2016/17

Better Care Fund – Bolder, Braver Bury – Towards GM Devolution

Bury Council / NHS Bury CCG

High Level Narrative

2016/17

Authorisation & Sign Off

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	
Date	

Related documentation

Document or information title	Link
Bury Joint Strategic Needs Assessment (JSNA)	http://www.bury.gov.uk/CHttpHandler.ashx?id=14238&p=0
Bury Locality Plan	www.bury.gov.uk/gmdevolution

Contents

Local Vision for health and social care services

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

Each of the seven strands of the Better Care funded schemes in Bury is designed to contribute to this overall vision – finding; providing information and advice; having a strengths based approach to assessing needs before finally treating people earlier; providing holistic wraparound services close to their homes and communities; ensuring there are sufficient specialist community services to support 'step up' and 'step down' to specialised secondary care services when people do fall ill; and that primary care is at the heart of service delivery locally. At the same time, patients will be put in control of their own care, allowing them to take ownership & responsibility for their heath and the care they receive.

This will be achieved through targeted strategies of self help, information and advice which promotes prevention and early intervention, reablement and rehabilitation, which in turn will support reductions in activity in acute services, supporting financial sustainability. When needed, formal care and support will be designed to create a coordinated and seamless health and care system. All services will be person-centred and will build on and develop local community assets. We recognise that there are many areas of opportunity to enhance and improve local services which cannot all be undertaken at once. Careful consideration has been given to prioritise the areas that will best utilise the resources available over the coming year, to achieve maximum output. The neighbourhood model has been informed by the JSNA, to influence the strategic priorities, and the requirements of the Health & Wellbeing Strategy. We have taken a co-production approach to building the neighbourhoods and have set ambitious priorities which the community have identified.

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

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

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

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

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

It contains within it the recent announcement that locally our commissioners will come together to work as one commissioning body with a significant pooled budget, the details of which are currently being worked through. It also details the agreement of a horizontal out of hospital alliance which includes the GP Federation, Out of Hours GP Services, Community NHS Services and social care.

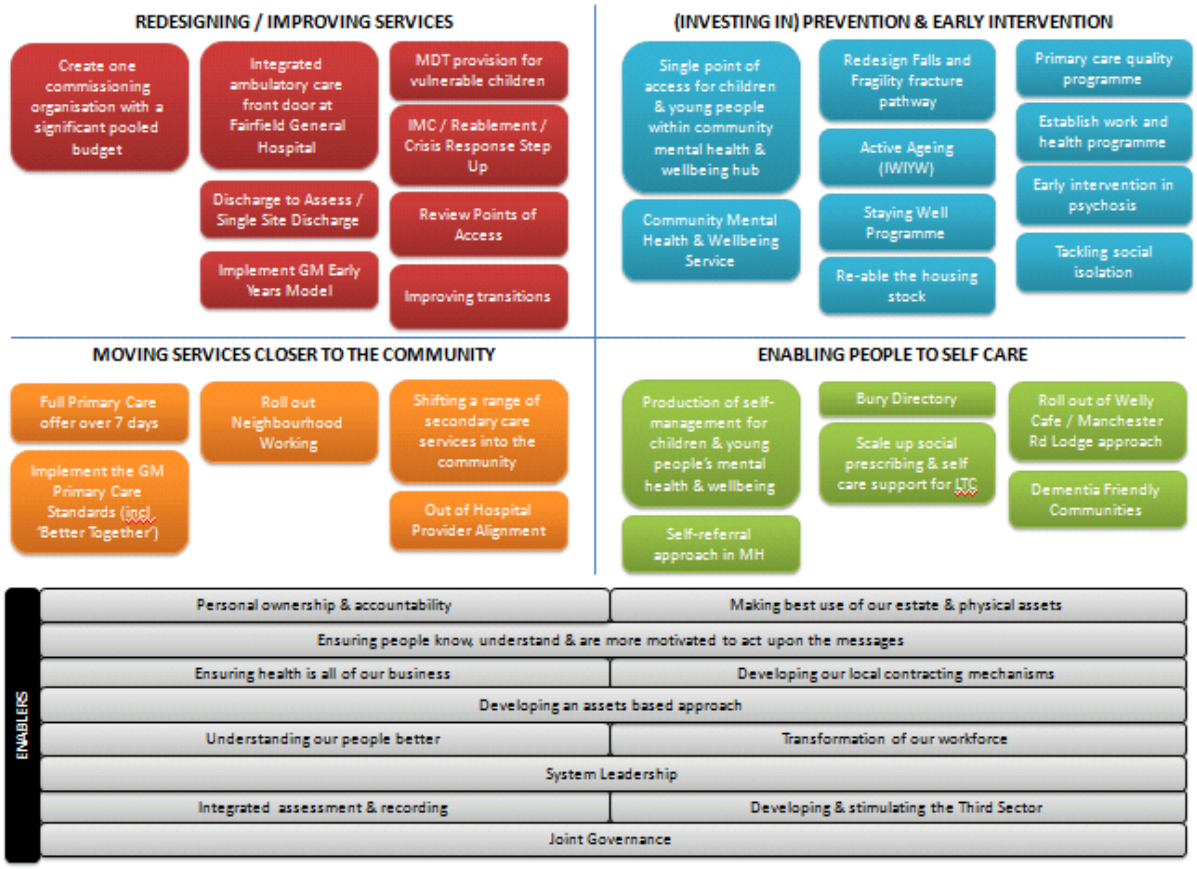
We will also need to work in close synergy with the wider thematic work being undertaken at a Greater Manchester level. These include:

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

At the same time as redesigning health & wellbeing services locally to deliver better outcomes, particularly in the context of wider health & social care changes delivered across the Greater Manchester footprint, we recognise that we need to ensure that the local system is financially sustainable. By investing in prevention and early intervention schemes, at the same time as

delivering an efficiency programme, together with a behavioural change programme for the residents of Bury, we believe we can deflect some of the potential future demand, taking some of the pressure off the secondary and specialist care system, allowing us to develop and reconfigure services.

We are doing significant work, as part of the GM Devolution agenda, which will support the delivery of this across the health & social care system locally and sub-regionally, at the same time as delivering on the Better Care Fund priorities. Our year one Locality Plan priorities can be shown graphically as follows, and this also identifies how the BCF schemes nest within this wider work:



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

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

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

- Improved outcomes and performance
- Improved safety and quality
- Greater integration of care across pathways which break down traditional barriers in primary, community, secondary and social care

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

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

Our communities

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

Primary Care

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

Community and Mental Health

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

already work in partnership with Pennine Acute Hospitals Trust to deliver more integrated models of care in Sexual health and Diabetes pathways (which includes traditional secondary care services being delivered in the community).

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

Secondary care

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

Social Care

The role of social care in delivering health outcomes is recognised and embraced, supported by appropriate integration and collaborative commissioning of services, both for children and older people. This approach will clearly focus on priority areas associated with the ageing population (such as dementia and frail older people) and children and young people in line with locally agreed priorities. . There will be a greater focus on more integrated community health and social care support and the wider integration of the community in neighbourhood models (e.g. short term

intervention services, reablement and general domiciliary care) to facilitate discharge from hospital and we will have significantly reduced delayed transfers of care, building on already existing good practice as demonstrated by AQuA data. We will be jointly commissioning more services together (eg nursing and residential homes), to ensure better value for money. Proactive market management techniques and engagement with providers will ensure sustainability of services for the future. Innovative use of assistive technology will support people to better self care and prevent escalation of need, including more joint deployment of technology (e.g. for telehealth/telecare) These initiatives will be developed within a culture of outcomes based accountability across health, social care and the wider community.

An evidence base supporting the case for change

Our case for change has previously been made in our last Better Care Fund submission.

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

Snapshot of the Locality

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

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

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

- The consequences of the growth and profile of our population will increase demand for services, particularly from older people
- The effect of social deprivation on poorer health outcomes for some of our population compared to others
- Social exclusion is both a cause and consequence of poor health outcomes and often results from limited rights, resources and opportunities

- The impact of lifestyle choices which are increasing the demand on services, increasing inequalities and will result in higher levels of ill-health and lower levels of wellbeing
- Premature mortality is higher than expected given our levels of deprivation

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

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

The BCF performance metrics indicate that we have achieved the following during 2015/16:

- Up until Q3 of 2015/16 non-elective admissions looked on track to be considerably lower than in 2014/15, although not quite achieving the 5% target set in the better care fund; however, hospital pressures which are both system wide and on a national scale in Q4 may mean that target is not achieved for the full year;
- Delayed transfers of care, up until Q3 of 2015/16, were also on track to achieve a significant reduction when compared to 2014/15.

The percentage of people remaining at home 91 days after discharge from reablement is on track to achieve target for 2015/16.

A coordinated and integrated plan of action for delivering that change

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

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

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

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

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

For the public, it means better, more co-ordinated care and less time spent in acute settings; for the system, it means more efficient public services; and for those that work in the system, it means more time delivering care rather than negotiating organisational barriers.

We are transforming local health and care services in Bury to make them more personalised and responsive to individual needs. We're making care available seven days a week, with better advice and support on offer, and with a single designated person responsible for organising the different elements of care more effectively. We want people to live independently at home for as long as possible, receiving the care that is most appropriate to their needs, without having to tell their story time and time again. This is about breaking down the organisational barriers so that the health and care services can work together, delivering the right care in the right place at the right time. The vision in Bury is one of self-support, self- care, prevention and early intervention to prevent or delay people needing services. The individual schemes funded from the pooled budget that will assist in delivering the vision are as follows:

Staying Well

The Staying Well Scheme is a targeted early intervention and prevention scheme which aims to improve health, wellbeing and quality of life for older people, reducing the risk of future health and social care need and preventing future crisis. This scheme will adopt a systematic and proactive approach (risk stratification) to identifying those at high risk of future care need and supporting people to maintain their health, wellbeing and independence. The scheme will be targeted at those aged 65 and over deemed moderate to low risk after application of risk stratification to that population. It will exclude those in receipt of formal social care and those under the care of the Multi-disciplinary Locality Team. The prime basis for proactive systematic targeting of this intervention will be through GP practice registers. Further criteria for prioritising within this cohort are being considered e.g. having one or more long term condition, living alone. The intervention will also be offered opportunistically eg: by the social care team if assessed as in-eligible for formal social care.

The Staying Well intervention comprises the following elements:

- A person-centred conversation about needs and assets using an holistic, evidence based Staying Well Conversation Checklist Tool
- Individual goal orientated action planning to ensure patient/service user activation
- Facilitation, beyond sign-posting, to help people build the confidence, knowledge, skills and trust to enable them to make the most of the support available and take steps to improve their current and future circumstances
- Identifying, building on and making the connections between the assets & strengths of individuals and their communities
- Support, information or advice to encourage self-care and self-management
- Provision of a feedback loop to support service improvement in the wider system

Extended Access to Primary Care

The key objectives for this scheme are to extend access to General Practice over 7 days a week and to place greater emphasis on primary and community care and reduce risk and incidence of crisis or emergency admissions to hospital.

As a Prime Minister Challenge Fund area, NHS Bury intends to continue and develop its extended access to Primary Care offer during 2016/17. In addition the CCG intends to develop the offer further in 2016/17 to include a vulnerable patient's service with the following features:

- Focus on patients at risk of admission
- Can be delivered by Practice Nurses or other Primary Care Practitioner
- Includes home visits
- Includes support for dementia, LD, patients, over 75's and long term condition patients
- Provides support for Nursing and Residential homes.

A joint venture between in an out of hours GP Providers is being considered as the delivery mechanism for this development.

The Extended Working Hours Programme is founded on the following principles:

- Right care at the right time for patients at a place convenient to them
- Provide services that better value patients time
- Offer patients greater freedom to exercise control when interacting with General Practice
- Ensuring Patients have the information they want to make better choices about GP services

The Programmes features are:

- Weekday shared opening to 8pm with evening surgeries from 6.30pm to 8pm
- Weekend access from 8am to 6pm with appointments available through the day for both routine and emergency problems.
- Visits for the extended hours to patients that needed them
- A Shared IT solution that involved the ability to access the full patient care record and all the letters / results
- A commitment by all practices to provide staffing cover to the weekday slots and to weekends by individual choice
- A commitment to staff the rotas wherever possible by local GP's to give the service the feel of an extended hours service

The CCG has successfully negotiated the inclusion of 5 of the 9 Greater Manchester Primary Care Clinical Standards. These are:

- Improving access to General Practice
- Improving cancer survival rates
- Embedding a culture of medical safety
- Improving outcomes in childhood asthma
- Proactive disease management

These are the first phase and the expectation is that the remaining four standards will be implemented in 2017/18. These evidence based standards will support patients to maintain their health and well-being in the community and minimise exacerbations which lead to emergency admissions.

Neighbourhood Work – Integrated Locality Teams (formerly 'Integrated Health and Social Care Team')

The integrated Locality Teams will support frail older people, children and people with Long Term Conditions in their own homes to manage their long terms conditions effectively providing care closer to home and a coordinated multi-disciplinary response for a targeted population. Linking to the extended access scheme, this scheme will place greater emphasis on primary and community care and reduce risk and incidence of crisis or emergency admissions to hospital. We are currently rolling out this scheme in Radcliffe and are currently planning for roll out later this calendar year in the Bury East Township.

There are two key elements to the roll out of this approach:

- Prevention and early intervention task team
- Community Paramedic Service

These schemes will deliver coordinated health and social care services that will wraparound the extended hours GP practices in localities with GPs holding accountability for all aspects of care. Wider work is underway around 'neighbourhood working' across a range of health, social care and voluntary partners (Team Bury) – this work complements the Better Care Funded work but is not part of the pooled budget at present.

Care of vulnerable adults

The aim of this service is to reduce the number of avoidable admissions within secondary care by improving the coordination and quality of care for those who need it most. All 33 GP practices have signed up to deliver the following modules of care:

- Module 1 – Increased Awareness/Administration of Flu Vaccinations: Targeted at patients over the age of 65, there will be a localised flu campaign, together with increased vaccination levels
- Module 2 - Quality Improvements via Coordinated Care: There three key components which by the nature of their remit will cover all ages but in particular those aged 65 and over are Comprehensive care plans to be offered to the following cohorts of patients; Increasing access to General Practice; and Delivery of Multi-Disciplinary Teams for those who need one (all ages).
- Module 3 - Dementia identification and management

Review Programme - Integrated Intermediate Care, Reablement and other related services

Bury CCG and Bury Councils Adult Social Care Services have agreed to undertake a joint commissioning review of a number of services within Bury which have a direct influence on the numbers of patients being admitted to hospital and which support effective and early discharge. The services are:

- Integrated intermediate care
- Crisis response
- Discharge liaison
- Reablement Service
- Community Pharmacy

Some of these services, but not all, form part of a cluster of services currently delivered by both health and social care providers that already support patients and customers in line with Better Care Fund outcomes, hence they have been aligned with the Better Care Fund. The objective of the review is to explore the feasibility and impact of integrating these services to provide a pathway which reduces system blockages and referral points. This means that elements of these services may be de-commissioned, re-commissioned or re-designed for example brought under single line management of one agency.

Capital Schemes

There will be a £1.423M investment enabling people to remain at home with their family and their community for longer, using the Disabled Facilities Grant allocation.

Alongside this, but outside of the scope of the Better Care Fund, we are also making a significant investment of £2.1M to remodel the Intermediate care scheme in Bury at Killilea and a further £3 million investment in a joint primary health and community service in Whitefield township to replace existing primary care premises which are no longer fir for purpose.

Protection of Social Care – Community Care

See section below on protection of social care for more detail.

In order to deliver our priorities we are committed to developing new ways of working, to establish a joint approach to commissioning care and services, working in collaboration with the public and provider organisations. We aim to maximise participation in the NHS and care system, to develop a system that will truly put the public and patients at the heart of both service planning and delivery and also put them in greater control of their own care.

As described in our previous BCF submission, our Integrated Health and Social Care Partnership Board oversees the progress and outcomes relating to the integration of health and social care in Bury, including the Better Care Fund. This board is jointly chaired by the Executive Director for Communities and Wellbeing at Bury Council and the Chief Officer at Bury NHS Clinical Commissioning Group.

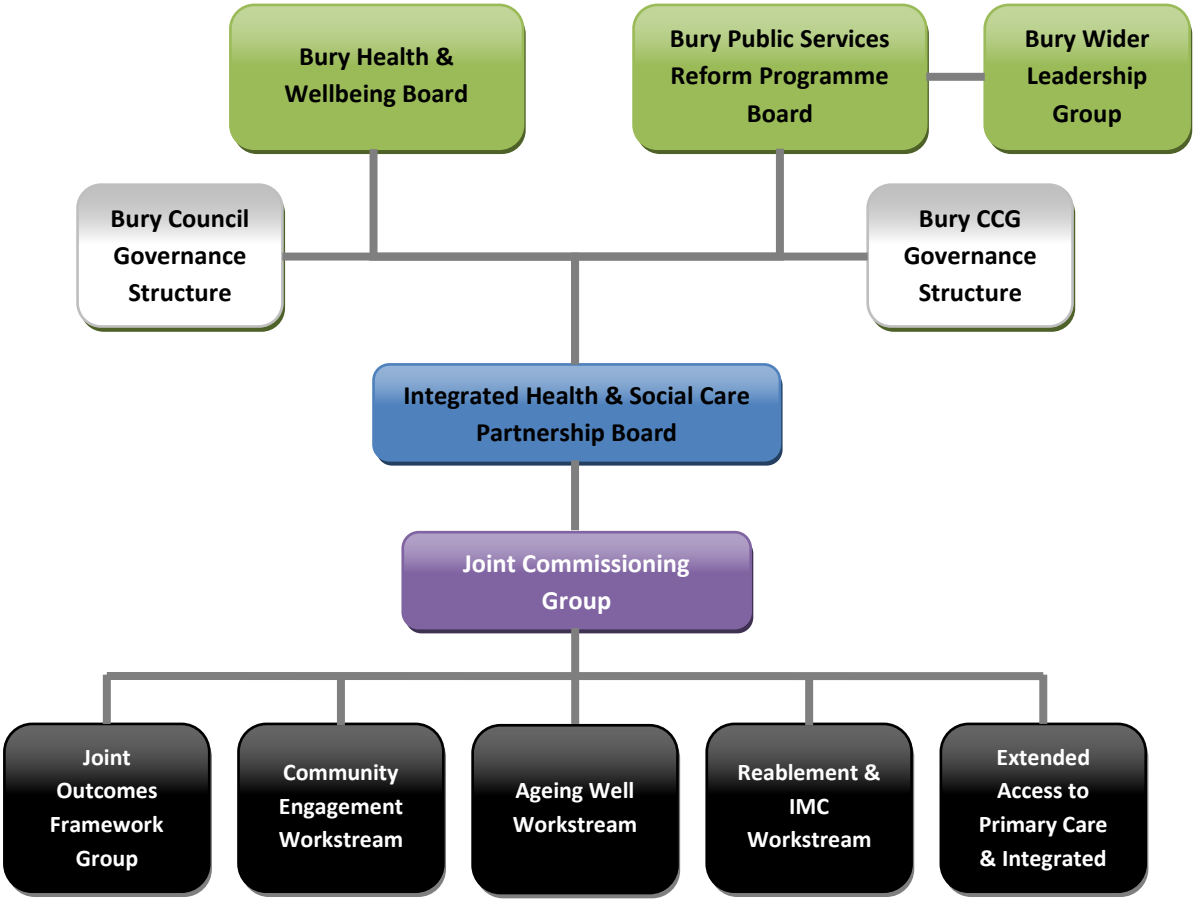
The Partnership Board strategically leads the strategic commissioning direction of health and social care integration and performance manages all activity. The Board is accountable to the Health & Wellbeing Board, providing regular updates on the development, progress and outcomes in the delivery of the programme of work and this is then reported to the Bury Wider Leadership Group and Team Bury Partners

A Joint Commissioning Group forms part of the overarching governance arrangements. The purpose of this group is to develop a joint commissioning approach and ensure robust financial modelling is undertaken to support the development and delivery of the integration model across health and

social care in Bury. Director level finance and commissioning managers from Bury CCG and Bury Council attend this meeting and the group makes recommendations for decision to the Bury Integrated Health & Social Care Partnership Board. The Joint Commissioning Group provides direction to and has oversight of the key integration work streams.

The Bury Provider Partnership is focused on further strengthening collaborative working to deliver the integration agenda in Bury. The group has representation from the following:

- Pennine Acute
- Pennine Care
- NWAS
- Bury GP Federation
- BARDOC
- Bury Council
- Bury CCG



As part of the work of GM health & social care devolution, we are in the process of creating a transformation programme plan, which includes all of the schemes contained within the Better Care Fund, as well as many more. This transformation programme will be overseen using the above governance structure and will be delivered and overseen with programme management office support.

The Better Care Fund schemes are referenced within Bury CCG's Operating Plan for 16/17.

Signed off by H&WB and other CCG/LA committees

Our Better Care Fund Plan was signed off at the Health & wellbeing Board meeting of 14 April 2016.

Prior to that, the report had been presented to and received feedback from the following bodies across the local authority and CCG:

- Integrated Health & Social Care Partnership Board (whose membership includes both commissioners and providers of wider Health and wellbeing services, including housing and leisure) – 17 March & 21 April 2016
- CCG Senior Management Team – 04 April 2016
- Joint Commissioning Group – 05 April 2016
- CCG Clinical Cabinet – 06 April 2016
- Bury Council Communities & Wellbeing Management Board – 08 April 2016

The Plan is also due to be presented at the following meetings:

- CCG Governing Body – 27 April 2016

A demonstration of how the area will maintain the provision of social care services in 2016/17

Social care services contribute to all areas of healthcare for a range of people and pathways:

- Intermediate tier services are recognised as a key contributor within the acute care services pathway, both in terms of avoiding admissions and effective and timely discharge
- Long term care and support provided or commissioned by the council ensures that significant numbers of people with care needs are maintained in their own home, within their community, for much longer than would otherwise be the case

The role of social care within the Bury health and care economy is therefore recognised as key. To this end, the protection of social care continues within the BCF plan for 2016/17 in the following specific ways:

- Funding at a headline level has been agreed by the Director of Finance (CCG) and the Assistant Director (Strategy Procurement & Finance) (Communities & Wellbeing)
- The initial template has been tabled and agreed in principle at the relevant Senior Management Team meetings, although some of the detail may need refining

The schemes are currently outlined as follows:

Summary Table of 2016/17 Better Care Fund Plan	
Description	Budget
Better Care Core Fund	-12,188,000
Better Care Capital Element	-1,423,000
Better Care Fund (additional CCG contribution)	0
Income Sub Total	**-13,611,000**
Protection of Social Care - community care	2,352,000
Protection of Social Care - Care Act	460,000
Protection of Social Care Reablement Service (LA)	2,300,000
Protection of Social Care - Integrated Intermediate Care (LA)	315,000
Protection of Social Care - Crisis Response (LA)	254,000
Contingency element - re NEL admissions	461,000
Neighbourhood working - Extended Access to Primary Care	1,240,000
Neighbourhood work - integrated locality teams; NWAS Car being rolled over	2,372,000
Neighbourhood work - pharmacy in primary care First year only	360,000
Staying Well	374,000
Integrated Intermediate Care (CCG)	820,000
Discharge Liaison (Pennine Care)	354,000
Crisis Response (Pennine Care)	400,000
Capital schemes agreed - DFGs and Reablment	1,423,000
Programme costs	126,000
Expenditure Sub Total	**13,611,000**
Total	**0**

Protecting social care services in Bury means that it is recognised that effective social care and targeted third sector support can contribute significantly to meeting the health care needs of people within the borough, and indeed, have been doing so for a number of years.

The Care Act requires us to ensure that people will be able to access timely information and advice and receive the support they need to meet their assessed needs in a time of growing demand and budgetary pressures. This means maintaining local Fair Access to Care (FACS) eligibility to include substantial. By maintaining a focus on self-care, prevention and early intervention, it is anticipated that the demand on long term health and social care support will be prevented or delayed in a number of cases. The development of a community asset based approach is a key factor in enabling this to happen.

In addition, the development of this community asset approach means that where long term support is required people will be empowered to self -direct this support, with a focus on community and informal support so that formal care services are available for those with the highest need.

Funding allocated under the NHS transfer to Social Care has been used to meet the demand pressures within social care, in light of significant budget pressures, and to continue to fund services where the budgets would have otherwise been cut. Examples include funding elements of reablement services, early intervention and prevention services including provision of equipment reablement and short stay for older people. Continued commissioning of domiciliary care for older people services and residential care at a slightly reduced level, mean that we have been able to maintain the appropriate level of services to meet demand. It is expected that directing NHS funding

to these services will facilitate market management to ensure future sustainability as identified in key strategies and Market Position Statement documents.

In addition, the NHS transfer to Social Care funding has been used to enable the local authority to sustain the FACS eligibility criteria at critical and substantial. To do this required assessment and care management services to assess and review the care needs of clients who are FACS eligible and without this funding there is a significant risk that the Council may have to consider a move of the FACS criteria to Critical only, to meet the growing demands on the services and the ever constrained and limited budgets.

We have significant resources separately identified by the local authority for carers and, whilst this will continue, it will not yet transfer into the pooled fund. All schemes and plans within the Locality Plan will take into consideration carer needs throughout their development and deployment.

Within the Care Act, there is additional responsibility to provide information and advice to people who do not meet FACS. These services will be required to be further enhanced as result of the requirements of the Care Act and 7 day working. Any potential change to eligibility criteria outlined in the Care Act will put greater pressure on services. Funding will be used to support these services such as transitions planning, carers assessments and breaks. The assessment of self-funders will place additional burdens, which is why we are looking at investment into assessment services.

Agreement has been reached that the use of the Better Care Fund monies will be used within the high level themes of reablement, assessment and care management services and domiciliary care services. These services enable us to manage the demand better in the community resulting in reductions of admissions to residential care and non –elective admissions in addition to supporting effective hospital discharge in a timely and effective manner, so avoiding delays for patients.

The provision of information and support to enable people to self-care as well as investment in prevention and early intervention will aim to reduce the impact on health and social care services.

Support by funding from the BCF will maintain and potentially upscale both the volume and scale of current health benefits including fewer people being admitted to hospital on an emergency basis. The specific services to be funded by the pooled budget on an ongoing basis will be signed off once a number of reviews have been undertaken and decisions taken to either:

- Re-commission as is;
- De-commission services totally where there is not continued benefit in line with integration and BCF priorities or
- Re-design services to ensure that there is continued benefit in line with integration and BCF priorities.

Confirmation of agreement on how plans will support progress on meeting 2020 standards for 7 day services, to prevent unnecessary non-elective admissions and support timely discharge

The plan forms the priorities for the out of hospital alliance, which will test new ways of working to achieve the reductions required in Acute activity and the shift into transformed community capacity.

We have secured resources through a bid from the provider partnership to develop systems leadership. Clearly workforce management is being undertaken in each of the partner organisations in Bury – the challenge will be to ensure effective system leadership such that this can be brought together for the benefit of the economy as a whole.

Through self-assessment, services will have clear feedback from the people who use services about the extent to which they feel supported to self-manage. Furthermore, services will be able to benchmark the above outcomes against other services across the borough. We will be able to develop action plans to address any areas of need, based on the above outcomes. We will also have a sustainable mechanism in place to support and drive continuous improvement with regard to self-management support.

Key success measures will be identified during the lifetime of the project that will be used to evaluate progress. It is anticipated that the measures and benefits will include:

- Quality of service – benefit to people who live in Bury
- People who use service users and their carers are enabled to make informed choices
- Greater awareness of when to access services and how
- Conditions are better managed leading to improved health outcomes, and improved motivation to sustain health changes
- The talents and strengths of people who use service users and their carers are fully appreciated and used in an equal relationship with health and social care practitioners to work together to contract on needs and outcomes which are jointly agreed
- Co-production and experience based design are used to develop services that meet people's needs

To complement the extended primary care hours, the out of hospital alliance is working towards extended hours across all community services. Significant progress has already been made in relation to Crisis response service, Community nursing service and hospital discharge teams, which act as step down and step up services. The integrated hospital teams include RAID mental health teams, access to AMHPS and access to discharge to assess models of care to ensure that delayed discharges are reduced.

A Discharge to Assess model is being looked at which would have the following features.

All Bury patients whose projected delay in discharge is more than 2 days will be transferred from Oldham and North Manchester to Fairfield. This repatriation should make things easier for the patients, families and discharge teams. The projected volume for Bury patients is approximately 50 patients at any one time. Medical cover for the initiative would be provided via the GP Federation.

We have developed a combined model solution using a ward at FGH and a combination of Bealey's Community Hospital, Spurr House (2 beds) and Killilea (5 beds).

The three pathways for the proposed Community Provider Hub D2A model are:

- Pathway 1 (For Patient Type 1) who can return home with some support
- Pathway 2 (For Patient Type 2) who need some bed-based Reablement/rehabilitation
- Pathway 3 (For Patient Type 3) who have more complex needs

We have completed a self assessment against the standards for seven day working and are considering associated resources.

As well as shifting services across a seven day pattern, we need to work with our communities to change their behaviour to understand the availability of services, which will influence their traditional behaviour of attending A&E because they think there are no alternatives – this forms a key strand of our Locality Plan.

Better data sharing between health and social care, based on the NHS number

Primary care, through the Prime Ministers Challenge Fund, have been sharing data across primary care for some time - we now propose to take this further through implementing a North East Sector solution which will further support the extended seven day and cross organisational working.

The Healthcare Gateway MIG Detailed Care Record will initially support secure real time sharing of GP records from the Vision GP Clinical system and Liquid Logic (used by Bury Local Authority) giving both organisations a read only view of records. Other organisations that require access to the integrated care record such as BARDOC, Pennine Acute and Pennine Care would access the data via a web based (over N3) record viewer or through an embedded view within their host system.

The following base data sets are available:

- Patient demographics
- Summary, including current problems, current medication, allergies, and recent tests
- Problem view
- Medication including current, past and issues
- Risks and warnings
- Procedures
- Investigations
- Examination
- Events consisting of encounters, admissions and referrals

Expected Benefits include:

- Improved patient outcomes for the overall course of treatment, through coordinated care driven by shared up to date and accessible information at the point of care.

- A reduction in GP telephone enquiries by community and social care services, as the patients' medical history will be available when needed.
- Easier access to End of Life data so more patients on the End-of-Life pathway would have their expressed wishes and preferences fulfilled.
- A reduction in unnecessary admissions to A&E, as community and social care services will have access to more information to treat the patient in the community and coordinate care, rather than being admitted or re-admitted to A&E.
- Consistent use of NHS number as the primary identifier

The North East Sector Integrated Detailed Care Record has been developed jointly by ten stakeholder organisations with appropriate clinical and managerial governance. All parties agree that it will provide a platform to allow sharing of data to support integrated and better care. The system that has been procured does support an API and moreover is being embedded within host clinical systems where possible. Appropriate Information Governance arrangements are in place and an Information Sharing Agreement and Information Sharing Protocol have been developed and agreed by a subgroup of the stakeholders. Publicity materials and information for local people are in development. The developments will be a significant enabler for integrated services across NE Sector. The NHS number is fully embedded as the unique identifier within the IDCR.

A joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care there will be an accountable professional

We have an established pathway to jointly manage complex patients who require both health and social care support, including testing frail elderly MDT working as part of our Healthier Radcliffe pilot. Frail older people often require care in hospital and it is often the right place for them to be. However, we know that frail older people are at greater risk of experiencing significant harm if admitted to hospital as an emergency – particularly if they are delayed in an emergency department. If frail older people are supported in living independently and in understanding their long-term conditions, and are educated to manage them effectively, they are less likely to reach crisis, to require urgent care support and to experience harm.

The need to ensure that preventative services that are 'fit for purpose' are in place and able to avoid unnecessary clinical and social deterioration in older people is paramount. With this in mind, providers in the borough feel that there is an urgent need to establish a multi-disciplinary team led clinic for Frail Older People that: assesses the needs of patients on an individualised basis; ensures that both primary and secondary care plans are in place and are linked; and make every attempt to maximise the health and self-management of the patient (and therefore reduce the risk of potentially avoidable Emergency Department presentation and emergency admissions). If these are unavoidable, the MDT clinics will ensure that secondary care interventions are targeted, appropriate and timely, and minim the primary care plans in place, thus minimising the risks outlined above in the NHSE report.

We have well established multi disciplinary teams working across learning disability and mental health services, with clear agreements about the role of care co-ordination and having a single point

of contact for patients, including clear pathways into review and recovery. Community Nursing and Reablement Services have plans to work together to improve patient experience, this will include the care co-ordination role being the most appropriate professional taking the lead dependant on primary presenting needs, using an agreed conversation tool as a primary assessment document. We also have an established transition into adulthood pathway across Health, education and social care, using the EHCP plans as the single assessment and support plan.

For patients with dementia, our Key Worker pilot project objectives are to 'improve the lived experience for people with dementia and their carers' and to 'reduce dependence on health and social care services'. This programme (developed by the Alzheimer's society), with a view that people who are newly diagnosed with dementia will have access to a key worker who can support them. It will be rolled out initially in Salford and then in Bury and Wigan, before rolling out the model to all ten GM localities and to ensure this is built into Locality Plans.

The objectives of the new service are:

- To identify patients early, supporting them to live well and to manage their health
- Prevent deterioration and social isolation, through regular monitoring and support to avoid unplanned admission to hospital and long-term residential care
- Provide high quality healthcare in the community
- Provide high quality hospital care to prevent unnecessary increases in length of stay

Through the shared IT portal, primary care will be supported to remain the accountable clinician for these patients.

Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans

The schemes identified in our 2016/17 BCF plan build on those already implemented in 2015/16. A full evaluation of the Healthier Radcliffe Stage 2 pilot schemes was undertaken (co-ordinated by the GP Federation) and has informed which schemes should continue, which schemes should be modified and which schemes should be terminated. Those decisions and the rationale have been through formal governance routes including:

- CCG Clinical Cabinet
- CCG Governing Body
- Bury Council
- Bury Joint Commissioning Group
- Bury Health and Social Care Partnership Board
- Bury Health and Wellbeing Board

Through these formal routes, we have engaged with all key stakeholders including Bury Council, primary care clinicians and CCG member practices, patient representatives, our local acute and community service providers, Public Health and the GP Federation. Our evaluations also included liaison with and supporting information from other scheme providers such as Age UK Bury, North West Ambulance Service and the Local Pharmaceutical Committee.

The most substantial impacts on our providers will be:

- Further reductions in non-elective admissions (mainly at Pennine Acute NHST)
- Continuation/extension of work by GP Federation, GP Practices, Social Services and Pennine Care FT (community services)

2016/17 contract negotiations are nearing completion and the CCG has reached agreement with Pennine Acute NHST to contract for a 2% reduction in non-elective spells compared to 2015/16 forecast outturn (value approximately £0.7m). This will be reflected in the contract activity schedules to be signed by the end of March.

Our Locality plan assumes circa 19% reduction over 5 years, with 3% of that (circa £1m) being delivered in 2016/17. Similarly, the CCG Operating Plan includes a 2% contract reduction (£0.7m) with a further 1% reduction (£0.3m) planned as in-year QIPP.

Pennine Acute NHST colleagues are also planning for a 2% reduction in non-electives and are aware of our additional QIPP plans (and have been advised to plan accordingly for the associated risk/loss of income). We believe an additional 1% reduction in non-electives is achievable based on the trends in activity witnessed in the last 3-6 months of 2015/16, and with the extension of successful schemes into 2016/17. For example, non-electives were 3% lower than base in quarter 3 of 2015/16 (see table below) and that trend is set to continue judging by indicative quarter 4 data.

The continuation of funding has been agreed with GP Federation, GP practices, Pennine Care FT and social services to allow for the continuation/extension/redesign of schemes into 2016/17.

Agreement to invest in NHS commissioned out of hospital services, or retained pending release as part of the local risk sharing agreement

The BCF Finance Plan template sets out Bury's approach to the themes and schemes funded as part of the Better Care Plan. The aim is to fund initiatives that will contribute significantly to the reduced target in non elective activity, in addition to creating an element of contingency that the CCG can rely on, should the proposed reduction in NEL not be achieved.

In addition, Bury has a risk share agreement in place, which is in the process of being reviewed and refreshed in light of the 16/17 BCF planning guidance, to ensure that the financial risk to the CCG in respect of continued increasing admissions, is mitigated as far as possible.

Based on the evaluation of schemes within the Better Care Fund for 2015/16, we are now taking forward the recommendation to roll out across Bury two specific schemes focussing on early intervention and prevention in neighbourhoods, previously piloted in Radcliffe – these are the NWAS Rapid Response Vehicle and Staying Well Team, as described above.

In addition, a new Pharmacy in Primary Care scheme is being introduced from 01 April 2016 which ensures that pharmacists contribute directly to the Greater Manchester Primary Care standards and patient safety. In addition, it is envisaged that the scheme will ensure appropriate and efficient use of the prescribing budget, as well as freeing up GP time for other primary care activities.

The agreed BCF pool for 2016/17 is £13.6m, funded as follows:

Funding Type	Funding Source	£000s
Better Care Core Fund	NHS Bury CCG	12,188
Better Care Capital Element	Bury MBC	1,423
		13,611

The CCG has ring-fenced its contribution of £12.2m in it's 2016/17 Operating Plan and budgets. The additional £1.4m funding is ring-fenced by Bury Council and represents the Disabled Facilities Grant funding. Both of these funding assumptions are included in the Bury Locality Plan figures.

Bury HWB has agreed on the application of the £13.6m pool as follows (and as detailed in the BCF planning return template):

Scheme	£000s
Personalised support/ care at home	374
7 day working	1,240
Integrated care teams	2,372
Improving healthcare services to care homes	486
Reablement services	4,443
Other	1,423
Personalised support/ care at home	2,812
Subtotal - planned spend on BCF schemes	**13,150**
Contingency	461
Total Pool	**13,611**

As explained earlier, the schemes are existing 2015/16 schemes that have been continued, extended or redesigned following an evaluation process; and the plans have been through a formal and rigorous governance process that included engagement with key stakeholders.

All of the above schemes represent investment in out of hospital care in line with our 4 key themes of:

- redesigning and improving services
- moving services closer to the community
- investing in early intervention and prevention
- enabling people to self-care.

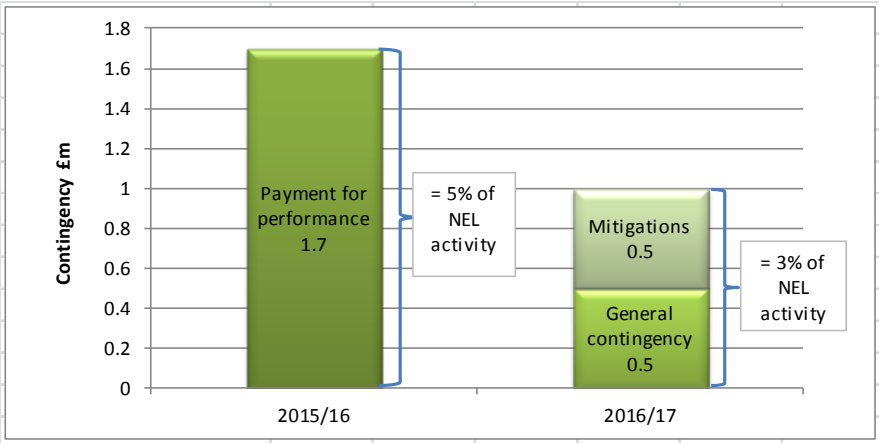
Contingency: 2015/16 P4P performance and 2016/17 risk management

In 2015/16, the Payment for Performance (P4P) contingency amounted to £1.7m based on an ambitious target of 5% reduction in non-electives. As the table below shows, the actual reduction was just 1%, so the CCG held back £1.3m P4P to pay for in-hospital activity.

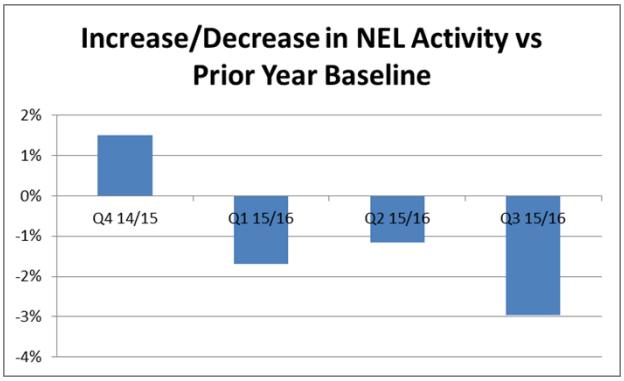
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	**Total**	change
Baseline	4,792	4,869	4,722	4,810	**19,194**	
Plan	4,553	4,626	4,486	4,570	**18,234**	-5%
Actual	4,864	4,787	4,667	4,668	**18,986**	-1%

Based on our 2016/17 target of 3% reduction in non-electives, there is an associated risk of around £1m in the event of under-performance. It has been agreed to set a general contingency at £0.5m, with appropriate mitigations of a further £0.5m (minimum) in the form of 'brakes' on investment and other measures built into a revised risk-share agreement (described in more detail, below). In

other words, a general contingency of £0.5m is available for the CCG to pay for excess non-elective activity (covering up to 50% under-achievement of target); and a further £0.5m will be available through delayed/cancelled investments and other measures through the year, if required.



This decision has taken into account the fact that, although overall reductions were disappointing in 2015/16 (just over 1%), the Q3 15/16 reduction was encouraging at 3% and indicative Q4 15/16 figures are similarly positive.



The details of the revised risk share are still being finalised.

Agreement on a local action plan to reduce delayed transfers of care (DTOC) and improve patient flow

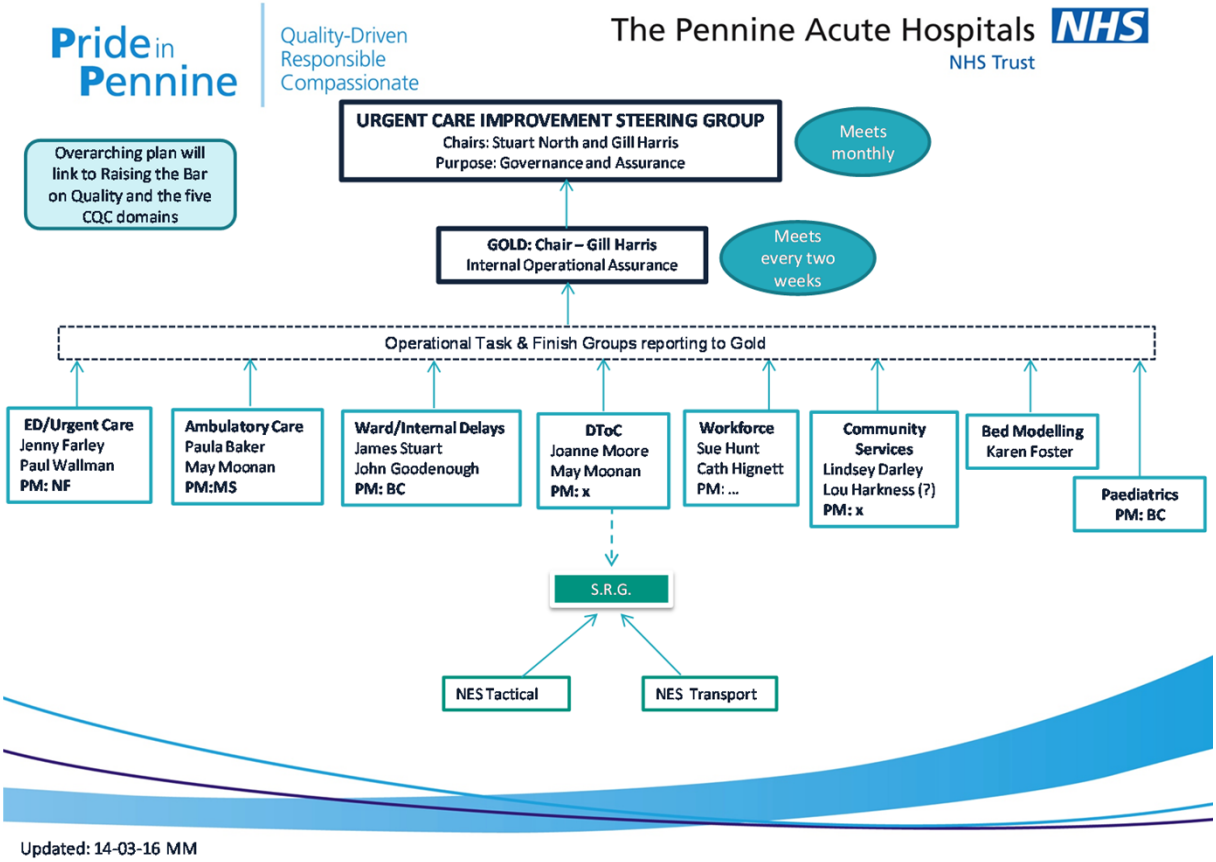
As explained, we have started discharge to assess pathways to support reduced delayed transfers of care. The North East Sector has a recovery plan across the four CCGs, local authorities and the acute service provider. This plan looks at how we can reshape services before hospital, in hospital and post discharge, with the aim of improving capacity, reducing demand, improving patient flow and improving and resolving workforce issues.

We have recently undertaken a four day whole systems thinking event, facilitated by the TDA , the outcomes of which will be fed into the action plan. We are developing a model of integrated ambulatory care based at Fairfield General Hospital. This model will ensure direct access is available for A&E attendances and primary care referral points both in and out of hours. This service transformation will deflect attendances, reduce admissions and support the improvement of flow through the hospital.

We have a discharge tracker pilot, which is currently being evaluated, which has been designed to report real time updates on progress for patients who are medically optimised.

In early March, we ran a logic modelling session focused on the ambulatory care system with the aim of making changes that will release capacity in the hospital system.

The governance structure associated with this work is as follows (reporting to the System Resilience Group):



The draft North East Sector DTOC plan is attached to this submission.

An agreed approach to financial risk sharing and contingency

It was recognised, when jointly developing the BCF in 2014, that the financial situation in Bury across the whole health and social care economy is almost unique in its lack of headroom to pump prime new initiatives through the BCF without achieving the full reduction in Non Elective Admissions. This situation continues today.

The CCG and Local Authority signed off a risk sharing agreement for the Better Care Fund for 2015/16; specific elements were identified to contribute towards risk mitigation for 2015/16, some of which will not be available for 2016/17.

The agreement in place is under review and will be formally refreshed by end of April 2016 – this will give time to review provisional year end positions of both organisations which may contribute to the short term plan. An element of the BCF has been ringfenced for social care protection, which totals £5.6M including elements of Intermediate Tier services in addition to an element of long term social care support. In the same way, £5.9M is planned to be spent on out of hospital care to ensure financial and clinical sustainability within Bury.

In addition, a specific contingency, of £461,000 has been identified to support the CCG to contribute towards the costs of any NEL target not achieved.

The 2015/16 Section 75 agreement includes details of the BCF risk sharing arrangements. As explained earlier, this is currently under review and a final re-draft will go to Bury HWB for sign-off by June 2016. The re-draft will take into account:

- Revised (lower) targets for non-elective reductions in 2016/17
- The abolition of the Payment for Performance mechanism
- The decision to create a £0.5m general contingency
- The decision to identify a minimum of £0.5m potential mitigations in addition to the general contingency.

The guiding principles of the agreement remain the same as in 2015/16:

- 50:50 share of risks and gains
- Regular, formal joint reporting, decision-making and governance arrangements for early identification and interventions in the event of over-spending and/or under-performance

In line with national guidance, the general contingency of £0.5m will be withheld by Bury CCG from the BCF pooled budget at the beginning of the year. The CCG will make payments into the pool on a quarterly basis equivalent to the value of admissions avoided, up to the maximum £0.5m. The CCG will ensure that unreleased funds are retained to cover the cost of additional non-elective activity. In addition, if the cost of additional non-elective activity exceeds £0.5m, the Health & Wellbeing Board will take mitigating actions which might include the following:

- Delaying investment in BCF schemes
- De-commissioning BCF schemes
- Seeking alternative funding sources for BCF schemes
- Agreeing additional contributions to the pool from the BCF partners

- Applying under-spends/slippage from other BCF schemes
- Applying Bury Council Treasury Management interest gained from hosting the pool

The mitigations identified above are still being firmed up but will be a minimum of £0.5m. Alongside the £0.5m contingency, that puts £1m of BCF funding "at risk" – sufficient to cover the full cost of under-delivery vs the 3% target reduction in non-elective activity.