AGENDA FOR

HEALTH SCRUTINY COMMITTEE

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To: All Members of Health Scrutiny Committee

Councillors: J Grimshaw, S Haroon, T Holt, K Hussain, N Jones, O Kersh, Smith, S Smith (Chair), Susan Southworth, R Walker and S Wright

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:	Thursday, 8 November 2018
Place:	Meetings Rooms A&B, Bury Town Hall
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 - 4)*

Minutes of the meeting held on the 6th September 2018 are attached.

5 LOCALITY PLAN UPDATE *(Pages 5 - 20)*

Geoff Little, Chief Executive Bury Council, Jeff Schryer, Chair Bury Clinical Commissioning Group and Chris O'Gorman, Independent Chair, Locality Care Alliance will attend the meeting. Reports attached.

6 NORTH EAST SECTOR - CLINICAL SERVICES TRANSFORMATION *(Pages 21 - 142)*

Representatives from Bury's Clinical Commissioning Group will report at the meeting.

7 CARE ACT POLICIES *(Pages 143 - 166)*

Helen Marrow, Personalisation and Support Business Manager and Shirley Allen, Project Lead will be in attendance. Report and presentation attached.

8 URGENT BUSINESS

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

Agenda Item 4

Minutes of: **HEALTH SCRUTINY COMMITTEE**

Date of Meeting: 6th September 2018

Present: Councillor S Smith (in the Chair)
Councillors J Grimshaw, S Haroon, T Holt, N Jones, Susan Southworth, R Walker and S Wright

Also in attendance: Geoff Little, Chief Executive, Bury Council
Dr Schryer, Chair of Bury Clinical Commissioning Group
Dave Latham, Programme Director, Bury Clinical Commissioning Group
Lesley Jones, Director of Public Health
Marcus Connor, Head of Corporate Policy
Julie Gallagher, Principal Democratic Services Officer

Public Attendance: 1 member of the public was present at the meeting.

Apologies for Absence: Councillors O Kersh and L Smith

HSC.139 DECLARATIONS OF INTEREST

There were no declarations of interest made at the meeting.

HSC.140 PUBLIC QUESTION TIME

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

HSC.141 MINUTES

It was agreed:

That the minutes of the meeting held on 21st June 2018 be approved as a correct record.

HSC.142 UPDATE FROM THE CHIEF EXECUTIVE, GEOFF LITTLE

Geoff Little, Bury Council Chief Executive attended the meeting to provide members with an update in respect of the delivery of the Locality Plan - "Transforming Health and Social Care in Bury".

The presentation contained information in respect of the two key areas of organisational changes for Bury:-
Locality Care Alliance (LCA); and
Single Commissioning Organisation (OCO)

The Chief Executive outlined the key components of the LCA and the OCO:

The LCA, will include five neighbourhood teams with staff co-located with a single line management system as well as a joined up case management system. Borough-wide integrated services will provide intermediate services and manage patient flows into and out of hospitals.

The purpose of creating a Single Commission Organisation is to align the Council's commissioning of social care and public health with the CCG commissioning of acute, primary, community and mental health services. The key components of the One Commission Organisation (OCO) will be:-

- Pooled budgets
- Single budget processes
- A single commissioning strategy
- Shared performance data and intelligence driving commissioning and decommissioning decisions
- New approaches to commissioning based on outcomes.

A single executive team will be created with combined roles covering both the CCG and Council responsibilities. This will require significant organisational development and staff engagement.

Those present were invited to ask questions and the following issues were raised.

Responding to a Member's question the Chief Executive reported that the proposals contained within the Locality Plan will help to address the CCG's 75 million pound funding gap by providing joined up services and shifting resources in to early intervention.

Responding to Member's concern in respect of lack of progress; the Chief Executive reported that there has been some slippage in the development of the OCO and the LCA. The Council has been informed that the transformation monies will not be released until further detailed information in respect of the Locality Plan is received. The proposals will require full consultation with staff.

The Chief Executive reported that the current fragmentation of commissioning has made it difficult to focus resources on the priorities set out in the Locality Plan. By working jointly with the CCG via the one commissioning organisation and taking a more holistic approach to the delivery of services this will help to address some of the Borough's health inequalities.

With regards to the implementation timelines, the Chief Executive reported that they are realistic and align with Greater Manchester and specific financial targets.

In response to a Member's question, the Chief Executive reported that the flow of patients is very complex and any changes across the Acute sector will need to be coordinated at a Greater Manchester level. Work is underway to improve services and outcomes as well as reduce costs within the Acute Trusts.

The Chief Executive reported that the way healthcare services are delivered will need to change and work will need to be undertaken with the public and other stakeholders to manage that change.

It was agreed:

The Chief Executive be thanked for his attendance and be invited to attend a subsequent meeting of the Committee, date to be confirmed. Future presentation will include information in respect of an updated transformation timeline, staffing implications, financial monitoring including transformation monies, managing risk/risk register and governance.

HSC.143 BURY CLINCIAL COMMISSIONING GROUP – CONSULTATION ON PROPOSED CHANGES TO IN-VETRO FERTISLISATION

Representatives from Bury's Clinical Commissioning Group attended the meeting to inform members of the proposed changes to the provision of IVF across the Borough.

Members considered the proposed changes, this followed an informal briefing undertaken by representatives from Bury CCG with the Committee Chair prior to the commencement of the consultation.

Members were reminded of their duties as prescribed in the Health and Social Care Act. Members were satisfied that the Chair had been engaged early in the process and by undertaking this engagement, the Chair was able to influence the consultation process. Members discussed the consultation documentation and were satisfied that sufficient information had been provided as to the reasons for the proposed change and adequate time had been allowed for the public consultation.

The committee discussed the rationale for the proposed changes in particular the wider financial pressures facing the CCG and the inability of the CCG to continue to address the financial gap through the use of non-recurrent monies.

Members sought assurances that responses to the public consultation would be taken into account when the CCG Governing Body convene to decide on the future provision of ICF services on 26th September 2018.

Member discussed the number of cycles offered across the other Greater Manchester areas; neighbouring authorities in Heywood, Middleton and Rochdale; Oldham and Tameside and Glossop currently all provide 3 cycles. Only four of the 195 CCG's currently offer three cycles of treatment, all four areas are in Greater Manchester.

It was agreed:

1. Members of the committee agreed unanimously that a reduction in the number of IVF cycles, would still allow safe, sustainable and accessible services for the local population.

2. In light of the financial pressures, members resolved not to specify a preference with regards to the number of IVF cycles stating only, that a service must still be provided (not option 4)
3. The principal democratic services officer would provide a response on behalf of the health overview and scrutiny committee for consideration at the CCG Board meeting due to be held on the 26th September 2018.

HSC.144 WORK PROGRAMME

It was agreed:

That the principal democratic services officer and the Chair would meet to review and update the work programme.

Councillor S Smith
In the Chair

(Note: The meeting started at 7pm and ended at 8.10pm)

Agenda Item 5

REPORT FOR DECISION

DECISION OF:	**Cabinet**
DATE:	**October 2018**
SUBJECT:	Progress on implementation of the Bury Health and Social Care Locality Plan and appointment of the Chief Officer of Bury CCG
REPORT FROM:	Cllr Andrea Simpson, Deputy Leader of the Council and Cabinet Member for Health and Wellbeing
CONTACT OFFICER:	Geoff Little, Chief Executive Julie Gonda, Interim Executive Director for Communities and Wellbeing
TYPE OF DECISION:	**KEY DECISION**
FREEDOM OF INFORMATION/STATUS:	
SUMMARY:	This report is to update Cabinet on progress on the implementing the Bury Locality Plan. In particular, it covers updates in respect of the development of: • The Local Care Alliance; • Bury's Single Commissioning Function; • The financial implications of the Locality Plan for the health and social care system overall and for the Council in particular and • Bury's position in relation to standardisation of hospital services across Greater Manchester and the future of the Pennine Acute Hospitals NHS Trust. The report also sets out proposals in respect of the appointment of the Chief Executive of Bury Council to also hold the post of as the Chief Officer of NHS Bury CCG.

OPTIONS & RECOMMENDED OPTION	Cabinet is recommended to: 1. Note the progress that has been made in the implementation of the Bury Locality Plan and approve the move to the next phase of integration; 2. Note the key milestones to be achieved by 31 March 2019 and agree the next steps of integration as set out in the report; 3. Approve the appointment of Bury Council Chief Executive as NHS Bury CCG's Chief Officer from 1 October 2018, as agreed at the Governing Body meeting of the CCG on 6 September 2018 and NHS approval. **Reasons for Recommendations** The approval of the recommendations will facilitate the next steps of the integration process for alignment of functions and governance arrangements to operate.

IMPLICATIONS:	Failure to support this work will result in the Council not delivering transformation in line with the Council's priorities and GM Devolution
Corporate Aims/Policy Framework:	Do the proposals accord with the Policy Framework? Yes
Statement by the S151 Officer: **Financial Implications and Risk Considerations:**	Reforming Health & Social Care in Bury is critical to the financial sustainability of the Council, the CCG and the wider Health & Social Care economy. Establishment of a single commissioning approach and a Local Care Alliance are key to the delivery of the Borough's Locality Plan. Activity outlined in this report will be funded using Transformation Funding obtained via Greater Manchester through the devolution deal.

Health and Safety Implications	No issues identified at this stage.
Statement by Executive Director of Resources (including Health and Safety Implications)	**There are no wider resource implications**
Equality/Diversity implications:	A key purpose of the Locality Plan is to reduce inequalities in healthy life expectancy between Bury and national averages and within the Borough. Any more detailed equality issues will be considered as part of the implementation of any specific elements of the proposals contained in this report, such as those associated with the proposed impact on staff structures.
Considered by Monitoring Officer:	The Council has the power to integrate health and social care and take decisions using a combination of powers comprising the Health Act 1999, the National Health Service Act 2006 and the general power of competence under Section 1 of the Localism Act 2011. The health legislation creates "flexibilities" for partnership working which include establishing pooled budgets, lead commissioning and integrated provision. The flexibilities can be used together, for example where one partner takes on the role of commissioning services and managing existing services and staff, whether or not the partners retain separate budgets. Alternatively, the partners can establish an integrated service, where services are pooled and staff are integrated and managed by one partner through a pooled budget. In addition the NHS and Public Health (Functions and Miscellaneous Provisions) Regulations 2013 enable certain Clincical Commissioning Group functions to be exercised jointly, including through a joint committee. Partners retain responsibility for their functions but can delegate within appropriate schemes of delegation as to the scope of activities to be performed. The Council must ensure that the statutory role of the Director of Adult Social Services is accountable for the delivery of those functions (set out in Schedule 1 of the Local Authority Social Services Act 1970). Suitable governance arrangements will be identified as work progresses. Amongst other matters, the report sets out further

	development of the Local Care Alliance and integrated commissioning of health and social care.
Wards Affected:	All
Scrutiny Interest:	

TRACKING/PROCESS **DIRECTOR:**

Chief Executive/ Strategic Leadership Team	Cabinet Member/Chair	Ward Members	Partners
Scrutiny Committee	Cabinet/Committee	Council	

1. **BACKGROUND**

In February 2015 as part of Greater Manchester's devolution plans, the 37 NHS organisations and local authorities signed an agreement to take charge of health and care spending within the city region. A strategic plan, 'Taking Charge of our Health and Social Care in Greater Manchester' was developed to address the known poor health outcomes and inequalities experienced by local people and the anticipated financial deficit of £2bn by 2020/21. As part of the devolution arrangements, each borough developed its own 'Locality Plan' to transform health and care, to improve outcomes and experience for local people in a sustainable health and care system.

In Bury too many people become ill too early, with significant health inequalities impacting upon the Borough's most deprived communities. Healthy life expectancy in Bury is 58.5 years for men compared to an England average of 63.3 and 62.2 for females compared to 63.9 for England. In Bury's most deprived communities healthy life expectancy is as low as 53.1 for men and 54.2 for women. One in three children are not school ready at age five.

On a do nothing basis, it is anticipated that the health and care system will have a £75.6m financial deficit by 2020/21. This is caused by limited resources whilst the population grows and becomes older. Bury's population is projected to increase by 3.4% by 2021 (to 194k) and the proportion of that population over 65 will increase by 9.5% over the same period.

Bury's Locality Plan identified a number of key relationships that needed to be developed differently to ensure that Health and Social Care transformation could be delivered effectively by 2020/21. The plan set out a number of key transformational changes and programmes to improve outcomes and close the financial gap, delivering financial sustainability. The objective was to empower local people to remain well for longer, making informed choices about their health and care, within an integrated delivery model with a focus on prevention and early intervention.

The plan articulated an ambition to bring together the main providers of health and social care services to explore innovative methods of delivery, improve outcomes for Bury people and reduce costs. To do this five partner organisations have come together in March 2017 to form a Locality Care Alliance. The five partners are:-

- Bury GP Practices Ltd. This is a federation of all GP Practices in Bury.
- The Council
- The Northern Care Alliance NHS Group. This is a group of NHS Trusts comprising Salford Royal NHS Foundation Trust and the Pennine Acute Hospitals NHS Trust (including Fairfield Hospital)
- Pennine Care NHS Foundation Trust which provides community health and mental health services to a number of localities across Greater Manchester including Bury
- BARDOC, a provider of primary care out of hours services across Bury, Rochdale and Bolton.

In April 2018, a formal agreement was signed which holds each partner to account in terms of operating 'system wide' with a focus on delivery of transformation and generating improved outcomes for the people of Bury.

The Locality Plan also highlighted the benefits of bringing together the health and social care commissioning functions of Bury Council and Bury CCG into One Commissioning Organisation, with a pooled or aligned budget, a single commissioning strategy and strategically commissioning for outcomes.

As part of Greater Manchester's plans to ensure acute hospital and specialist services are sustainable and of a consistently high quality, Pennine Acute Hospitals NHS Trust (PAHT) services are currently being managed by Salford Royal NHS Foundation Trust via a management agreement. Running until December 2019, this agreement will support the development of new ways of working that will ensure patients receive consistently high standards of care.

Longer-term plans for PAHT are being developed to ensure stabilisation and transformation of the hospital sites, delivering improved care and patient experience, economies of scale and value for money. Whilst plans are subject to due diligence, business case approval, financial plan agreement and receiving support from NHS Improvement and the Competition and Markets Authority, the direction of travel is for the Fairfield site, along with the Royal Oldham and Rochdale Infirmaries to be acquired by Salford Royal Foundation Trust with the North Manchester site acquired by Manchester University NHS Foundation Trust.

2. Update in respect of the development of the Locality Care Alliance (LCA)

The purpose of the LCA is to help people to remain healthy for as long as possible and when people do need health and care services for these to be provided for as long as possible in their own houses. The intention is therefore to reduce admissions to acute health and residential care services by shifting more care and resources into the community. This will be a major contributor to improving the services received by Bury people and reducing the financial gap.

The work in respect of the LCA is driven through the sponsorship of the Chief Executives of the 5 partner organisations within the Alliance together wth the LCA Board. Each Chief Executive reports through the governance of their own organisations. In the Council's case this is through the Cabinet Member with responsibility for health and social care and the Deputy Leader in the Council, Councillor Andrea Simpson.

The following progress has been made in the last three months:-

- The host arrangements for the LCA have been transferred from Pennine Care Foundation Trust to the Northern Care Alliance, including back office support. This is bringing additional capacity for delivery.

- The LCA Partnership Board terms of reference have been refreshed with equality of votes between the five provider partners. This Board will hold the LCA management team to account. The Bury Voluntary, Community and Faith Alliance (VCFA) and Persona are included on the Board as non-voting members;

- Additional senior capacity to deliver has been put in place through the full-time appointment of Kath Wynne-Jones, a senior manager from Northern Care Alliance as Interim Executive Lead, and a Director of Transformation & Delivery Lindsey Darley who expected to start in December.

- An LCA management team is in the process of being established to accelerate delivery and operate as a single management team, including key roles from within each partner organisation, such as:

    - a senior manager of the GP Federation to support the leadership and coordination role of Primary Care in each of the five neighbourhoods.
    - a senior manager of Adult Social Care,
    - a senior manager of Community Health
    - a senior manager of Community Mental Health

These decisions, and the introduction of additional capacity at a senior level have led to the development of a detailed work plan for the next six months which focuses on the following components of the LCA and with key milestones to ensure delivery by 31 March 2019:-

Five Integrated Neighbourhood Teams (INTs) covering the whole of the Borough that consist of primary care, adult social care, community care and VCFA staff will be operational by April 19. The teams will have:

- Single line management by five team leaders, reporting to a single post in the LCA management team
- Co-located community health, adult social work and VCFA staff in neighbourhoods supporting the delivery of high quality primary care
- Joint access to case management systems and access to relevant care records
- Risk stratified identification of cohorts, from the beginning of INTs going live.

Not all services will be based in the neighbourhood teams because of economies of scale. These services will be borough wide, or in the case of links to services in front of A&E and Integrated Discharge Teams, in hospitals in and beyond Bury. These services will be fully part of the LCA service model so that the flow of demand into and out of hospitals and residential care can be regulated.

The neighbourhood teams will be fully integrated with the intermediate tier of provision (ie between neighbourhood and hospital based services).This will bring together services such as reablement, intermediate care and end of life care provision to enable patients to effectively step up and down through different levels of intensity of care across Bury.

The purpose of the LCA is to help Bury people remain healthy for as long as possible and when they do need health and social care services for the care to be provided for as long as possible in their own homes and less often in hospital or residential care. This objective requires more than a change in the way public service organisations work together; it requires a shift in the relationships between front line staff and between those staff and residents, patients and their careers and families.

The importance of both mental health services and social care services in transformation, and their links with physical health, cannot be underestimated. As we move forward with integration we need to truly respond to all the needs of a person rather than continuing to work in silos. Mental health will be fully integrated into all the pillars of the Transformation Plan, and there is work underway to understand how Mental Health Primary Care capacity can be built into the Integrated Neighbourhood Teams.

The detailed work now underway to develop the LCA is therefore based on a strength based approach to relationships. This means different types of assessment where time is taken to really listen to people and their families and connecting to the support within families, neighbourhoods and communities. The approach focuses on what people can do, not just on fitting needs into services. This will apply to the way packages of care are designed and managed after assessment. Assessments by one service will be trusted and used by other services so that people do not need to keep repeating the same information.

Connecting to the strengths in families and communities will require front line staff in the LCA to have a good understanding of the strengths or assets in families and communities. This is one of the reasons why the voluntary and community sector through Bury VCFA will be built in from the start of the LCA, with the sector represented at all levels of governance, management and operational delivery.

The specific programme regarding Mental Health Service transformation is being led by Pennine Care Foundation Trust in line with the GM Mental Health programme; this has a particular focus on enhanced Crisis & Urgent Care for people with mental health conditions and Increasing Access to Psychological Therapies (IAPT), in particular for people with long-term conditions, in addition to a number of initiatives for young people.

Council staff in the LCA and the Council's statutory responsibilities for Adult Social Care

The Council is a key partner within the development of the LCA, with Adult Social care being essential to the effective establishment of the Integrated Neighbourhood Teams. The work on scope and phasing of services to be transformed into the LCA proposes that the Council's Adult Social Care Services should transfer in 2019/20 with aspects of Children's services and some public health services transferring later. The reason for this is to make this change manageable and to start with the services which will have the highest impact on activity levels in acute and residential care.

This will mean approximately 235 adult social care staff being deployed from the Council into the LCA. This will initially include approximately 33 moving into the INTs and approximately 100 moving into the integrated intermediate tier of the LCA. The remainder will follow when the LCA has been further developed.

The staff will remain employed by the Council. They will be operationally line managed by LCA managers, irrespective of the professional background of the manager. In other words staff in the LCA will not be managed within service silos.

However it is essential that the professional expertise of staff is not diminished and that the Council's statutory responsibilities for adult social care are protected. The senior adult social care manager on the LCA management team will therefore provide professional supervision and development support to adult social care staff. The senior adult social care manager will be accountable to the Council's Director of Adult Social Care (a statutory post held by the Acting Executive Director of Communities and Wellbeing) who will in turn remain accountable for the Council's statutory duties to the Council Chief Executive and to the Deputy Leader of the Council who holds the statutory adult social care responsibilities. Approximately 13 adult social care operational staff will remain with the Council to run the Adults Safeguarding functions.

The arrangements to protect the Council's role as an employer and to ensure that the statutory duties for adult social care, which cannot be delegated, are properly discharged will be set out in detail in a legally binding agreement between the five LCA partners.

3. Update in respect of the Strategic Commissioning Function (OCO)

The Locality Plan commits Bury to establishing a single health and care commissioning function – The One Commissioning Organisation. Bury's One Commissioning Organisation Partnership Board, established in April, meets monthly, bringing together clinicians and lay members from the CCG Governing

Body and members of the Council's Cabinet and officers. The partnership board has a number of key priorities for the OCO, namely development of:

- A commissioning and decommissioning strategy;
- A joint financial plan and reporting;
- Pooled and aligned budgets and management arrangements;
- A performance and outcomes framework;
- A risk and quality assurance framework;
- Governance structures for the partnership, to be incorporated into a partnership agreement including integrated commissioning proposals.

The OCO Partnership Board is the foundation of the OCO and will be developed into a formal Single Commissioning Board for Bury with equal equality of representation from Members of the Council and the CCG Governing Body. The Board will be accountable to the Cabinet of the Council maintaining the local democratic control of Council commissioning and to the Governing Body of the CCG maintaining the CCG accountability for NHS resources.

A single executive team will be created with combined roles covering both CCG and Council responsibilities. This will require significant organisational development and staff engagement.

To drive forward these priorities the development of a business plan for the OCO is underway, with key dates and deadlines still to be finalised. This work is led by the OCO Joint Executive Group, which brings together the senior management teams of the CCG and the Council.

The plan covers the following key areas:

- Develop and implement a target operating model
- Produce joint commissioning strategy, plans and approaches
- Establish joint financial planning and reporting mechanisms
- Establish 'business as usual' risk and quality assurance frameworks and processes
- Staff development and engagement

Work is progressing to develop a target operating model (TOM) for the OCO, that reflects its size, functions and statutory duties. The TOM will also be informed by the GM Commissioning Framework and learning from models in place across Greater Manchester. OCO senior managers recently visited Tameside to understand their development journey and single commissioning function arrangements.

In order to both make savings and progress commissioning on a joint basis, four test-bed areas of thematic commissioning have been identified. These test beds are:

- Carers
- Continuing healthcare and complex cases, including Learning Disability services
- Mental Health
- Special Educational Needs & Disability

Update reports will be brought to Cabinet at regular intervals.

4. Appointment of joint leadership – Chief Executive of Bury Council and Accountable Officer for NHS Bury CCG

One of the most significant opportunities of Greater Manchester devolution is to create single place based leadership of health and social care. The most important part of such place based leadership is the partnership between the political leaders of Councils and local clinical leaders in the NHS. In Bury this is being successfully achieved through the OCO Partnership Board and the Health and Wellbeing Board. This political and clinical partnership now provides the basics for single managerial leadership.

On 5 September 2018 following interview, the CCG recommended the appointment of Geoff Little, Chief Executive of Bury MBC to the position of Accountable Officer to the CCG. This was subsequently confirmed by Simon Stevens, Chief Executive of NHS England. This is subject to approval by the Council's Cabinet.

Should Cabinet approval be given, this appointment will

- Be consistent with a number of other areas within Greater Manchester, with five out of the 10 areas having dual appointments of Chief Executive / Chief Officer;
- Underpin the fact that a joined up and consistent approach is essential to effective commissioning for the future to meet the needs of Bury people;
- Bring the functions and responsibilities of two separate organisations into one place, providing a stronger basis for system-wide decision making than the historical reliance on effective partnership working;
- Strengthen the ability to move the health and care system to a preventative wellbeing model, with proactive short term care when needed, thus reducing reliance on high cost acute and responsive care.

The Cabinet is therefore requested to approve the appointment of the Chief Executive of Bury Council as the Chief Officer of Bury CCG.

5. Financial position of the Bury Health and Social Care System

Overview

The financial gap of the health and care system in Bury will reach £74.6m by 2020/21. £32m of the projected "do nothing" gap relates to Adults and Children's Social Care.

	Recurrent Gap 2020/21 £m	**%age of 2020/21 cost base**
BMBC ASC and CSC	32	26
Bury CCG	15	5
Hospitals / Providers	27	12
Total	**74**	

Without transformation of the health and care system, many of the council savings targets will not be achieved. The interdependencies within the system

cannot be underestimated, and it is essential that the NHS and Council do not work in isolation of each other.

Financial Opportunities

The Council, CCG and other stakeholders are better equipped to address the systemic problems in the health and care economy through collaboration, rather than acting independently. The work described in Section 3 and 4 above will deliver improved services and experiences for the public as well as financial efficiencies. The financial efficiencies can be categorised as:

- Optimal pathway design and better care
- Optimal decision making and joint working
- Technical opportunities and wider benefits

Optimal pathway design and better care

This includes the programmes of work described in the Locality Plan, and supported from the GM Transformation Fund. The GM Health and Social Care Partnership awarded £19.2m Transformation Funding in 2017 to Bury Locality. To date the following sums have been earmarked and/or approved for the various programmes:

	£m
Transforming Primary, Community and Social Care	8.0
Transforming Urgent Care	2.0
Giving Every Child the Best Start in Life	0.5
Enabling Local People and Keeping Bury Well	2.0
Transforming Mental Health	
Enabling and development fund	8.0
Contingency	2.0
Local funding	(3.3)
Total	19.2

These funds are to support the implementation costs and pump priming of transformational schemes, and to cover "double running" costs (i.e. the costs of running "as is" services in parallel to building new ones).

It was understood and agreed by all stakeholders involved in the production of the Locality Plan that most of the financial savings (c£40m) will be generated by avoiding unnecessary hospital admissions and attendances; and the majority of those hospital "deflections" would be achieved through the LCA. Hospital deflections reduce CCG commissioning costs, which in turn allows funds to be reprioritised "downstream" to community, primary and social care commissioning.

The table below shows the original deflection ambition by 2020/21 from the Locality Plan compared to the latest projections. Note: most of the reduction in 2020/21 targets is due to slippage in programme implementation.

	A&E %	Non Elective %	Elective %	O/P First %	O/P F-up %
Original deflection target (vs 16/17 base)	(17.0)	(21.6)	(13.0)	(20.0)	(25.0)
Deflection target after applying 12 months' slippage	(9.2)	(8.0)	(5.8)	(5.0)	(10.0)
Optimism bias to be applied	*20.0*	*20.0*	*40.0*	*40.0*	*20.0*
Revised deflection targets after moderating for optimism bias (17/18 base)	(6.6)	(5.9)	(3.4)	(3.0)	(8.1)

There is a detailed piece of work being undertaken, led by the Locality Care Alliance, to re-assess the scale and phasing of targets beyond 2020/21, with a particular focus on Transforming Primary, Community and Social Care. The key milestones in this 90 day review are:

- Mid October: Neighbourhood model description locked down and LCA Management Team in place.

- Mid November:

1) full system model (including enablers) and in scope/hosting arrangements locked down and described, following stakeholder engagement (including the 1:1 CE meetings).
2) Proposed operational arrangements for staff working within the neighbourhood teams from a governance, HR, estates and digital perspective.
3) Mid December: next iteration of the mutually binding agreement agreed, supported by
4) A description of revised governance arrangements (including terms of reference for strategic groups, operational groups and formally established LCA management team)
5) The list of in-scope services to be included in go live April 19.
6) Data pack which describes the key health and social care needs of the Borough
7) The financial, activity and outcome schedule (connected to the planning and contracting round) for the next 3 years between the LCA and OCO
8) Proposal for the allocation of the remaining resources
9) Full financial schedule developed for the Transformation Fund
10) Scheme of Delegation and Workforce Protocol agreed describing how Operational, Transformational and Professional accountabilities will be managed
11) Hosting agreement
12) Risk and reward framework

Risk stratification data suggests that each INT will need a caseload of circa 160 in order to deliver the deflection targets. This is deemed as achievable within timescales. It is also recognised that there should be significant opportunities for workforce efficiencies and savings in, for example, residential care packages (through keeping people at home or in more appropriate settings for longer).

Optimal decision making and joint working

Joint working has already delivered financial benefits of c£0.5m in premise costs. There are further opportunities in management structure and back office functions.

Four "test beds" are currently being fast tracked for pooling of budgets, associated due diligence and joint working. As noted above, they are:

- Packages of care (including Learning Disability)
- Mental Health
- Special educational needs
- Carers

Technical Opportunities and Wider Benefits

Integration allows the Council and CCG to agree and work towards a shared vision for Bury's residents and start to pool resources and share risks, managing on a place base rather than in organisational silos. This will move away from the kind of harmful decisions seen in the past which have, at best, resulted in cost shunts between organisations and, at worst, seen increased costs to the public sector as a whole.

Integration of the Council and the CCG will allow the whole of spending on health and care to be connected to total public spending in Bury. This will enable a focus on the underlying determinates of health such as increasing school readiness, the Bury Life Chances Commission, transformation of mental health service for children and adults, housing including Extra Care and supported housing, air quality and social prescribing.

Integration makes this much more doable.

There are a number of potential technical financial benefits arising from integration. E.g. opportunities for different funding sources, different VAT rules and flexibilities.

Working together should bring improved procurement results, e.g. by jointly commissioning nursing and residential home beds. There may be some economies of scale in overheads, too.

Integration of Data is a critical enabler for transformation. Giving front line staff shared access to patient and service user records should significantly improve the efficiency of services as well as the patient experience and outcomes. Sharing of "big data" should also allow better risk stratification, allowing us to target limited resources more effectively and get a bigger return.

6. Pennine Acute Transaction and what it means for Bury

As part of Greater Manchester-wide plans to ensure acute and specialist hospital services are sustainable and of a high quality, plans are being developed for the Pennine Acute Hospitals NHS Trust sites.

The planned acquisition of the North Manchester site by Manchester University NHS Foundation Trust is progressing. It is anticipated that the Fairfield site,

together with Royal Oldham and Rochdale Infirmary sites, will be acquired by Salford Royal NHS Foundation Trust.

The work is currently developing and will soon complete a case for change. It is intended that this be considered by the CCG's Governing Body, the One Commissioning Organisation Partnership Board and Council Cabinet.

Once the case for change is finalised the Board will then agree evaluation criteria and examine the various options for each site, including any changes affecting services accessed by Bury residents, before moving to formal consultation on proposed changes. Work is also proceeding with the Health and Care particular on the improvement of acute health services across GM. The implications of this work for Bury people and patients will be considered. Further updates will be provided to Cabinet as work progresses.

Contact Details:-

Geoff Little – Chief Executive, Bury Council

Julie Gonda – Interim Executive Director for Communities and Wellbeing

Bury Locality

Risk Description	Pre-mitigation			Actions	Completion Date for Actions	Post-mitigation		
A statement describing the risk event, cause and impact	Likelihood	Impact	RAG Status	*The actions and activities planned to take place that will when implemented or completed reduce, eliminate or minimise the risk*	*Each action should have a completion date set*	Likelihood	Impact	RAG Status
Risk: Inability to mobilise Information Management Technology (IMT) requirements Cause: due to insufficient capital investment Impact: suboptimal new models, in particular integrated neighbourhood working	4	5	20	• Refresh of IMT requirements within mobilisation plans • Establishment of IMT Enabling Workstream within programme governance with single system leadership and clear set of system-wide deliverables and implementation plans • Recruitment to specialist capacity and capability within PMO establishment • Harness current and planned GM initiatives such as ISG and Datawell • Build upon existing strengths such as Vision across General Practice • System-wide risk share of financial and other implementation exit costs • Submission of DTF bids for 2018/20	31/12/2018	2	5	10
Risk inability to identify high risk / priority cohorts Cause: lack of dynamic risk stratification Impact: resources won't be targeted to deliver improvements in outcomes / to reduce activity	4	5	20	• Review of current system risk stratification capabilities • Identification of transformation model short, medium and longer-term risk stratification requirements • Develop required risk stratification tools, building upon existing capabilities	31/12/2018	2	5	10
Risk: cuts to services Cause: Efficiency / savings programmes across the system Impact: on impact of transformation programmes / systems ability to transform	5	4	20	• System wide transparency and openness • Joint planning • Development of OCO and LCO • Finance workstream to provide oversight of system-wide savings plans - to avoid double counting, • Transformation prioritisation process to consider risks associated with existing services	31/12/2018	3	4	12
Risk: lack of necessary system working Cause: lack of adequate risk share agreements across providers and commissioners - Bury, NES and GM Impact: performance and savings ambitions will not be realised	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 • Local risk share arrangements to be set out in LCO mutually binding agreement and Bury Investment Agreement (linked to transformation programmes) • Provider commitment to establish risk and reward agreement contained in LCO mutually binding agreement	31/03/2019	2	4	8
Risk: workforce shortages for new care models Cause: inability to recruit / develop skills required for new models Impact: unable to implement new models	4	4	16	• Early understanding of workforce requirements • Early proactive workforce planning • Establishment of HR / Workforce Enabling Workstream within programme governance with single system leadership and clear set of system-wide deliverables and implementation plans • Reallocation of existing resource, use of agency and consultancy support where appropriate • PMO dashboard to report key resourcing issues • GM workforce planning programmes	31/09/2019	2	4	8

Bury Locality

Risk Description	Pre-mitigation			Actions	Completion Date for Actions	Post-mitigation		
A statement describing the risk event, cause and impact	Likelihood	Impact	RAG Status	*The actions and activities planned to take place that will when implemented or completed reduce, eliminate or minimise the risk*	*Each action should have a completion date set*	Likelihood	Impact	RAG Status
Risk: business as usual performance will be impacted upon by transformational change Cause: diversion of capacity and / or capability. Disruption to BAU caused by change programmes Impact: failure to deliver quality and performance standards, e.g. NHS constitutional standards	3	4	12	• Ongoing performance monitoring and management via existing performance management structures, systems and processes - see capacity issue • Development and implementation of transformation / change management programme • Additional resource to be secured to undertake / backfill capacity released to deliver transformation where required	31/12/2018	2	4	8
Risk: transformation programmes don't deliver planned improvements Cause: inaccurate planning / modelling assumptions, poor execution of programmes Impact: sustainability, outcomes and performance improvements not realised	4	5	20	• Programme level impact / benefit modelling • Locality plan aggregation sense checking, eliminating double counting • PMO approach implemented to ensure successful delivery • Programmes developed for transformation drivers (e.g. workforce, comms and engagement, IM&T etc) to support transformation programme success	30/09/2018	2	4	8
Risk: local people, staff and other stakeholders don't buy-in to new models Cause: failure to engage and involve them in the design, development and delivery of transformation programmes Impact: required behaviour / culture changes not realised	4	5	20	• Establish Communications and Engagement workstream including system-wide representation • Secure dedicated specialist resource to lead work programme development and delivery • Development of comprehensive internal and external communications, engagement and involvement strategies and plans - including local people and staff working in H&SC • Develop communications and engagement toolkit to enable effective and consistent delivery	31/12/2018	3	4	12
Risk: inability to co-locate integrated neighbourhood teams Cause: lack of suitable estate Impact: inability to implement preferred integrated neighbourhood team model	4	4	16	• Establish Bury Strategic and Operational Estates Groups, ensuring system-wide representation • Undertake neighbourhood asset review • Map existing estate to neighbourhood footprints • Identify future estate requirements - aligned to new models / ways of working • Develop property options and scenarios' through the Bury SEG. • Ensure integration with other enablers. • Early id of resource needs, project responsibilities and reporting.	31/12/2018	3	4	12

North East Sector Clinical Services Transformation:

A Shared Hospital Service, for our shared population

NES Clinical Services Transformation Programme

The aim of the programme:

- The aim of this programme is for North East Sector commissioners and providers to co-develop a plan that secures the clinical, financial and workforce sustainability of all acute services by 2024/25.

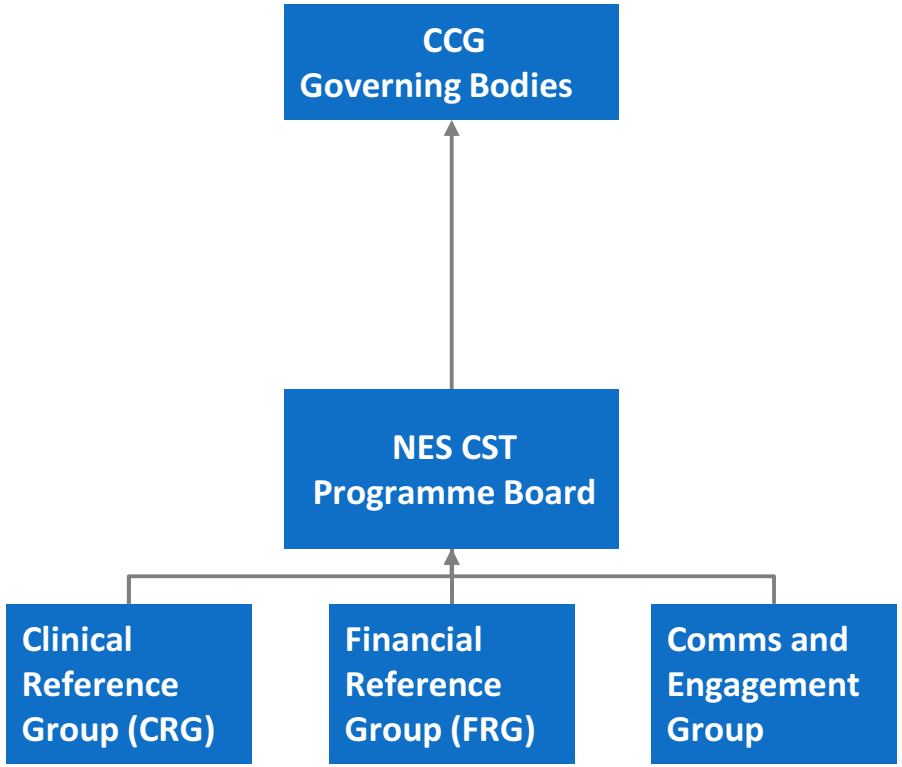
- These plans support and complement wider LCO plans to strengthen community support, deliver more care closer to home and maximise the use of all estate within the 3 CCG / LA co-terminus footprint.

- Support a shift of focus to Bury Locality Plan Programmes
  - Enabling local people
  - Giving every child the best start in life
  - Keeping Bury well
  - Transforming mental health
  - Transforming urgent and emergency care
  - Transforming primary, community and social care

A governance structure has been agreed for the programme

Roles and responsibilities

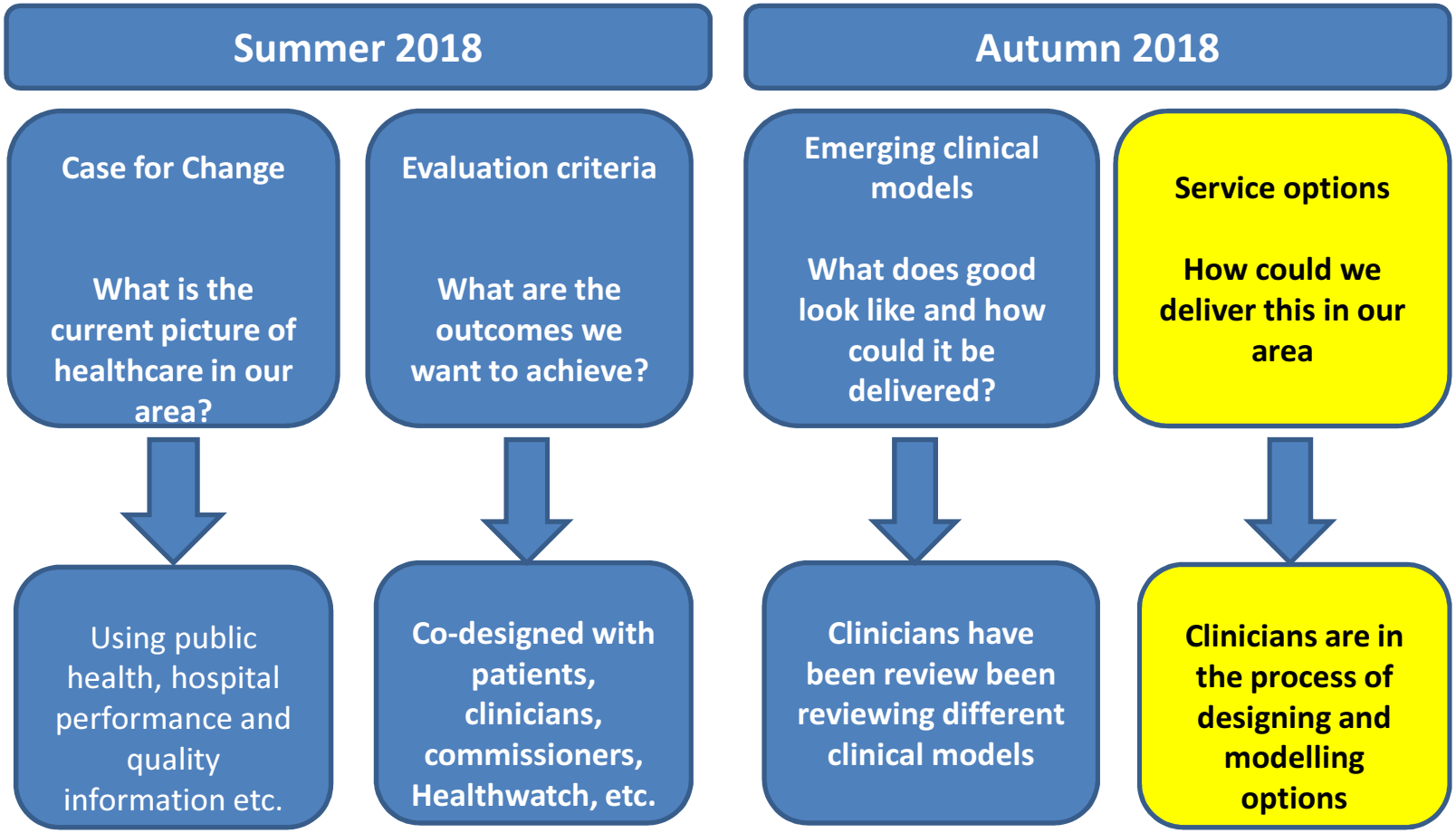
- A final decision about what option(s) to consult on will need to be made by the CCG Governing Bodies, in line with their statutory duties.
- The final recommendation to the CCG Governing Bodies will be made by the Clinical Services Transformation (CST) Board, who are responsible for overseeing the progress of the review.
- All other groups will be responsible for debating and agreeing key issues and assumptions to inform the CST Board.



We need to be able to answer the following five questions through the process we have established:

1. What is the case for change from a clinical, workforce and financial perspective, and which services are most impacted?
2. What evaluation criteria should be used to assess the options?
3. What are the range of clinical models that could underpin any future service configuration options?
4. What is the shortlist of service configuration options that we should assess against the evaluation criteria?
5. How do those options stack up against the evaluation criteria?

The process


Summer 2018
Autumn 2018
Case for Change
What is the current picture of healthcare in our area?
Evaluation criteria
What are the outcomes we want to achieve?
Emerging clinical models
What does good look like and how could it be delivered?
Service options
How could we deliver this in our area
Using public health, hospital performance and quality information etc.
Co-designed with patients, clinicians, commissioners, Healthwatch, etc.
Clinicians have been review been reviewing different clinical models
Clinicians are in the process of designing and modelling options

The Case for Change

- The local population is growing and getting older. Across NES, there is an opportunity to **save over 2,000 lives per year** through better acute services and higher quality care closer to home. LCO plans seek to transform out-of-hospital care, which should deflect some hospital activity
- Delivery of these plans will put further pressure on acute sites, which:

Already exhibit wide variation in the **quality of care** they deliver, which could worsen as clinical teams in service areas that experience suboptimal volumes of activity will be less able to develop and maintain their skills – this is especially the case for critical care and cardiology

Will have difficulty in maintaining **access** to services that need to be provided 7 days a week

Will be additionally challenged to maintain access and improve quality by **workforce** shortages, especially in critical care, which are likely to worsen due to national shortages

Face a large **financial** gap of ~£100m by 2023 for the hospital with insufficient funding to invest in LCO plans as well as large capital costs to maintain or refurbish estate

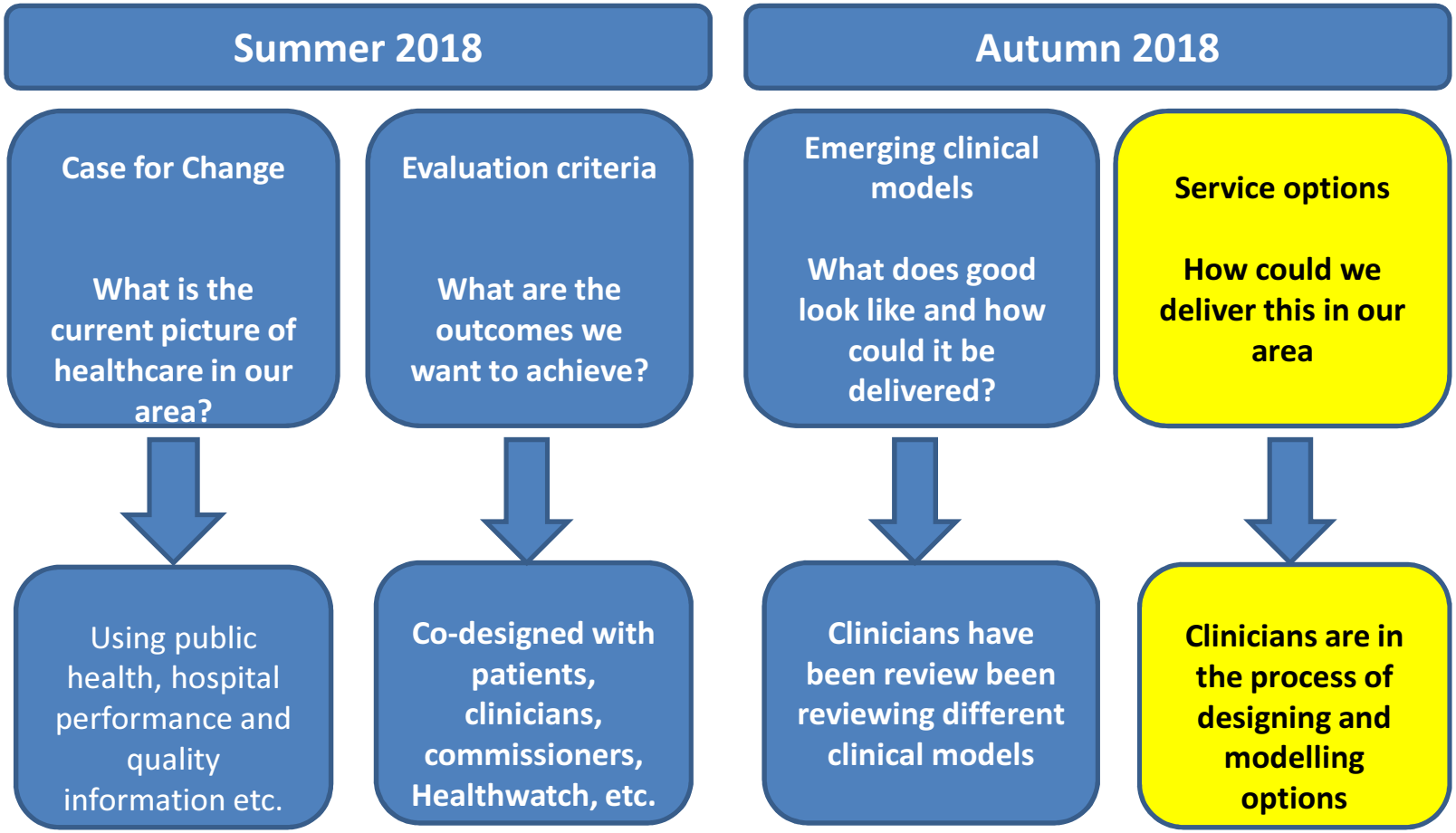
Will therefore face an increasing requirement for service consolidation, although this will need to be considered in terms of the **deliverability** of any change

- Therefore, the evaluation criteria against which the service change options are scored reflect these five aspects of the case for change

Evaluation criteria

	Criteria	Sub-criteria	Description
1	Quality of care for all	▪ Clinical effectiveness	▪ Improved delivery against clinical and constitutional standards, access to skilled staff and specialist equipment, comparison of current clinical quality of sites ▪ Supports integration and co-ordination of pathways with community and primary care
		▪ Patient and carer experience	▪ Improved patient and carer experience with excellent communication & good estate
		▪ Safety	▪ Expected impact on excess mortality, serious untoward incidents
2	Access to care for all	▪ Distance and time to access services	▪ Impact on population weighted average travel times (blue light, off-peak car, peak car, public transport) to reflect average impact for emergency and elective treatment and total impact for more isolated populations ▪ Improved delivery and reduce variation in patient outcomes and health inequalities
		▪ Service operating hours	▪ Ability of model to facilitate 7 day working and improved access to care out of hours
		▪ Patient choice	▪ Provides patients with choice in line with their rights in the NHS constitution
3	Affordability and value for money	▪ Capital cost to the system	▪ Capital requirement to achieve required capacity & quality
		▪ Transition costs	▪ One off costs (excl. capital & receipts) to implement changes
		▪ Net present value	▪ Total value of each potential option incorporating future capital and revenue/cost implications and compared on like-for-like basis
		▪ Meets regulatory requirements	▪ E.g. Surpluses generated by Foundation Trusts
4	Workforce	▪ Scale of impact	▪ Supports new workforce models which reflect new ways of working and education and training needs.
		▪ Sustainability	▪ Potential impact on current staff and retraining required ▪ Likelihood to be sustainable from a workforce perspective, facilitating 7 day working and addresses any other recruitment challenges
		▪ Impact on local workforce	▪ Potential impact on staff attrition due to change
5	Deliverability	▪ Expected time to deliver	▪ Ease of delivering change within 5 years
		▪ Co-dependencies with other strategies	▪ Alignment with other strategic changes (e.g. STP, any other national and local NHS strategies) and provides a flexible platform for the future

The process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Co-designed with patients, clinicians, commissioners, Healthwatch, etc.
Clinicians have been review been reviewing different clinical models
Clinicians are in the process of designing and modelling options

The process – next steps

Winter 2018/19

Identify preferred options

What are the possible options for delivery in our area?

Evaluation criteria will be used to identify the preferred option

National and local assurance processes

External clinical leaders and experts will check our proposals are robust, evidence-based and deliverable

To be confirmed

CCGs will make a decision about consultation

Implementation

Questions?

NES Clinical Services: Case for Change

DRAFT DOCUMENT

Summary case for change

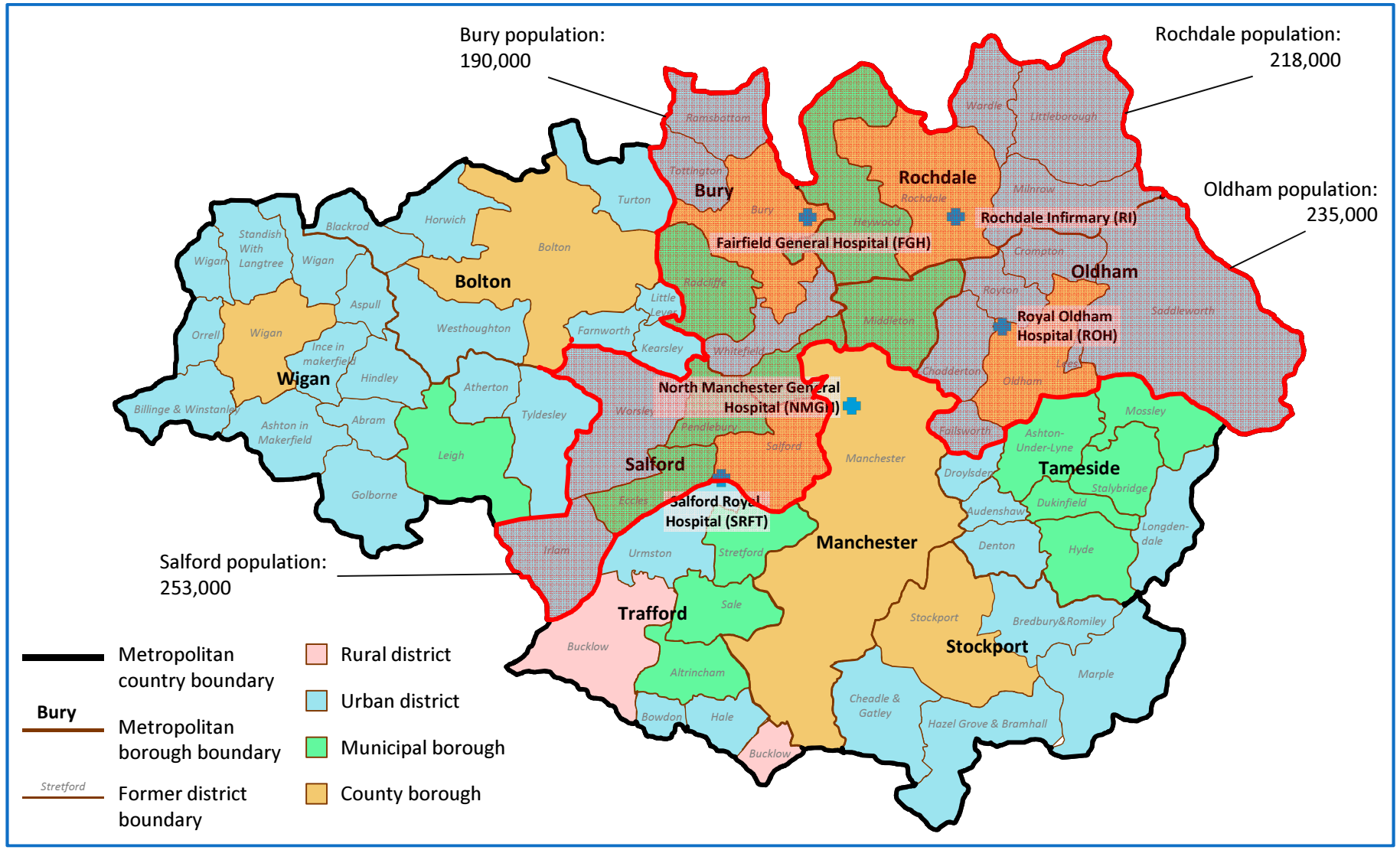
The local population is growing and getting older, within a system already delivering some poor outcomes	▪ NES commissioners are responsible for commissioning care for Oldham, Rochdale and Bury, with most care delivered across 4 sites – Fairfield General Hospital (FGH), Rochdale Infirmary (RI), North Manchester General Hospital (NMGH) and Royal Oldham Hospital (ROH) – as well as links to Salford Royal Hospital via the Northern Care Alliance ▪ Collectively, along with Salford CCG, NES CCGs serve a population of ~900,000, which is **growing by 0.5% per year** with the number of people **over 70 projected to grow 12% by 2025**. This will result in a higher prevalence of long term conditions (LTCs) and frailty ▪ **Avoidable mortality rates** are already much **higher than the England average**, while life expectancy is among the lowest nationally
To address this, a different sort of care will be required to that historically provided …	▪ To address rising population health demands, LCOs are seeking to transform **out-of-hospital care** focused on **prevention of ill health, integration** and **moving care delivery closer to home** ▪ Greater Manchester has **been given £450m over 5 years** as part of devolution to invest into delivering these changes in care delivery ▪ Technology will play a key part in supporting many of these new models of care e.g. virtual outpatient clinics or remote monitoring
… resulting in decreased hospital activity and better health outcomes …	▪ The clinical evidence base suggests that a greater focus on prevention of ill health and on caring for people with LTCs and frailty in the community can significantly reduce the need for acute hospital care resulting in better health status and greater independence ▪ CCG plans to implement new models of care to deflect acute activity are underway, and over the past five years, **admissions across PAHT hospitals have fallen by 1% p.a. on average** while **average non-elective LoS is one of the lowest in the country** for its case mix ▪ Currently, **51% of NHS funds** available locally are **spent on acute care** and this percentage has been falling
… this is good for the local population, but will put further pressure on already fragile acute services …	▪ Current acute hospital services are split over five sites – FGH, RI, ROH, Salford Royal Hospital and also NMGH. Declining hospital activity will result in **subscale services** at each site – below levels recommended by national clinical bodies ▪ Services that need to be provided 7 days a week are particularly difficult to provide on sites where volumes of activity are low – this is particularly the case for **critical care**, which has **consultant shortfalls at FGH and NMGH** ▪ Lower volume services have been shown to be associated with **poorer quality of care**, with clinical teams less able to develop and maintain their skills, as well as **higher costs** due to **underutilised estate and workforce** ▪ There is variation in the quality of care across sites serving the NES population, with ROH and NMGH recently rated as **"requiring improvement"** and patients with MI and HF having **relatively poor access to consultant cardiologists** at ROH ▪ Operationally, 4-hour A&E **waiting times performance has been deteriorating** and is below the national average at ROH, NMGH and Salford, while **18-week RTT at ROH and NMGH is lower than the national average** and has been **declining** ▪ In terms of cost, the NCA had an underlying **£82m financial gap** in 2017/18 **projected to reach an underlying deficit of over £100m by 2022/23** assuming productivity increases of just over 2% are delivered each year ▪ Furthermore, recent workforce data shows that **7-18% of medical and nursing positions are vacant** at sites serving NES population, with **high levels of agency spend** to try to cover these positions
Consolidation is one of several ways to address the fragility of acute services	▪ The Healthier Together business case (2015) has already recommended that some services, e.g. general surgery, move in order to capture the benefits to clinical quality, workforce and financial sustainability from delivering services at scale ▪ Further consolidation may deliver similar improvements in other fragile services ▪ In addition, **reductions to length of stay** and **increasing throughput** of theatres, diagnostic services and outpatients will all enable more **efficient hospital services** and allow continued **investment in out-of-hospital care**

Contents

Section summary

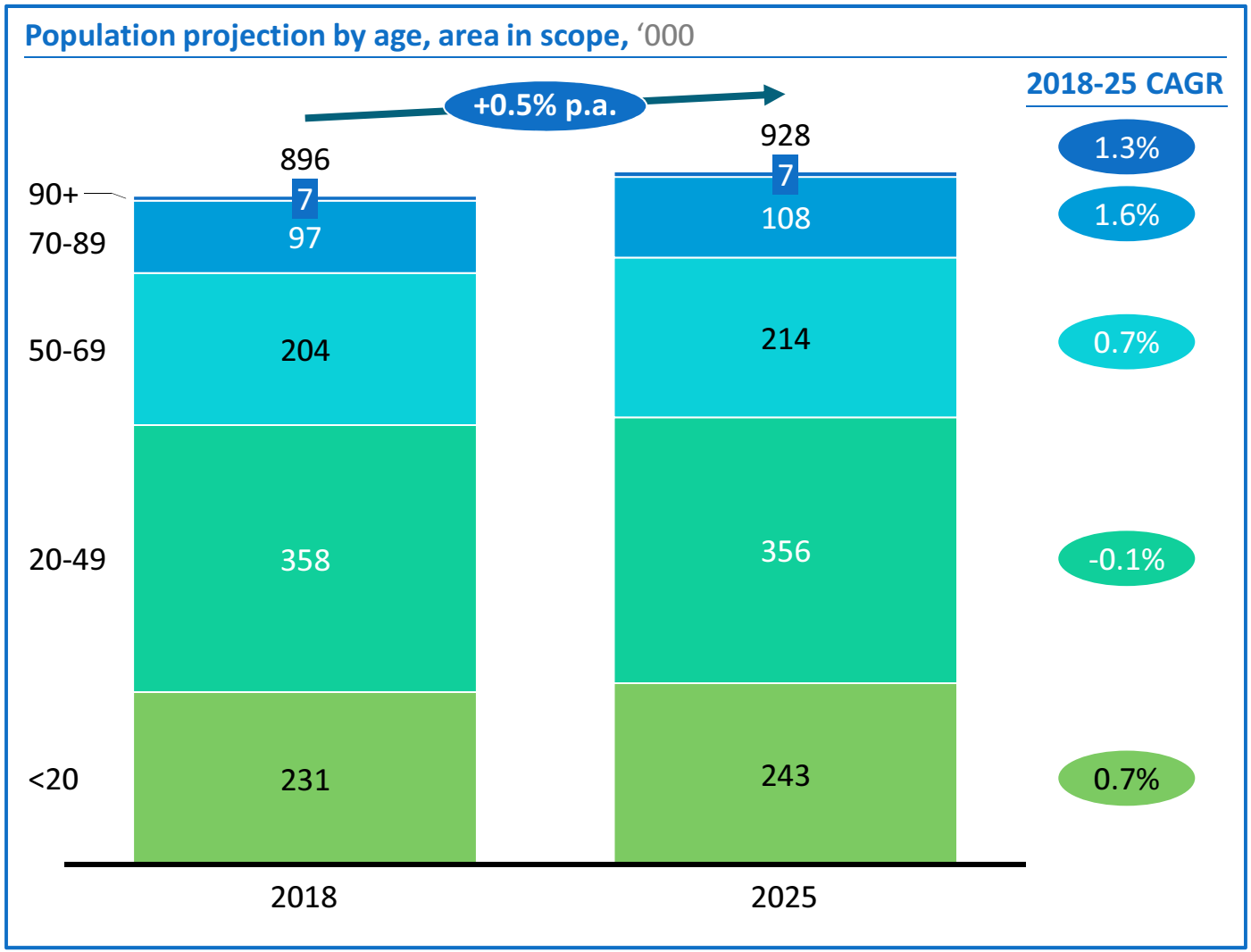
- NES CCGs commission care for Bury, Rochdale and Oldham; however any service change will have implications for Salford and North Manchester, as well as vice versa
- The population of the Bury, Rochdale, Oldham and Salford boroughs is slightly younger than the England average and is set to increase by 0.5% p.a. by 2025 with the over 70's and 90's being the fastest growing
- The NES and Salford areas have very high levels of deprivation, with particularly high pockets of deprivation in Rochdale and Salford
- Obesity and smoking are particularly prevalent in parts of Rochdale and Salford
- Respiratory diseases, especially smoking-related ones, and depression are higher than the national average
- Moreover, avoidable mortality rates are higher than other areas of the country with life expectancy generally less than surrounding areas apart from pockets in Oldham and Bury

The NES serves three boroughs; however any service change will have implications for Salford and NM, as well as vice versa



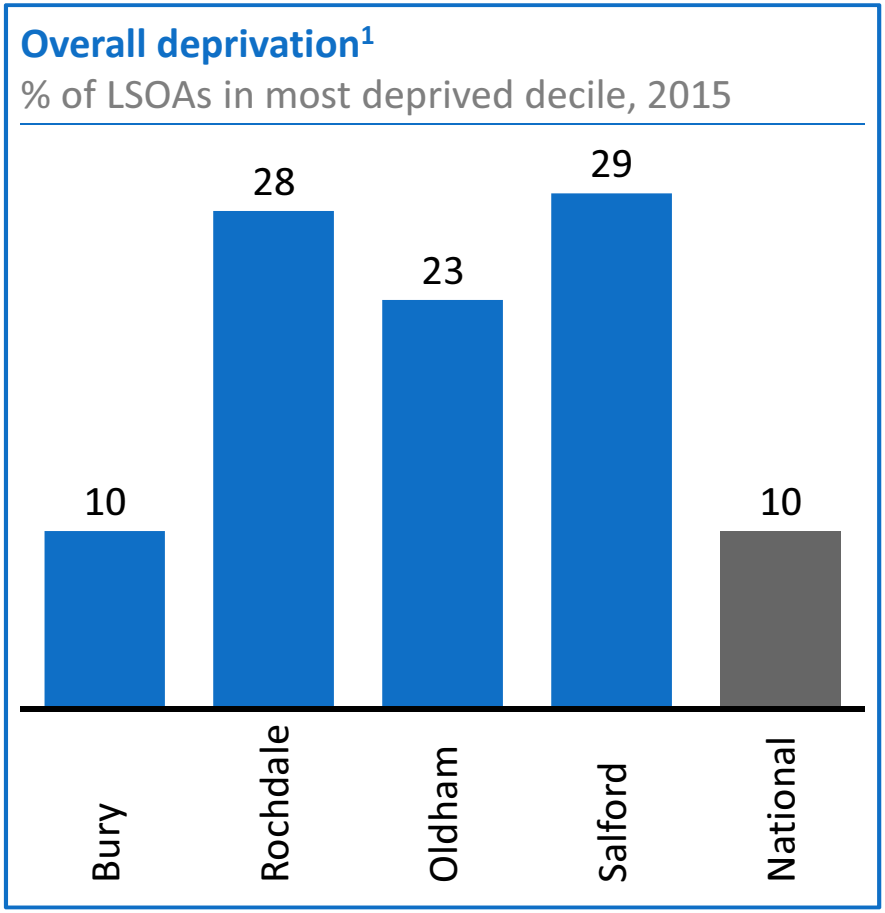
SOURCE: ONS 2018-based Sub National Population Projections; catchment area defined as the wards in the Boroughs of Bury, Oldham, Rochdale and Salford

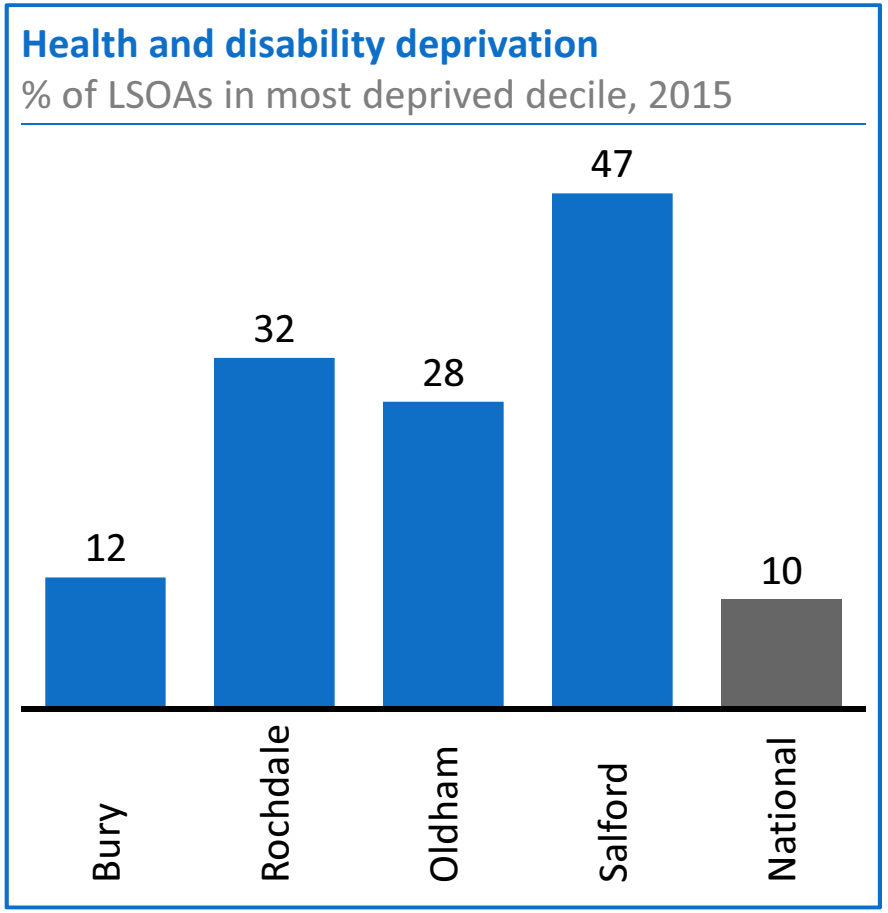
Population in the four boroughs is set to increase by 0.5% p.a. by 2025 with the over 70's and over 90's being the fastest growing



SOURCE: ONS 2018-based Sub National Population Projections; catchment area defined as the wards in the Boroughs of Bury, Oldham, Rochdale and Salford

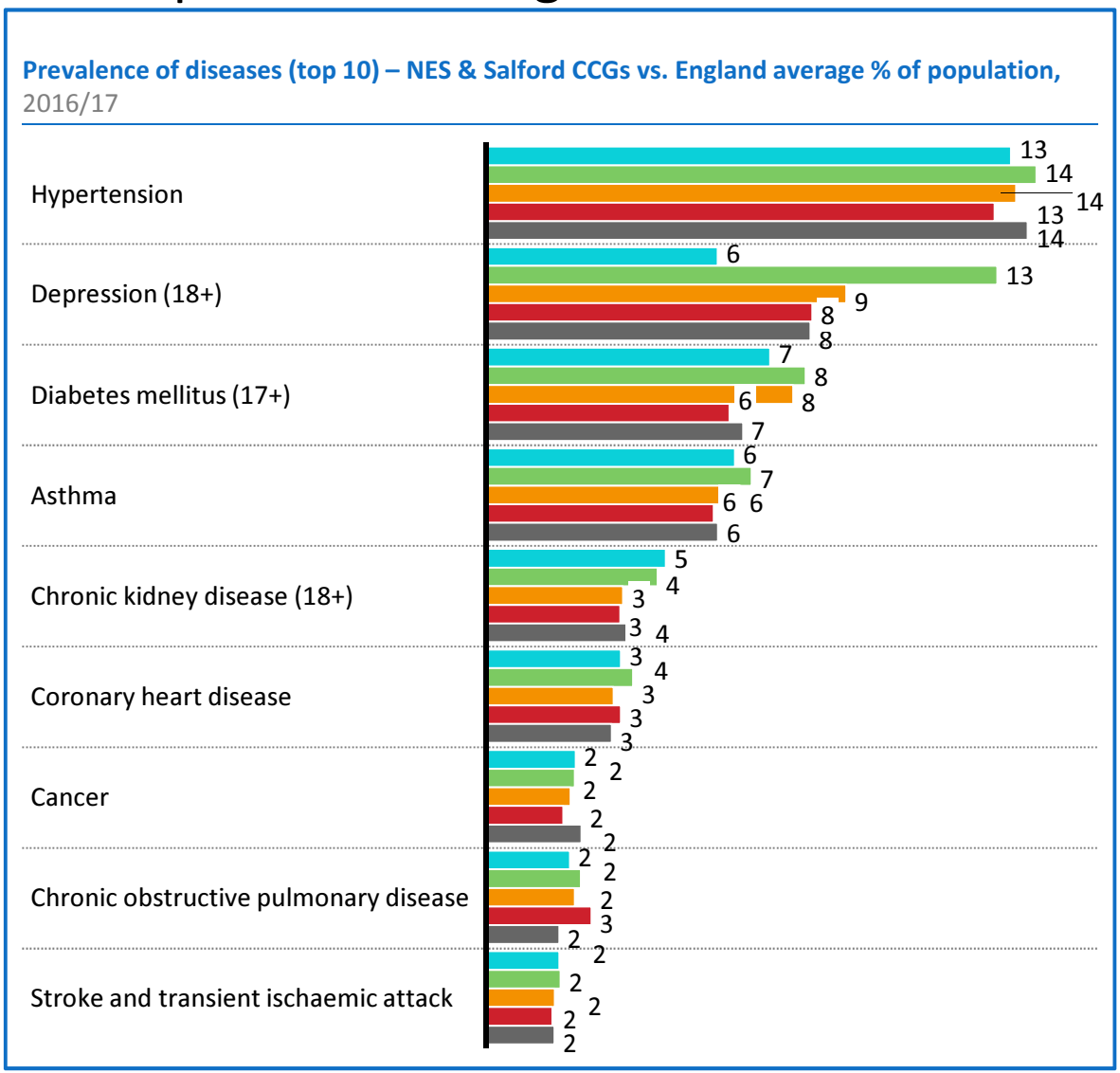
The NES and Salford areas have very high levels of deprivation, with particularly high pockets of deprivation in Rochdale and Salford

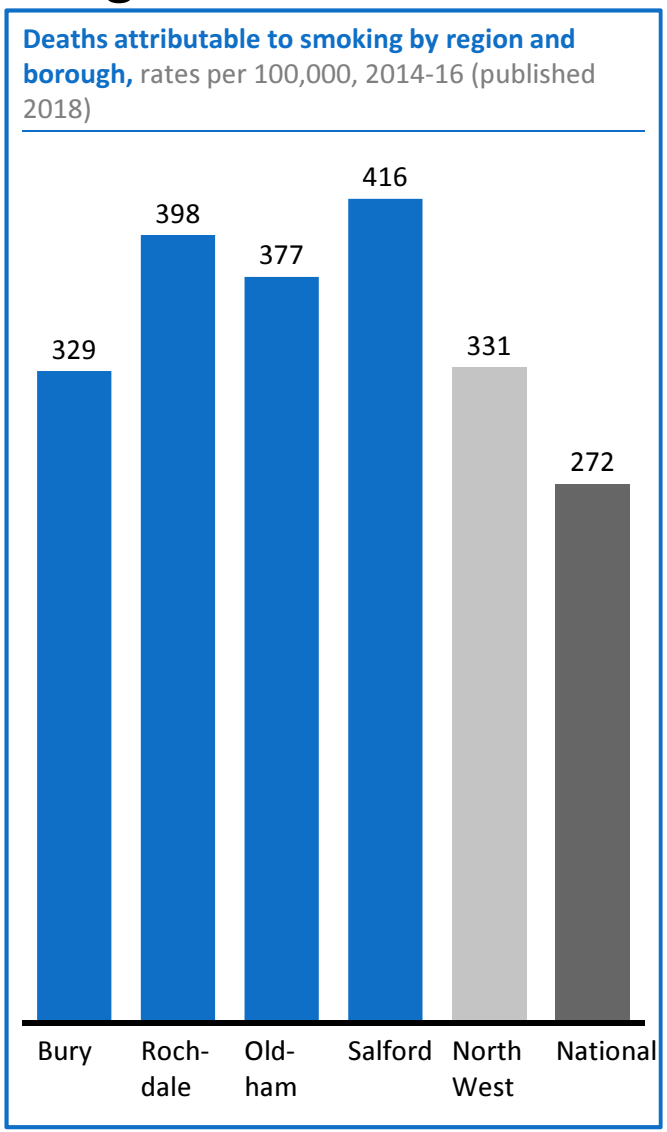




SOURCE: Ministry of Housing, Communities & Local Government – English indices of deprivation 2015

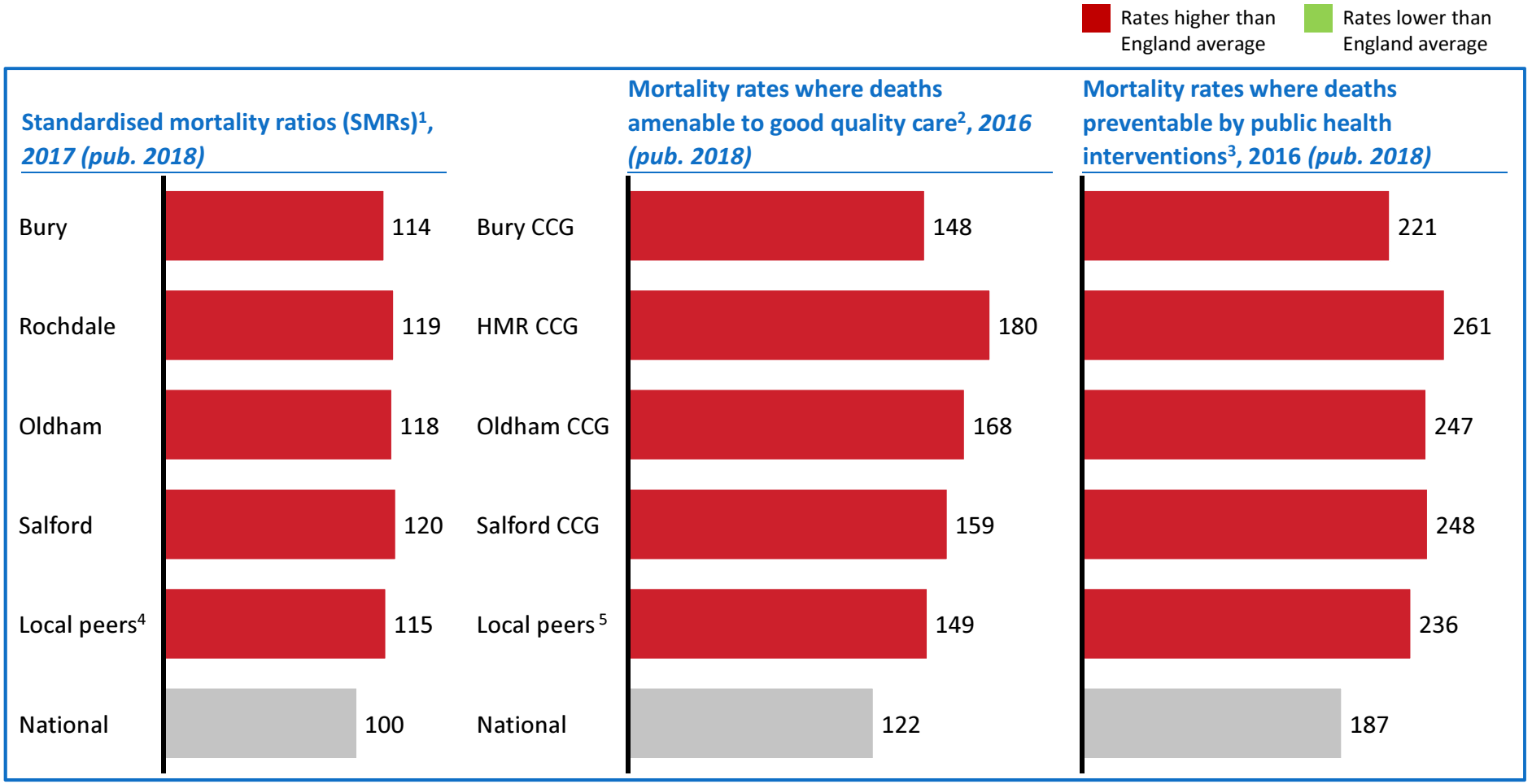
Respiratory diseases, especially smoking-related ones, and depression are higher than the national average





SOURCE: QOF 2016/17; NHS Digital Statistics on Smoking - England 2018 reporting data over 2014 to 2016 period

Avoidable mortality rates are higher than other areas of the country



1 SMRs give a comparison of mortality in the borough / region of interest against England population as a whole, while allowing for differences in age structure
2 Age-standardised mortality rate per 100,000 where if, in light of medical knowledge and technology available at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided through good quality healthcare
3 Age-standardised mortality rate per 100,000 where if, in the light of understanding of the determinants of health at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health interventions in the broadest sense
4 Local peers as unitary authorities/counties/districts for Bolton, Manchester, Stockport, Tameside, Trafford and Wigan
5 Local peers as CCGs for Bolton, Stockport, Tameside and Glossop, Trafford, Wigan Borough and Manchester CCGs before the merger

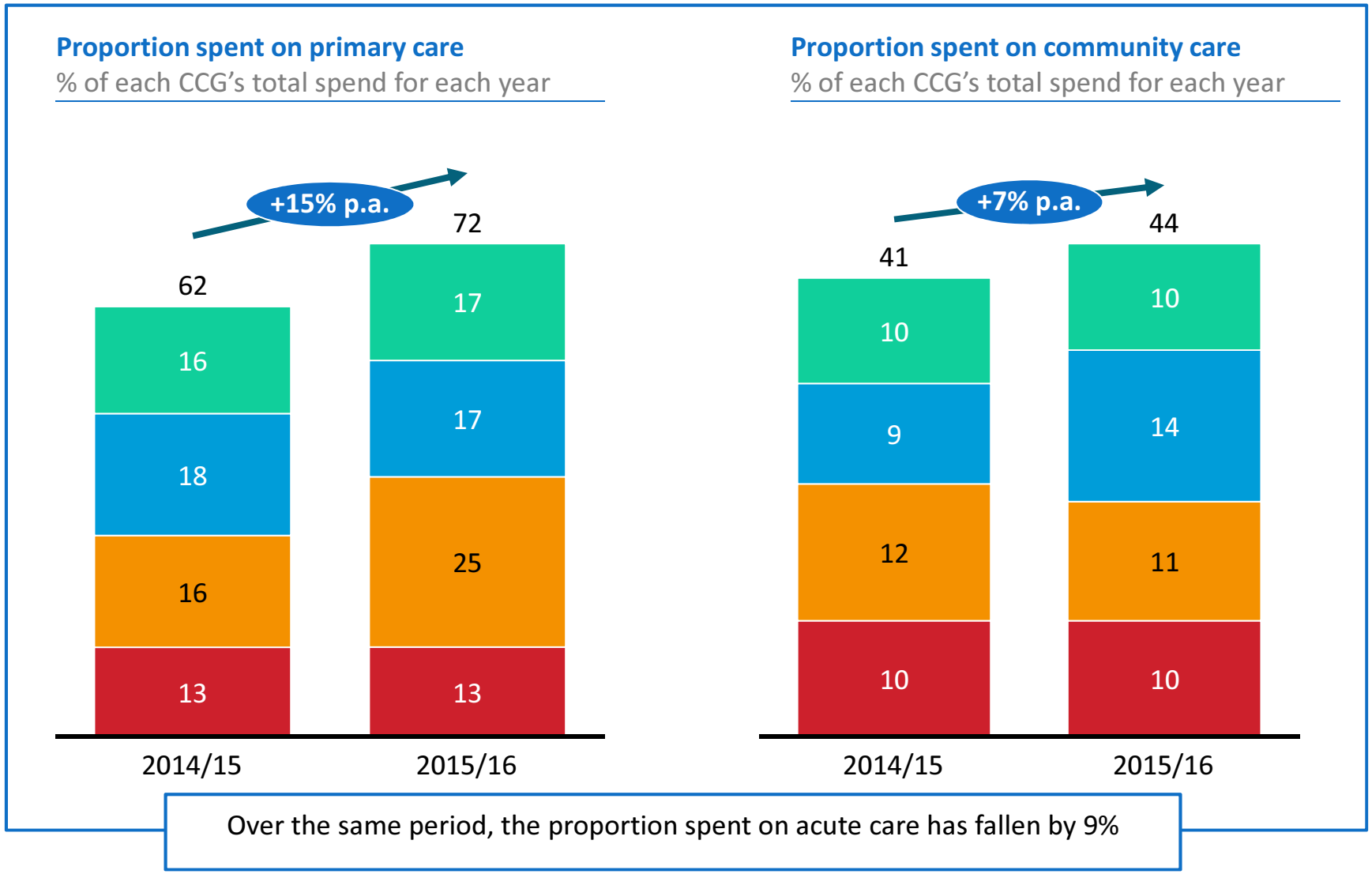
SOURCE: ONS Deaths Registrations Summary Statistics, 2018 reporting data for 2017; ONS Avoidable mortality in England and Wales: 2018 reporting data for 2016

Contents

Summary of this section

- To address rising population health demands, LCOs are seeking to transform out-of-hospital care through a greater focus on prevention of ill health, integration and moving care delivery closer to home
- To deliver these changes, Greater Manchester has been given £450m over 5 years as part of its devolution agreement
- The proportion of CCG budgets spent on primary and community care rose by 15% and 7%, respectively, between 2014/15 and 2015/16 – in line with LCO plans to shift activity out of hospitals
- In terms of primary care, there are a few very large GP practices in Salford and Oldham
- Oldham in particular has many more registered patients per permanent GP on average than nationally and a slightly higher proportion of GP practices rated inadequate than neighbouring CCGs

The proportion of CCG budgets that has been spent on primary and community care has risen significantly



Over the same period, the proportion spent on acute care has fallen by 9%

SOURCE: CCG spend breakdown, NHS Digital, 2017

There is some variation in quality of care for diabetes mellitus among Bury and HMR GPs

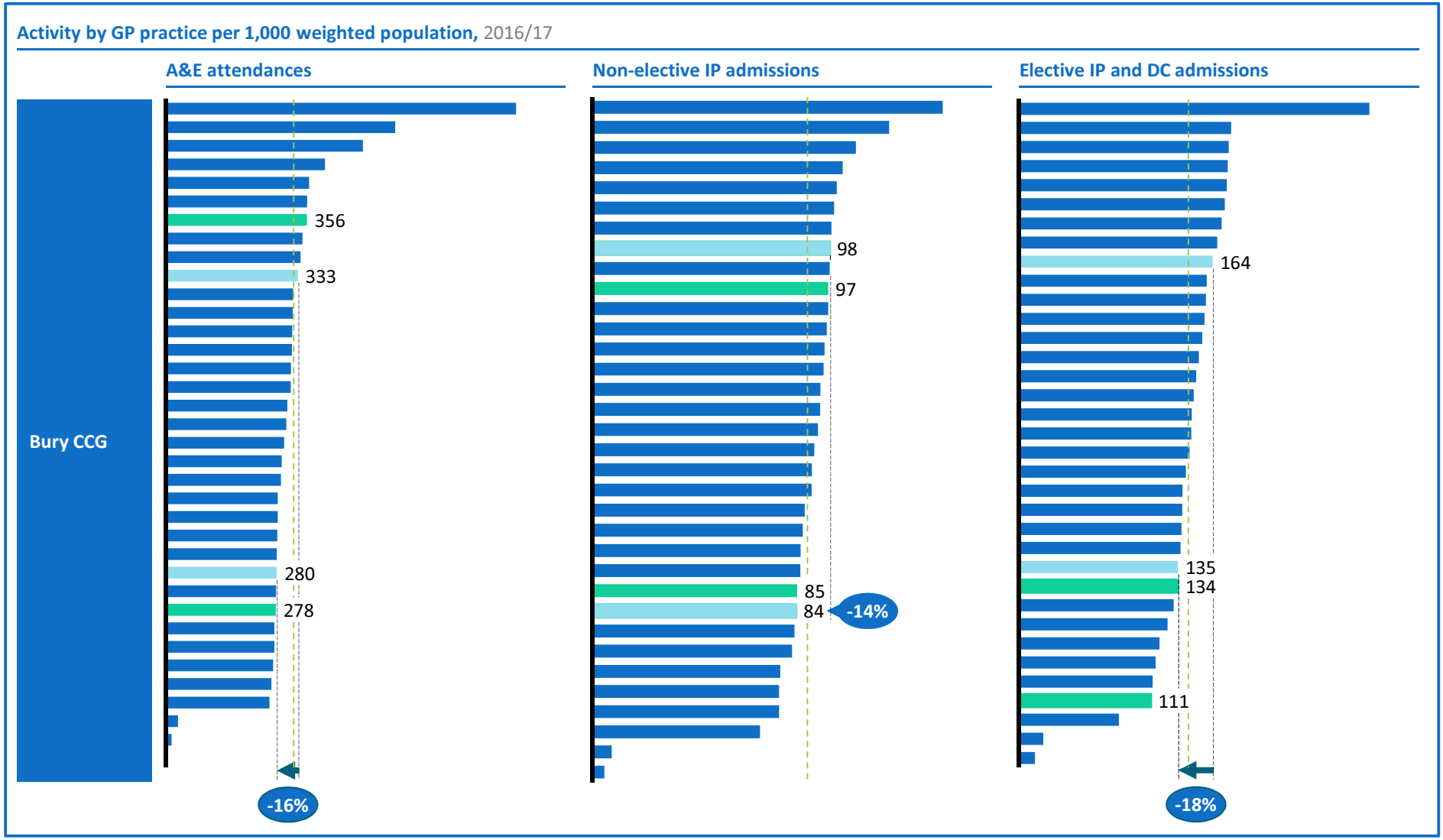
SOURCE: QOF 2016/17 published in 2018

Contents

Section summary

- CCG plans to deliver new models of care to deflect acute activity are underway
- Bury has relatively high elective admission rates, Oldham has high non-elective activity while HMR has high activity for all types
- However, over the past five years, admissions across PAHT hospitals – where NES CCGs commission the great majority of care – have fallen by 1% p.a. on average
- Moreover, the proportion of spending on the acute care sector is equivalent to or lower than the national average for all NES CCGs and this percentage has been falling

Bury has high elective admission rates with the lowest quartile rate similar to the national median



SOURCE: HES 206/17 M13 APC and A&E data, c/o NHS Digital

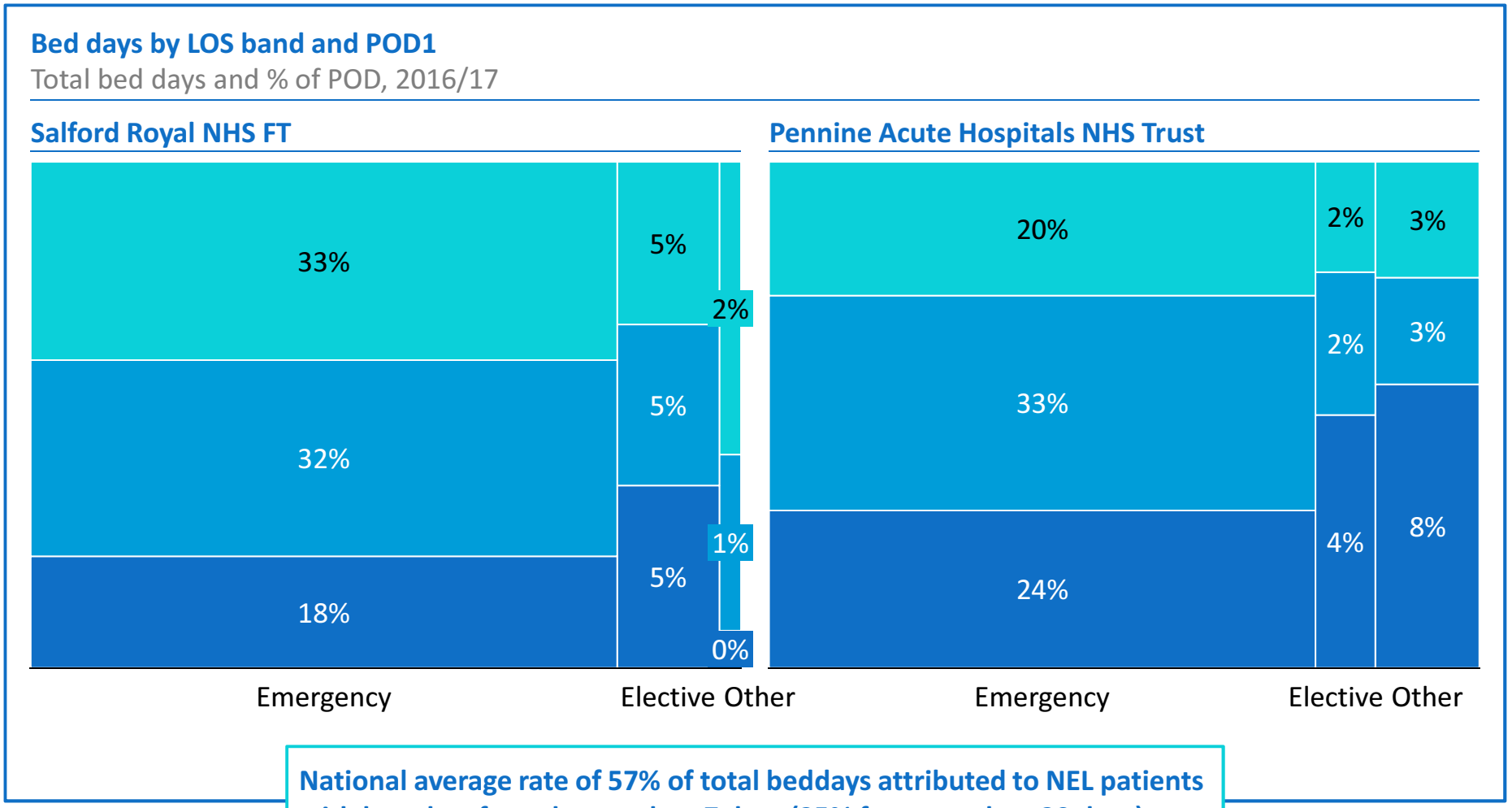
Contents

Section summary

Focus of today's discussions

- Services that need to be provided 7 days a week will become even more difficult to provide on sites if volumes of activity decrease
- There is already difficulty ensuring that patients with MI and HF have rapid access to specialist staff and procedures at ROH
- In critical care, there have been notable consultant shortfalls at FGH and NMGH
- Recent workforce data shows that 7-18% of medical and nursing positions are vacant with high levels of agency spend to cover these positions
- Operationally, 4-hour A&E waiting times performance has been deteriorating and is below the national average at ROH, NMGH and Salford, while 18-week RTT at ROH and NMGH is lower than the national average and has been declining
- Additionally, ROH was recently rated as "requiring improvement" in critical and medical care safety, effectiveness and responsiveness
- Meanwhile, NMGH required improvement in safety and effectiveness of medical care and surgery, plus responsiveness for critical care and urgent & emergency care
- This is all despite PAHT already having low NEL ALoS – among the top 10% nationally
- In terms of estate, NMGH in particular has high backlog maintenance costs and inefficient use of floor area, driven in part by its age
- In terms of finances, the NCA had an underlying £82m financial gap in 2017/18 that is projected to reach over £100m by 2017/18

>50% of all bed days at both trusts are occupied by stranded NEL patients with length of stay longer than 7 days



National average rate of 57% of total beddays attributed to NEL patients with lengths of stay longer than 7 days (25% for more than 30 days)

1 Excluding RA (Regular Attenders) and Other (not recorded type), Paediatrics patients are defined by age 0-18 y.o.

SOURCE: HES 2016/17

Quality indicators for myocardial infarction and heart failure

Performance below England average

Performance above England average

Quality indicator		FGH	RI	ROH	Salford	NMGH	England average
MI process metrics	nSTEMI patients seen by a cardiologist, *%, 2015/16 (pub. 2017)*	90.1	N/A	94.4	91.7	96.0	96.2
	MI patients who received all secondary prevention Rx they were eligible for, *%, 2015/16 (pub. 2017)*	88.7	N/A	94.1	97.5	96.9	91.1
HF process metrics	HF patients receiving input from consultant cardiologist, *%, 2015/16 (pub. 2017)*	43.6	2.3	44.9	36.0	42.9	56.9
	HF patients receiving echo, *%, 2015/16 (pub. 2017)*	64.4	34.1	46.8	82.7	69.3	90.1

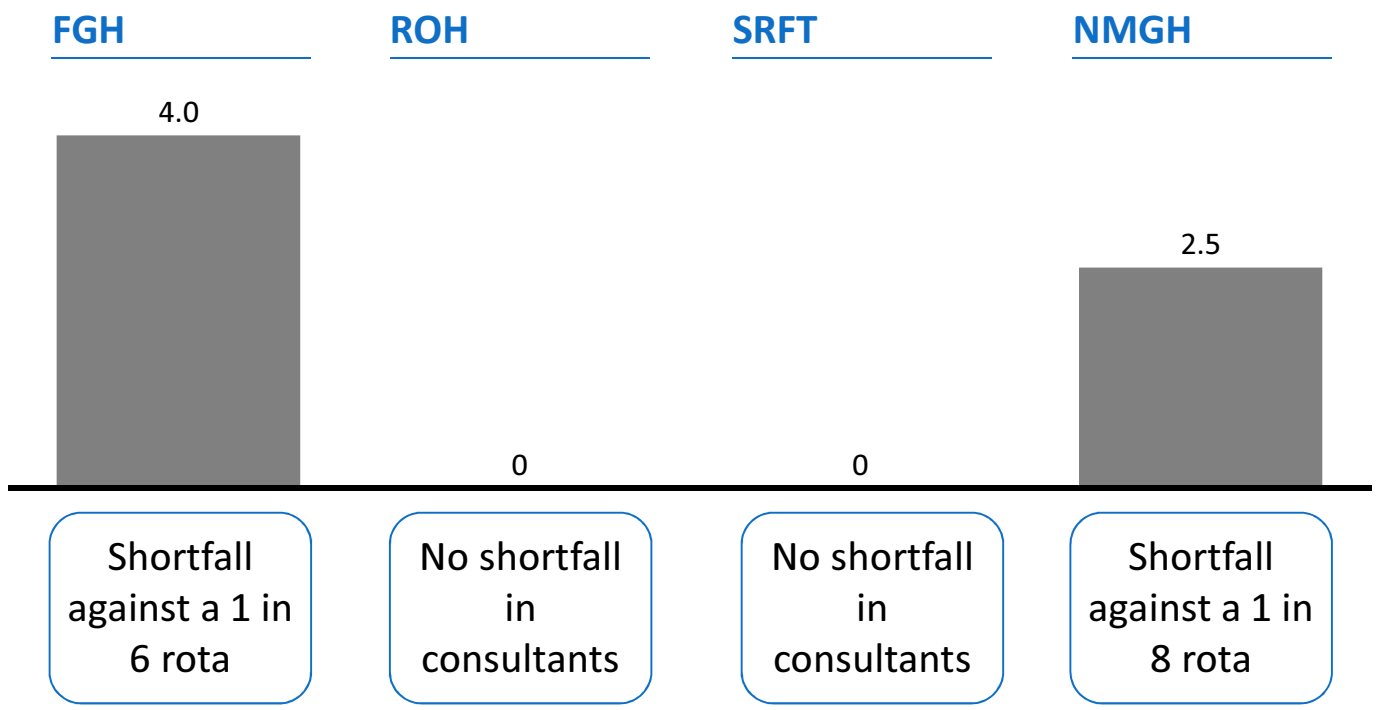
		Bury CCG	HMR CCG	Oldham CCG	Salford CCG	England average
HF out-comes	Mortality 12 mo after a first emergency hospital admission for HF in >15y, *indirectly standardised ratio, 2010/11 to 2015/16*	107.3	103.5	103.6	107.7	100.0

SOURCE: Myocardial Ischaemia National Audit Project 2017, National Heart Failure Audit 2017, CCG Outcomes Indicators 2018

Staffing levels for critical care

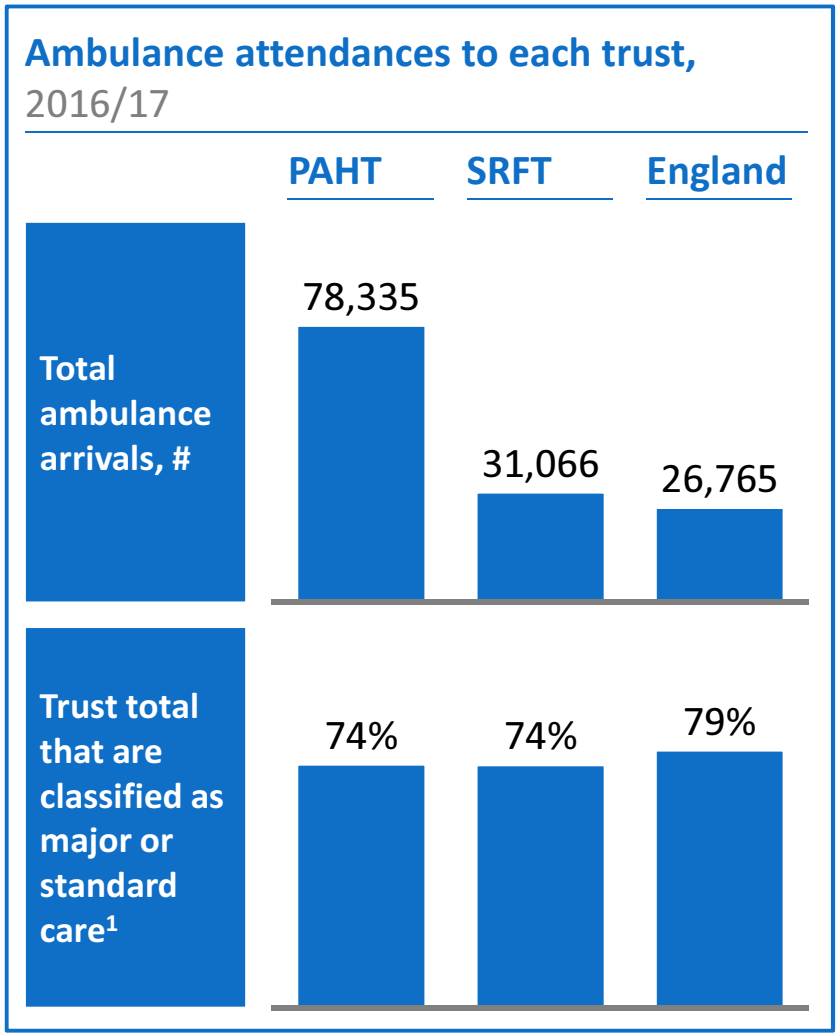
Consultant shortfall for critical care

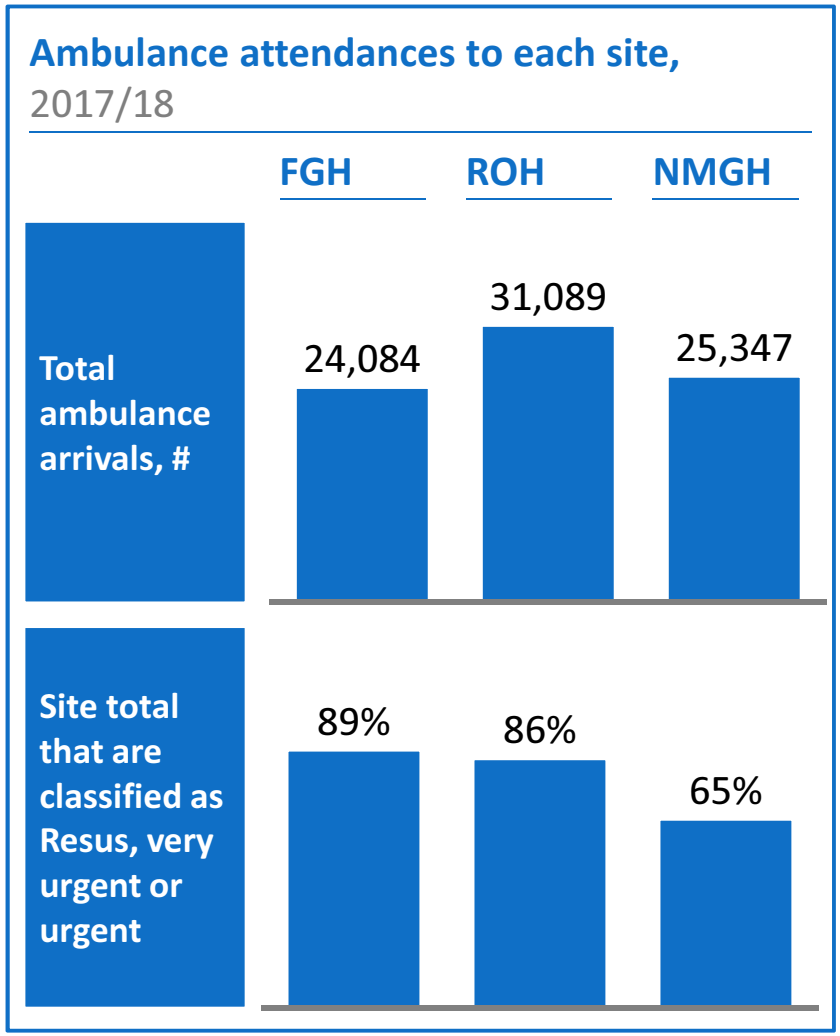
Number of WTEs, September 2018



SOURCE: Trust ESR data 2018

Ambulance activity to each of the NES and Salford sites

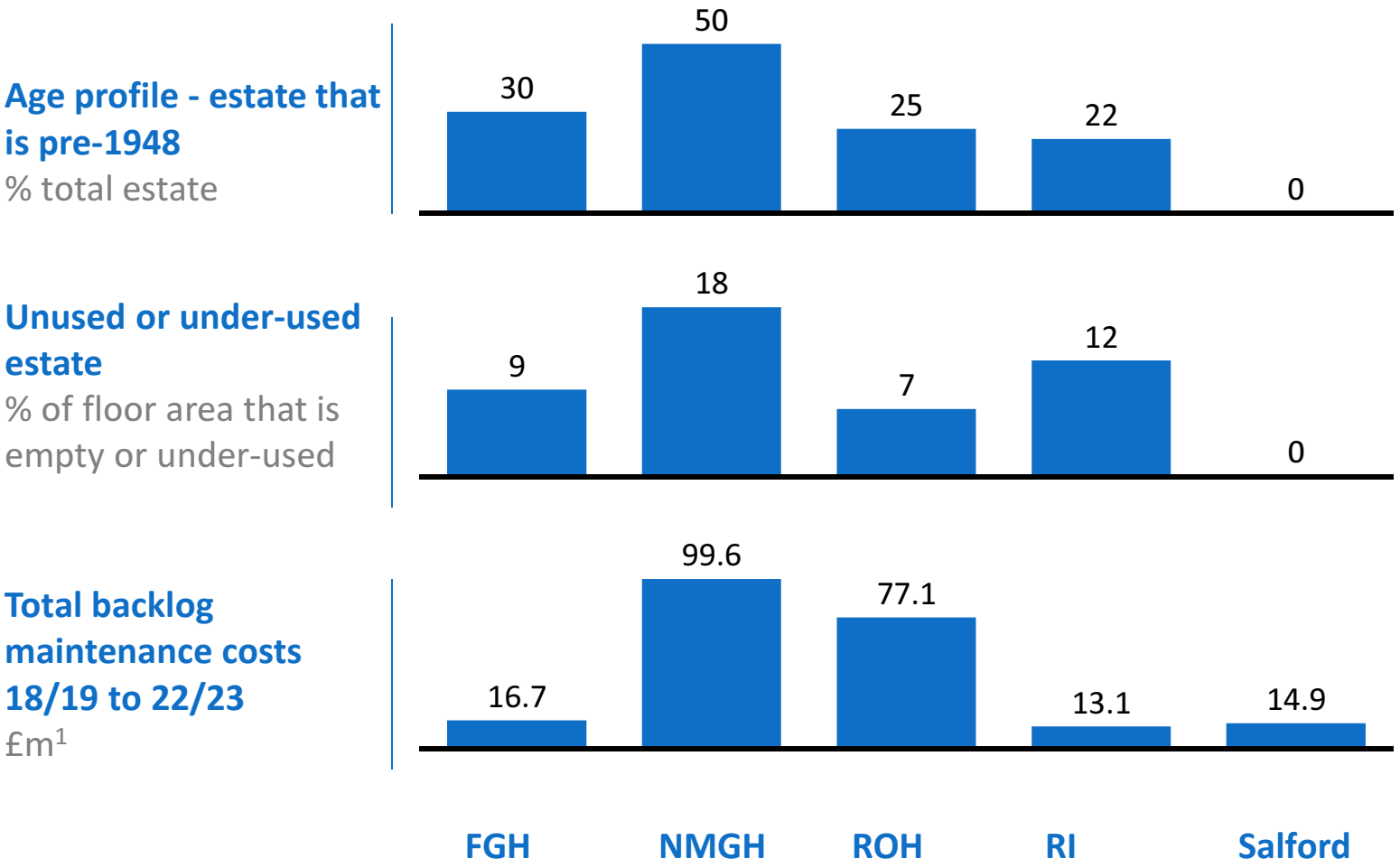




1 Defined for Salford, PAHT overall and England average based on HRGs VB01Z-VB08Z

SOURCE: Pennine Acute Trust data, 2018; HES A&E M13 2016/17 data, c/o NHS Digital

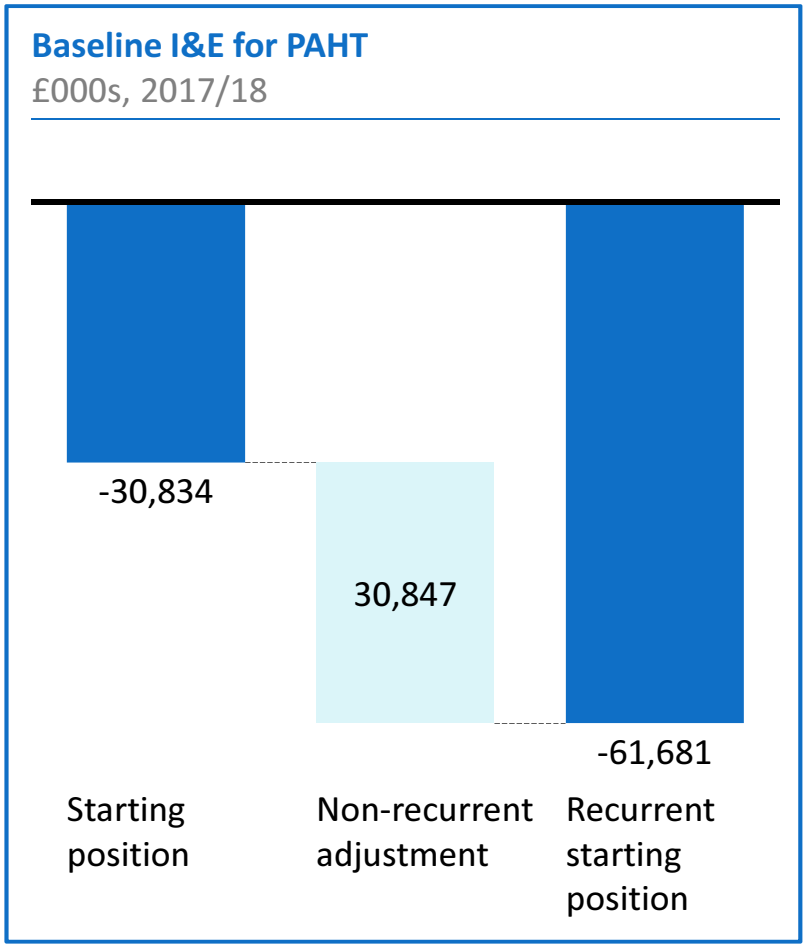
NM, in particular, does not use estate as efficiently as other sites, and has substantial backlog maintenance costs of nearly £100m

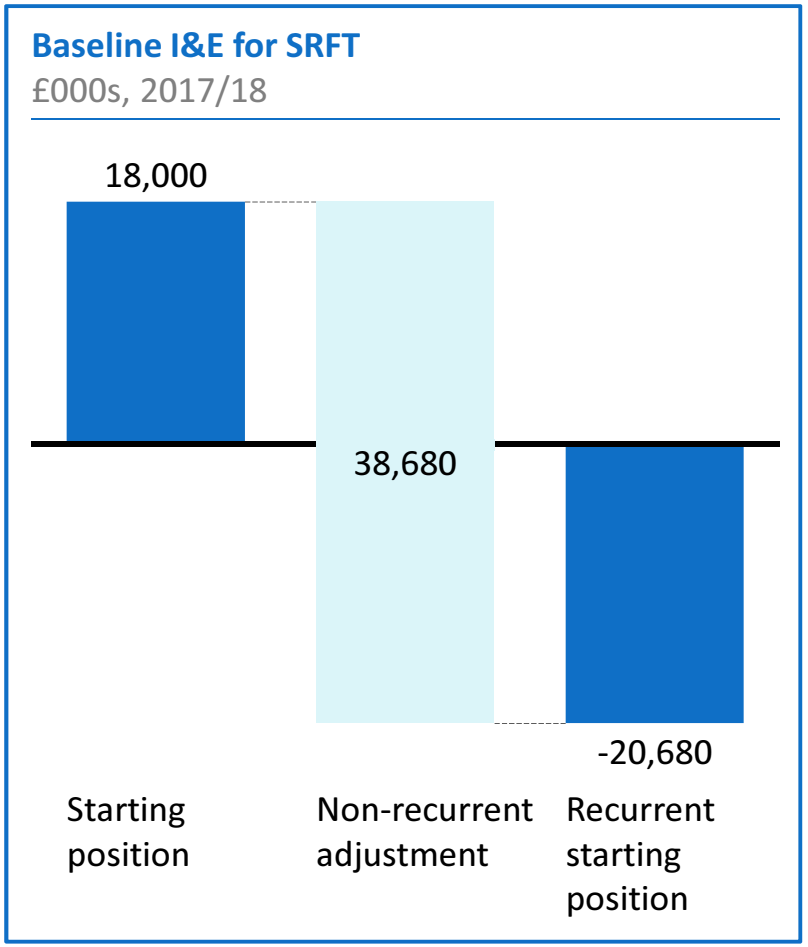


1 Data for Pennine sites is based on a Capita review for backlog over the next six years; data for Salford site is based on ERIC 17/18 returns

SOURCE: ERIC 17/18 and Capita review of Pennine sites

Both Trusts have underlying financial deficits





SOURCE: Provider and Commissioner model, GM Theme 3

NES Clinical Services: Case for Change

DRAFT DOCUMENT

Summary case for change

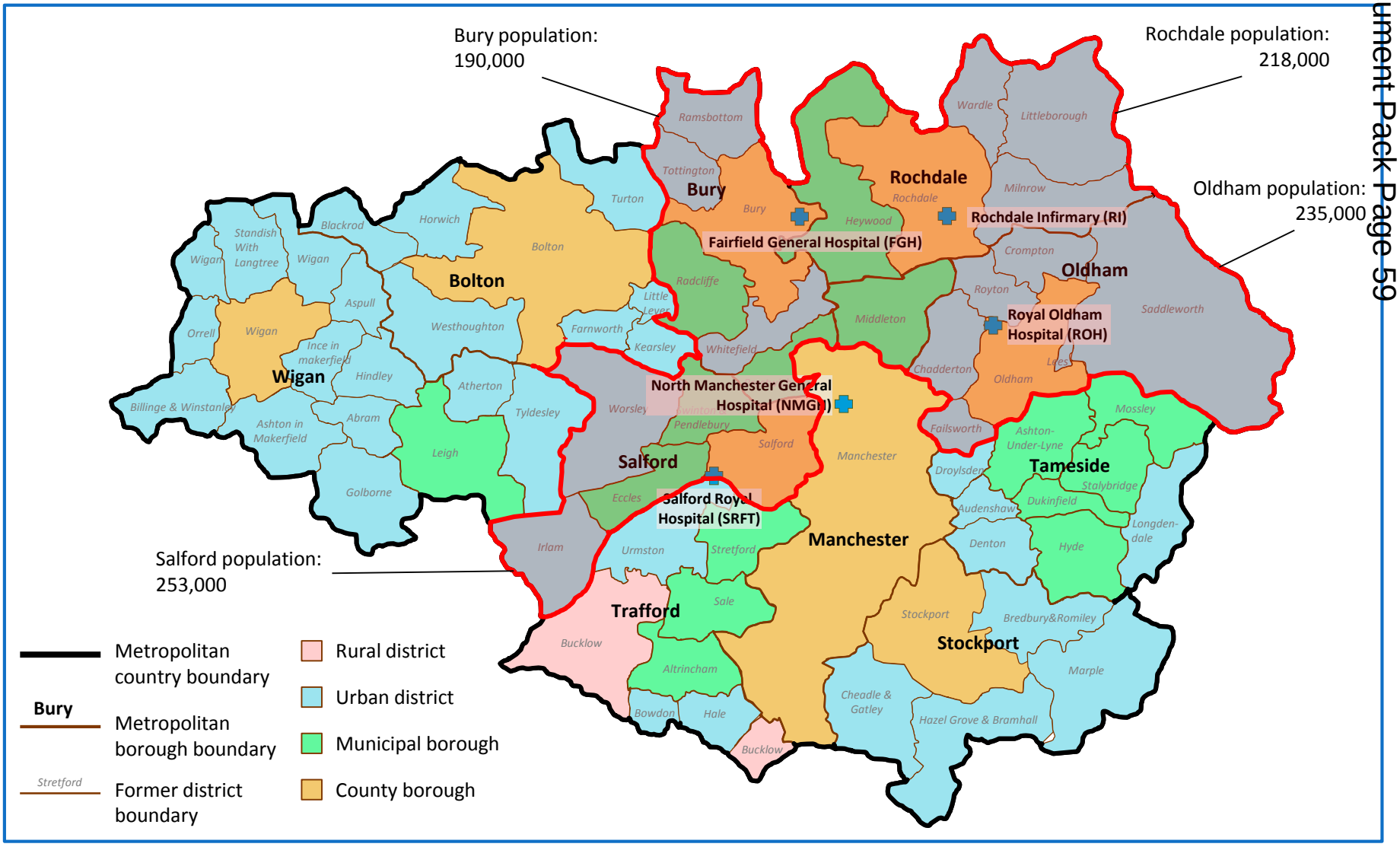
The local population is growing and getting older, within a system already delivering some poor outcomes	▪ NES commissioners are responsible for commissioning care for Oldham, Rochdale and Bury, with most care delivered across 4 sites – Fairfield General Hospital (FGH), Rochdale Infirmary (RI), North Manchester General Hospital (NMGH) and Royal Oldham Hospital (ROH) – as well as links to Salford Royal Hospital via the Northern Care Alliance ▪ Collectively, along with Salford CCG, NES CCGs serve a population of ~900,000, which is **growing by 0.5% per year** with the number of people **over 70 projected to grow 12% by 2025**. This will result in a higher prevalence of long term conditions (LTCs) and frailty ▪ **Avoidable mortality rates** are already much **higher than the England average**, while life expectancy is among the lowest nationally
To address this, a different sort of care will be required to that historically provided …	▪ To address rising population health demands, LCOs are seeking to transform **out-of-hospital care** focused on **prevention of ill health, integration** and **moving care delivery closer to home** ▪ Greater Manchester has **been given £450m over 5 years** as part of devolution to invest into delivering these changes in care delivery ▪ Technology will play a key part in supporting many of these new models of care e.g. virtual outpatient clinics or remote monitoring
… resulting in decreased hospital activity and better health outcomes …	▪ The clinical evidence base suggests that a greater focus on prevention of ill health and on caring for people with LTCs and frailty in the community can significantly reduce the need for acute hospital care resulting in better health status and greater independence ▪ CCG plans to implement new models of care to deflect acute activity are underway, and over the past five years, **admissions across PAHT hospitals have fallen by 1% p.a. on average** while **average non-elective LoS is one of the lowest in the country** for its case mix ▪ Currently, **51% of NHS funds** available locally are **spent on acute care** and this percentage has been falling
… this is good for the local population, but will put further pressure on already fragile acute services …	▪ Current acute hospital services are split over five sites – FGH, RI, ROH, Salford Royal Hospital and also NMGH. Declining hospital activity will result in **subscale services** at each site – below levels recommended by national clinical bodies ▪ Services that need to be provided 7 days a week are particularly difficult to provide on sites where volumes of activity are low – this is particularly the case for **critical care**, which has **consultant shortfalls at FGH and NMGH** ▪ Lower volume services have been shown to be associated with **poorer quality of care**, with clinical teams less able to develop and maintain their skills, as well as **higher costs** due to **underutilised estate and workforce** ▪ There is variation in the quality of care across sites serving the NES population, with ROH and NMGH recently rated as **"requiring improvement"** and patients with MI and HF having **relatively poor access to consultant cardiologists** at ROH ▪ Operationally, 4-hour A&E **waiting times performance has been deteriorating** and is below the national average at ROH, NMGH and Salford, while **18-week RTT at ROH and NMGH is lower than the national average** and has been **declining** ▪ In terms of cost, the NCA had an underlying **£82m financial gap** in 2017/18 **projected to reach an underlying deficit of over £100m by 2022/23** assuming productivity increases of just over 2% are delivered each year ▪ Furthermore, recent workforce data shows that **7-18% of medical and nursing positions are vacant** at sites serving NES population, with **high levels of agency spend** to try to cover these positions
Consolidation is one of several ways to address the fragility of acute services	▪ The Healthier Together business case (2015) has already recommended that some services, e.g. general surgery, move in order to capture the benefits to clinical quality, workforce and financial sustainability from delivering services at scale ▪ Further consolidation may deliver similar improvements in other fragile services ▪ In addition, **reductions to length of stay** and **increasing throughput** of theatres, diagnostic services and outpatients will all enable more **efficient hospital services** and allow continued **investment in out-of-hospital care**

Contents

Section summary

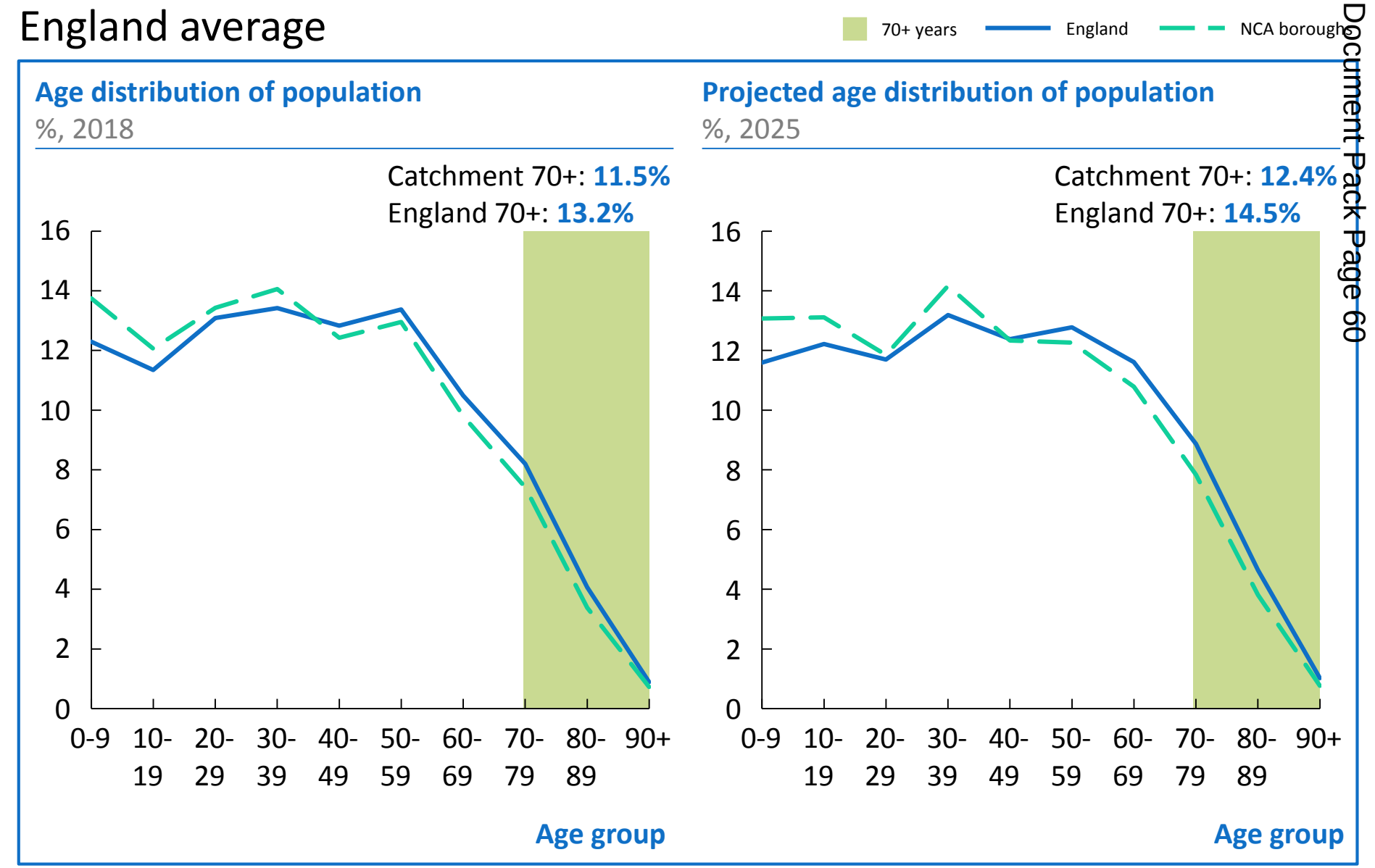
- NES CCGs commission care for Bury, Rochdale and Oldham; however any service change will have implications for Salford and North Manchester, as well as vice versa
- The population of the Bury, Rochdale, Oldham and Salford boroughs is slightly younger than the England average and is set to increase by 0.5% p.a. by 2025 with the over 70's and 90's being the fastest growing
- The NES and Salford areas have very high levels of deprivation, with particularly high pockets of deprivation in Rochdale and Salford
- Obesity and smoking are particularly prevalent in parts of Rochdale and Salford
- Respiratory diseases, especially smoking-related ones, and depression are higher than the national average
- Moreover, avoidable mortality rates are higher than other areas of the country with life expectancy generally less than surrounding areas apart from pockets in Oldham and Bury

The NES serves three boroughs; however any service change will have implications for Salford and NM, as well as vice versa



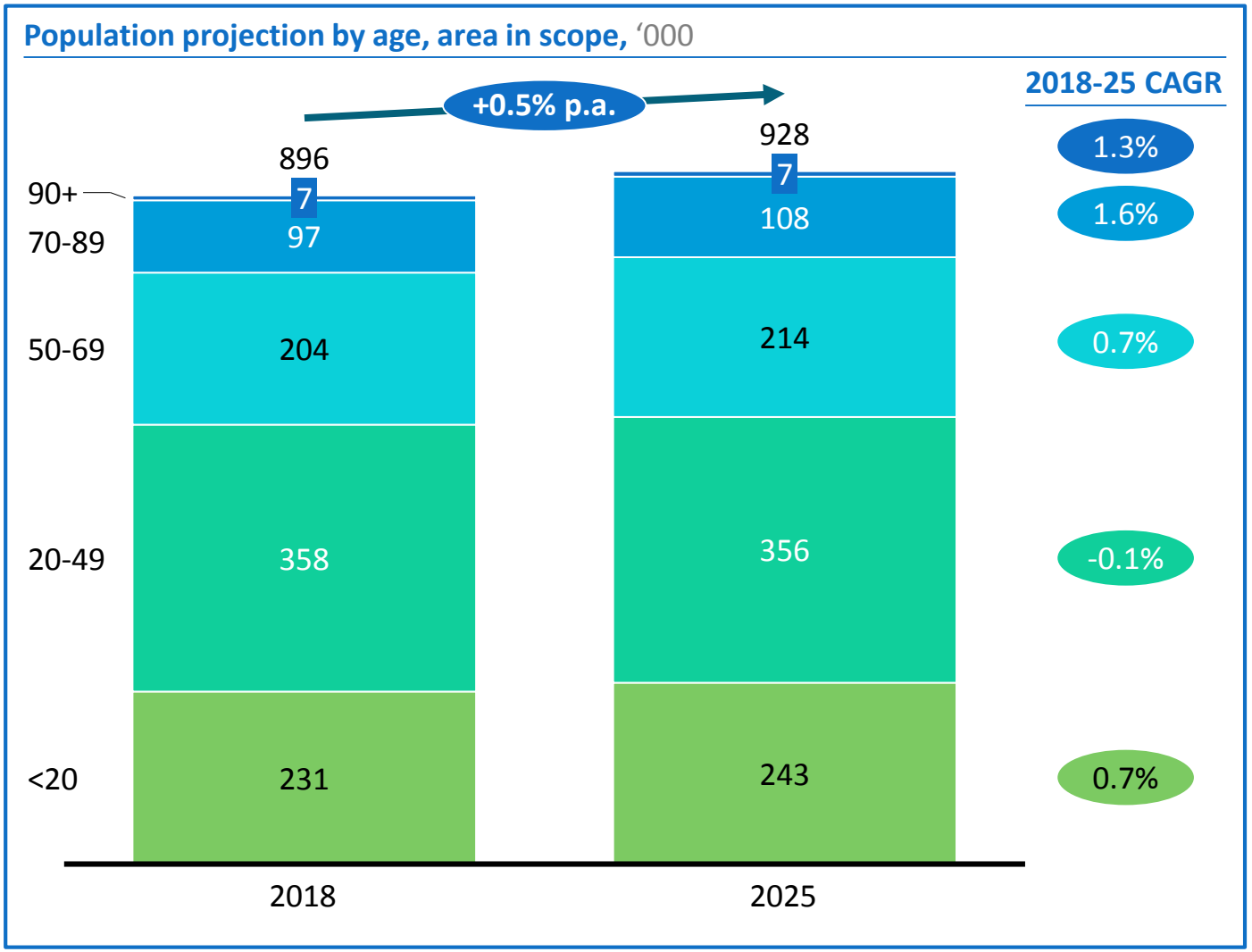
SOURCE: ONS 2018-based Sub National Population Projections; catchment area defined as the wards in the Boroughs of Bury, Oldham, Rochdale and Salford

The population of the four boroughs is slightly younger than the England average



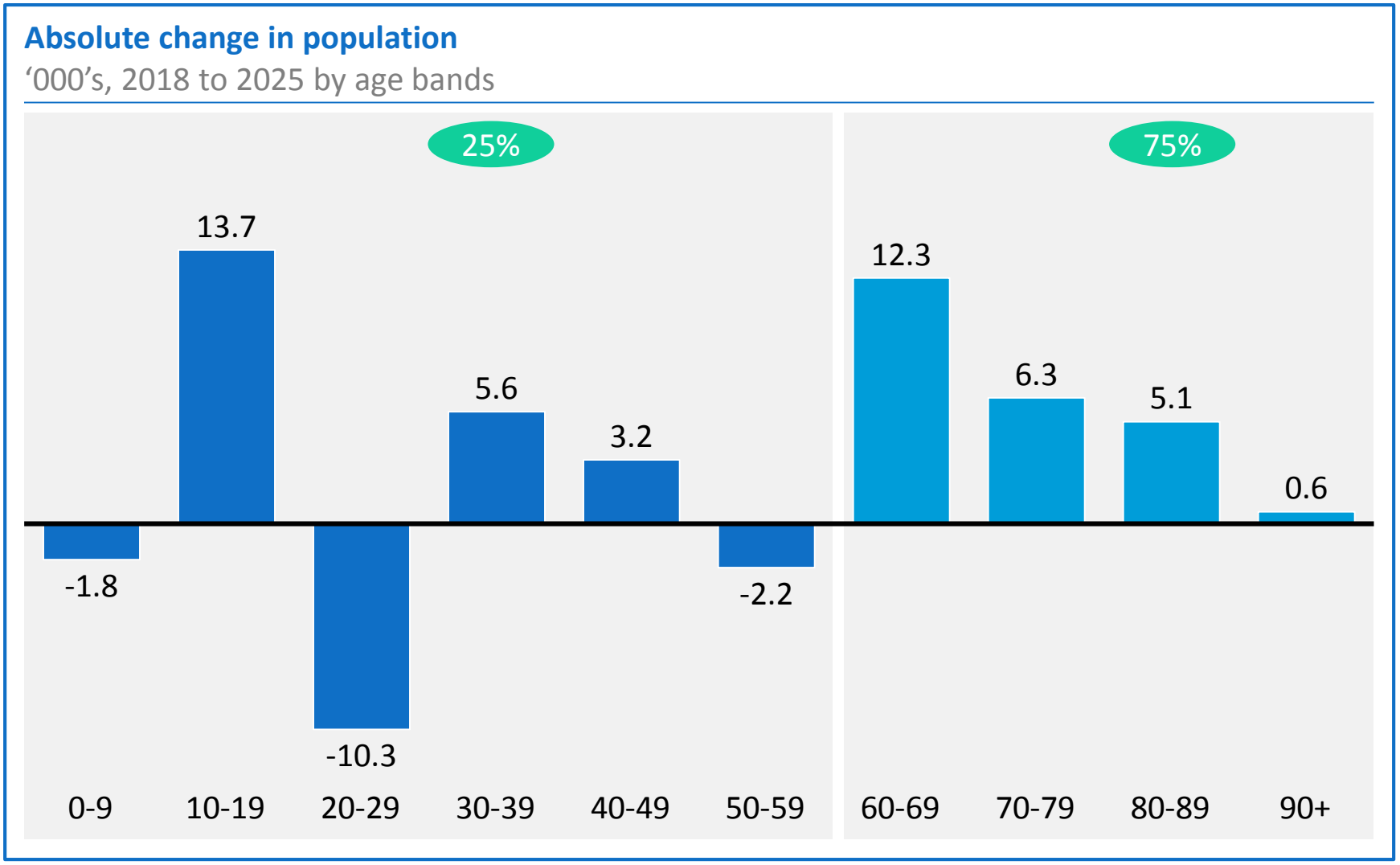
SOURCE: ONS 2018-based Sub National Population Projections; catchment area defined as the wards in the Boroughs of Bury, Oldham, Rochdale and Salford

Population in the four boroughs is set to increase by 0.5% p.a. by 2025 with the over 70's and over 90's being the fastest growing



SOURCE: ONS 2018-based Sub National Population Projections; catchment area defined as the wards in the Boroughs of Bury, Oldham, Rochdale and Salford

Almost three-quarters of the total population increase between 2018 and 2025 will be in the over 60's

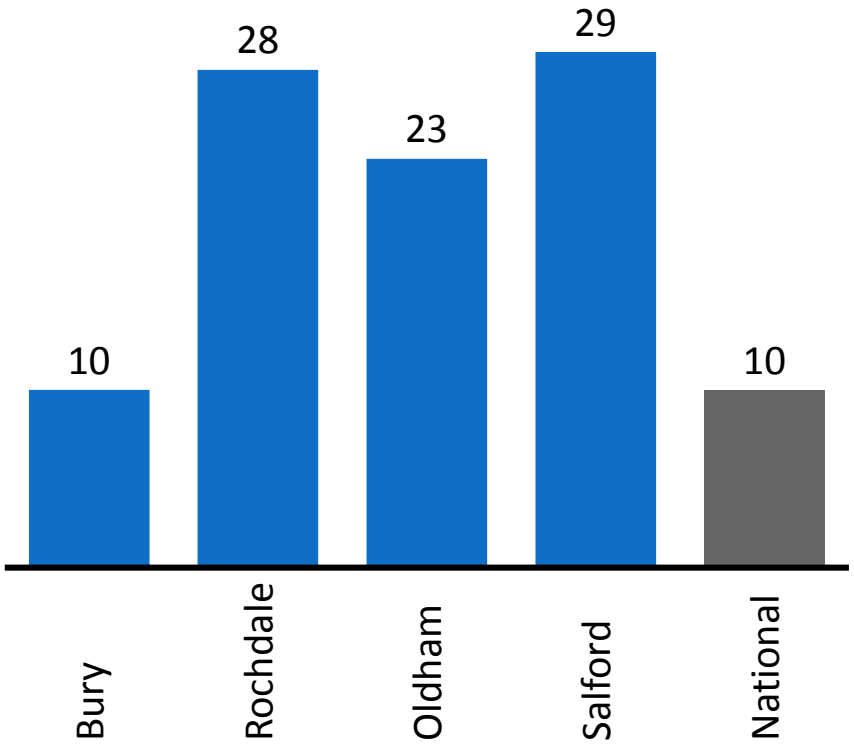


SOURCE: ONS 2018-based Sub National Population Projections; catchment area defined as the wards in the Boroughs of Bury, Oldham, Rochdale and Salford

The NES and Salford areas have very high levels of deprivation, with particularly high pockets of deprivation in Rochdale and Salford

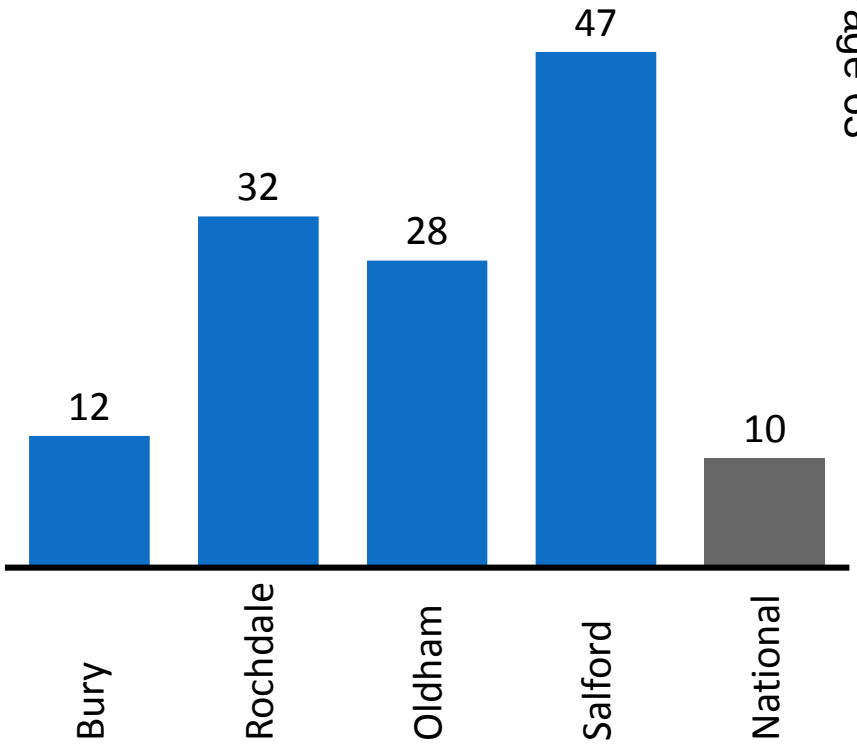
Overall deprivation[1]

% of LSOAs in most deprived decile, 2015



Health and disability deprivation

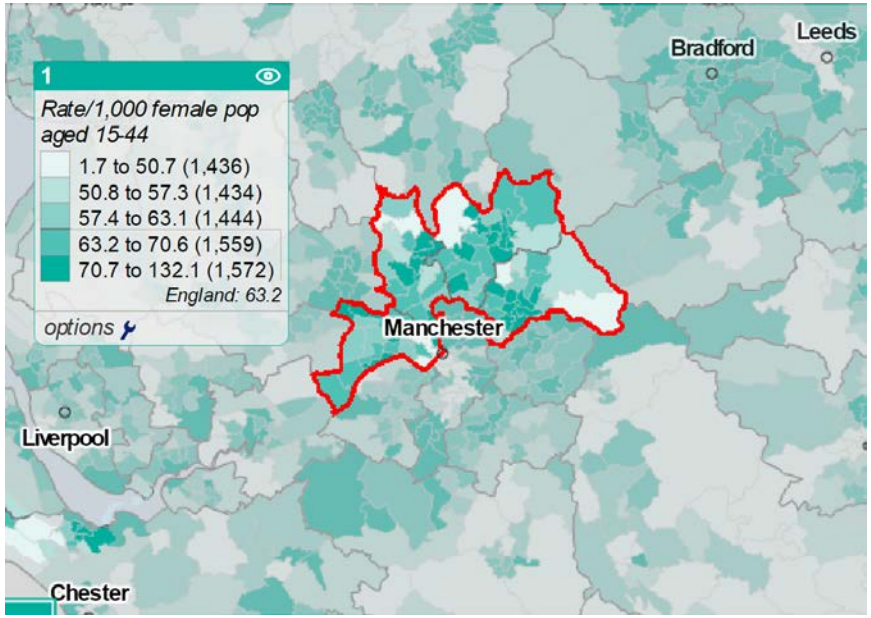
% of LSOAs in most deprived decile, 2015



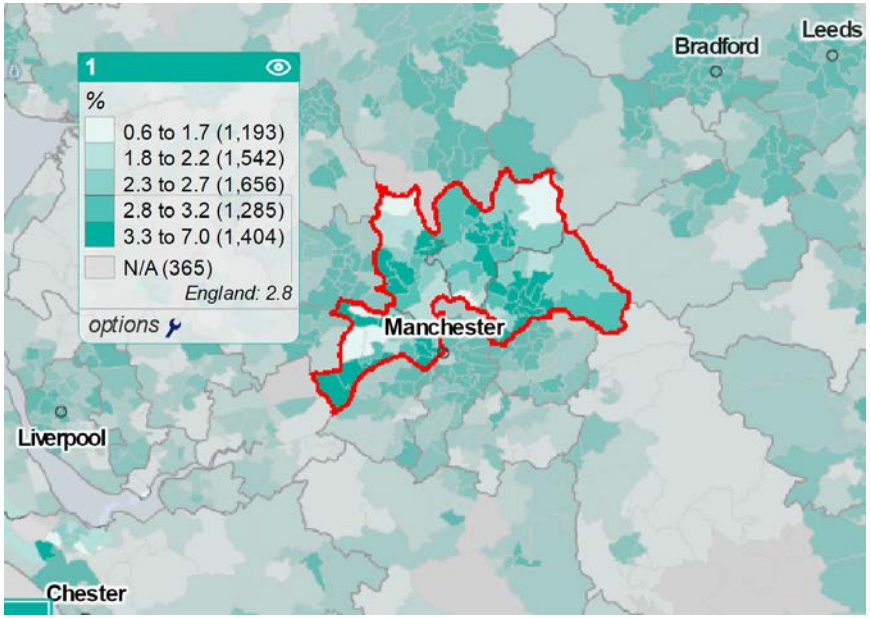
SOURCE: Ministry of Housing, Communities & Local Government – English indices of deprivation 2015

There is low overlap between those areas with high fertility rates and those with low birth weight term babies

Fertility rate, 2011-15 (darker areas indicate higher fertility rate per 1,000 female population)



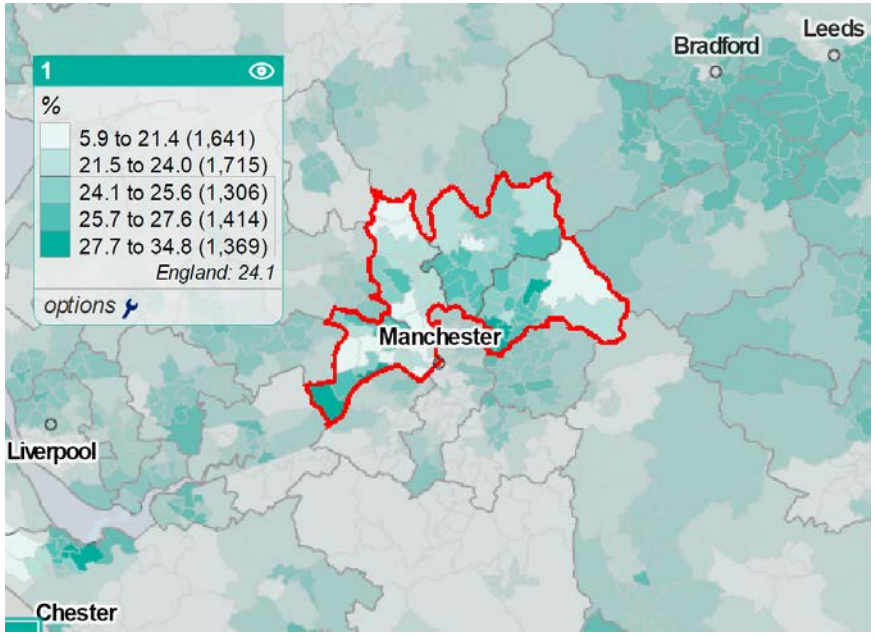
Low birth weight of term babies, 2011-15 (darker areas indicate higher %)



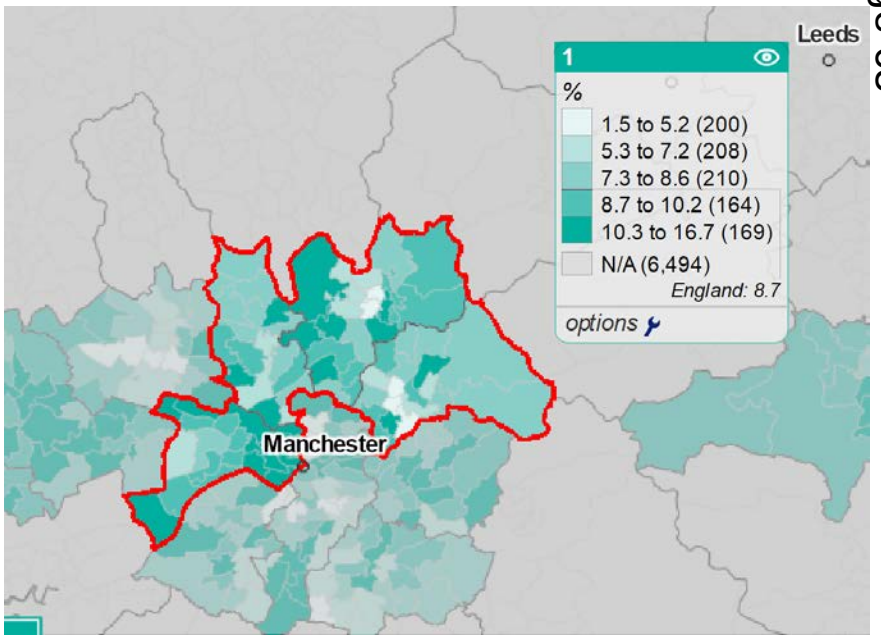
SOURCE: PHE local health tool, accessed online in August 2018 [http://www.localhealth.org.uk]

Obesity and smoking are particularly prevalent in parts of Rochdale and Salford

Obese adults, %, 2011-15 (darker areas indicate a higher %)

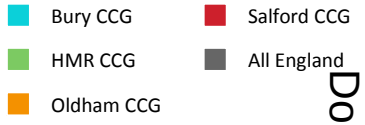


Regular smokers, %, 2011-15 (darker areas indicate higher %)

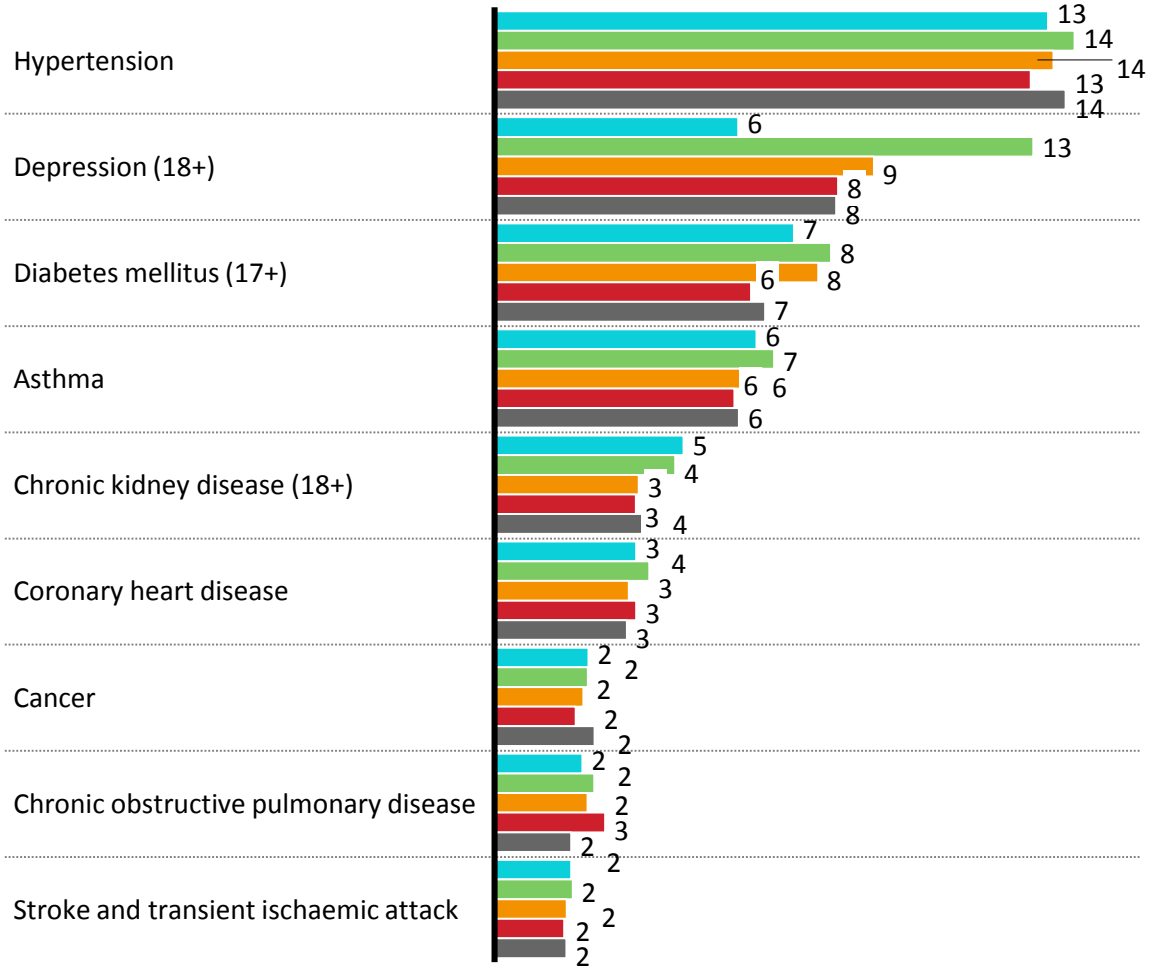


SOURCE: PHE local health tool, accessed online in August 2018 [http://www.localhealth.org.uk]

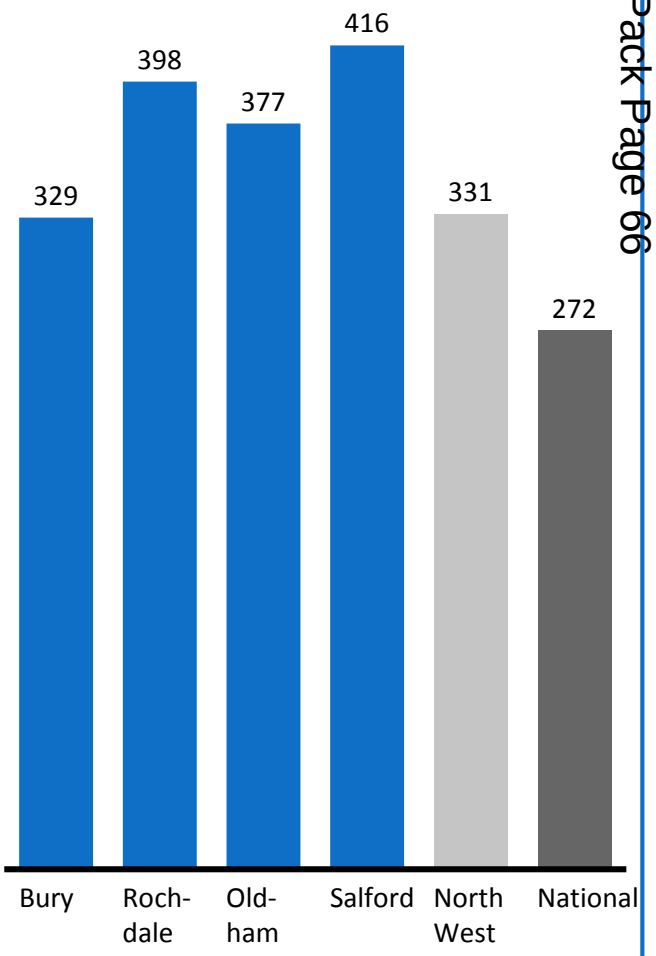
Respiratory diseases, especially smoking-related ones, and depression are higher than the national average



Prevalence of diseases (top 10) – NES & Salford CCGs vs. England average % of population, 2016/17

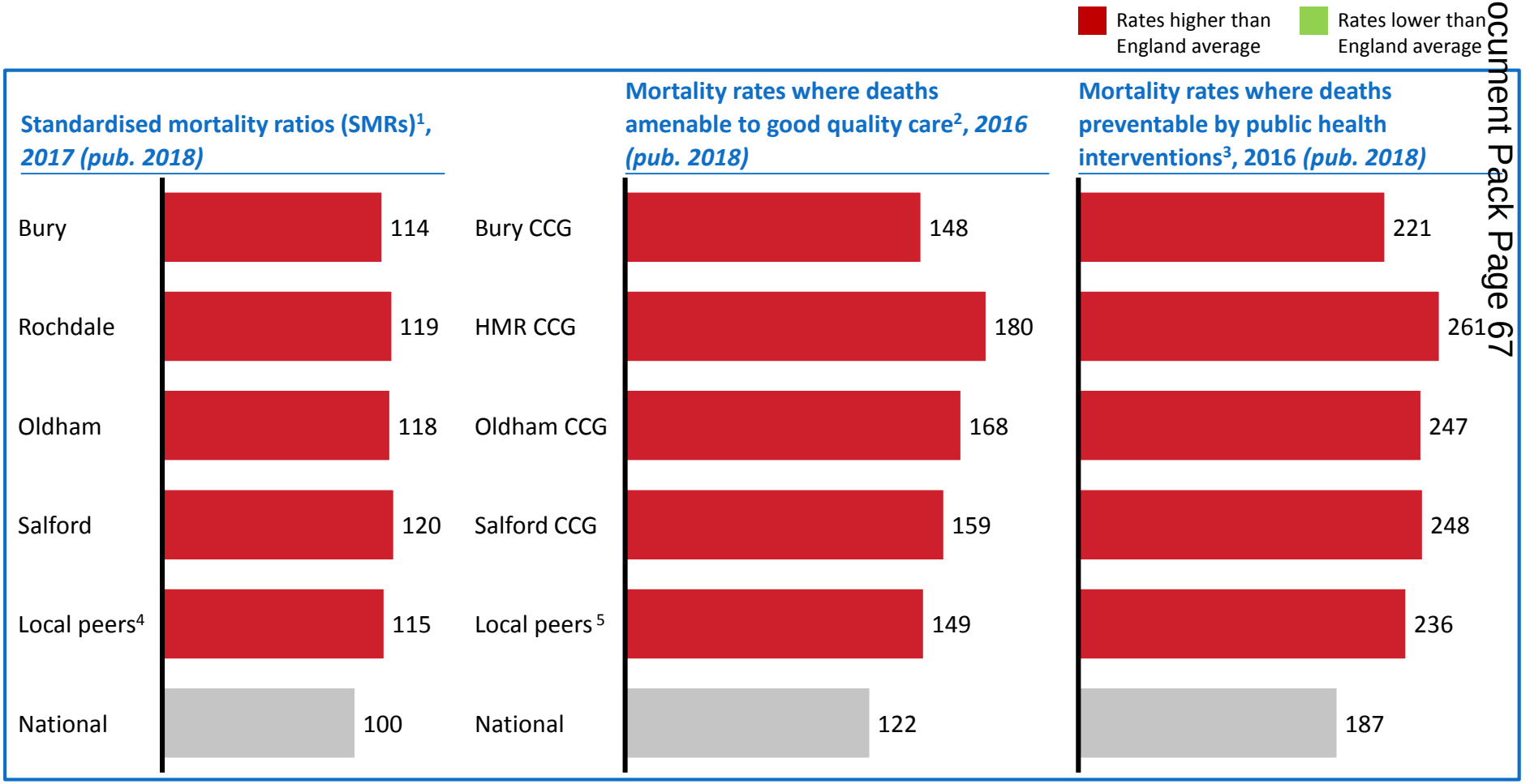


Deaths attributable to smoking by region and borough, rates per 100,000, 2014-16 (published 2018)



SOURCE: QOF 2016/17; NHS Digital Statistics on Smoking - England 2018 reporting data over 2014 to 2016 period

Avoidable mortality rates are higher than other areas of the country

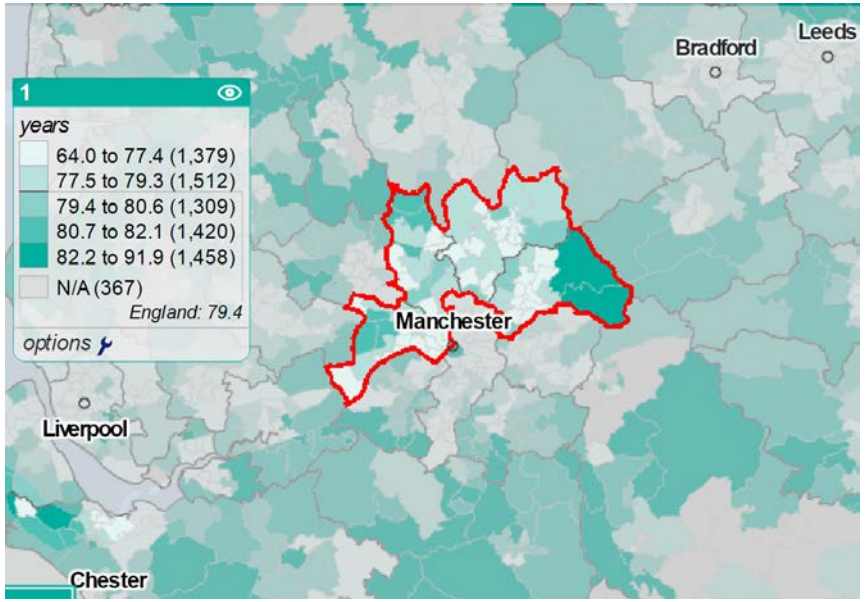


1 SMRs give a comparison of mortality in the borough / region of interest against England population as a whole, while allowing for differences in age structure
2 Age-standardised mortality rate per 100,000 where if, in light of medical knowledge and technology available at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided through good quality healthcare
3 Age-standardised mortality rate per 100,000 where if, in the light of understanding of the determinants of health at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health interventions in the broadest sense
4 Local peers as unitary authorities/counties/districts for Bolton, Manchester, Stockport, Tameside, Trafford and Wigan
5 Local peers as CCGs for Bolton, Stockport, Tameside and Glossop, Trafford, Wigan Borough and Manchester CCGs before the merger

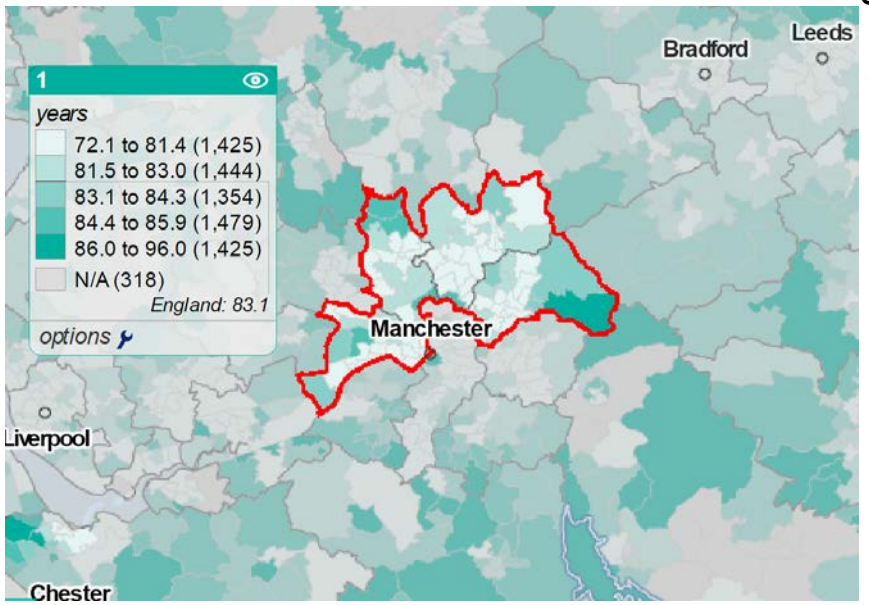
SOURCE: ONS Deaths Registrations Summary Statistics, 2018 reporting data for 2017; ONS Avoidable mortality in England and Wales: 2018 reporting data for 2016

Life expectancy is considerably less than surrounding areas and the England average apart from parts of Oldham and Bury

Life expectancy at birth for males, 2011-15
(lighter colour is associated with lower life expectancy)



Life expectancy at birth for females, 2011-15
(lighter colour is associated with lower life expectancy)



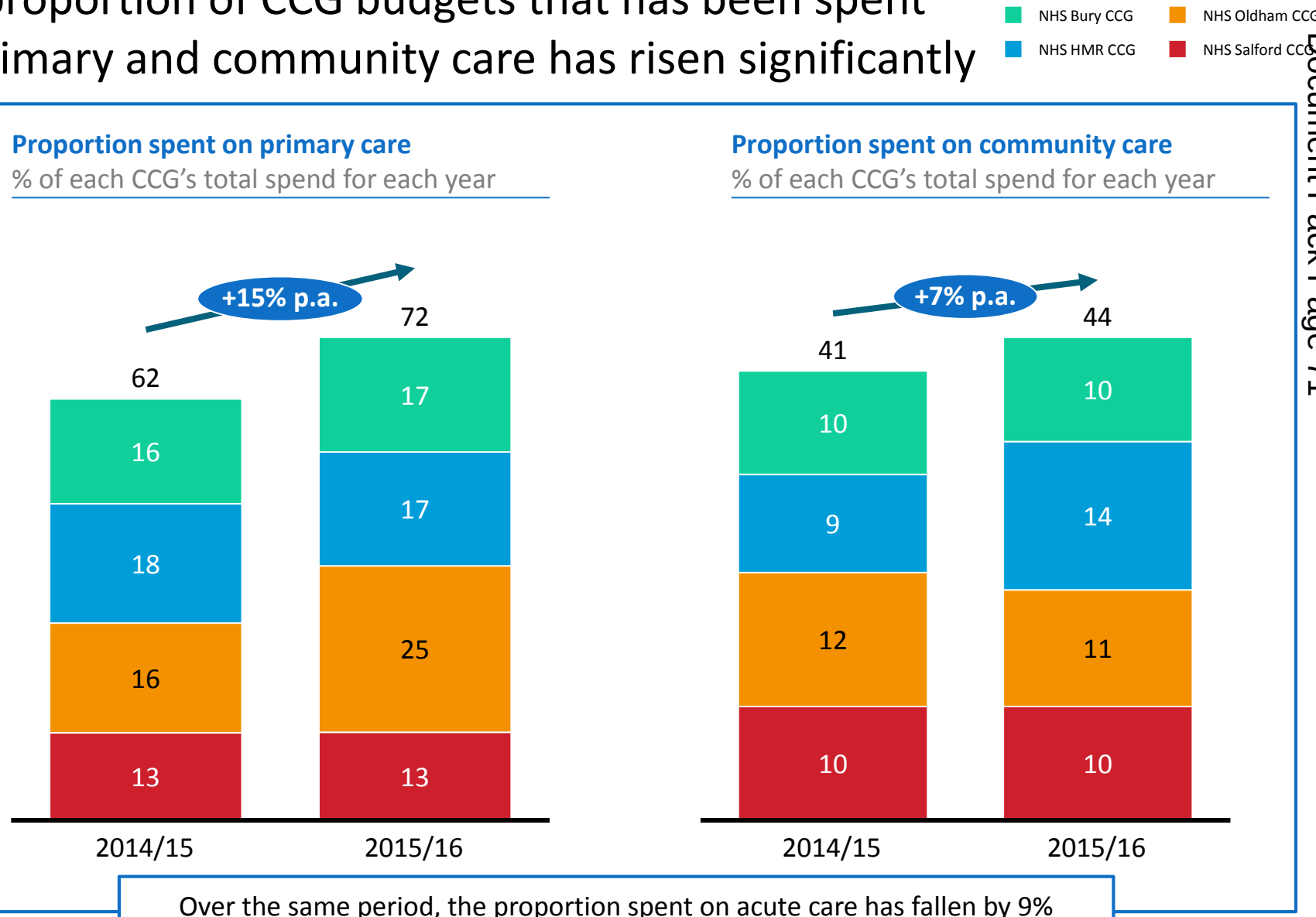
SOURCE: PHE local health tool, accessed online in August 2018 [http://www.localhealth.org.uk]

Contents

Summary of this section

- To address rising population health demands, LCOs are seeking to transform out-of-hospital care through a greater focus on prevention of ill health, integration and moving care delivery closer to home
- To deliver these changes, Greater Manchester has been given £450m over 5 years as part of its devolution agreement
- The proportion of CCG budgets spent on primary and community care rose by 15% and 7%, respectively, between 2014/15 and 2015/16 – in line with LCO plans to shift activity out of hospitals
- In terms of primary care, there are a few very large GP practices in Salford and Oldham
- Oldham in particular has many more registered patients per permanent GP on average than nationally and a slightly higher proportion of GP practices rated inadequate than neighbouring CCGs

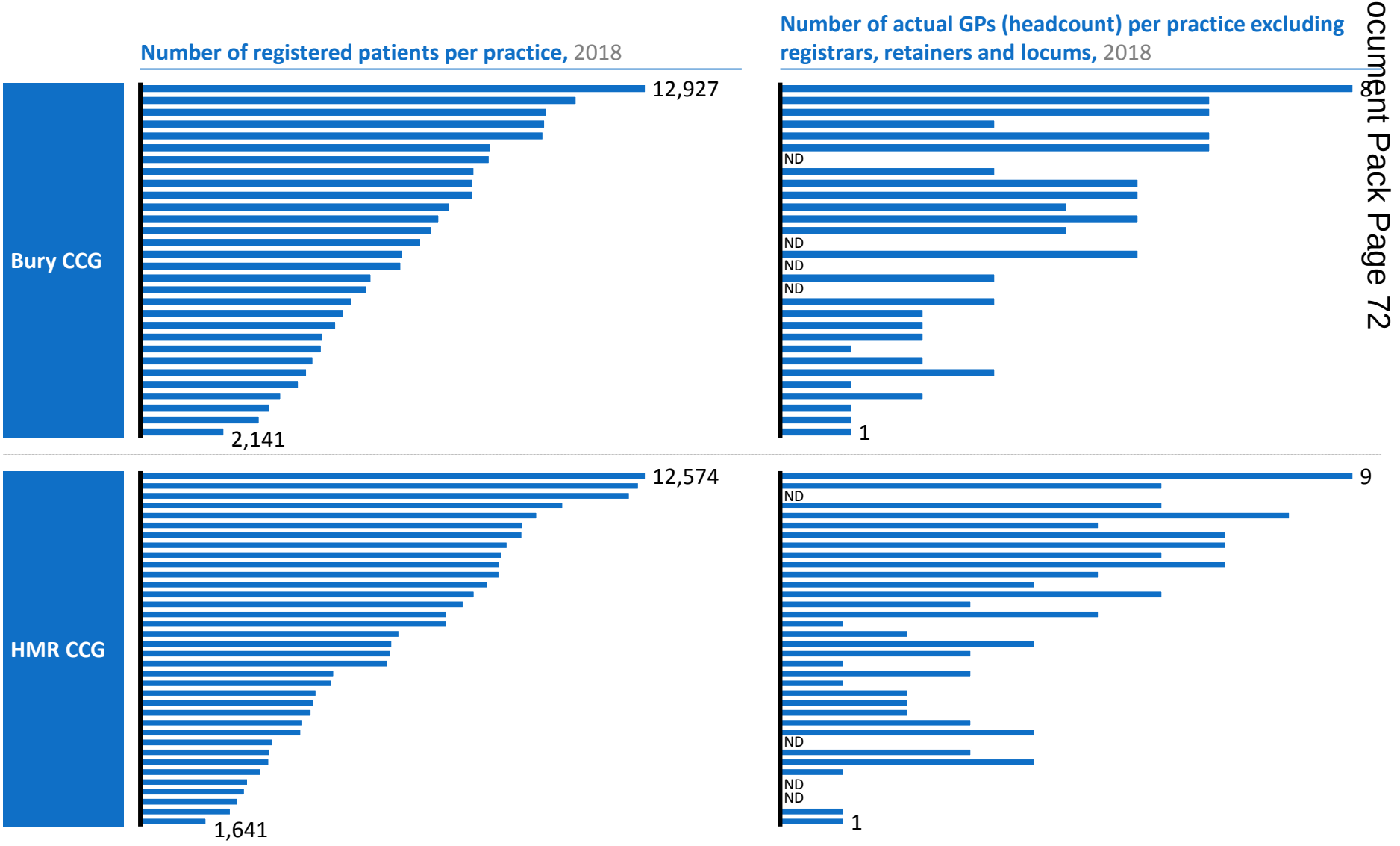
The proportion of CCG budgets that has been spent on primary and community care has risen significantly



Over the same period, the proportion spent on acute care has fallen by 9%

SOURCE: CCG spend breakdown, NHS Digital, 2017

Current list size and GP provision by GP practice (1/2)



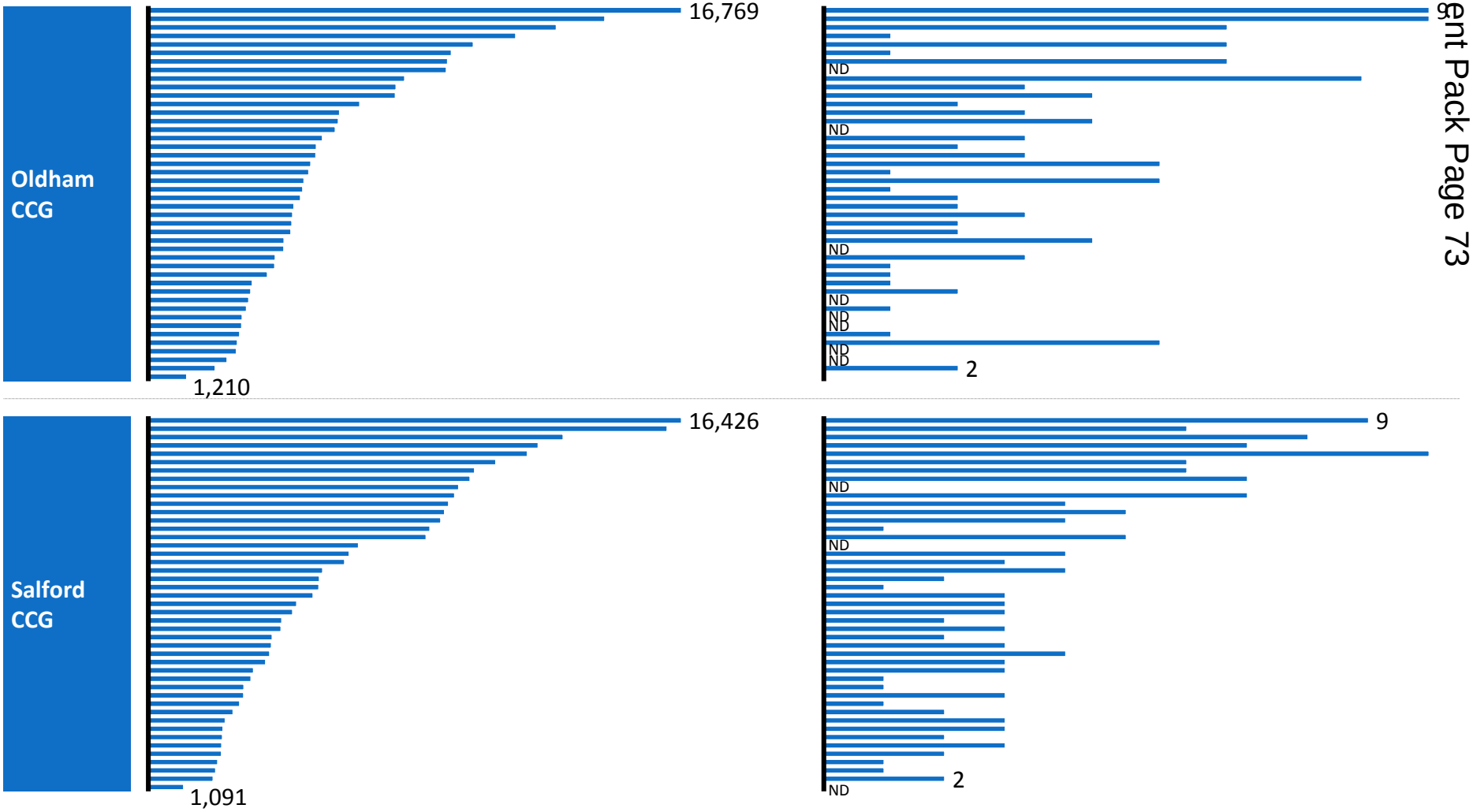
ND – data not determined for this GP practice

SOURCE: General and Personal Medical Services, March 2018, NHS Digital; Patient List Sizes, March 2018, NHS Digital

Current list size and GP provision by GP practice (2/2)

Number of registered patients per practice, 2018

Number of actual GPs (headcount) per practice excluding registrars, retainers and locums, 2018



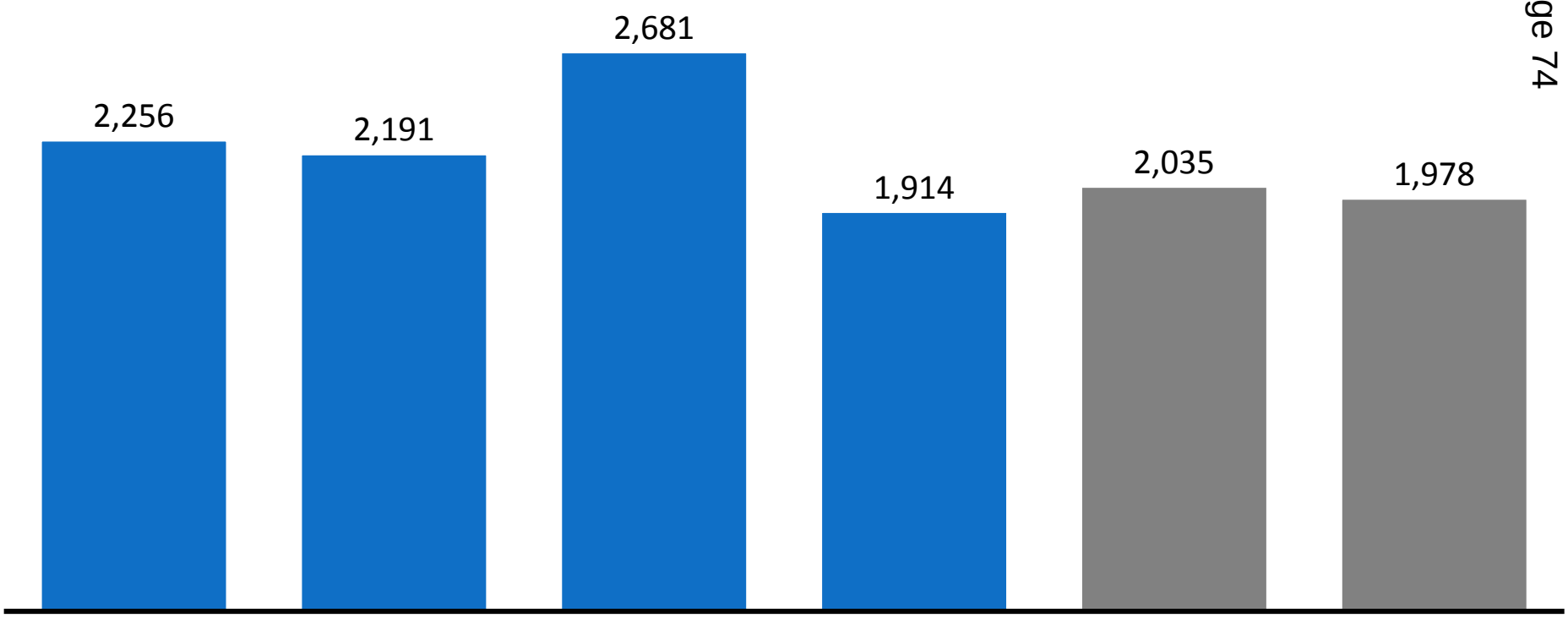
ND – data not determined for this GP practice

SOURCE: General and Personal Medical Services, March 2018, NHS Digital; Patient List Sizes, March 2018, NHS Digital

Oldham in particular has many more registered patients per permanent GP on average than nationally or in other GM CCGs

Patients to permanent GPs at practice level[1]

Number of registered patients per actual GP (headcount), 2018

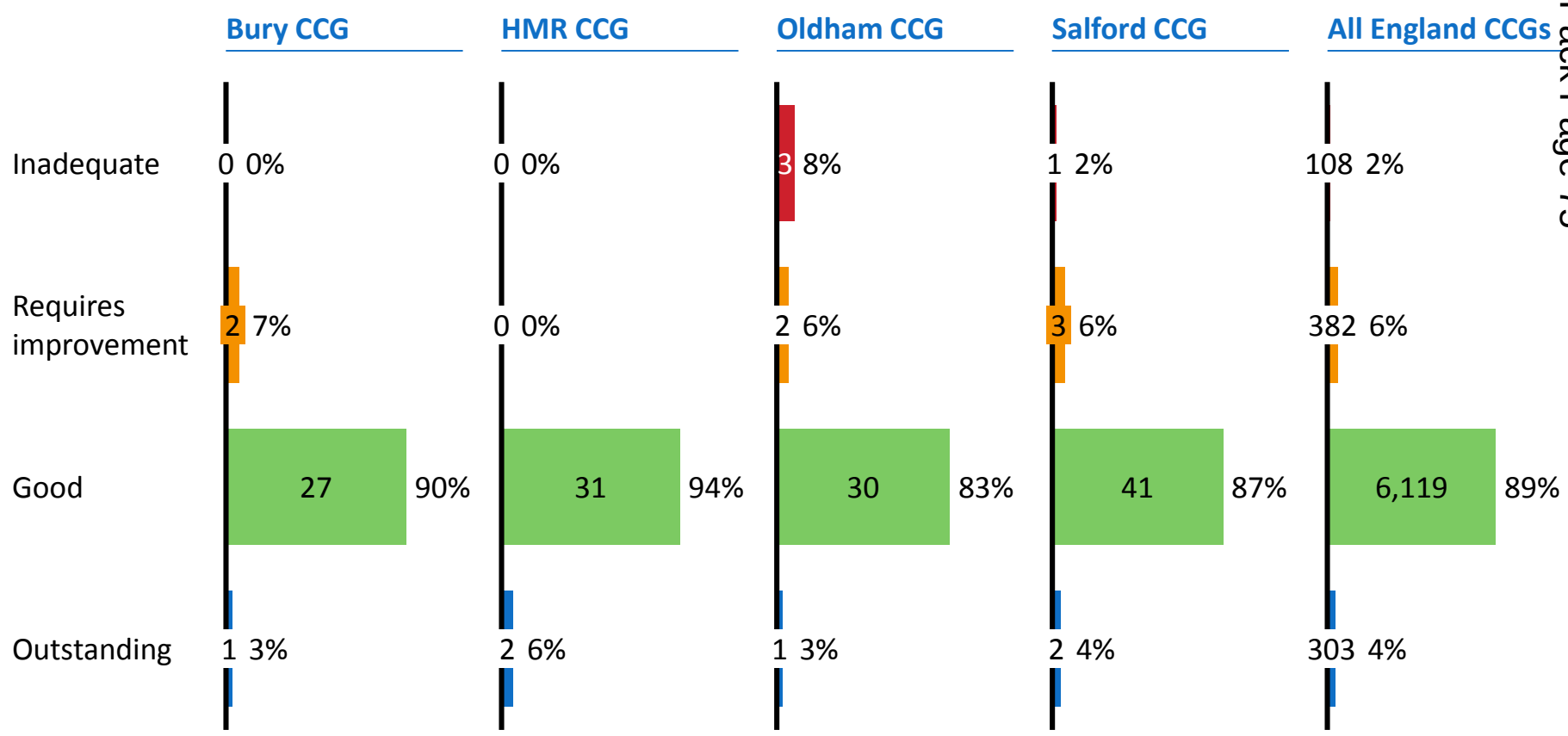


1 Excludes registrars, retainers and locums. Practices where staff numbers were not determined are excluded
2 Local peers as CCGs for Bolton, Stockport, Tameside and Glossop, Trafford, Wigan Borough and Manchester CCGs before the merger

SOURCE: General and Personal Medical Services, March 2018, NHS Digital; Patient List Sizes, March 2018, NHS Digital

Oldham CCG has a slightly higher proportion of GP practices rated inadequate than neighbouring CCGs

GP practice ratings, % of GP practices in each CCG, 2017

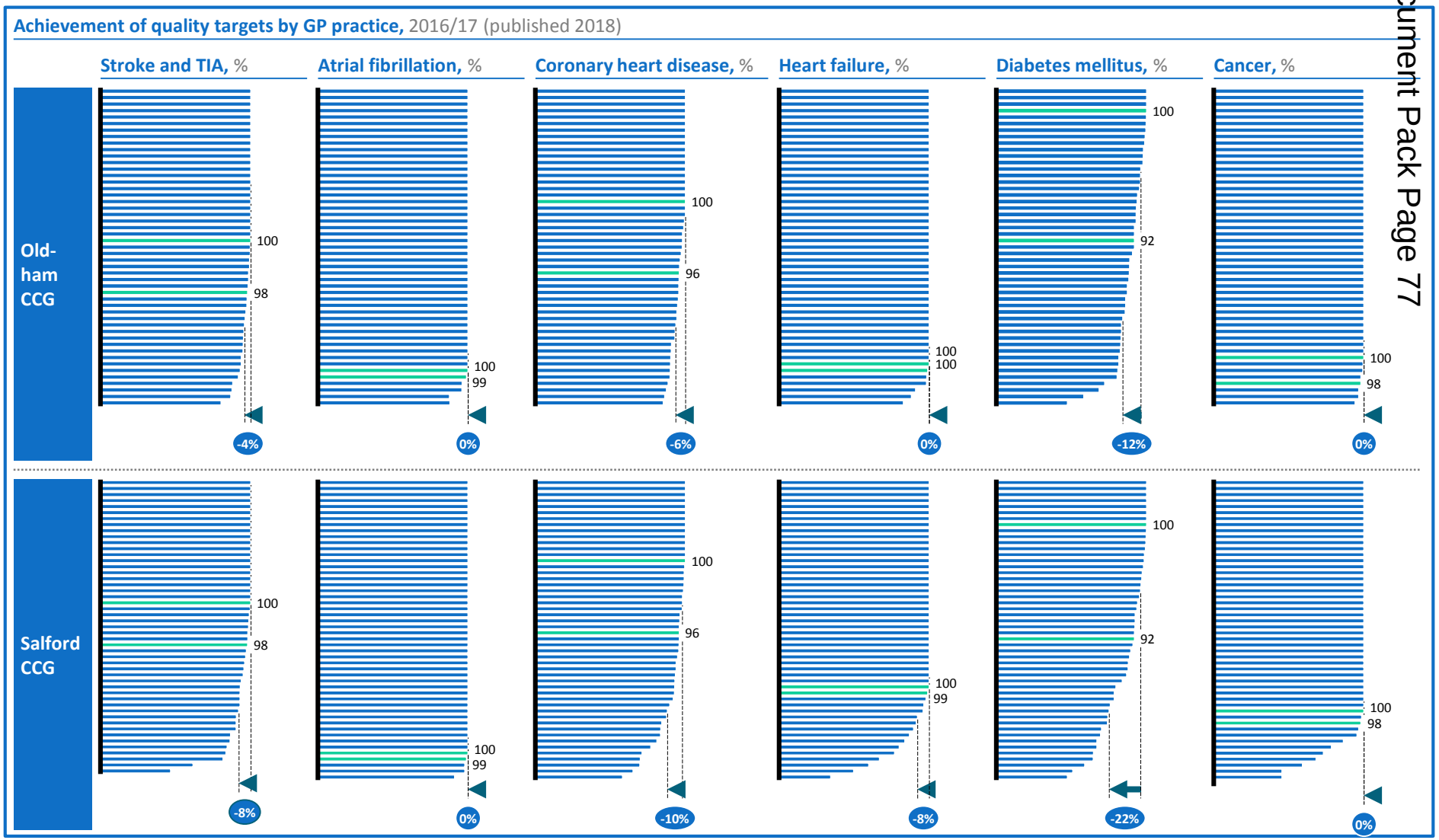


SOURCE: CQC State of Care 2017

There is some variation in quality of care for diabetes mellitus among Bury and HMR GPs

SOURCE: QOF 2016/17 published in 2018

There is some variation in quality, particularly among Salford GPs for CHD and diabetes mellitus



SOURCE: QOF 2016/17 published in 2018

Contents

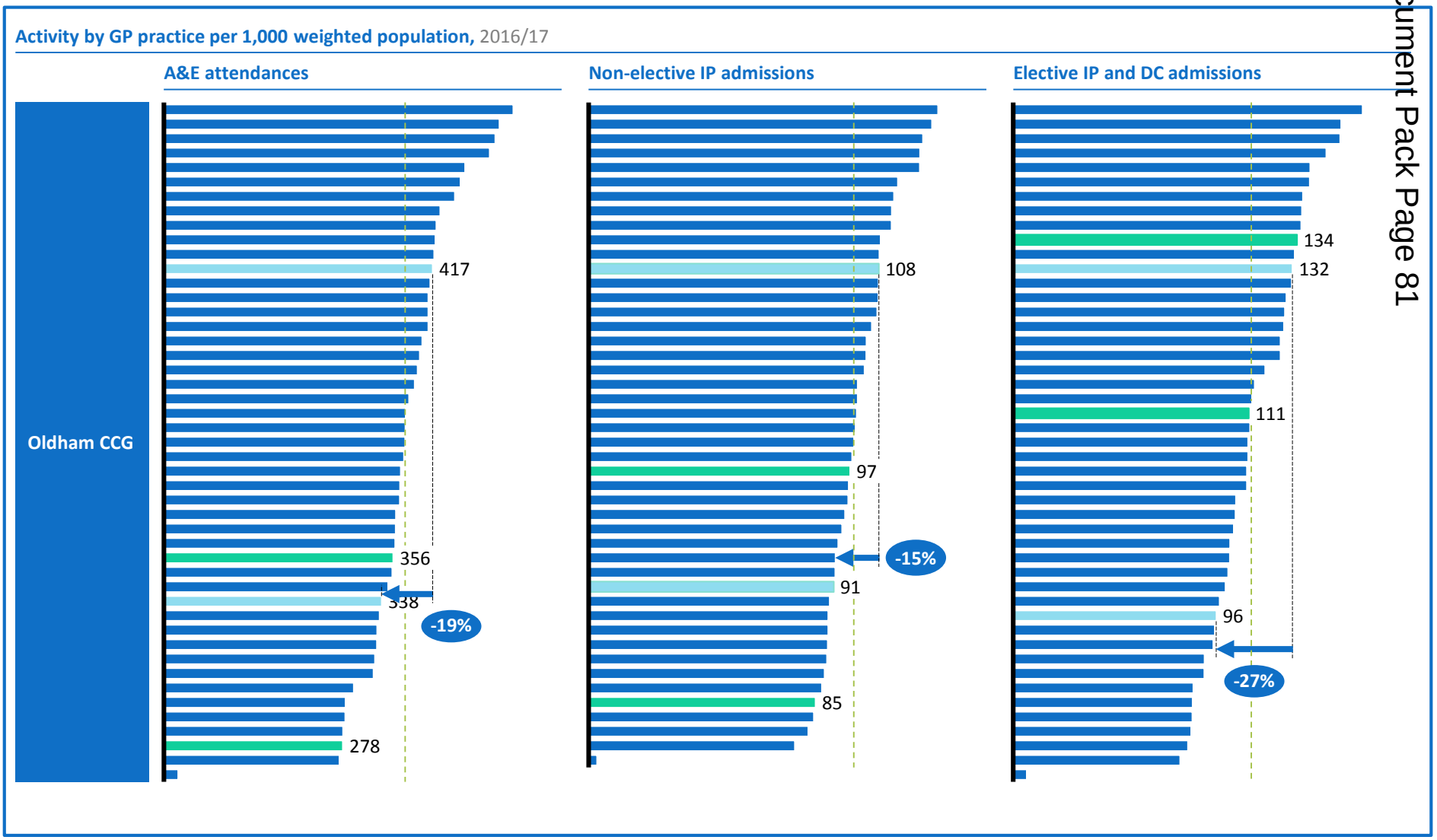
Section summary

- CCG plans to deliver new models of care to deflect acute activity are underway
- Bury has relatively high elective admission rates, Oldham has high non-elective activity while HMR has high activity for all types
- However, over the past five years, admissions across PAHT hospitals – where NES CCGs commission the great majority of care – have fallen by 1% p.a. on average
- Moreover, the proportion of spending on the acute care sector is equivalent to or lower than the national average for all NES CCGs and this percentage has been falling

Bury has high elective admission rates with the lowest quartile rate similar to the national median

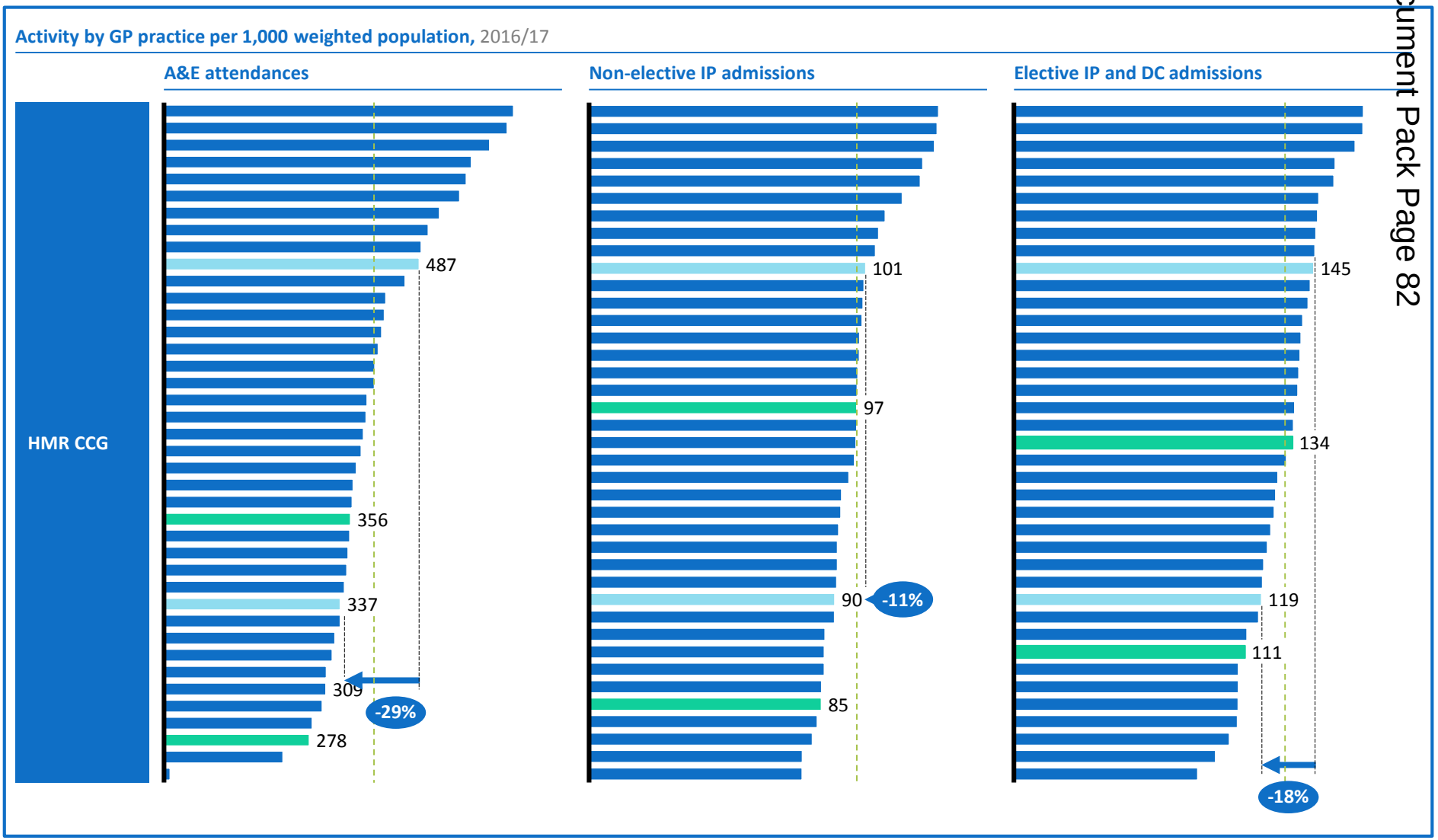
SOURCE: HES 206/17 M13 APC and A&E data, c/o NHS Digital

Oldham has high non-elective / emergency activity and high variation in elective activity



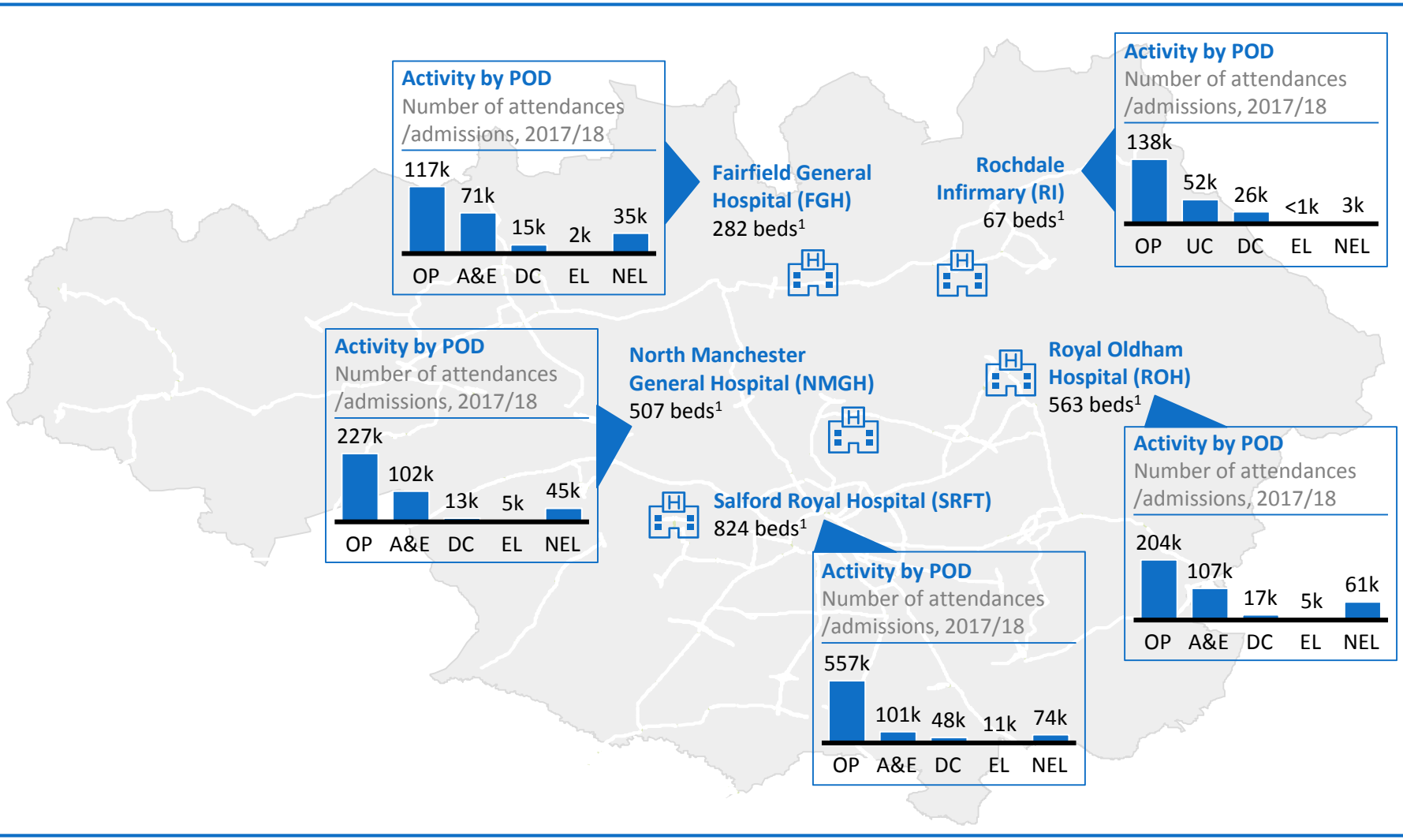
SOURCE: HES 206/17 M13 APC and A&E data, c/o NHS Digital

HMR has high levels of all activity with particulary high variation in A&E attendances



SOURCE: HES 206/17 M13 APC and A&E data, c/o NHS Digital

There are four sites within the NCA with some acute care for the NES commissioned at NMGH

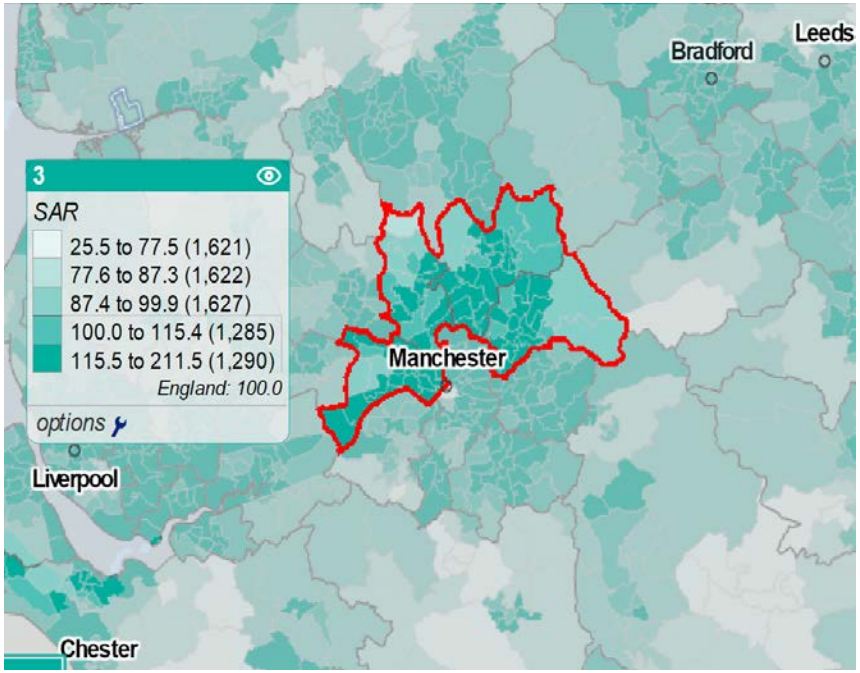


1 Bed numbers include acute, maternity, paediatric and daycase beds
OP are outpatient attendances; IP are inpatient admissions excluding daycase episodes; A&E and UC are A&E and urgent care attendances, respectively

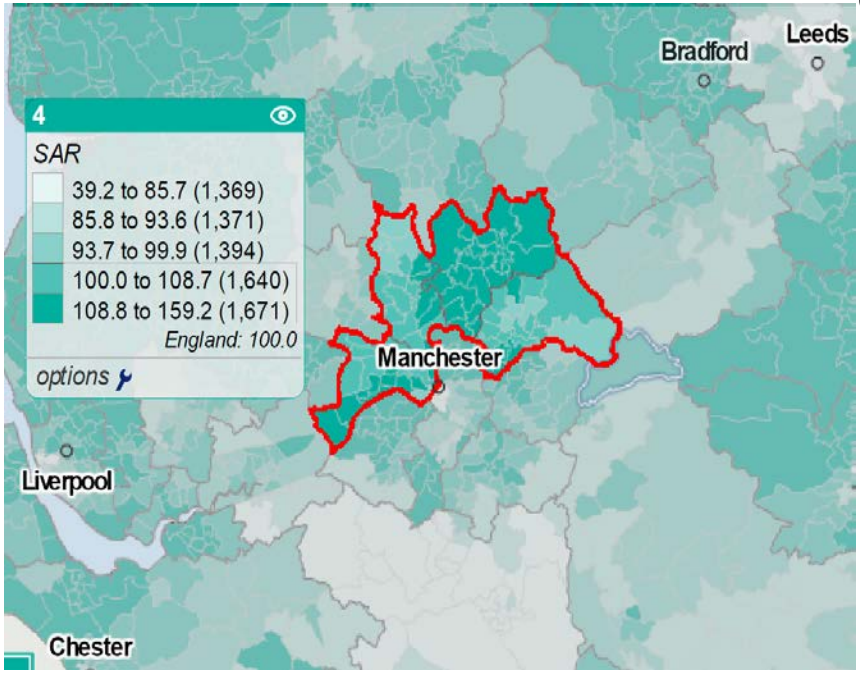
SOURCE: PLICS data 2017/18

Emergency and elective hospital admissions are slightly higher than the national average

Emergency hospital admissions, all causes, 2011/12 to 2015/16 standardised admission ratio (darker areas indicate more admissions)



Elective hospital admissions, all causes, 2011/12 to 2015/16 standardised admission ratio (darker areas indicate more admissions)

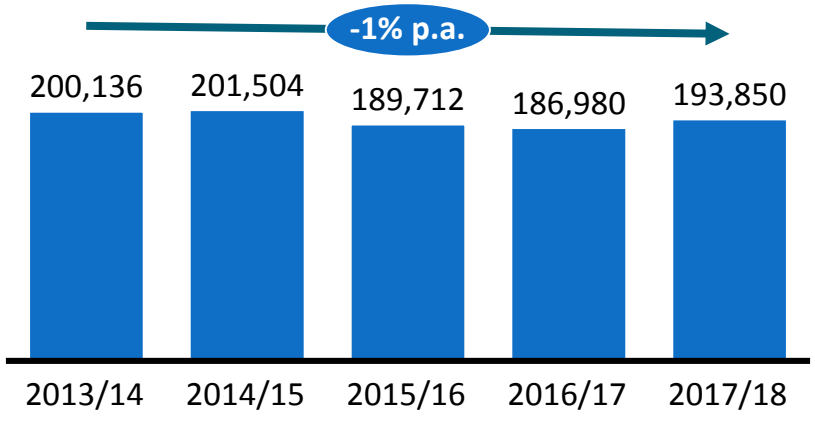


SOURCE: PHE local health tool, accessed online in August 2018 [http://www.localhealth.org.uk]

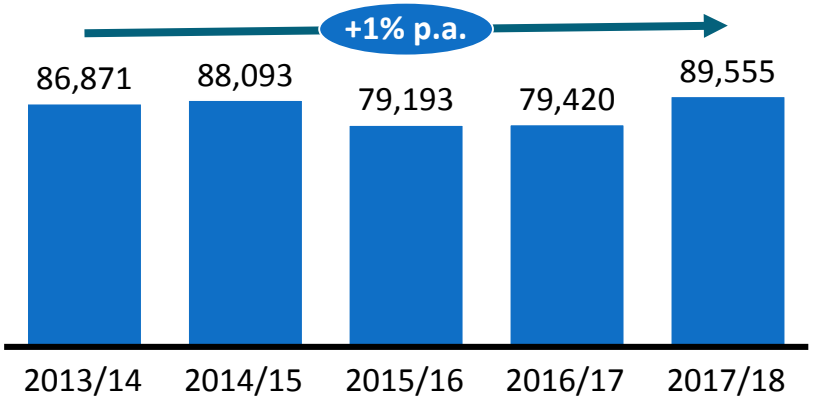
Total admissions at PAHT have fallen with some inter-year fluctuations

Yearly activity at PAHT

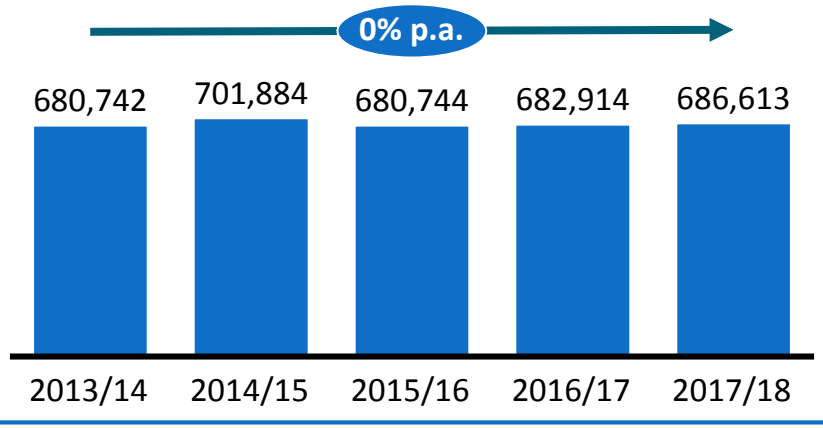
Total Admissions[1]



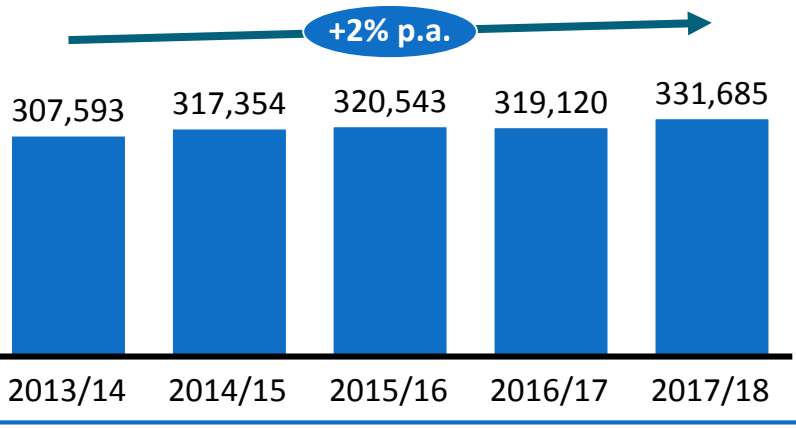
Emergency Admissions[1]



Planned Outpatient Attendances



A&E Attendances



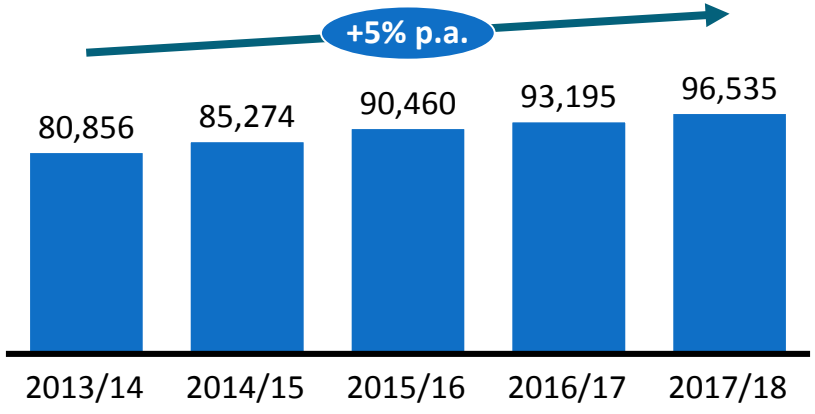
1 Includes daycase episodes

SOURCE: HES Online

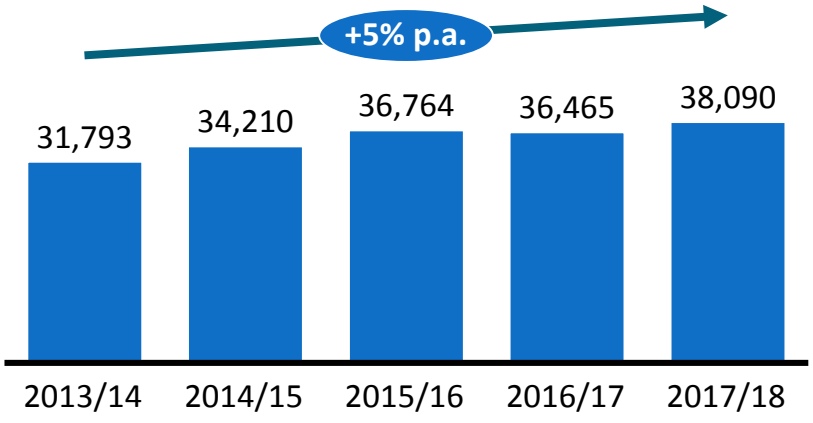
SRFT has seen growth across all activity, especially OP attendances

Yearly activity at SRFT

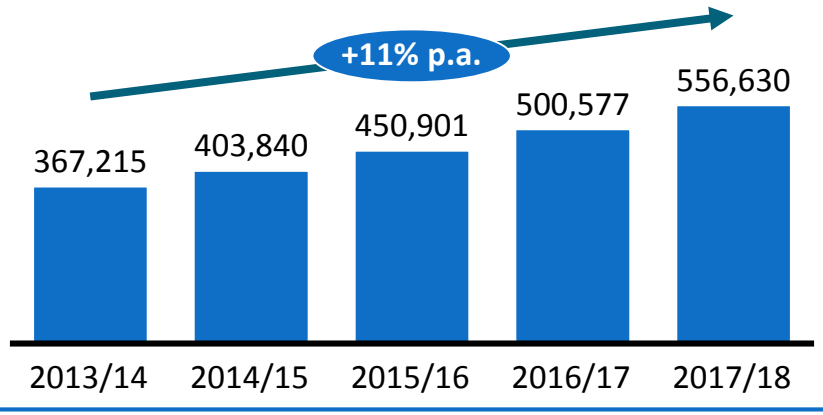
Total Admissions[1]



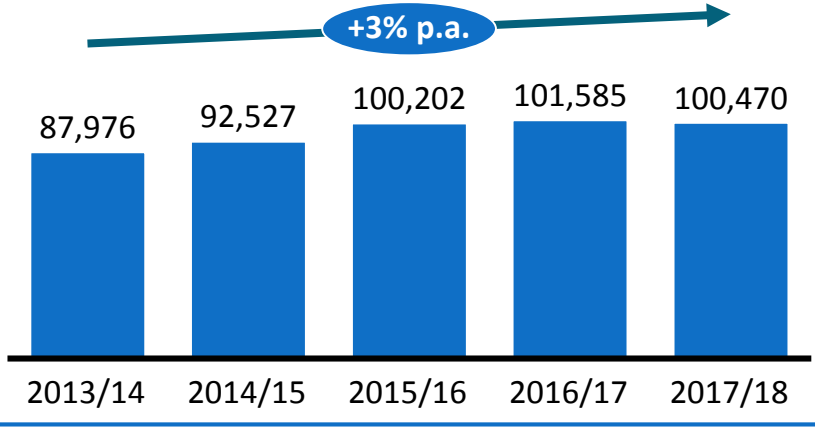
Emergency Admissions[1]



Planned Outpatient Attendances



A&E Attendances



1 Includes daycase episodes

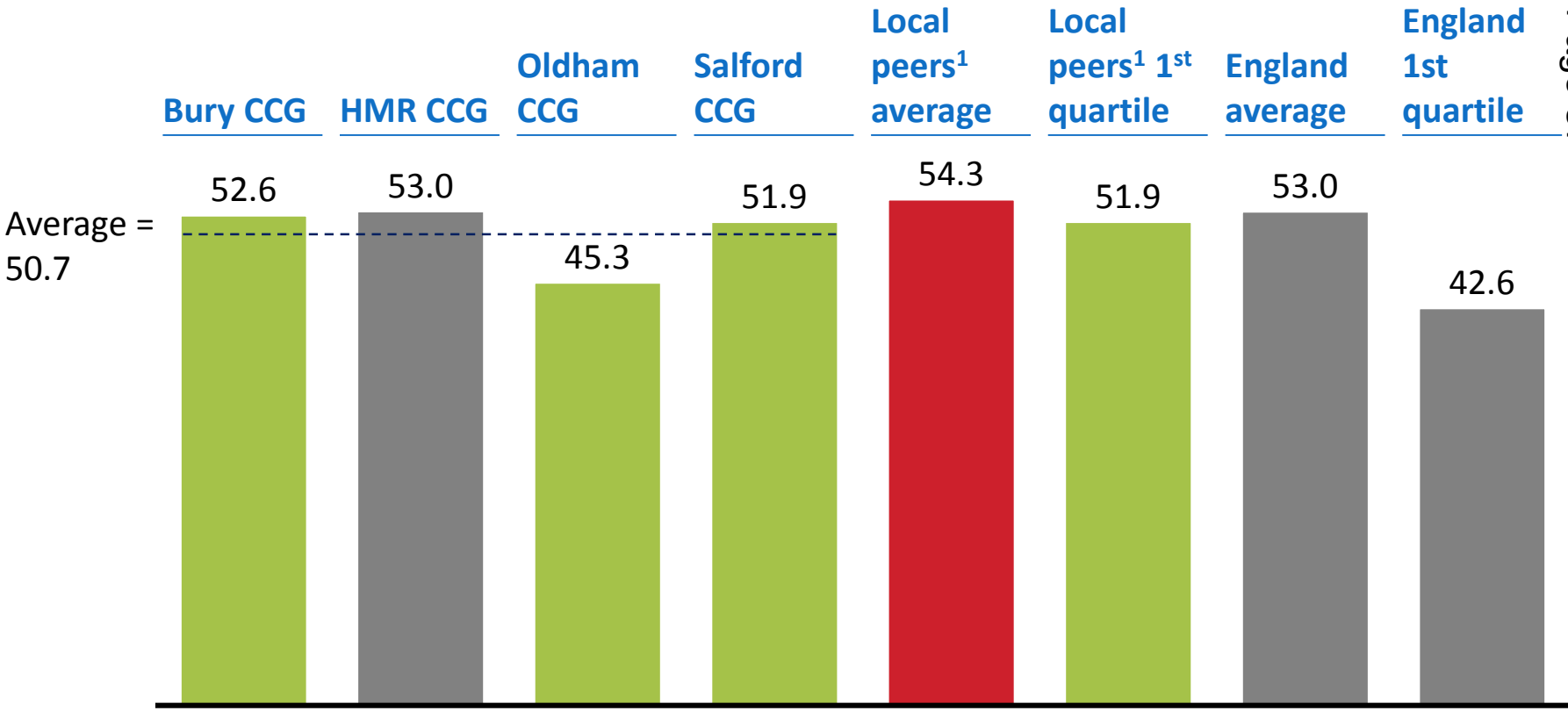
SOURCE: HES Online

Acute care spending is mostly lower than the national average but not as low as the lowest quartile in the country

CCG acute care spend above England average
CCG acute care spend below England average

Acute care sector spend

Percentage of total CCG spend that is spent on general and acute care



1 Local peers as CCGs for Bolton, Stockport, Tameside and Glossop, Trafford, Wigan Borough and Manchester CCGs before the merger

SOURCE: CCG spend breakdown, NHS Digital, 2017

Contents

Section summary

Focus of today's discussions

- Services that need to be provided 7 days a week will become even more difficult to provide on sites if volumes of activity decrease
- There is already difficulty ensuring that patients with MI and HF have rapid access to specialist staff and procedures at ROH
- In critical care, there have been notable consultant shortfalls at FGH and NMGH
- Recent workforce data shows that 7-18% of medical and nursing positions are vacant with high levels of agency spend to cover these positions
- Operationally, 4-hour A&E waiting times performance has been deteriorating and is below the national average at ROH, NMGH and Salford, while 18-week RTT at ROH and NMGH is lower than the national average and has been declining
- Additionally, ROH was recently rated as "requiring improvement" in critical and medical care safety, effectiveness and responsiveness
- Meanwhile, NMGH required improvement in safety and effectiveness of medical care and surgery, plus responsiveness for critical care and urgent & emergency care
- This is all despite PAHT already having low NEL ALoS – among the top 10% nationally
- In terms of estate, NMGH in particular has high backlog maintenance costs and inefficient use of floor area, driven in part by its age
- In terms of finances, the NCA had an underlying £82m financial gap in 2017/18 that is projected to reach over £100m by 2017/18

HRG codes can be used to categorise A&E visits into major, standard and minor treatments or investigations

Category	Typical investigation	Typical treatment
5		▪ CPR ▪ Thrombolysis
4		▪ General anaesthetic ▪ Manipulation of limb fracture ▪ External pacing
3	▪ Ultrasound ▪ MRI ▪ CT	▪ Primary sutures ▪ Intramuscular injection ▪ Occupational therapy assessment
2	▪ Plain X-ray ▪ Cross-match ▪ Bacteriology	▪ Wound closure with steristrips ▪ Physio for falls prevention ▪ Local anaesthetic
1	▪ ECG ▪ Biochemistry ▪ Urine dip	▪ Remove sutures ▪ Eye drops ▪ Advice/guidance

Category combination

Typical investigation	Typical treatment	
Any	5	MAJOR
3	1-4	
2	4	
2	1-3	STANDARD
1	3-4	
1	1-2	MINOR
None	None	

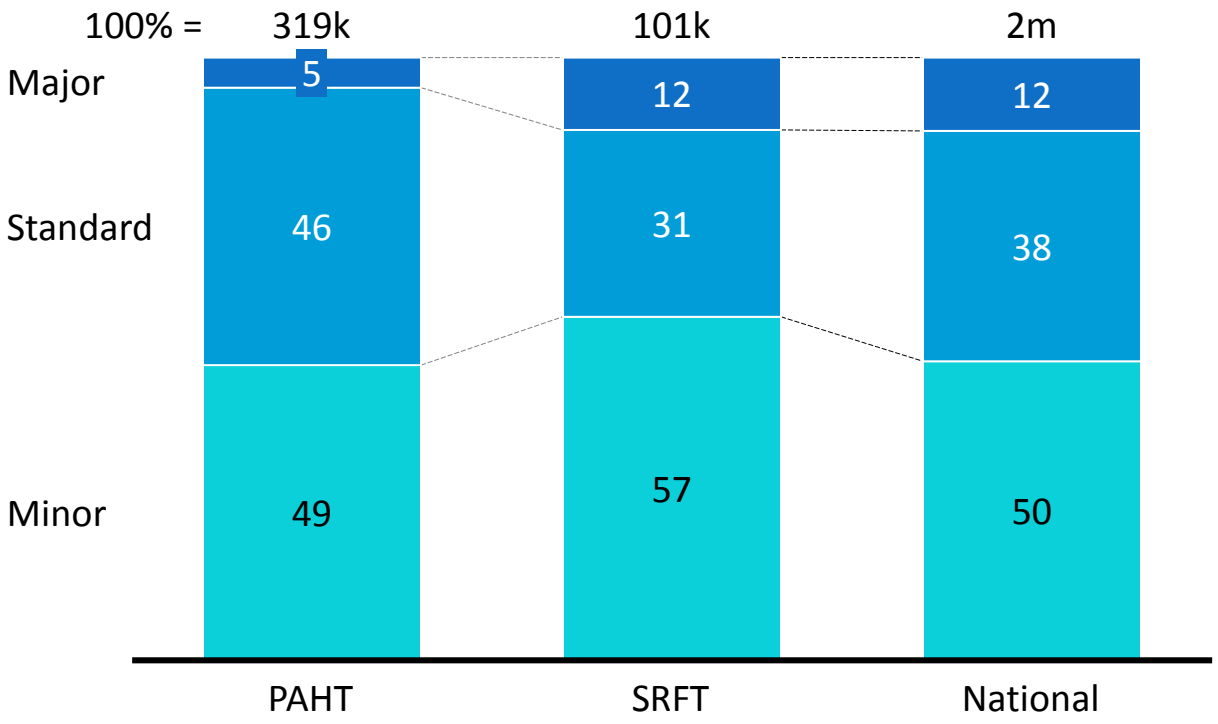
HRG category results depend on what investigations or treatments actually take place in A&E as opposed to other units or departments and how well standards of care are adhered to, and not just acuity

SOURCE: HRG reference data

A higher proportion of A&E attendances at PAHT and SRFT involve Standard and Minor investigations / treatments, respectively, than the national average

A&E attendances by investigation / treatment category vs nationally

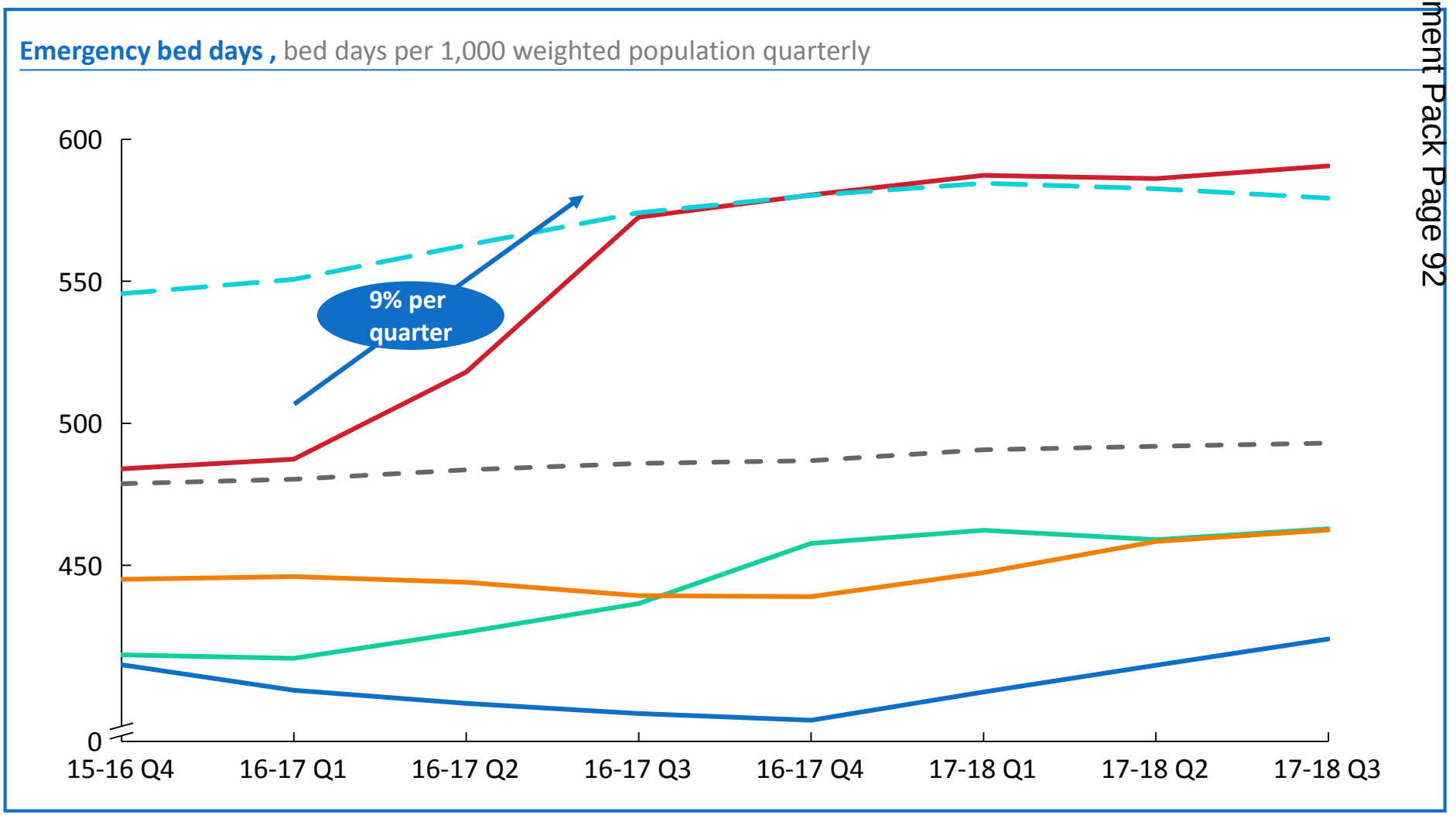
A&E attendances (% of total), 2016/17



HRG category results depend on what investigations or treatments actually take place in A&E as opposed to other units or departments and how well standards of care are adhered to, and not just acuity

SOURCE: A&E HES data 2016/17

Emergency bed days rose 9% per quarter in 16/17 Q1 to Q3 in Salford



1 Local peers as CCGs for Bolton, Stockport, Tameside and Glossop, Trafford, Wigan Borough and Manchester CCG

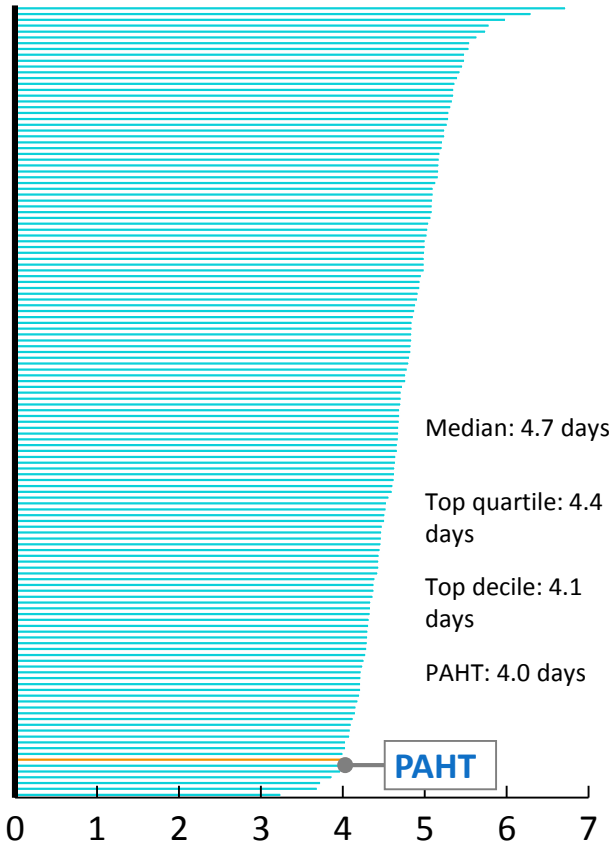
SOURCE: CCG improvement and assessment framework 2017/18

Case-mix adjusted average length of stay is relatively low at PAHT but relatively high at SRFT

- Case-mix adjustment[1] separates Trust performance from the complexity of the case-mix
- The ALoS for all other Trusts is calculated in the scenario in which all other Trusts had the same case-mix of HRGs as PAHT or as SRFT

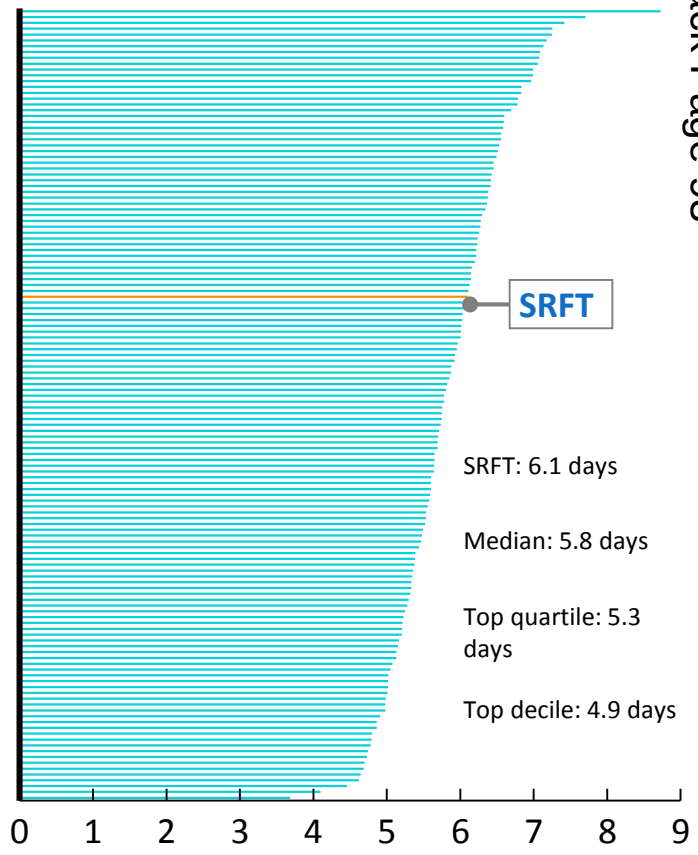
Case-mix adjusted non-elective[1] ALoS, PAHT vs non-specialist acute Trusts in England,

Days, 2016/17



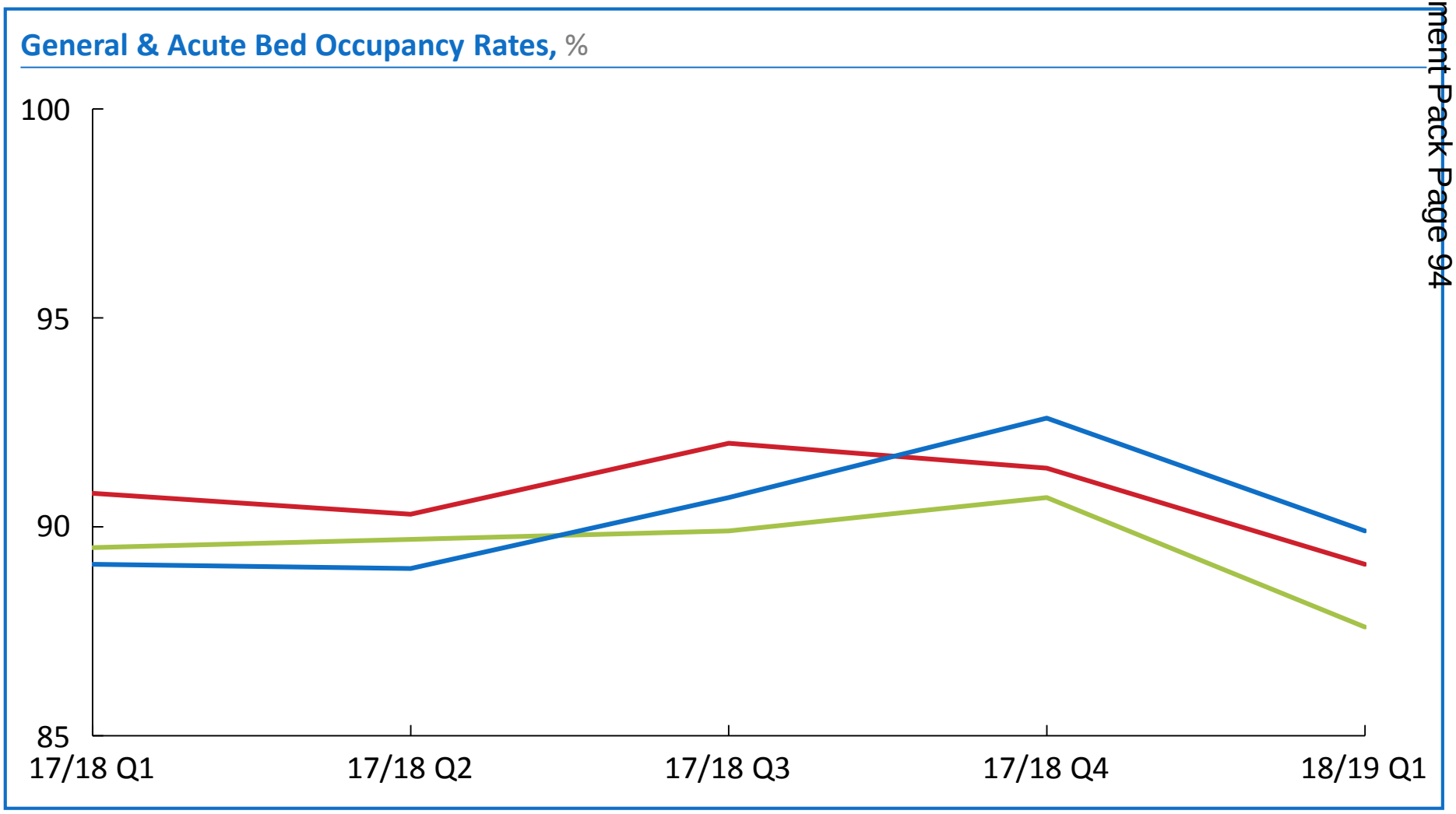
Case-mix adjusted non-elective[1] ALoS, SRFT, vs non-specialist acute Trusts in England

Days, 2016/17



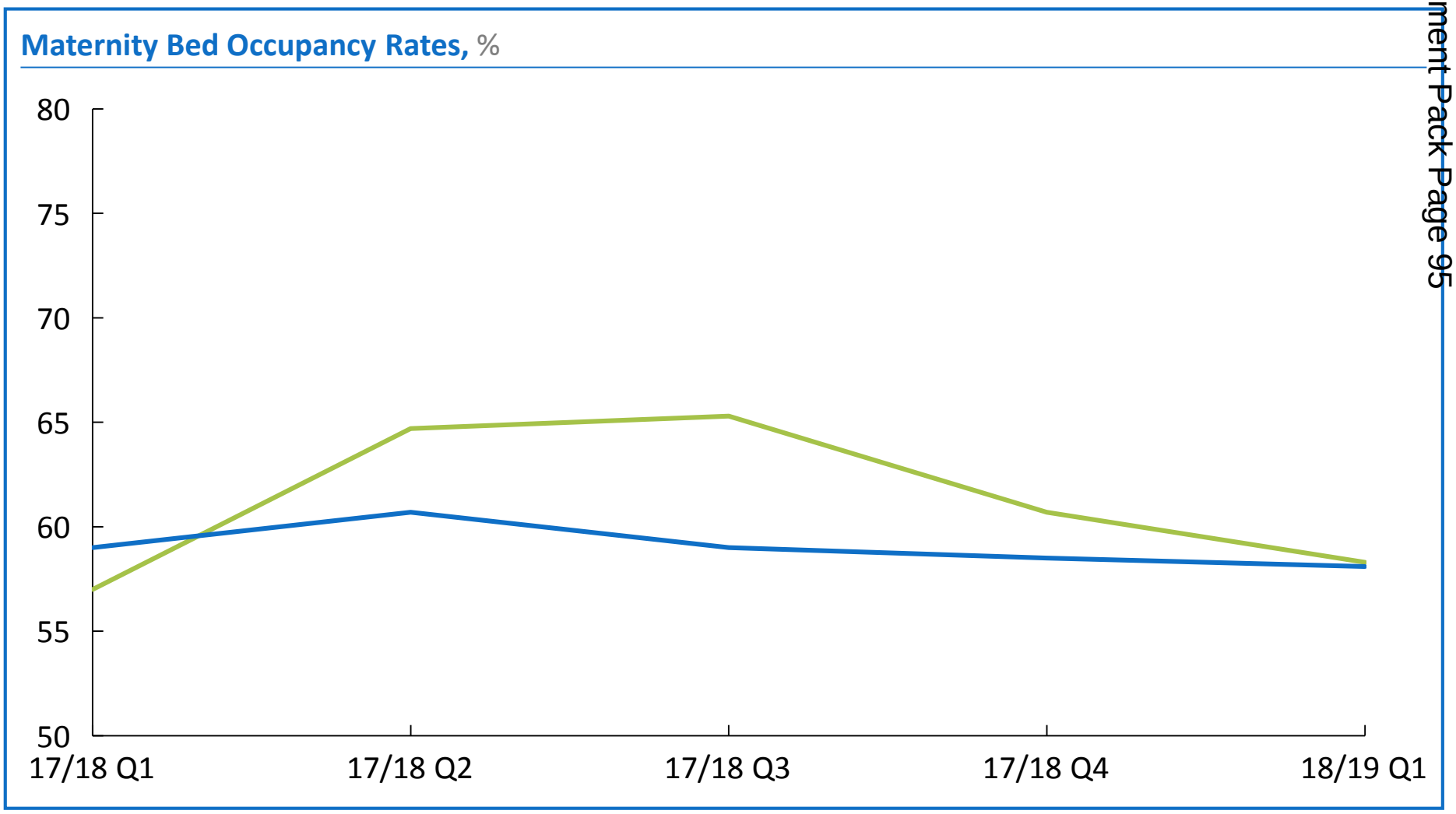
1 Adjusted by taking into account the average length of stay by HRG, in each service line, at all acute NHS Trusts in England
2 Excluding maternity specialty and for acute hospitals only
3 Case-mix adjustment may not account for complexity of specialist services delivered at Salford
SOURCE: HES 2016/17 APC datset M13, c/o NHS Digital

General and acute bed occupancy is consistently higher at SRFT than at PAHT sites



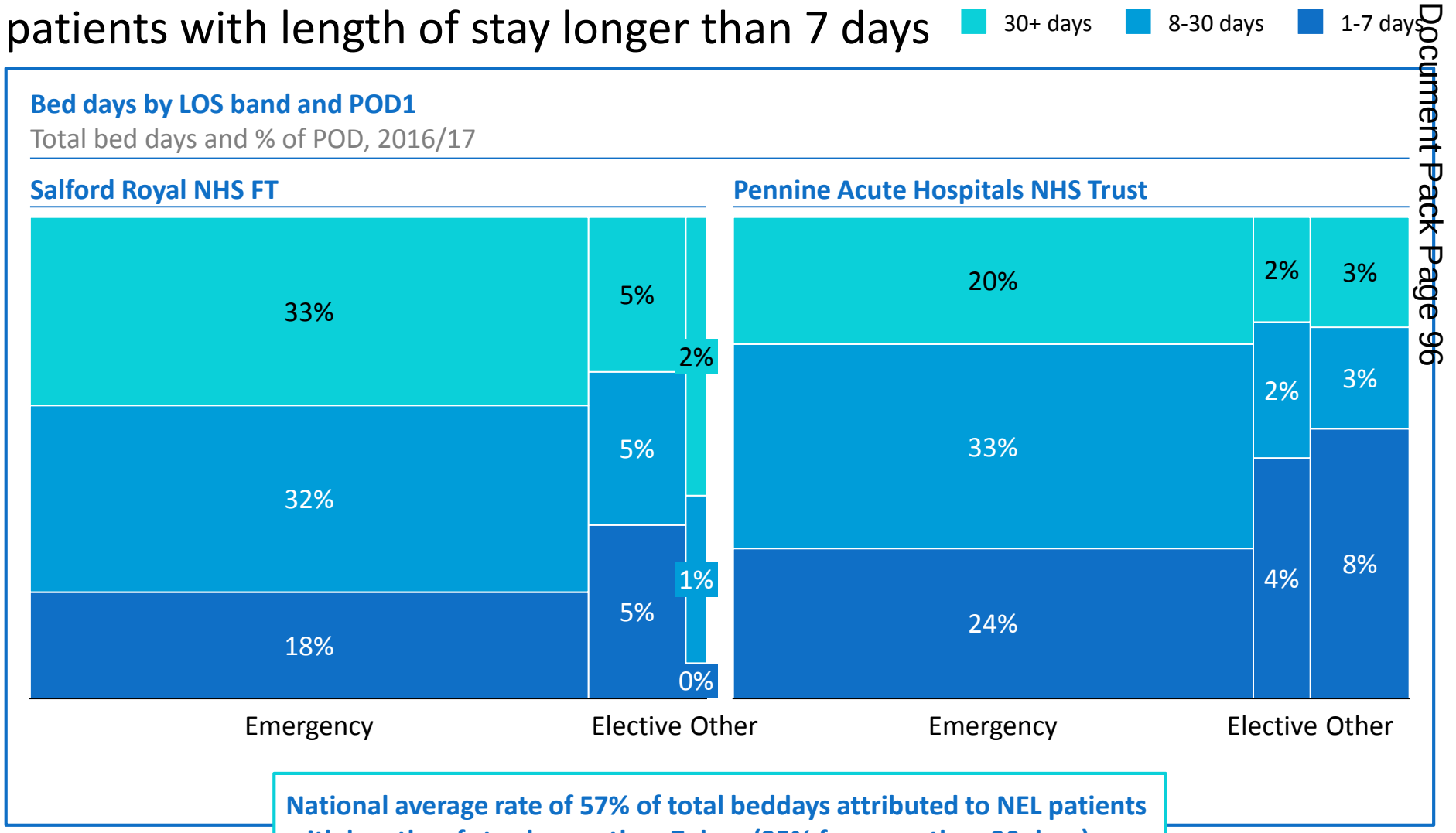
SOURCE: NHS website – Bed Availability and Occupancy statistics 2017/18

Maternity bed occupancy at PAHT has been historically higher than the national average but has recently dipped



SOURCE: NHS website – Bed Availability and Occupancy statistics 2017/18

>50% of all bed days at both trusts are occupied by stranded NEL patients with length of stay longer than 7 days

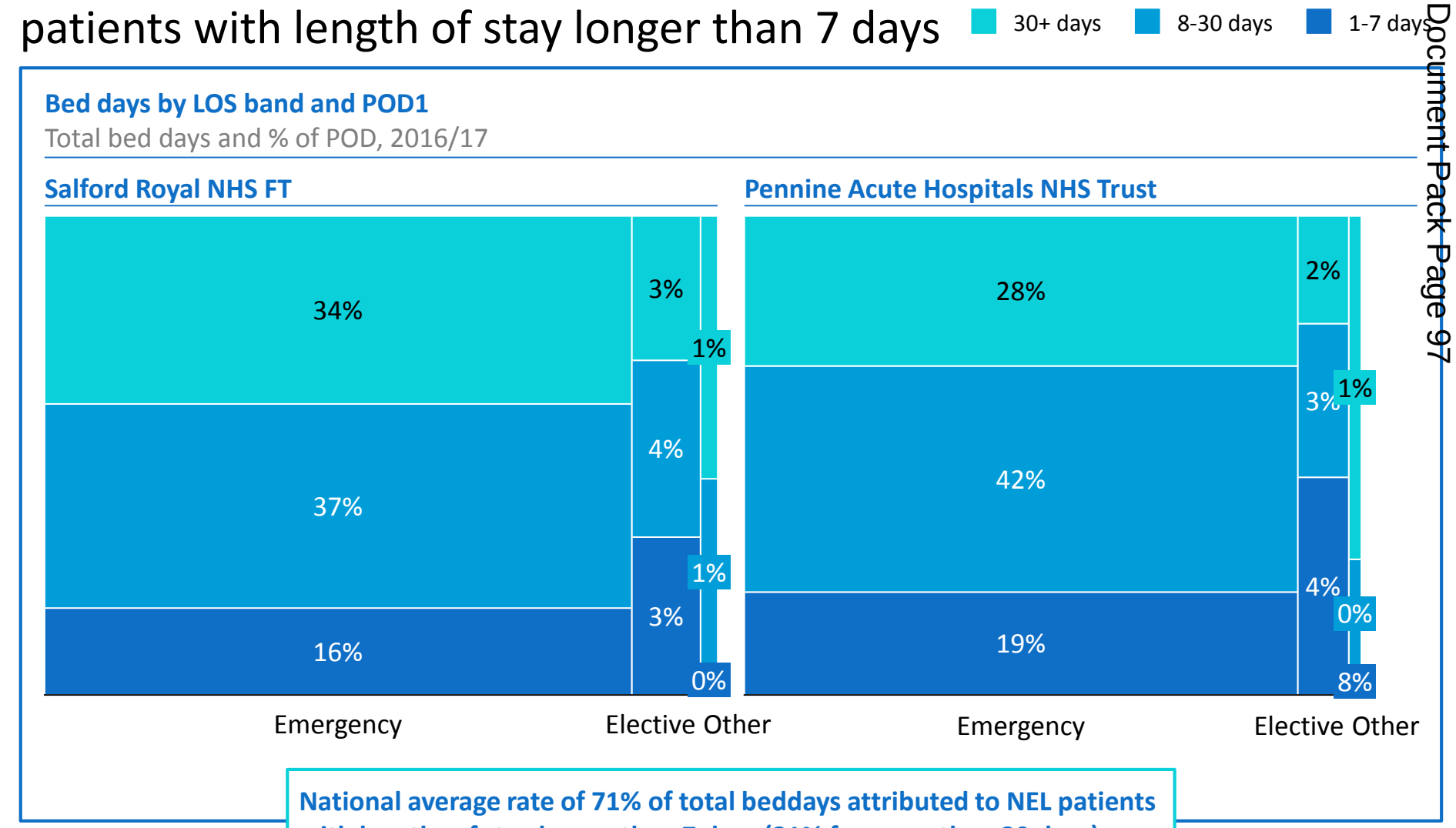


National average rate of 57% of total beddays attributed to NEL patients with lengths of stay longer than 7 days (25% for more than 30 days)

1 Excluding RA (Regular Attenders) and Other (not recorded type), Paediatrics patients are defined by age 0-18 y.o.

SOURCE: HES 2016/17

>70% of all bed days for people aged 65+ are occupied by stranded NEL patients with length of stay longer than 7 days

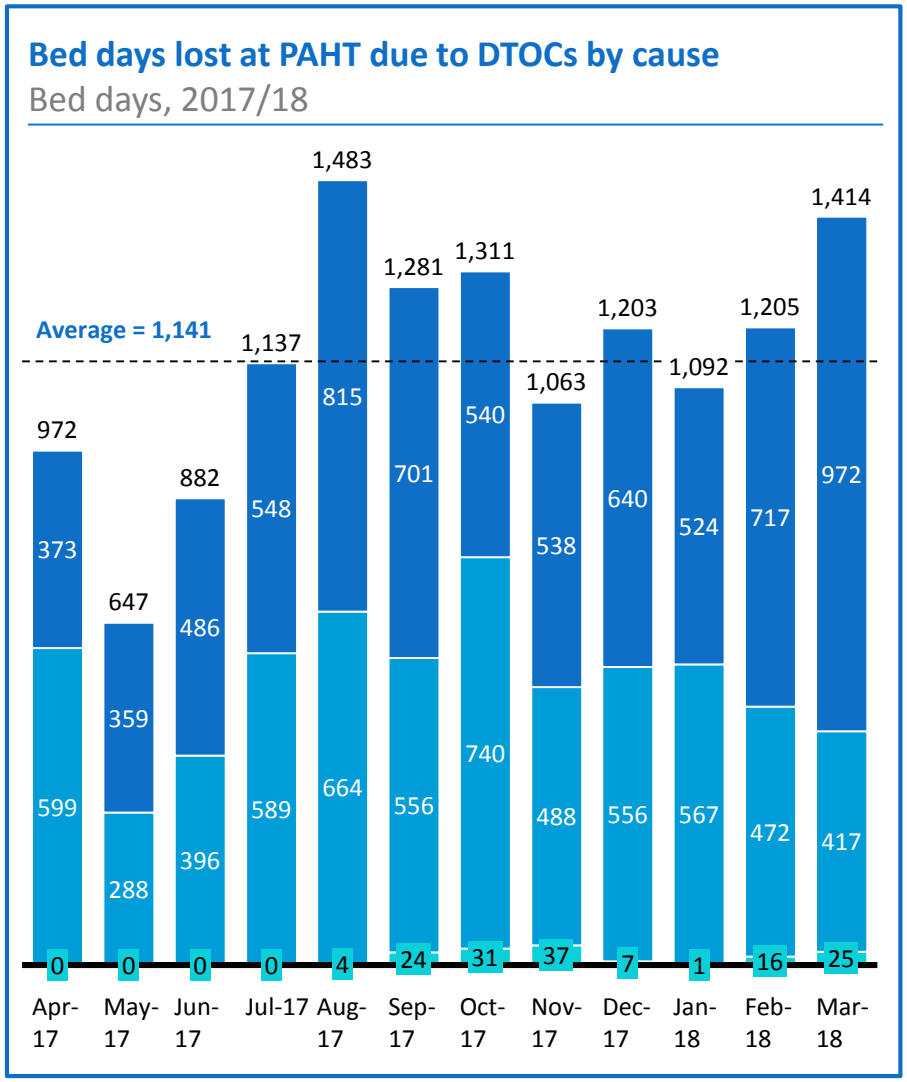


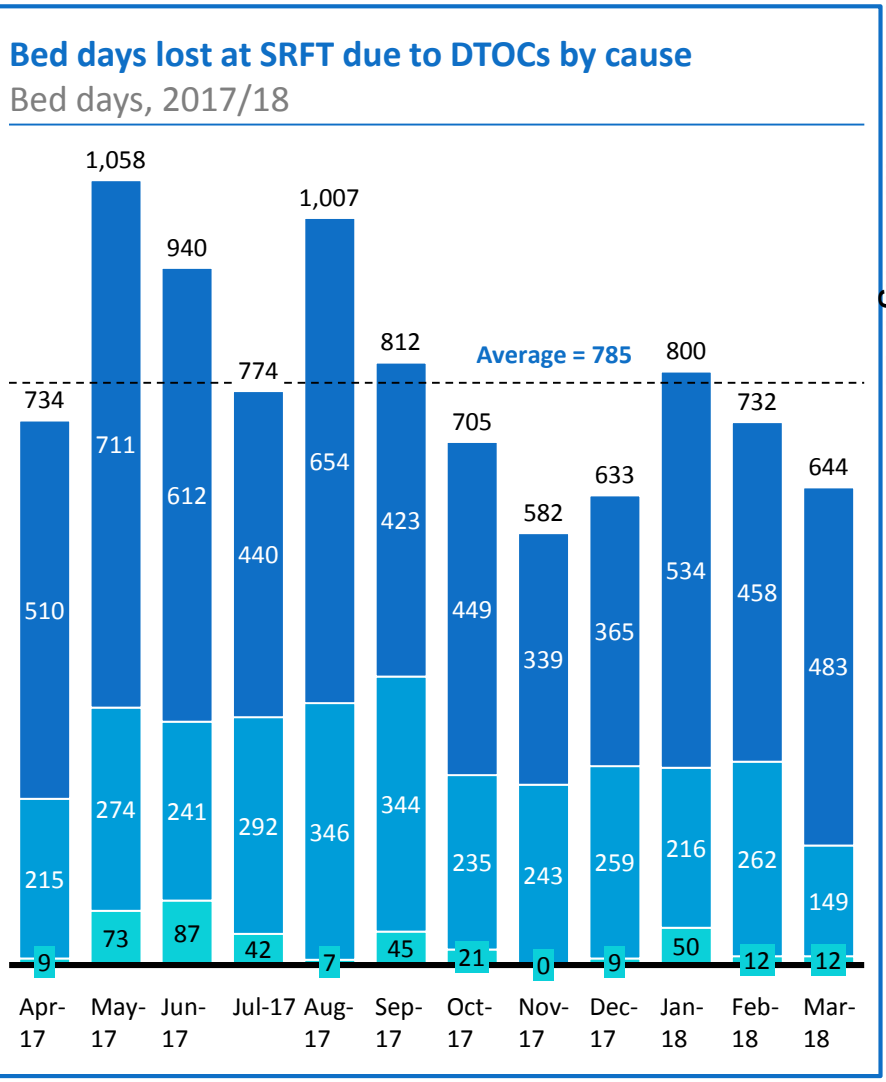
National average rate of 71% of total beddays attributed to NEL patients with lengths of stay longer than 7 days (31% for more than 30 days)

1 Excluding RA (Regular Attenders) and Other (not recorded type), Paediatrics patients are defined by age 0-18 y.o.

SOURCE: HES 2016/17

On average, 1,141 and 785 bed days are lost at PAHT and SRFT, respectively, every month due to DTOCs





SOURCE: HES Online 2018

Both Bury and Rochdale sites were rated good by the CQC while ROH and NMGH required improvement

Requires improvement · Inadequate · Outstanding · Good

Fairfield General Hospital, Bury

Latest inspection in Oct 2017, reported Feb 2018

Overall **Good**	
Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Rochdale Infirmary, Rochdale

Latest inspection in Feb 2016, reported Aug 2016

Overall **Good**	
Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Royal Oldham Hospital, Oldham

Latest inspection in Oct 2017, reported Feb 2018

Overall **Requires Improve-ment**	
Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement

North Manchester General Hospital, Manchester

Latest inspection in Oct 2017, reported Feb 2018

Overall **Requires Improve-ment**	
Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement

SOURCE: CQC website

Fairfield scored good or outstanding for most services with critical care and end of life care not included in the latest inspection

Rating change since last inspection	Same	Up one rating	Up two rating	Down one rating	Down two rating
Symbol	➔➔	↑	↑↑	↓	↓↓

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Feb 2018	Good ➔➔ Feb 2018	Good ➔➔ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018
Medical care (including older people's care)	Good ↑ Feb 2018	Good ↑ Feb 2018	Outstanding ↑ Feb 2018	Outstanding ↑↑ Feb 2018	Good ➔➔ Feb 2018	Outstanding ↑↑ Feb 2018
Surgery	Good ↑ Feb 2018	Good ↑ Feb 2018	Good ➔➔ Feb 2018	Good ➔➔ Feb 2018	Good ➔➔ Feb 2018	Good ↑ Feb 2018
Critical care	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Requires improvement Aug 2016
End of life care	Requires improvement Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Requires improvement Aug 2016
Outpatient and Diagnostic imaging	Good Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Requires improvement ➔➔ Feb 2018	Good ↑ Feb 2018	Good ➔➔ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018

SOURCE: CQC website

Rochdale is awaiting inspection, with the previous one from 2016 noting the need to improve urgent and emergency care

Rating change since last inspection	Same	Up one rating	Up two rating	Down one rating	Down two rating
Symbol	➔	↑	↑↑	↓	↓↓

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Requires improvement Aug 2016
Medical care (including older people's care)	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Surgery	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Outpatient and Diagnostic imaging	Good Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016

SOURCE: CQC website

ROH required improvement in many service areas including critical and medical care, plus care for children and young people

Rating change since last inspection	Same	Up one rating	Up two rating	Down one rating	Down two rating
Symbol	→ ←	↑	↑↑	↓	↓↓

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018
Medical care (including older people's care)	Requires improvement → ← Feb 2018	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2018	Requires improvement ↓ Feb 2018	Requires improvement → ← Feb 2018
Surgery	Requires improvement → ← Feb 2018	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2018
Critical care	Requires improvement ↑ Feb 2018	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2018	Requires improvement ↑ Feb 2018	Requires improvement ↑ Feb 2018
Maternity	Requires improvement Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Services for children and young people	Requires improvement ↑ Feb 2018	Requires improvement → ← Feb 2018	Good ↑ Feb 2018	Requires improvement → ← Feb 2018	Requires improvement ↑ Feb 2018	Requires improvement ↑ Feb 2018
End of life care	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Requires improvement Aug 2016
Outpatient and Diagnostic imaging	Requires improvement Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Requires improvement ↑ Feb 2018	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2018	Requires improvement ↑ Feb 2018	Requires improvement ↑ Feb 2018

SOURCE: CQC website

NMGH required improvement in several service areas, especially in medical care and surgery

Rating change since last inspection	Same	Up one rating	Up two rating	Down one rating	Down two rating
Symbol	➔➔	↑	↑↑	↓	↓↓

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑↑ Feb 2018	Good ↑ Feb 2018	Good ➔➔ Feb 2018	Requires improvement ↑ Feb 2018	Good ↑↑ Feb 2018	Good ↑↑ Feb 2018
Medical care (including older people's care)	Requires improvement ↑ Feb 2018	Requires improvement ➔➔ Feb 2018	Good ➔➔ Feb 2018	Requires improvement ➔➔ Feb 2018	Requires improvement ↑ Feb 2018	Requires improvement ↑ Feb 2018
Surgery	Requires improvement ➔➔ Feb 2018	Requires improvement ➔➔ Feb 2018	Good ➔➔ Feb 2018	Good ➔➔ Feb 2018	Good ↑ Feb 2018	Requires improvement ➔➔ Feb 2018
Critical care	Good Aug 2016	Good Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016
Maternity	Requires improvement Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Services for children and young people	Requires improvement ↑ Feb 2018	Requires improvement ➔➔ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good Feb 2018	Requires improvement ↑ Feb 2018
End of life care	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Outpatient and Diagnostic imaging	Good Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Requires improvement ↑ Feb 2018	Requires improvement ➔➔ Feb 2018	Good ➔➔ Feb 2018	Requires improvement ➔➔ Feb 2018	Good ↑↑ Feb 2018	Requires improvement ↑ Feb 2018

SOURCE: CQC website

Royal Salford was recently rated outstanding by the CQC with kind, caring staff and highly responsive services

Salford Royal Hospital, Salford
Latest inspection in Apr 2018, reported Aug 2018

Rating change since last inspection	Same	Up one rating	Up two rating	Down one rating	Down two rating
Symbol	→ ←	↑	↑↑	↓	↓↓

Overview

Inadequate · Requires improvement · Good · ☆ Outstanding

Overall Outstanding

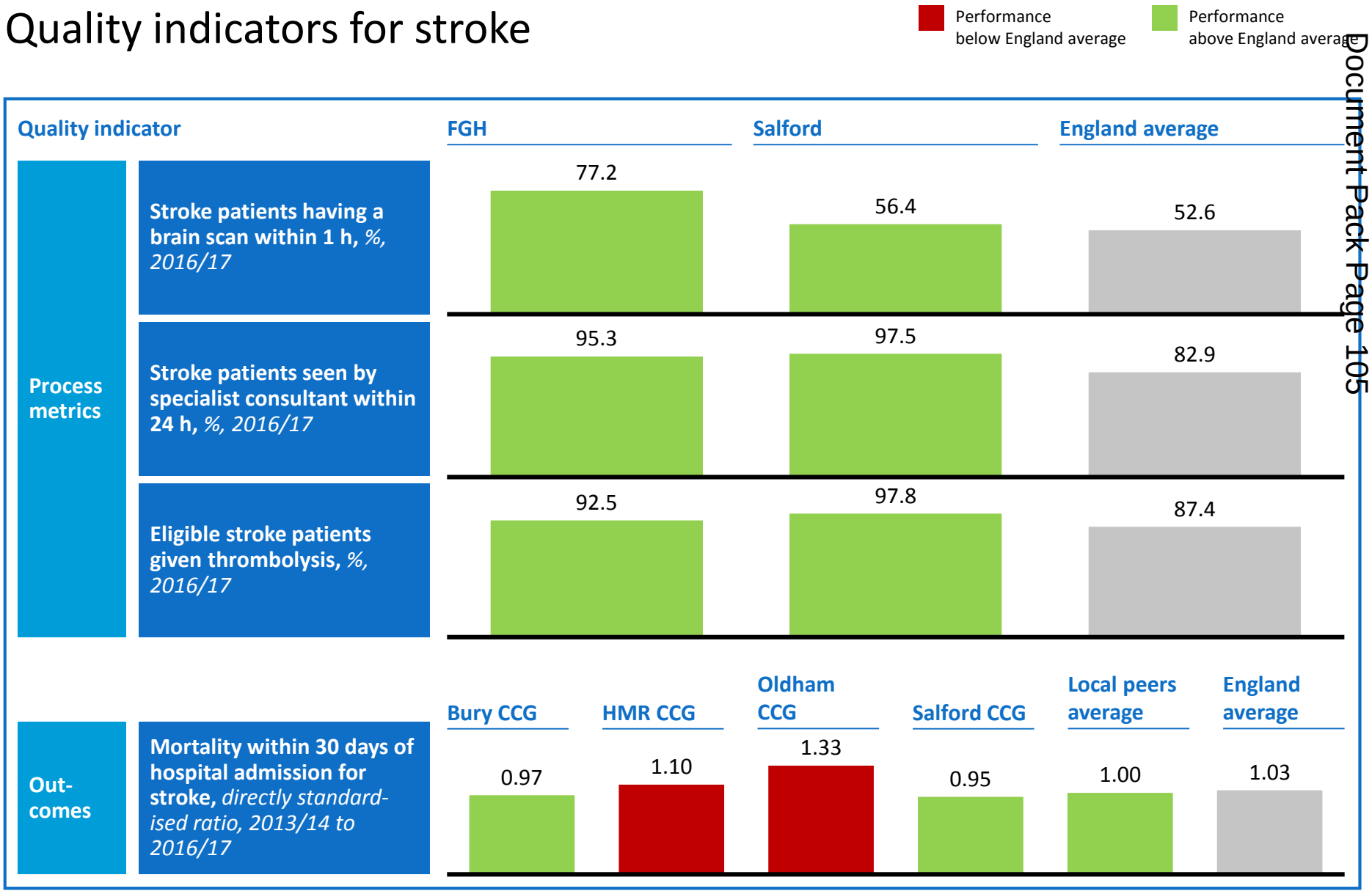
Safe	Good	Responsive	Outstanding ☆
Effective	Good	Well-led	Good
Caring	Outstanding ☆		

Specific service areas

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↓ Aug 2018	Good → ← Aug 2018	Good ↓ Aug 2018	Good → ← Aug 2018	Good ↓ Aug 2018	Good ↓ Aug 2018
Medical care (including older people's care)	Good ↓ Aug 2018	Good → ← Aug 2018	Good → ← Aug 2018	Outstanding → ← Aug 2018	Good ↓ Aug 2018	Good ↓ Aug 2018
Surgery	Good ↑ Aug 2018	Good → ← Aug 2018	Good → ← Aug 2018	Good → ← Aug 2018	Good ↑ Aug 2018	Good ↑ Aug 2018
Critical care	Good → ← Aug 2018	Good → ← Aug 2018	Outstanding ↑ Aug 2018	Good ↓ Aug 2018	Good → ← Aug 2018	Good → ← Aug 2018
Services for children and young people	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Requires improvement Mar 2015	Good Mar 2015
End of life care	Good Mar 2015	Good Mar 2015	Outstanding Mar 2015	Outstanding Mar 2015	Outstanding Mar 2015	Outstanding Mar 2015
Outpatients	Good Aug 2018	N/A	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018
Overall	Good → ← Aug 2018	Good → ← Aug 2018	Outstanding → ← Aug 2018	Outstanding → ← Aug 2018	Good → ← Aug 2018	Outstanding → ← Aug 2018

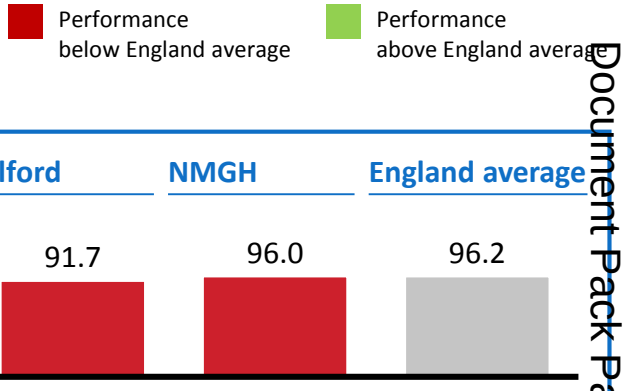
SOURCE: CQC website

Quality indicators for stroke



SOURCE: Sentinel Stroke National Audit Programme 2017, CCG Outcomes Indicators 2018

Quality indicators for myocardial infarction and heart failure

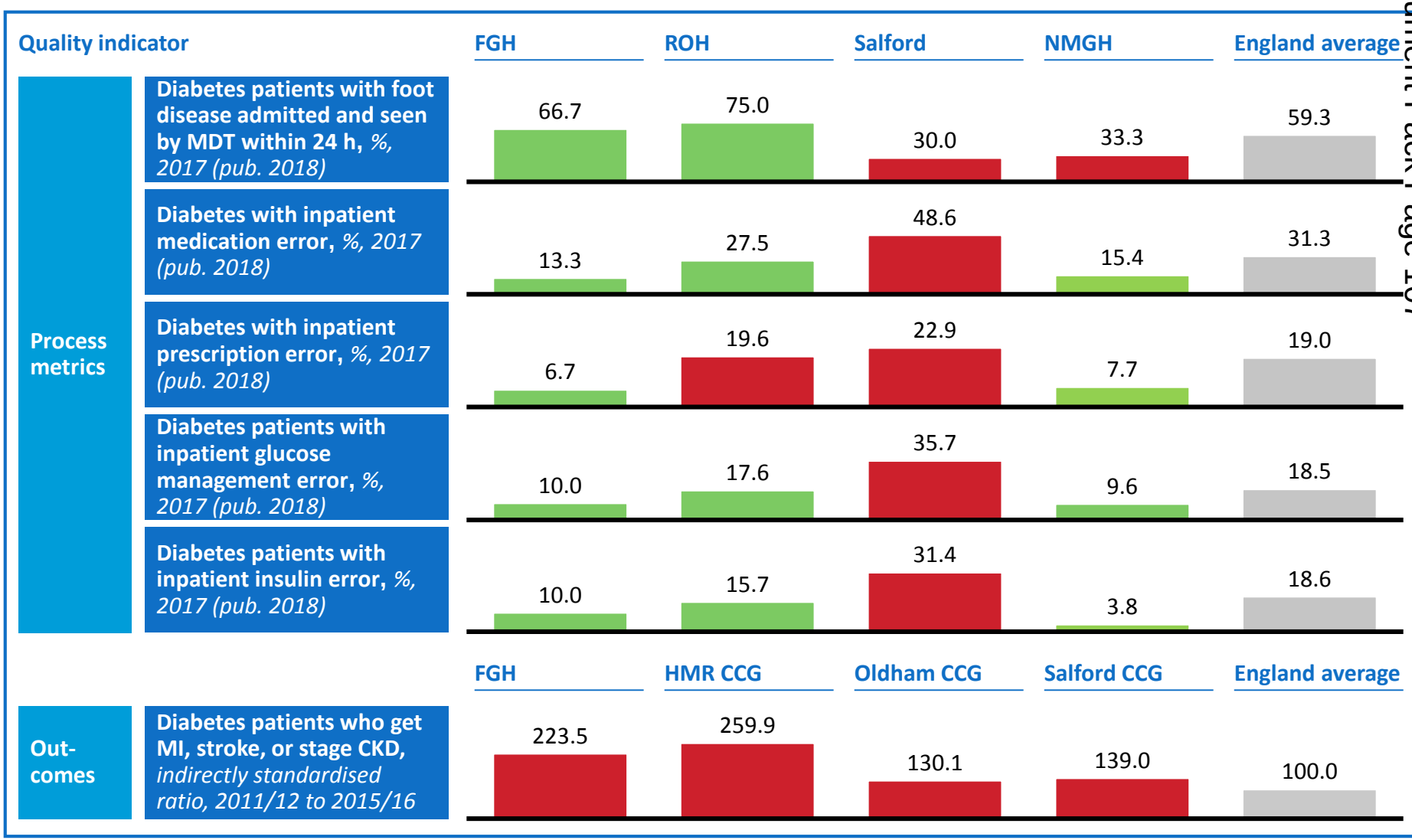


SOURCE: Myocardial Ischaemia National Audit Project 2017, National Heart Failure Audit 2017, CCG Outcomes Indicators 2018

Quality indicators for diabetes mellitus

Performance below England average

Performance above England average



SOURCE: National Diabetes Inpatient Audit 2018, CCG Outcomes Indicators 2018

Quality indicators for adult critical care (1/2)

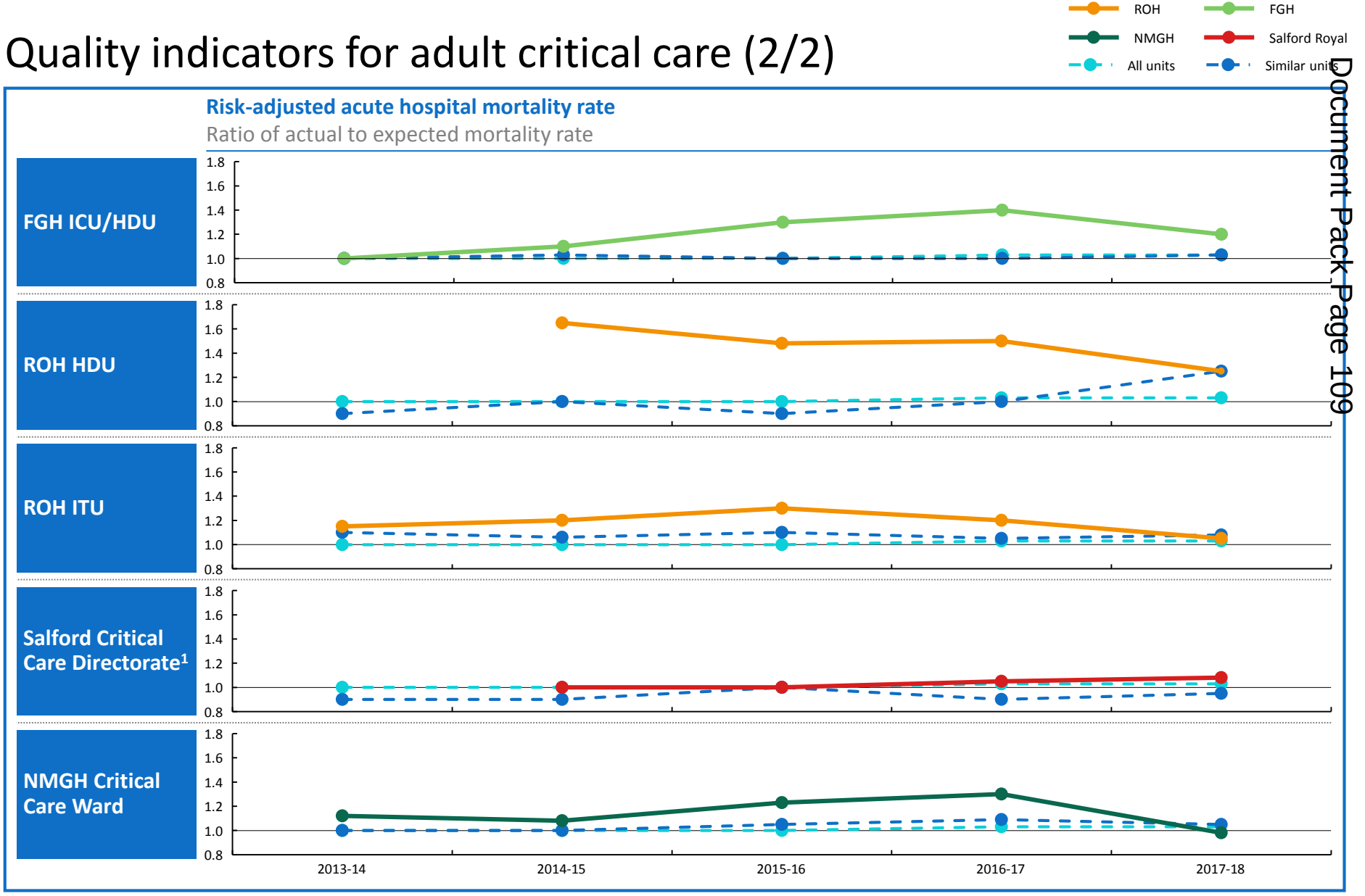
Trust performance below England average

Performance above England average

1 Reported for unit survivors discharged to a ward in the same hospital (or direct to home)

SOURCE: ICNARC Annual Quality Report 2018 for adult critical care

Quality indicators for adult critical care (2/2)



1 Salford recently started admitted patients with devastating brain injuries, which are not explicitly risk-adjusted for

SOURCE: ICNARC Annual Quality Report 2018 for adult critical care

Quality indicators for bowel cancer

Trust performance below England average

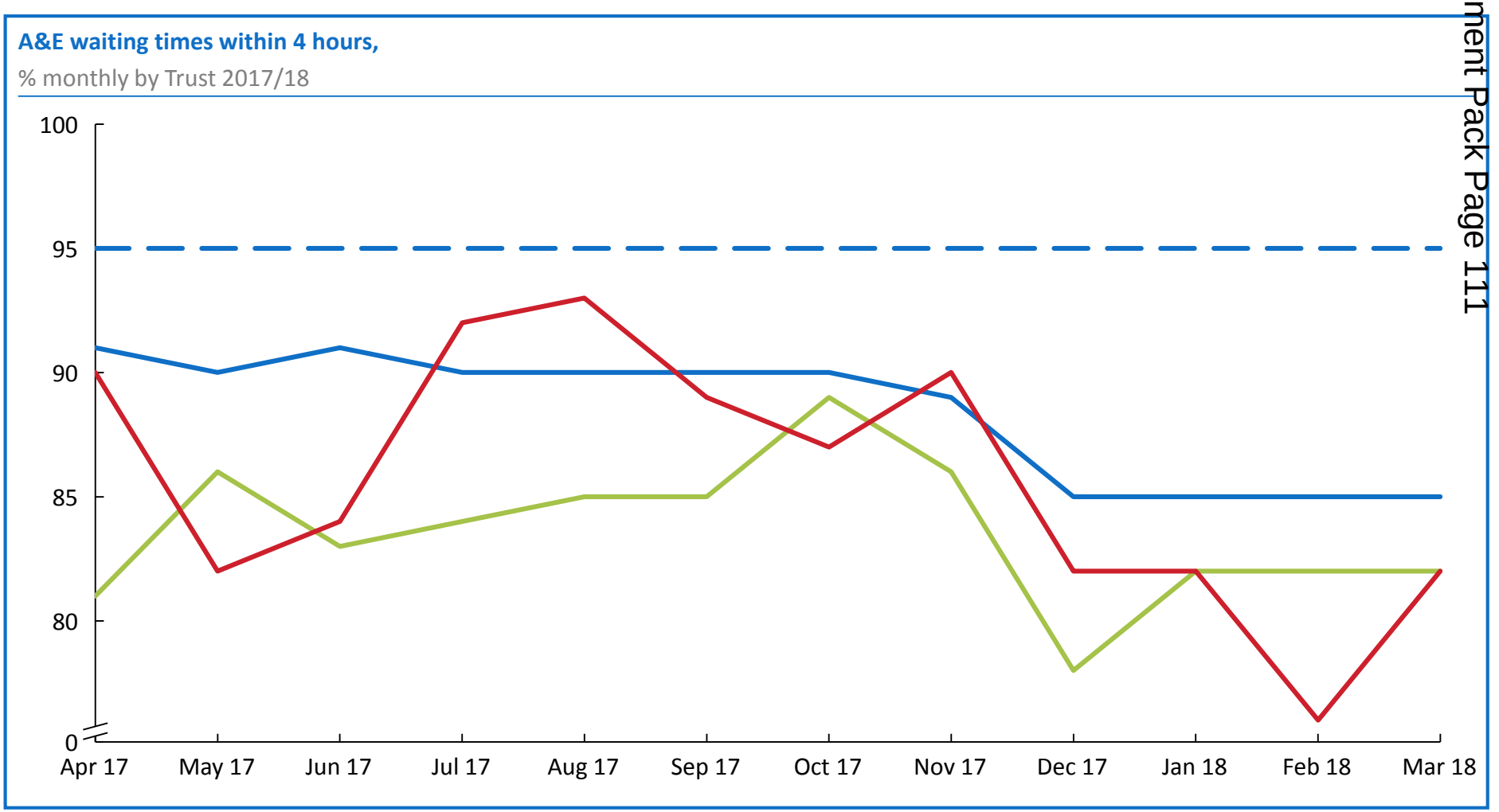
Trust performance above England average

Quality indicator	PAHT	SRFT	Peer average	Peer top-performing quartile	England average	England top-performing quartile
Underwent major urgent/emergency surgery, *%, 2015/16 (pub. 2017)*	19.0	11.0	16.9	13.5	16.0	12.0
Bowel Cancer LoS > 5 days *%, 2015/16 (pub. 2017)*	71.0	80.0	75.0	73.5	70.0	64.0
Bowel Cancer Adjusted 30-day unplanned readmission *%, 2015/16 (pub. 2017)*	7.0	8.6	8.7	5.8	9.8	7.4
Bowel Cancer Adjusted 90-day mortality *%, 2015/16 (pub. 2017)*	2.1	1.9	2.4	1.3	3.6	2.3

1 Local peers as Bolton; Manchester; Stockport; Tameside & Glossop; Wrightington, Wigan & Leigh Trusts

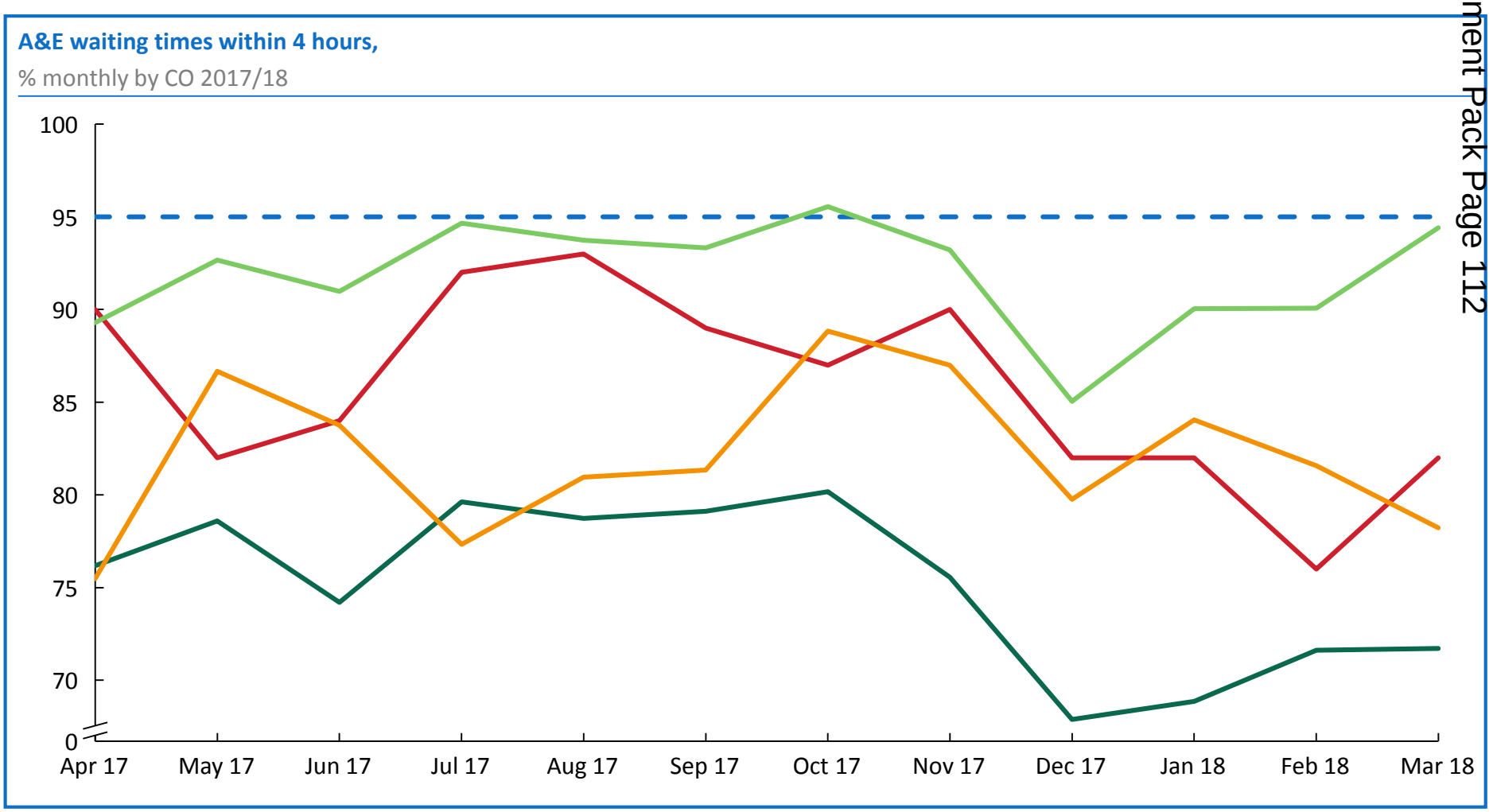
SOURCE: National Bowel Cancer Audit 2017

A&E waiting times are below the national 95% target and trending down



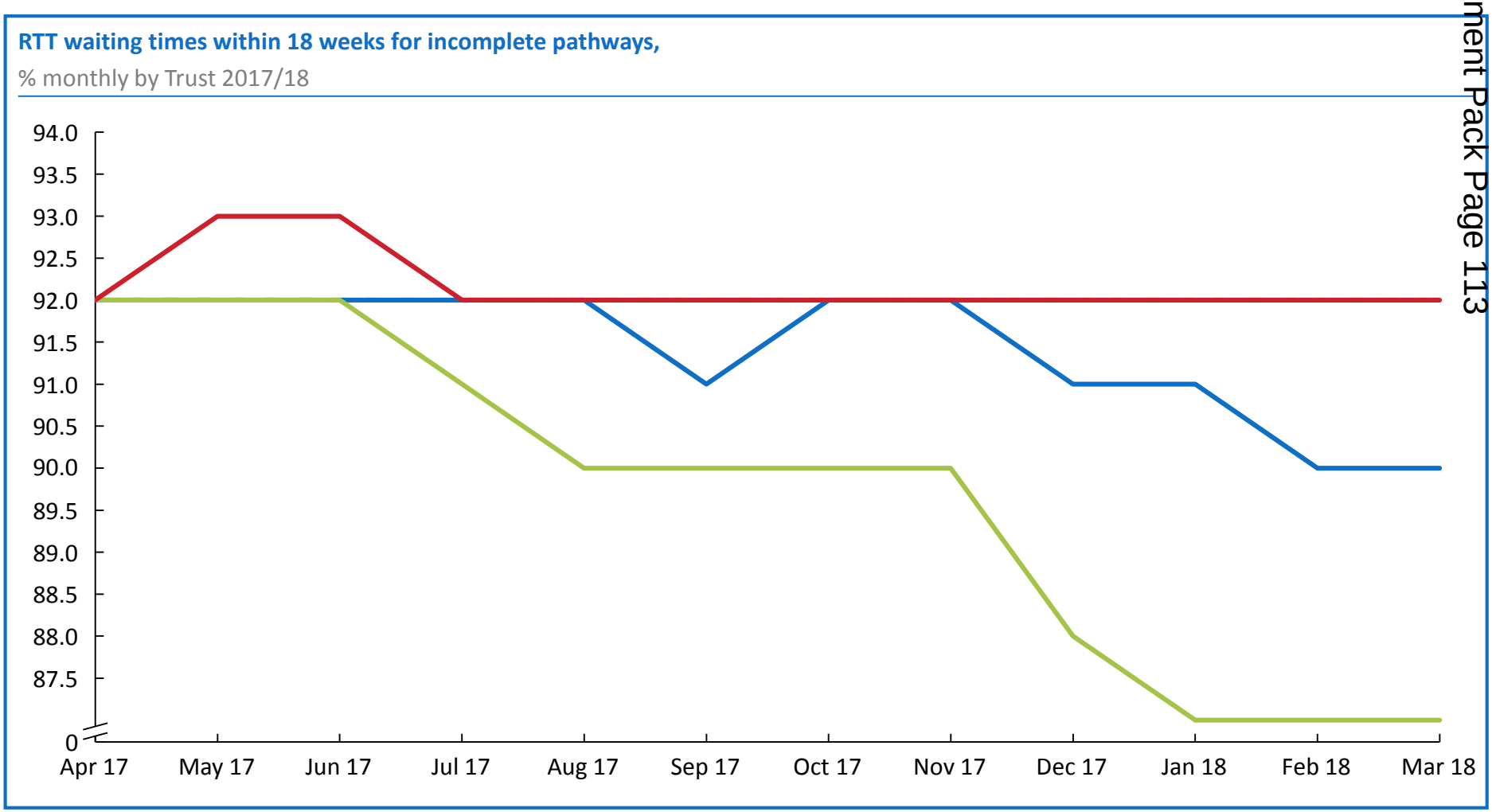
SOURCE: NHSE A&E Unify2 data collection – MSitAE 2018, HSJ Intelligence 2018

For Pennine, the deteriorating performance is driven by waiting times at NMGH and ROH



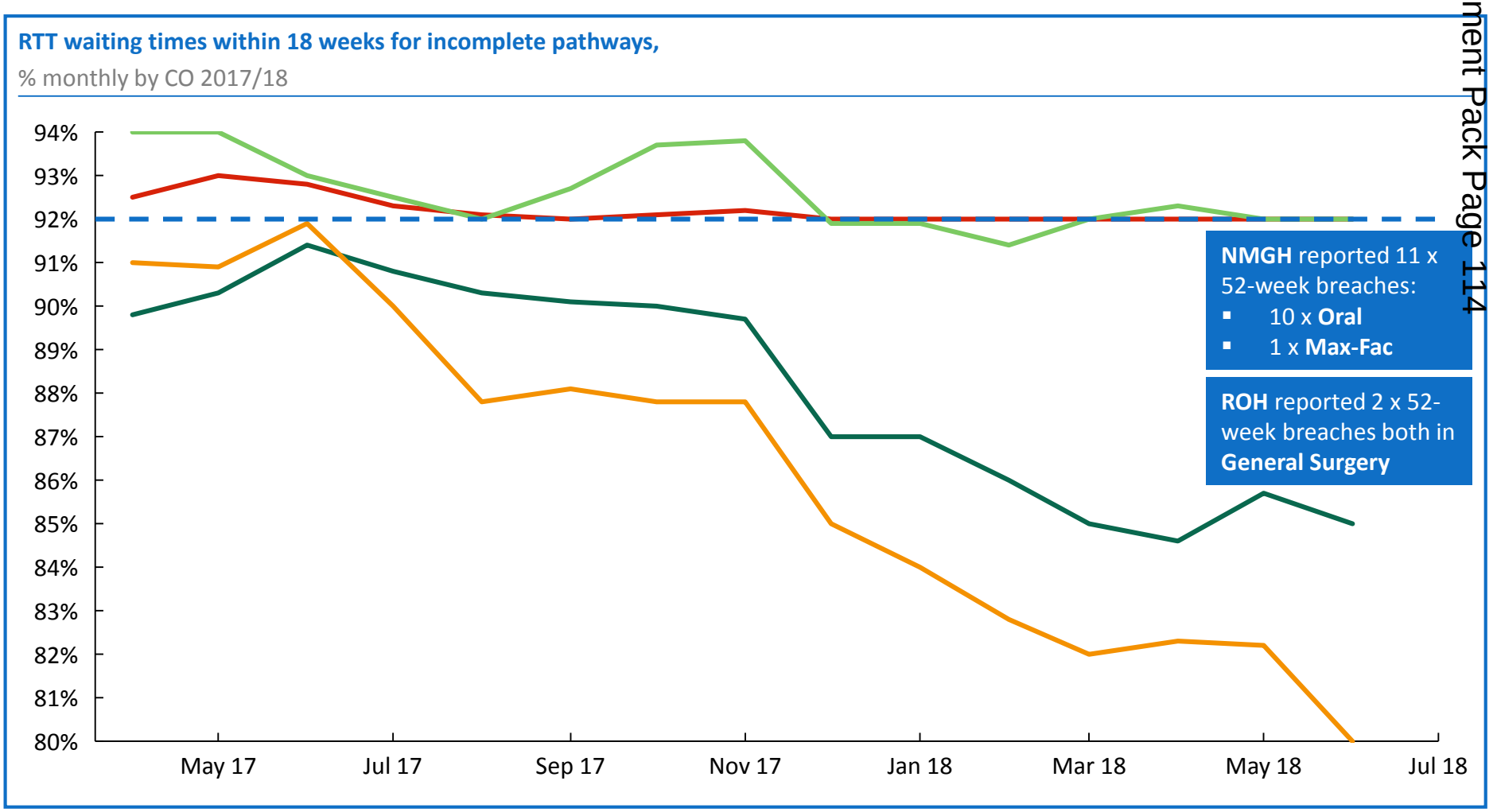
SOURCE: NHSE A&E Unify2 data collection – MSitAE 2018, HSJ Intelligence 2018

RTT waiting times within 18 weeks are below the national average at PAHT



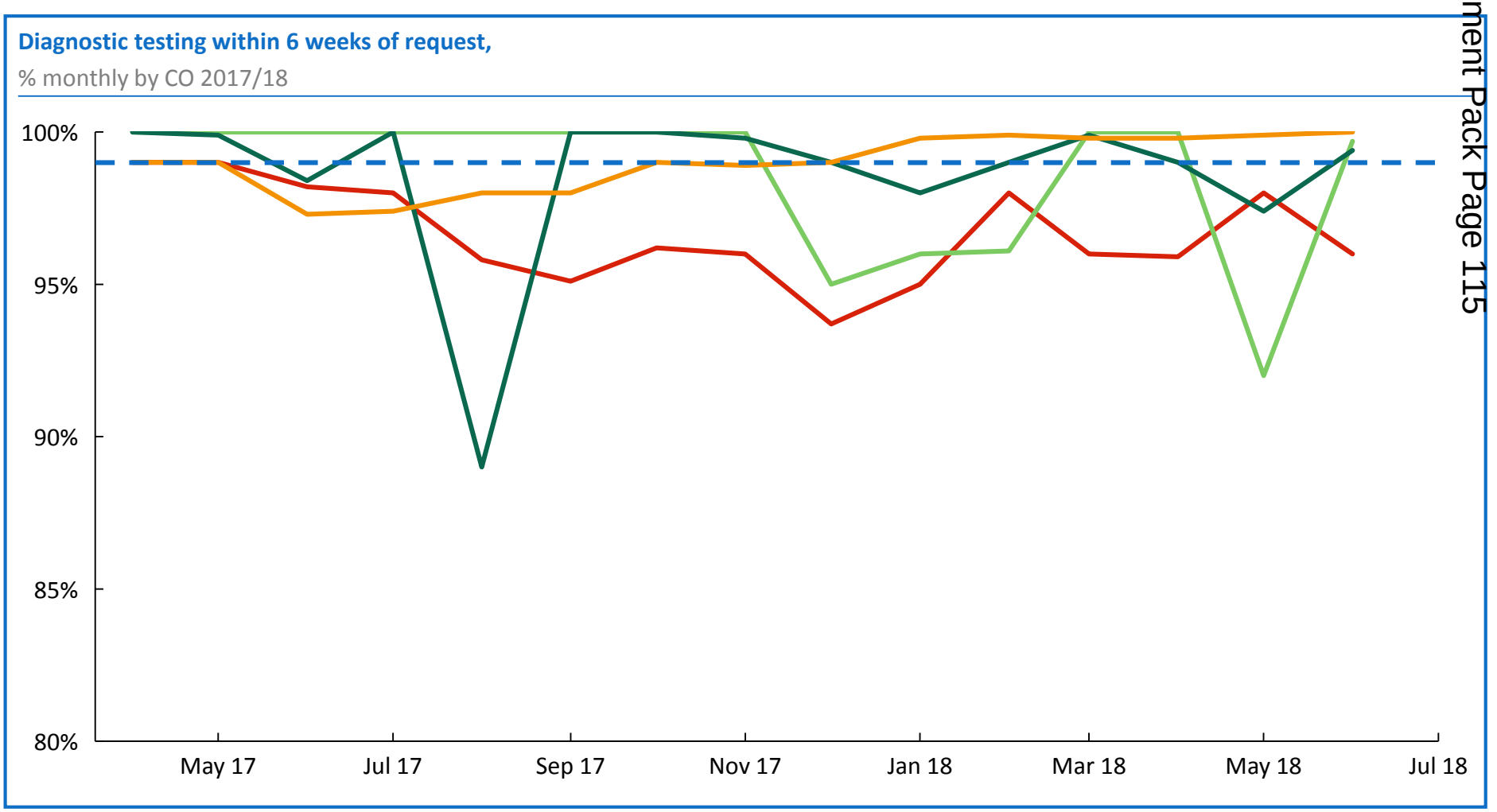
SOURCE: NHSE A&E Unify2 data collection – MSitAE 2018, HSJ Intelligence 2018

This is primarily driven by declining RTT waiting time performance at NMGH and ROH



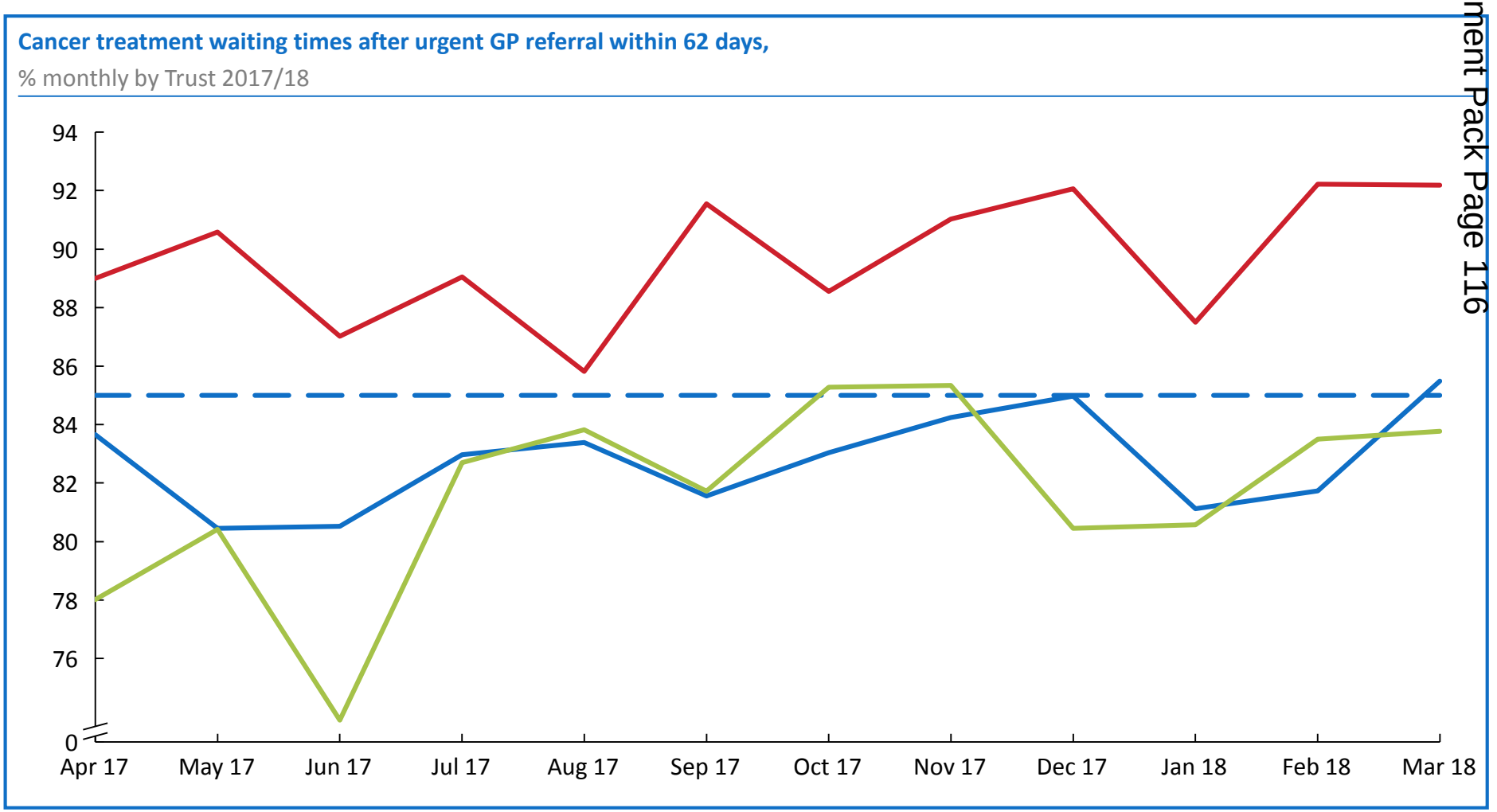
SOURCE: NCA CiC July 2018 pack

Six-week diagnostic performance varies considerably from month to month with Salford CO consistently below the target



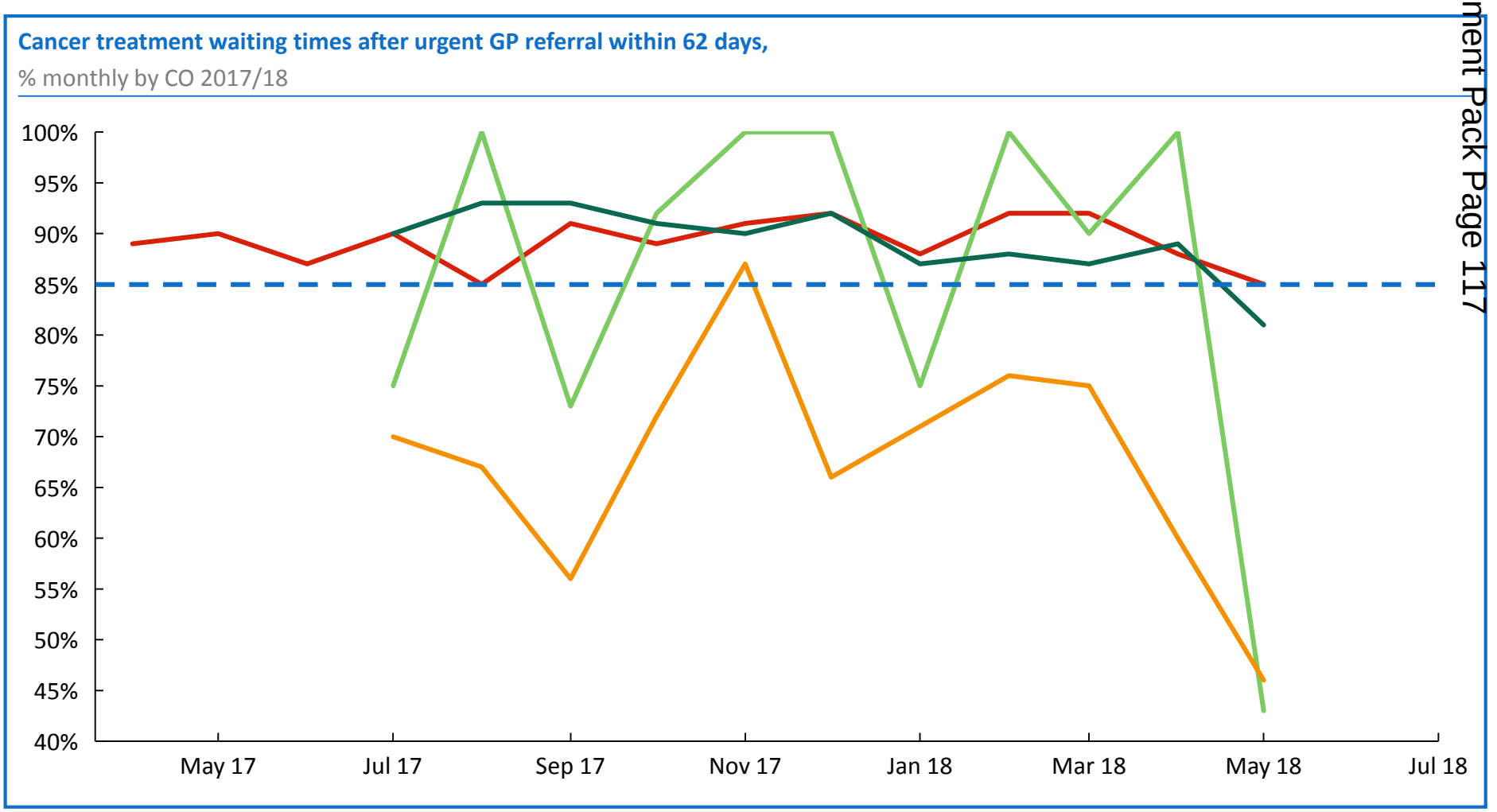
SOURCE: NCA CiC July 2018 pack

Cancer treatment waiting times are better than the national average and the national target at SRFT



SOURCE: NHSE A&E Unify2 data collection – MSitAE 2018, HSJ Intelligence 2018

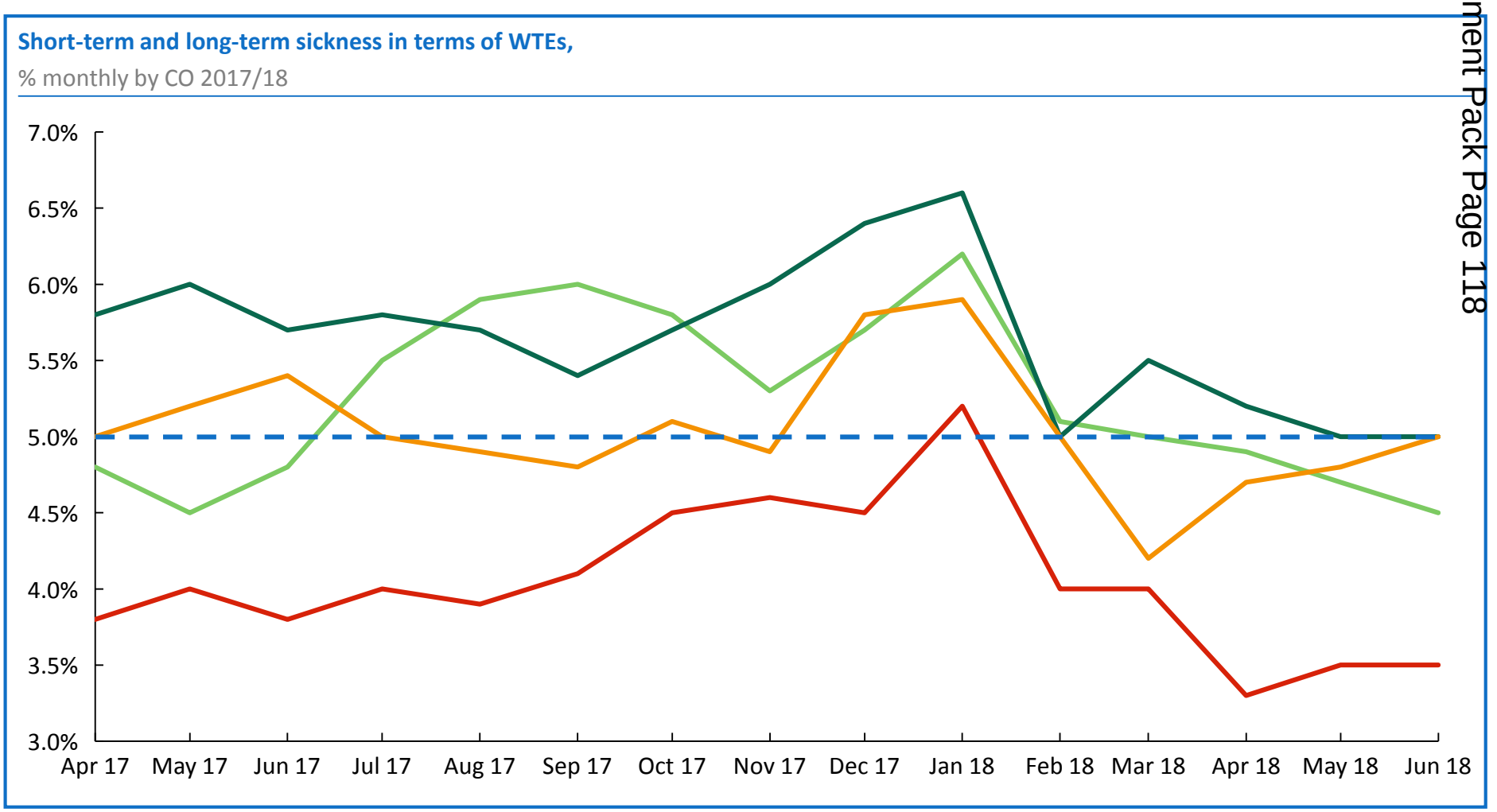
Both Oldham and Bury & Rochdale COs have seen declining cancer treatment waiting time performance



Bury & Rochdale CO covers ENT tumour groups

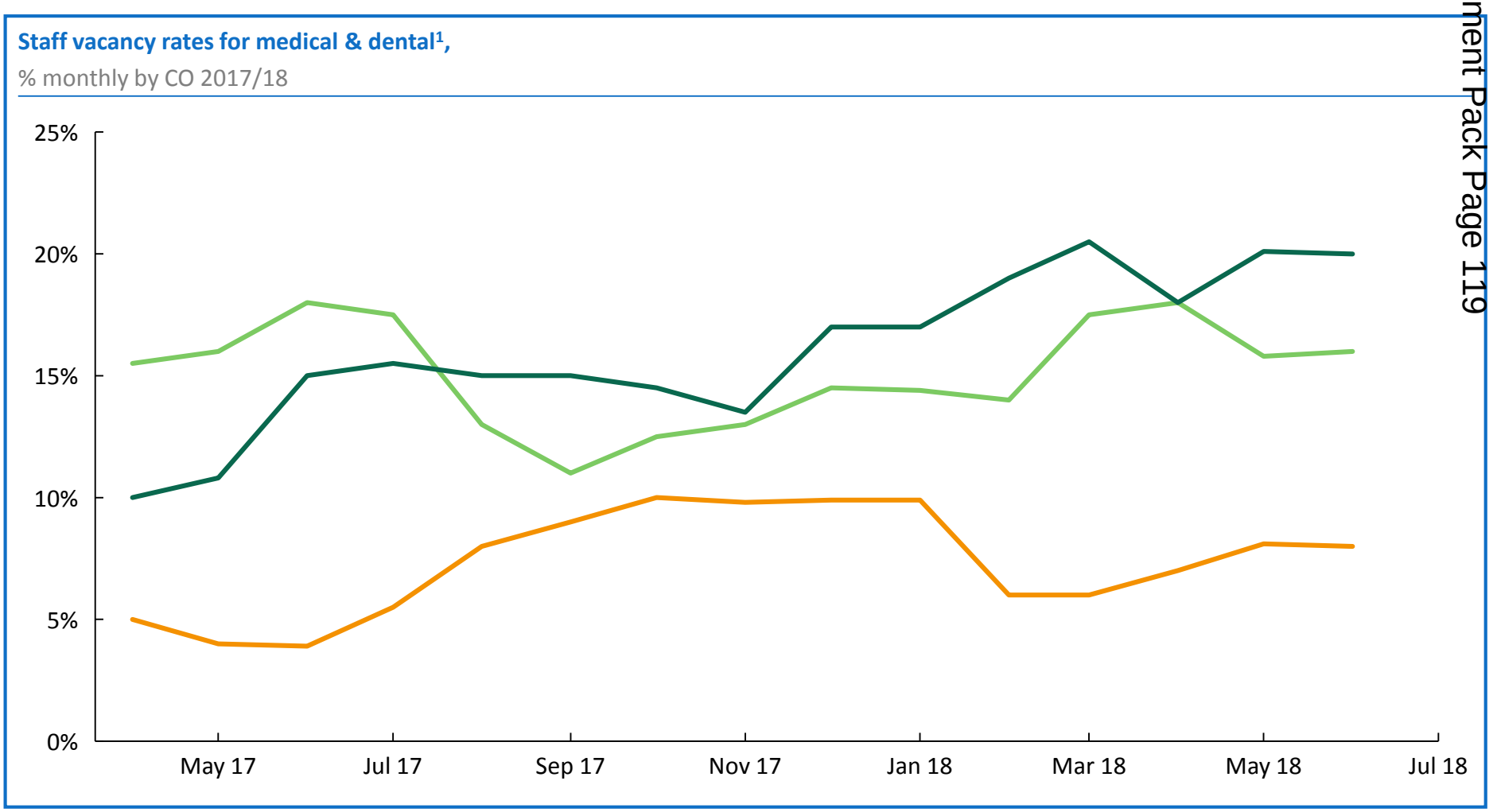
SOURCE: NCA CiC July 2018 pack

Sickness absence at Oldham and NM are now around the target while Salford and Bury & Rochdale are doing better



SOURCE: NCA CiC July 2018 pack

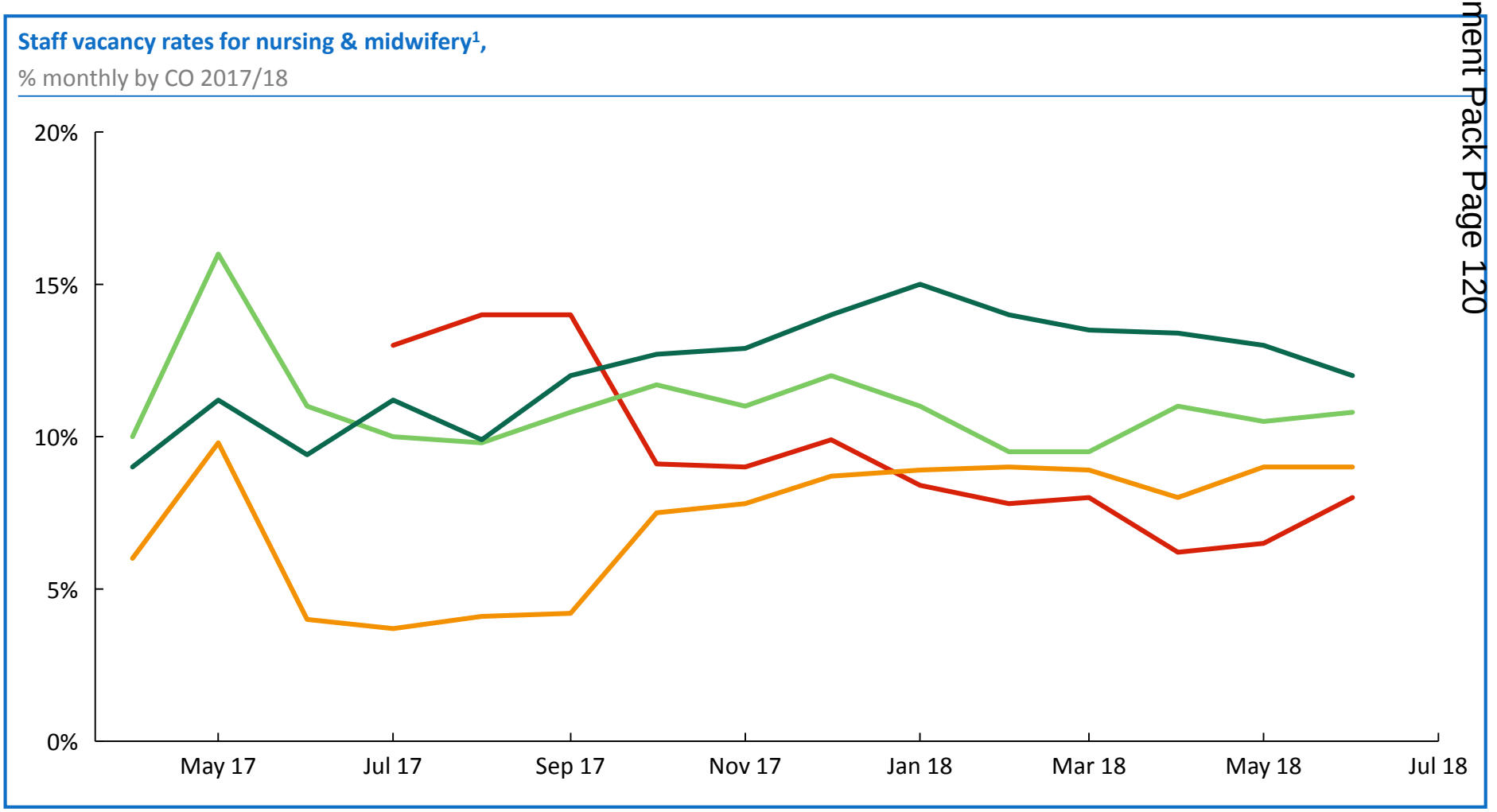
Vacancy rates for medical & dental staff roles are relatively high at NM and are trending upwards



1 Vacancy rates are primarily a function of staff turnover
Data for Salford were unavailable as of August 2018 but are undergoing validation

SOURCE: NCA CiC July 2018 pack

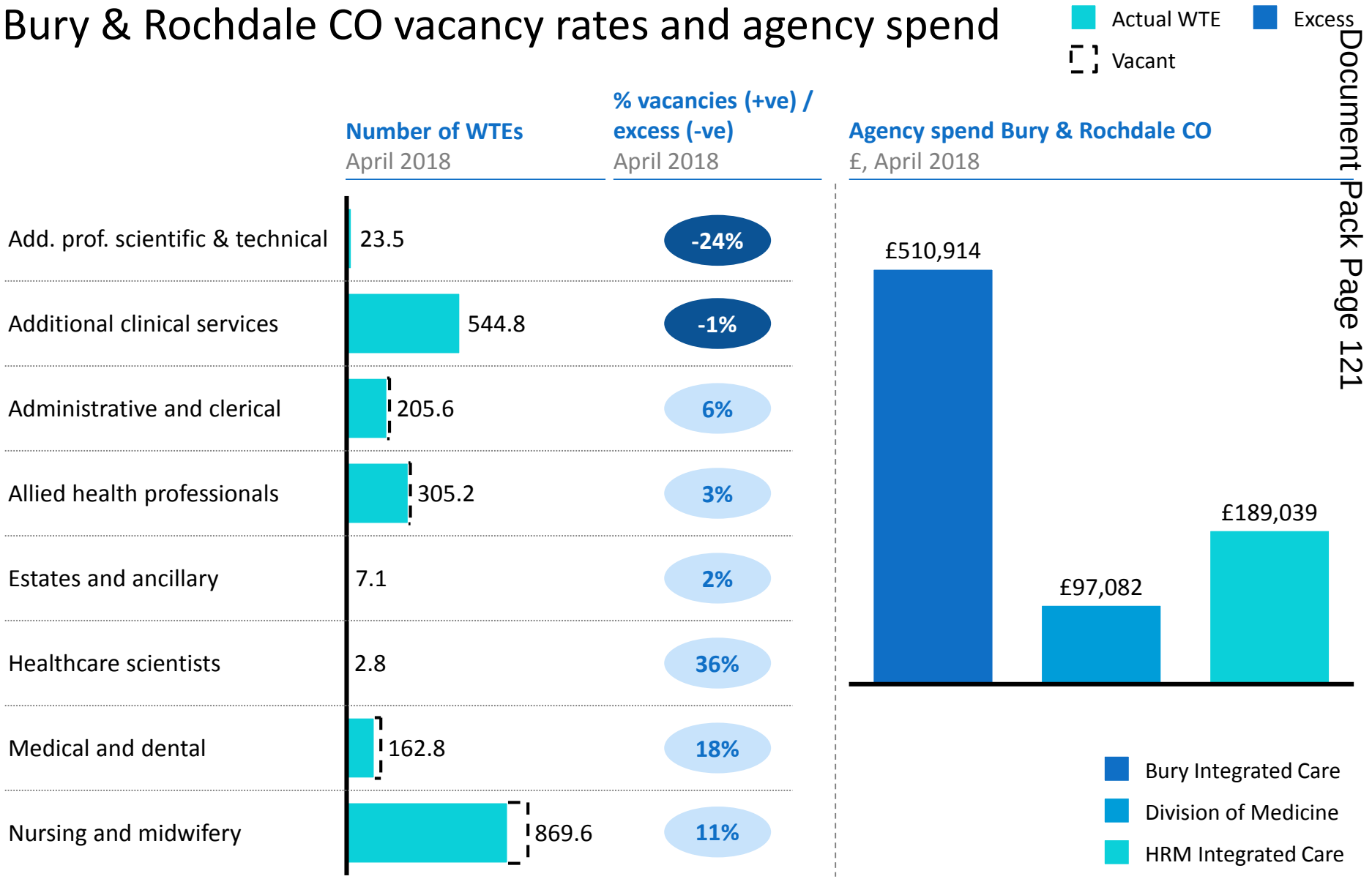
Vacancy rates for nursing & midwifery staff roles are highest at NM



1 Vacancy rates are primarily a function of staff turnover

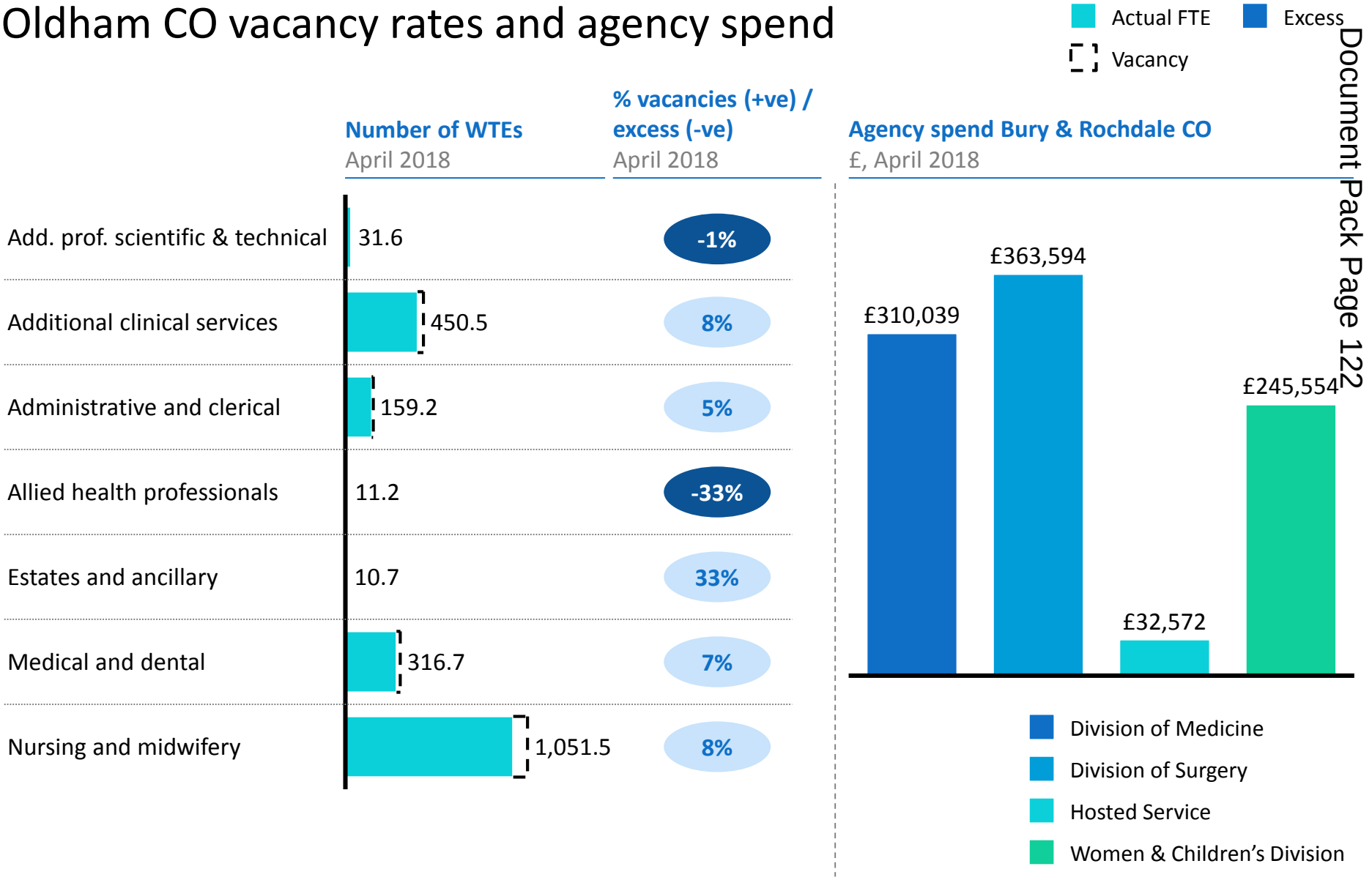
SOURCE: NCA CiC July 2018 pack

Bury & Rochdale CO vacancy rates and agency spend



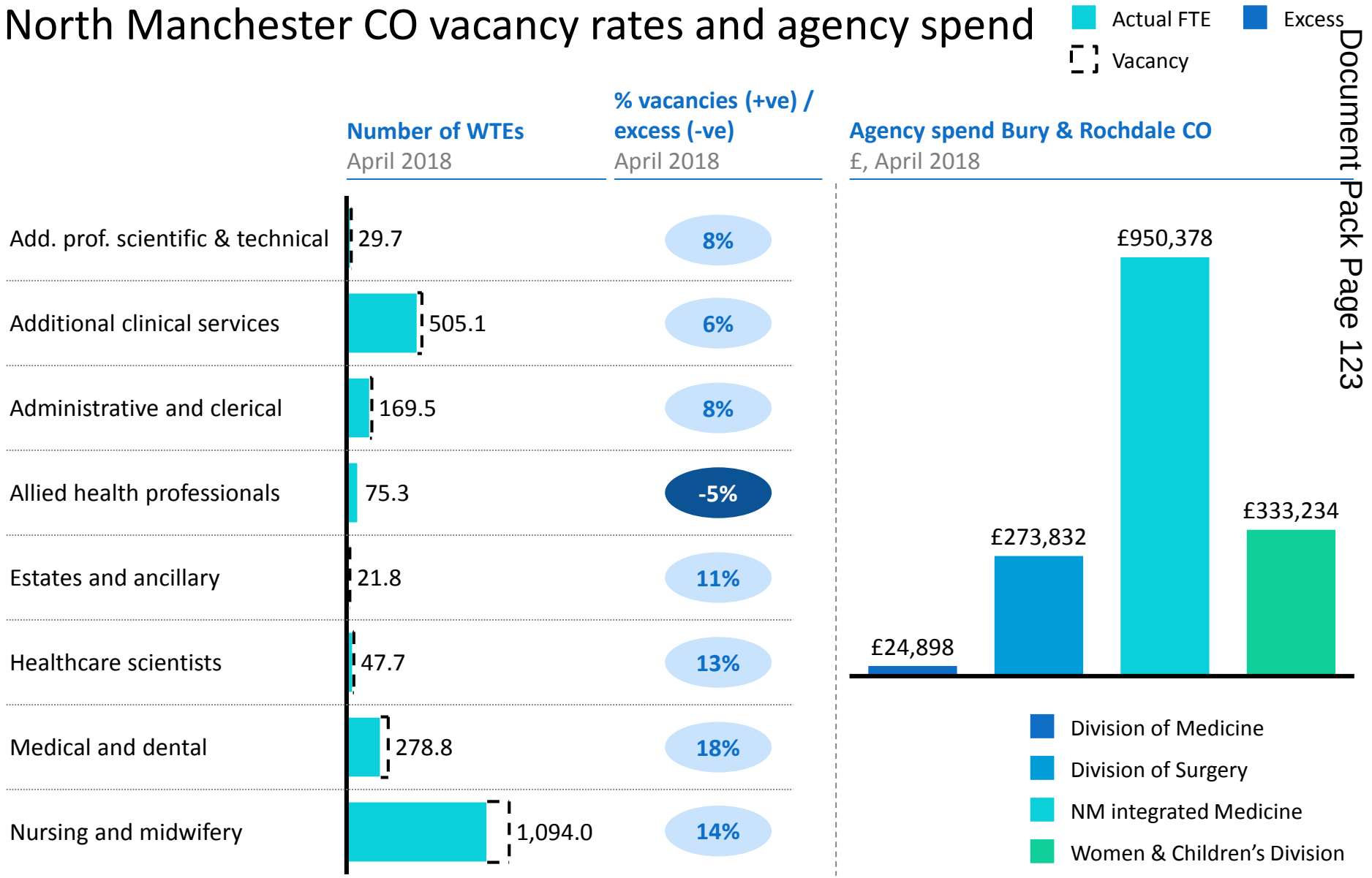
SOURCE: Joint Health Overview and Scrutiny Committee for Pennine Acute NHS Trust, 2018

Oldham CO vacancy rates and agency spend



SOURCE: Joint Health Overview and Scrutiny Committee for Pennine Acute NHS Trust, 2018

North Manchester CO vacancy rates and agency spend

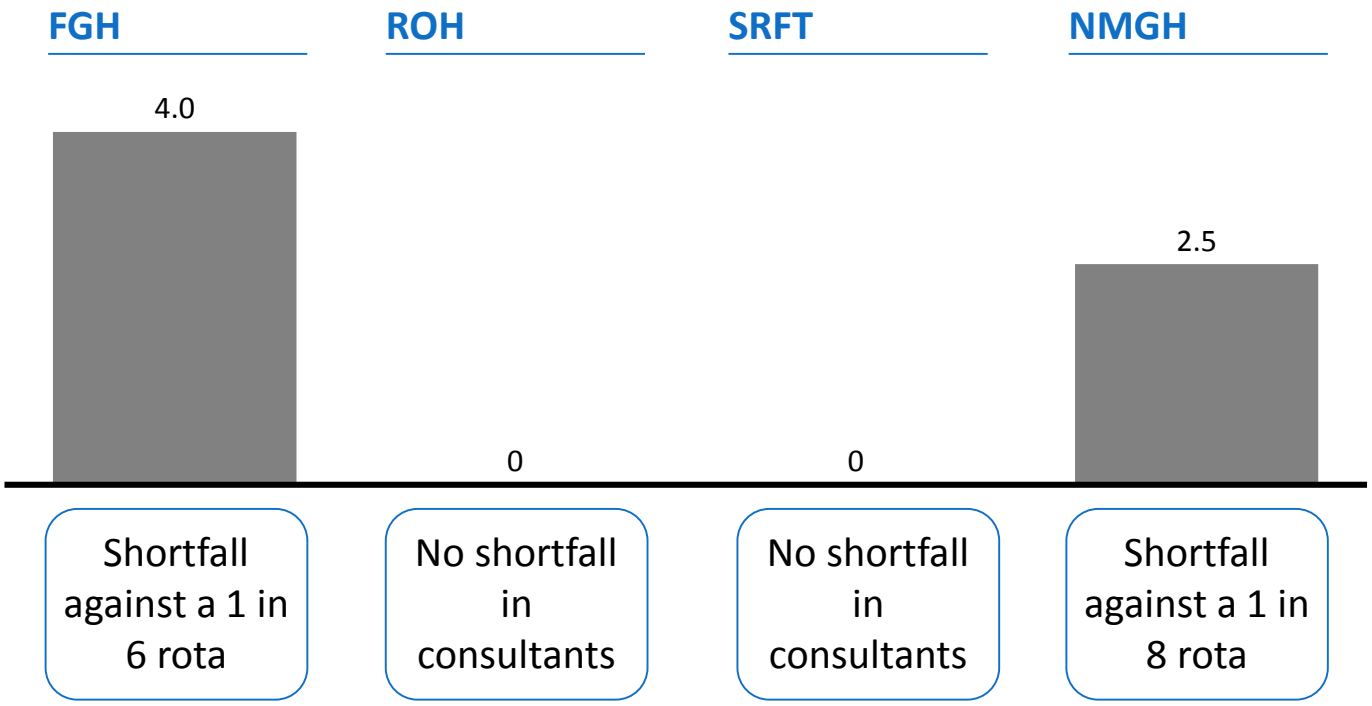


SOURCE: Joint Health Overview and Scrutiny Committee for Pennine Acute NHS Trust, 2018

Staffing levels for critical care

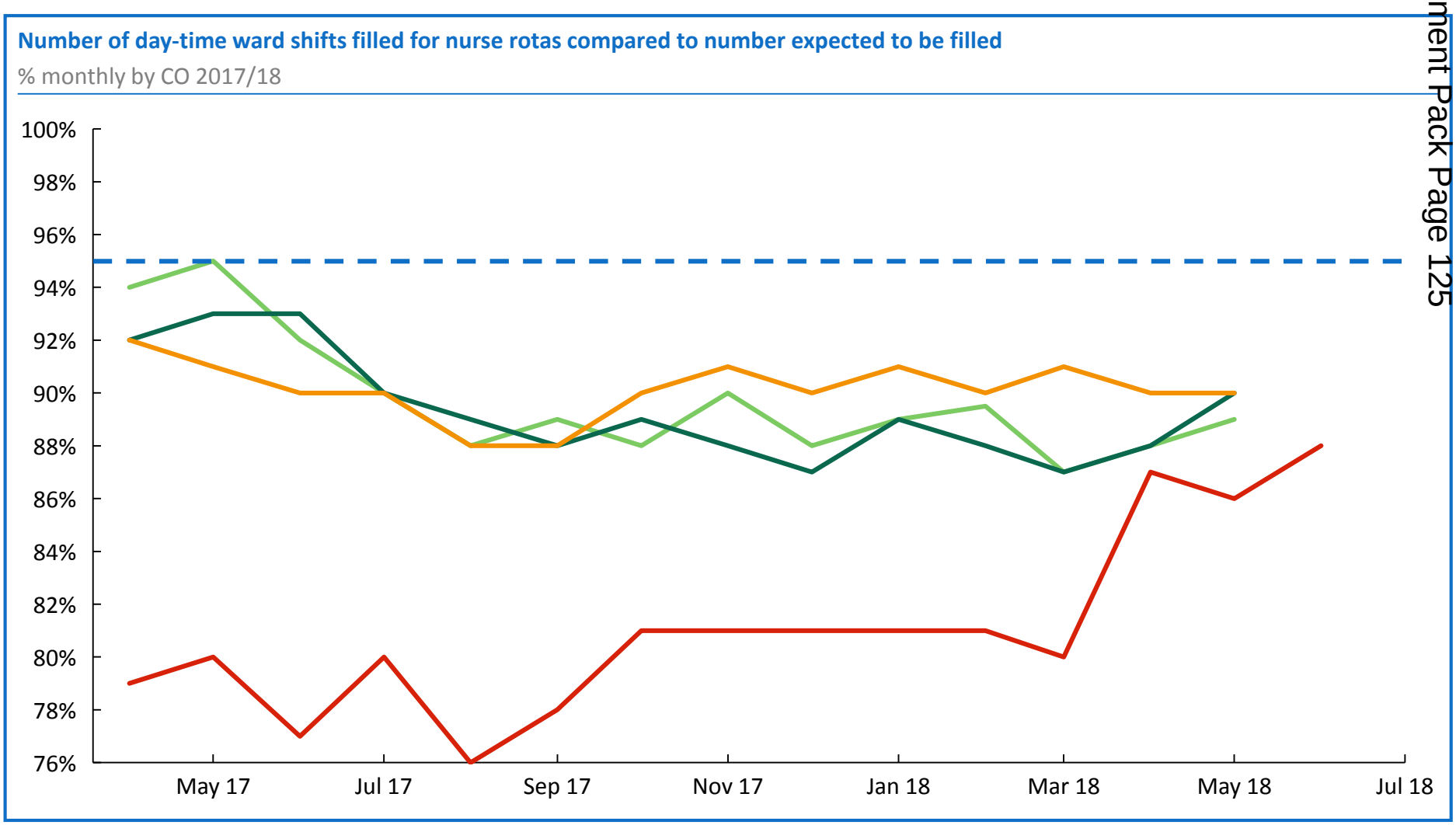
Consultant shortfall for critical care

Number of WTEs, September 2018



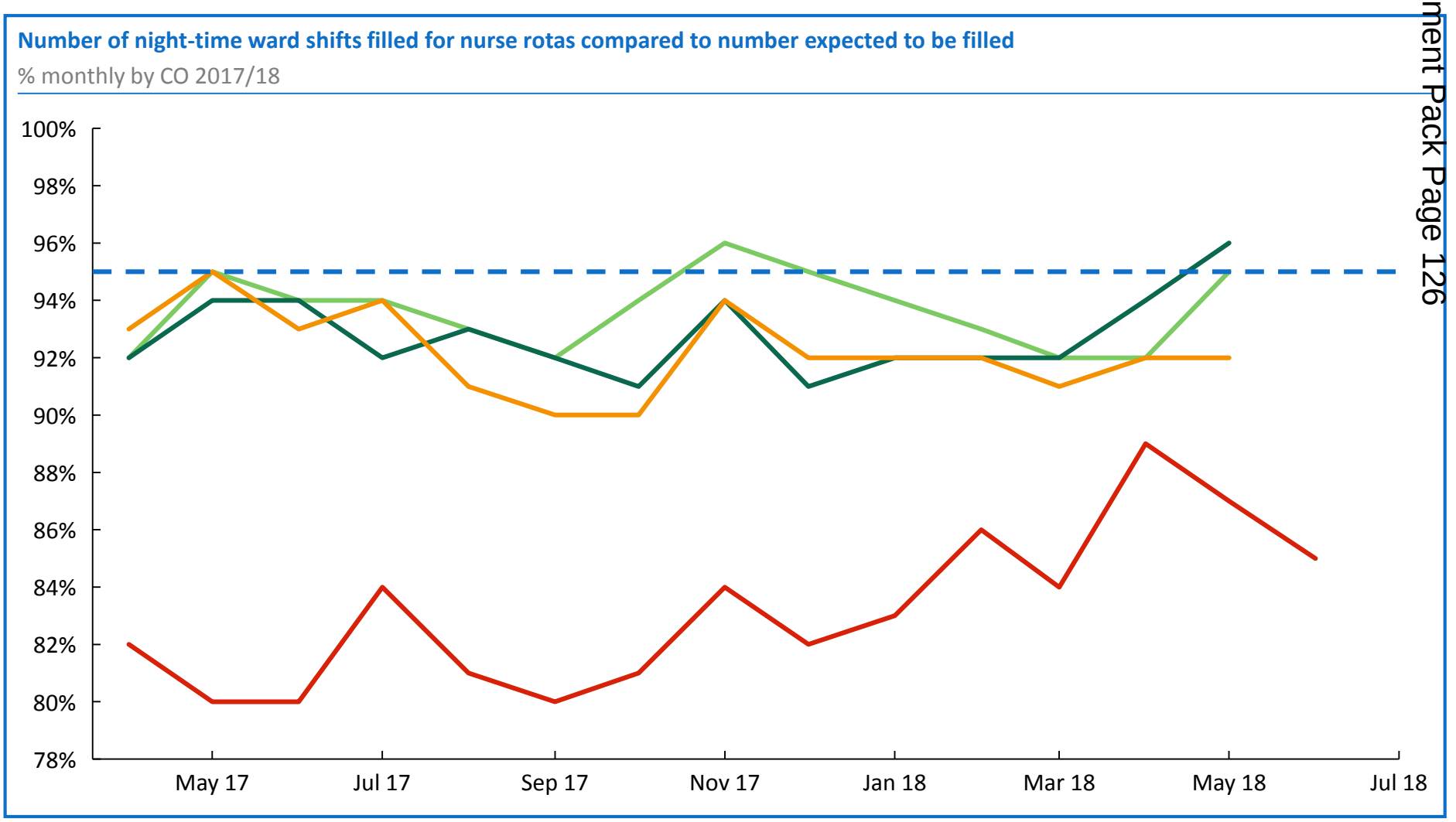
SOURCE: Trust ESR data 2018

Staffing levels for day-time nursing shifts are below the optimal staffing target at all COs



SOURCE: NCA CiC July 2018 pack

Staffing levels for night-time nursing shifts are below the optimal staffing target at Oldham and Salford



SOURCE: NCA CiC July 2018 pack

T&O and some GM wards at FGH are below optimal levels – there are also very low care staff fill rates for critical care

Above or at 95% optimal staffing level target

Below 95% optimal staffing level target but at or above 85%

Below 85% optimal staffing level

Hospital	Main specialty	Ward	Day		Night	
			Average fill rate - registered nurses	Average fill rate - care staff	Average fill rate - registered nurses	Average fill rate - care staff
Fairfield General Hospital	Cardiology	Ward 2 CCU	99.20%	76.70%	95.80%	98.40%
	Critical care	Ward 10 (ITU/HDU)	101.60%	55.00%	101.70%	56.70%
	General medicine	Ward 21	85.40%	91.20%	94.40%	97.80%
		Ward 5	92.20%	112.90%	80.00%	141.30%
		Ward 7	78.70%	93.30%	81.50%	88.00%
		Ward 8	87.00%	102.50%	87.50%	100.90%
	General surgery	Ward 14	100.00%	106.60%	120.80%	145.80%
	Geriatric medicine	Ward 20	83.30%	104.20%	96.70%	106.70%
	Trauma & orthopaedics	Ward 9	74.30%	78.10%	78.90%	101.70%
	Rehabilitation	Ward 11a	65.30%	106.30%	87.80%	99.30%
		Ward 11b (Stroke)	87.60%	105.00%	97.80%	130.60%
Rochdale Infirmary	General medicine	Clinical Admissions Unit	112.10%	97.10%	100.00%	118.10%
		Oasis Unit – RI	104.20%	99.40%	96.70%	121.90%
	Intermediate Care	Wolstenholme Unit - RI	98.30%	101.20%	100.00%	97.90%
	Rehabilitation	Floyd Unit	104.10%	108.10%	98.30%	130.80%

Fill rates are calculated as the percentage of day / night-time ward shifts expected to be filled that are actually filled, and averaged over the month for each ward. This is a function of vacancy and sickness rates, as well as admissions

SOURCE: NCA CiC July 2018 pack – June 2018 data

Certain general surgery and ob-gyn wards at ROH are below optimal staffing levels

- Above or at 95% optimal staffing level target
- Below 95% optimal staffing level target but at or above 85%
- Below 85% optimal staffing level

Hospital	Main specialty	Ward	Day		Night	
			Average fill rate - registered nurses	Average fill rate - care staff	Average fill rate - registered nurses	Average fill rate - care staff
Royal Oldham Hospital	Cardiology	Ward CCU	95.80%	220.00%	88.30%	0.00%
	Critical Care	Critical Care	93.70%	89.20%	100.00%	121.90%
	General Medicine	A&E Observation Ward	100.00%	285.70%	100.00%	214.30%
		Ward AMU	78.20%	97.40%	86.70%	108.60%
		Ward FIO	100.00%	112.70%	91.10%	155.90%
		Ward F7	92.90%	100.40%	101.10%	104.60%
		Ward F8	105.80%	98.30%	100.00%	113.80%
		Ward F9	105.00%	88.80%	90.00%	141.10%
		Ward G1	90.60%	107.10%	66.70%	141.30%
	General Surgery	Ward 62	92.30%	91.70%	87.50%	100.00%
		Ward T3	89.50%	100.00%	82.20%	127.40%
		Ward T4 STU	94.80%	115.40%	98.90%	130.20%
		Ward T5	88.30%	101.10%	92.20%	136.10%
		Ward T6	78.10%	74.10%	72.70%	86.20%
		Ward T7	78.80%	106.40%	86.20%	103.30%
	Gynaecology	Ward Fl	84.50%	78.00%	97.00%	100.00%
	Haematology	Ward Fli	89.90%	161.60%	94.50%	173.40%
	Obstetrics	Antenatal Ward	113.30%	126.20%	111.70%	90.00%
		Labour Ward	100.20%	85.80%	105.60%	85.00%
		Neonatal Unit	82.30%	25.80%	76.30%	0.00%
		Postnatal Ward	102.40%	88.50%	115.00%	87.50%
	Paediatrics	Childrens Unit	81.50%	109.20%	90.70%	68.20%

Fill rates are calculated as the percentage of day / night-time ward shifts expected to be filled that are actually filled, and averaged over the month for each ward. This is a function of vacancy and sickness rates, as well as admissions

SOURCE: NCA CiC July 2018 pack – June 2018 data

Certain obstetrics, general surgery and paediatrics wards at NMGH are below optimal staffing levels

- Above or at 95% optimal staffing level target
- Below 95% optimal staffing level target but at or above 85%
- Below 85% optimal staffing level

Hospital	Main specialty	Ward	Day		Night	
			Average fill rate - registered nurses	Average fill rate - care staff	Average fill rate - registered nurses	Average fill rate - care staff
North Manchester General Hospital	Cardiology	Ward CCU 64	84.70%	93.30%	100.00%	100.00%
	Critical Care	Critical Care	94.20%	96.70%	97.00%	106.70%
	Gastro-enterology	Ward D5	93.30%	104.20%	98.30%	100.00%
		Ward D6	92.80%	102.50%	101.50%	100.00%
	General Medicine	Ward C5	102.20%	113.00%	95.00%	133.70%
		Ward C6	97.40%	90.30%	100.00%	101.80%
		Ward E1	93.70%	111.10%	103.30%	205.40%
		Ward F4	95.90%	153.30%	106.70%	138.50%
		Ward H3	96.00%	108.10%	100.00%	129.60%
		Ward I6	98.30%	131.00%	93.30%	121.30%
		Ward J6	97.80%	105.80%	98.30%	135.00%
	General Surgery	Ward C3	104.70%	102.50%	105.00%	146.90%
		Ward C4	58.70%	77.50%	68.30%	76.70%
		Ward F3	89.40%	97.50%	113.30%	101.70%
		Ward F5	89.90%	94.20%	118.30%	96.70%
		Ward F6	92.40%	96.70%	103.30%	101.70%
	Infectious Diseases	Ward J3J4	91.80%	107.50%	97.30%	102.20%
	Obstetrics	Antenatal Ward	84.30%	83.30%	83.30%	106.70%
		Labour Ward	94.60%	58.10%	96.00%	62.70%
		Neonatal Unit	76.70%	89.70%	75.60%	-
		Postnatal Ward	98.70%	96.10%	97.10%	91.10%
	Paediatrics	Childrens	88.50%	49.40%	92.20%	123.50%
	Trauma & Orthopaedics	Ward I5	75.60%	89.80%	101.10%	135.00%
	Urology	Ward STU	71.00%	88.30%	100.00%	96.70%

Fill rates are calculated as the percentage of day / night-time ward shifts expected to be filled that are actually filled, and averaged over the month for each ward. This is a function of vacancy and sickness rates, as well as admissions

SOURCE: NCA CiC July 2018 pack – June 2018 data

Salford Royal has staffing challenges for registered nurse rotas, in particular, across several specialties

Above or at 95% optimal staffing level target

Below 95% optimal staffing level target but at or above 85%

Below 85% optimal staffing level

Hospital	Main specialty	Day		Night	
		Average fill rate - registered nurses	Average fill rate - care staff	Average fill rate - registered nurses	Average fill rate - care staff
Salford Royal Hospital	Acute Stroke Unit	64.85%	91.75%	70.00%	95.74%
	Acute Trauma	89.52%	140.37%	72.69%	175.22%
	Cardiology	78.57%	90.91%	100.00%	125.00%
	Care of the elderly	79.44%	107.58%	100.00%	118.45%
		84.46%	104.88%	91.75%	132.50%
	Critical Care Unit	92.96%	55.90%	78.57%	126.67%
	Dermatology	97.28%	100.00%	100.00%	100.00%
	Emergency Assessment Unit	96.67%	100.00%	95.00%	96.67%
	Gastroenterology	76.99%	90.42%	69.77%	177.27%
	General Surgery	69.62%	80.15%	68.54%	108.40%
		86.36%	140.00%	75.00%	230.00%
		83.45%	95.00%	78.26%	108.33%
	Haematology	64.00%	178.26%	65.22%	1742.86%
	Heart Care Unit	86.22%	88.89%	70.25%	97.44%
	Intestinal Failure Unit	106.91%	79.41%	98.33%	115.87%
	Medical / diabetes	101.31%	98.60%	93.90%	104.65%
	Medical HDU	90.94%	95.26%	81.37%	127.27%
	Neuro Rehab	123.19%	58.93%	92.18%	67.45%
	Neuro surgery & ENT	90.61%	95.24%	74.71%	142.86%
	Neurology	72.15%	83.56%	70.09%	107.44%
		100.00%	101.67%	100.00%	100.00%
		93.30%	87.73%	89.66%	115.79%
	Neurosurgery	110.26%	100.60%	75.56%	102.16%
		59.06%	77.32%	89.66%	97.99%
	Programmed Investigation Unit	80.96%	105.68%	86.54%	110.65%
	Renal	86.12%	97.01%	100.00%	100.00%
	Respiratory	79.44%	87.22%	75.83%	133.90%
	Stroke	70.33%	84.07%	76.52%	114.86%
	Stroke Rehab Unit	71.43%	91.30%	100.00%	98.98%
	Sub-Acute Care (Pendleton Suite)	-	-	-	-
	Surgery	93.41%	103.85%	97.78%	109.68%
	Surgical HDU	66.43%	90.66%	86.67%	100.81%
	Surgical Triage Unit	100.00%	98.31%	100.00%	100.00%
	Trauma Orthopaedics	97.91%	93.21%	96.67%	100.00%
	Trauma Rehab	83.63%	105.68%	100.00%	93.18%
	Urology	65.66%	118.92%	71.11%	132.97%

Fill rates are calculated as the percentage of day / night-time ward shifts expected to be filled that are actually filled, and averaged over the month for each ward. This is a function of vacancy and sickness rates, as well as admissions

SOURCE: NCA CiC July 2018 pack – June 2018 data

North West Ambulance Service quality assessment

Requires improvement · Inadequate · Outstanding · Good

NWAS – covers Greater Manchester, Cheshire, Merseyside, Cumbria & Lancashire

Latest inspection in Jun 2016, reported Jan 2017

Overview

Overall **Requires Improvement**

Safe?	Requires improvement
Effective?	Good
Caring?	Good
Responsive?	Good
Well-led?	Requires improvement

Ratings of specific services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Patient transport services (PTS)	Good	Good	Good	Good	Requires Improvement	Good
Emergency operations centre (EOC)	Requires Improvement	Good	Good	Good	Good	Good
NHS 111 service	Good	Good	Good	Good	Good	Good

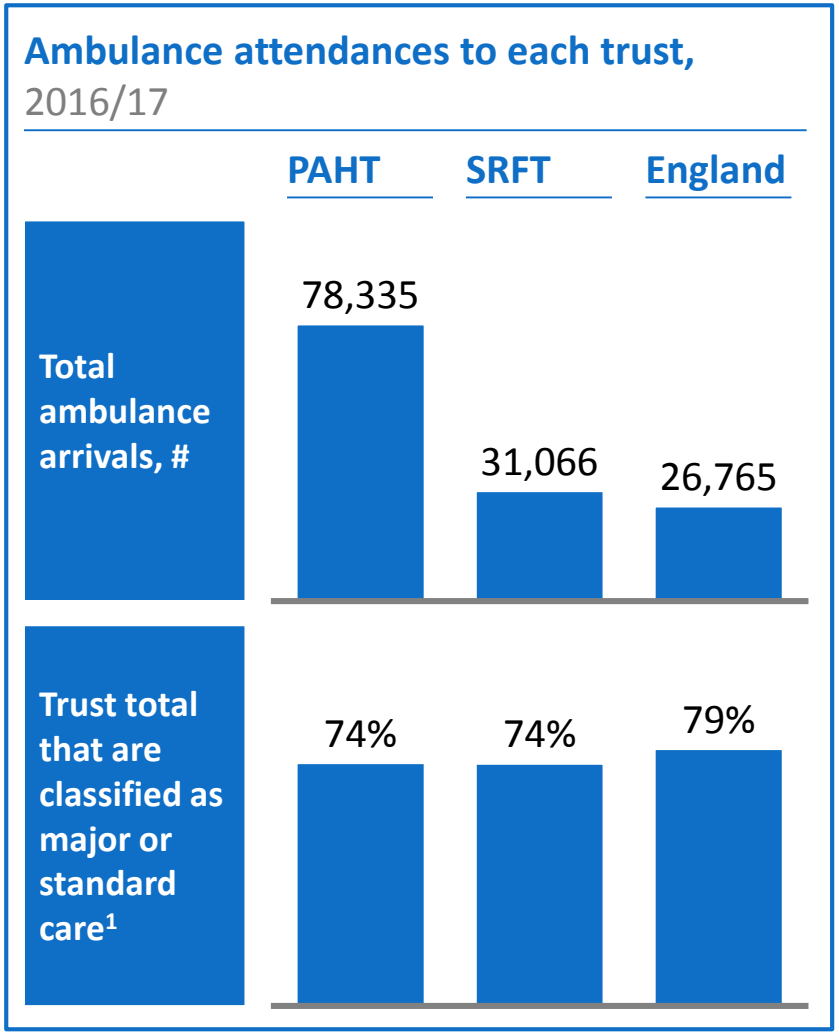
Specific recommendations

- Review the process for pre-alerting hospital accident and emergency departments to make sure that communication is sufficient for the receiving department to be made fully aware of the patient's condition
- Make sure that emergency operations centre staff across all three emergency operation centres (EOCs) are consistently identifying and recording incidents as
- Improve access to clinical supervision for all clinical staff
- Ensure all staff receive the mandatory training necessary for their role

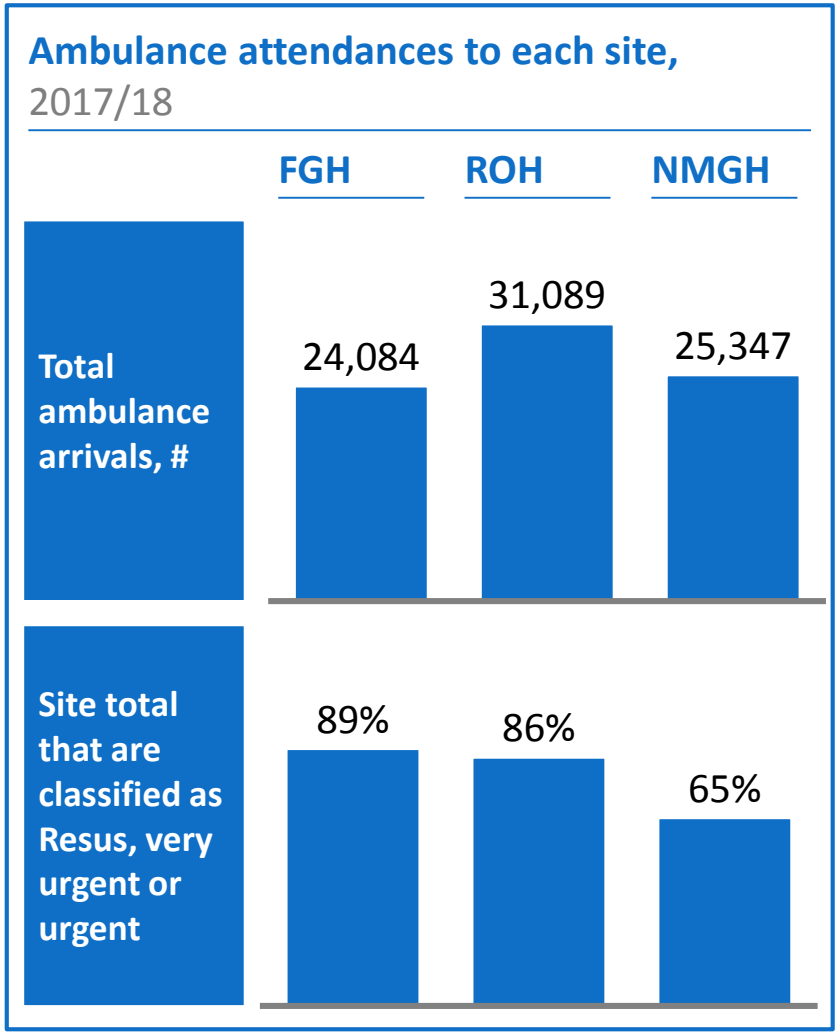
SOURCE: CQC website

Ambulance activity to each of the NES and Salford sites

Ambulance attendances to each trust, 2016/17



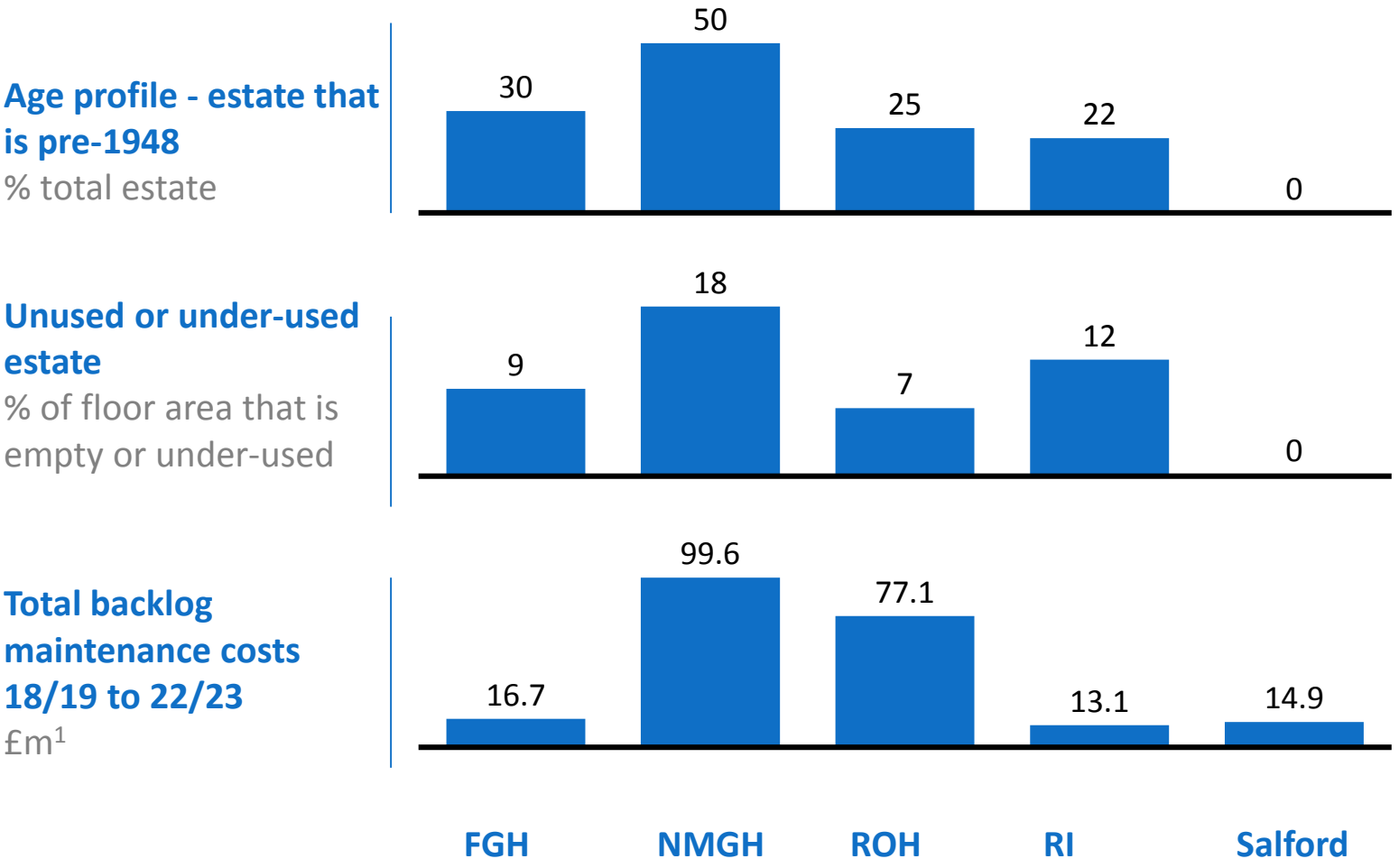
Ambulance attendances to each site, 2017/18



1 Defined for Salford, PAHT overall and England average based on HRGs VB01Z-VB08Z

SOURCE: Pennine Acute Trust data, 2018; HES A&E M13 2016/17 data, c/o NHS Digital

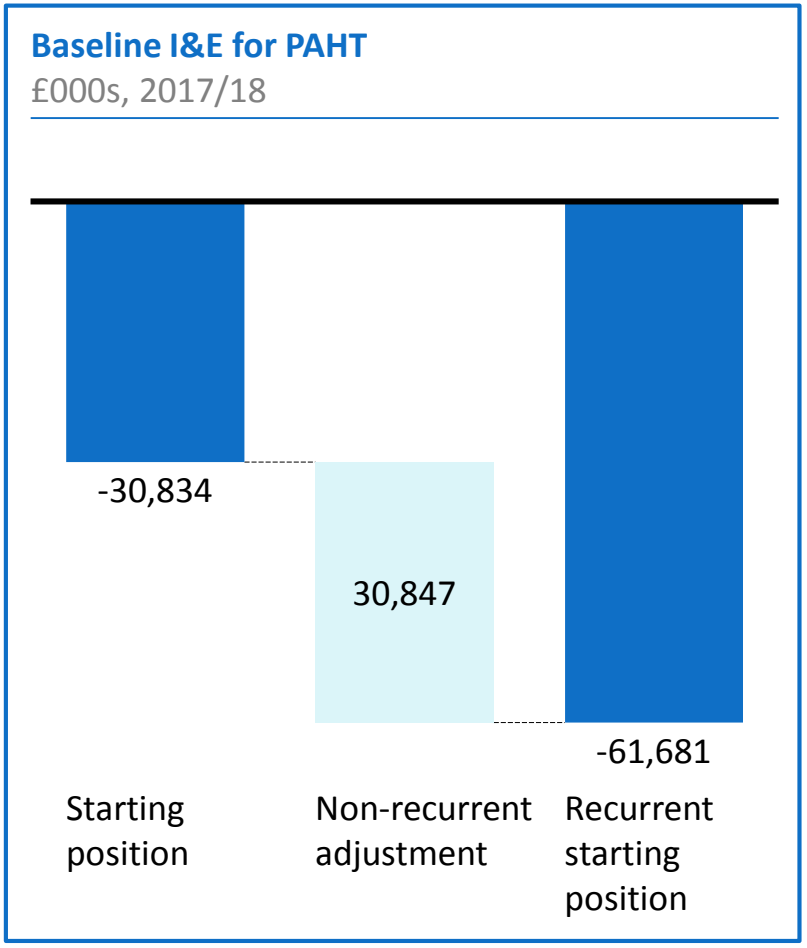
NM, in particular, does not use estate as efficiently as other sites, and has substantial backlog maintenance costs of nearly £100m

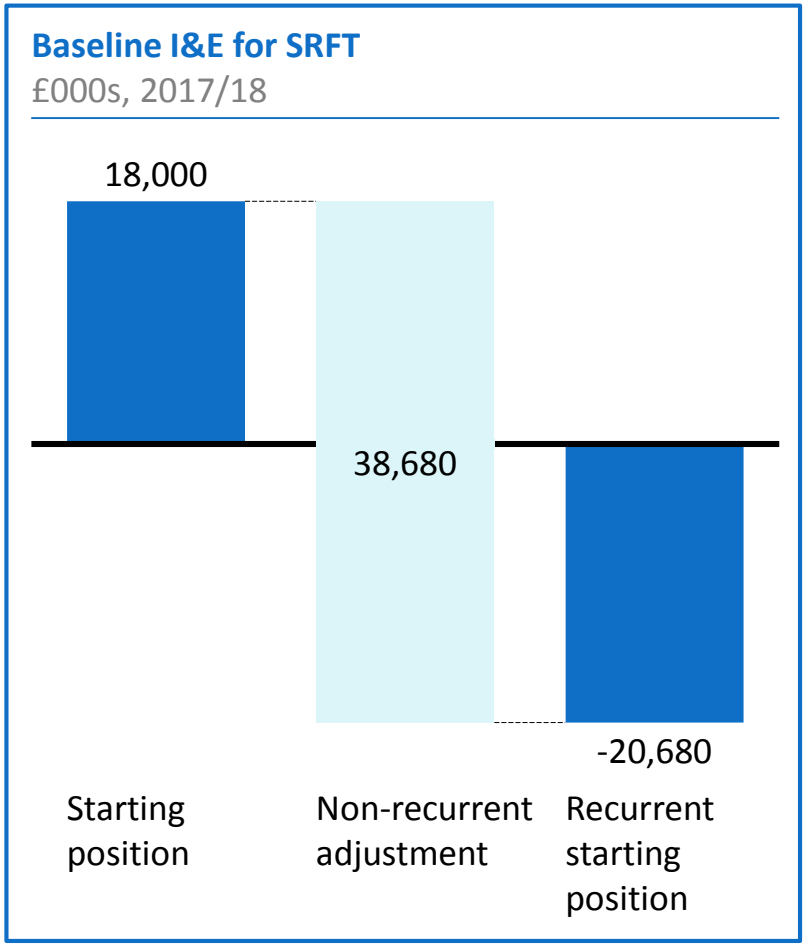


1 Data for Pennine sites is based on a Capita review for backlog over the next six years; data for Salford site is based on ERIC 17/18 returns

SOURCE: ERIC 17/18 and Capita review of Pennine sites

Both Trusts have underlying financial deficits





SOURCE: Provider and Commissioner model, GM Theme 3

Contents

Section summary

Focus of today's discussions

- Changes to consolidate activity at sites have already been agreed for certain services
- The Healthier Together business case (2015) has already recommended that some services, e.g. general surgery, move in order to capture the benefits to clinical quality, workforce and financial sustainability from delivering services at scale
- Further consolidation may deliver similar improvements in other fragile services as well as the use of estate that provides a better care experience for both patients and staff

Fairfield General Hospital profile

Current situation

- Fairfield General Hospital (FGH) is part of the Bury & Rochdale CO
- FGH has already been significantly reconfigured
- It predominantly provides medical and elective surgery and specialises in stroke, cardiology, ENT and orthopaedics, providing these services for the PAHT (Pennine Acute Hospital Trust) element of the NCA (Northern care Alliance)
- FGH does not provide acute or non-elective surgery, trauma, inpatient paediatrics or maternity, or gastroenterology

Rationale for change

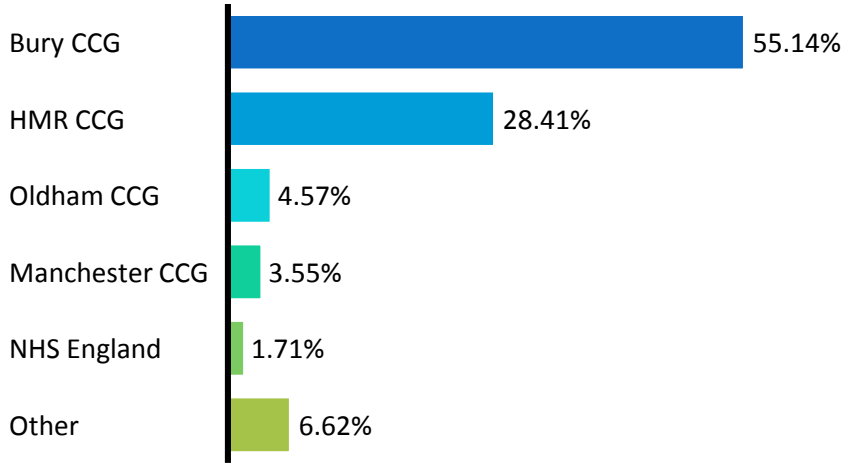
- Bury, Oldham and Rochdale locality plans and Transformation Fund bids propose major shift of activity away from FGH, which could reduce activity to a level that could potentially result in:
  - Lower quality of care due to a lack of opportunity for workforce to maintain skills
  - Higher costs due to underutilised estate and workforce
- Critical care service is provided at both FGH and ROH, where rotas are linked, and which has seen both quality and workforce sustainability issues with a consultant shortfall and very low care staff fill rates
- There is an opportunity to maximise use of capacity at FGH as part of shared hospital services across NCA

Key facts about the site

Fairfield key facts, 2017/18

Number of beds	282 acute beds; 0 other beds & trolleys[1]
Inpatient spells	NEL: 35,434; EL: 2,234
A&E attendances	71,449
Number of day cases	15,006
Number of outpatients	117,162

Fairfield activity split, all activity[2], 2016/17, NES = 87%



1 Includes maternity beds, paediatric beds, and daycase trolleys
2 Includes OP attendances, A&E attendances and admissions
SOURCE: Pennine Acute Hospitals NHS Trust annual report 2016/17; Pennine Trust Bed Stock 2018

Rochdale Infirmary profile

Current situation

- Rochdale Infirmary is part of the Bury & Rochdale CO and has a partnership with Rochdale Health Alliance to support the delivery of improved primary care services
- Rochdale was significantly reconfigured as part of the Healthy Futures reconfiguration across Pennine Acute and the North East Sector including North Manchester
- It now provides an urgent care centre and clinical assessment unit, a small number of inpatient medical beds, 23-hour day case provision, ophthalmology for the North East Sector, rheumatology and respiratory services and range of outpatient services. It has developed an innovative rehabilitation service with intermediate care, integrated community teams (neighbourhood based), the OASIS unit which is an inpatient facility for people with acute illness and dementia
- It no longer provides NEL Surgery, Trauma, A&E, Paediatrics, or Maternity and has a very small number of inpatient medical beds

Rationale for change

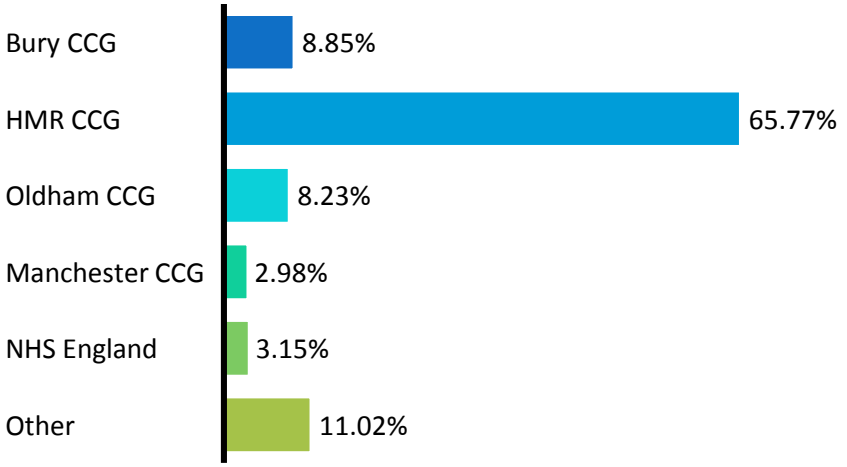
- Significant change has already happened at RI and the site currently functions well
- The Bury and Rochdale Care Organisation will host the Rochdale Local Care Organisation and this presents further opportunities to integrate health and social care community and acute services more effectively, manage patients with long-term conditions more effectively and further strengthen the partnerships with primary care, the VCSE and mental health services
- Innovative models such as the OASIS unit and the Wolstenholme unit could be replicated across other sites in NCA

Key facts about the site

Rochdale key facts, 2017/18

Number of beds	16 acute beds; 51 other beds & trolleys[1]
Inpatient spells	NEL: 3,373; EL: 178
A&E attendances	51,666
Number of day cases	25,533
Number of outpatients	137,764

Rochdale Infirmary activity split, all activity[2] 2016/17, NES = 83%



1 Includes maternity beds, paediatric beds, and daycase trolleys
2 Includes OP attendances, A&E attendances and admissions
SOURCE: Pennine Acute Hospitals NHS Trust annual report 2016/17; Pennine Trust Bed Stock 2018

Royal Oldham Hospital profile

Current situation

- The Royal Oldham Hospital (ROH) is part of the Oldham CO
- ROH will be a high acuity site inclusive of a trauma unit in addition to being a local general hospital, with a revised front end with A&E, streaming to primary care, AMU and ambulatory care
- It is the designated Healthier Together hub site for the North East Sector (NES) and will therefore see an increase in General Surgery emergency and high-risk patients – for which it has received capital investment
- Christie services are available from ROH as well as full critical care, maternity, centralised pathology for the NES, gynaecology services and paediatrics including a NICU

Rationale for change

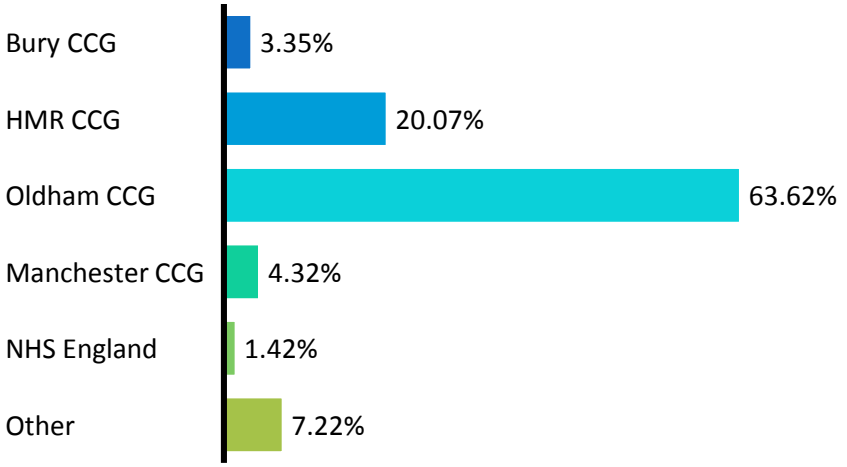
- Locality plans and Transformation Fund bids propose deflecting activity away from acute services at ROH through a greater focus on preventing ill health and delivering more out-of-hospital care
- This will be great for improving population health outcomes in Oldham; however, it may result in subscale activity in certain acute service lines. This in turn could result in:
  - Lower quality of care due to a lack of opportunity for workforce to maintain skills
  - Higher costs due to underutilised estate and workforce
- In particular, critical care, which shares rotas with FGH, is already experiencing quality challenges as revealed by a recent CQC inspection and ICNARC report

Key facts about the site

Royal Oldham key facts, 2017/18

Number of beds	382 acute beds; 181 other beds & trolleys[1]
Inpatient spells	NEL: 60,554; EL: 4,683
A&E attendances	106,924
Number of day cases	17,287
Number of outpatients	204,480

Royal Oldham activity split, all activity[2] 2016/17, NES = 87%



1 Includes maternity beds, paediatric beds, and daycase trolleys
2 Includes OP attendances, A&E attendances and admissions
SOURCE: Pennine Acute Hospitals NHS Trust annual report 2016/17; Pennine Trust Bed Stock 2018

North Manchester General Hospital profile

Current situation

- North Manchester General Hospital (NMGH) is part of the North Manchester CO
- The NMGH site is due to be acquired MFT, and will no longer be part of PAHT
- MHCC intend to utilise the site for much of its current provision as well as a health and well-being hub and mental health services. The site is undergoing master planning to identify other potential uses including educational facilities and housing options
- Its services are used by Manchester residents as well as by Bury and HMR patients as well. Some services on the site provide services to all the Pennine population such as diagnostics and urology. About 57% of activity on the site is outside of North Manchester

Rationale for change

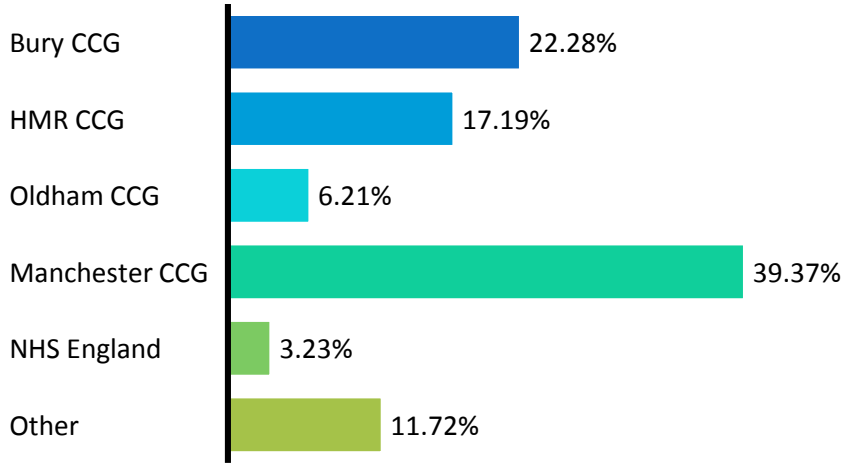
- There have been challenges with estate at NM:
  - In June, four theatres in the older part of the hospital were closed for safety reasons with most displaced activity being absorbed within the remaining nine theatres
  - A further two theatres will be in need of replacement in 18 months
- However, change at this site will be out of scope of the NES service strategy – nonetheless, agreed and possible future changes will impact PAHT sites
- For example, all high acuity general surgery activity will transfer to ROH as agreed in the Healthier Together consultation while other services are part of the GM Theme 3 review and will be reconfigured as a result of new care models

Key facts about the site

North Manchester key facts, 2017/18

Number of beds	370 acute beds; 137 other beds & trolleys[1]
Inpatient spells	NEL: 45,351; EL: 4,740
A&E attendances	101,645
Number of day cases	12,534
Number of outpatients	227,207

North Manc General activity split, all activity[2] 2016/17, NES = 46%



1 Includes maternity beds, paediatric beds, and daycase trolleys
2 Includes OP attendances, A&E attendances and admissions
SOURCE: Pennine Acute Hospitals NHS Trust annual report 2016/17; Pennine Trust Bed Stock 2018

Salford Royal Hospital profile

Current situation

- Salford Royal is part of a fully integrated care organisation, Salford CO, which brings together adult social care, mental health, community and acute services
- Provides medical and surgical services for the local Salford population with elective orthopaedic services at the Manchester Elective Orthopaedics Centre
- Designated Healthier Together high acuity site for General Surgery for the North West Sector (NWS)
- Provides a range of GM services including GM Neurosciences Centre; GM Major Trauma services (adult); GM Comprehensive Stroke Centre; and specialised services in Dermatology, Renal, and Intestinal Failure
- Designated GM site for the Oesophageal Cancer surgery and is one of the two North West providers of bariatric surgery
- Hosts The Christie Radiotherapy services
- Does not provide maternity, IP paediatric, elective breast surgery services or opthamology – these are provided at Bolton

Rationale for change

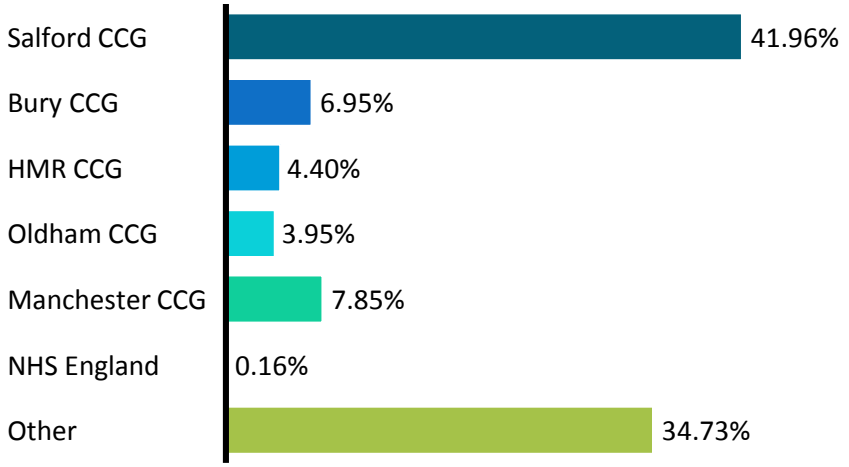
- Salford Royal has scored outstanding on its recent inspection by the CQC for the second time
- However, the site is facing some challenges, particularly operational and workforce challenges:
  - Operational: A&E waiting time and diagnostic waiting time performance has been deteriorating
  - Workforce: ward shift fill rates for registered nurses are consistently below target levels

Key facts about the site

Salford Royal key facts, 2017/18

Number of beds	792 acute beds; 32 other beds & trolleys[1]
Inpatient spells	NEL: 68,527; EL: 10,971
A&E attendances	100,586
Number of day cases	47,831
Number of outpatients	556,630

Salford Royal activity split, all activity[2] 2016/17, NES = 15%



1 Includes maternity beds, paediatric beds, and daycase trolleys
2 Includes OP attendances, A&E attendances and admissions
SOURCE: NCA CiC July 2018 pack; Bed Availability and Occupancy, NHS England Q1 2018/19; NCA activity model

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Agenda Item 7

REPORT TO HEALTH SCRUTINY COMMITTEE

TITLE:	**Care Act 2014 Policies**
DATE OF MEETING:	**Health Scrutiny Committee – 8th November 2018**
REPORT FROM:	**Shirley Allen/Helen Marrow**
CONTACT OFFICER:	**Shirley Allen**

1. INTRODUCTION

1.1 The Care Act 2014 is the biggest change to English adult social care law in over 60 years, reforming the law relating to care and support for customers and carers. The Care Act became effective from 1st April 2015 and replaces a number of different pieces of legislation with a single modern law and a new legal framework that affects how Councils support people with care and support needs and carers.

1.2 The Care Act introduced a number of significant changes to how care is charged for, who may have to contribute and how much people will have to pay towards their care.

2. SUMMARY

2.1 As a result of the implementation of the Care Act, Bury Council have reviewed and refreshed the following key operational policies and produced an internal staff Personal Budget guidance document.

- Assessment and Eligibility Policy
- Charging and Financial Assessment Policy
- Personal Budget Policy
- The Residential Care Top Up Policy is a new policy that has been developed as a result of the legislation and will require processes and pathways to be established prior to implementation.

- Personal Budget Policy Staff Guidance (for internal use only)

2.2 There will be a staff and budget resource requirement to implement the changes, this amounts to £ £46,284 and will be funded temporarily, in the first instance for 12 months from obtaining policy approval.

2.3 Work is underway to develop the pathways and processes required for implementation, and it is expected this will be completed by January 2019.

2.4 On completion of this development work the policies, processes and pathways will be published and implemented.

2.5 A copy of each of the policies can be found in background papers item 1.

2.6 Detailed Care Act 2014 guidance can be found in the link in background papers item 3.

3. KEY POLICY CHANGES

3.1 To introduce a national eligibility criteria which will apply to all councils in England.

3.2 Replacement care is a significant part of the Act, this has now to be incorporated into the customers support plan and financially assessed accordingly.

3.3 People who only receive a Day Service will now be asked to pay a charge but will have the opportunity to have a financial assessment of their ability to pay.

3.4 To remove from the calculation an allowance of the amount between the Disability Living Allowance (DLA) higher/middle rate where night sitting services are not received.

3.5 The charge and financial assessment will be worked out against 100% of the value of the personal budget package.

3.6 People who receive more than one carer at the same time may now be required to pay an increase in charges.

3.7 In relation to residential care top up charges- a person (third party) agreeing to pay the extra amount will have to sign a legal agreement with the Council, agreeing to meet the extra costs and agreeing to provide details of their personal information.

3.8 A full list of the Care Act changes can be found in background papers item 5.

4. CHANGES AS A RESULT OF IMPLEMENTATION OF THE POLICIES?

4.1 The key changes will have an impact both in terms of Council and customer resources, the implications for council resources have now been scoped, all of the changes and their possible impact are provided in full detail below;

4.2 **Assessment and Eligibility Policy**

4.2.1 To introduce a national eligibility criteria which will apply to all councils in England. This will bring consistency as everybody will be subject to the same determination wherever they live in England. This has been implemented since May 2015. All assessment officers have received appropriate training but this is now being reviewed in the light of strengths based assessment transformation activity.

4.2.2 All carers to be offered an assessment and the development of a national eligibility criteria for carers which will apply to all councils in England. Although Bury has always undertaken carers assessments, some councils do not.

4.2.3 Specialist assessments must be provided for people with autism and adults who are deaf blind. This now applies across England. Bury is already doing this.

4.2.4 Council has to ensure there is an appropriate individual who can facilitate involvement in the assessment process for people who would have substantial difficulty, if no suitable individual is available the Council must facilitate access to an independent advocate. There is an advocacy service in place for Bury which can also be accessed by carers in their own right.

4.3 **Replacement Care**

4.3.1 Replacement care is a significant part of the Act, which removes the ability to have services delivered to a customer on the basis of a carers' assessment. This has now to be incorporated into the customers support plan and financially assessed accordingly.

4.3.2 This will impact upon all current carers who have replacement care on their support plans although in most cases this will be transferred to the cared for support plan with no changes to services or additional payments. If a cared for person has been financially assessed and has reached the maximum contribution they can pay towards services there will be no additional payments.

4.3.3 This has applied to all new customers since May 2015 and the majority of existing customers have now had an annual review and replacement care has been transferred across to the cared for support plan.

4.4 **Charging and Financial Assessment Policy**

4.4.1 Social Care services are not free and the Government expects councils to charge and collect income to help provide these services. Social Care Services might include, for example, care at home, day services, or residential care services. The Council has to make sure that it follows the rules that the Government has set in the Care Act 2014.

4.4.2 People who only receive a Day Service will now be asked to pay a charge but will have the opportunity to have a financial assessment of their ability to pay. Some people will already be paying their individual maximum amount if they are receiving other services and have already had a financial assessment. Therefore they will pay no more. Some people will already be receiving services with no charge because of the result of their financial assessment. This will not change.

4.4.3 To remove from the calculation an allowance of the amount between the Disability Living Allowance (DLA) higher/middle rate where night sitting services are not received. This allowance will now be removed from the financial assessment and this may increase charges for some people. We have already been doing this for new customers or at a change in circumstances since May 2015.

4.4.4 The charge and financial assessment will be worked out against 100% of the value of the personal budget package. People whose elements of the support plan are not personal care will now be charged, previously these non - personal care elements were left out of the financial calculations.

4.4.5 Charges will be for the total time for all carers required to carry out the task. People who receive more than one carer at the same time may now be required to pay an increase in charges, people with only one carer or who already pay the maximum financially assessed amount will not be affected.

4.5 **Residential Care Top Up Policy**

4.5.1 The person (third party) agreeing to pay the extra amount will have to sign a legal agreement with the Council, agreeing to meet the extra costs and agreeing to provide details of their personal information. This will affect people who have agreed to meet the extra costs on behalf of a resident in a care home, that charges more that the agreed rate, where previously the person contracted directly with the care home but will now contract with the Council.

4.5.2 The person (third party) must provide financial details, if the required Top-Up Fee is more than £50.00 per week to confirm they have;

4.5.3 At least 3 year's worth of savings to cover the extra costs, or they have;

4.5.4 Enough weekly income above this weekly expenditure to meet the extra costs. This calculation and the process are new and pathways and procedures will need to be developed once the policies are approved.

4.5.6 To introduce a way of calculating that the person (first party) living in the care home can pay this extra cost themselves, this is usually only when they have a house to sell. Checks will need to be made that there is enough capital within the property to offset the additional costs for at least 3 years.

4.6 **Personal Budget Policy**

4.6.1 Clarifies the amounts allowed to be spent from the personal budget to purchase services needed, the budget will be generated using a series of established fees and will apply to all people who receive direct payments. This makes sure it is fair and consistent approach compared with those people who chose to have their services provided to them by the Council. Further details are contained in the appendices of the Personal Budget Policy.

4.6.2 If a person chooses a service at a higher rate it must be identified who will be willing and able to meet the additional costs. This will apply to all people receiving direct payments who choose services higher than standard rate. This makes sure it is a fair and consistent approach compared with those people who choose to have their services provided to them by the Council.

5. THE ENGAGEMENT PROCESS

5.1 A steering group was set up to look at how Bury Council could communicate these impending changes to as many people as possible in Bury, including current customers, providers and the wider general public.

5.2 The engagement exercise began in the second week of September 2017 and ran until the 18th of January 2018. The following engagement methods were used;

5.3 An engagement booklet was produced with details of the process, all of the changes, how people could let us know about any particular issues, details of a number of public drop in sessions and where further information could be found. The engagement booklet was designed to allow people to contact us to let us know their thoughts and was designed so that it could be folded up and sealed and returned postage paid to the Council. Details of the engagement booklet can be found in background papers item 4.

5.4 5000 hard copies of the engagement booklet were designed and printed and 4500 were distributed to various sources.

5.5 Hard copies of the engagement booklet were sent through the post to current customers and carers, or their nominated representatives, where we had the information on our systems.

5.6 Hard copies were also made available at all libraries, the Town Hall, Knowsley Place, Whittaker Street and Humphrey House reception areas, Connect and Direct Hub and the Carers Centre on Silver Street.

5.7 Hard copies were also provided to social care assessment staff. Social care assessment staff were provided with information about the engagement process at least two weeks before commencement so that they would be able to respond to any issues that arose as part of their day to day duties.

5.8 The engagement booklet, draft copies of the four policies and the Care Act guidance were available to read or download on the Bury Directory.

5.9 Comments could also be provided on line through survey monkey, the link to the survey was widely advertised amongst partners and all council staff and via social media by the Social Development Team.

5.10 A designated telephone line was provided and advertised widely so that people could contact the Council if they had any queries, wanted copies of the draft policies, or needed the information in a different format. A number of people used this method to find out how the changes in policies would affect them personally.

5.11 A number of public drop in sessions, one in each township, were held where people could drop in and find out more. Most of the people attending the drop ins wanted to know how the changes would impact upon them personally.

5.12 Appropriate staff also attended a number of targeted forums where the changes were discussed in detail. One coffee morning at the Carers Centre where over 50 carers attended, one session at the Carers Forum at which over 40 people were in attendance, two provider forums.

5.13 Officers also attended other forums that were already booked and initiated discussions around the changes.

5.14 All Bury Council staff with internet access were sent an electronic copy of all of the engagement information and given the opportunity to feed back any comments.

5.15 Electronic information was sent to all care at home, residential and nursing and supported living providers registered with Bury Council, to Bury Clinical Commissioning Group for distribution to their staff, Bury Dementia Action Alliance members and to the local Dementia Champions network.

5.16 **Numbers of people engaged with over the period;**

- 45 people attended drop in sessions set up at Radcliffe Library, Elms Community Centre, Ramsbottom Centre, Elton Community Centre, The Mosses Centre and the Green Room Textile Hall.
- 2 provider forums were held at which 60 representatives from various providers attended.
- Over 110 people attended the two carers events.
- The dedicated phone line received 34 calls and 40 responses were received back from either online survey monkey or hard copies sent pre - paid back to the Council.
- The Bury Directory received 447 views between 1st September to 31st December 2017 which was up by 200.65% on the site average

5.17 **Feedback Received**

5.18 The majority of people who contacted the Council or attended an event wanted to know how the changes would affect them personally. Where this was the case officers contacted them personally and discussed these issues in private.

5.19 The most common themes from the drop ins were;

- People's concerns about Residential Care Top Ups and the financial checks that would be required to check sustainability.
- A number of people wanted to let us know that they were currently being charged a top up by care homes for their relatives.
- Just to note that at every session, excepting the provider forums we received comments/complaints about this.

5.20 **Other common themes that were discussed were;**

- Charges for day care, charges for 2 carers and replacement care.

- A number of people were concerned about the changes to DLA and PIP and how this may result in them having to pay more for services.

6. EQUALITY AND DIVERSITY

6.1 The Care Act 2014 was bought into legislation in order to offer clearer more equitable access to social care and services. Many of the changes to policies will ensure that customers for whom the Council commissions services will be treated equally to those for whom the Council provides a personal budget to buy their own services as the funding available to a customer will be formulated from the same fee baselines as detailed in the Charging and Financial Assessment Policy appendices.

6.2 In relation to the Assessment and Eligibility process all cared for customers and carers will be subject to the same eligibility criteria across England no matter where they live.

6.3 In relation to the Residential Care Top Up policy this is expected to ensure that all customers are treated fairly in relation to additional charges set by Residential Care Homes and that there is a transparent system in place so that customers who choose to have an enhanced service from a provider know exactly what they are being charged extra for. All EIAs are included in the background papers for further information.

6.4 Equality Impact Assessments for each of the policies can be found in background papers item 2.

7. RISK

7.1 The full financial implications of the legislative changes have not yet been fully scoped. Each customer is treated individually under the personalisation agenda and as such will have to be individually assessed to assess personal impact. There are a number of variations to be assessed including type and complexity of services provided and personal income that will be subject to financial assessment.

8. FUTURE PLANS AND PRIORITIES

8.1 An implementation plan has been drawn up highlighting all of the key actions that need to take place between now and January 2019 (item 6 in the background papers).

List of Background Papers:-

1. Policies for Approval


Eligiblity and Assessment Policy FI


Charging and Financial Assessmen


Personal Budget Policy - Staff Guidan


Personal Budget Policy v0.13 May201


Residential Care Top Up policy v0.7 M

2. Equality Impact Assessments


Equality Analysis - Charging and Financi


EA - Equality Analysis Form Care A


Equality Analysis Residential Care Top


EA - Equality Analysis Form Perso

3. Link to the Care Act 2014 Guidance
https://www.gov.uk/government/publications/care-act-statutory-guidance

4. Care Act Engagement Booklet


40087 Bury Council questionaire bookle

5 Full list of changes to business processes required


Appendix 1 full list of changes.docx

6. Care Act Policy Implementation Plan


Copy of Copy of Care Act Policy Impl

Contact Details:-

Shirley Allen
Project Lead
Communities and Wellbeing - Strategic Development Unit
S.Allen@bury.gov.uk
0161 253 6302

Care Act 2014

The Care Act 2014 is the biggest change to English adult social care law in over 60 years, reforming the law relating to care and support for customers and carers.

The Care Act became effective from 1st April 2015 and replaces a number of different pieces of legislation with a single modern law and a new legal framework that affects how councils support people with care and support needs and carers.

As a result of the implementation of the Care Act, We have reviewed and refreshed the following key operational policies and produced an internal staff Personal Budget guidance document.

MAKING CHANGES FOR A BETTER BURY

Care Act 2014

2 revised and refreshed policies

Charging and Financial Assessment Policy

Personal Budget Policy

2 new policies

Residential Care Top Up Policy

Assessment and Eligibility Policy

1 Personal Budget Policy staff guidance document

MAKING CHANGES FOR A BETTER BURY

What is the Care Act trying to Achieve?

That care and support:

- is clearer and fairer
- promotes people's wellbeing
- enables people to prevent and delay the need for care and support, and carers to maintain their caring role
- puts people in control of their lives so they can pursue opportunities to realise their potential

MAKING CHANGES FOR A BETTER BURY

Framework of the Act

Underpinning Principle

Wellbeing

General responsibilities and key duties

Prevention
Integration, Partnerships and transitions
Information, advice and advocacy
Diversity of provision and market oversight
Safeguarding

Key Processes

Assessment and eligibility
Charging and financial assessment
Care and support planning
Personal budgets and direct payments
Review

MAKING CHANGES FOR A BETTER BURY

Changes to Assessment and Eligibility

To introduce a national eligibility criteria which will apply to all councils in England. This will bring consistency as everybody will be subject to the same determination wherever they live in England. This has been implemented since May 2015. All assessment officers have received appropriate training but this is now being reviewed in the light of strengths based assessment transformation activity.

All carers to be offered an assessment and the development of a national eligibility criteria for carers which will apply to all councils in England. Although Bury has always undertaken carers assessments, some councils do not.

Specialist assessments must be provided for people with autism and adults who are deaf blind. This now applies across England. Bury is already doing this

Council has to ensure there is an appropriate individual who can facilitate involvement in the assessment process for people who would have substantial difficulty, if no suitable individual is available the Council must facilitate access to an independent advocate. There is an advocacy service in place for Bury which can also be accessed by carers in their own right.

MAKING CHANGES FOR A BETTER BURY

Replacement Care

Replacement care is a significant part of the Act, which removes the ability to have services delivered to a customer on the basis of a carers' assessment. This has now to be incorporated into the customers support plan and financially assessed accordingly.

This will impact upon all current carers who have replacement care on their support plans although in most cases this will be transferred to the cared for support plan with no changes to services or additional payments. If a cared for person has been financially assessed and has reached the maximum contribution they can pay towards services there will be no additional payments.

This has applied to all new customers since May 2015 and the majority of existing customers have now had an annual review and replacement care has been transferred across to the cared for support plan.

MAKING CHANGES FOR A BETTER BURY

Charging and Financial Assessment Policy

Social Care services are not free and the Government expects councils to charge and collect income to help provide these services. Social Care Services might include, for example, care at home, day services, or residential care services. The Council has to make sure that it follows the rules that the Government has set in the Care Act 2014.

People who only receive a Day Service will now be asked to pay a charge but will have the opportunity to have a financial assessment of their ability to pay. Some people will already be paying their individual maximum amount if they are receiving other services and have already had a financial assessment. Therefore they will pay no more. Some people will already be receiving services with no charge because of the result of their financial assessment. This will not change.

To remove from the calculation an allowance of the amount between the Disability Living Allowance (DLA) higher/middle rate where night sitting services are not received. This allowance will now be removed from the financial assessment and this may increase charges for some people

The charge and financial assessment will be worked out against 100% of the value of the personal budget package. People whose elements of the support plan are not personal care will now be charged, previously these non - personal care elements were left out of the financial calculations.

Charges will be for the total time for all carers required to carry out the task. People who receive more than one carer at the same time may now be required to pay an increase in charges, people with only one carer or who already pay the maximum financially assessed amount will not be affected.

MAKING CHANGES FOR A BETTER BURY

Residential Care Top Up Policy

The person (third party) agreeing to pay the extra amount will have to sign a legal agreement with the Council, agreeing to meet the extra costs and agreeing to provide details of their personal information. This will affect people who have agreed to meet the extra costs on behalf of a resident in a care home, that charges more that the agreed rate, where previously the person contracted directly with the care home but will now contract with the Council.

The person (third party) must provide financial details to confirm they have;

At least 3 year's worth of savings to cover the extra costs, or they have enough weekly income above this weekly expenditure to meet the extra costs. This calculation and the process are new and pathways and procedures will need to be developed.

To introduce a way of calculating that the person (first party) living in the care home can pay this extra cost themselves, this is usually only when they have a house to sell. Checks will need to be made that there is enough capital within the property to offset the additional costs for at least 3 years.

MAKING CHANGES FOR A BETTER BURY

Personal Budget Policy

Clarifies the amounts allowed to be spent from the personal budget to purchase services needed, the budget will be generated using a series of established fees and will apply to all people who receive direct payments. This makes sure it is fair and consistent approach compared with those people who chose to have their services provided to them by the Council. Further details are contained in the appendices of the Personal Budget Policy

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MAKING CHANGES FOR A BETTER BURY

The Engagement Process - 1

The engagement exercise began in the second week of September 2017 and ran until the 18th of January 2018. The following engagement methods were used.

An engagement booklet was produced with details of the process, all of the changes, how people could let us know about any particular issues, details of a number of public drop in sessions and where further information could be found.

5000 hard copies of the engagement booklet were designed and printed and 4500 were distributed to various sources including through the post to current customers and carers, or their nominated representatives, where we had the information on our systems.

Hard copies were also made available at all libraries, the Town Hall, Knowsley Place, Whittaker Street and Humphrey House reception areas, Connect and Direct Hub and the Carers Centre on Silver Street.

The engagement booklet, draft copies of the four policies and the Care Act guidance were available to read or download on the Bury Directory.

Comments could also be provided on line through survey monkey, the link to the survey was widely advertised amongst partners and all council staff and via social media by the Social Development Team

A designated telephone line was provided and advertised widely so that people could contact the Council if they had any queries, wanted copies of the draft policies, or needed the information in a different format. A number of people used this method to find out how the changes in policies would affect them personally.

MAKING CHANGES FOR A BETTER BURY

The Engagement Process - 2

A number of public drop in sessions, one in each township, were held where people could drop in and find out more. Most of the people attending the drop ins wanted to know how the changes would impact upon them personally.

Appropriate staff also attended a number of targeted forums where the changes were discussed in detail. One coffee morning at the Carers Centre where over 50 carers attended, one session at the Carers Forum at which over 40 people were in attendance, two provider forums.

Officers also attended other forums that were already booked and initiated discussions around the changes.

All Bury Council staff with internet access were sent an electronic copy of all of the engagement information and given the opportunity to feed back any comments.

Electronic information was sent to all care at home, residential and nursing and supported living providers registered with Bury Council, to Bury Clinical Commissioning Group for distribution to their staff, Bury Dementia Action Alliance members and to the local Dementia Champions network.

MAKING CHANGES FOR A BETTER BURY

The Engagement Process - 3

45 people attended drop in sessions set up at Radcliffe Library, Elms Community Centre, Ramsbottom Centre, Elton Community Centre, The Mosses Centre and the Green Room Textile Hall.

2 provider forums were held at which 60 representatives from various providers attended

Over 110 people attended the two carers events.

The dedicated phone line received 34 calls and 40 responses were received back from either online survey monkey or hard copies sent pre - paid back to the Council.

The Bury Directory received 447 views between 1st September to 31st December 2017 which was up by 200.65% on the site average

The majority of people who contacted the Council or attended an event wanted to know how the changes would affect them personally. Where this was the case officers contacted them personally and discussed these issues in private.

The most common themes from the drop ins were;

People's concerns about Residential Care Top Ups and the financial checks that would be required to check sustainability.

A number of people wanted to let us know that they were currently being charged a top up by care homes for their relatives.

MAKING CHANGES FOR A BETTER BURY

Current activities and Next Steps

An implementation plan has been drawn up highlighting all of the key actions that need to take place between now and January 2019 (item 6 in the background papers).

Eligibility and Assessment

- Update all leaflets, booklets, print, circulate and publish on Bury Directory

Residential Care Top Up Policy

- Create the Bury legal agreement for 3rd parties to sign
- Create Top-Up application form
- Speak to providers and request details of who has existing top-ups, copies of pricing policy, how much each top- up is worth and what the top-up is for
- Write to 3rd parties to inform of the change and request financial details
- Calculate affordability assessment and write to inform of decision/outcome
- Arrange for legal agreement to be signed
- Set up internal financial systems
- Update all leaflets, brochures, print, circulate and publish on Bury Directory

MAKING CHANGES FOR A BETTER BURY

Current activities and Next Steps

Charging and Financial Assessment Policy

- Recruit 2 new temporary financial assessment officers
- Establish who attends day care and contact details and check details in support plan and Protocol
- Establish who already has a current valid financial assessment and/or do a DWP CIS check
- Notify customer of any new charges and amount to be paid
- Set up internal changes to systems - ABACUS
- Arrange for a new financial assessment to be carried out if needed
- Remove DLA allowance/charge against 100% of package
- Charge for 2nd carer if required and any cancelled visits
- Write to affected customers with details of new personal charges
- Update all leaflets, booklets, print, circulate and publish on Bury Directory

Personal Budget Policy

- Update agreement and all PBST letters, leaflets and forms
- Publish the approved list of Managed Account Companies
- Transfer cases with non-approved providers
- Create a new Direct Payment booklet, print, circulate and publish on Bury Directory

MAKING CHANGES FOR A BETTER BURY

Any Questions?

MAKING CHANGES FOR A BETTER BURY

Conclusion

MAKING CHANGES FOR A BETTER BURY