social care intelligence and performance, establishing a common language and set of geographies, sharing and aligning any insight and addressing any associated barriers.
- **Integrated assessment & recording**
  - For us to develop a truly integrated offer around health and wellbeing, we firstly need to understand the individual as a whole. Once we do, we can then offer holistic services that build upon the assets available to an individual and pulls upon our collective strengths and abilities. A single joint holistic assessment if therefore key and we will also look to work towards a trusted assessment model.

- We also need to use the IT systems available to us to be able to produce an integrated record, with access to appropriate parts available to the various professionals and organisations involved.
- We need to ensure that we effectively share data at an individual and at an aggregate level (for planning purposes) and develop a robust information governance framework.

- **Leadership**
  - We know we need to reshape the workforce to one that is able to deliver coordinated care in new ways, focusing on the person as an equal partner in their care and support and promoting self-management to improve community resilience. The self-management support agenda is also identified as a pragmatic enabler for services to manage an increasing demand on services.
  - A critical barrier to this is eliciting behavioural change across the workforce to support better self-management. It has been recognised nationally that services are traditionally delivered in a paternalistic culture, which creates dependency on services/practitioners, and limits the extent to which people are supported to be empowered to take responsibility for their own health and wellbeing.
  - The systems leadership activity that we propose to take forward is whole system workforce self-assessment of their service offer with regard to self-management support across Bury. This is a complex and demanding responsibility, especially in the context of changing services and financial pressures. We see it is a combination of four interrelated activities:
    - Workforce intelligence - analysing and managing information about the resources, capacity, skills and knowledge available to meet the demands of people using current services in Bury and the ability to promote self-management and state of readiness
    - Feedback from people who use our services - what are their future needs around workforce
    - Workforce planning - analysing population projections and estimating future numbers of people who are likely to need care and support
    - Workforce development - establishing a common vision and shared sense of purpose across partners, engaging with and motivating staff at all levels, and driving strategic changes such as the development of integrated workforce strategies and a self-management strategy

Much of the engagement around the development of the locality plan priorities has already been done as part of the original development of the individual elements of our plans; however, we plan to undertake some engagement as part of the development of this locality plan as a whole. This will include:

- Discussion at a range of partnership groups, such as the Health & Wellbeing Board, the Health & Social Care Strategic Partnership Board, the Joint Commissioning Group, our (health & wellbeing) Provider Partnership and our Community Engagement for Health Group
- A range of one to one / group meetings with key staff from a range of organisations, for example:
  - Chair of our strategic public sector estates partnership
  - Commissioning leads within the council and the CCG
  - Partnership leads within Children's Services
  - Clinical Commissioning Group Leads
  - Director of Public Health
- The senior management teams of the Communities & Wellbeing Department, the Children, Young People & Culture Department, the council as a whole and the Clinical Commissioning Group
- The Clinical Cabinet of the CCG
- Locality Plan development workshops with a range of stakeholders, including providers.

In order to ensure support for the new ways of working that are being proposed, it is important that people understand the need for change and effectively contribute to the design and re-shaping of health and care services through a co-production approach wherever possible. Examples of where this has been successful include:

- The CCG's Patient Cabinet and the Urgent Care Patient Focus Group involved in the development of the urgent care plan
- The council's engagement with local people as part of the 'Our Place, Radcliffe' project, which included the use of participatory budgeting to allocate grant resources locally
- The council's Customer Task Force group in the remodel of Advocacy Services and user testing of The Bury Directory
- Customer and Carer Engagement through meetings, workshops and questionnaires

A multi-agency 'Community Engagement for Health' group has also developed a number of locality plan proposals:

- Development of proposals around asset based community development
  - Allowing communities to drive the development process themselves, responding to and creating local economic opportunity
  - Driving the community development process and leverage additional support and entitlements
  - Building social capital
- Adoption of participatory budgeting as a means of allocating resources and influencing resource allocation decisions
- Examining and reducing the 'red tape' that creates barriers to communities self organising and doing things for themselves and presents an unnecessary administrative burden on third sector organisations
- Developing a strong and vibrant Voluntary and Community Sector which is resilient to funding challenges, providing services which meet the needs of local people and build on the strengths and opportunities of grass root organisations
- Development of a network of engagement mechanisms and further development of service user groups and community groups to share and spread best practice
- Developing a comprehensive approach to self care

THE FINANCIAL CHALLENGE

As stated previously, the Bury locality has a history of significant underfunding across health and social care. As a result, significant inroads have already been made in the efficiency and change agendas – many of the 'easy wins' have already been taken.

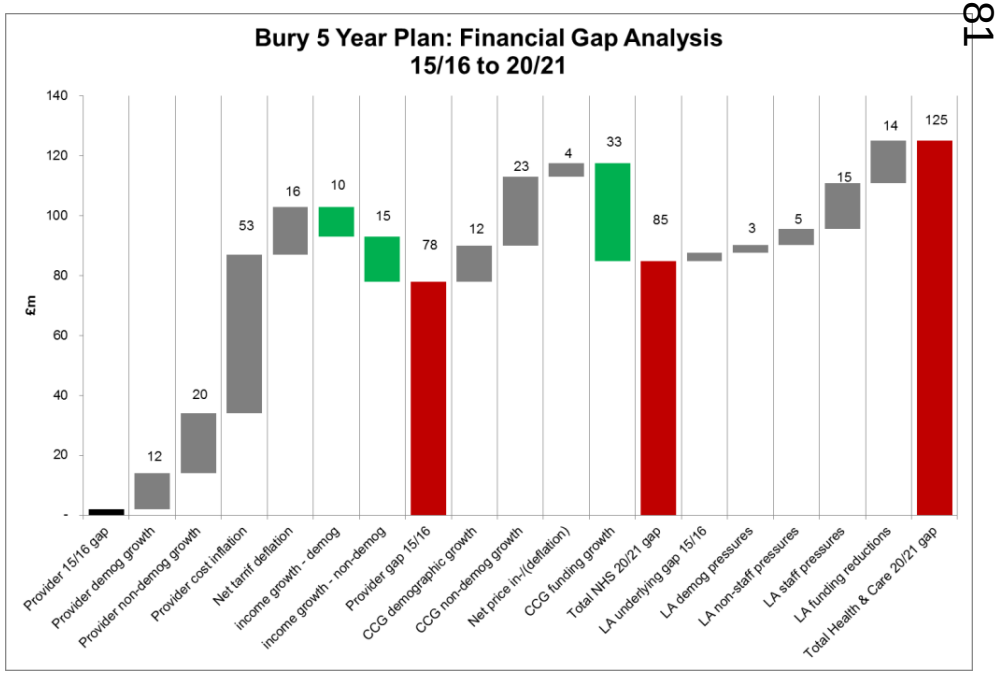
Financial modelling has been undertaken at a local level in order to assess the financial challenge facing the locality over the next 5 years. This shows:

- Commissioning resources are projected to be £379.3m per annum by 2020/21
- Without reform, commissioners would need to spend £426.1m each year by 2020/21 to meet health and care requirements.
- This leaves a joint financial challenge for commissioners of £47m per annum
- NHS providers face a financial pressure building up to £78m per annum without any further cost improvement and transformational changes.
- As a result the total financial challenge facing the health and care system in Bury by 2020/21 is forecast to be £125m per annum.

There are a number of key assumptions that have been used in these calculations:

- NHS provider figures have been taken from GM-wide analysis provided by the devolution team in order to allow for consistency and aggregation.
- CCG figures are based on the GM Five Year Forward View assumptions with the following adjustments:
- The baseline used is the 2015/16 forecast outturn as at month 6 (rather than 14/15 outturn used by GM)
- GP and directly commissioned Primary Care services have been included at an estimated baseline expenditure of £43m
- We have included additional recurrent pressures, over and above the standard GM assumptions, for the local impact of Mental Health Payment by Results (£1.5m) and other structural issues (£1m)
    - We have assumed an additional £3.5m funding, over and above the standard GM assumptions, to reflect the NHSE commitment to bring all CCGs to within 5% of distance from target (DFT).
- The social care baseline spend figures are set based upon the 2015/16 position and include all adult and children's social care services.
- We have included estimates of known social care pressures and council funding reductions based on LGA projections applied to Bury Council's baseline spend.

The bridge chart below shows the components of this gap at the end of the 5 year period (2020/21).



CLOSING THE GAP

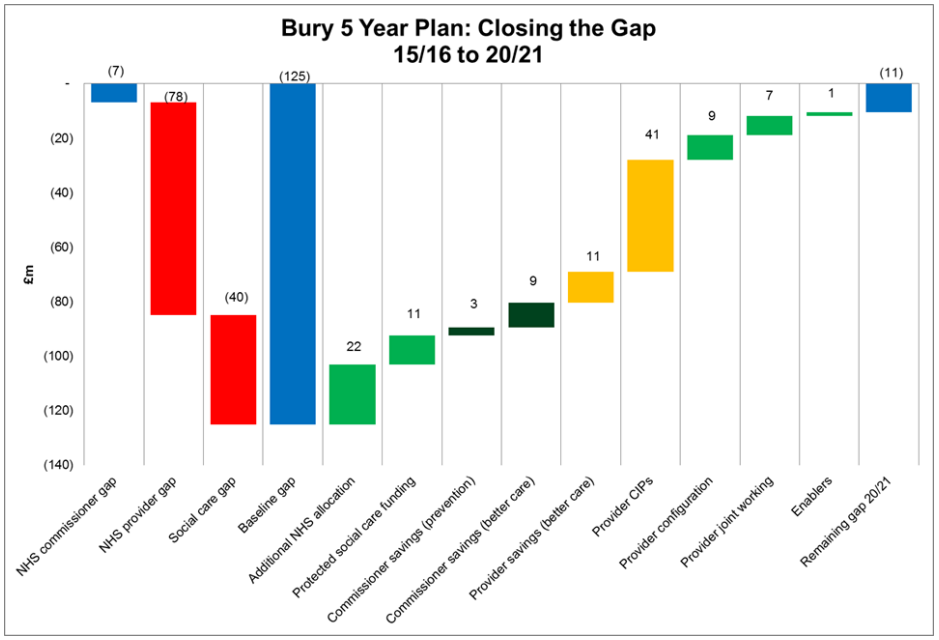
There are a number of key assumptions that have been used in these calculations:

- Bury locality receives an additional £22m as its share of the nationally agreed additional £8bn NHS funding (being the CCG and primary care element of this for Bury).
- Demographic growth is assumed at the GM level of 0.7% pa, but this may understate Bury's local position due to significant growth in the over 50s
- Council non-staffing inflationary growth is set at 2% in line with local assumptions
- Council staffing inflationary growth is estimated at 2% in line with local assumptions
- We believe that the growth in cost for commissioned services due to the impact of the Living Wage is vastly understated and so have used detailed local modelling.
- We have assumed that Bury Council will receive its share of the £255m to protect spend on adult social care services in support of the locality plan. This equates to £10.7m for Bury. If and how any protection would be received is very uncertain and will not be known until the time of the local government settlement. It is also unclear if this funding will be ring-fenced. We see this as a high risk assumption and need to continue work on local contingency plans should this not be agreed in order to ensure that the local authority financial position is balanced.
- In line with the CSR 'ask', we have assumed no reduction in social care funding.
- We do recognise that we need to continue to redesign, redevelop and reshape social care services to make most effective use of the Bury pound and ensure no negative impact on health services.
- £4.5m of prevention savings are targeted over the period. It is assumed that reinvestment is required at 40% and so the net saving is £3m over the period. We believe that savings will increase beyond this over a 10 year period as the lead in time for prevention schemes will extend beyond 5 years in some cases.
- Better care savings targets are £13.5m for commissioners. It is assumed that reinvestment is required at 40% and so the net saving is £9m over the period.
- NHS provider savings have been taken from GM-wide analysis provided by the devolution team in order to allow for consistency and aggregation. However, this assumes high levels of annual CIPs are delivered by providers. This is a high risk assumption for the locality given that our main local acute provider is currently not delivering its CIP target this year. More work will be needed with our providers in order to gain assurance over the CIP plans development as any CIPs provided through income generation will be a risk to the locality's overall financial plan.

The table over the page provides further detail on the assumptions used to calculate the financial gap over the next 5 years:

	16/17	17/18	18/19	19/20	20/21	15/16	16/17	17/18	18/19	19/20	20/21
						£m	£m	£m	£m	£m	£m
Acute Services	1.4%	0.5%	0.5%	0.5%	0.5%	129.8	131.6	132.2	132.9	133.6	134.3
MH services	1.4%	0.5%	0.5%	0.5%	0.5%	21.9	23.7	23.8	23.9	24.1	24.2
Community services	2.6%	1.7%	1.7%	1.7%	1.7%	26.9	27.6	28.1	28.5	29.0	29.5
Continuing Care services	5.4%	4.5%	4.4%	4.5%	4.5%	12.1	12.8	13.3	13.9	14.5	15.2
Primary & Prescribing services	6.0%	5.9%	5.9%	6.2%	6.2%	35.0	37.1	39.3	41.6	44.2	47.0
Other Programme services	2.6%	2.6%	2.7%	2.7%	2.7%	7.6	7.8	8.0	8.2	8.4	8.7
CCG Running Costs	1.9%	1.9%	2.0%	2.0%	2.0%	4.2	4.3	4.4	4.4	4.5	4.6
CCG Reserves & Contingency	1.9%	1.9%	2.0%	2.0%	2.0%	3.2	4.3	4.3	4.4	4.5	4.6
Business Rules						1.2	2.9	3.0	3.1	3.1	3.2
Non Recurrent Items							1.6				
GP services	5.8%	4.7%	4.7%	4.7%	4.7%	22.9	24.2	25.4	26.6	27.8	29.1
DC - Primary Care services	3.6%	3.6%	3.7%	3.7%	3.7%	20.2	20.9	21.7	22.5	23.4	24.2
Total CCG Expenditure						**285.0**	**298.8**	**303.5**	**310.1**	**317.2**	**324.6**
Funding - standard uplifts	1.9%	1.9%	2.0%	2.0%	2.0%	241.9	246.5	254.7	259.8	265.0	270.3
Funding - DFT adjustment	1.4%						3.5	0.0	0.0	0.0	0.0
Funding - national budgets	1.9%	1.9%	2.0%	2.0%	2.0%	43.1	43.9	44.8	45.6	46.6	47.5
Total CCG Funding						**285.0**	**293.9**	**299.4**	**305.4**	**311.5**	**317.8**
CCG Surplus/(Deficit)						**0.0**	**(5.0)**	**(4.1)**	**(4.6)**	**(5.7)**	**(6.9)**
Adult and Childrens Social Care Expenditure	7.5%	5.2%	4.9%	4.6%	4.4%	78.3	84.2	88.6	92.9	97.2	101.5
Adult and Childrens Social Care Funding	-7.5%	-6.0%	-2.1%	-3.4%	-1.0%	75.6	69.9	65.7	64.3	62.1	61.5
						(2.7)	**(14.3)**	**(22.9)**	**(28.6)**	**(35.1)**	**(40.0)**
Overall Commissioner Gap											**(46.9)**
Add Provider Gap											**(78.0)**
TOTAL ECONOMY GAP											**(124.9)**

The bridge chart below provides a high level analysis of current plans to close the £125m financial gap over the 5 year period.

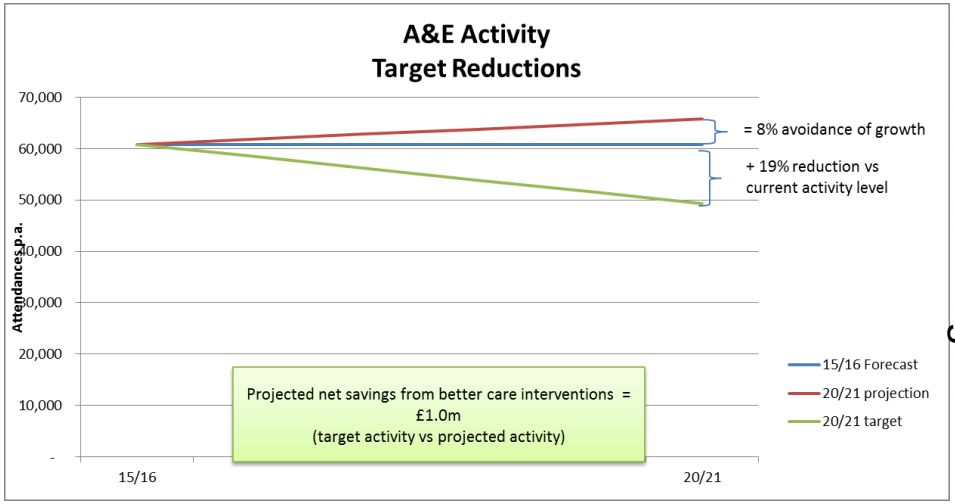


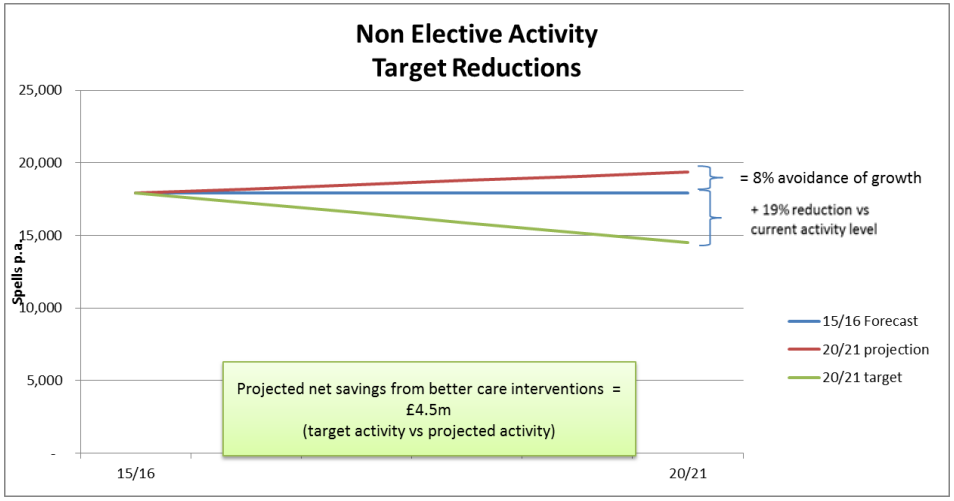
COMMISSIONER BETTER CARE SAVINGS

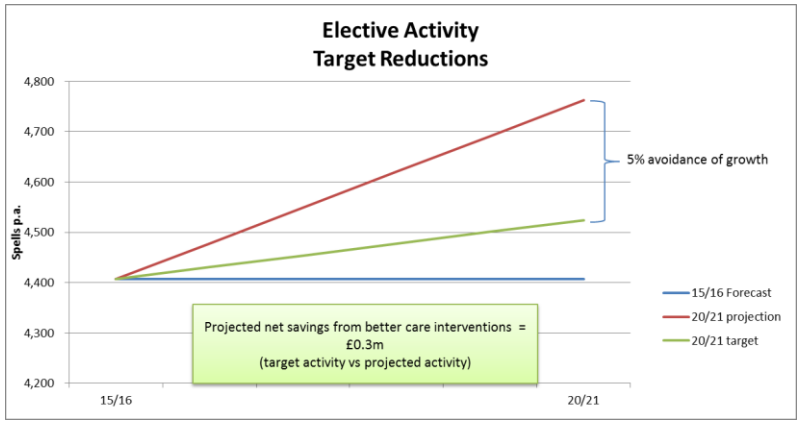
We estimate, at this point, that of the £9m net savings, £7.9m is achievable from the following areas – A&E, Non-Electives, Electives, Day Cases, Outpatients and Excess Bed Days. A further £1.1m is projected from independent sector activity, high cost drugs and devices, etc, giving a total saving in this area of £9m.

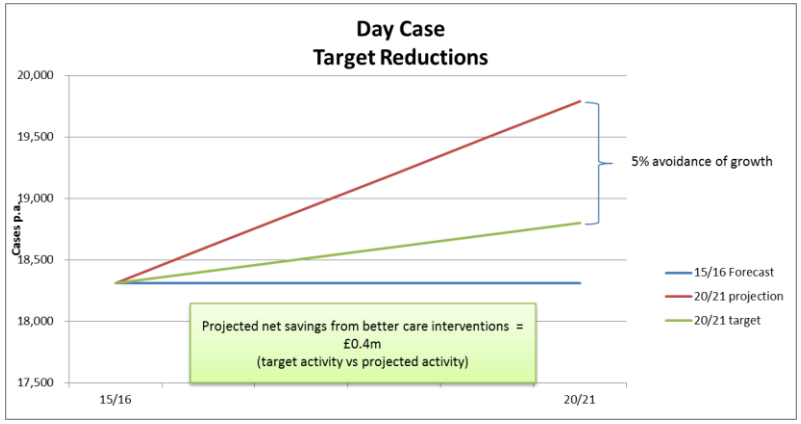
The following graphs show the levels of reductions in hospital activity being targeted over the period in order for reinvestment in care in out of hospital settings. The graphs show:

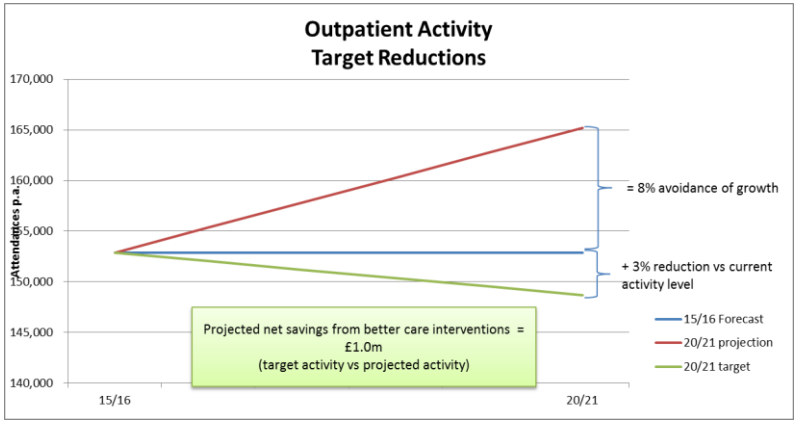
- Current activity levels by point of delivery grouping
- Target activity reductions from Better Care interventions
- Savings, net of 40% re-provision reinvestment costs

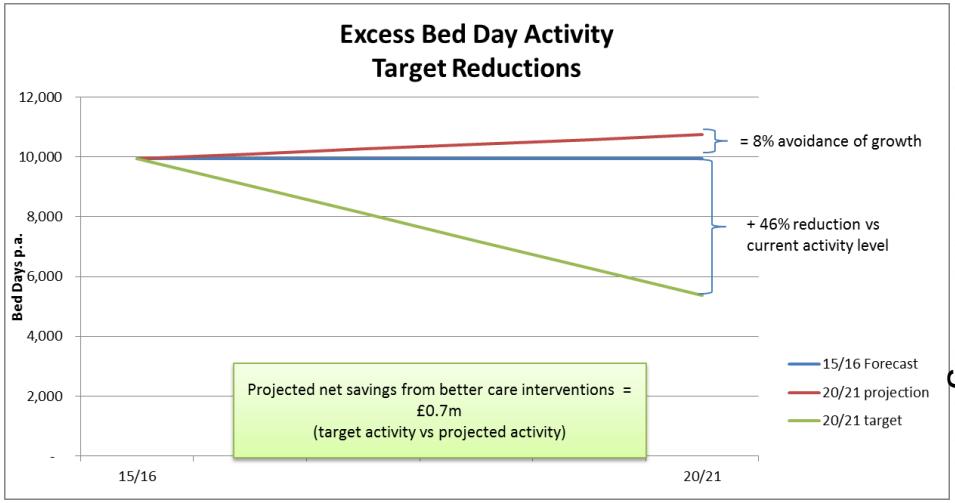










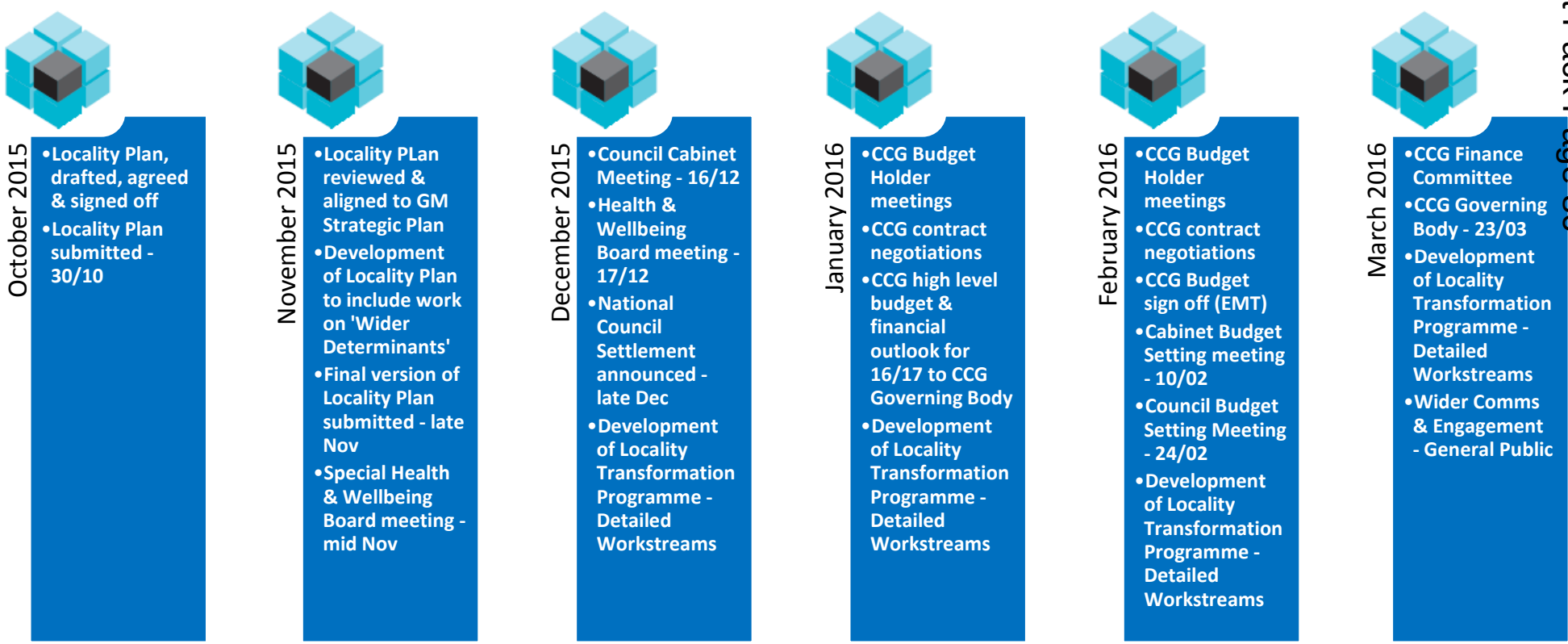


TRANSFORMATION FUNDING

We anticipate that for many initiatives there will be a non-recurrent transitional costs incurred, for example, in double running services whilst new services are developed. These costs are still being calculated but it is anticipated that they will be a call on the GM transformational funding received and are not included in the financial plan presented here.

We see this as the beginning of a process that will culminate, after the budgets have been agreed for the respective organisations, in a series of detailed transformation programmes for the locality.

This will allow us to work through the detail in terms of aspirations, detailed project plans, outcomes and detailed savings plans and ensure that the transformation programme is phased correctly and takes full account of the system interdependencies. This is represented graphically below:



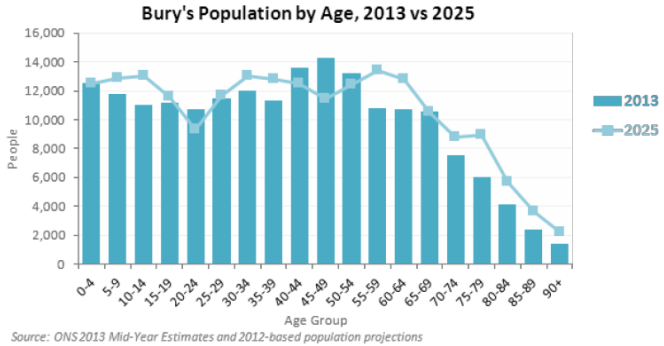
Appendices

Appendix 1: Detailed Snapshot of the Locality

Appendix 2: Greater Manchester Thematic Workstreams

Appendix 3: Quadrant Diagram

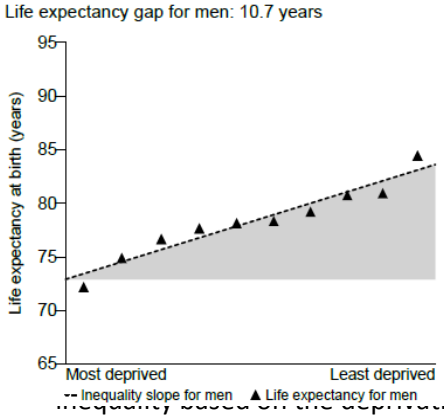
There are a range of diverse health and wellbeing challenges that Bury faces:

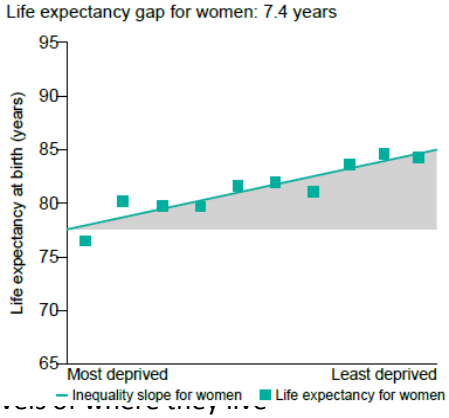


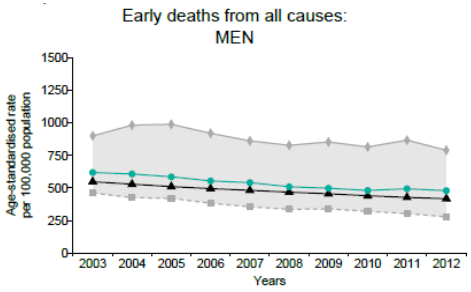
Source: ONS 2013 Mid-Year Estimates and 2012-based population projections

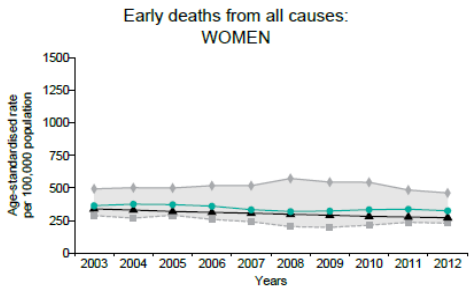
- By 2025...
  - ...the proportion of the population aged 65 or over is expected to rise (from 17% to 20%)
  - ...the proportion of the population aged 80 or over is expected to increase by 46% on the 2013 figure (from 4% to 6%) - This means there will be 11,500 people aged 80 and over living in Bury
- Whilst deprivation in the borough is lower than average, about 16.9% (6,400) children live in poverty
- The number of children in care is high
- The proportion of children who are considered school ready at the age of 5 is below average
- Breastfeeding rates are below average, with a significant drop off between initiation and 6-8 weeks
- Whilst Bury's educational results remain significantly higher than the England average, there are educational attainment gaps between ethnicities, for those on free school meals and for looked after children
- Nearly 1 in 5 five year olds and 1 in 3 ten year olds are overweight or obese. In Year 6, 20.4% of children are classified as obese
- Teenage pregnancy rates are higher than the national average
- Local levels of smoking in pregnancy are high compared to the England average
- Smoking related deaths in Bury are significantly higher than the England average, although adult smoking rates are slightly lower than the England average
- Bury has a high cancer incidence rate and the early death rate from cancer is higher than the average for England
- It is estimated that 18,300 adults aged between 18 and 64 have a mental health problem
- Over two thirds of the adult population are overweight or obese
- Only 11.6% of adults were undertaking recommended levels of physical activity, with a correlation between areas of high deprivation and low levels of participation
- The rate of self-harm hospital stays was worse than the average for England
- One in five of Bury's adult population is living with a long-term health condition. Those with long term conditions are also two to three times more likely to experience mental health problems
- The 2011 census tells us that, in Bury, 11% of the population (20,000 people) were providing some form of unpaid care. Carers providing support for 50 hours a week or more are twice as likely to be in poor health as those not in a caring role. Only around 15% of carers are known to the council's Carer Service Team or the Carer's centre
- Fewer adults who are in contact with secondary mental health services live in stable and appropriate accommodation than the average of our statistical neighbours
- The number of people living with dementia (and who are aged 65 and over) will increase by 34% over the next 10 years
- Around 35% of people aged 65 and over living in the community fall each year and this increases with age; around 20% of those who have a hip fracture (often due to a fall) will die within four months

- Life expectancy in the borough is still below the England average and this gap is widening, despite steady and lasting improvements in how long people can expect to live, partly due to a significant reduction in cardiovascular deaths - Life expectancy is 10.7 years lower for men and 7.4 years lower for women in the most deprived areas of Bury than in the least deprived areas (these areas are as little as four miles apart!)

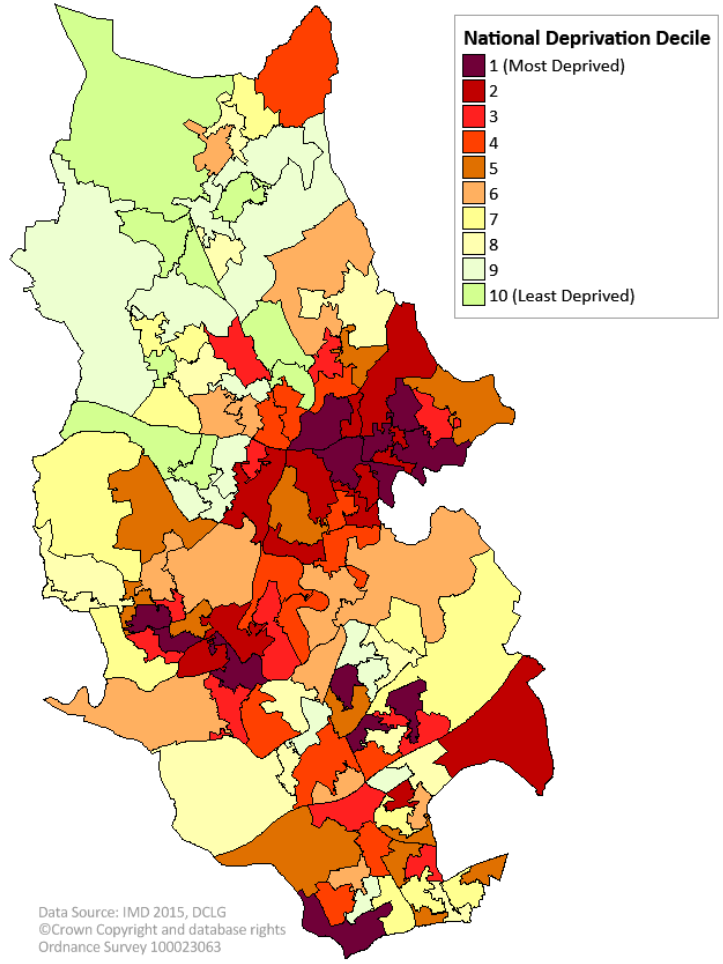








Deprivation in Bury
Index of Multiple Deprivation 2015



All of our Locality Plan work will need to reference and take account of the wide range of workstreams that are being led at and delivered by Greater Manchester wide thematic groups.

Estates

Creation of a city-wide Devolution Estates Task & Finish group, with membership from across the public sector, to work on a number of key challenges:

- Making most effective use of significant public sector assets
- Agreeing capital investment priorities
- Agreeing disposal of surplus land and properties
- Managing estates on a GM footprint

Work is also underway to provide more detailed analysis and work to support the assumptions included in the GM financial model. In particular it focuses on:

- The potential revenue and capital implications of reconfiguring estates in line with a redesigned approach to health and social care delivery
- Engage each of the 10 localities in the development of this analysis and use case studies to provide a deeper "dive" into how estates may change and the potential financial implications of such change
- Improve the data available to GM around estates and agree protocols for developing a single database going forward
- Provide the foundations for estate change beyond December and set out the steps needed to implement change

Information Management & Technology

The aim of this workstream is:

- To establish a GM vision for IM&T within the context of health and social care devolution
- To build on an understanding of IM&T requirements of the other devolution workstreams
- Identify GM standards for IM&T required to deliver devolution
- Respond to the requirements of CCG areas to develop a digital roadmap

Mental Health and Children & Young People's Mental Health

This is a revised version of the group that already existed and has overall responsibility for the GM Mental Health Work. The aim of the workstream is the development of an all age GM strategy for mental health. The strategy will:

- Set the priorities for GM Mental Health services
- Identify those things that need to be delivered at the GM level
- Provide the context for the development of locality plans
- Define the standards of service individuals and families can expect across GM – driving consistency
- Identifying best practice from localities
- Identify priority cohorts for GM and our collective response
- Facilitate cross border working and reduce out of borough placements

Primary Care Transformation

- The development and implementation of a new primary care strategy for Greater Manchester, ensuring it is aligned with the Greater Manchester Health and Social Care Devolution strategic plan and individual locality plans.
- Engagement with key stakeholders is planned for early November.

Early Years

- A small reference group was established to consider the re-development of the early years workstream in the context of start well. This was a task and finish group rather than an ongoing governance group. The aims of the workstream are:
- Develop a single programme of activity for early years across GM
- Inform the early years implementation programmes across GM
- Undertake workforce development activity across GM

Learning Disabilities

The initial aim was to bring together the GM bid for funding following the announcement of being a Fast Track area. This includes the GM vision and key objectives for learning disability including future targets. Following the bid and announcement of the funding, the aim of the workstream is now to develop and oversee the implementation of the GM vision and delivery of targets. Current progress and next steps:

- Vision developed including key objectives and targets
- Bid for funding submitted – this had two elements; one around the GM system capacity and another around the approach to Calderstones
- Implementation planning started

Housing

Housing's role in early intervention and prevention is key. Poor housing, unsuitable housing and precarious housing circumstances affect both physical and mental health. The health of older people, children, disabled people and people with long-term illnesses is at greater risk from poor housing conditions. The right home environment can:

- Protect and improve health and wellbeing and prevent physical and mental ill-health Enable people to manage their health and care needs, including long-term conditions, and ensure positive care experiences by integrating services in the home
- Allow people to remain in their own home for as long as they choose

And in doing so can:

- Delay and reduce the need for primary care and social care interventions, including admission to long-term care settings
- Prevent hospital admissions
- Enable timely discharge from hospital and prevent re-admissions to hospital
- Enable rapid recovery from periods of ill-health or planned admissions

•We need to engage with the housing sector in the transformation of health and social care to maximise their community asset base for engaging with communities to improve health and wellbeing.

Dementia

The programme will focus on improvements which directly impact on the 'lived experience' for people with dementia. Through broad stakeholder engagement, they will continue to narrow the focus during the outline planning phase, developing the thematic focus of 'connectedness' and enabling work streams. The programme will be designed in two distinct parts. 1) a description of the 'early win' commitment to the Devolution programme before March 2016, and 2) a 5 year dementia programme for Greater Manchester.

The early win has the following deliverables:

- Developing a transparent GM dashboard of metrics which will be updated monthly by January 2016.
- Determining and agreeing an improvement goal for GM to achieve.
- Offering support, for example by learning from the best, peer coaching, collating and building resources to spread learning.
- Establishing a governance structure to provide oversight to the early win and 5 year programme, September 2015.
- Pilot the key worker programme (developed by the Alzheimer's society) using the Salford Centre of Contact, with a view that people who are newly diagnosed with dementia will have access to a key worker who can support them.
- Launch the 5 year dementia programme for Great Manchester in March 2016.

The 5 year strategy will focus on three core elements: Monitor my Health; Enrich my World; and Connect me to my Support System.

GM Leadership within New Society

This work is designed to:

- Develop leaders across GM who can lead not only within and behalf of their organisations and professions, but increasingly can work beyond this to lead within and on behalf of 'place'. This new approach will be flexible enough to accommodate different spatial levels of place such as city region, district or neighbourhood.
- Develop a more coherent approach to leadership development that is not organised through professional disciplines (eg: health, social work etc.), or is structured around organisations (eg: local authorities, etc.).
- Develop an approach which will incorporate skills and behaviours identified by places and through GM work streams as essential to the delivery of our ambitions for GM.

GM Specialised Services Transformation Programme

- The purpose of this operational group is to develop the GM Specialised Services strategy, implement a transformation process for Specialised Urology and OG Cancer Surgery, identify and manage programme risks and provide assurance on delivery to the GM Specialised Services Oversight Group (GM SCOG).
- The workstream aim is: the development and implementation of a Specialised Services strategy for Greater Manchester, ensuring it is aligned with the Greater Manchester Health and Social Care Devolution strategic plan and individual locality plans; Oversight of on-going specialised services transformation programmes; and Oversight of the day to day commissioning and performance of GM Specialised Services.

BURY LOCALITY PLAN

REDESIGNING / IMPROVING SERVICES

- Create one commissioning organisation with a significant pooled budget
- Integrated ambulatory care front door at Fairfield General Hospital
- Discharge to Assess
- Single Site Discharge
- Implement GM Early Years Model
- MDT provision for vulnerable children
- IMC / Reablement / Crisis Response Step Up
- Review Points of Access
- Improving transitions

(INVESTING IN) PREVENTION & EARLY INTERVENTION

- Single point of access for children & young people within community mental health & wellbeing hub
- Community Mental Health & Wellbeing Service
- Redesign Falls and Fragility fracture pathway
- Active Ageing (IWIYW)
- Staying Well Programme
- Re-able the housing stock
- 'Better Together' / Primary care quality programme
- Establish work and health programme
- Early intervention in psychosis
- Tackling social isolation

MOVING SERVICES CLOSER TO THE COMMUNITY

- Roll out wraparound Locality Hubs
- Full Primary Care offer over 7 days
- Shifting services out of general practice into other services
- Implement the GM Primary Care Standards
- Shifting a range of secondary care services into the community
- Out of Hospital Provider Alignment

ENABLING PEOPLE TO SELF CARE

- Production of self-management for children & young people's mental health & wellbeing
- Self-referral approach in MH
- Bury Directory
- Scale up social prescribing & self care support for LTC
- Roll out of Welly Cafe / Manchester Rd Lodge approach
- Dementia Friendly Communities

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Locality Plan

Locality Plan update to Bury Health Scrutiny Committee 26 January 2016

Julie Gonda

Assistant Director

Communities & Wellbeing

Bury Clinical Commissioning Group

Bury Council

Locality Plan Update

- Background to the plan
- Bury's approach
- Next steps

GM Devolution Health & Social Care Background

- Bigger impact, more quickly, on the health, wealth and wellbeing of GM people
- Respond to the needs of local people by using their experience to help change the way we spend the money
- It will allow us to better co-ordinate

GM Strategic Plan

Greater Manchester Strategic Plan

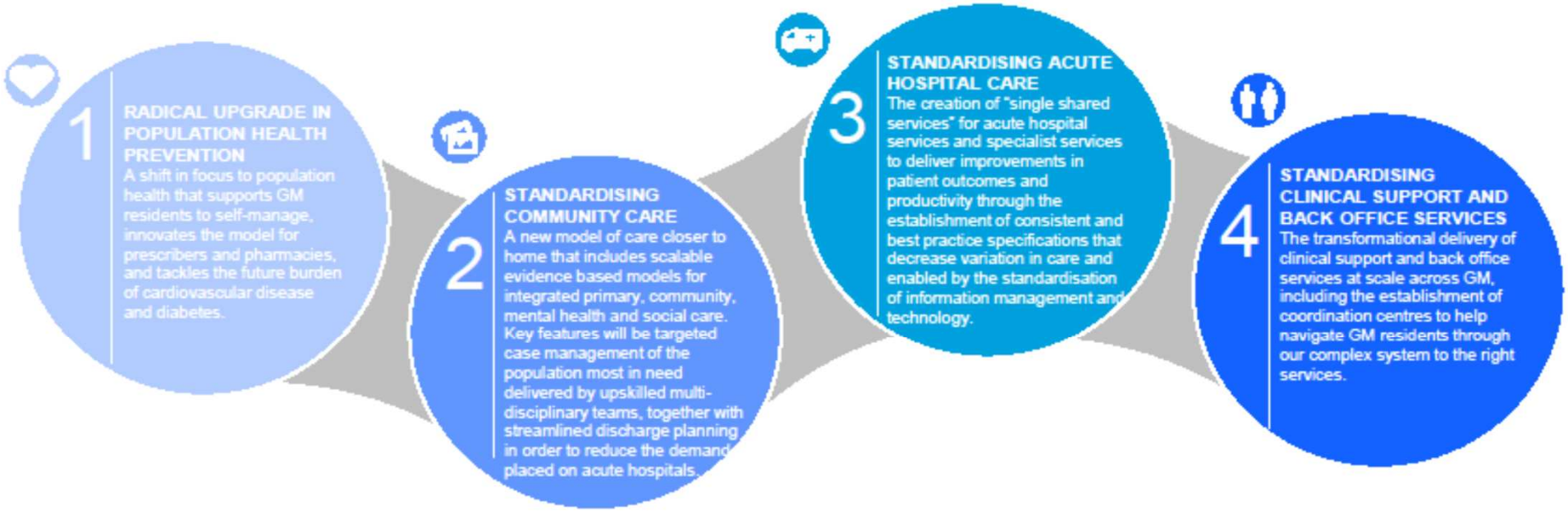
- 'Taking charge'
- High level and shows the GM direction of travel
- The themes are around encouraging far greater self care, self management and patient empowerment
- Freedom and flexibilities to work differently

GM Strategic Plan

- GM has to make efficiencies
- Deliver services differently
- Become financially sustainable
- Deliver safe care
- Recognises the need for workforce changes across the health and care sectors

GM Plan

The recommendations span four main areas that will deliver fundamental change for Greater Manchester



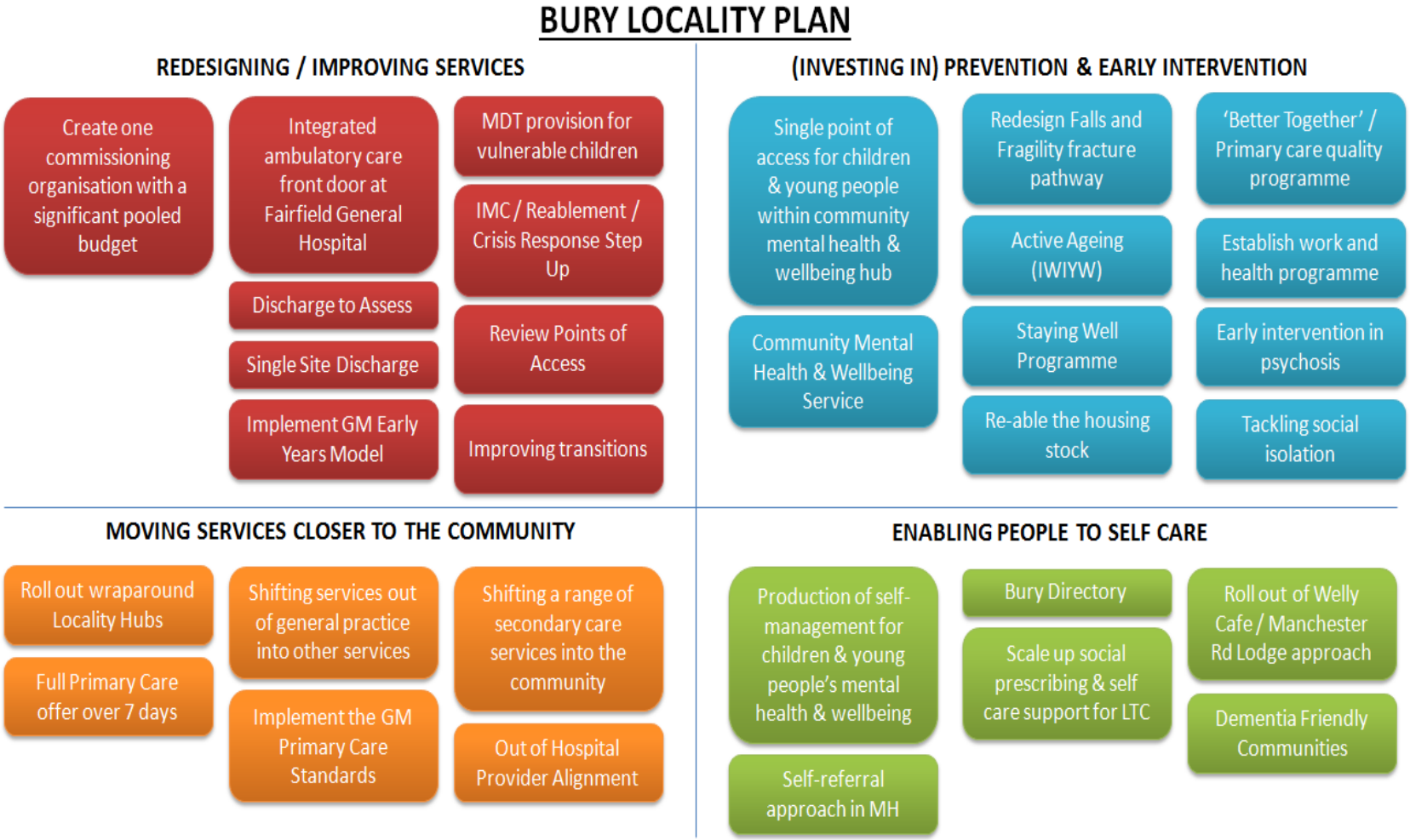
Bury's Locality Plan

- Executive summary covers the key points
- Adopted 4 key themes

  Redesigning and improving services
  Moving services closer to the community
  Investing in early intervention and prevention
  Enabling people to self care

- Plus commissioner alignment as Bury's exemplar project

Bury's Locality Plan

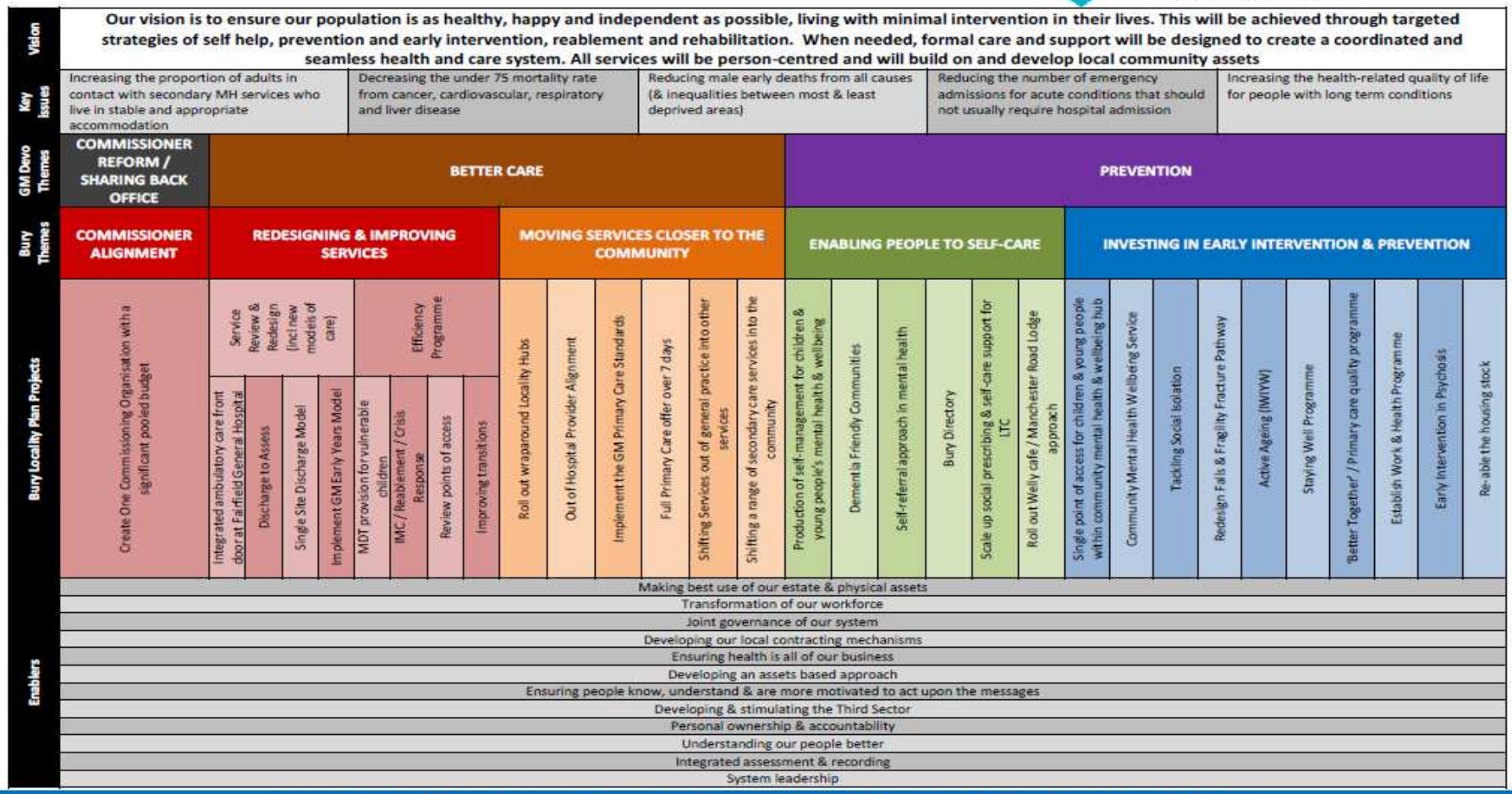


NHS
Bury Clinical Commissioning Group

Bury COUNCIL

Bury's Locality Plan

Team Bury
Working Together For A Better Bury



BOLDER, BRAVER BURY – TOWARDS GM DEVOLUTION – EXECUTIVE SUMMARY

NHS
Bury Clinical Commissioning Group

Bury COUNCIL

Locality Plan workshop

Commissioning Intentions

- Bury Council and Bury CCG have committed to work towards establishing one commissioning function
- Right for Bury People, Right for the Bury £
- Initial workshop to begin dialogue on the vision and framework for development, underpinned by the stated objectives for Bury
- Opportunity to provide early briefing for Providers

NHS
Bury Clinical Commissioning Group

Bury COUNCIL

Locality Plan workshop

One Commissioning Function for Bury

Working Definition:

To develop a commissioning purpose that changes people's lifestyle behaviours through high quality providers of:

- Education and Information
- Prevention
- Self care and self management
- Care and Support

In order to maximise the number of people who live out their lives in the best possible way as determined by the individual

Bury Clinical Commissioning Group

Bury Council

Financial challenge in Bury

- Financial gap of £125m by 2021:
  - NHS - £85m
  - Social care - £40m
  - Total - £125m

Bury Locality Plan next steps

- Move to implementation phase, development of implementation plan
- Develop Project Management Approach to delivery
- Engagement and communication plan

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Minutes of: **PHYSIOTHERAPY OVERVIEW PROJECT GROUP**

Date of Meeting: 3rd December 2015

Present: Councillor Skillen (in the Chair); Councillors: S. Kerrison, C. Preston, S Haroon, J Harris

Also in attendance: Dr K. Patel, Chair Bury Clinical Commissioning Group
Mr D. Galvin, Patient's Advocate, Radcliffe
Julie Gallagher; Democratic Services Officer

Apologies for absence: There were no apologies for absence.

POPG.01 APPOINTMENT OF CHAIR

It was agreed:

Councillor Skillen would be appointed Chair of the Physiotherapy Overview Project Group.

POPG.02 DECLARATIONS OF INTEREST

There were no interests declared at the meeting.

POPG.03 PHYSIOTHERAPY SERVICES

Members of the Group considered a presentation from the Chair of Bury CCG Dr K Patel. The Presentation contained the following information:

The CCG has an annual budget of £250 million. In the financial year 2015/16 the CCG must make savings of £9million. The CCG therefore resolved to review smaller contracts provided by the CCG and re-assess if there was still a need for the service/contract. As part of this review the CCG reviewed the physiotherapy provision.

At the commencement of the review the physiotherapy service was provided by Pennine Acute NHS Trust and two private providers in Radcliffe and Prestwich. Pennine Acute NHS Trust provides physiotherapy outpatient services at Fairfield Hospital and North Manchester Hospital; physiotherapy services provided include; specialist stroke services, cardiac rehabilitation, paediatric physiotherapy and domiciliary services.

The cost of providing the contract was £1.3 million with Pennine Acute and £128,000 split between the two private providers. As part of the review process the CCG looked at costs across the service, activity, benefits, prescribing costs, orthopaedic referrals and demographic information.

The CCG in consultation with the clinical cabinet agreed that Pennine Acute would be the sole provider of physiotherapy services across

the Borough. Dr Patel reported that the reason for the decision was in part due to financial constraints but also to standardised provision across the Borough.

The decision was discussed with the patient cabinet and it was agreed that it would not be necessary to undertake a full public consultation with regards to the proposals.

Since the proposals have been agreed there are have been 16 clinics established in Radcliffe operating three days a week, two in the Town Centre, two in Prestwich, two at the Elms; clinics in the north of the Borough will be operational soon.

In respect of waiting times it is envisaged that the average waiting time will be 3-4 weeks, this will be a reduction in waiting time for the majority of service users.

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

- Members sought assurances that there would be consistency of provision/staffing at the new clinics
- Members expressed concern with regards the perceived lack of planning in terms of the transitional arrangements
- Members expressed concern with regards to the problems with communications between the acute sector and community services in respect of physio provision
- Members wanted to be assured that the waiting times for access to physiotherapy services would be three to four weeks

Members of the group considered a verbal update from Doug Galvin, Patient Advocate.

The Patient Advocate reported that the need for physiotherapy services in the Radcliffe area is greater due to the demographic make-up of the area. It is estimated that 15 to 20% of GP workload is taken up with MSK complaints.

The patient advocate expressed concern that since the withdrawal of physiotherapy services the, "do not attend rates" have risen to 40%; a figure disputed by Dr. Patel.

The Patient Advocate expressed concern that there had been no consultation with the Patient Cabinet in respect of the proposed changes to physiotherapy services.

With regards to the cost of the new service, the Patient Advocate reported that the cost per referral is far greater with Pennine Acute than with the previous private providers.

In response to the concerns raised, Dr. Patel reported that the contract with Pennine Acute is a block contract and costs the CCG £1.3 million annually. If the CCG were to replicate the service

provided to residents in Radcliffe with Pennine Acute, the cost of providing the service would rise to £1.7 million.

In respect of waiting times; Dr. Patel reported that he would like to have waiting time of three to four weeks for all clinical services.

Members discussed the proposed changes to physiotherapy services and the impact this would have across the Borough. Members sought assurances from Bury CCG that information relating to any further proposed changes would be communicated to Councillors in the first instance. Members accepted that the main driver for the changes was to ensure equity of physiotherapy service provision across the Borough as well as at the same time having to make financial savings.

It was agreed:

1. Dr. Patel would provide democratic services with the number of patients who did not attend their physiotherapy appointment.
2. The provision of the revised physiotherapy service would be reviewed by the Physiotherapy Overview Project Group in six months.
3. Any press releases issued by Bury Clinical Commissioning Group relating to proposed clinical service changes would be forwarded to Democratic Services for circulation to Elected Members.

COUNCILLOR R Skillen
Chair

(Note: The meeting started at 4.00pm and ended at 5.20pm)

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