

AGENDA FOR

HEALTH SCRUTINY COMMITTEE

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To: All Members of Health Scrutiny Committee

Councillors : P Adams, N Bayley, M D'Albert,
J Grimshaw, S Haroon, K Hussain, Kerrison (Chair),
O Kersh, J Mallon, A McKay, Susan Southworth 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, 12 September 2017
Place:	Meeting Rooms A & B, 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:	

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 - 6*)

Minutes of the meeting held on 16th March are attached.

5 DELAYED DISCHARGE (*Pages 7 - 68*)

6 TRANSFORMATION UPDATE (*Pages 69 - 92*)

Dave Boulger, Programme Director (Devolution) will attend the meeting to provide members with an update in respect of:

- Governance including Risk register
- Measures of Success
- Pooled Budgets
- Transformation Monies
- Financial Sustainability

7 HEALTH AND WELLBEING BOARD ANNUAL REPORT (*Pages 93 - 112*)

The Social Development Manager and HWB Policy Lead will report at the meeting. Report attached.

8 WORK PROGRAMME UPDATE (*Pages 113 - 114*)

A draft work programme for Member's consideration is attached.

9 URGENT BUSINESS

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

Minutes of: HEALTH SCRUTINY COMMITTEE**Date of Meeting:** 16th March 2017**Present:** Councillor S Kerrison (in the Chair)
Councillors P Adams, N Bayley, J Grimshaw, A McKay, M D'Albert, O Kersh, J Mallon, Susan Southworth and R Walker**Also in attendance:** Dr Jeff Schryer, Clinical Lead Mental Health, Bury CCG
Shirley Allen, Programme Manager, Dementia, Bury Council
Cath Tickle, Senior Commissioning Manager, Bury CCG
Jon Hobday, Public Health Consultant
Marcus Connor, Corporate Policy Manager
Julie Gallagher, Principal Democratic Services Officer**Public Attendance:** 6 members of the public were present at the meeting.**Apologies for Absence:** Councillors Haroon and Hussain**HSC.605 DECLARATIONS OF INTEREST**

There were no declarations of interest made at the meeting.

HSC.606 PUBLIC QUESTION TIME

The Chair invited questions from members of the public present and the following questions were raised:

Mr Coates a member of the public asked the following question

"Given that the CCG's consultation survey:

1. dishonestly reports the results of its "engagement" survey, 2. does not consult about the key issue of whether the Walk-in-centres should be closed or kept open, 3. fails to mention in the question about the phone help line that the first contact will be with the unpopular NHS111, and 4. words every one of its questions asking for the public's opinion of its proposals in a way which is clearly leading,

I would like to ask the representatives of the CCG: [if they are present]

- a. whether, when the consultation is re-started, you will replace the current survey with one that genuinely tries to establish the public's view of your proposals, and if not:

- b. are you are not ashamed of the dishonesty of your consultation, and

c. how can you expect a public which you clearly hold in contempt to have any further trust in you?"

The Principal Democratic Services Officer reported that as no member of the Senior Leadership Team from the CCG was present, the question would be forwarded on to them for consideration and a written response would be compiled and sent on to Mr Coates within five working days.

In respect of the Committee Mr. Coates expressed concern that the online survey would form a major part of the review and asked for the Committees views on this. Responding on behalf of the Committee, Chair Councillor Kerrison reported that, the Committee had in the first instance received information in respect of the engagement exercise undertaken. The Health O&S Chair met with the Chair of the CCG to discuss the consultation arrangements. At the meeting held on 7th February the Committee reserved the right to receive details about the outcome of public consultation before it makes its response so that the response can be informed by patient and public opinion.

The Principal Democratic Services Officer reported that the consultation on Bury's proposed future model for urgent care is to be paused to allow NHS Bury Clinical Commissioning Group a chance to consider a new directive aimed at improving urgent and emergency care nationally.

It was agreed:

Democratic Services would liaise with Bury Clinical Commissioning Group to obtain a response to the Public Question raised by Mr. R. Coates. Once received, the response will be circulated to members of the Health Overview and Scrutiny Committee.

HSC.607 MINUTES

It was agreed:

That the minutes of the meeting held on 7th February 2017 be approved as a correct record.

HSC.608 MENTAL HEALTH THEMED UPDATE

- **Parity of Esteem**

Dr Jeff Schryer, Clinical Lead for Mental Health, Bury CCG attended the meeting to update Members on the work undertaken on behalf of the CCG with regards to parity of esteem. The presentation contained the following information:

There is a national requirement that Bury CCG increases expenditure in Mental Health by at least the same percentage as the CCG overall growth. Bury CCG growth 2017/18 is 2.01%; 2018/19 is 1.99%.

Dr Schryer reported that the CCG would want to ensure Mental Health services are not disadvantaged as a result of other competing pressures, mental health expenditure in the CCG in 2016/17 was cica £31.5m.

Dr Schryer reported that work is already underway and that includes planned investments in Children and Young People's Services (refreshing plan with stakeholders including Local Authority); investments in Learning Disabilities and Dementia, working with local providers to ensure patient safety and working with third sector to improve local services.

Recent investments include, safer staffing on wards, early Intervention in Psychosis, Rapid Access Interface and Discharge Service (RAID) and telephone street triage; health minds; big white wall project.

Dr Schryer reported that there is an acute transformation pilot to support the crisis pathway and avoid hospital attendances and admissions. This will include:

- Next day clinics staffed by RAID practitioners
- Supported discharge team
- Increase in capacity in the Home Treatment Team
- 7 day Community Therapy Programme
- Clozapine Initiation Clinic in the community

Dr Schryer reported that there has been a number of recent investments via the voluntary sector including grants to Turning Point, Groundwork and Earlybreak.

Questions were invited from those present at the meeting and the following points were raised:

In response to a Member's question, the Clinical Lead for Mental Health reported that the majority of patients would complete a talking therapies session within eighteen weeks. Once completed the practitioner would look at the patient's need and how they have responded to the treatment before deciding what course of action to take next.

With regards to only 15% of patients with depression accessing psychological therapy support, Dr Schryer reported that this is a relatively new service and it is hoped this will increase to 25% by 2020/21.

Dr Schryer reported that mental health service providers are actively engaged in providing training to police officers in how to recognise members of the public who may be in distress as a result of a mental health condition.

In response to a Member's question Dr Schryer reported that funding for projects in the voluntary sector are usually for two years. The providers

must evidence how the work undertaken relieves pressure in other areas of the NHS as well as evidence outcomes.

In respect of funding for mental health services, the Commissioning Manager reported that the CCG is working with a number of different agencies to better recognise mental health problems before they escalate to crisis point. The Director of Public Health reported that one of the workstream within the Locality Plan is the Children and Young People's Plan, the aim of this work is to take a holistic approach to tackling mental health including providing support for the whole family.

- **Dementia**

Shirley Allen, Programme Manager Bury Council attended the meeting to provide members with an update with regards to the work being undertaken to support people in the Borough suffering from Dementia. The presentation contained the following information:

The Programme Manager reported that 1773 people have received a diagnosis of dementia and the forecast prevalence of people who may have dementia in Bury is 2041. Of 397 people referred for a dementia diagnosis in 2015 – 70% received a diagnosis and of these only 12 waited for longer than 6 weeks for their diagnosis.

The Programme Manager reported of those people with a diagnosis – 362 are receiving home care, 383 are receiving care in a residential setting and 1032 are receiving neither. Hospital admissions for people with dementia are 42.5% per 1000 and 16.2% were re admitted to hospital these figures are the best in Greater Manchester. The Length of stay is 11.1 days per admission, the Programme Manager acknowledged that there is some improvement required in this area.

The Programme Manager reported that the key is to provide a person centred approach and this should be at the heart of good dementia care.

Dr Schryer reported that the role in primary care is to assess, diagnose and manage 'non-complex' cognitive impairment/dementia in primary care without referral to the specialist Memory Assessment Service (MAS). Primary care clinicians are now expected to manage their patients along the whole pathway in the same way as other long-term conditions.

Dr Schryer reported that each practice has appointed a named Dementia Clinical Lead (DCL) a comprehensive ongoing education programme for DCLs – led by consultants and other specialists including Dementia Adviser Service has been established.

The Dementia Advisor Service is an integral part of the redesigned pathway, the service provides information covering diagnosis, signposting to available support, coping strategies and planning for the future for people with dementia and their carers.

Dr Schryer reported there is a great deal of work underway to up skill GPs to better understand Dementia. GPs, Opticians and Pharmacists will be aligned to Care Homes to improve consistency in care and also to try and keep patients out of hospital, where appropriate.

In response to a Member's question the Programme Manager reported that replacement care can be offered for someone suffering with Dementia, if it is identified within the person's personal support plan.

- **Children and Young People's Plan**

Cath Tickle, Senior Commissioning Manager Bury CCG attached the meeting to provide Members with an overview of the Children and Young People's Plan. The plan was published in November 2015 and details the local strategy to meet these objectives and improve health and wellbeing outcomes for our children and young people. Since publication the CCG has:

1. Commissioned a new community eating disorder service, which will soon operate from Bury town centre.
2. Developed and recruited to a new 'link worker' role within the Healthy Young Minds Team. The two link workers provide mental health advice, guidance and support for schools and other services – better enabling prevention and early help.
3. Implemented the Single Point of Access.
4. Begun co-working within the new Neighbourhood Hubs.
5. Commissioned specific support from local 3rd Sector organisations including Early Break and Homestart.
6. Significantly reduced waiting times for Healthy Young Minds (CAMHS).
7. Continued to work closely with GM colleagues to develop crisis resolution and liaison services.

The Senior Commissioning Manager reported that the current plan will be refreshed and republished by the end of March 2017.

With regards to concerns raised, the Senior Commissioning Manager reported that the workforce needs to adapt and work in partnership and be more alert to identifying those in need of mental health support. The CCG work with vulnerable groups including Looked after children and young carers to understand their needs and any support they may require.

- **Suicide update**

Jon Hobday, Public Health Consultant attended the meeting to provide members of the Committee with an update in respect of the scale and cost of the problem, to raise awareness of the key factors; what is happening to address this and what more can be done.

6 key areas for actions

- Reducing risk of suicide in high risk groups

- Tailoring approaches to improve mental health in specific groups
- Reducing access to means of suicide
- Providing better information and to support those bereaved or affected by suicide
- Supporting media to delivering sensitive approaches to suicide and suicidal behaviour
- Supporting research, data collection and monitoring
- Reducing rates of self harm as a key indicator for suicide

The Public Health Consultant reported that a recent Greater Manchester Suicide Audit identified key themes and factors which included; Social isolation; physical health conditions; relationship problems and breakdowns; job loss, job issues, and long term unemployment; financial problems including benefits and debt. Drugs and alcohol was a common theme with some very high intake of alcohol.

The Public Health Consultant reported that suicide rates in Bury have been reviewed, audits have been undertaken as to what activities each agency is doing to reduce/prevent suicide. A suicide multi agency action plan has been developed.

It was agreed:

A sub group of the Health Overview and Scrutiny Committee will be established to review the Bury Suicide Prevention Action Plan.

HSC.609 URGENT BUSINESS

There was no urgent business reported.

**Councillor S Kerrison
In the Chair**

(Note: The meeting started at 7pm and ended at 9.25pm)

Bury Reporting Delayed Transfers of Care (DToCs) Health Overview and Scrutiny

12th September 2017

What will we cover?

1. Definition – what is a delayed transfer of care and why is it important?
2. Performance Reporting re DToCs
 - Historical performance
 - Future reporting and trajectories
3. GM Standards relating to Urgent Care Performance
4. Bury implementation of the GM Standards
5. Questions

Definition

Definition – what is a delayed transfer of care

According to NHS England, a 'delayed transfer of care' occurs when an adult inpatient in hospital is ready to go home or move to a less acute stage of care but is prevented from doing so.

There are 3 conditions that must be met before a someone can be transferred:

- a clinical decision has been made that the patient is ready for transfer, (medically fit for discharge), and

- a multidisciplinary team has decided that the patient is ready for transfer, and

- the patient is safe to discharge/transfer (eg care package must be in place)

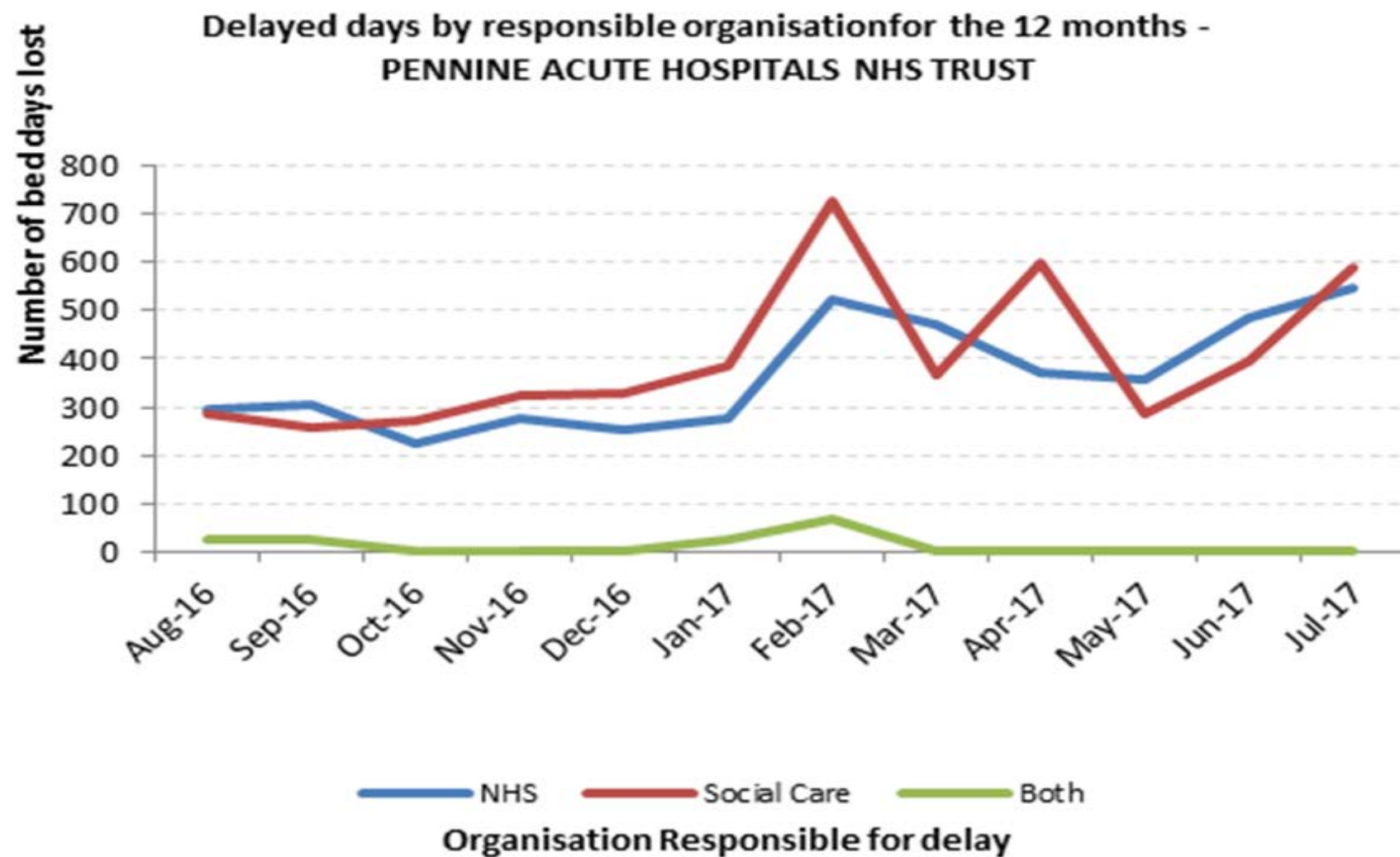
Performance Reporting

GM HSCP report on this weekly

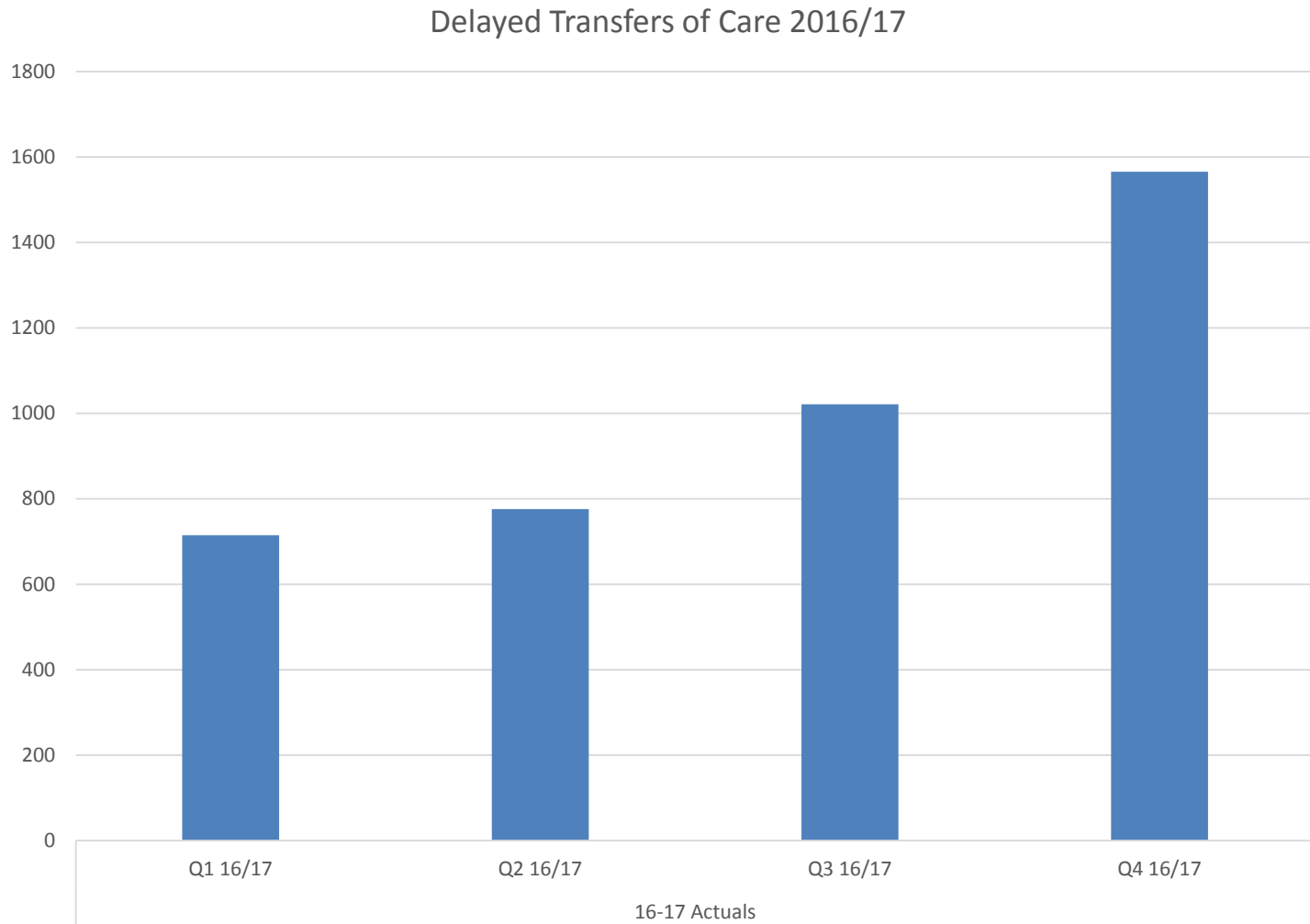
It is high profile and is a key measure of the success of Devolution

Split between a number of categories, summarised as health / social care

Sign off should take place regularly by operational managers incl social care



Bury Actuals 2016/17



Future reporting / targets

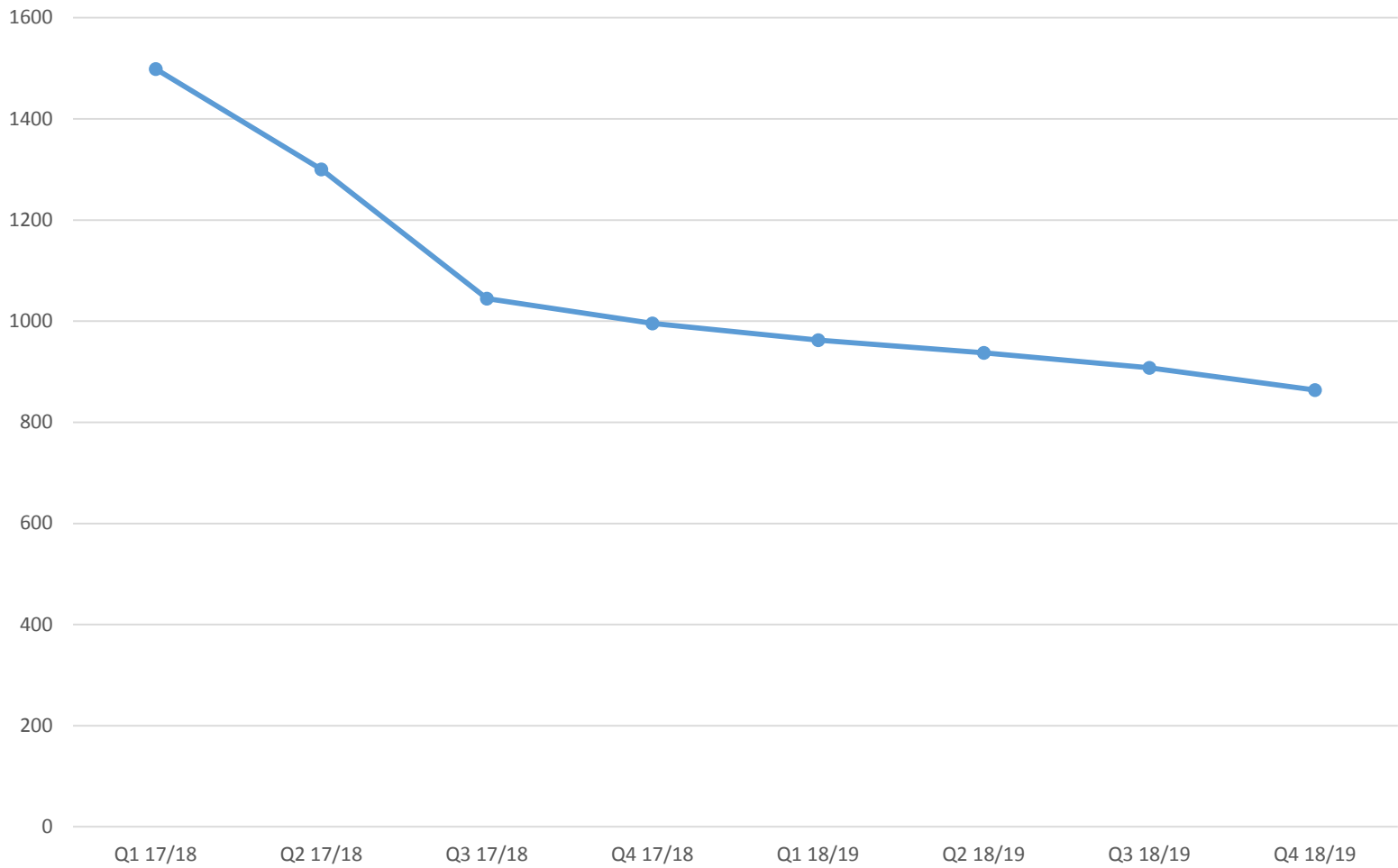
Now in place – agreed with GM HSCP and set as part of the Better Care Fund Reporting

Currently working on the trajectories for this year in detail to assure the GM team that they can be achieved

The GM Hospital Discharge Standards will underpin the operations of how these targets can be achieved

Future reporting / targets Bury

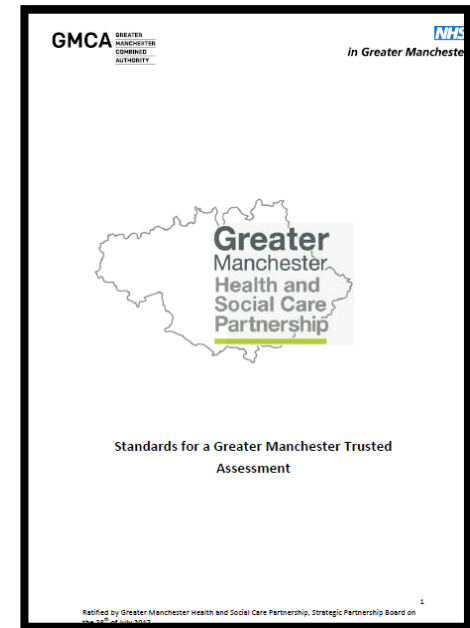
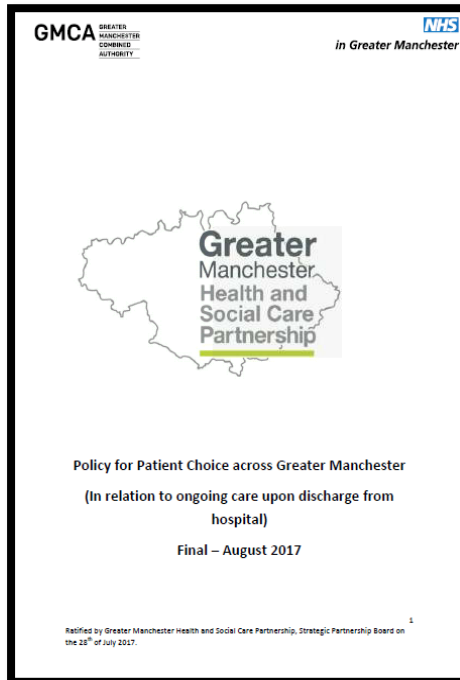
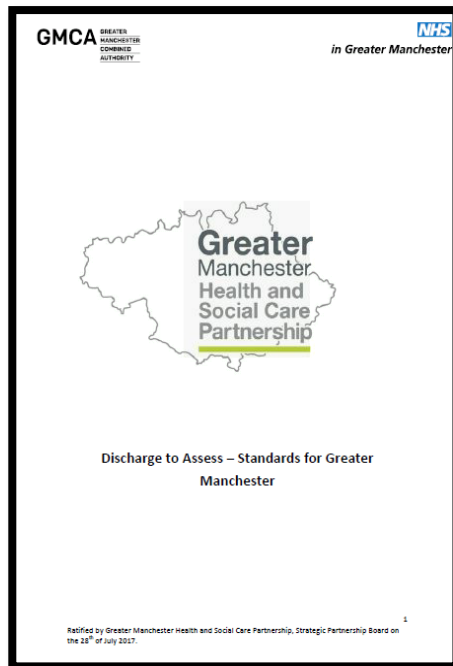
Delayed Transfers of Care Targets 2017/18 and 2018/19



GM Standards

GM HSCP have agreed 3 Hospital Discharge Standards that all 10 areas are expected to implement

Discharge to Assess, Patient Choice, Trusted Assessment



**What have we done in Bury
to improve DToCs?**

What we have implemented as a 'system':

Integrated discharge teams have been in place both at FGH and NMGH since at least the beginning of May

Additional reablement capacity is in place, focussed on the south of Bury to support issues at NMGH

Implementation of the Care at Home tender on a neighbourhood basis

In discussion with agencies re D2A beds for social care assessments

D2A beds have been put in place for Continuing Health Care Assessments

Questions

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Discharge to Assess – Standards for Greater Manchester

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1. Introduction

The Discharge to Assess Model is a key element of the Eight High Impact Changes, developed by the Helping People Home Team in order to support the safe and timely discharge of patients from a hospital setting. It is recognised as best practice for all patients and supports the national indicator that 90% of all Continuing Healthcare Assessments are conducted outside of acute settings.

Across the conurbation, there are a significant number of people in acute beds, whose medical episode is complete, but who are awaiting further assessment to decide the best way forward for their long-term care needs. There is a degree of variation in the way in which this is being approached; this paper sets out the GM Standard for all providers of health and social care.

It is expected that all health and social care systems in Greater Manchester will adopt these Standards from September 2017. Robust plans to ensure that local arrangement meet or exceed these standards should be in place by September 2017 and monitoring of performance indicators identified in this document will commence at this stage.

2. Definition of Discharge to Assess

Discharge to Assess is an integrated person-centred approach to the safe and timely transfer of medically ready patients from an acute hospital to a community setting for the assessment of their health and/or social care needs.

No decision about long-term care needs should be taken in an acute setting and as such, all adult patients should have the opportunity to access a discharge to assess pathway.

Patients should be moved home or to identified community provision as soon as they are medically ready. They should be then given appropriate support until a full assessment can take place and a longer term care package can be implemented.

No patient should be discharged before they are medically ready and discharge to assess must add value to the patient pathway through improved outcomes or experience. It must not be used as a method of freeing up a bed.

Patients must not be transferred without considering the best interests and informed consent must be received.

3. Discharge to Assess Pathways

Four potential pathways are identified as part of the Discharge to Assess model:

Pathway 0

For patients who can go home with no support or with the continuation of their existing packages of care.

All patients may be able to return home without any additional support. This pathway should be made available as soon as the patient is ready for transfer.

Pathway 1

For patients who can return home with additional support

- The patient is discharged home and care and therapy are provided by a community support and reablement team in order to support the patient's recovery to independence.
- This support should be in place for a maximum of six weeks, with up to four visits per day from the identified team. It is anticipated however that the timescales will be shorter.
- During this time, the patient will be assessed and referred to the most appropriate ongoing care.
- The patient will be discharged from the service, and will move under their GP's care, self-funded care; local authority funded care or funded Continuing Health care, according to the outcome of the appropriate assessment.

Pathway 2

For Patients who could potentially return home after a period of additional rehabilitation (National evidence shows there is minimal need for this pathway- Rehabilitation and reablement deliver the best outcomes if they are done in the person's own home)

- Through this pathway, the patient is discharged to temporary residential care/intermediate care facility/community hospital/ supported accommodation setting for up to six weeks and are provided with rehabilitation and reablement services in this setting
- An assessment of their long-term care needs are completed in this setting and appropriate referrals made.

Pathway 3

- **For patients likely to need ongoing care in a residential setting**
 - Through this pathway the patient is referred to a nursing or care home facility with recovery and comprehensive assessment.

- These patients will have been assessed by the multi-disciplinary care team as having very complex care needs and are likely to require continuing care in a residential home.
- The pathway will be common for those whom CHC funding is likely.

Pathway 4

For patients who have a significantly specialist need and require a specialist placement and therefore cannot be discharged for assessment

4. Greater Manchester Standards for Discharge to Assess

The following key standards should be adhered to in the implementation of discharge to assess.

- a. Pathways should be supported by a formal signed-off agreement between provider, CCG and Local Authority to ensure clear, effective agreements and processes including funding arrangements.
 - i. NB: where hospital sites may need to bind in multiple CCGs and Adult Social Care organisations, individual agreements may be required to take account of repatriation across geographical boundaries
- b. There is a clear “Discharge to Assess” implementation plan which has been agreed between all stakeholders, which has considered local barriers to implementation and appropriate capacity.
- c. There is a communication and engagement plan in place for the Discharge to Assess model for system stakeholders and for patients and their carers.
- d. Provision is free at the point of delivery, regardless of ongoing funding arrangements.
- e. Agreed clinical criteria for each of the four pathways
- f. Clear referral and assessment pathways for each of the four pathways
- g. Provide rapid access to appropriate care arrangement outside of the hospital setting for each of the pathways.
- h. Ensure that assessment is rapid, effective and able to mobilise the required services.
- i. Each patient on the discharge to assess pathway must have an agreed care plan
- j. Ensure that no patient is required to make decisions about their long-term care whilst in crisis.
- k. Staffed by appropriate staff who are able to assess long-term care needs and whose roles and responsibilities are clear.
- l. Ensure that assessments are not unnecessarily duplicated from the hospital to home.
- m. Be delivered using process improvement methodologies ensuring that evaluation and feedback mechanisms are in place.
- n. Any concerns regarding capacity to decide discharge planning must be dealt with appropriately and in line with the Mental Capacity Act.

5. Greater Manchester Benefits of Discharge to Assess

The benefits of Discharge to Assess can be defined as:

- a. Assessment is 'context specific' and the patient's immediate and long term needs can be more appropriately evaluated at home or in another community setting
- b. Issues which may have been developing for some time which precipitated an acute admission will be assessed and plans put in place while the patient is still at home or in a more appropriate care setting
- c. Patient's needs reduce and may become less resource intensive than predicted in a hospital environment, saving demand on social care service resources.
- d. Prevention of avoidable admission to long-term care settings
- e. Increased patient and family satisfaction
- f. Removal of steps, processes and delays in the discharge process which consume valuable resources and do not add value for the patient
- g. Reduced length of stay
- h. Reduced risks associated with vulnerable patients remaining in hospital
- i. Increased discharge rates
- j. Hospital beds are freed which reduces medical outliers
- k. Increased patient flow through the hospital
- l. Reduced delayed transfers of care and medically optimised patients remaining in an acute hospital setting
- m. Improved performance with accident and emergency four hour standard
- n. Reduced occupied beds

6. Greater Manchester Performance Indicators for Discharge to Assess

The following indicators for measuring the impact and success of the Discharge to Assess model need therefore to be put in place by systems:

- a. Average patient length of stay
- b. The total number and percentage of stranded patients
- c. The total number and percentage of beds occupied by delayed transfers of care
- d. The total number of patients discharged to a discharge to assess pathway (split by pathway)
- e. The percentage of patients discharged from discharge to assess pathway within 6 weeks.
- f. Patient and family experience (split by pathway)
- g. The number of readmissions from discharge to assess pathways (split by pathway)
- h. The percentage of patients who require ongoing care further to discharge from discharge to assess pathway

- i. The percentage of CHC assessments that take place outside of an acute setting (target 85%)
- j. Number of patients still at home after 30 days and 90 days.
- k. Level of care still required on discharge from Discharge to Assess
- l. Number of CHC placements to nursing homes and residential homes
- m. The number of readmissions from discharge to assess pathway
- n. Number of Council placements over 18 per 100'000

Systems will need to agree with GM Health & Social Care Partnership and locally how they will determine and achieve an improvement trajectory in respect of CHC assessment and social care assessments that are completed outside of the acute environment.

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Policy for Patient Choice across Greater Manchester
(In relation to ongoing care upon discharge from
hospital)

Final – August 2017

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1. Background

- 1.1. Patients exercising 'patient choice' is a contributory factor in delayed transfers of care across Greater Manchester with around one in ten delayed patients being due to patients not wishing to leave the hospital when identified as ready for discharge.
- 1.2. Best practice in discharge planning can avoid many of the issues that lead to patient choice issues, involving the patient, family and carers early in the process and actively managing expectations from the outset can all contribute to a positive patient experience.

2. Purpose of the Policy

- 2.1. It is essential that people access alternative care and support services in a timely way to ensure that the NHS can make hospital services available for people that need them.
- 2.2. The consequences of a patient who is ready for discharge remaining in a hospital bed longer than necessary include:
 - Exposure to an unnecessary risk of hospital acquired infection
 - Physical and mental decline and loss of mobility / muscle use;
 - Frustration and distress to the patient and relatives due to uncertainty during any wait for a preferred choice to become available;
 - Increased patient dependence, and greater demand for social care and support in the community, as the hospital environment is not designed to meet the needs of people who are medically fit for discharge;
 - Severely ill patients being unable to access services due to beds being occupied by patients who are medically fit for discharge creating pressures on the whole system
- 2.3. The need to decide to accept care or support at home, to move to an alternative care environment or to live in a nursing or residential home is a major decision that is often made at an very challenging time.
- 2.4. Personal circumstances can change significantly once a person is admitted to hospital, including adjustment to disability, increasing dependence and potential erosion to social networks.
- 2.5. On occasion, individuals decline the options that are available and to continue to remain in hospital longer than is necessary. This may be due to a variety of reasons such as:
 - A lack of knowledge about the options and how services and systems work

- Their first choice of nursing or residential care home or community carer is not available
 - Anxiety at facing the major life transition of moving from hospital to a care home for the first time, possibly for the rest of their life.
 - Concerns about either the quality or cost of the care provision
 - Reluctance to transfer to another hospital that is not local to their home because loved ones might find it difficult to visit.
 - Unwillingness to move into interim accommodation and then move again later.
 - There is uncertainty or conflict about who will cover costs of care
 - The choices available do not meet the patient's preferences
 - Concerns that their existing home is unsuitable, cold or needs work done to ensure a safe environment for discharge
 - Unrealistic expectations about their ability to cope and worry about expectations of what family and carers can and will do to support them
 - Mental capacity issues
 - Ethnic or religious beliefs that limits providing a certain type of service
- 2.6. It is important that the multi-disciplinary team is sensitive to the above issues when discussing discharge options, however patients must also be made aware of the potential issues of remaining in a hospital bed and staff must ensure that barriers to discharge are removed as early as possible in the care pathway.
- 2.7. Patient participation, engagement and communication are essential to the process for managing choice on hospital discharge
- 2.8. This policy has been designed to support people's timely, effective discharge from an NHS inpatient setting, to a setting which meets their diverse needs and is their preferred choice amongst available options.
- 2.9. It applies to all adult inpatients in Greater Manchester NHS settings, including acute and non-acute. It should be applied before and during admission to ensure that those who are assessed as medically fit for discharge can leave hospital in a safe and timely way.
- 2.10. All patients should be assumed to have mental capacity to make a decision about their ongoing care, including as regards discharge. A capacity assessment should be undertaken at any point during the process if their capacity, in relation to the discussions and decisions on discharge, is in doubt. Where the patient lacks capacity to make decisions about discharge from hospital, then the application of the policy should be adapted as explained in Appendix 1, following the Mental Capacity Act 2005.

- 2.11. This policy seeks to ensure that choice is managed sensitively and consistently through the discharge planning process, and people are provided with effective information and are supported to make a choice.
- 2.12. This policy is designed to offer guidance support and to provide a framework with which to work with individuals and representatives to manage the challenges of patient choice.
- 2.13. Both the policy and the process of managing choice on discharge apply equally to all patients, whether or not they need ongoing NHS or social care and whoever may be funding any such care.
- 2.14. For patients who are at the end of life and whose choice it is to die in hospital this decision should be respected.
- 2.15. Patients do not have the legal right to remain in hospital longer than is clinically indicated. A summary of legal responsibilities and rights, along with associated case law is contained as Appendix 2 of this document.

3. National Guidance on Choice on Discharge

- 3.1. LAC (2004)20: Guidance on Choice of Residential Accommodation, states that where patients have been assessed as no longer requiring NHS inpatient care, they do not have the right occupy indefinitely an NHS bed. If an individual continues to unreasonably refuse the interim care home or care package, the council is entitled to consider that it has fulfilled its statutory duty to assess and offer services, and may then inform the individual, in writing, they will need to make their own arrangements. The position also applies to the unreasonable refusal of permanent home care, not just the interim care home or care package
- 3.2. The Choice Directions Guidance, Ready to Go, Department of Health, states that discharge or transfer from hospital is frequently delayed when an individual's preferred accommodation is not available. Where it is entirely reasonable for a person to exercise choice at an extremely difficult and vulnerable time in their lives, the guidance makes it clear that, as long as an interim placement meets the needs of the individual, it is acceptable for a patient to move from an acute hospital to an interim placement until the permanent or alternative choice becomes available. It is important that consistent messages and information are given to patients and carers by all staff about the likely length of stay in hospital, and the need to move on to more appropriate care when they are ready to do so. This will avoid misunderstandings and surprises later in the process.

- 3.3. Patient Choice, NHS Constitution 2015, clearly places the patient at the heart of the NHS and upholds the views that patients need to be consulted and involved and offered guidance on the choices they can make.

4. Patient Choice in Discharge Planning

- 4.1. This policy supports existing guidance on effective discharge planning. It should be delivered within the context of an integrated discharge team, supported by strong executive leadership.
- 4.2. Discharge plans, that consider patient choice, should be developed before a patient becomes medically fit for discharge.
- 4.3. This policy supports discharge where the SAFER flow bundle is effectively used in inpatient care settings to support the timely discharge of patients.
- 4.4. Planning for safe, effective, transfer of care, in collaboration with the patient, their representatives and all members of the multi-disciplinary should start on admission, and for elective patients, before admission.
- 4.5. Patient choice should be considered as soon as possible after admission along with any other barriers to discharge.
- 4.6. Communication is central to the process of managing patient choice. Patients should be provided with high quality information, advice and support in a form that is accessible to them as early as possible, for elective admissions this should be before their inpatient stay, to enable effective participation in the discharge process and in making an informed choice. Patients and their representatives should be involved in all decisions about their care.
- 4.7. Where someone is providing care or considering providing care post-discharge, unpaid as a carer, they must be informed and invited to be involved in the discharge process and informed about their rights and sources of support. People have a choice about whether or not to provide care for other adults and people must be informed about their choices when establishing whether they are willing and able to provide care. Carers must be offered the information, training and support they need to provide care following discharge, including a carer's assessment.
- 4.8. Patients may wish to involve a member of their family, a carer, friends or others in their choice of care and this person should be identified as soon as possible to ensure that they can be involved in discussions and decisions within appropriate timeframes. This person is referred to as their representative within this document.

- 4.9. Where the patient has capacity to make their own decisions about confidentiality and information sharing, confidential information about the patient should only be shared with those others with the patient's consent.
- 4.10. Through appropriate implementation of this policy, patients and their representatives should fully understand that they cannot continue to occupy an inpatient bed if appropriate options have been provided for their care. If their preferred location or care provider is not available, the patient should be fully aware that they need to accept an alternative as an interim placement.
- 4.11. The process and timelines contained in this document should be clearly communicated to the patient so that by the time is medically fit for discharge, they are aware of and understand the discharge process and the decisions and actions that they need to undertake and the support that they will receive.
- 4.12. Where individuals no longer need inpatient care and their first choice of nursing or residential care home or community carer is not available, the hospital will support a timely decision to be made regarding an interim care location.
- 4.1. The process of offering choice of care provider and/or discharge destination will be followed in a fair and consistent way and there should be an audit trail of choices offered to people.
- 4.14. Patients should not be expected to make decisions about their long-term future while in hospital: home care, reablement or intermediate care or other supportive options should always be explored first through a discharge to assess model, where this is appropriate for their needs.
- 4.15. Where the patient wants, and where appropriate, all possible efforts should be made to support people to return to their homes instead of residential placements, with options around home care packages and housing adaptations considered. A discharge to assess model should always be considered for patients.
- 4.16. Where a discharge to assess model is in place, patients should be assessed for this provision as soon as possible during the patient pathway to enable decisions about longer-term care to be made in the most appropriate care setting.
- 4.17. If a patient is not willing to accept any of the available, appropriate alternatives, them, it may be that they are discharged, after having had appropriate warning of the risks and consequences of doing so. This option will only be pursued following the offer and rejection of available, appropriate options of care and appropriate safeguards and risk assessments.
- 4.18. The discharge plan should be developed to include patient choice where possible, and recognise the patient's autonomy to choose from available options.

- 4.19. Where available, patients should be offered a range of options and multi-disciplinary team should provide support to facilitate safe and timely transfer.
- 4.20. Except where a patient with the relevant capacity has made an informed decision to discharge himself/herself against the advice of health or social care professionals, the discharge process must not put the patient or their carers at risk of harm or that could breach their right to respect for private life. It should not create a situation whereby the independence of the carer or the sustainability of their caring role is jeopardised. This decision should be made by the multi-disciplinary team caring for the patient.

5. The Patient Choice Process

- 5.1. All actions taken to discharge a patient and discussions held with patients and their representatives regarding choice should be clearly documented in the patient's notes to ensure that there is an audit trail.
- 5.2. The discharge planning process should be led by a named health or social care professional, working as part of an integrated discharge team as part of the broader multi-disciplinary ward team; this will usually be the patient discharge coordinator.
- 5.3. The patient discharge coordinator should be responsible for ensuring that the process is appropriately followed and where issues or potential issues with discharge according to the policy are identified, and where appropriate escalated to a senior member of the team.

5.4. Stage One – Information provided within the first 48 hours

- 5.4.1. Information regarding discharge should be provided at the start of the patient stay, usually within the first 48 hours, or for elective admissions in advance of the admission to the patient, and where appropriate their identified representative. Information should be provided both verbally and in writing to the patient and to the representative where appropriate. Patients should be provided with the following key information at the stage:
- Factsheet A (Appendix 3) should be provided to the patient and where appropriate, their representative. Its contents should also be discussed verbally with the patient to ensure that it has been appropriately communicated.
 - The Estimated Date of Discharge should be communicated to the patient and their identified representatives.
- 5.4.2. If the patient wants a representative, such as a family member, carer or friend, to be involved in their decisions, the discharge coordinator should identify these people at the start of the process, appropriate consent should be received and all information

should be provided to them in the most appropriate manner. Early involvement and engagement of such representatives can significantly reduce the length of time it takes to discharge a patient.

- 5.4.3. If additional support is available to patients regarding discharge from the voluntary or third sector, these organisations should be signposted to patients at this stage and patients should be supported to access these services.

5.5. Stage Two – Assessing Future Care Needs

- 5.5.1. The likelihood of the patient and any carers needing health care, social care, housing or other support after discharge should be considered as soon after admission as possible.

- 5.5.2. If the patient is likely to have ongoing needs after discharge, the discharge coordinator should obtain consent from the patient and ensure timely referral to these other services for assessment. This should be from a holistic and patient-centred perspective of a person's needs and the care and support options may include, for example:

- Discharge to assess provision;
- Intermediate care (or step down care), either bed based or community based;
- Social care assessment;
- Community nursing services, including community matrons;
- Reablement;
- Short-term placement in a care home;
- Care at home support package;
- Financial assessment and benefits advice;
- Eligibility for NHS Continuing Healthcare or Funded Nursing Care;
- Home assessment for aids, adaptations and / or assistive technology;
- Other local health, social or voluntary service.

- 5.5.3. Where there is a trusted assessment model in place for the service provision, a referral should be made to this service to prevent the patient requiring multiple assessments and to reduce the timeframes waiting for the assessment process to be completed.

- 5.5.4. It should be made clear to the patients (and their carers, where appropriate) what the assessment in hospital is for, and what further assessments they can expect in the places they are transferred to.
- 5.5.5. Patients and/or their representative should be actively involved in the assessment process and in the development of care plans to enable full and effective assessments and to support planning.
- 5.5.6. Patients should be informed of the rights they have to complain about an assessment or decisions about their need for support.

5.6. Stage Three – Provision of Information to Patient about Care Needs

- 5.6.1. The discharge coordinator should advise verbally and in writing the outcome of the assessment at the earliest opportunity.
- 5.6.2. This stage should be completed well in advance of the estimated date of discharge in order to reduce delays to transfer and to provide as much time as possible for the patient and/or representative to make appropriate decisions about their future care.
- 5.6.3. The patient and/or representative should be informed about the care options available to them, including the funding arrangements of these options.
- 5.6.4. Where residential or nursing care home provision is required, where possible, the patient should be provided with all available and appropriate placements that can meet their needs and are registered with the Care Quality Commission. These choices should initially be within the CCG catchment area, however there may be occasions when a range of options are provided that are outside of this. Information should be provided to the patient and/or representatives about the costs of these placements.
- 5.6.5. Where it is not possible to provide three available, appropriate placements, due to limitations in the market, the rationale for providing limited options should be provided to the patient and/or representative.
- 5.6.6. Information should be confirmed by providing the patient and their representative with Letter 1, A, B or C as shown in Appendix 4, the version is dependent upon the patient destination. It is important that patients are talked through with patients in advance of their provision.
- 5.6.7. The patient and/or their representative has the right to look at alternatives that fall within the criteria that are set by the local authority based on their individual needs and the option to top up, or the criteria set by the NHS; however timeframes for decisions should be adhered to.
- 5.6.8. Whilst it is recognised that patients and/or their representatives may want to choose a residential or nursing care home other than those that have been identified, it is important that the risks of this approach are highlighted to the patient and/or representative.
- 5.6.9. Self-funding patients have the right to look at alternative placements; however, the limitations of the market should be explained and it should be advised at this stage that for those residential care homes with waiting lists, a patient does not have the right to wait in hospital until the placements becomes available. Furthermore, the patient and/or representative should be advised that an interim arrangement may be offered until the meantime and whilst this will be funded by **[funding]**

arrangements to be agreed], this funding will be available for a maximum of three weeks.

- 5.6.10. At this stage, if the patient is interested in taking up the offer of personal budgets (social care), personal health budgets (NHS) or integrated personal budgets, the discharge coordinator should advise them where to get information, who to contact locally and refer them to the lead.
- 5.6.11. Patients should be informed of the rights they have to complain and provided with details of how to do so. In order to minimise the need for patients to have recourse to the formal complaints procedure, all agencies should make every effort to ensure that patients are involved in all stages of decisions that affect them, and that their agreement to such decisions is obtained.

5.7. Step Four – Choosing a Placement within 7 days

- 5.7.1. Once all information is provided to the patient, including the provision of Letter 1 (Appendix 4), the patient and/ or their representative should make a decision about discharge within seven consecutive days of the date of this letter or a longer timeframe that is in advance of the date of discharge.
- 5.7.2. The discharge coordinator will advise the patient that the hospital will expect discharge to be achieved within the agreed timescale.
- 5.7.3. The discharge coordinator will proactively support the patient during this process and will provide advice and support regardless of how the placement is to be funded. Regular communication will be maintained through this period.
- 5.7.4. In some circumstances, it is recognised that more than seven days are required in order for people to make decisions. This may be the case for out of area patients and/or whose representatives have to travel further distances in order to make arrangements. However, a deadline should still be defined for achieving a decision regarding discharge which takes in to consideration the specific circumstances.

5.8. Step Five – Where a decision has not been made or an offer has been refused

- 5.8.1. Where a decision has not been made within seven days, and additional time has not been agreed for this decision, an interim package of care or placement should be offered to a patient.
- 5.8.2. Patients do not have the right to wait in hospital for their preferred option to become available.
- 5.8.3. Members of the multi –disciplinary team will liaise within two working days of the date the decision was anticipated. The multi-disciplinary team will discuss and seek to agree the recommended interim package or placement with the patient.

- 5.8.4. The multi-disciplinary team should advise the patient that an interim arrangement is available which meets their assessed needs. This should be confirmed by the provision of letter 2, Appendix 5, (version dependent on funding arrangements). It is important that this letter is addressed to the patient, is personalised to reflect their circumstances and that the process is also discussed with the patient.
- 5.8.5. The interim package/placement will allow further time for those choices to be resolved outside of hospital. This interim option would normally be one of the initial packages/placements offered if still available.
- 5.8.6. Discussions regarding permanent options should be continued during the interim placements, with the discharge coordinator providing that liaison.

5.9. Step Six – Formal Escalation

- 5.9.1. If no agreement has been reached regarding discharge arrangements after the first five steps, and transfer arrangements are challenged by the patient, the issue should be escalation to a local director or identified senior manager.
- 5.9.2. A formal meeting should be arranged with the patient and their representative to enable all parties to discuss concerns and seek to agree transfer to the most appropriate care provider, at least as an interim option
- 5.9.3. The discharge coordinator should send Letter 3 following the formal meeting, summarising the discussion, including discussions about risks, and next steps.
- 5.9.4. If it has not been possible to arrange a formal meeting, or the patient did not engage in the formal meeting, Letter 3, appendix 6 should be sent to the patient and their representative including the details of the arranged meeting.
- 5.9.5. If the patient declines the available support and care, including interim arrangements, the hospital has the right to discharge the patient. This step should not be taken without considering the risks of discharge and where appropriate, the hospital should consult their local legal advisors regarding legal proceedings

6. Overview of Process

- 6.1. A flow diagram of the process is available in Appendix 7 of this document.

7. Funding Arrangements

- 7.1. This policy applies equally to people regardless of the funding arrangements and the nature of their ongoing care.

- 7.2. Those self-funding care will be offered the same level of advice, guidance and assistance regarding choice as those fully or partly funded by the Local Authority or NHS, although it is recognised that some of the content of that care may be different.
- 7.3. A full assessment for NHS CHC should only be undertaken where the longer term needs of the individual are clear. In the majority of cases, these assessments should be conducted outside of hospital within a reasonable time frame and should not be a reason for delaying discharge to care outside of hospital.
- 7.4. Where the individual has a 'rapidly deteriorating condition which may be entering a terminal phase' the NHS CHC Fast Track Pathway should be considered.
- 7.5. For self-funding patients where it has not been possible to transfer a patient to their choice of care home, interim placements will be funded by [funding to be agreed] for the first three weeks. It is anticipated that the transfer to the permanent placement will be facilitated within this timescale, and the funding made by the self-funding patient.

8. Consultation and Approval Process

- 8.1. This policy has been adapted from a national policy on patient choice that has been implemented nationally by a number of NHS organisations.
- 8.2. The health and social care community across Greater Manchester has been consulted on its revised content. It has been formally signed off by the Greater Manchester Strategic Partnership Board on [insert date].

9. Review and Monitoring

- 9.1. This policy will be reviewed within 12 months of its launch across Greater Manchester by Greater Manchester Health and Social Care Partnership.
- 9.2. Local monitoring of its implementation should take place by each hospital through a local audit of the following:
 - Staff training to check that training courses are relevant to the policy and ensure training is undertaken;
 - Policy effectiveness;
 - Review of when choice information is provided;
 - Patient and/or representative feedback and complaints;
 - Number of Delayed Transfers of Care;

- Length of Delayed Transfers of Care;
- Equality monitoring.

APPENDIX 1

HOSPITAL DISCHARGE AND MENTAL CAPACITY ISSUES

All staff must follow the five guiding principles of the Mental Capacity Act 2005 ("MCA"). This means:

- Presume that adults from 16 are mentally capable of making their own decisions;
- Do not determine the person lacks capacity until all practicable steps to support them have been taken without success;
- Do not consider someone to lack capacity because they make a decision we consider to be unwise;
- When the patient is assessed to lack capacity we must act in their best interests;
- Before taking any action or decision on their behalf we must consider if it can be achieved in a less restrictive way.

Capacity is specific to the decision that must be made, at the relevant time, and so it is possible that a patient who has been assessed as having capacity to consent to or refuse the treatment they have had as an inpatient may lack capacity to make decisions around discharge and care planning (and vice versa). Where there is a reason to doubt capacity for a particular decision, it must be specifically assessed, in accordance with the MCA, the MCA Code of Practice and relevant case law and documented appropriately.

All practicable steps must be taken to support the patient to make the decision before concluding that they are unable to make it themselves. This might involve taking a number of steps such as a providing information in a different format or breaking information down into smaller chunks.

If a person is assessed to lack capacity this means that staff have tested whether they can:

- Understand the information relevant to the decision,
- Retain the information long enough to make a decision,
- Use and weigh the information as part of the decision making process and
- Communicate the decision they want to make.

In the context of a discharge decision, the information relevant to the decision will include an understanding of their care needs on discharge, the process and outcome of the assessment of

needs, offers of care and options available, with the person being given concrete information to consider, not starting with a blank sheet approach.

Options which are not available (e.g. placements which are not available, care which is not considered clinically appropriate, or care which will not be funded) should not be considered in either capacity assessments or in best interest decision-making. A patient with capacity cannot insist on staying in hospital after they are medically fit for discharge and so neither is it an option for a patient who lacks capacity for the discharge decision.

Where a patient, despite all reasonable efforts to support them, lacks capacity for discharge decisions, the decision must be made in their best interests (see MCA s4).

It is important to identify who the decision maker is as it could be a number of different people. The decision maker may be an attorney (if a health and welfare Lasting Power of Attorney has been granted, and is valid, applicable and registered) or a Deputy (if a health and welfare Deputy has been appointed by the Court). If neither of these are appointed then it will be the health or care professional who needs to make the decision in question. The wishes and feelings of the patient are paramount, but this does not mean they will always get what they want, anymore than a patient with capacity would.

“Best interests” is interpreted widely, and goes beyond medical risk and benefit to include social, psychological and emotional factors. Before making a best interests decision, it should be tested by asking whether the patient’s best interests can be achieved in a way which is less restrictive of their rights and freedoms.

A patient is entitled to an Independent Mental Capacity Advocate (IMCA) where it is proposed that an NHS body or a local authority provides accommodation in a care home for 8 weeks or longer unless there is someone to consult about their best interests other than a paid professional (MCA s38-39).

If the proposed placement or care package on discharge puts a patient without capacity to consent to it at risk of being deprived of liberty (Article 5, European Convention of Human Rights), currently as interpreted by the Supreme Court in *Cheshire West* [2014] UKSC 19 to mean “under continuous supervision and control and not free to leave” then additional safeguards are required to ensure that the deprivation is lawful.

Where the proposed deprivation of liberty is in a hospital or a registered care home, a referral must be made for a standard authorisation under the Deprivation of Liberty Safeguards (DoLS). However, DoLS do not extend to other placements, such as supported living or domiciliary care and so any proposed deprivation of liberty there can only be authorised by the Court of Protection. [In either case, case law has found that it is preferable for any proposed deprivation of liberty to be authorised in advance by a prior referral to DoLS or Court application – see for example *Re AJ* (DoLS) [2015] EWCOP 5, or *Re AG* [2015] EWCOP 78]

[It may be appropriate to seek legal advice on cases where deprivation of liberty after discharge appears to be an issue.]

APPENDIX 2

SUMMARY OF LEGAL RESPONSIBILITIES AND RIGHTS

This appendix includes a brief summary of selected key legal responsibilities held by participating organisations and the rights that patients have in relation to the specific topic of this policy, with references to specific legislation and case law.

This list does not cover all of the legal complexities in relation to this issue – it is only provided as a guide to the people reading this policy and should not be used in place of legal advice.

	Responsibility or right in relation to choice at discharge	Relevant legislation / case law
Hospital (NHS Trust)	<p>No clinician or Trust is obliged to offer anything which is not clinically indicated. This includes provision of an acute inpatient bed.</p> <p>A Trust is obliged to carry out its functions “effectively, efficiently and economically”, which is not consistent with prolonged occupation of inpatient beds by patients who are medically fit for discharge</p> <p>In some cases, where the patient’s refusal to leave hospital when medically fit for discharge constitutes a nuisance or disturbance, an offence may be committed and there is a power to remove the patient</p> <p>Alternatively, other remedies may be available to Trusts under property law</p> <p>Where appropriate, where the Trust considers it will not be safe to discharge a patient unless arrangements for care and support are in place it must give notice to local authority, including provision in some circumstances for a financial remedy against the local authority where discharge is delayed as a result of failure to meet needs</p> <p>Responsibility to seek authorisation for any deprivation of liberty occurring in the hospital</p>	<p>R (Burke) v GMC [2005] EWCA Civ 1003; Aintree University Hospitals NHS FT v James [2013] UKSC 67</p> <p>NHS Act 2006 (as amended) s26, 63</p> <p>Criminal Justice and Immigration Act 2008, ss119-121 [and see NHS Protect guidance]</p> <p>Barnet PCT v X [2006] EWHC 787</p> <p>Care Act 2014, Schedule 3, Care and Support (Discharge of Hospital Patients) Regulations 2012, and Delayed Discharge (Continuing Healthcare) Directions 2013</p> <p>MCA Schedule A1, paras 1-3 , 24 and 76</p>
Local Authority	Responsibility to assess a patient’s needs for care and support where it appears to the local authority that the patient may	Care Act 2014 s9

	<p>have such needs</p> <p>Responsibility to assess a carer's needs for support and choice about caring</p> <p>Responsibility to provide patient's choice of accommodation in care home / shared lives / supported living, where this is to be arranged by the local authority, in some circumstances</p> <p>Responsibility to provide information and support on choices</p> <p>Responsibility to offer choices / involve the patient in preparation of a care and support plan</p> <p>Responsibility to provide a Care Act advocate if a patient would experience substantial difficulty in participating in the assessment of need or care planning process unless there is another (unpaid) appropriate person to fill this role</p> <p>Responsibility to authorise deprivation of liberty in care homes and hospitals</p>	<p>Care Act 2014 s10</p> <p>Care Act 2014 s30, Care and Support and After-care (Choice of Accommodation) Regulations 2014</p> <p>Care Act 2014 s4</p> <p>Care Act 2014 s25</p> <p>Care Act 2014, s67</p> <p>MCA Schedule A1 paras 21, 50</p>
Clinical Commissioning Group [and NHS England]	<p>Responsibility to ensure an assessment for eligibility for NHS funded Continuing Healthcare where it appears that there may be a need for such care. [This is the responsibility for NHS England for military personnel and prisoners]</p>	<p>NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, reg 21</p>
Patient	<p>Right to assessment for care and support by local authority and for NHS Continuing Healthcare as appropriate</p> <p>No right to insist on particular treatment which is not clinically indicated, including provision of an acute inpatient bed when medically fit for discharge</p> <p>Right to be involved in decision making about care</p> <p>Right to choice of accommodation in care home / shared lives / supported living, where this is to be arranged by the local authority, in some circumstances (but no right to remain in hospital when medically</p>	<p>Care Act 2014, s9 and NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, reg 21</p> <p>Barnet PCT v X [2006] EWHC 787; R (Burke) v GMC [2005] EWCA Civ 1003</p> <p>NHS Constitution</p> <p>Care Act 2014 s30, Care and Support and After-care (Choice of Accommodation)</p>

	<p>fit for discharge while preferred choice is awaited)</p> <p>Right to respect for family life and to not be treated in an ‘inhuman or degrading’ way</p>	<p>Regulations 2014</p> <p>Human Rights Act 1998 s6 in relation to Articles 3 and 8 of the European Convention of Human Rights</p>
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APPENDIX 3

FACTSHEET A FOR PATIENTS

Date:

Dear <Name>

Plans for your discharge after your hospital stay.

We want to give you the support you need to get home as quickly as possible. Most patients can be discharged back to their own home as soon as they are well enough. However, some patients require some form of additional care after their hospital stay, such as intermediate care, care provided in your own home or in supported accommodation options and longer-term care such as residential or nursing home care.

We will involve you in all the decisions about your care, treatment and discharge and give you all the information and support you need to make the best decisions.

We will tell you when your treatment is due to end and when you would be considered well enough to leave hospital - we will aim to tell you this within 48 hours of you being admitted and will discuss with you if this changes.

We will provide you with a named staff member to support you throughout your time in hospital and make sure that things happen when they are supposed to.

We will tell you have to access information, advice and support to help you make your discharge decision. This will include helping you to understand your care needs, the process of assessing your needs and the care options available to you.

With your permissions, we will request assessment to find out what needs you have and the services you might need to be safely discharged from hospital. The assessment could be for social care, home assessment for any adaptations, eligibility for NHS continuing healthcare, etc.

It may be necessary to assess how any ongoing care will be funded, although in most circumstances to avoid any delay this will be carried out after you have been discharged. It is important to note that whilst NHS care is free to everyone, social care is not. Speak with your named member of staff to find out what the time limits are for free care and what this might mean for you.

Once you have received information about the discharges choices that are available for you, **we require you to make a decision within 7 days**. You may wish to arrange for yourself or a family member to meet with care providers during this time. We will do our best to help make this possible for you and you will be able to speak to *[insert local support arrangements]* about these choices.

If your preferred choice is not available when you are ready for discharge, an alternative option will be arranged for you temporarily.

It is not possible for you to wait in this hospital once you no longer need hospital care.

Your anticipated date of discharge will be communicated to you as soon as it is known so that the hospital can work with you to make appropriate arrangements for your discharge.

Most patients can be discharged back to their own home as soon as they are well enough. However, some patients require some form of care after their hospital stay such as intermediate care, care provided in their own home or longer-term care such as a residential or nursing home. Your care after your hospital stay will be considered by the team involved in your care and the options for your care will be discussed with you during your stay.

If your choice of care provision is not available at the time of your discharge, an interim arrangement which is appropriate for your needs will be offered to ensure that you are in the best setting for your care needs. It will not be possible for you to wait in hospital.

Whilst you will not be asked to leave hospital until you are medically ready, leaving hospital as soon as possible after this will allow you to recuperate and give you more independence than being on the ward.

Hospitals are not places of safety and longer stays in hospital are associated with an increased risk of infection, low mood and reduced motivation. If you remain in hospital longer than is necessary, severely ill patients may be unable to access a bed if beds in the hospital are occupied with patients who are medically fit for discharge.

If you wish to make a complaint or appeal against any part of the discharge process, then contact at any point *[insert details of local complaints and appeal procedures]*

If you would like a copy of this information to be given to someone else or you have any questions, please speak to one of the nurses on your ward or any members of the team caring for you.

With best wishes for a speedy recovery,

[Insert NHS Trust Chief Executive Signature]

APPENDIX 4

LETTER 1 (A).

Date:

Dear <Name>

You now need to choose a care package at home

In order for you to receive the right on-going care we request that you take the following actions:

1. Consider the care at home options currently available to you;
 2. Choose one of these care at home options;
- OR

Advise us of an alternative option that you have arranged.

We request that you make your decision within 7 days of receiving this letter {or insert a longer timeframe if letter is sent more than 7 days before the EDD}. We will arrange for a temporary package of care or accommodation to be made available to you if you need longer than 7 days to make your decision, or need to wait for your preferred care provider.

Additional information to help you with your decision

The recent assessment looked at your care needs and wellbeing and showed that you will need a care package at home following discharge on {insert estimated discharge date}.

We want to help you leave this hospital as soon as possible because home is the best place for you to recuperate, and will give you more independence than being on a hospital ward.

To support you at this time we will ensure that:

- You now have all of the information about the choices currently available to you, including details of any costs, and you have spoken about this with a member of the team;
- You have access to further high quality information, advice and support to make your decisions [include details of where this can be accessed];
- This includes [include details of support service] and the option to involve your family, friends and carers to support you, as you wish.
- You can make a complaint or appeal at any stage of the discharge process by contacting [insert details of local complaints and appeals procedures].

Please do not hesitate to ask one of the nurses on your ward, or to any member of the team caring for you, if you have any questions or if you would like a copy of this letter to be given to someone else.

Yours sincerely,

[Letter to be signed by senior clinician]

APPENDIX 4

LETTER 1 (B).

Date:

Dear <Name>

You now need to choose a care home.

In order for you to receive the right on-going care we request that you take the following actions:

1. Consider the care home options currently available to you, including visiting any care homes;
2. Choose one of these care homes;

OR

Advise us of an alternative option that you have arranged.

We request that you make this decision within 7 days of receiving this letter {or insert a longer timeframe if letter is sent more than 7 days before the EDD}. We will arrange for temporary accommodation to be made available to you if you need longer than 7 days to make your decision, or need to wait for your preferred choice if it has no current vacancies.

Additional information to help you with your decision

The recent assessment looked at your needs and wellbeing and showed that you will need to be discharged to a care home {insert for how long if a temporary placement} on {insert estimated discharge date}.

We want to help you leave this hospital as soon as possible because a care home is the best place for you to recuperate, and will give you more independence than being on a hospital ward. To support you at this time we will ensure that:

- You now have all of the information about the choices currently available to you including details of any costs, and you have spoken about this with a member of the team;
- You have access to further high quality information, advice and support to make your decisions [include details of where this can be accessed];
- This includes [include details of support service] and the option to involve your family, friends and carers to support you, as you wish.
- You are able to make a complaint or appeal at any stage of the discharge process by contacting [insert details of local complaints and appeals procedures].

Please do not hesitate to ask one of the nurses on your ward, or to any member of the team caring for you, if you have any questions or if you would like a copy of this letter to be given to someone else.

Yours sincerely,

[Letter to be signed by senior clinician]

APPENDIX 4

LETTER 1 (C).

Date:

Dear <Name>

You now need to choose an available housing option.

In order for you to receive the right on-going care we request that you take the following actions:

1. Consider housing support options currently available to you, including undertaking any visits;
2. Choose or agree to one of these housing support options;

OR

Advise us of an alternative option that you have arranged.

We request that you make this decision within 7 days of receiving this letter {or insert a longer timeframe if letter is sent more than 7 days before the EDD}. We will arrange for temporary accommodation to be made available to you if you need longer than 7 days to make your decision, or need to wait for your preferred choice if it has no current vacancies.

Additional information to help you with your decision

Your recent assessment looked at your care needs and wellbeing. It showed that you will need support from housing support services before being discharged on {insert estimated discharge date}. We want to help you leave this hospital as soon as possible because supported housing is the best place for you to recuperate, and will give you more independence than being on a hospital ward.

To support you at this time we will ensure that:

- You now have all of the information about the choices currently available to you, including details of any costs, and you have spoken about this with a member of the team;
- You have access to further high quality information, advice and support to make your decisions [include details of where this can be accessed];
- This includes [include details of support service] and the option to involve your family, friends and carers to support you, as you wish.
- You are able to make a complaint or appeal at any stage of the discharge process by contacting [insert details of local complaints and appeals procedures].

Please do not hesitate to ask one of the nurses on your ward, or to any member of the team caring for you, if you have any questions or if you would like a copy of this letter to be given to someone else.

Yours sincerely,

[Letter to be signed by senior clinician]

APPENDIX 5

CHOICE LETTER 2 (a)

Date:

Dear <Name>

Notification of plan to transfer to interim care whilst waiting for a preferred home

We understand that you are well enough to leave hospital and move to a care home, but <you have not yet found one that you like> OR <the one you prefer is not able to offer you a room at this time>.

We do not wish to cause you or your family anxiety, but unfortunately you will not be able to stay at this hospital whilst you continue to <search> OR <wait> for a care home.

- Staying in a care home will allow you to recuperate and give you more independence than being on a hospital ward;
- A care home is the best place for you to continue your recovery once your acute illness is over;
- Severely ill patients may be unable to access services, if beds in this hospital are occupied with patients who are medically fit for discharge.

As it has taken longer than 7 days to organise your discharge, we are now offering to transfer you to temporary accommodation in the following location, which has been assessed as suitable to meet your short-term needs because <insert reason for decision>. This will be funded by <insert organisation(s)> for <x> weeks . Beyond <x> weeks the costs of this care will need to be met by <insert responsible organisation or by you>.

Discharge destination: <Name of location>

Address: <Address of location>

Tel number: <Phone number of location>

Proposed date of transfer/discharge: <Discharge date>

You will be offered further support there with any decisions you need to make and you can wait there until transfer to a preferred home can be arranged.

Please discuss discharge plans with <insert name and contact details>. You will need to either transfer to the temporary accommodation outlined above or inform us of an alternative arrangement to leave the hospital without further delay.

If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you.

If you would like to make a complaint or appeal against this decision then please [insert details of local complaints and appeals procedures].

Please do not hesitate to ask if you have any questions.

Yours sincerely, [letter to be signed by senior clinician]

APPENDIX 5

CHOICE LETTER 2 (b)

Date:

Dear <Name>

Notification of plan to transfer to interim care whilst waiting for preferred care at home services
We understand that you are well enough to leave hospital with care at home but <you have not yet found a care service that you like> OR <the care service you prefer is not able to accommodate you at this time>.

We do not wish to cause you or your family anxiety but unfortunately you will not be able to stay at this hospital whilst you continue to <search> OR <wait> for a care at home package.

- Leaving hospital will allow you to recuperate and give you more independence than being on a ward;
- Severely ill patients may be unable to access services, if beds in this hospital are occupied with patients who are medically fit for discharge.

As it has taken longer than 7 days to organise your discharge, we are now offering to transfer you to temporary accommodation in the following location, which has been assessed as suitable to meet your short-term needs because <insert reason for decision>. This will be funded by <insert organisation(s)> for <x> weeks . Beyond <x> weeks the costs of this care will need to be met by <insert responsible organisation or by you>.

Discharge destination: <Name of location>

Address: <Address of location>

Tel number: <Phone number of location>

Proposed date of transfer/discharge: <Discharge date>

You will be offered further support there with any decisions you need to make and you can wait there until your preferred care at home package can begin.

Please discuss discharge plans with <insert name and contact details>. You will need to either transfer to the temporary accommodation outlined above or inform us of an alternative arrangement to leave the hospital without further delay.

If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you.

If you would like to make a complaint or appeal against this decision then please [insert details of local complaints and appeals procedures].

Please do not hesitate to ask if you have any questions.

Yours sincerely,

[letter to be signed by senior clinician]

APPENDIX 5

CHOICE LETTER 2 (c)

Date:

Dear <Name>

Notification of plan to transfer to interim care whilst waiting for housing support services

We understand that you are now well enough to leave hospital but require housing support services <that are not yet completed> OR <that you have not yet decided upon>.

- We do not wish to cause you or your family anxiety but unfortunately you will not be able to stay at this hospital whilst you continue to <wait> OR <decide> upon housing support services.
- Leaving hospital will allow you to recuperate and give you more independence than being on a ward;
- Severely ill patients may be unable to access services, if beds in this hospital are occupied with patients who are medically fit for discharge.

As it has taken longer than 7 days to organise your discharge, we are now offering to transfer you to temporary accommodation in the following location, which has been assessed as suitable to meet your short-term needs because <insert reason for decision>. This will be funded by <insert organisation(s)> for <x> weeks . Beyond <x> weeks the costs of this care will need to be met by <insert responsible organisation or by you>.

Discharge destination: <Name of location>

Address: <Address of location>

Tel number: <Phone number of location>

Proposed date of transfer/discharge: <Discharge date>

You will be offered further support there with any decisions you need to make and you can wait there until the housing support services <are completed> OR <are available>.

Please discuss discharge plans with <insert name and contact details>. You will need to either transfer to the temporary accommodation outlined above or inform us of an alternative arrangement to leave the hospital without further delay.

If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you.

If you would like to make a complaint or appeal then please [insert details of local complaints and appeals procedures].

Please do not hesitate to ask if you have any questions.

Yours sincerely, [letter to be signed by senior clinician]

APPENDIX 6

CHOICE LETTER 3 (a)

Date:

Dear <Name>

Confirmation of discharge plans following formal meeting

Thank you for meeting with us on <insert date> to discuss your discharge arrangements from this hospital and on-going care requirements.

OR

{Dr ??} and the discharge team met in your absence on <insert date> to discuss your discharge arrangements from this hospital and on-going care requirements.

Discharge options discussion

We want to help you leave this hospital as soon as possible now you no longer need hospital care. A hospital ward is not the best place for you to continue your recovery and other types of services are now better equipped to support your needs. In addition we have a responsibility to make sure that beds on our wards are available for people who need treatment that can only be provided in a hospital.

At the meeting we discussed the following points:

<insert summary discussion here>.

We discussed the following options to enable the discharge process to proceed:

<insert options provided here>.

Discharge plan discussion

The following discharge plan was agreed:

<insert agreed next steps here>.

OR

We noted the reasons why you are unwilling to engage with this process:

<insert reasons here>.

The risks of you refusing the care options provided after being discharged from NHS hospital care were also discussed and identified:

<insert risks identified here>.

We will continue to work with you to try to come to a mutually agreeable solution. However, in the meantime the hospital will now need to consult our legal advisers about your situation and how we can arrange for you to be safely discharged from this hospital as soon as possible. We have a responsibility to consider and to ensure your health and wellbeing throughout this process. You also have the right to consult with your own legal advisers.

If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you.

If you would like to make a complaint or appeal against any part of the discharge process then please [insert details of local complaints and appeals procedures].

Please do not hesitate to ask if you have any questions.

Yours sincerely, [letter to be signed by senior clinician]

APPENDIX 7

OVERVIEW OF PATIENT CHOICE PROCESS

Step 1: Providing Information: Start discharge planning before or shortly after admission. Discuss discharge with patient and/or representative. Identify discharge coordinator and other people who have the patient's consent to be involved in discussions and decisions. Ensure patient and/or representative is aware of the Patient Choice Protocol and expectations. Inform patient of estimated date of discharge. Refer to support services and advocacy as required. **Provide patient with Patient Discharge Factsheet.**



Step 2: Assessing Need: Obtain consent from patient to undertake assessment. Make appropriate referral to identified service as soon as patient is ready and ensure patient is involved throughout the process. Discharge coordinator to ensure that assessments are completed in a timely manner.



Step 3: Preparing for Discharge: Provide patient and/or representative with Letter A. Explain the process to them ensuring that it is essential that they choose an available discharge option, either on an interim or permanent basis. Provide the patient and/or representative with up to three available options. Where this is not possible, explain the rationale for providing limited option.



Step 4: Patient Choice (7 Days): The patient and/or representative should be given up to seven consecutive days to make a decision, or in advance of the estimated date of discharge, whichever is the longer period. Advise that the hospital will expect discharge within the agreed timescale. This should be used by families to view placements. In exceptional circumstances, a longer timeframe may be given, however a clear deadline for decision must be given.



Step 5: Interim Placement: If discharge has not been achieved within seven consecutive days, advise the patient and/or their representative that an interim placement or service has been arranged, which meets assessed need and a date for this transfer will be given. Information should be provided regarding funding arrangements. **Provide patient with Letter 2.**



Step 6: Escalation: If no agreement has been reached regarding discharge, and/or transfer arrangements are challenged, senior staff to hold formal meeting with patient to understand and resolve issues and reiterate policy. Consult legal advisors if necessary. **Provide Patient with Letter 3.**

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Standards for a Greater Manchester Trusted Assessment

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1. Introduction

The *Trusted Assessment Model* is a key element of the Eight High Impact Changes developed by the Helping People Home Team¹ in order to support the timely transfer of patients to the most appropriate care setting and to effect a reduction in the number of delayed transfers of care. The model is being supported nationally by the Emergency Care Improvement Programme. It is also mandated in the Five Year Forward View.

Limited national guidance around the Trusted Assessment model was provided in March 2017 by the Emergency Care Improvement Programme and is referenced in this document; however there is no nationally agreed model for the Trusted Assessment which allows a high risk of variance across GM.

This document provides the GM standards against which set out how a Trusted Assessment Model should be delivered by partners across Greater Manchester. This will ensure that a high quality, consistent and standardised model is delivered and the identified benefits of the model are realised.

It is expected that all health and social care systems in Greater Manchester will adopt these Standards from September 2017. Robust plans to ensure that local arrangement meet or exceed these standards should be in place by September 2017 and monitoring of performance indicators identified in this document will commence at this stage.

2. Definition of the Trusted Assessment Model

In brief, a Trusted Assessment is an assessment that has been completed, through formal agreement by a member of staff with the required competency levels, who has been 'trusted to undertake assessments on behalf of other organisations.

Patients often receive multiple assessments in hospital, for example a patient may be assessed by different individuals for the following assessments:

- Social Care Assessment
- Nursing Care Assessment
- Therapy/Community Health Assessment
- Nursing/Residential Home Assessment
- Equipment Assessments

- Discharge/Transfer to Assess Assessments
- CHC/Funded Nursing Care Assessments

These assessments are usually undertaken by identified individuals working in these environments and a patient can be assessed a number of times by a number of different individuals.

The process is largely inefficient, as patients undergo a number of assessments which can waste resources that are already challenged. It can also be unsettling and disturbing for the patient to undergo a number of different assessments whilst recovering from an acute inpatient episode of care. Furthermore, there can be a significant lead in time for these assessments and this can lead to an unacceptable wait for care outside of the acute hospital setting and significant delays can occur whilst patients wait for multiple assessments. This is not in the best interests of the health care system or of the patient.

The Trusted Assessment model is the completion of a single holistic assessment which is accepted and undertaken by all care providers in the system using pooled budgets.

Examples of this model include:

- Acute-based therapy staff referring directly to local authority run enablement services, without the need for direct social work input.
- Social work staff assessing for and referring patients directly to NHS intermediate care beds.
- NHS practitioners undertaking assessments on behalf of privately run care home organisations.
- NHS or social work staff assessing need and referring for equipment requirements.

Four key types of Trusted Assessment have been identified across Greater Manchester, these are:

- a) Trusted Assessment between NHS organisations in the same locality e.g. Acute Trust to Intermediate Care or Discharge to Assess Services.
- b) Trusted Assessment between NHS and Local Authority Services
- c) Trusted Assessment between NHS and Local Authority Providers and private care organisations e.g. care and residential homes
 - i. Where a patient is already resident at the care or residential home and the assessment seeks to confirm that they remain suitable for the provision
 - ii. Where a patient is a new referral to the care or residential home and the assessment seeks to confirm that they are suitable for the provision
- d) Trusted Assessment between the NHS and Local Authority to all out of area services, including NHS, Local Authority and Private Care Organisations within Greater Manchester and across its boundaries.

3. The Greater Manchester Approach to Trusted Assessment

All systems in Greater Manchester are required to implement a Trusted Assessment model that effectively delivers the following key benefits:

- Holistic Assessments of needs are completed with patients, and accepted by partner organisations where there is the most need
- Duplication of assessments is minimised
- Response times for assessment are improved
- Safe and Timely discharge is supported
- The length of stay, reportable delayed transfers of care, and the percentage of stranded patients are all reduced.

The standards that need to be achieved in relation to the Trusted Assessment model are set out below:

4. Greater Manchester Standards for Trusted Assessment

4.1 Greater Manchester Urgent Care Delivery Boards are required to identify those organisations with which they should implement a Trusted Assessment model.

- The rationale for this decision should provide a balance between working with those organisations where the most benefits from the model can be achieved and those organisations where benefits could be achieved within short timescales.
- This may require local mapping of services to take place, to obtain where the most benefit could be achieved.
- Decisions should be in line with national prioritisation, i.e. local authority reablement services however should also consider the local picture.
- Decisions should be made jointly between health and social care organisations.

4.2 A formal signed agreement should be put in place between identified providers of care that outlines, as a minimum, the following elements:

- The professional that will undertake the assessment on behalf of the provider
- The competencies required to undertake the assessments
- The training requirements and methods for staff undertaking the assessments
- The process for assessment and referral to the identified services
- The method through which the process will be reviewed
- The process if the receiving service deems that the assessment is flawed and therefore does not accept it
- Information sharing arrangements and agreements, including IT access rights
- Access to and training on appropriate electronic assessment and referral systems

- Commissioning arrangements and payment models
- The responsibilities for the roll-out of the process

4.3 A Holistic Assessment Form must be designed and agreed

A key element of the Trusted Assessment model is the use of an agreed holistic assessment tool between providers; assessment documentation needs to be designed and formally agreed between organisations.

4.4 Assessment and Referral Pathways must be clearly documented

Assessment and referral pathways should be designed and agreed between organisations, clearly documented and communicated appropriately.

5. Greater Manchester Performance Indicators for Trusted Assessment

The following metrics should be used to understand the impact and success of the Trusted Assessment model:

- a) The number of services where there is a signed formal agreement relating to Trusted Assessment
- b) The number/percentage of assessments completed using a Trusted Assessment model
- c) The time from completion of the Trusted Assessment to the date of discharge
- d) The average time taken to complete a Trusted Assessment
- e) Compliments/complaints received around the assessment processes for services using the Trusted Assessment model.
- f) A reduction in the delays in discharge attributed to “waiting for assessment”

Systems will need to agree with GM Health & Social Care Partnership and locally how they will determine and achieve an improvement trajectory in respect of delays for assessment in both the acute and community environment.

Bury Locality Plan & GM Transformation Fund Update

Health Overview and Scrutiny

12th September 2017

What will we cover?

1. Recap

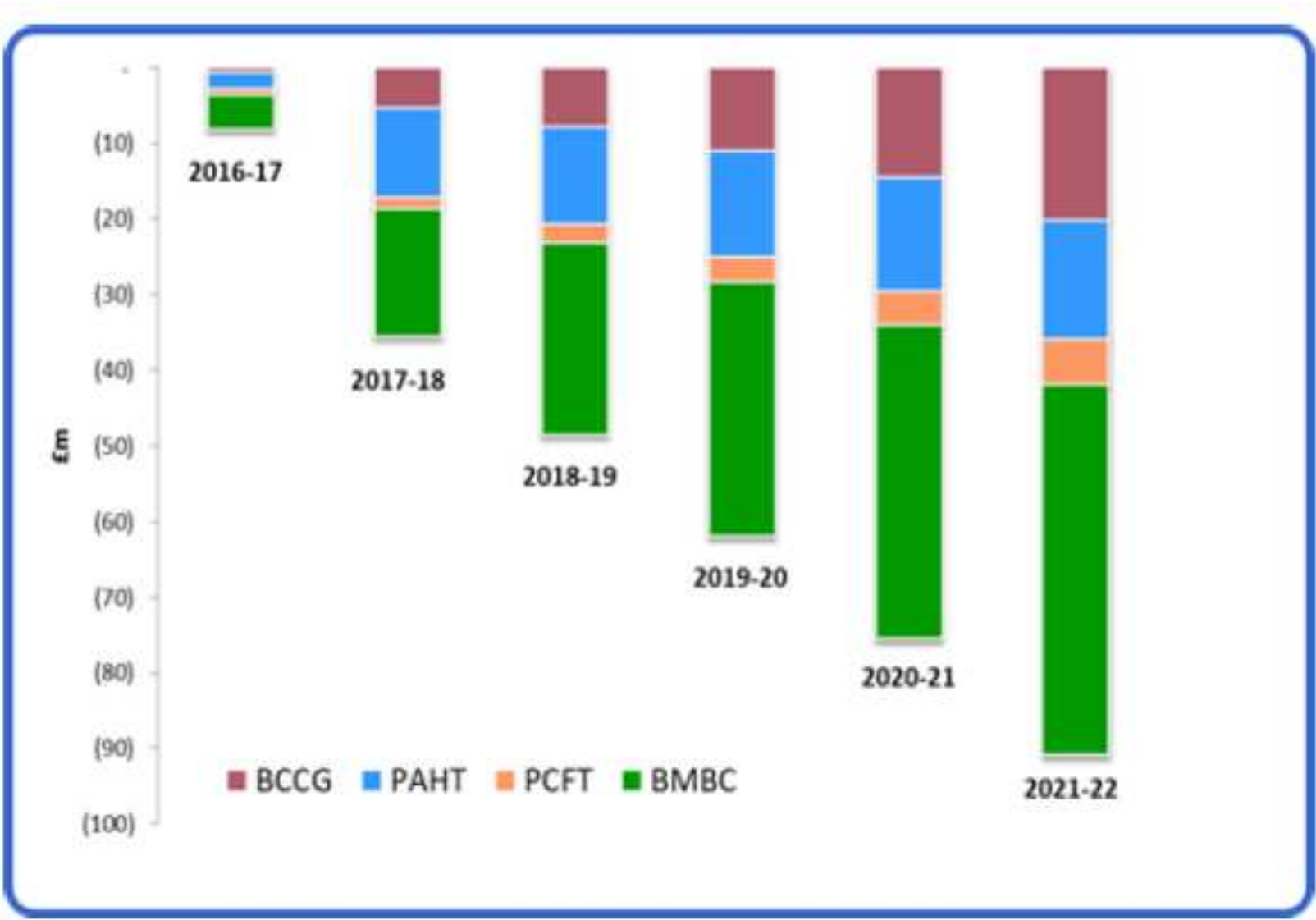
2. Updates:

- GM Transformation Fund
- Financial Sustainability
- Governance
- Risk Management
- Pooled Budgets

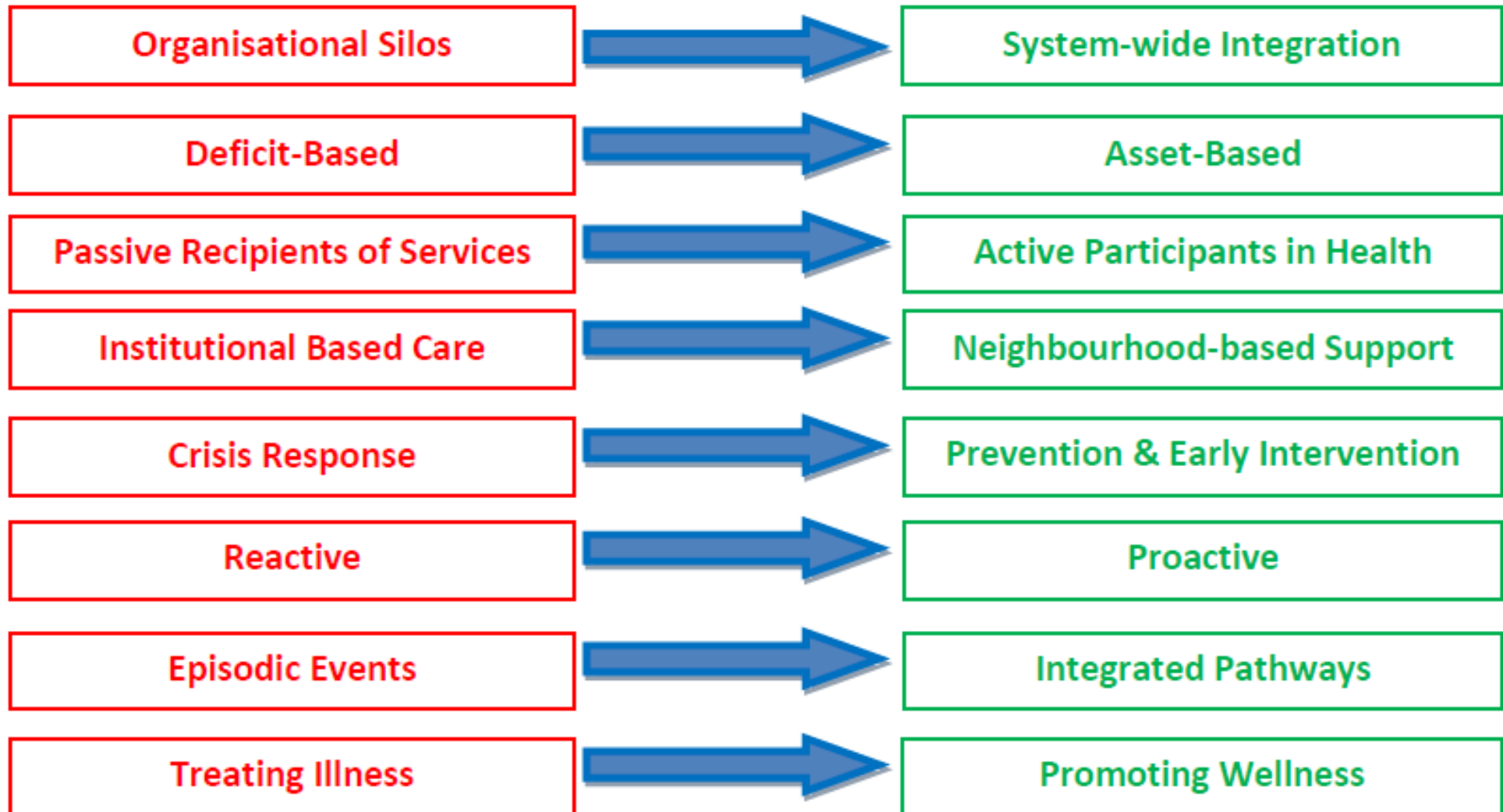
3. Questions

Recap

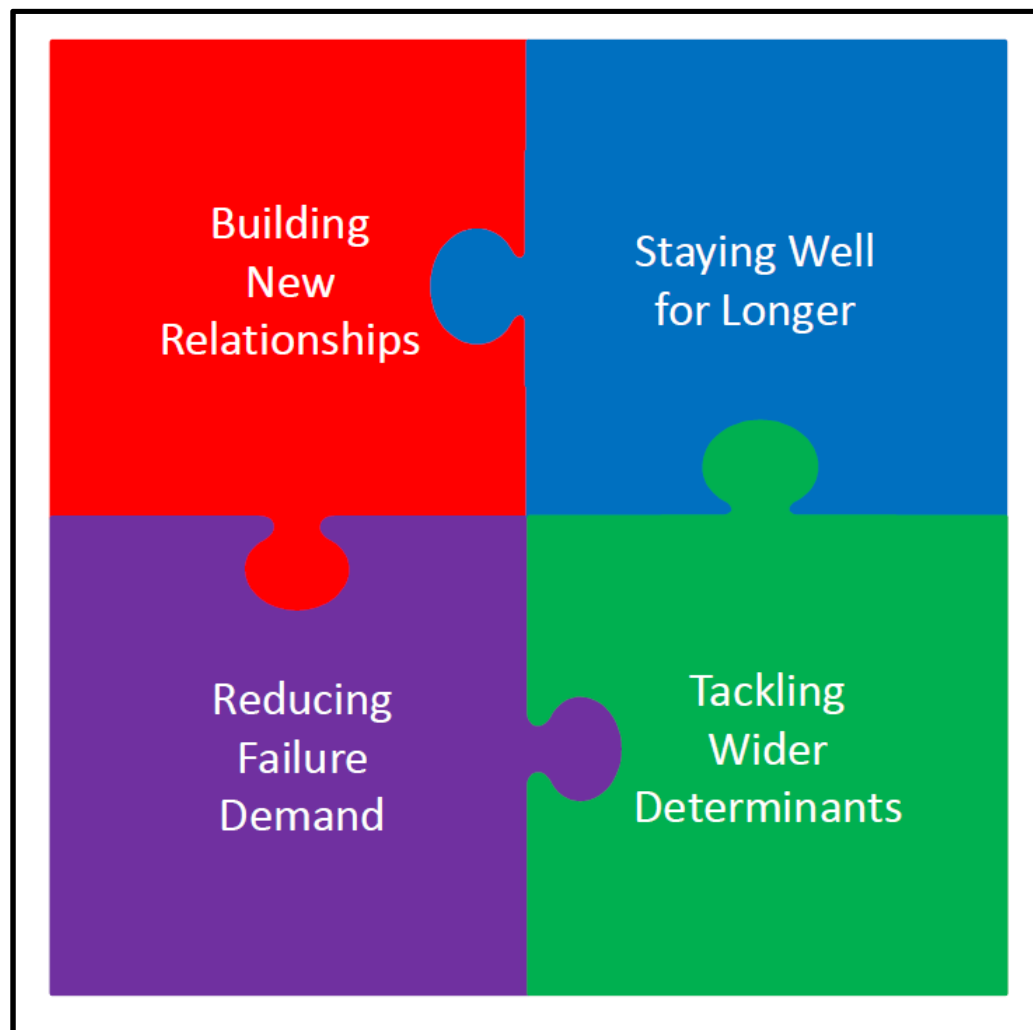
An unsustainable financial challenge:



Mobilising an entire system to make 8 fundamental shifts:



4 Strategic Priorities:



...A Locality Plan providing a blueprint for wide ranging transformational change



...Including 6 Flagship Transformation Proposals ‘Pump-Primed’ through the GM Health and Social Care Transformation Fund:

- 1. Enabling Local People**
- 2. Integrated Neighbourhood Approaches**
- 3. Keeping Bury Well**
- 4. Giving Every Child the Best Start in Life**
- 5. All Age ‘Home First’**
- 6. Transforming Urgent & Emergency Care**

Updates

Transformation Monies

- Investment from GM Transformation Fund agreed:

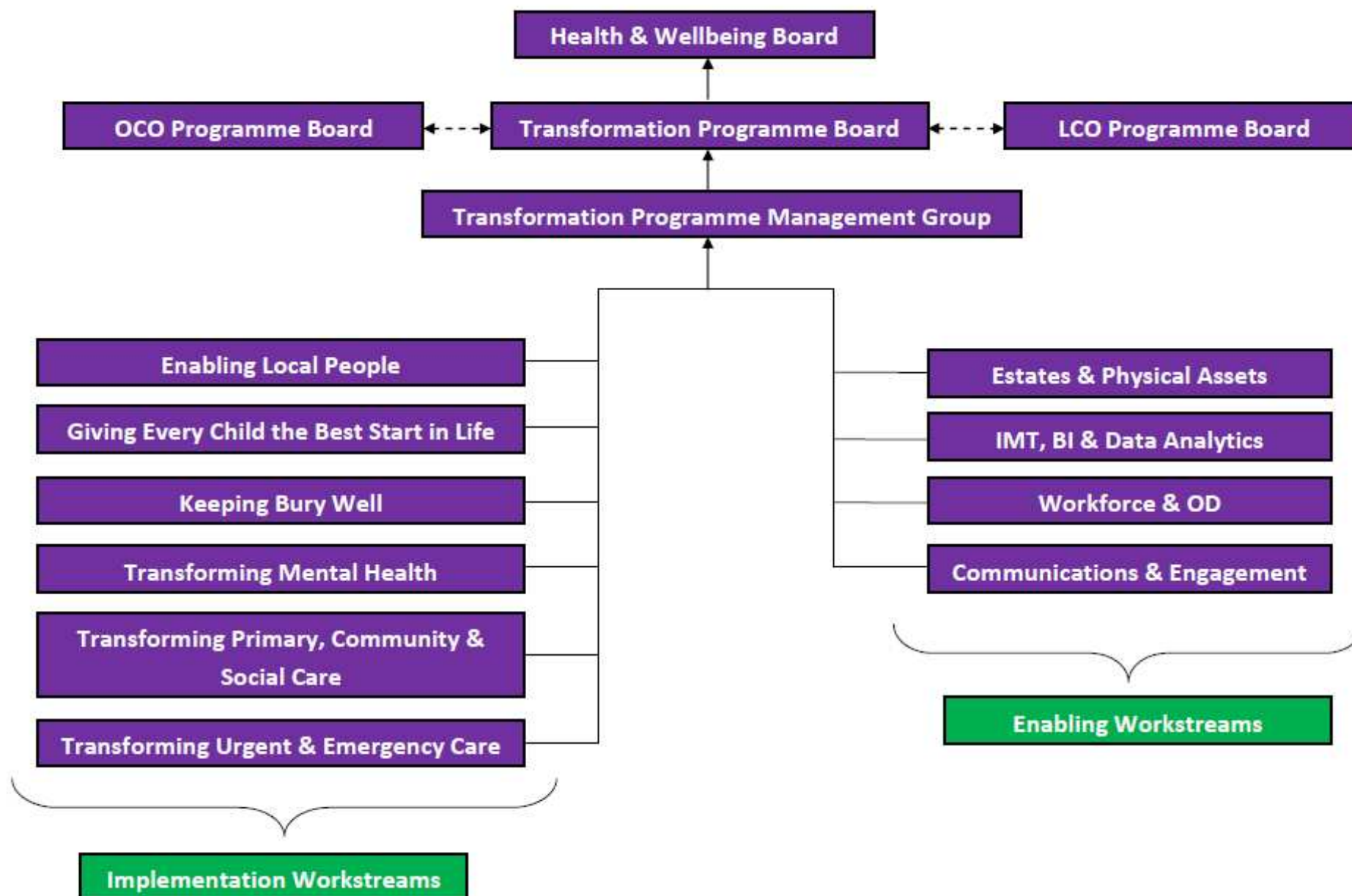
	2016/17 (£m)	2017/18 (£m)	2018/19 (£m)	2019/20 (£m)	Total (£m)
Total (£million)	0.995 (DF)	7.031	6.311	4.893	19.231

Financial Sustainability

Shifts from a projected **£75.6million** financial gap by 2020/21, to a **£4.6million** projected surplus in 2020/21, increasing to a projected surplus of **£5.6million** in 2021/22:

	2017-18	2018-19	2019-20	2020-21	2021-22
	£'000	£'000	£'000	£'000	£'000
Do nothing (deficit)	(35,614)	(48,595)	(61,977)	(75,599)	(90,967)
Impact of CIPs/ other income	21,296	22,033	24,511	25,556	28,689
Impact of themes	(7,031)	(17,998)	3,929	21,135	26,901
Impact of CBS productivity savings	-	-	8,850	8,849	8,850
Impact of Provider divestment	-	-	1,596	14,671	17,241
Impact of GM wide schemes	-	1,316	6,003	9,942	14,935
Residual financial surplus/ (deficit)	(21,349)	(43,244)	(17,088)	4,555	5,649

Governance



Managing Risk

- Risk Register & Risk Strategy
- Key Risks:
 - Lack of system capacity to mobilise proposed changes;
 - Inability to recruit staff into required roles;
 - Inability to mobilise required IMT requirements;
 - Cuts to existing services undermine transformation
 - Level of provider restructuring/ reconfiguration required
 - Risk share agreements non existent or are insufficient

Measures of Success

Locality Plan:

- Financial and Clinical Sustainability
- Improved Health Outcomes for Local People
- Reduce Health inequalities amongst Local People
- Local People actively involved in their own health & wellbeing

Programme Outcomes & Outputs:

- Under development

Pooled Budgets

- One Commissioning Development Plan
- Budget Mapping and Due Diligence under way
- Provider pooled budget – Early adopter approaches
- Risk Share Agreements under development across providers

Questions

Risk Number	Risk Owner	Risk Manager	Strategic Priority	Theme	Risk	Likelihood	Impact	Rating	Control Measures
P1	SRO (SN / PJG)	Programme Director (DB)	Overall	Locality Plan	Locality Plan not signed off by Health and Wellbeing Board within required timescales	N/A	N/A	N/A	Signed Off 26/4/17 RISK CLOSED
P2	SRO (SN / PJG)	Programme Director / Deputy CFO (DB / RC)	Overall	Locality Plan	Locality Plan proposals do not close the projected 2020/21 financial gap	3	4	12	Plan developed which closes the financial gap. RISK CLOSED
P3	SRO (SN / PJG)	Programme Directors (DB / LM)	Overall	Locality Plan	Lack of "buy in to"Locality Plan proposals	2	4	8	* Locality Plan developed collaboratively * Development of a clear and compelling narrative * Ongoing engagement with key stakeholders * Draft versions and opportunities for engagement * Regular updates in range of settings * Locality Plan approved by Clinical Cabinet
P4	SRO (SN / PJG)	Julie Gonda	Overall	Locality Plan	Planned Adult Social Care budget reductions adversely impact upon capacity of the system to transform and overall system resilience	N/A	N/A	N/A	Merged into wider risk P30 RISK CLOSED
P5	SRO (SN / PJG)	Karen Dolton	Overall	Locality Plan	Planned Children's Services budget reductions adversely impact upon the capacity of the system to transform and overall system resilience	N/A	N/A	N/A	Merged into wider risk P30 RISK CLOSED
P6	SRO (SN / PJG)	Programme Directors (DB / LM)	Overall	Locality Plan	Lack of system capacity to mobilise proposed changes	4	5	20	* Clear and proportionate TF 'ask' in relation to requisite capacity * Use of TF Development Fund to create additional local capacity including dedicated programme management resource, and backfill. * Consideration of increasing capacity in advance of GMTF decision. * Structured approach to creating system capacity including: recruit; Reorganise; Backfill; Stop Doing and Forward Plan * Decision from Programme Board re approach to system capacity * Development of Central PMO Function * TPMG given autonomy and authority to act.
P7	SRO (SN / PJG)		Overall	Locality Plan	Lack of One Commissioning Organisation (OCO) readiness to deliver transformation at scale and pace	3	4	12	* OCO Implementation Plan * OCO Risk Register * OCO Governance * OCO Implementation Resource * COO of CCG now a member of Council SLT * Work programme being established to fully integrate commissioning functions by April 2018 * Single outcome framework established and rolled out
P8	SRO (SN / PJG)	LCO Chair (COG)	Overall	Locality Plan	Lack of Locality Care Organisation (LCO) readiness to deliver transformation at scale and pace	3	4	12	* LCO Implementation Plan * LCO Risk Register * LCO Governance * LCO Implementation Resource * LCO Provider Alliance already established with an MOU signed off by all partner organisations * LCO Programme Director already appointed * LCO Programme Board in process of appointing an Independent Chair
P9	SRO (SN / PJG)		Overall	Locality Plan	LCO not empowered to implement transformation at scale and pace	3	4	12	* System wide agreement to LCO role as lead around TF Proposals implementation. * OCO and LCO readiness as per P7 and P8 * Use of System Resilience monies as LCO "test bed"

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P10	SRO (SN / PJG)	Workforce & OD Lead (TM)	Overall	Locality Plan	Proposed transformational changes destabilise the workforce	3	3	9	* Clear and proportionate TF 'ask' in relation to Workforce & OD Support * Workforce participation in detailed design and implementation * Development of Workforce Engagement Strategy * Application of a clear and consistent workforce transformation process
P11	SRO (SN / PJG)	CFO / S151 Officer (MW / SK)	Overall	Locality Plan	Potential to double-count impact of proposed transformational activity and existing business as usual cost improvement programmes.	3	4	12	* Detailed understanding of both transformation proposals and CIP * Accurate reflection in modelling and "do something" financial analysis. * Robust impact analysis methodology
P12	SRO (SN / PJG)	CFO / S151 Officer (MW / SK)	Overall	Locality Plan	Feasibility of delivering existing Cost Improvement Programme savings or Budget Reductions in additional to wider system transformation.	3	3	9	* Detailed understanding of both transformation proposals and CIP * Accurate reflection in modelling and "do something" financial analysis. * Robust impact analysis methodology
P13	SRO (SN / PJG)	Workforce & OD Lead (TM)	Overall	Locality Plan	Inability to recruit staff into required roles within transformation programmes	4	4	16	* Early understanding of workforce requirements * Early proactive workforce planning * Consideration to going 'at risk' in advance of GMTF agreement
P14	SRO (SN / PJG)	Programme Directors (DB / LM)	Overall	Locality Plan	Governance is not mobilised that supports system-wide transformation	1	3	3	* Implementation of agreed transformation governance structure * Proportionate GMTF 'ask' to enable thematic and systems leadership
P15	SRO (SN / PJG)	Programme Director (DB)	Overall	Transformation Fund Proposals	TF Proposals do no secure stakeholder 'buy in'	2	4	8	* TF proposals developed collaboratively * Development of a clear and compelling narrative * Ongoing engagement with key stakeholders * Draft versions and opportunities for engagement * Regular updates in range of settings * TF proposals approved by Clinical Cabinet * Robust business cases * Clear implementation plans
P16	SRO (SN / PJG)	Programme Director (DB)	Overall	Transformation Fund Proposals	TF Proposals are not signed off by Health and Wellbeing Board	N/A	N/A	N/A	Signed off 26/4/17 RISK CLOSED
P17	SRO (SN / PJG)	Programme Director / Deputy CFO (DB / RC)	Overall	Transformation Fund Proposals	TF Proposals do not sufficiently contribute to closing the projected gap	N/A	N/A	N/A	TF Proposals lead to a surplus position by 2020/21 RISK CLOSED
P18	SRO (SN / PJG)	Programme Director (DB)	Overall	Transformation Fund Proposals	TF Proposals do not receive any funding	1	5	5	* High quality TF submission within a requisite elements. * Ongoing engagement with GMHSC in advance of submission.
P19	SRO (SN / PJG)	Programme Director (DB)	Overall	Transformation Fund Proposals	TF Proposals receive lower levels of funding than those requested	4	4	16	* High quality TF submission within a requisite elements. * Ongoing engagement with GMHSC in advance of submission. * Contingency plan in place and articulated in the TF submission.
P20	SRO (SN / PJG)	Programme Director (DB)	Overall	Transformation Fund Proposals	TF Proposals are not submitted to GMHSCP within an acceptable timeframe	N/A	N/A	N/A	Submitted 26/4/17 RISK CLOSED
P21	SRO (SN / PJG)	Programme Director / Deputy CFO (DB / RC)	Overall	Transformation Fund Proposals	TF Proposals are not underpinned by robust data and analysis	2	4	8	* Commissioning of an independent specialist to undertake baseline and impact modelling; * Engagement of local specialist staff * Engagement with New Economy re CBA * Development of a robust local model
P22	SRO (SN / PJG)	Theme Leads	Overall	Transformation Fund Proposals	Recurrent costs in proposals are contingency based estimates and may need to be revised/increased once final service designs and complete. This may affect return on investment and future system costs to achieve planned benefits.	4	3	12	* Detailed design phase * Rigorous programme management * Early identification of emerging issues * Meaningful programme governance
P23	SRO (SN / PJG)	Programme Directors (DB / LM)	Overall	Transformation Fund Proposals	Lack of system capacity and readiness to implement proposals at pace	3	4	12	* Clear and proportionate TF 'ask' in relation to requisite capacity * Use of TF Development Fund to create additional local capacity * Consideration of increasing capacity in advance of GMTF decision. * Completion of implementation plans * Identification of 'quick win' or 'early adopter' initiatives. * Implementation of agreed programme governance and functioning fully prior to GMTF decision.
P24	SRO (SN / PJG)	IMT Lead (JH)	Overall	Enablers	Transformation attempts undermined by inability to mobilise IMT requirements, including insufficient capital investment and lack of dynamic risk stratification.	4	5	20	* Articulation of IMT ambitions and requirements within Locality Plan and Business Cases * Establishment of IMT Enabling Workstream within programme governance with single system leadership * Bid for GM Digital Transformation Fund * Recruitment to specialist capacity and capability within PMO establishment

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P25	SRO (SN / PJG)	Workforce & OD Lead (TM)	Overall	Enablers	Transformation attempts undermined by inability to undertake workforce change in a meaningful and timely manner.	3	4	12	* Continuation of Locality Workforce Transformation Group within programme governance with single system leadership * Implementation of a coherent workforce change process * Active early engagement of workforce and unions * GMTF 'ask' in relation to non-recurrent HR, OD and Legal support to enable workforce transformation.
P26	SRO (SN / PJG)	Comms & Engagement Lead (HC)	Overall	Enablers	Transformation attempts undermined by inability to engage local people in the transformation journey	3	4	12	* Establishment of Communications and Engagement Enabler Workstream under programme governance and with single system leadership. * Development of a single system-wide transformation brand and C&E strategy * GMTF 'ask' in relation to non recurrent C&E capacity and capability.
P27	SRO (SN / PJG)	Estates Lead (AH)	Overall	Enablers	Transformation attempts undermined by inability to create an affordable and fit for purpose public service estates	3	3	9	* Continuation of Strategic Estates Group within programme governance with single system leadership * Completion of asset mapping activity * Completion of activity to understand asset profile and opportunities for disposal * Development of specific capital pipeline business cases linked to transformation propositions
P28	SRO (SN / PJG)	Programme Directors (DB / LM)	Overall	Northeast Sector	Cumulative impact across shared providers is unrealistic and unachievable	3	4	12	* Ongoing engagement across NES to map and mitigate risk.
P29	SRO (SN / PJG)	Programme Directors (DB / LM)	Overall	Northeast Sector	Lack of consistency across Bury, Oldham and Rochdale	3	3	9	* Ongoing engagement across NES to ensure consistency where appropriate.
P30	SRO (SN / PJG)		Overall	Locality Plan	Cuts to existing services undermine the potential to undertake meaningful transformation that has the anticipated impact	5	4	20	* System wide transparency and openness * Joint planning * Development of OCO and LCO * Potential use of one off investment, including Council reserves. *
FIN01	CFO/ S151 Officer (MW/ SK)		Overall	Financial Sustainability	The level of provider restructuring/ reconfiguration required to deliver levels of savings is not possible within required timeframes	4	5	20	* Collation and development of plans across provider footprints. * On-going engagement with stakeholders to develop political case for change. * Full options appraisal re LCO future form and function * GM delivery of Theme 3 (including Healthier Together) * Collaboration across the Northeast Sector * PAHT Clinical Services Strategy * PCFT CQC Improvement Plan * Development of Joint Commissioning arrangements and establishment of One Commissioning Organisation (OCO)
FIN02	CFO/ S151 Officer (MW/ SK)		Overall	Financial Sustainability	Risk share agreements within the Locality, across NES and GM are non existent or are not robust/ sufficient to bridge the performance and cash gap to financial sustainability in 2020-21.	4	4	16	* Collation and development of plans across provider footprints to determine the impact on each organisation. * Ongoing engagement with stakeholders including NHSE, NHSI and GMHSC to develop an agreed approach. * Shared understanding of baseline metrics * Assessment and agreement of local risk appetite. * Development of agreements which identify what the risk is, who is involved, and recognise non-financial risks.
FIN03	CFO/ S151 Officer (MW/ SK)		Overall	Financial Sustainability	The modeled impact on organisations outside of the Locality is not delivered and/ or achievable.	3	4	12	* Collation and development of plans across provider footprints to determine the impact on each organisation. * On-going engagement with key associate providers to ensure that the details of proposals are deliverable.
FIN04	CFO/ S151 Officer (MW/ SK)		Overall	Financial Sustainability	The inclusion of all Locality stakeholders financial position is not included within the 'do nothing' gap and/ or plans are not developed for all stakeholders e.g. third sector.	3	3	9	* On-going engagement with all Locality stakeholders to ensure that all information is included and plans address are comprehensive.
FIN05	CFO/ S151 Officer (MW/ SK)	Programme Director / Deputy CFO (DB / RC)	Overall	Financial Sustainability	Assumptions used to estimate the 'do nothing' gap and develop workstream and theme intervention impacts are outside of an acceptable tolerance.	3	4	12	* Agreement of assumptions used across all partners. * Model outputs have been reviewed and moderated where required. * Detailed financial, activity and workforce planning will be competed in the next programme delivery phase.
FIN 06	CFO/ S151 Officer (MW/ SK)		Overall	Financial Sustainability	Bridging the contracted £4million gap between the £23.231 programme cost and the £19.231 GMTF proposal	3	5	15	* Development of contingency plan * Discussion with NHSE and GMHS CP
INA1	Julie Gonda		Building New relationships	Integrated Neighbourhood Approaches	Proposals for Integrated Neighbourhood Teams are more ambitious and larger scale than pilot/test areas from which evidence base has been drawn. Judgement and assumptions required on how evidence based can be applied to Bury system at scale and to make substantial contribution to future system funding gap.	3	3	9	* Engagement of key stakeholders * Dedicated programme resource to support implementation * Clear and rigorous implementation place * Evaluation and performance framework

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INA2	Julie Gonda	Heather Crozier	Building New Relationships	Integrated Neighbourhood Approaches (Asset Based Community Investment)	VCS resilience and sustainability during period of change	3	4	12	* Ongoing VCS support and development programme * Earlier mobilisation of VCS infrastructure and investment programme
INA3	Julie Gonda	Heather Crozier	Building New Relationships	Integrated Neighbourhood Approaches (Asset Based Community Investment)	Dependence on VCS development and integration to deliver projected benefits	3	4	12	* Ongoing VCS support and development programme * Earlier mobilisation of VCS infrastructure and investment programme
INA4	Julie Gonda	Heather Crozier	Building New Relationships	Integrated Neighbourhood Approaches (Bury Directory)	Reluctance of local people to shift to a digital first model	4	3	12	*Development of a credible and meaningful Bury Directory * Extensive Communications & Engagement programme * Use of behavioural insights research to influence behaviour change.
W1	Martin Clayton		Staying Well for Longer	Keeping Bury Well	Find and Treat - Financial envelope hasn't been tested by the market	3	3	9	* Development of detailed proposal and specification * Market testing * Amendment as required
MH1	Keith Walker	Hayley McGowan / Sian Wimbury	Tackling Failure Demand	MH Transformation	Inability to deliver different aproaches in different areas of the NES.	4	3	12	* Crisis Café service proposition included in both Bury and HMR MH transformation plans as part of overarching locality plans. * Targeted communication to key stakeholders regarding service access criteria if funding for proposed scheme is agreed. * Comprehensive monitoring of acute service utilisation and escalation of concerns to respective commissioner if proposed scheme is implemented * Revised service offer to be developed if schemes are not approved in more than one borough
MH2	Keith Walker	Hayley McGowan / Sian Wimbury	Tackling Failure Demand	MH Transformation	The crisis line, community clozapine initiation and RAID follow up clinics proposals are only viable propositions if they are delivered across two or more of the boroughs in the North East Sector.	4	3	12	* Propositions for the continuation of these pilot services have been included in both Bury and HMR MH transformation plans as part of overarching locality plans. * Revised service offer to be developed if schemes are not approved in more than one borough
CYP1	Karen Dolton		Staying Well for Longer	Giving Every Child the Best Start in Life	Detailed design and engagement does not validate the high level assumptions made to date, and limited evidence base could lead to impact not being as expected.	3	3	9	* Full engagement of all the system to ensure clarity of vision * A number of engagament workshops to be held to co design the details of the plan * Detailed understanding of the transformation proposals. * Understanding of the financial analysis * Ongoing engaagement with key stakeholders * Opportunity to review and change the proposal detail if required
CYP2	Karen Dolton	Klare Rufo	Staying Well for Longer	Giving Every Child the Best Start in Life	Lack of engagement by schools	3	4	12	* Full engagement of all the system to ensure clarity of vision * A number of engagament workshops to be held to co design the details of the plan * Detailed understanding of the transformation proposals. * Ongoing engagement with key stakeholders * Opportunity to review and change the proposal detail if required
HF1	Keith Walker	Tracy Minshull	Reducing Failure Demand	Home First	Care Home provider market may not respond to design principles (e.g. flexible capacity and workforce development) on which the model is based.)	3	3	9	* GM level initiative expected to deliver significant transformation of Care Home provision for Bury residents *Local NHS providers to consider ability to offer temporary additional capacity and consider viability of provision model.
HF2	Keith Walker	Amy Lepiorz	Reducing Failure Demand	Home First	GP capacity - multiple new demands and assumptions on use of GP capacity within the system may mean HF role is not prioritised/resourced.	3	3	9	* Programme level design of GP role will confirm future role of GP capacity within a trnasformed system. * GP capacity expected to be prioritised to support the most value adding/cost effective use of GP time over other demands. HF and INT expected to be high priority.
HF3	Keith Walker		Reducing Failure Demand	Home First	Poor uptake/user resistance to adoption of telehealthcare solutions	3	2	6	* Early adopters and local champions will demonstrate and publisce the value of AT based interventions. * capacity included in service delviery team to focus on high value projects and cases that will illustrate case for adoption. * Organic growth expected to be acheived thorough patient and carer support/demand for new care approaches.
HF4	Keith Walker		Reducing Failure Demand	Home First	Ability of existing NE Sector providers to respond to a Bury specific design.	3	3	9	* LCO management arrangements will need to be effectively implemented with decisions in principle on scope of collaboration to support Bury designs - this will require claryi on how decisions will be made and how money will flow within the LCO. * Ongoing NES collaboration

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UEC1	Keith Walker	Steve Taylor	Reducing Failure Demand	Transforming Urgent and Emergency Care (NWS Green Car)	The scheme does not achieve the level of impact and therefore return on investment envisaged	3	3	9	* The scheme proposal and projected impacts are based on a detailed review and evaluation of the operation of the existing scheme especially over the past 10 months. * The impact assumptions are based on the available business intelligence relating to A&E attendance and non-elective admissions. Lower impact assumptions have been used. * The scheme would be formally contracted with NWS with agreed KPIs, regular reporting and contract review meetings.
UEC2	Keith Walker	Steve Taylor	Reducing Failure Demand	Transforming Urgent and Emergency Care (NWS Green Car)	Staffing issues lead to scheme disruption / lack of continuity	3	3	9	* Operation of the scheme will be supported by a robust business continuity plan with assurances sought from NWS about staffing levels and continuity.
UEC3	Keith Walker	Steve Taylor	Reducing Failure Demand	Transforming Urgent and Emergency Care (NWS Green Car)	Scheme impact in relation to A&E deflection is limited by lack of local alternatives to attendance / admission	3	3	9	* Implementation of wider Locality Plan proposals and GMTF schemes.
UEC4	Keith Walker	Steve Taylor	Reducing Failure Demand	Transforming Urgent and Emergency Care (Primary Care Streaming)	PAHT do not receive NHSE Capital Funding for build work	3	4	12	* The application was developed jointly by PAHT and the CCG. * If unsuccessful then alternative fund would be explored. * If unsuccessful then alternative accommodation would be considered.
UEC5	Keith Walker	Steve Taylor	Reducing Failure Demand	Transforming Urgent and Emergency Care (Primary Care Streaming)	Failure to ensure HMR CCG support.	2	4	8	* Confirmed % funding split with HMR CCG. * Keeping HMG CCG in the communications as proposals develop. * HMR CCG to be part of the project implementation group.
UEC6	Keith Walker	Steve Taylor	Reducing Failure Demand	Transforming Urgent and Emergency Care (Primary Care Streaming)	Failure to implement service within tight timescales	3	2	6	* Completion of detailed design * Comprehensive implementation plan * Robust programme governance
UEC7	Keith Walker	Steve Taylor	Reducing Failure Demand	Transforming Urgent and Emergency Care (Primary Care Streaming)	Formal Procurement exercise may delay programme timelines	3	2	6	*Shared Services advice on the procurement options. * Commencement of procurement 'at risk'of required.
UEC8	Keith Walker	Vicky Riding	Reducing Failure Demand	Transforming Urgent and Emergency Care (IVCH)	Insufficient funding to establishing the new NHS111 transfer of activity for local triage and response plus the 'upstream' of Mental Health triage 24/7/	3	4	12	* Analysis of existing activity levels. Monitoring of demand when new pathway established. Agree activity thresholds with the CCG. * Development of contingency plans
UEC9	Keith Walker	Vicky Riding	Reducing Failure Demand	Transforming Urgent and Emergency Care (IVCH)	Lack of alignment with GM wide developments around IVCH and CAS	3	3	9	* Ensure engagement with GM wide developments via the GM Urgentcare Leads and GM NWS meetings.

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RISK ASSESSMENT SCORING MATRIX					
IMPACT / CONSEQUENCES	LIKELIHOOD				
	RARE (1)	UNLIKELY (2)	POSSIBLE (3)	LIKELY (4)	ALMOST CERTAIN (5)
ALMOST NONE (1)	1	2	3	4	5
MINOR (2)	2	4	6	8	10
MODERATE (3)	3	6	9	12	15
MAJOR (4)	4	8	12	16	20
CATASTROPHIC (5)	5	10	15	20	25

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Bury Health and Wellbeing Board

Annual Report for 2016/17



**Our Vision,
Priorities
and Principles
for Health and
Wellbeing
in Bury**

2015–2018

Bury Health and Wellbeing Board

Annual Report for 2016-17

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1. Introduction:

I am pleased to introduce the annual report of Bury's Health and Wellbeing Board, covering the period from April 2016 to March 2017 whilst I have been Chair. 2016-17 has been a busy year, the Board has overseen the development and signed off:

- The Bury Locality Plan
- The Health & Wellbeing Board Annual Report 2015/16
- The Better Care Fund Quarterly Performance Reporting

Key achievements and highlights are detailed below:

- We have received and agreed to support all recommendations within the Director Of Public Health Annual Report for 2015/16
- We have continued to strengthen our governance arrangements for the Health and Wellbeing Board and Strategy
- Aligned the work of the Board to the Single Outcomes Framework that has been adopted by the whole of Team Bury. Infographics have been produced to demonstrate progress for each of the five priority areas.
- In order to raise awareness about the work of the Board, including membership and our strategy, a Health and Wellbeing Section has been created on the Bury Directory. www.theburydirectory.co.uk/healthandwellbeingboard
- Information Boards have been created and the work of the Board has been promoted at a number of Team Bury and Community events.
- Member Development prior to each board meeting has continued and been strengthened by:
 - A Member Development away day to 'bring the Health & Wellbeing Strategy to life' that took place in the form of a series of market place sessions to showcase progress against each priority of the strategy. This event was opened up to wider partners alongside Members and Deputies of the Board.
 - A Member Development half day session took place that focussed specifically on 'Neighbourhood Working', which is the way in which Team Bury's whole system transformation will be mobilised across the borough. This event was also opened up to wider partners alongside Members and Deputies of the Board.
 - The membership has been expanded to include a greater range of partners on the Board. In January 2017, the Board welcomed Pennine Acute Hospitals Trust and Pennine Care NHS Foundation Trust as members of the Board.

All Members of the Board and Deputies have:

- Successfully obtained the Royal Institute of Public Health, Understanding Health Improvement Level 2 Qualification.
- Received Dementia Friends training and are now officially 'Dementia Friends'.
- Received a detailed Adult Safeguarding Briefing to improve their awareness and understanding of safeguarding reporting and processes.

The Board has overseen the development of:

- The work of Greater Manchester Devolution, with emphasis on Health and Social Care Devolution.
- The digital Joint Strategic Needs Assessment (JSNA) and integration with assets on The Bury Directory.

We are looking forward to working on the emerging key objectives for 2017/18.



Councillor Trevor Holt
Chair, Bury Health and Wellbeing Board

2. Background to the Health and Wellbeing Board:

2.1 Team Bury:

Team Bury is Bury's local strategic partnership – a network of geographic and thematic partnerships across the Borough which involves the public, private and voluntary sectors.

Team Bury has three priorities:

- Health and Wellbeing
- Stronger, Safer Communities
- Stronger Economy

The Health and Wellbeing Board has responsibility for the Team Bury priority - Health and Wellbeing.

2.2 Bury Health and Wellbeing Board:

The Bury Health and Wellbeing Board is a statutory committee of Bury Council. It brings together senior leaders from across Bury Council and the NHS with Elected Members, Healthwatch, Greater Manchester Police, Greater Manchester Fire and Rescue Service and representatives from the community and voluntary sectors, to set out a vision for improving health and wellbeing in the Borough.

The Health and Wellbeing Board supports and encourages partnership arrangements to ensure that services are effectively commissioned and delivered across the NHS, social care, public health and other services. Its main purpose is to ensure improved health and wellbeing outcomes for the whole population of Bury.

Bury's Health and Wellbeing Board's Vision:

"Improve health and wellbeing through working with communities and residents to ensure that all people have a good start and enjoy a healthy, safe and fulfilling life"

2.3 **Membership:**

The membership has been expanded to include a greater range of partners on the board. In January 2017, the board welcomed Pennine Acute Hospitals Trust and Pennine Care NHS Foundation Trust as members of the Board.

Between April 2016 and March 2017, Bury's Health and Wellbeing Board had the following members:

Membership	
Chair	- Cabinet Member for Health and Wellbeing
Vice Chair	- Executive Director of Adult Social Care
Elected Members	<ul style="list-style-type: none"> - Leader of the Council, Cabinet Member for Business Engagement and Regeneration - Cabinet Member for Children and Families - Shadow Cabinet Member for Health and Wellbeing
Local Authority	<ul style="list-style-type: none"> - Executive Director for Children, Young People and Culture - Director of Public Health
Partners	<ul style="list-style-type: none"> - Chair, Bury CCG - Chief Operating Officer, Bury CCG - Health Watch - Community and Voluntary Sector - GM Police - GM Fire and Rescue - Pennine Acute Hospitals Trust - Pennine Care NHS Foundation Trust
Other	<ul style="list-style-type: none"> - Policy Lead, Head of Social Development - Democratic Services Officer - Assistant Improvement Advisor

2.4 **Functions of the Board:**

Health and Wellbeing Boards have a number of core responsibilities in relation to health, public health and social care. The responsibilities have been established under the Health and Social Care Act 2012. These include:

- Strategic influence over commissioning decisions.
- Bringing together clinical commissioning groups (CCGs) and councils to develop a shared understanding of communities' health and wellbeing needs.
- Lead the preparation of a Joint Strategic Needs Assessment (JSNA).
- Develop a health and wellbeing strategy to address needs identified in the JSNA including recommendations for joint commissioning.
- Drive local commissioning of health care, social care and public health
- Consider and contribute to debates about issues which affect health and wellbeing, such as housing and education services.
- Overseeing the production of the Pharmaceutical Needs Assessment.
- Contributing to and approving the Better Care Fund.
- Overseeing the development of the Joint Strategic Needs Assessment.

2.5 Structure and Governance:

The structure and governance has been refined for the Health and Wellbeing Strategy and Board. The sub groups identified below are responsible for overseeing and delivering the strategy.

2.6 Health and Wellbeing Board Strategy:

The Health and Wellbeing Board has a duty to ensure effective delivery of the Health and Wellbeing Strategy, which runs from 2015 - 2018.

The Priorities are:

- Priority 1, Starting well
- Priority 2, Living well
- Priority 3, Living well with a long term condition or as a carer
- Priority 4, Ageing well
- Priority 5, Healthy Places

Updates are provided on a yearly basis for all priority areas to demonstrate progress. As the current strategy is approaching a time when it is up for refresh it will then take into account whole system transformation and emerging local, regional and national policy changes.

3. Activities and Achievements:

3.1 Continued to strengthen our governance arrangements for the Health and Wellbeing Board and Strategy:

The Health and Wellbeing Board is a statutory committee of the Council and is subject to the same requirements of openness and transparency as other Council committees.

The governance for the Health and Wellbeing Board is finalised and on our webpage and the subgroups responsible for the successful delivery of the priorities provide their minutes to the Health and Wellbeing Board. Along with the minutes, an infographic has been produced that summarises key achievements and performance against each priority.

3.2 Utilised performance management tools (Clear Impact) and Outcome Based Accountability (OBA) to measure progress against the Health and Wellbeing Strategy and Priorities:

The performance tools used for monitoring the priorities has been refined and all indicators are now measured using the Clear Impact system, which is being used to manage performance against Team Bury's Single Outcome Framework. Infographics have been produced to demonstrate progress against each of the five priority areas.

3.3 Developments put in place to raise awareness of the work of the Health and Wellbeing Board, its membership and the Strategy we have developed:

A) A Health and Wellbeing Board Section on the Bury Directory:

- This has a shortened URL
www.theburydirectory.co.uk/healthandwellbeingboard
- This contains pages that promote the work and membership of the board; along with videos of the members, profiles of the members, links to partner organisations and the infographic's.

B) Events:

- Information Boards have been created and the work of the board has been promoted at a number of Team Bury and Community events.
- A Member Development Away Day to 'Bring the Health and Wellbeing Strategy to life' took place to showcase progress in each of the five priorities. This session was opened up to wider partners and Deputies.
- A Member Development half day session took place that focused on 'Neighbourhood Working, this session was also opened up to wider partners and Deputies.

B) Performance Infographics:

- This gives a high level overview of the progress against each priority.
- It is colour coded to have a consistency with the Plan on a Page Document
- It uses performance information from the Clear Impact performance management system.
- A brief overview of the six infographics has been produced and condensed into one overarching infographic for ease of reference below.
- A copy of the detailed infographics produced for each priority can be found in Appendix 1.

3.4 Membership

The membership has been expanded to include a greater range of partners on the Board. In January 2017 the Board welcomed Pennine Acute Hospitals Trust and Pennine Care as members of the Board.

3.5 Member and Board training

There has been a continued programme of member and chair training sessions. The members and deputies have successfully obtained the Royal Institute of Public Health, Understanding Health Improvement Level 2 Qualification. They have received Dementia Friends training and are now officially 'Dementia Friends'. The members have also received a detailed Adult Safeguarding Briefing to improve their awareness and understanding of safeguarding reporting and processes. This has been identified as good practice.

3.6 The Board has successfully overseen the development and/or signed off:

- The work of Greater Manchester Devolution.
- The digital Joint Strategic Needs Assessment (JSNA) and integration with assets on The Bury Directory.
- Bury Locality Plan.
- Whole System Transformation across Bury, mobilised by Neighbourhood Working.
- The Health & Wellbeing Board Annual Report 2015/16.
- The Director of Public Health's Annual Report 2015/16.
- The Better Care Fund Quarterly Performance Reporting.
- Communication and Marketing of the Board.

3.7 Matters brought to and considered by the Board during the year, split by Health & Wellbeing priority areas included:

Linked to Priority 1- Starting Well:

- Child Death Overview Panel Report
- Outline Business case Bury's Children and Young People Integrated Health and Wellbeing Service
- Bury Safeguarding Children Board Annual Report 2015/16
- Performance Infographic – Priority 1 – Starting Well

Linked to Priority 2- Living Well:

- Director of Public Health Annual Report
- City of Manchester Single Hospital Site
- The Bury Directory Annual Report
- Presentation on the work of GM Fire and Rescue Service
- GM Population Plan
- Suicide Update
- Health Watch Annual Report
- Performance Infographic – Priority 2 – Living Well

Linked to Priority 3- Living Well with a Long Term Condition or as a Carer:

- Presentation on the work of the Pharmaceutical Committee
- Help Yourself to Wellbeing progress update
- Employment Summit Feedback
- Tobacco Control Annual Report
- Learning Disability Strategy and Action Plan 2016-19 – Update
- Supporting People Service Review – Update

- Carers Action Plan
- Understanding Advocacy
- Urgent Care Re-design
- Presentation on the work of Pennine Care Health and Well Being college
- Performance Infographic – Priority 3 – Living Well with a Long Term Condition or as a Carer

Linked to Priority 4- Ageing Well:

- Annual Safeguarding and Governance
- Urgent and Emergency Care Update
- Annual Safeguarding Adults report
- Presentation on the work of Groundwork - Ambition for Ageing
- Performance Infographic – Priority 4 – Ageing Well

Linked to Priority 5- Healthy Places:

- Performance Infographic – Priority 5 – Healthy Places

4. Future Plans and Activities

In 2017-18, the Board will continue with its strategic role of influencing and leading delivery of health and social care in Bury. It will:

4.1 Further Develop the Health and Wellbeing Strategy:

- Continue to produce infographics for the priority updates.
- Regular priority themed meetings.
- Hold a member development day focusing on performance.
- Continue to map the Health and Wellbeing Board Performance with Team Bury's Single Outcome Framework.
- Refine and refresh the strategy as required in line with the Whole System Transformation agenda for Bury.

4.2 Governance:

- Refine and refresh board membership as required, in line with the Whole System Transformation agenda for Bury.
- Refine and refresh board governance and partnership arrangements as required, in line with the Whole System Transformation agenda for Bury.

4.3 Marketing and Communication:

- Continue to distribute all Plans on a Page and Business cards.
- Improve links through networking events with the wider community to promote the work of the Health and Wellbeing Board.
- Continue to develop webpage's in line with new members or developments to the board.

4.4 Meetings:

- Overseeing the production of the Pharmaceutical Needs Assessment.
- Oversee the development and work of the Bury Locality Plan
- Pre-board member development sessions will be replaced by more regular half day thematic sessions to reflect the priorities for the board throughout 2017/18.
- Develop the forward planner for 17/18

5. Executive Summary

Membership			
	Where have we come from (April 2015 – March 2016)	Where are we now (April 2016 – March 2017)	Where we want to be (April 2017 – March 2018)
Chair	- Cabinet Member for Health and Wellbeing	- Cabinet Member for Health and Wellbeing	- Cabinet Member for Health and Wellbeing
Vice Chair	- Executive Director for Communities and Wellbeing	- Executive Director for Communities and Wellbeing	- Executive Director for Communities and Wellbeing
Elected Members	<ul style="list-style-type: none"> - Cabinet Member for Finance and Housing - Cabinet Member for Children and Young People - Shadow Cabinet Member for Health and Wellbeing 	<ul style="list-style-type: none"> - Leader of the Council (Business Engagement and Regeneration) - Cabinet Member for Children and Families - Shadow Cabinet Member for Health and Wellbeing 	<ul style="list-style-type: none"> - Leader of the Council (Business Engagement and Regeneration) - Cabinet Member for Children and Families - Shadow Cabinet Member for Health and Wellbeing
Local Authority	<ul style="list-style-type: none"> - Executive Director for Children, Young People and Culture - Director of Public Health 	<ul style="list-style-type: none"> - Executive Director for Children, Young People and Culture - Director of Public Health 	<ul style="list-style-type: none"> - Executive Director for Children, Young People and Culture - Director of Public Health
Partners	<ul style="list-style-type: none"> - Chair Bury CCG - Chief Operating Officer, Bury CCG - Healthwatch - Community and Voluntary Sector - GM Police - GM Fire and Rescue 	<ul style="list-style-type: none"> - Chair Bury CCG - Chief Operating Officer, Bury CCG - Healthwatch - Community and Voluntary Sector - GM Police - GM Fire and Rescue - Pennine Acute Hospitals Trust - Pennine Care NHS Foundation Trust 	<ul style="list-style-type: none"> - Chair Bury CCG - Chief Operating Officer, Bury CCG - Healthwatch - Community and Voluntary Sector - GM Police - GM Fire and Rescue - Pennine Acute Hospitals Trust - Pennine Care NHS Foundation Trust
Other	<ul style="list-style-type: none"> - Policy Lead - Democratic Services Officer - Assistant Improvement Advisor 	<ul style="list-style-type: none"> - Policy Lead - Democratic Services Officer - Assistant Improvement Advisor 	<ul style="list-style-type: none"> - Policy Lead - Democratic Services Officer - Assistant Improvement Advisor

Board Management			
	Where have we come from (April 2015 – March 2016)	Where are we now (April 2016 – March 2017)	Where we want to be (April 2017 – March 2018)
Board Meetings	7 Meetings per year	7 Meetings per year	7 Meetings per year
Planning	Agenda Regular agenda setting meetings	Agenda Standing agenda items introduced	Agenda Agenda to be timed to help the board run more efficiently.
	Reports & Forward Planner Template developed and split into key parts: <ul style="list-style-type: none"> - Interactive Discussion - Reports for Discussion - Reports for Decision - Reports for Information 	Reports Align all agenda items to priorities of the H&WB Strategy update per meeting	Reports Reports to be refined to include links to the Health and Wellbeing Web Pages and Strategy
		Forward Planner Forward Planner refined to include thematic meetings	Forward Planner Forward Planner to continue in the current format.
Development Sessions	Meeting Scheduler Developed to include: <ul style="list-style-type: none"> - Member Development full days 	Meeting Scheduler Refined to include: <ul style="list-style-type: none"> - Pre populated themes for all member development sessions and full member development days 	Meeting Scheduler Refined further to include: <ul style="list-style-type: none"> - Pre populated themes only when required for member development sessions, to ensure full engagement - More frequent half day member development sessions which will have relevant sessions opened to wider partners
	Chair Development Sessions Developed to evaluate progress of the Health and Wellbeing Board and set the future direction of travel – 3 per year	Chair Development Sessions Refined to evaluate the progress of the Health and Wellbeing Board and set the future direction of travel – 3 per year	Chair Development Sessions To regularly evaluate the progress of the Health and Wellbeing Board and set the future direction of travel.
	Pre-Board Member Development Sessions Developed to cover specific service areas – 7 per year prior to each board meeting	Pre-Board Member Development Sessions Refined to become thematic based on the boards priorities – 7 per year prior to each board meeting	Pre-Board Member Development Sessions To be replaced by more regular half day thematic sessions unless specific pre-meet required.

	<p>Member Development Days Developed to include Royal Society for Public Health (RSPH) Understanding Health Improvement, Level 2 qualification</p>	<p>Member Development Days Refined and increased to two per year which included:</p> <ul style="list-style-type: none"> - Market place to make the H&WB Strategy 'come alive' - Member Thematic Training *Royal Society for Public Health (RSPH) Understanding Health Improvement, Level 2 qualification for new members *Dementia Friends Training - *Whole system transformation Vision for 2020 (including Locality Plan and Neighborhood Working) 	<p>Member Development Days Increased to 4 per year (half or full days as required) to include wider membership where appropriate.</p>
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Health and Wellbeing Strategy			
	Where have we come from (April 2015 – March 2016)	Where are we now (April 2016 – March 2017)	Where we want to be (April 2017 – March 2018)
General	Developed : <ul style="list-style-type: none"> - Governance arrangements - Performance indicators - Reporting back to the board on successful delivery of the strategy 	Refined: <ul style="list-style-type: none"> - Governance arrangements - Performance indicators - Reporting back to the board on successful delivery of the strategy 	To refresh the strategy to ensure alignment with emerging Whole System Transformation in Bury
Priorities	Ensured successful delivery of each priority area in Year one via a detailed work plan.	Ensured successful delivery of each priority area in Year two via an info graphic to support the work plan	Continue to monitor performance against the priorities in line with the Single Outcomes Framework plan
Governance	Developed Governance Framework to establish HWB Board Sub groups responsible for the development of a detailed work plan for each priority area.	Refined Governance Framework for each priority area to identify governance for each subgroup and refined work plan so the progress can be reported as a 'plan on a page' info graphic	To strengthen governance arrangements in line with Whole System Transformation in Bury. Extend Member Development Away Day to include Sub Group members.
Performance	<ul style="list-style-type: none"> - Created Performance Dashboard - Developed Local Indicators 	Outcome based accountability scorecard created for each priority also included on the 'plan on a page' infographic	<p>To develop and enhance the information on Clear Impact (performance management system) to enable discussions to understand performance.</p> <p>Further align the performance of the strategy to the Team Bury Single Outcomes Framework and the wider Transformation agenda.</p>
Leads	Identified priority leads responsible for the successful delivery of a priority	Priority leads responsible for annual progress update to the board (one priority per meeting)	To review priority leads to ensure they are representative of the wider board membership.
Promotion of the Strategy	Identified a 'plan on a page' to summarise the work of the board and strategy in one easy to read document	<ul style="list-style-type: none"> - Promoted the plan on a page and progress to date of the strategy - Held an event focused around 	The Board will be refreshing the strategy in line with Whole System Transformation in Bury between now and 2018 when it expires.

		<p>making the strategy 'come alive' as one of the member development day's</p> <ul style="list-style-type: none"> - Distribution of the strategy at the following events: - Annual General Meeting – Exhibition of CCG work - Love Bury East Community Event - Love Radcliffe Community Event - Employment Summit Event 	<p>A communication and marketing plan will be developed as part of the refresh of the document.</p>
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Work of the Board			
	Where have we come from (April 2015 – March 2016)	Where are we now (April 2016 – March 2017)	Where we want to be (April 2017 – March 2018)
Led in the successful development of:	<ul style="list-style-type: none"> - Refreshed Board Membership - Board Management - Member Development - Chair Development - Interactive JSNA - The Bury Directory 	<ul style="list-style-type: none"> - The work of Greater Manchester Devolution - Updates on the Joint Strategic Needs Assessment (JSNA) - Bury Locality Plan Developments - Health & Wellbeing Board Annual Report 2015/16 - Communication and Marketing of the Board 	To continue with the development work undertaken within 2016/17
Overseen work areas relating to the Health and Wellbeing Strategy	Starting Well <ul style="list-style-type: none"> - Child Death Overview Panel Report - Children's Services Devolution update - Annual Safeguarding Children's Report 	Starting Well <ul style="list-style-type: none"> - Child Death Overview Panel Report - Outline Business case Bury's C&YP Integrated Health and Wellbeing Service - Bury Safeguarding Children Board Annual Report 2015/16 - Performance Infographic 	Continue to receive reports relating to the progress and development of work relating to the strategy.
	Living Well <ul style="list-style-type: none"> - Director of Public Health Annual Report 2014/15 - Physical Activity and Sport Strategy - Domestic Abuse Strategy - The new Healthy Lifestyle Service - Drug & Alcohol Strategy - Public Health Memorandum of Understanding 	Living Well <ul style="list-style-type: none"> - We have received and agreed to support all recommendations within the Director Of Public Health Annual Report for 2015/16 - City of Manchester Single Hospital Site - The Bury Directory Annual Report - Presentation on the work of GM Fire and Rescue Service - GM Population Plan - Suicide Update - Performance Infographic - Health Watch Annual Report 	
	Living Well with a Long Term Condition or as a Carer <ul style="list-style-type: none"> - Greater Manchester Working Well Expansion - Carers in Employment - Presentation on the work of the 	Living Well with a Long Term Condition or as a Carer <ul style="list-style-type: none"> - Presentation on the work of the Pharmaceutical Committee - Help Yourself to Well-Being progress update - Employment Summit Feedback - Tobacco Control Annual Report - Learning Disability Strategy and Action Plan 2016-19 – Update - Supporting People Service Review – Update 	

	AFN (Armed Forces Network)	<ul style="list-style-type: none"> - GM Service Specification - Carers Action Plan - Understanding Advocacy - Urgent Care Re-design - Presentation on the work of Pennine Care Health and Wellbeing college - Performance Infographic 	
	Ageing Well <ul style="list-style-type: none"> - Annual Safeguarding Adults report 	Ageing Well <ul style="list-style-type: none"> - Annual Safeguarding and Governance - Urgent and Emergency Care Update - Annual Safeguarding Adults report - Presentation on the work of Groundwork - Ambition for Ageing - Performance Info graphic 	
	Healthy Places <ul style="list-style-type: none"> - Fuel Poverty and its effects presentation 	Healthy Places <ul style="list-style-type: none"> - Performance Infographic - Priority 5 - Healthy Places 	
Thematic	<ul style="list-style-type: none"> - Integration of Health and Social Care - GM Devolution - Greater Manchester Primary Care Strategy - NHS England - Development of a single commissioning unit 	<ul style="list-style-type: none"> - Looking ahead to 2016/17 - Briefing on the Pharmaceutical Committee and Priority 1 theme - Presentation on Greater Manchester Fire and Rescue Service and Priority2 theme - Greater Manchester Population Health Plan and Priority 3 - Briefing on the Locality Plan - Briefing on Whole System Transformation and Neighborhood Working phase 1 	To continue to develop the work of the Board in line with Whole System Transformation in Bury and GM priorities
Oversee Development of and/or Signed off:	<ul style="list-style-type: none"> - The Better Care Fund - Pharmaceutical Needs Assessment - Locality Plan - Health & Wellbeing Board Annual Report 2014/15 	<ul style="list-style-type: none"> - The work of Greater Manchester Devolution - The Better Care Fund (BCF) - Whole System Transformation including Development of a Single commissioning unit and Neighbourhood Working phase 1 - Bury Locality Plan - Health & Wellbeing Board Annual Report 2015/16 - Director Of Public Health's Annual Report for 2015/16 - The Better Care Fund Quarterly performance reporting - Quarterly NHS England Commissioning Reports - Greater Manchester Primary Care Strategy - NHS England 	To sign off: <ul style="list-style-type: none"> - The Better Care Fund - Pharmaceutical Needs Assessment - Locality Plan - Health & Wellbeing Board Annual Report - Refreshed Health and Wellbeing Strategy - Relevant Whole System Transformation work for Bury - Re-aligned Governance Arrangements to transformation and

			GM priorities
Communication and Marketing	<ul style="list-style-type: none"> - Plan on a Page produced for the Board and strategy - Development of a Health and Wellbeing Board Webpage on The Bury Directory www.theburydirectory.co.uk/healthandwellbeingboard - Created Business Cards to promote the Board - Promote the Board and members at key events 	<ul style="list-style-type: none"> - Raised the profile of board members via members section of the website including videos and member profiles - Developed the content of the website further - Engaged communities in the work of the board - Continued to promote the board at events. 	<ul style="list-style-type: none"> - To develop the webpage to include new members of the board - To include all performance and infographics on the website - Continue to engage communities in the work of the board - Continue to promote the board at events.

Appendix 1:
2016/17 Info-graphics:



Info-graphics.pdf

Appendix 2:
Health and Wellbeing Plan on a Page



Vision-Priorities-Health
hWBoard-leaflet-web

For any queries relating to this report please email healthwellbeing@bury.gov.uk

April 2017

Item for consideration		
Transformation	Work Force Assets and estates Governance including Risk register Measures of Success Pooled Budgets Transformation Monies Financial Sustainability	September 2017 September 2017 September 2017 September 2017
Nursing and Residential Care Homes	Home First Standards within Care Homes Persona Update Workforce issues in care homes	
GP Extended Hours and Access to Primary Care		
Learning Disabilities and Access to Health Care		
Healthier Together Update		
Health Protection Report		December 2017
B HM&R Diabetes Services Update		
PAT Maternity Services Update		
Delayed Discharge		
Care at Home Contract		
Sexual Health Services		

- Annual Complaints Report
- Public Health Annual Report
- Adult Safeguarding Annual Report
- Health and Wellbeing Board Annual Report

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