WORKING DOCUMENT v3

Better Care Fund planning template – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Bury Council**
Clinical Commissioning Group	**Bury Clinical Commissioning Group (CCG)**
Boundary Differences	**Co -terminus**
Date agreed at Health and Well-Being Board:	**30 January 2014**
Date submitted:	**14 February 2014**
Minimum required value of ITF pooled budget: 2014/15	
2015/16	
Total agreed value of pooled budget: 2014/15	
2015/16	**£11,727,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Stuart North
Position	Chief Officer
Date	<date>

Signed on behalf of the Council	
By	Mike Kelly
Position	Chief Executive
Date	<date>

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Rishi Shori
Date	<date>

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

We recognise the importance of working with our providers in partnership and have therefore involved providers at every stage of our integration programme including the development of this Better Care Fund plan. Some specific examples of our approach to demonstrate this are as follows:

- Bury CCG has issued commissioning intentions around Integrated Care to Pennine Acute Health Trust (PAHT) in October 2013 which highlighted the level of financial shift that would be required from the acute to the community sector
- The CCG meets PAHT bi -weekly to work through the system impact of planned changes and to ensure their 5 year Integrated Business Plan includes all assumptions
- CCG and PAHT Financial Analysts are working on an integrated finance plan at a Greater Manchester and North East Sector level
- There is commitment across all providers for a shared workforce plan which reduces risk to staff and maximises opportunities and we are currently considering the most appropriate way to take this work forward
- Executive meetings have taken place with Pennine Care Foundation Trust around

the longer term strategy and impact of integration on a monthly basis

- A series of integration workshops have taken place including providers to define Integrated Care Aims and Principles
- We established an Integrated Care Model Group to further develop the Integration agenda with representation from key stakeholders – including health providers
- The above group has developed into a Bury Co-ordinated Community Based Care Group with the specific purpose of developing and coordinating our community based care developments to include primary care and integrated care services. This group meets monthly and reports to our Integrated Partnership Board as can be seen in our Governance structure. The group has provider representatives as well as other key stakeholders including Social Care, GPs and a Patient Cabinet representative
- Our Healthier Radcliffe Demonstrator Community strategic group has provider representation on the group. A Healthier Radcliffe workshop to take the developments through to the next stage took place in January 2014 and this was well supported by providers
- A Third Sector Development workshop took place in September 2013 where we outlined Bury CCG's priorities and approach to integration as well as highlighting opportunities for the Third Sector
- Limited consultation with social care and housing providers has taken place to date around the specific integrated health and social care agenda and the expected changes resulting from it, other than as part of the Radcliffe pilot at this stage. The initial outcomes from the Healthier Radcliffe pilot are awaited before designing a wider model with the understanding of which types of providers would be needed as part of borough-wide integrated services.
- However, Adult Care Services engages with social care and housing providers on a regular basis, through provider forums, specific events and workshops regarding the co-production of strategies and other strategic documents, and there is ample opportunity to engage with providers in a meaningful way to work with us on the specifics of a new model. A number of events to engage social care, housing and 3rd sector providers specifically will be planned to support the design of models of care that will meet the future care needs of the people of Bury.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

NHS Bury CCG and Bury Local Authority have been working with other key partners on the development of a strategy for communication and engagement linked to their wider integrated care plans.

Our vision is:

Patient, customers and community ownership of the health and social care reform agenda and their role in maintaining and improving their own health & wellbeing and supporting others to do the same.

Our objectives are:

- Patients, customers and the public understand and have ownership of the service reform agenda
- Reform strategies and plans are informed by the patient, customer and public perspective
- Services are co-designed around an understanding of patient and customer needs
- Patients and customers are able to self-care as much as possible
- Patients, customers and members of the public are engaged in the delivery of support to improve health and quality of life of those with health and social care needs
- Patients, customers and the public understand and make appropriate choices about use of services
- Patients and customers are fully involved in decision-making about their own care – no decision about me without me

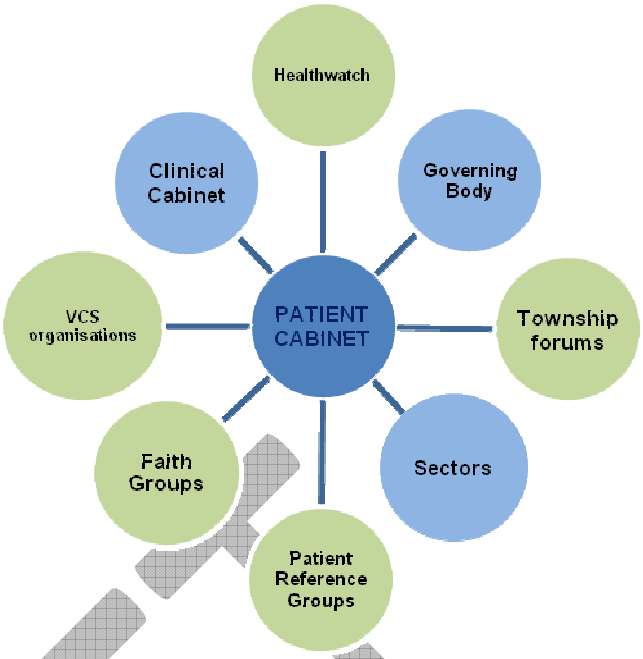
This strategy builds on an established commitment to patient, service user and public engagement that also underpins the Better Care proposals described. A number of existing mechanisms have been deployed to engage patients, service users and members of the public in the development of the Health & wellbeing Strategy, the JSNA and local health and social care integration plans as well as redesign and development of specific services for example, the CCG's Patients Cabinet, Adult Social Care Task Force and Township Forums. These on-going conversations have all informed the development of the Better Care Fund plan.

CCG Patient's Cabinet

NHS Bury CCG has sought to develop an integrated approach to Patient and Public Involvement (PPI). This has happened by *hard-wiring* patient and public voice into the structure of the CCG with the development of a Patient Cabinet. The Patient Cabinet is a group of 13 local people from a range of backgrounds who themselves use local health services. The Patient Cabinet has a key role in ensuring meaningful involvement and engagement with local people and communities - gathering views and feedback and making sure that people have a chance to feed into and actively participate in the CCG's consultations and service planning. Through the Patient Cabinet the CCG aims to ensure that services it commissions are geared around the people who use them and that decisions take into account local views.

Members of the Patient Cabinet have grass roots connections within their local communities and the Cabinet is developing a work plan, which dovetails with the work of the wider CCG. As a formal sub-committee of the CCG's Governing Body (Board) it meets on a monthly basis, and issues raised through the Patient Cabinet have a direct route into the Clinical Cabinet and the Governing Body via its Chair, who is a non-executive director.

In turn there has been a process of building links from the Patient Cabinet with a network of organisations and community groups.



Bury's integration plans reflect the much of the feedback given by patients in a small scale patient survey designed and delivered by Patient Cabinet members in February 2013. Thematic content analysis showed that immediate priorities for patients included:

- Better access to primary care
- More GP appointments
- Shorter waiting times

In the longer term respondents identified priorities including:

- Having access to a wider range of treatment and care services in GP surgeries
- 7 day and evening access to local GP services
- Better services for chronic and long term conditions
- Better access to services for disabled people
- Improved mental health services
- Improved cancer and palliative care

Respondents were critical about:

- Current access to primary care
- Having to go to multiple (hospital) sites for treatment
- Disjointed NHS services

In October 2013 the Patient Cabinet provided feedback on the vision and high level plans for the delivery of integrated care in Bury and in November 2013 the Patient Cabinet had the opportunity to comment on the draft commissioning intentions for 2014-15. Further sessions with the Patient Cabinet on the Bury model and plans for integrated care are planned for February and March 2014.

NHS Bury CCG has implemented an approach to service redesign which involves members of the Patient Cabinet working closely with clinical leads to develop and implement plans and many of these are integral to the overall delivery of integrated care.

The Cabinet and its members have been involved in a number of projects including:

- The development of proposals for new glaucoma and minor eye conditions pathways
- Workshops with local clinicians to identify innovative ways of reducing unnecessary A&E attendances
- Providing early feedback on emerging models for the reorganisation of acute hospital care in Greater Manchester – Healthier Together

- The development of public health plans to improve prevention and self-care
- Several work streams relating to the improvement and better integration of services for people with long term conditions including asthma and diabetes

Adult Social Care Customer Task Force

The Adult Care Customer Task Force (previously the Service User Panel) is a group of volunteers made up of customers and carers who receive services from Adult Care and/or Six Town Housing. The group meets three or four times a year but can be contacted via post or telephone up to six times a year.

The aim of the group is to involve customers in developing and shaping future care services, so we can make sure our services meet the needs of our customers.

A number of different interactive workshops are run at each meeting, designed to make the topics easy to understand and interesting to all parties. These will be consultations or changes to services which are being planned at that time. Examples include:

- **Self Directed Support** – members designed collages of what is important to them to help them understand personal budgets and support planning, as well as informing the team on the requirements of customers.
- **Adult Care Connect and Direct** – members were involved in the design of the reception including choosing the furniture for the Assessment Room, telling us which services they would like to invite for drop in sessions in the Green Room and whether Customer Advisors should wear uniforms.
- **Website** – members tested our website and told us whether it was easy to use. They also made suggestions on how it could be improved.

From the events 'You said, We did' documents are produced which shows what has been done from their suggestions. This has proved a valuable tool in showing the members that they are at the centre of our services and they have really made a difference.

Township Forums

There are six Township Forums covering the Borough of Bury. Each Township Forum consists of all the councillors representing the area and a co-opted advisory group of local representatives from the business community, voluntary organisations or community groups within the area. Each area forum meets every two months at local venues, in places such as schools and community centres. All area forum discussions are fed back to the council for appropriate action.

Healthier Radcliffe Demonstrator Project:

This project is the test bed for approaches to the provision of 7 day a week access to primary care and integration of community based services from which lessons are being learnt for wider roll out across the Borough of Bury. Patient, Service User and Public Involvement is fundamental to the design and delivery of this project.

A member of the Patient Cabinet has played a key role in the development of the bid and the subsequent implementation of the Healthier Radcliffe Demonstrator site working

alongside officers from the CCG, the local GP Federation and local GPs. The Patient Cabinet member sits on both the implementation and operational groups which are driving the project; has led on the development of a communications and engagement strategy and will be supporting the development of a 'super Patient Representative Group' which will bring local patient groups together as part of the programme of practice and wider health and social care integration.

Information about the Radcliffe demonstrator pilot and the wider vision for integrated care has been shared with patients and the wider public via the Bury CCG Patient Cabinet (Oct 2013); the Radcliffe Township Forum (Nov 2013); at a public launch of the Patient Cabinet (Oct 2013) and with Healthwatch Bury (Feb 2013) and the Jewish Care Forum (Jan 2013). In addition information about the enhanced services has been shared amongst the patients affected by the investment (within the 6 GP practices taking part in the pilot), some 34,000 patients in total, and with the wider community through the press and media, attracting national media attention. Lessons learnt from these approaches will be applied to patient; service user and public engagement work in the rest of the borough.

Health & Wellbeing Strategy Consultation

The consultation highlighted that the priorities for patients, service users and the public are on prevention, early intervention and self care, informal support to stay well and maintain independence, joined up working between partners and professionals and asset based community development. Our Health and Wellbeing Strategy and subsequent Health and Social Care Integration plan have been built on and strongly reflect these themes.

Healthier Together Consultation Events

Reconfiguration of hospital-based services is being led at a Greater Manchester level by NHS England through a programme called 'Healthier Together'. The public discussions began in August 2012 and involved a series of patient groups, members of the public and representatives from the community and voluntary sector. The aim was to recruit patients to a series of patient panels to support the public discussions leading up to the anticipated public consultation in Spring 2013. The first phase of the discussions branded as 'The Big Conversation' commenced in August and continued until October 2012. The discussions with our patients/public for the first phase have focussed on the broad principles for change. The remainder of the 'The Big Conversation' will be separated into Phases Two and Three and will focus on the models of care and option development. By adopting a phased approach we will be able to tailor messages and materials that dovetail with each of the programme steps, it will also allow us obtain specific feedback and outcomes.

An event was held in Bury in October 2013, and involved in a range of interactive discussions. A range of presentations and question and answer sessions were delivered by clinicians leading the Healthier Together Programme, clearly demonstrating the clinical leadership and strong commitment for delivering the programme in partnership with clinicians, patients and key partners.

The majority of participants understood and agreed with the proposed changes emphasising the need for more emphasis on prevention and self care, easy and quick access to primary care and access to senior medical opinion. However there were some

caveats which we are also taking into consideration in our plans such as the need for better discharge planning and access to information about sources of support

Key messages

Whilst recurrent themes in consultations on health priorities and service provision include an emphasis on prevention, support to maintain independence, better access to primary care and joined up care; concerns have also been expressed about the capacity of community based care to manage shifts in activity from the acute sector. There are also worries about quality of care with for example people being worried about being left isolated at home, being put to bed early and not having access to support overnight.

Future Developments

We are planning to expand on the work to date by working with the newly formed local Healthwatch for example to engage more with equality target action groups and Bury's Third Sector Development Agency for example to enhance volunteering and community group involvement in the design and delivery of our plans.

We have established a work-stream within our governance structure focused specifically on further developing our work around patient, service user and community engagement which will focus on widening participation in consultation and planning work, and strengthening engagement in self care and service delivery though embedding of the Greater Manchester Community Based Care Standards, patient education, co-production and asset based community development approaches.

e) Related documentation

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

Document or information title	Synopsis and links
Bury Joint Strategic Needs Assessment	The Refreshed JSNA was approved for consultation by the Health and Wellbeing Board in December. A consultation plan has been drawn up and formal consultation will begin in February. A multi-agency steering group (including B3SDA, Healthwatch and Patients Cabinet reps) are scoping a work programme for further development of the JSNA which will be informed by the consultation and further consultation with commissioners & stakeholders
Bury Joint Health and Wellbeing Strategy (HWBS) Living Well in Bury: making it happen together	The HWBS has had final approval and we are now working to pull together a delivery plan

Developing a new model of Integrated Care and Support for People in Bury 2013 - 2018	Report detailing the proposals for Integrating health and social care in Bury submitted to Greater Manchester for the purposes of Healthier Together consultation
Bury Mental Health Strategy 2013 - 2018	Bury Council and Bury NHS Clinical Commissioning Group are committed to improving the mental health and emotional wellbeing of all adults in Bury. The Bury Mental Health Strategy 2013 - 18 sets out how we will achieve this over the next five years. The strategy has been jointly developed by the Local Authority and CCG and co-produced with service users and other stakeholders. Its main aims are to reinforce prevention and recovery based approach to mental health, including the further development and support of community and 3rd sector services. http://www.bury.gov.uk/index.aspx?articleid=3228
Bury Public Service Reform (PSR) first phase implementation plan	Local Implementation plan for Public Service Reform
Bury Dementia strategy	The joint local dementia strategy supports the creation of an environment where we can enhance existing services to improve the quality of life for people with dementia and their carers in Bury. Working in partnership will ensure that people receive early and timely diagnosis so they continue to live and function well with dementia. http://www.bury.gov.uk/index.aspx?articleid=3313
Carers strategy	The aim of the strategy is to recognise, enable and support carers of all ages from the whole community to have a quality life of their own. It was developed in partnership with the CCG and carers themselves, and it recognises the valuable role that carers play in supporting their loved ones. http://www.bury.gov.uk/index.aspx?articleid=4903
A Healthier Radcliffe - 2013	Bid documents submitted to NHS England
National Voices	

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?

- What differences will this make to patient and service user outcomes?

Vision for health and social care services for Bury

Bury are committed to transforming the whole health and social care system over the next five years in order to support people and enable them to live in their own homes and communities. The vision is that people will live well, stay well, remain active and have better outcomes and experiences. There will be a focus on citizenship, prevention, self-care and independence with the aim of reducing the demand for services and making efficient and effective use of both health and social care resources.

We will provide better support for people at home with the provision of coordinated services in their own communities to prevent people needing emergency care in hospital or being inappropriately admitted to care homes.

In order to achieve the cultural shift that will be necessary we will have to utilise our workforce more effectively, considering skill mix, reorientation and training opportunities for staff.

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

Person centred coordinated care will 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. We have therefore adopted the **narrative and "I" statements for person centred coordinated care** as defined by National Voices (May 2013) and the definition of integration in Bury is:

Person centred coordinated care

"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"

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

- Person centred coordinated care
- A partnership approach with people who use services and their cares to ensure their engagement and involvement in designing services
- Empowering and enabling people to become experts in their own condition and to access services appropriately
- Fully inclusive of all communities

- Access to services 7 days per week from 8.00am to 8.00pm
- Integrated multi-disciplinary teams based in defined localities wrapping around an identified primary health care and social care hub
- GP practices will be at the centre of the primary care delivery model coordinating care, providing core services and holding accountability for the overall health of the person
- Access for all ages with a specific focus on people at a higher risk such as people with long term conditions and over 65's risk stratified
- Access to and availability of screening and prevention services which promotes wellbeing
- Sharing resources, records, risks, decision making and benefits
- Jointly defined outcomes framework
- Joint commissioning of services to meet needs

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

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

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

Changes to the General Medical Services (GMS) contract from April 2014 will also support more proactive integrated and personalised care through:

- Ensuring that all people aged 75 and over have a named, accountable GP who is responsible for overseeing their care
- Introducing more systematic arrangements for risk profiling and proactive care management, under the supervision of a named GP, for patients with the most complex health and care needs, and
- Giving GP practices more specific responsibilities for helping monitor the quality of out-of-hours services for their patients and supporting more integrated working with out-of-hours services.

Joint evaluation and outcomes framework

Whilst we focus on service reform and reconfiguration, our driving ambition is that we design a health and social care system which has at its heart the core purpose of supporting people to maintain their own health and well- being and independence. We are designing a joint evaluation and outcomes framework across the Radcliffe Demonstrator project and Borough wide Integration Plan built around these outcomes, which will enable us to evaluate whether our plans are making a positive difference to people.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Integrated care in Bury means:

- Placing people and carers at the centre and developing wider networks of support and care that is based around their needs and puts them in control
- Coordinating delivery of services in a way that enables people and their carers to achieve better outcomes and maximises their independence, health and well being
- Recognising that the care can be provided by single or multiple organisations, what is important is that the different parts of the organisations work together to combine and coordinate all of the services needed to meet the assessed needs of each person
- Working in partnership across health and social care services, independent and voluntary sector services, physical and mental health services, primary and secondary health care services

Integrated care in Bury aims to:

- Ensure people take responsibility for their own health and well- being though self-care, ownership and accountability for their lifestyles
- Provide information and access to advice to help people to understand what is available in the community to facilitate them taking ownership and accountability for their life styles
- Where someone requires support, the support will involve the persons/families natural circle of support and maximise the use of the community assets
- Integration will help to facilitate this approach by providing the right workforce in localities in the right place and at the time

In developing our aims for integrated care we have focused on the whole care pathway for Mrs Peel, an 83-year-old resident of Bury with multiple problems**.**

The measures of health gain that we will apply to our population relate to improved outcomes – healthy life expectancy, reductions in premature mortality and self -reported wellbeing taking account of addressing inequalities.

In order to manage and track outcomes from our aims and objectives we are developing three products:

1. "Turn the curve" reports for our main arching population level outcomes
2. A dashboard based on indicators associated with primary and secondary prevention of long term conditions in primary care as part of our joint CCG and Public Health "Better Together" programme
3. A dashboard based service activity data from community, secondary care and social care services linked as far as possible to individual GP practices that will enable reporting in a number of different formats

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Following a strategic review of the Joint Strategic Needs Assessment we have determined that there are three key deliverables which deliver the vision and shared outcomes of integrated Health and Social Care. These three deliverables are the main elements of our joint work programme as follows:

1) Prevention/ Helping people stay well
2) Reablement and Intermediate Care
3) Integrated community and primary care services

The services provided under each of these headings are described below. We do have a number of joint initiatives already in place in Bury, which support the future development of integrated working; these will be reviewed and re-shaped to ensure that the services will be able to meet the stringent targets set through the integration agenda.

1) Prevention/ Helping people stay well

'Better Together'

This programme aims to ensure systematic implementation of primary and secondary prevention and chronic disease management in primary care. Through benchmarking, targeted incentive schemes and engagement with primary care colleagues, we will identify the 'missing thousands' from disease registers and ensure all patients receive best care.

Integrated wellness services

We have a number of existing services and programmes which aim to provide support to help people live a healthier lifestyle and be better able to manage their own health and care. We will appropriately scale and better integrate these services with primary care to ensure contribution to population level health outcomes.

'Staying Well'

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

Self Care Programmes

We will expand on our highly successful and effective 'Helping yourself to Health' programme which builds confidence, motivation and health literacy to enable people to self care.

Active ageing

Building on Bury's Sport England funded 'I Will if you Will' campaign we will develop a comprehensive programme aimed at supporting older people to make regular physical activity as part of their everyday life.

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

Affordable warmth

We will more systematically identify households in or at risk of fuel poverty and target support to help people keep warm and well through winter

Seasonal Flu Jab uptake

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

2) **Reablement and Intermediate Care**

Bury has a number of bed based intermediate nursing and social care facilities. These will be reviewed in the first 6 months of 2014/15 and an integrated model developed which will allow patients to receive holistic bed based and community based step up and step down rehabilitation care including:

Intermediate care in Bury has delivered some successful outcomes for health and social care over the last five years. The introduction of the reablement service led by Adult care has seen these outcomes significantly enhanced over the last three years. However we do recognise that there is potential for duplication within both services.

During 2014/15 there will be a review of both these services to identify how a greater emphasis can be given to support at home and step up services, whilst those people who do require support within bed based facilities receive this service in a timely manner.

There needs to be greater flexibility of the workforce to allow staff to follow the patients through their journey of reablement.

Consideration will be given to how we respond to the urgent health and social care needs to patients to reduce the likelihood of them attending A&E or going into residential care, this will require consideration being given to how current specialists services could be provided nearer the patients own home.

We already have successful joint discharge teams based at the hospital which has significantly reduced the numbers if delayed discharged, we are consistently within the top quartile across the North West as reported through AQUA.

We have a well established complex care panel which manages joint packages of care across Health, education, children's and Adults Social care. We are using the skills and expertise within the teams to build and prepare for the implementation of SEND by September 2014.

We will identify through the review how the BCF may be used to further reshape and redefine these services.

Integrated Community and Primary Care Service

Following a successful bid for funding from NHS England we have established a Demonstrator Community - **A Healthier Radcliffe.** We have agreed that this is the initial phase of our integrated delivery model in Bury and enables us to focus on one geographical location. It is providing us with the opportunity to test out developments prior to rolling out the model across the whole of Bury.

Radcliffe is one of Bury's six townships with a GP registered population of 34,162. The township has the 2nd lowest life expectancy for male and females age 76 years as compared to Bury's highest ward which is 83 years, 2nd highest mortality rate and is the 2nd most deprived township in the borough of Bury. Some indicators in Radcliffe North and Radcliffe East are within the top 10% of the most deprived areas in England. Radcliffe is also significantly worse than all other areas in Bury for childhood obesity, teenage conceptions and smoking.

The Demonstrator Community has adopted the Bury integration aims and principles which will be achieved by a multi-disciplinary partnership of health and social care providers working together in Radcliffe. The partnership will be a coordinated network of Radcliffe people, carers, local health providers including six GP Practices, public health, social care, third sector, North West Ambulance Service (NWAS), Bury Hospice and voluntary services. The team will identify vulnerable people needing intensive targeted support and work collaboratively as partners in Radcliffe to deliver an integrated, coordinated approach. People will be helped to take control of their own care through integrated care plans that are person-centred and compliment and build on their assets

The first stage of the project has commenced and delivered as follows:

- Successful go live 2nd December 2013
- 6 local practices working together innovatively to deliver extended primary care access for both booked urgent and planned care - 8-8 Mon-Fri, 8-6 Sat & Sun & Bank Holidays

- Single care delivery location for extended hours to aid patients navigating the health system
- Shared appointment book, directly bookable by any of the 6 practices
- Shared read / write access to full GP record to aid continuity of care
- Designed in sufficient capacity to meet local need
- Service delivered by local clinicians - not locums
- Clinical protocols created to define new ways of working & how practices will work together
- Solid joint working & the coming together of a new team to deliver the project against very challenging time frames

The second stage of the project is now underway with a recent multi- agency workshop identifying the key deliverables. The focus will be on frail older people ad children from complex families and a comprehensive action plan is now being drafted. This stage will deliver Health and social care services that will wrap-around the GP practices in Radcliffe with GPs holding accountability for all aspects of care. The model will facilitate the further development of integrated services and care plans by:

- Engaging with local people from all communities to hear their experiences, value their views, work with them to find solutions and enabling them to challenge the system if it fails to deliver

- Changing mind-sets and creating a culture of shared values, cooperation and coordination between partner agencies in the planning and provision of services

- Developing skill mix to make best use of available resources and progress training and education on integration in partnership with the North West Local Education and Training Board

- Encouraging an atmosphere of trust and collaboration in service development alongside clear formal agreements on shared guidelines and protocols ensuring that care processes and pathways engage all relevant partners

- Creating service specifications which include jointly agreed integrated care outcomes

- Providing a named lead professional responsible for coordinating the care of people with complex needs and rationalised access through a single contact centre and shared portal

- Ensuring that carers are provided with increased support

- Mapping community assets to include neighbours and other local resources

- Delivering a Directory of Services with easy access for public and professionals

- Developing integrated IT systems and person data sharing with a single health and social care record and care plan which individuals can access

- Embracing the potential for innovation in telehealth / telecare

- Testing new models of commissioning and alternative payment arrangements

The Radcliffe Pilot also includes Care Coordination focusing on/providing services to adults with Long Term Condition (LTC) who are assessed and treated in the most appropriate setting to meet their needs. The emphasis of the care is on providing:

- Independence and autonomy – to focus on prevention, self-care/self-management strategies and independence
- Supported self-management – to offer support, intervention and signposting; working with the patient's GP and other members of the multidisciplinary team
- (MDT) through patient centred consultation, collaborative care planning, behavioural change support, medicine review and support on dealing with exacerbations
- Enhanced care – to provide proactive early intervention and management when individuals need specific help. This may be due to the complexity of their condition or the interventions required by the number of co-morbidities and how they interact or their level of dependency and therefore support needed.
- Specialist Care – delivered by an MDT to meet the complex multifaceted needs of the individual requiring specialist support for their LTC. Traditionally specialist care has been delivered from hospital. the role of the Care Coordinator will be to support the individual in the community and in the different levels of the model

The model of care for children and families follows the principle of Early Intervention in the early years, supporting and empowering families to reduce reliance on public service. This model of care prioritises:

- Early intervention and prevention
- Self-care/self-management and good parenting
- Safeguarding – domestic violence/child protection/child in need

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Health and social care services are under unprecedented financial pressure and it is known that this will increase in coming years. This is one of the key drivers for change in

order to avoid services becoming steadily less sustainable.

The strategy adopted by the Bury economy is to reduce the reliance on hospital based services and support people in their local community to maintain their independence for as long as possible. It is therefore envisaged that there will be a reduction in the use of acute hospital care for people, in particular for those with complex needs and multiple long terms conditions. The shift away from hospital based care and the development of primary, community and social care will inevitably lead to a reduction in bed utilisation by avoided admission and by reduced length of stay and will therefore lead to bed reconfiguration and a related reduction in income and expenditure for the acute trusts. This ongoing local discussion links strategically to the wider discussion across Greater Manchester, Healthier Together.

3) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The governance arrangement that oversees the progress and outcomes for the work on integrating health and social in Bury is the Integrated Health and Social Care Partnership Board. This is jointly chaired by the Executive Director for Adult Care Services at Bury Council and the Chief Operating Officer at Bury NHS Clinical Commissioning Group and has representation from key stakeholders across the whole health and social care economy.

The partnership board strategically leads the direction and performance manages all activity. The Board is accountable to the Bury Public Service Reform (PSR) Programme Board, providing regular updates on the development, progress and outcomes in the delivery of the programme of work and this is then reported to the Bury Wider Leadership Group and Team Bury Partners.

The Partnership Board provides regular progress and outcome reports to the Bury Council Health Scrutiny, the Health and Wellbeing Board and Healthwatch, Bury CCG Governing Body, Clinical Cabinet and Patient Cabinet.

Appendix 1 shows the Bury Integrated Health and Social Care Governance and project structure

The development of the Better Care Fund is led by the Finance and Joint Commissioning Group, involving and engaging with a wider range of stakeholders including the Housing Strategy Programme Board with reference to the Joint Strategic Needs Assessment, the Health and Wellbeing Strategy and undertaking an Equality Impact Assessment.

The timetable to which consultation on the BCF has taken place is as shown in the table in appendix 2

It is anticipated at this stage that the Council will hold the BCF pooled budget on behalf of both parties. The governance arrangements around this pooled budget will be defined locally, but in line with requirements of statutory instruments.

4) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

Protecting social care services in Bury means that it is recognised that effective social care and targeted 3rd 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.

It is also how we will ensuring 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 register is a key factor in enabling this approach 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.

Please explain how local social care services will be protected within your plans

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 fund services where the budgets have been cut. It is expected that this will continue.

In addition, the funding has been used to enable the local authority to sustain the FACS eligibility criteria at critical or substantial. To do this required assessment and care management services to assess and review the care needs of clients who are FACS eligible. 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 Bill and 7 day working.

The maintenance of a community asset base requires investment to ensure the information is up to date and relevant for people, including professionals, and investment to 3rd sector to support prevention and early intervention and enable people to self- care and reduce the impact on health and social care services.

Supported by funding from the BCF to maintain and potentially upscale both the volume and scale of current health benefits including fewer people being admitted to hospital on an emergency basis.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

We have already started to put in place operational services to maximise the opportunities of 7 day working which is being tested through the Healthier Radcliffe pilot. We are clear that 7 day working is not just to facilitate hospital discharge and does not focus purely on hospital services. So in response to this we are building a community infrastructure which will provide responsive services linked with GP practices. GP practices will be extending their core hours over 7 days and it is important that they are supported by specialist services for advice about patient care and community services both health and social care who can provide information to patients, practical care and support and an urgent care response to maintain people in their own home. This is the main focus of the Healthier Radcliffe pilot.

Those with Long Term Conditions will have a community care plan in place that is developed through a Multi- Disciplinary Team approach, which is centred upon the patient. This will describe individual professionals who are available to support the patient should their condition deteriorate; however the emphasis will always be on self - care as the primary response.

Should patients require hospital admission there will be an MDT pod based at the hospital who are able to plan with the patient and their carer a safe but timely discharge to a place appropriate to meet their needs through the patient journey.

Pennine Care Foundation Trust and the local Authority are working together with joint commissioners to jointly develop a delivery plan that will underpin the integrated services, which will be wrapped around individuals within each locality. This will cover mental and physical health and social care needs.

In addition Pennine Care NHS Foundation Trust as the provider of mental health services has worked in the local leadership team to ensure that they are able to engage with the system over the 7-day week. They have already implemented a 7 day Rapid Assessment Interface and discharge team (RAID) service into the General Hospital to ensure those with co-morbid mental health problems are assisted to move through both A&E and hospital beds to discharge. Home Treatment services for older people with mental health problems are also being enhanced to offer more robust cover at weekends.

The Pennine Acute Trust is currently working on the development of a strategy that will include an action plan to deliver the clinical standard requirements to support seven day working. The strategy will be in two parts commencing with Elective pathways first then

non-Elective pathways.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

The NHS number is currently not used as the primary identifier across Health and social care. Social care has just completed their implementation of a new case recording system. There is the facility to record the NHS number on this and we expect this to be in place and reportable by 1 April 2015.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

We have a new social care database which has the facility to embed the NHS number as a customer identifier. We expect this to be in place and reportable by 1 April 2015.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are committed to adopting systems based upon open API's we currently use;

Adastra- is the system use by out of Hours GPs, this communicates with GPs in localities to provide virtually real time updates on treatments and advice given to their patients

Symphony- Is the system used within the Acute sector we are exploring ways in which health and social care professionals can access to facilitate discharge and deflect admissions where appropriate

Vision – is the system used by the GP's which is currently being piloted in Healthier Radcliffe as a way to share information across practices

Paris- is the new patient record system being implemented in Pennine community & mental health services. Pennine Care is working with the local authority to develop interoperability between this and protocol.

Protocol- social care case management system, which will store NHS, numbers as the primary identifier for patients in the future.

We already have secure email facilities in place and use this as a tool to correspond between social care and NHS colleagues. Health and Social Care community providers are working together over the next 12 months to join up their IT systems to share information. This will include Mental Health.

The Healthier Radcliffe pilot is already successfully sharing data between practices and we are considering how to further advance this across the whole of the borough.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

As a partnership, both health and social care fully embrace the seven principles of Caldicott 2. We see these as a way of strengthening our opportunities to share information not only amongst professionals but also with patients. We have used the principles to overcome potential barriers to information sharing, specifically in relation to Multi-disciplinary teams working together for people with long term conditions.

We are exploring honorary contracts as a way to overcome further barriers to information sharing.

We are committed to ensuring that appropriate Information Governance controls are in place in line with the NHS standard contract.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

We know that people living with long-term conditions (LTC's) are the main driver of cost and activity in the NHS and account for around 70% of overall health and care spend. They are disproportionate high users of health services and account for:

- 50% of GP appointments
- 64% of outpatient attendances
- 70% of inpatient bed days
- 58% of A&E attendances
- 59% of practice nurse appointments

We are also aware that the average cost per year of someone without a long term condition is around £1,000; which rises to £3,000 for someone with one condition and to £8,000 for people with 3 or more conditions

Bury is therefore taking multiple approaches to these challenges which include:

1. LTC AQUA (Risk modelling etc)

2. Care Coordinators
3. Better Together (case finding and solutions for undiagnosed LTC)
4. Tier 2 services (hubs for primary / secondary care working) .

1.LTC AQUA

Advancing Quality Alliance (AQuA) is a membership body, which aims to promote and share knowledge of best practice to improve the quality of healthcare. AQUA is funded by members including: Foundation Trusts, Mental Health Trusts, Clinical Commissioning Groups and Local Authorities. AQuA acts as a catalyst for change across the North West of England and beyond.

AQUA has a LTC programme and there are three core elements to the programme and its delivery:

- Predictive risk modelling of each GP practice population
- Provision of virtual ward care for risk stratified patients
- Empowering patients to maximise self-care, self-management and choice, through shared decision-making and motivational interviewing.

Predictive Risk Modelling

The foundation of the service is based on the risk stratification of the local population, which is facilitated through the use of a computer-based algorithm (CPM - Combined Predictive Model). This combines GP and hospital data on every patient to reach a predictive risk of emergency admission in the next 12 months. All patients can then be ranked according to their future risk of emergency admission. The combination of patient identification through predictive risk assessment and multi disciplinary case management of these patients is described here as 'virtual ward' care.

The practice reviews the data and proactively manages the patients with medium risk. The patients that the practices find to have more challenging needs are taken to multi-disciplinary team meetings.

Integrated Care Team – Multidisciplinary Team (MDT)

The overarching aim of the MDT is to support patients to ensure better self-care and management with:

- Increased confidence to self-manage
- Improved experience & increased satisfaction
- Improved access to information and support services
- Appropriate use of care services & resources
- Increased awareness of support groups
- Improved quality of life & well being
- Increased confidence and ability to make good care decisions

The MDT also aims to avoid emergency attendances, hospital admissions and re admissions as well as to promote better discharge planning through better co-ordination and communication across services

The following professionals are considered essential members of the MDT:

- GP(s) accompanied when appropriate and practicable by their practice nurse(s) and the Practice Manager.
- Care Co-ordinators
- District Nursing Sister
- Psychological Therapist
- Adult Social Care worker

This list is not intended to be exhaustive and where agreed and appropriate the following additional inputs are also considered:

- Specialist nursing
- Care Co-ordinators
- Allied health professionals including physiotherapy / occupational therapy
- Pharmacist
- Voluntary Sector Representative

As a minimum a GP and the Care Coordinator / District Nursing Sister need to be in attendance for the MDT.

The MDT will support integrated patient care and management to avoid duplication of care or missed service provision, whilst improving the quality of care to patients. Fundamental to the success of the MDT is for a "Lead Professional" to take responsibility for a patient and to work with the team to deliver the outcome. The most appropriate professional in coordinating the care and support for the patient is identified as the "Lead Professional".

1. Self management and shared decision making

There is good evidence to suggest that a better understanding of a long-term condition can improve people's understanding of their symptoms and enhance long-term health and wellbeing. The role of the care professional is to support people by promoting self confidence and self care, help them feel more in control of their lives, support problem solving, and to direct people towards the type of support and information they need. This means listening to their goals and having a more patient outcome focused approach to planning, agreeing and reviewing their care plan.

Development of the self-management and shared decision making aspects of this programme has been developed and will be rolled out over the coming months.

2. Care Co-ordinators

Targeting those individuals who are at highest risk and who are amenable to preventative care will ensure the proposed outcomes of the Care Coordinator role are met. The risk stratification tool and/or clinical judgement will be used to identify individuals who are at high risk of hospital admission. Offering care coordination to patients who are currently experiencing emergency admissions can improve efficient as well as patients that can be identified before they deteriorate, has the potential to reduce admissions.

The Care Coordinator assesses the patient in terms of both their current level of ability and their physical and social care needs. The care planning process brings together an individual's personal circumstances (including housing situation, welfare benefit status and access to informal care) with their health and social care needs to create a plan that aims to match needs with service provision.

The Care Coordinator pilot is up and running in some localities in Bury. The pilot and will be reviewed in May 2014 with consideration then being given to roll out across Bury from May 2014.

3. Tier 2 services

A community based hub that will provide clinical solutions closer to patients that would otherwise be provided in a hospital setting. The teams are also charged with improving patient education, shared decision making and reducing the variation of standards within primary care. Diabetes care will be the initial Tier 2 service and will be up and running by April 2014. Discussions for a respiratory and cardiac service are planned.

Overall

Overall in the solutions we have developed and continue to develop there are some overarching principles that we are putting in place:

- Be person centred, enabling the person to be in control of their lives
- Look at the person as a whole
- Mental health is as important as physical health
- Having a lead professional responsible
- Reduce variation and duplication
- Improve communication
- Developing Self care and Self management
- Critical for partners to learn together and develop

The Radcliffe Demonstrator Community is providing us with an opportunity to particularly focus on testing out aspects our multi-disciplinary working within one locality in Bury along with our partners.

5) RISKS

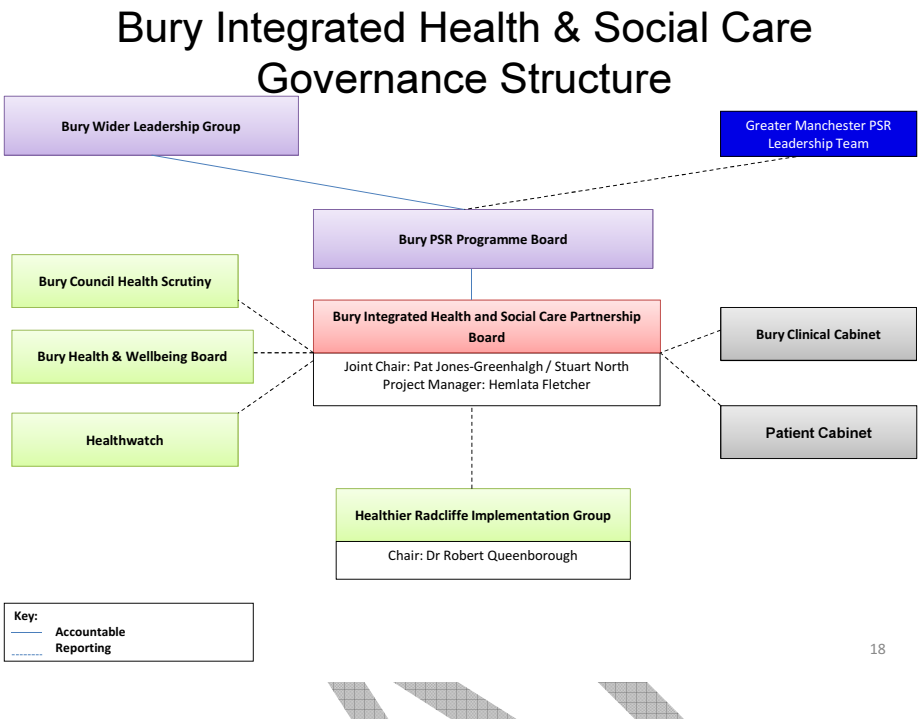
Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

The table below provides an overview of some of the key risks identified through the co-design process to-date. A full risks and mitigations log is being produced in support of our finalised BCF submission.

Risk	Risk rating	Mitigating Actions
Shifting of resources to fund new joint interventions and schemes will destabilise current service providers, particularly in the acute sector.	High	• Our current plans are based on the agreed strategy for Bury. • The development of our plans for 2014/15 and 2015/16 will be conducted within the framework of Healthier Together Programme, which includes hospital reform, Primary Care Transformation and Integrated Care. This allows for a holistic view of impact across the provider landscape and putting co-design of the end point and transition at the heart of this process.
A lack of detailed baseline data and the need to rely on current assumptions means that our financial and performance targets for 2015/16 onwards are unachievable.	High	• The Whole Systems Integrated Care programme is undertaking a detailed mapping and consolidation of opportunities and costs that will be used to validate our plans. • We are investing specifically in areas such as customer satisfaction surveying and data management to ensure that we have up-to-date information around which we will adapt and tailor our plans throughout the next 2 years. • An integrated workforce strategy will be developed to support the Integrated Care development.
Operational pressures will restrict the ability of our workforce to deliver the required investment and associated projects to make the vision of care outlined in our BCF submission a reality.	High	• Our 2014/15 schemes include specific non- recurrent investments in the infrastructure and capacity to support overall organisational development.
Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute	High	• We have modelled our assumptions using a range of available data.

and nursing / care home activity by 2015/16, impacting the overall funding available to support core services and future schemes.		• 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications
The introduction of the Care Bill, currently going through Parliament and expected to receive Royal Assent in 2014, will result in a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.	High	• We have undertaken an initial impact assessment of the effects of the Care Bill and will continue to refine our assumptions around this as we develop our final BCF response, and begin to deliver upon the associated schemes. • We believe there will be potential benefits that come out of this process, as well as potential risks
Insufficient clinical engagement in the models	medium	• Clinical leads for each work stream • Clinician will be involved within the steering group
Inability to integrated care models because of technical issues.	High	• IM&T lead to be integral to the development of the model and the technology solution to be developed alongside.
Information Governance, ensuring processes and policies are in place to enable data sharing	High	• Information governance lead and Caldecott guardians to be involved in project from start and develop policies to support the service model.

Bury Integrated Health and Social Care Governance structure



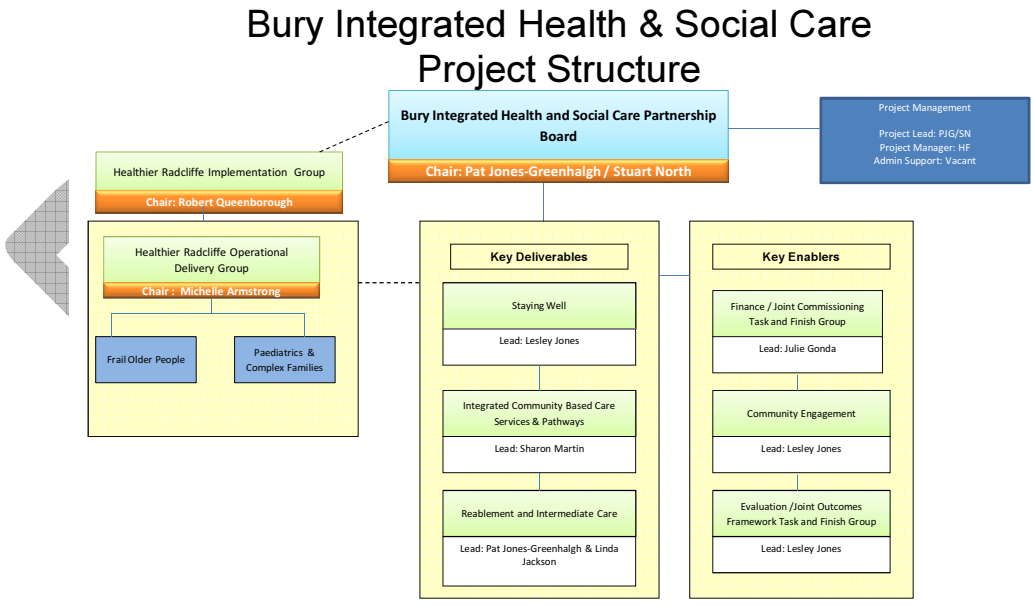


Table: Bury's Better Care Fund Plan – Consultation Timetable Governance Process

Date	Governance Process
Better Care Fund Plan	
7 January 2014	First draft to members of the Finance & Joint Commissioning T&F Group
8 January 2014	Public Service Reform (PSR) Programme Board
9 January 2014	Bury Clinical Commissioning Group (CCG) Patient Cabinet
17 January 2014	Iterations of comments and feedback and updating of document
21 January 2014	Finance and Joint Commissioning Task and Finish Group
21 January 2014	Bury Wider Leadership Group
21 January 2014	Bury Integrated Health and Social Care Partnership Board
22 January 2014	Bury CCG Governing Body
	Bury CCG Clinical Cabinet
28 January 2014	First draft submission to Bury Council Health Scrutiny
28 January 2014	Providers
30 January 2014	First draft submission to the Health and Wellbeing Board to sign off
5 February 2014	Bury CCG Clinical Cabinet
6 February 2014	Bury CCG Patient Cabinet
10 February	Finance and Joint Commissioning Task and Finish Group
14 February 2014 - Draft submission of Better Care Fund plan to NHS England	
2 Year Operating Plan	
5 Year Strategic Plan	
19 February 2014	Public Service Reform (PSR) Programme Board
25 February 2014	Bury Integrated Health and Social Care Partnership Board
26 February 2014	Bury CCG Governing Body
4 March 2014	Bury Wider Leadership Group
5 March 2014	Bury CCG Clinical Cabinet
6 March 2014	Bury CCG Patient Cabinet
6 March 2014	Bury Health and Wellbeing Board
18 March 2014	Finance and Joint Commissioning Task and Finish Group
20 March 2014	Bury Council Health Scrutiny
25 March	Bury Integrated Health and Social Care Partnership Board

2014	
26 March 2014	Bury CCG Governing Body
2 April 2014	Bury CCG Clinical Cabinet
3 April 2014	Bury CCG Patient Cabinet
4 April 2014 - Submission of final Better Care Fund plan; 2 year operational plans and draft 5 year strategic plan	
10 April 2014	Bury Health and Wellbeing Board
22 April 2014	Finance and Joint Commissioning Task and Finish Group
23 April 2014	Bury CCG Governing Body
29 April 2014	Bury Integrated Health and Social Care Partnership Board
1 May 2014	Bury CCG Patient Cabinet
7 May 2014	Bury CCG Clinical Cabinet
18 May 2014	Bury Council Health Scrutiny
27 May 2014	Bury Integrated Health and Social Care Partnership Board
28 May 2014	Bury CCG Governing Body
4 June 2014	Bury CCG Clinical Cabinet
5 June 2014	Bury CCG Patient Cabinet
18 June 2014	Bury Council Health Scrutiny
20 June 2014 - Submission of final 5 year strategic plans • **Years 1 & 2 of the 5 year plan will be fixed per the final plan submitted on 4 April 2014**	