NHS
Bury Clinical Commissioning Group

NHS Bury Clinical Commissioning Group

Strategic Plan 2014-2019 and Delivery Plan 2014-2016

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Chair and Chief Officers Foreword

"Welcome to our 5 year strategic Plan. This plan describes how services need to look in five years' time to meet the health needs and health challenges that we face in Bury. We need services to be fit for purpose, to improve health outcomes for patients and keep people well for longer. We have been engaging with local patients, carers and groups to hear their views about local services and what they feel works well, what could work better and what is missing. The feedback will be used to inform our plans.

There are ambitious plans for the year ahead, which are supported by the CCG, to improve access to GP services throughout the whole of Bury. Through the GP Federation, Bury has been awarded around £2.7 million to pilot increased access to GP services right across the town. This will mean that appointments will be available to all Bury patients into the evening and at the weekend. In addition to improved access to see a GP, new technology will also be used to make accessing GP services more simple. Bury is one of only 20 areas to be allocated money from the Prime Minister's Challenge Fund to fund this one year pilot. We are looking forward to seeing how the project progresses over the coming months for the benefit of local patients.

We hope you enjoy reading our 5 year strategic plan. If you have any comments on it, or the information contained within it, please let us know using the contact information on the back page. We would be pleased to hear from you."

Dr. Kiran Patel
Chair and
Clinical Lead,
NHS Bury Clinical
Commissioning
Group

Stuart North
Chief Officer,
Accountable Officer,
NHS Bury Clinical
Commissioning
Group

Section 1 - Our Vision; Values and Principles

1.1 Our Vision:

"To continually improve Bury's health and wellbeing by listening to you and working together across boundaries."

In Bury we 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.

1.2 Values and Principles

Our Strategic Plan will be delivered through effecting demonstrable change in pathways of care which will:

- Improve the health of the population
- Reduce health inequalities
- Deliver Parity of Esteem

The Strategic Plan is informed and shaped by these values and also by the national and local policy context. Bury faces significant challenges in addressing health deprivation and inequalities. Partners, the public, staff and stakeholders have been widely engaged during the development of the values.

Our local values are:

Figure 1- Local Values

Section 1 - Our Vision; Values and Principles

1.2.1 Listening to you and learning together

The public and patients are at the centre of everything we do and every decision we make, wherever possible they are involved themselves. People have a right and an expectation to be treated with dignity, respect and compassion. That is why we will always commission services and care that; promotes these ideals; improves access and makes sure that the public and patients are equal partners in decisions about their care. We are committed to listening to and acting on what really matters to local people by:

- Making their priorities our priorities
- Ensuring that the care and support given is tailored around their needs, goals and lives.
- Engaging through a whole range of approaches from events through to online communications
- Reaching out into local communities to systematically gather insights and ideas, as well as concerns that will directly inform commissioning and planning.

1.2.2 Value individuals and promote self development

It is recognised that some staff are being stretched; caring for more people, with more complex needs, in less time. This shows us that we need to continually consider how to ensure our workforce matches local need and demand. Some staff are simply in short supply such as, GPs, care staff, some hospital specialities and nurses, are well documented examples. We will need to work with local providers and the education system to encourage more people to follow fulfilling and rewarding careers in the NHS and Social Care sectors. We will ensure a workforce strategy is developed across all of our providers to support this strategy, which will ensure risk to staff from transformational change is minimised and we will involve Health Education England, the Academic Health Science network, the Deanery and local academia, in the development of this strategy to ensure innovative approaches.

1.2.3 People centred, clinically effective, efficient and sustainable care

Local patients deserve the highest quality care we can give, therefore our aim is to commission care which is safe, effective and delivers a good experience. We face a big financial challenge in our local NHS and Care system over the next five years, however we will never talk about the cost of services without talking about the quality of them; they are inextricably linked. Spending less time in hospital, with fewer cancelled appointments and living a full and independent life, supported by local services, is better for patients. Our Strategy is based around this value. In short, transforming services, not cutting them, is how we will keep services safe, of high quality and meet the financial challenges we face. To deliver both quality and value we will always listen to what local people and clinicians tell us about and we will combine this with what the data and information shows us, so that we can identify when things aren't right and address it. We will also support and empower staff to offer great care; we know that happier staff give better care, which means a better experience for the public.

1.2.4 Inclusive and transparent decision making

Staff delivering service are a driving force for change, because they know their services, their clients and often know the solutions to the problems that the NHS and care system faces. To realise the potential of staff we will provide excellent management support, from clear performance and programme management systems, to rigorous approaches to corporate management and business; it's this partnership that will make a difference for the people of Bury. Therefore our service redesign work will always be multi-disciplinary incorporating the skills and knowledge of a broad range of expert clinicians.

Section 1 - Our Vision; Values and Principles

1.2.5 Challenge inequalities with partnership working

Health and social care inequalities are a very real problem in Bury. There are areas amongst the most deprived in England and differences in life expectancy of ten years variance exists between different communities. We are committed to doing our part to reduce these inequalities over the life of this strategy and will review specific local needs for every clinical programme of change to:

- Improve our understanding of the issues local people face in access to services and in the outcomes they experience.
- Ensure that we can invest resources appropriately
- Develop services proportionally to the unique needs of different areas according to principles set out by Sir Michael Marmot (2010).
- Work in partnership putting joint plans in place for agreed joint areas of work, where we will focus on prevention through the Better Together programme.

Integration means that the Bury population experience joined-up care, because most people are not worried about who provides or commissions their care, so long as it is seamless, high-quality and delivered with compassion. To make this a reality we must work together, in collaboration with partners, breaking down the artificial barriers between organisations. We know that living with complex and multiple long-term conditions often requires complex health and social care responses and can mean the experience of care is confusing and dis-jointed. We have worked as a system to develop this strategy and the vision. This has set the precedent for a new way of working and for new ways of behaving, rooted in collaboration, innovation and transparency. Through strong integrated leadership we have developed plans to transform services, so that we can allow local providers to deliver these changes on the ground with our support. The work on integration will be part of this process.

1.2.6 Bold, innovative and supportive

General Practitioner (GP) Practices in Bury are grouped into sectors; they know their population well and therefore have an important role to play in meeting the unique and changing needs of local communities. The sectors are leading the commissioning of integrated care models in their locality. People don't look at health and social care as a set of services, organisations and teams; they see it as a journey; their journey from prevention, through to treatment and on to recovery. That is why we commission in that same way, along pathways. Working in this way helps us to remove duplication by reducing hand-offs between clinical teams, making the patient's journey as seamless as possible; it is also much more efficient and cost-effective to provide. This also means that we can design services to improve access and support providers, to develop innovative approaches to how they run their services. This will be important to ensure that the local NHS can continue to meet the rights set out in the NHS Constitution (2012) and will mean that services work better together, so that in partnership they can cope with changes in demand and growing system pressures. We know that seven-day working right across the system will be a key part of this. Taking a whole pathway approach in everything we do, also means that we can take a more holistic view of a person's wellbeing and have the opportunity to put prevention at the heart of service design, ensuring people get lifestyle support and signposting to support services, at every step of their journey. It also means that we can ensure that physical health and mental health are treated on an equal basis; delivering true parity of esteem for our population. New technologies, medicines and procedures have changed the way we can diagnose and treat people, which changes the way staff work. Whilst these are good for the population, they can increase the costs of providing care. To ensure that we can make the most of these improvements we must change the way we work to make funds available for reinvestment into new and emerging technologies.

Section 2 - Executive Summary

There is national recognition of increasing demand causing pressure on budgets for public services. In order to ensure that safe, sustainable services are available now and for future generations, changes will be required. The NHS and the Government announced the need for transformation to occur, by way of creating a single pooled budget to support health and social care, in the form of the Integrated Care agenda.

Representatives from across Bury have come together to form the Health & Wellbeing Board, to support and encourage partnership arrangements for health and social care services. A strategy has been produced, aiming to collaboratively meet the needs of the local population, using resources such as the Joint Strategic Needs Assessment (JSNA), which outlines five cross cutting local priorities. A partnership approach has been established to plan and deliver the changes required and a joint submission outlining the plans and the resources needed to support them called 'The Better Care Fund' was devised, to support the development of the Integrated Care agenda.

All plans have been developed taking the views of the public, patients and stakeholders into account and there is strong commitment to ensure local people are included in decisions, not only about the care being given, but also on the commissioning and delivery options for service provision.

Integrated care will include areas such as; prevention, promotion of wellness and self-care, early intervention, community based support programmes and extended primary care services for the population, delivered across the life course.

If the proposed integrated care model is to be a success, resources and demand must be redirected into the primary care, community based setting and away from the acute hospital, secondary care setting, wherever it is safe and appropriate to do so. The plan therefore is for the improved care provision in the community setting to bring about a reduction in the hospital setting by by 20% in urgent, 15% in elective care and 5% in both day cases and out patients appointments.

Bury CCG has developed a five year strategy with this focus, to facilitate the process of transformational change, while at the same time recognising that quality and safety must remain of the utmost importance. The CCG has also considered its role as a corporate organisation around; the risks, governance and implications of these changes, developing collaborative arrangements and partnerships, where necessary, to collectively manage the impact of change.

The Local Authority and the CCG are committed to further developing and strengthening the collaborative working agenda. The aim over the coming months and years is to align visions, strategies and processes, to achieve a one system approach to health and social care in Bury. It is understood that this will not be accomplished overnight or without difficulty, however the level of enthusiasm and determination within departments, to achieve the improvements required, will enable the challenges encountered to be overcome.

Section 3 - Context: About Bury

3.1 The Bury Population Profile

In the 2011 Census, the population of Bury was estimated to be 185,100. This is expected to rise to 199,300 by 2021.

Around 10.9% of Bury's population are from Black and Minority Ethnic (BME) communities.

The key headline regarding population changes is an ageing population. It is expected there will be 6,700 (23%) more people aged over 65 by 2021. This means our total 65 and over population will be around 36,200 which will be 18.2% of the 2021 population. It is also anticipated that the proportion of aged 85 and over will increase by 36% to about 4,900.

The ageing population will mean an increasing burden of poor health in later years and a significant increase in demand for health and social care. For example, as the population ages, the level of late onset dementia is expected to rise by about 5% over the next 10 years, which will result in a higher dependency on hospitals, carers and specialist care services. Services will need to be shaped according to these changes. We need to support people to remain safe and independent for as long as possible.

3.2 Life Expectancy in Bury

Life expectancy in the borough is still below the England average and this gap is widening. For males life expectancy is around 77.5 years, just over 1 year less than the England average at 78.6 years. For women life expectancy in Bury is 81.2 years, which is 1.4 years less than the England average of 82.6 years. Across the borough there are big differences in life expectancy. For men there is a gap of 10.8 years and 12 years for women, between the most and least deprived areas across the borough.

Bury has just under 1,800 deaths a year, with the main causes being cancer and circulatory disease, with respiratory disease also a main contributor. Early death rates from heart disease and stroke have fallen but are still worse than the England average. Deaths from Liver disease are increasing.

Table 1 shows that for females, mental and behavioural disorders cause the greatest number of excess deaths (111), followed by respiratory diseases (106 combined) then circulatory diseases (63 combined). For males circulatory diseases cause the greatest number of excess deaths (83 combined), followed by cancer (45 combined), then respiratory diseases (37 combined). Lifestyle factors such as smoking, levels of physical activity, and healthy eating, greatly affect the risk of developing all of these conditions.

Table 1

Disease Area	Excess Deaths		
	Male	Female	Combined
Mental Health	(18)	**111**	129
Respiratory Diseases	**37**	**106**	143
Circulatory Diseases	**83**	**63**	146
Cancer	**45**	(34)	79
Total	**183**	**314**	**497**

Numbers in () indicate no concerns for that gender

Four themes are consistent throughout the 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.

Section 3 - Context: About Bury

- 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.

3.3 Local People Lifestyle

Liver disease in the UK is the fifth biggest cause of death in England and Wales, after heart disease, cancer, stroke and respiratory disease. The rate of death in all these major causes of death is reducing in the UK, except for one - liver disease. A total of 16,087 people died from liver disease in 2008 and if the rate continues at its current pace, deaths from liver disease are predicted to double in the next 20 years.

UK under 65 standard death rate for various diseases (1970 = 100%)

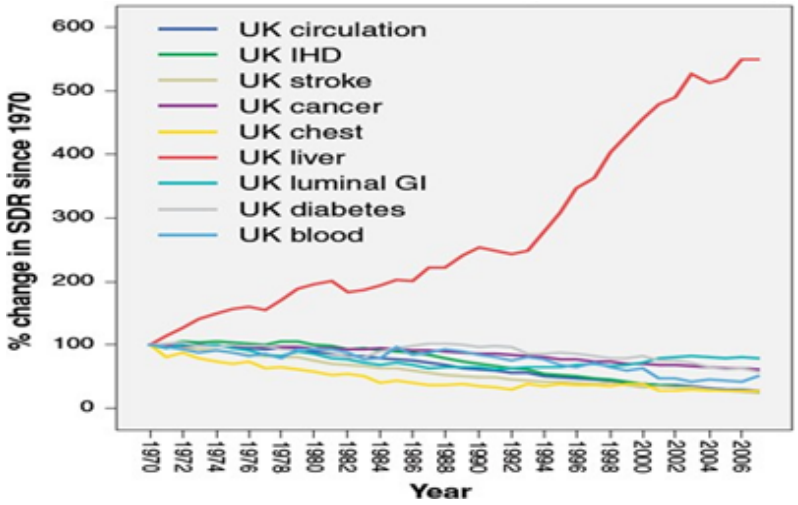


Figure 2 - Under 65 Standard Death Rates

Alcohol-related death rates, United Kingdom, registered in 2002-2012

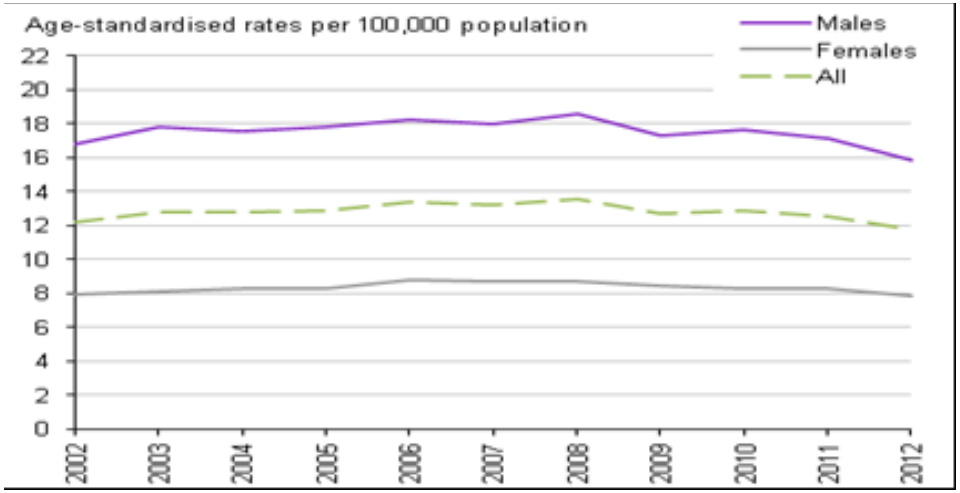


Figure 3 – Alcohol Related Death Rates

- In 2012 there were 8,367 alcohol-related deaths in the UK, 381 fewer than in 2011 (8,748).
- Males accounted for approximately 65% of all alcohol-related deaths in the UK in 2012.
- Death rates were highest among men aged 60 to 64 years (42.6 deaths per 100,000 population) and women aged 55 to 59 years (22.2 deaths per 100,000).
- Of the four UK constituent countries, only in Scotland were male and female death rates in 2012 significantly lower than in 2002.
- In England and Wales, 63% of all alcohol-related deaths in 2012 were caused by alcoholic liver disease, with 16% of these deaths occurring among those aged 55 to 59 years.
- In England, alcohol-related death rates were highest among regions in the North and lowest amongst those in the South throughout the period 2002–2012.

Section 3 - Context: About Bury

Research by the Association of Public Health Observatories has demonstrated the prevalence of alcohol-specific and alcohol-attributable hospital admissions increases with higher levels of deprivation. At a ward level the highest rates of admissions are indeed present in more deprived areas of the Borough, ranging from 32.0 per 1000 population in Moorside and 30.1 in East, to just 12.6 in Sedgley. Of great concern however is the synthetic estimate of the prevalence of binge drinking (intake of more than twice the daily recommended limit), developed by the North West Public Health Observatory. This suggests that the rate in Bury is in excess of national, regional and all comparators, with the exception of Stockton-on-Tees. Engaging in binge drinking is linked to accidental injury as well as the higher levels of A&E attendance observed during night time economy hours. Regular binge drinking can lead to significant health consequences, including liver damage, cancers, heart disease, diabetes and obesity. The Bury Health Survey 2010, found a significant association between BMI scores over 24.9 and drinking above sensible levels.

Many of the leading causes of death and ill health are preventable. A focus on healthy lifestyles is critical in increasing life expectancy and narrowing the inequalities gap, both locally and nationally. Smoking related deaths in Bury are significantly higher than the England average[1] Smoking levels are 22% in adults, which is higher than the England average of 20%[2]. In Bury, over half of the adult population is overweight or obese[3] and there are indications that this trend is being replicated in children with rising levels of obesity, according to the National Child Measurement Programme[4]. Levels of physical activity are low in adults in Bury[5] and alcohol related harm is higher than the England average[6]. The rates of new STI diagnoses in Bury have declined between 2012 and 2013 from 703.5 per to 648.8 per 100,000 population[7]. Unhealthy lifestyles are risk factors in the development of long term conditions and the burden of ill-health associated with them. Ensuring we have joined-up services, focused on addressing the needs of the customer, and the promotion of self-care will be critical.

Despite falling rates of teenage pregnancy, levels in Bury are still worse than the England average. In Bury, there are increases in both terminations and repeat terminations for conceptions amongst the under 18s[8]. Breastfeeding rates are below the national average and there is significant drop off between initiation and breastfeeding at 6-8 weeks[9].

Smoking in pregnancy is a key factor in low birth weight and infant mortality. Local levels of smoking in pregnancy are high at 16.6%, compared to the England average of 13%[10]. Giving children the best start in life is essential to their future social, health and economic outcomes right across life.

Bury's educational results remain significantly higher than the England average[11]. However there are educational attainment gaps between ethnicities. Those on free school meals and looked after children also experience lower attainment levels than the wider population.

Education has an impact on employment and wider wellbeing issues throughout life. Bury has an unemployment rate consistently below the regional average, but there are small areas that fall into the most deprived for employment nationally, particularly Chesham Fold and Coronation Road. Disadvantaged groups are likely to require greater support to help them into work.

[1] http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1215589013908

[2,6,9,10,11] Public Health England, 2012, Bury Health Profile

[3] NHS Bury, 2010, Bury Health Survey, Public Health Department

[4] Health and Social Care Information Centre, 2012, National Child Measurement Programme – England 2011/12

[5] NHS Bury, 2010, Bury Health Survey, Public Health Department

[7] NHS Bury 2012, Bury Sexual Health Strategy 2012 – 2015, Public Health Department

[8] Bury Council 2013, Teenage Pregnancy and Repeat Abortions In Depth Needs Assessment

Section 3 - Context: About Bury

Bury has high rates of unplanned admissions for:

- Asthma, Diabetes and Epilepsy in under 19s
- Acute conditions that should not usually require hospital admission
- Alcohol related liver disease
- Children with lower respiratory tract infections

- than similar CCGs and the England average.

3.4 Assessment Commissioning for Value Tool:

NHS England provided CCGs with a Commissioning for Value pack which identified areas for further local consideration. The areas below were identified for Bury CCG:

- The programme areas that appear to offer the greatest opportunity in terms of both quality and spending are: Circulation Problems (CVD), Respiratory, Cancer, Mental Health, Endocrine, Nutritional and Metabolic.

- The programme areas that appear to offer the greatest opportunity for quality-related improvements are: Circulation Problems (CVD), Respiratory System Problems, Cancer & Tumours, Mental Health Problems and Endocrine, Nutritional and Metabolic Problems.

- The programme areas that appear to offer the greatest opportunity for financial savings are: Circulation Problems (CVD), Cancer & Tumours, Musculoskeletal System Problems, Endocrine, Nutritional and Metabolic Problems and Genitourinary.

The CCG needs to balance the need to improve quality and reduce spend with the feasibility of making the improvements in the identified areas.

3.5 Health Care Provision in Bury

Health Care for Bury patients is made up of community and primary care, secondary acute (hospital) care, tertiary care (specialist hospital services), the ambulance trust, mental health and independent and third sector providers (such as Spire Hospitals).

Figure 4 summarises NHS Bury Clinical Commissioning Group providers and the current proportionate investment into the relevant provider services.

Provider Landscape

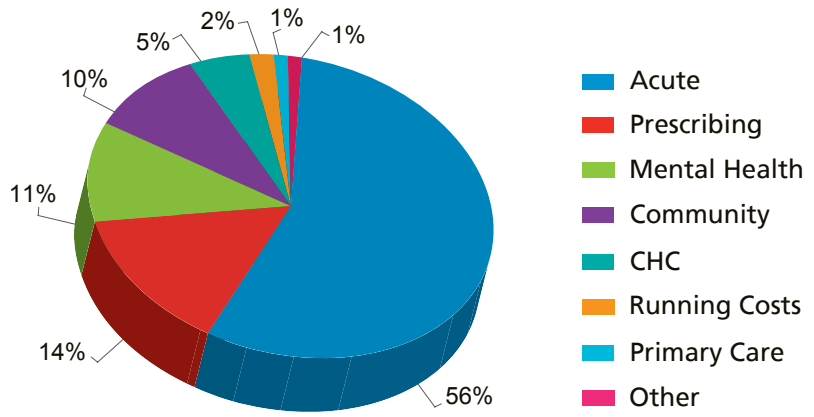


Figure 4 - Provider Landscape

The majority of our secondary care activity (77%) is undertaken by the Pennine Acute Hospitals NHS Trust, which is based across four sites at; Fairfield General Hospital, Oldham, North Manchester and Rochdale.

Section 3 - Context: About Bury

Care UK commenced in February 2009 providing services from mobile clinical units, which visit sites in Bolton, Denton, Longsight, Oldham, Rochdale, Salford and Trafford. The Clinical Assessment and Treatment Service, also known as CATS, provide a full clinical assessment of patients and subsequent treatment, or onward referral to secondary (hospital) care where this is indicated. Five specialties are provided, these are: general surgery, ear, nose and throat, musculoskeletal (muscles and bones), gynaecology and urology. The contract provides for an average of 85,000 referrals every year.

In addition, local independent sector providers are available as a choice for patients through Choose and Book (an electronic booking system), as an alternative to traditional secondary care (hospital) providers.

Figure 5 shows the split of provider on the basis of patient choice for their first booking.

Choice by Provider

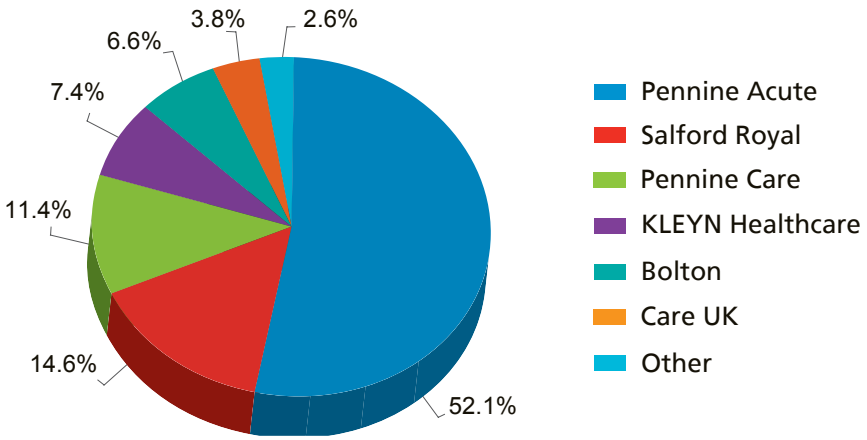


Figure 5 - Patient Choice by Provider

Pennine Care NHS Foundation Trust is the main provider of inpatient and community services for NHS Bury Clinical Commissioning Group's population. Primary care based mental health services have seen substantial expansion and investment in recent years, through the all age Improving Access to Psychological Therapies (IAPT) service.

There are 33 GP practices in Bury and 30 of these practices recently federated to form a GP federation. The NHS Commissioning Board (NHSCB) is responsible for commissioning primary care services i.e.

- Primary medical service commissioning i.e. GP services
- Primary dental service commissioning
- Pharmaceutical service commissioning, and
- Ophthalmic (optician) service commissioning

Whilst CCGs no longer directly commission primary care services, we have a statutory responsibility to support the NHSCB to improve the quality of primary medical care.

NHS Bury Clinical Commissioning Group commissions community services from Pennine Care Foundation Trust.

The future service model for integrated care in Bury requires wider development of integrated community based alternatives to hospital admission and a greater emphasis on health promotion, social wellbeing and disease prevention, for both physical and mental ill health. This will support people in making the lifestyle changes necessary to reduce future levels of chronic disease and ill health and where appropriate, enable people to manage their own conditions. This model will require a more integrated, multi-disciplinary team approach with greater specialisation in the primary, community and social care workforce. This will require providers to work together in integrated teams.

Section 3 - Context: About Bury

In Bury a small number of independent and Third Sector providers are currently commissioned across a wide range of services for all ages of the population. Some examples of this include: the advocacy provider (MIND) which offers advocacy services for community clients and inpatients, and Macintyre Care, which provides 24-hour intensive support to highly complex learning disability clients in their own homes.

Commissioning from the Third Sector is essential to ensure a full breadth of services is available. However, many Third Sector organisations are small and do not have the processes and procedures in place to work within the contractual frameworks required from commissioned services. Bury CCG and the Local Authority are already working with Bury Third Sector Development Agency (B3SDA) to empower local Third Sector services.

3.6 Summary of the review of the current position in Bury

The following summarises the findings from the analysis of demographic indicators, population health status, health needs, outcomes and lifestyle:

- Health outcomes in Bury are poorer than nationally and in some cases than the North West. Lifestyle factors are a major contributor to this, as are the needs of people requiring support to take responsibility for their health. Prevalence is in line with North West average but outcomes in some areas are worse.
- The ethnic profile of Bury is changing with the most rapid growth in the Pakistani community.
- The diseases which cause the highest mortality in Bury are
  - Circulatory Disease (CVD)
  - Stroke
  - Respiratory Disease
  - Cancer
  - Alcohol Related Liver Disease
- Cancer treatment and access rates for screening are overall good, but there are groups who do not know how to access services and this may affect their outcomes.
- Lifestyle choices are a major cause of poor health and health inequalities in Bury.
- Equality Target Groups are not consistently accessing available services and targeted community development work must be undertaken to improve this.
- Alcohol misuse is becoming a significant health issue for the population of Bury.
- Prevalence of hypertension will increase significantly as recording improves, this will have an impact on prescribing costs.
- Mental health issues need to be detected early and supported to reduce worklessness.
- The ageing population will have a significant impact on the utilisation of health services and therefore prevention of ill health and enabling care to be provided at home needs to be a significant focus.
- A focus on performance must be sustained to improve and to ensure patients experience is positive.

Section 4 - Context: Drivers for Transformation

4.1 National Drivers

- **Economic Position and the need to focus on Quality**
  In 2013, NHS England reflected on the 65 year success of the NHS and also the challenges that currently face NHS organisations, due to pressures that threaten to overwhelm the system in the future. The population in England is ageing, which brings a significant rise in the number of people with long term conditions, such as diabetes and heart disease, increasing the demand on services and raising costs. In order to ensure that the NHS can continue to meet the increased demands on its services, NHS England recognises things must be done differently and a new approach to health care must be taken in the future.

Figure 6 – NHS England Mission - http://www.england.nhs.uk/about/imp-our-mission/

In April 2013, NHS Improving Quality (NHS IQ) was established and is the driving force for improvement across the NHS in England. Working to improve health outcomes for people, providing improvement and change by bringing together expertise and experience from across the NHS, working to the five domains of the NHS Outcomes Framework.

There is a requirement for CCGs to focus on both quality and safety, particularly responding to the Francis, Winterbourne View, Keogh and Berwick reports, acting on recommendations and ensuring assurance processes are in place.

- **The NHS Constitution** contains details of what staff, patients and the public can expect from the National Health Service. It sets out rights and pledges, for patients, public and staff, which the NHS is committed to achieve. It also outlines the responsibilities of the public, patients and staff, to ensure resources are used responsibly and help the NHS to work effectively.

- **National direction for Integrated Health & Social Care, Partnership Approach / Care Bill**
  The Government announced in the June 2013 Spending Round, there was to be a transformation in integrated health and social care. This change creates a single pooled budget, to support health and social care services to work more closely together in local areas and is called the Better Care Fund (BCF).The Integrated Care agenda, not only brings together NHS and Local Government resources, but also provides a real opportunity to improve services and value for money, protecting and improving social care services by shifting resources from acute services into community and preventative settings.The national vision to deliver change is to be developed locally by Clinical Commissioning Groups, Local Authorities, Health and Wellbeing Boards and other partners working together with patients and the public, to identify local needs and form a five year strategic plan, which will drive

Section 4 - Context: Drivers for Transformation

change and create high quality sustainable health and social care services, to meet the needs of the local population.

- **Parity of Esteem**
  NHS England has prioritised improving services for people of all ages with mental health conditions, valuing mental health equally with physical health. A Parity of Esteem Programme has been developed in order to focus effort and resources on improving clinical services and health outcomes in this field. Three areas have been identified as initial priorities for urgent focus, for which, a system wide approach is required in order to deliver real progress. These are:

  Improving diagnosis and support for people with Dementia – with a national ambition of two thirds of people with dementia receiving a formal diagnosis and accessing care and support by the end of March 2015.

  Improving Access to Psychological Therapies (IAPT) – with a national ambition for at least 15% of those with anxiety or depression having access to clinically proven talking therapy services and that those services will achieve 50% recovery rates by the end of March 2015.

  Improving awareness and focus on the duties within the Mental Capacity Act – concerns have been raised that there is a low level of appreciation of the duties and expectations under this legislation which spans across patient groups.

- **A Call to Action**
  A national 'Call to Action' was created, to engage staff, stakeholders, patients and the public, in the process of designing an NHS that serves current and future generations. It created the opportunity for the public, NHS users and staff to debate the big issues and give a voice to all who care about the future of the NHS. Many health groups such as GPs, Pharmacies and Health Visitors were given the opportunity to engage in the broadest, deepest and most meaningful public discussion the NHS has ever undertaken.

Section 4 - Context: Drivers for Transformation

4.2 Greater Manchester Drivers

4.2.1 Reform of Acute Hospitals across Greater Manchester

It is widely recognised that the different parts of the health and social care system are inter-dependent, and that major changes to services in the community are required before significant hospital changes can take place. The wider Healthier Together programme brings together the locality programmes developing Community-based Care (Integrated Care and Primary Care) with the reform of "In Hospital" Care across Greater Manchester for the "in-scope" services (these are: Urgent, Acute and Emergency Medicine; General Surgery; and Women and Children's services).

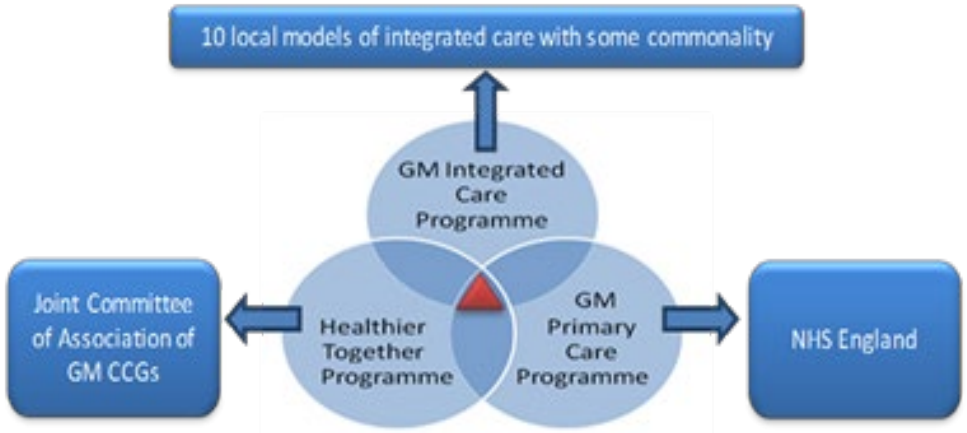


Figure 7 – Greater Manchester Reform

The way hospital services in Greater Manchester have evolved and are currently organised, with a hospital in each borough providing a similar broad range of services, was designed to meet the needs of the last century. It is clear that this is not suited to the way in which a broad range of individuals require care. Many of the excellent developments we have seen have arisen from local interest rather than from strategic planning. This has led to variations in the range and quality of services available in different areas, resulting in inequality of access to services in different areas. For example, the mortality of patients who undergo Emergency General Surgery varies from **23.1** to **51.7per** 1,000 spells across Greater Manchester, depending on where people are treated. This needs to change, with everyone entitled to the best outcome wherever they live, and yet we have a limited number of specialist clinicians, rising demand and serious financial pressures. An analysis by Mott McDonald has forecast the financial gap between expected activity in acute trusts and available funding across Greater Manchester over the next 5 years at £742 million, with a further £333 million gap in social care funding – a total system-wide pressure of over £1 billion. Doing nothing is not an option. Work on determining the figures for each locality will be completed in February 2014. As more people receive appropriate treatment at home or in the community, those patients that do need to be admitted into hospital, especially in an emergency, are likely to have more complex needs. They are most in need of very specialist care and being assessed by a senior doctor will improve their chances of recovery. Senior doctors are not available in all specialities on site 24 hours a day, 7 days a week due to the large spread of services across Greater Manchester. This means that Greater Manchester has an inequity of provision out of hours and at weekends often leading to poorer outcomes for patients.

Section 4 - Context: Drivers for Transformation

4.3 Local Drivers

4.3.1 Health and Wellbeing strategy priorities

The Bury Joint Health and Wellbeing Strategy has been developed creating a five-year vision for improving health and wellbeing in the borough, based on a range of information about health and wellbeing from a wide variety of sources, including the Joint Strategic Needs Assessment (JSNA). It identifies five cross-cutting local priorities:

Priority 1 - Ensuring a positive start to life for children, young people and families.
Priority 2 - Encouraging healthy lifestyle and behaviours in all actions and activities.
Priority 3 - Helping to build strong communities, wellbeing and mental health.
Priority 4 - Promoting independence of people living with long term conditions and their carers.
Priority 5 - Supporting older people to be safe, independent and well.

4.3.2 Children's Trust Priorities

The Bury Children and Young People's Plan sets out how the partners within the Children's Trust will work together towards agreed priorities and what is hoped to be achieved. The starting point is a shared desire to ensure that all children and young people in Bury should be the best that they can be. The Plan focuses on a small number of priorities, whereby partners working together are able to make progress and meeting these priorities is of fundamental importance. The priorities are:

Priority 1 - To improve the lives of families with multiple needs
Priority 2 - Ensure that all children and young people experience parenting that keeps them safe, healthy and ready to learn
Priority 3 - Ensure that all young people make a successful transition to adulthood.

4.3.3 Public Service Reform

The Public Service Reform (PSR) is a key strategic aim of the draft Greater Manchester Strategy (2013-2020) and forms part of the wider Greater Manchester PSR programme. The vision for Bury is to lead, shape and maintain a prosperous, sustainable Bury that is fit for the future.

The objectives of the Bury PSR programme are:
- To ensure that residents in the borough can benefit from future economic growth, by designing services that can better support them to make positive choices and be independent

and
- To meet the challenge of public sector austerity by reforming services collectively, such that outcomes for residents in the borough are better than they would have been, had reforms been undertaken solely by agencies acting alone

Team Bury Partners are committed at the highest level to meet these objectives for the people in Bury, through a collective PSR programme.

The PSR Programme is the means by which Team Bury and Bury Wider Leadership Group will ensure that this vision becomes a reality. It will form one of the primary strands of work undertaken by the Corporate and Adult Care Services Directorate.

Section 5 - Context: How we Commission

5.1 Commissioning with the Local Authority

5.1.1 Governance

In Bury we have collaborated through the Health and Wellbeing Board to produce a strategy with a clear vision and five agreed joint priorities, which are outlined in section 4.3.1.

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. We aim to have agreed standards, formulated using a joined up approach, ensuring joint understanding, from which we will commission care and services with pooled budgets in the future. We recognise that in order to do this we will need to align our objectives, agree a prioritisation process and formulate integrated work plans. There has been significant progress made already in Bury, as our integrated care plan has been developed via a collaborative approach from the CCG, Local Authority and Public Health, through the Integrated Partnership Board and Health and Wellbeing Board. Several groups have also been established to enable the development of our plans this includes a Learning Disability Partnership Board. This Board makes sure that we have the right support in Bury to help people achieve the life they want. Members of the Board include people with learning disabilities, carers of people with learning disabilities, people who work for Bury Council, people who work for NHS Bury and people who provide services.

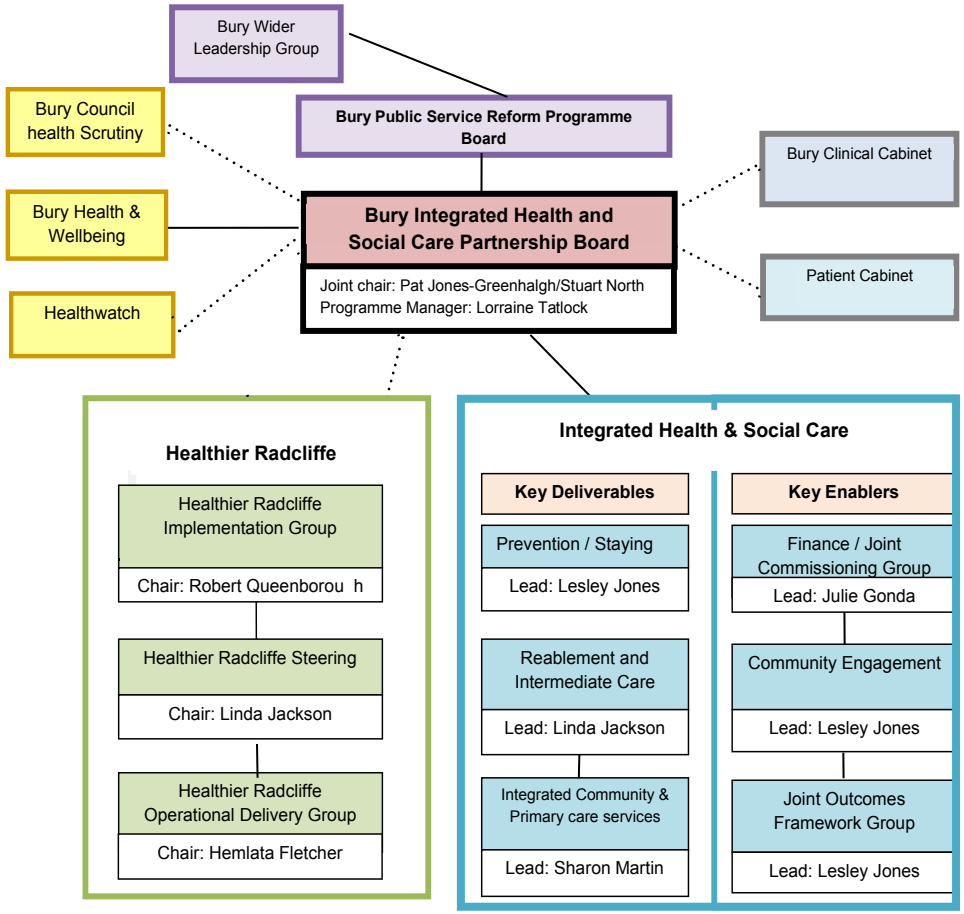


Figure 8 - The Bury Integrated Health and Social Care Governance and project structure

Section 5 - Context: How we Commission

5.1.2 The Integrated Health and Social Care Partnership Board

The Integrated Health and Social Care Partnership Board, oversee the progress and outcomes for the work on integrating health and social care in Bury. 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 (CCG). The Partnership Board strategically leads the direction of health and social care integration, 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 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. The Bury Integrated Health and Social Care Governance and project structure is shown in figure 7 and further identifies the various work streams relating to the key deliverables and enablers as identified below. This governance structure is subject to review in June 2014 in line with the progression of the integration agenda in Bury.

5.2 Commissioning in Partnership with North East Sector CCGs

The CCGs in the North East Sector of Greater Manchester include:

- Bury
- Heywood, Middleton and Rochdale
- North Manchester, and
- Oldham

Together, the North East Sector CCGs have established a partnership, underpinned by a formal agreement. This formal agreement builds on the previously established arrangements in the North East Sector, with the aim of implementing a partnership approach to the commissioning of secondary care (hospital) services where this makes sense. A joint Commissioning Board has been established, which has authority to make decisions in the best interests of CCGs across the North East Sector - staff are working collaboratively across the sector to cover collective agendas e.g. performance improvement.
The North East Sector Commissioning Board has the responsibility to:

- Review, plan, procure and performance monitor agreed services to meet the health needs of Members' populations as follows:
  i. Acute (hospital) services, (particularly the contract with Pennine Acute Hospitals NHS Trust)
  ii. Mental health services
  iii. Community services
  iv. Cancer services
- To undertake reviews of services, manage the introduction of new services, drugs and technologies and oversee the implementation of NICE (National Institute for Health and Clinical Excellence) and/or other National guidance or standards relating to the services being collaboratively commissioned.

Section 5 - Context: How we Commission

- To co-ordinate a common approach to the commissioning of services from the defined providers, with a particular focus on the financial viability.
- To manage the budget for commissioning the agreed services, be held accountable for its use, and develop financial risk sharing arrangements.
- To develop, negotiate, agree, maintain and monitor service level agreements/ contracts for collaboratively commissioned providers.
- To work in partnership with other commissioners across Greater Manchester and the North West, and act as lead commissioner where agreed.

Principles upon which the Commissioning Board is based include:

- The Commissioning Board will support member CCGs in working to achieve financial stability, by effective collaborative commissioning of major contracts.
- The Commissioning Board will support Member CCGs in striving to reduce the inequalities in access to, and delivery of services for the populations the Member CCGs served through the effective negotiation of borough level schedules.
- Commitments made by the Commissioning Board will be binding on all Members.
- In commissioning and procuring services, the Commissioning Board will support member organisations to comply with all applicable statutory duties.
- The Commissioning Board will review, plan, develop and monitor the agreed services in partnership with clinicians, providers and service users.
- The Commissioning Board will maintain close working links with service providers, clinical networks and other commissioners or commissioning groups, fora and partnerships.
- A standard facilitation/arbitration procedure will apply should disputes between Members arise.

The North East Sector Commissioning Board (CB) is the body mandated by the four North East Sector CCGs as set out in the North East Sector Partnership Agreement. Delivery at a North East Sector Level is underpinned by two work streams

- **Programme Level Development Boards (DB)** with a focus on the development and implementation of new projects and work streams, to improve health outcomes and/or the efficiency of delivering those outcomes.
- **Operations and contracting** with a focus on contract, quality and performance monitoring and taking action to address performance issues will become the responsibility of this group.

Section 5 - Context: How we Commission

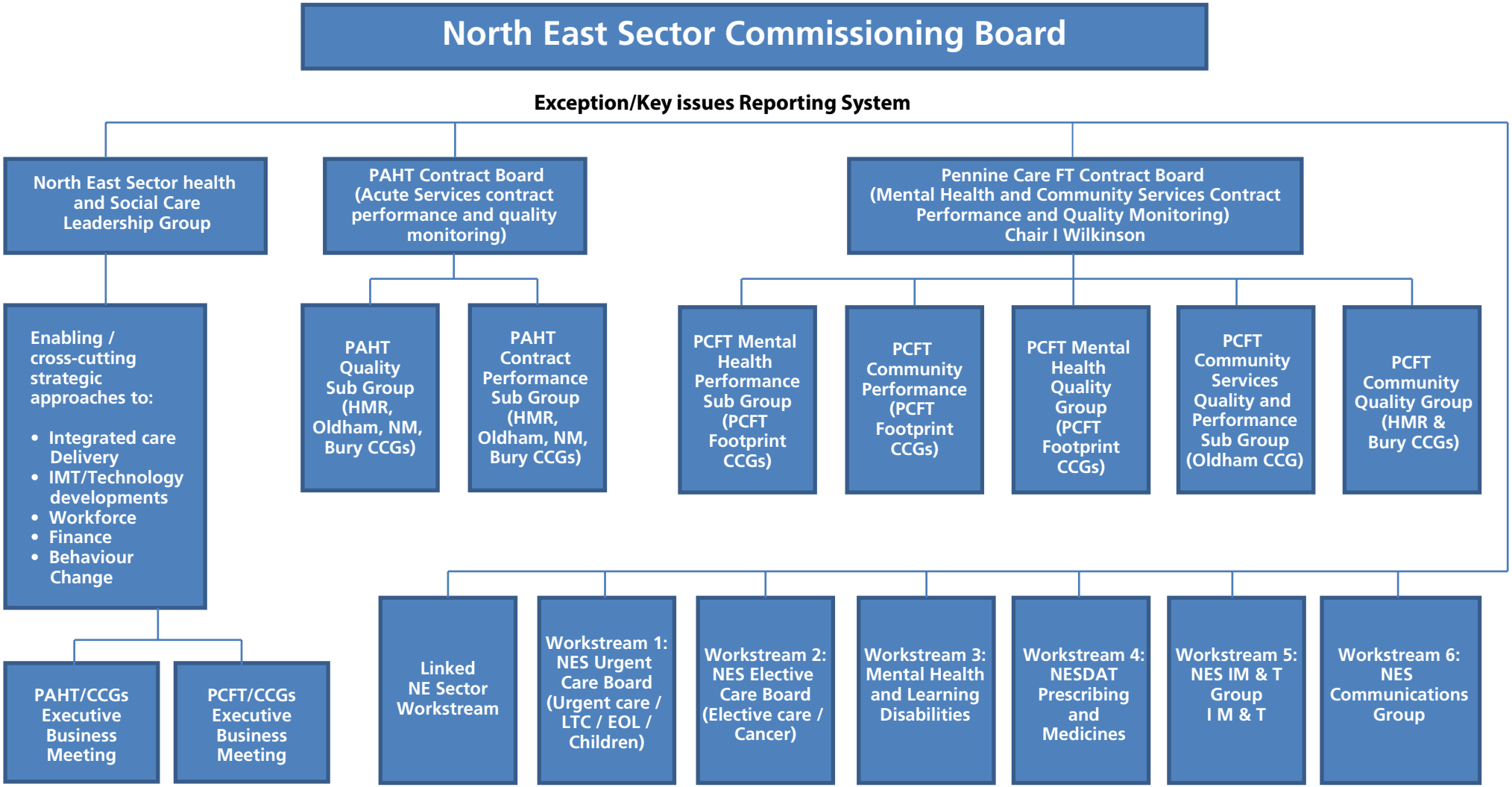


Figure 9 - North East Sector Structure

Section 5 - Context: How we Commission

Strategic Transformation

The priority work stream for 2013/14 has been the management of the economic challenges across the North East Sector Health and Social care economy over the next 5 years. To this end, a North East Sector Health and Social Care Board has been established, accountable to the North East Sector Commissioning Board.

The shift away from hospital based care, and the development of primary, community and social care, will lead to a reduction in bed utilisation by avoided admissions and a reduced length of stay for some patients. We recognise that whilst activity will decrease, the average length of stay for some patients may possibly increase, as the acute sector deals with a more complex patient spectrum. This will need careful modelling to determine appropriate bed configuration and income / expenditure analysis for the PAHT in particular, linked also to the plans the Trust has for service reconfiguration, to ensure financial viability. PAHT is developing its 5-year Business Plan to move to Foundation Trust Status. For the past 12 months the North East Sector CCGs have been working together with PAHT and the Trust Development Agency, to ensure all known activity assumptions around the Healthier Together, Integrated Care, Primary Care and QIPP schemes are reflected in this plan. To this end, the CCG's have jointly funded 2 roles to support a joint modelling of impact across the sector.

A series of strategic financial planning assumptions have been agreed with key partners across Health and Social Care. These reflect the activity shift assumptions expected to be delivered through the above programmes over the 5-year period. The plans acknowledge that reinvestment will be required in the community and other services to secure reductions in hospital capacity. The timing and level of investments required (recurrent, non-recurrent and transition costs) will be driven by the pace of change of the Greater Manchester and Borough wide programmes.

The reduction in activity PAHT will expect to see across the North East Sector of Greater Manchester is significant, and will not be realised without a significant change in the way their services are delivered. Options for change are currently being considered by PAHT and the CCGs that support the out of hospital agenda, whilst ensuring that PAHT is economically viable.

The financial plans and business cases for the Better Care Fund have been developed at Borough level in the context of the anticipated financial position for the 4 Councils and the Clinical Commissioning Groups over the next five years. The health and care sector challenges have been widely communicated across the North East Sector, and the significant task of reducing and managing the CCGs and Councils financial pressures, together with delivery of Pennine Acute and Pennine Care Cost Improvement Programmes, is being addressed through a variety of inter-dependent programmes, including monthly business meeting with PCFT and PAHT at a Director level.

Plans for year one reduction have been built into the PAHT contract for 2014/15 - the Trust has plans to reduce its capacity accordingly. The CCGs and PAHT are developing a programme of shared monitoring, to ensure any risk to delivering activity reductions is identified immediately and can be acted upon.

5.3 Commissioning in Partnership with Specialist Commissioners

The Cheshire Warrington and Wirral Area Team commission specialist services for 3 sub-regions (Greater Manchester, Lancashire and Cheshire & Merseyside). Each area has a dedicated Local Project Team. It is responsible for:

- Informing and supporting the development of the Greater Manchester contribution to the North West Specialised Service 5 Year Strategic Plan, in line with nationally prescribed timescales.

Section 5 - Context: How we Commission

- Framing its contribution within the context of improving outcomes for patients and achieving best value for money from specialised commissioning resources.
- Identifying priorities for action.
- Reporting to the North West Specialised Services Programme Board, which is accountable for development and delivery of the Strategic North West Specialised Services Plan.

We are currently working with specialist commissioners on the five year strategic plan, which will be published in autumn 2014, to develop, align and co-ordinate the Greater Manchester contribution to the North West Specialised Services 5 Year Strategic Plan through:

- Modelling impact of any changes and aligning with other system change
- Provider Management and Financial viability
- Prioritisation
- Communication and engagement

Strategic Clinical Networks (SCNs)

Bury CCG is part of the Greater Manchester Lancashire and Cumbria Strategic Clinical Network. Strategic Clinical Networks work in partnership with commissioners (including local government), supporting their decision making and strategic planning, by working across the boundaries of commissioner, provider and voluntary organisations, as a vehicle for improvement for patients, carers and the public. In this way, SCNs will:

- Reduce unwarranted variation in health and well-being services
- Encourage innovation in how services are provided now and in the future
- Provide clinical advice and leadership to support their decision making and strategic planning

SCNs focus on priority areas: Cancer, Cardiovascular (including Diabetes, Renal and Stroke), Maternity and Young People and Mental health (including Learning disabilities), Dementia and Neurological Conditions. Threaded through these areas are spreading good practice; advancing equality and tackling health inequalities; palliative and end of life care; patients, carers and public engagement

The work programmes for the next five years are:

- Improving mental & physical well being
  - Parity of esteem for people with mental health problems
  - Reducing premature death for people with learning disabilities
  - Unacceptable variation in maternity & children's services
- Improving pathway programme: prevention, early identification & diagnosis
  - Reduction in perinatal mortality
  - Cancer prevention, awareness & early detection programme
- Improving pathway programme: treatment & recovery
  - Improving treatment for people with neurological conditions
  - CAMHS early intervention, transition & integrated pathways
  - Improve pathways in maternity & children's services (including reconfiguration)
  - Treatment/acute care provision for cancer
  - Improving cardiology services to enable 24/7 working
  - Review & optimisation of stroke services
  - Vascular services review
  - Improving renal services
- Improving pathway programme: living with & beyond the condition
  - Cancer survivorship and patient/carer involvement
  - Improving services for people with diabetes
  - Improving life for people with dementia
- Improving pathways programme: palliative care & end of life
  - Increasing expected deaths in usual place of residence

Section 5 - Context: How we Commission

5.4 Commissioning in Partnership with Greater Manchester CCGs

5.4.1 Collaborative Commissioning

The 12 Clinical Commissioning Groups in Greater Manchester have developed arrangements to enable them to work together on matters of mutual benefit. There are a number of reasons for this:

- To support each other through lead commissioning arrangements for some specialised areas such as stroke, cancer, mental health, military veterans.
- The need for CCGs to collaborate to be, an effective single "voice" for CCGs in their relationship with Providers.
- Ensure governance arrangements for strategic change programmes e.g. Making it Better and Healthier Together, which allow and ensure mutual accountability between CCGs, when one leads on behalf of all on a particular issue.
- Maximise the benefits in adopting as far as possible, the same policies and procedures e.g. NICE guidance.
- Represent the views of the 12 CCGs collectively to other agencies and processes e.g. The Local Area Team (LAT), Association of Greater Manchester Authorities (AGMA).
- To support CCGs in sharing information and good practice and offering each other support when necessary and possible.
- To provide a focus for the development and reporting of joint work across the CCGs and reducing unnecessary duplication of effort.
- To provide a properly constituted forum for issues, where CCGs consider it beneficial to their own objectives, to have a collective decision of the GM CCGs in the spirit of mutuality, or to address issues necessitating formal agreement by the GM CCGs.
- To provide a basis for Collaborative Commissioning between CCGs in Greater Manchester consistent with the intentions of the Health and Social Care Act 2012.

5.4.2 Healthier Together

The Healthier Together programme is part of the Greater Manchester (GM) Programme for Health and Social Care (H&SC) Reform, which aims to provide the best health and care for Greater Manchester. It is the largest and most ambitious health and care reconfiguration programme in the country. Delivery of this programme will support the delivery of all of the mentioned transformation areas. The programme is responsible to the 12 Clinical Commissioning Groups across Greater Manchester, with the CCGs exercising our statutory responsibility for commissioning through a shared decision-making body, the Healthier Together Committees in Common (formally a sub-committee of each CCG).

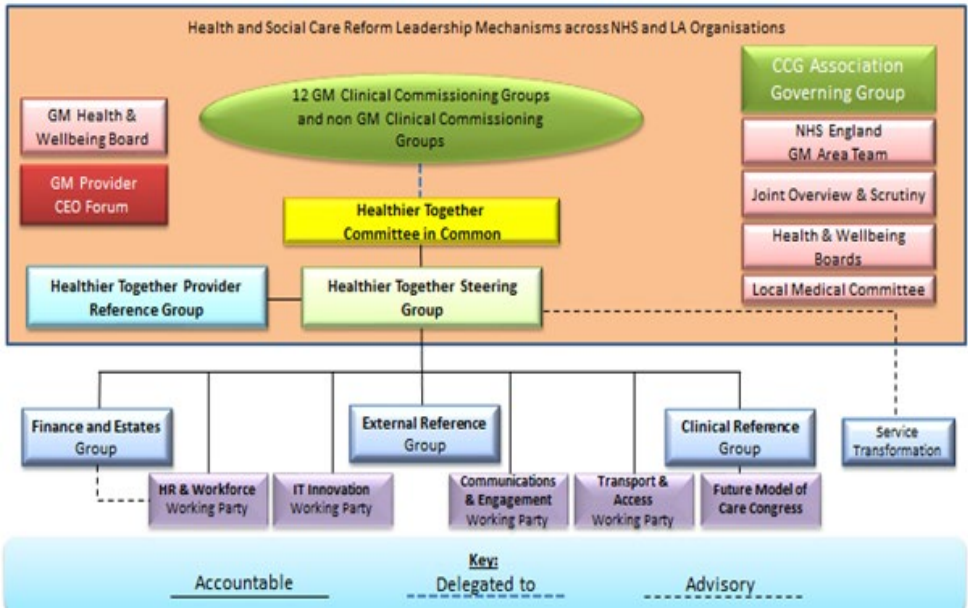


Figure 10 - Healthier Together

Section 5 - Context: How we Commission

5.4.3 Commissioning for the Armed Forces

Physical Health

- Members of the Armed Forces are typically younger and fitter than the general population. As such, there is low prevalence of long-term conditions but higher incidence of musculoskeletal injury. Combat-related injuries aside, Armed Forces healthcare needs can usually be met by standard NHS services. The greater investigation of the population, to meet occupational requirements, may give rise to asymptomatic but unmet health needs.
- The families and dependants of serving Armed Forces members have health needs typical of their age and gender. Maternity services and children's health services in particular must be planned and commissioned with the needs of military families in mind, where they are present in large numbers in a community.
- Members of the Armed Forces may also have specific Health needs that relate to their occupation or employment and have extensive occupational health support requirements.

Mental Health

- The ex-service population has comparable health to the general population and a broadly similar prevalence of mental health-related conditions.
- Current UK military personnel have higher rates of heavy drinking than the general population.
- The most common mental health issues experienced by ex-service personnel are alcohol misuse, depression and anxiety disorders. Military personnel with mental health problems are more likely to leave the armed forces and are at increased risk of adverse outcomes in post-service life.
- The minority who leave the military with psychiatric problems are at increased risk of social exclusion and on-going ill health.
- The overall rate of suicide is no higher than for the general UK population, with the exception of male veterans aged 24 or younger who are at increased risk compared to their general population counterparts.
- Early service leavers are more likely to have adverse outcomes and carry out risk taking behaviours than longer serving veterans.
- Deployment to Iraq or Afghanistan is associated with adverse mental health outcomes for some groups, particularly those with pre-service vulnerabilities, those who experience a high level of combat and reservists.

It is recognised that military personnel put themselves in harm's way in the service of their country, risking risk injury or death in the course of their duty. Successive governments have recognised the debt society owes to its Armed Forces, their families and veterans, and most recently Society's obligations were recently set out in the Armed Forces Covenant, a framework for the duty of care Britain owes its Armed Forces. In terms of healthcare, the key principle is that they experience no disadvantage in accessing timely, comprehensive and effective healthcare. They will also receive bespoke services in some agreed areas for their particular needs or combat-related conditions, including for instance, specialist limb prostheses and rehabilitation.
Bury CCG is the lead Armed Forces commissioner for Military Veterans services for the North West of England CCGs and works closely with NHSE to secure services in line with the covenant. This includes delivery of priorities as outlined in the plan on page (appendix 1) and commissioning a bespoke IAPTs service for Veterans.

Section 5 - Context: How we Commission

5.4.4 Ambulance Commissioning

Commissioning Intentions for the Paramedic Emergency Service (PES) have been produced by the lead commissioner, NHS Blackpool CCG, with the 33 CCGs in the North West (NW). The PES commissioning intentions document recognises the need for whole system transformation in order to move towards the healthcare system described by both the House of Commons Health Committee 'Urgent and Emergency Services' report (July 2013), and the Keogh 'Urgent and Emergency Care Review' (November 2013). Both reports describe PES as having a changed role within an enhanced system of urgent care; a role where conveyance to hospital will be one of a range of clinical options open to ambulance services and allow PES to become "mobile urgent treatment centres" (Keogh, 2013). One of these key required changes is to achieve a reduction in conveyance to hospital, and the PES contract for 2014/15 has been designed to encourage this by incentivising through CQUIN. This will allow the provider, North West Ambulance Service (NWAS), to build on the progress they have already made with commissioners over recent years; developing and implementing initiatives such as the Urgent Care Desk, Paramedic Pathfinder, Referral Schemes into Primary Care, Targeting Frequent Callers, and increasing the percentages of patients that are treated by 'See and Treat' and 'Hear and Treat'. All of these schemes support the achievement of 'Safe Care Closer to Home', which is a strategic goal of NWAS, as well as supporting our CCG plans for integration.

In Bury CCG, we have been engaging with NWAS, to understand their role in supporting extended access to primary care and integrated care teams, to manage patients with emergency and urgent care needs in their own home. This has included testing the Paramedic Pathfinder and GP Navigation Schemes. NWAS sits on the local Urgent Care Working Group / Board.

Bury CCG is actively engaged in Ambulance Commissioning and through Greater Manchester Coordinated Commissioner arrangements have a representative on the Strategic Partnership Board' (SPB), which maintains the strategic oversight of all county area reconfigurations, both at county and CCG level; acting as 'Change Management Board' and seeking assurance that county and local changes, translate into a North West level. A key element of the Ambulance Commissioning governance framework is the 'Clinical Development Group' (currently being refreshed to include NHS 111 to progress urgent care system transformation) and Greater Manchester has clinical and managerial representation on this group, which feeds directly into the local Urgent Care Network Board.

Arriva provide Patient Transport Services for Greater Manchester. The current service specification contains increased operating hours, and higher quality standards than the previous one. The service is provided for eligible patients. Planning for the next tender will begin during 2014/15, which will include reviewing the current service specification against new and emerging policy and guidance, such as 24/7 working. Bury CCG will engage in this process via the Greater Manchester Ambulance Commissioning Group.

Section 6 - Context: Engaging Providers in Service Transformation

We recognise the importance of working with our providers in partnership and have therefore involved providers in all elements of our planning. The CCG and Local Authority have developed a Bury Co-ordinated Community Based Care Group, with the specific purpose of developing and coordinating our community based care developments, to include all providers. This group meets monthly and reports to our Integrated Partnership Board (This is a joint Health and Social Care Commissioning Board Chaired by the Director of Adult Care Services and the CCG Chief Officer). The Bury Co-ordinated Community Based Care Group has provider representatives as well as other key stakeholders, including; Social Care, GPs and a Patient Cabinet representative. There is an absolute recognition of the need for providers to be partners in developing the integrated plan from all parties. Some specific examples of our approach to demonstrate this are as follows:

6.1 Pennine Acute Hospital Trust (PAHT)

Bury CCG issued commissioning intentions around integrated care, to Pennine Acute Health Trust (PAHT) in October 2013, which highlighted the level of activity 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. The CCG has identified a 20% reduction in non-elective activity by 2018/19. Plans for year one have been built into the contract for 2014/15 and the trust has reduced its capacity accordingly. The CCG and PAHT are developing a programme of shared monitoring to ensure any risk to delivering activity reductions is identified immediately and can be acted upon. PAHT is developing its five year Business Plan to move to Foundation Trust Status. Across the North East Sector of Manchester, the CCGs are working together with PAHT to ensure all activity assumptions around integrated care are reflected in this plan. The reduction in activity PAHT will expect to see across the North East Sector of Greater Manchester is significant and will not be realised without a significant change in the way their services are delivered. Options for change are currently being considered by PAHT and the CCGs, which deliver the activity reductions whilst ensuring PAHT is economically stable. The Trust Development agency and NHS England are partners in the planning.

6.2 Pennine Care Foundation Trust (PCFT)

The CCG commissions Mental Health and Community services from PCFT. It is clear 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 Co-ordinated Community Based Care Group. PCFT have agreed to redesign their services to support the Integrated Care Model and already work in partnership with PAHT to deliver more integrated models of care in Sexual health and Diabetes pathways (which includes traditional secondary care services being delivered in the community).

6.3 Primary Care

The development of Primary Care is central to our reform of services to deliver integrated care and we have had a number of workshops with the CCGs sectors to share this model. Each of the four sectors in Bury has been developing their vision for integrated care. There is an active GP Federation and 30 of the 33 General Practices in Bury, are members of the federation. The work the CCG members did through the sectors and the establishment of the GP Federation, culminated in the West sector being ready to bid to become one of the Greater Manchester Demonstrator Communities, delivering a programme called 'A Healthier Radcliffe'. This is a provider led system reform programme involving six GP practices covering 3 wards of Bury, from which learning can be rapidly rolled out across the rest of the Borough. Each of the four sector clinical leads

has a seat on the Bury Co-ordinated Community Based Care Group to ensure Primary Care is represented.

The Bury GP Federation also has been successful in its bid for the Prime Ministers Challenge Fund, to roll out the above programme across Bury. The programme will cover four main areas:

- **Extended hours - longer opening hours including**:
  - Weekday opening (8am to 8pm), and
  - Saturdays and Sundays (8am to 6pm)
- **Tele consultations**
  - To ensure that all patients who request an appointment are offered the option of a telephone consultation
- **Increased Online Access**
  - To increase use of online services from the current 4% of patients to 60%+
- **Development of a "GP-Comparison" website**
  - To enable patients to make better choices about GP services

The CCG is in the process of a series of workshops with all GPs to work up the mobilisation of the named GP for the over 75 year old population and investment to provide enhanced services to vulnerable older people. This explicitly links to the wider integrated care plans and will enable delivery of the outcomes agreed through the Better Care Fund.

6.4 Voluntary Sector

The CCG and Local Authority are committed to maximising the use of the Third Sector within the integrated care plan. 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. The CCG is currently planning an open market development day where we are introducing the third sector to larger health care providers. We hope this stimulates larger providers to work with our third sector when developing their services or tendering for new business.

Hospice care is developing within Bury and plans are in place for provision of a children's hospice called 'Graces Place'. The CCG will ensure that services offered by Graces Place are integrated into local pathways.

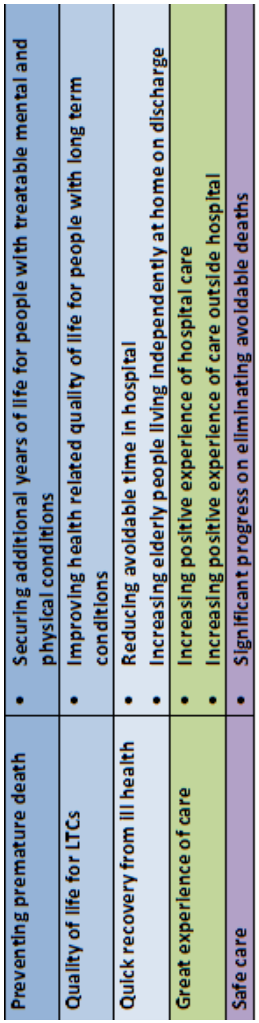
6.5 Local Authority

High-level 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, as part of the Healthier Radcliffe pilot. The initial outcomes from the 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. It is for this reason that the engagement of social care and housing providers has been high level, until we can be clear exactly what we want from them in terms of longer term support. We are already working with domiciliary care providers around locality based delivery as part of the on-going tender process. The providers of both assessment and reablement services have been heavily involved in the development of our integration plans and are leading the stage 2 implementation of Healthier Radcliffe. Adult Care Services engage 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.

Section 7 - The Vision for Bury

Vision

To continually improve Bury's health and wellbeing by listening to patients and the public, working together across boundaries to deliver a safe, sustainable, high quality health and social care system



Transformation schemes

Establish Collaborative Prevention, Wellness and Life Support Programmes

Living Well and Dying

Ambitions delivered through interventions

- Delivery the Better Care Fund Integration Programme
- Engage in the Better Together Collaborative Programme
- Integrated Wellness Services
- Staying Well and Self Care Programmes
- Active Ageing, Falls Prevention and Affordable Warmth
- Immunization Programmes
- Mental Health and Learning Disability Support
- Extend GP Services via the GP Challenge Fund - 7 day Services
- Integrated Care Pathways
- Enhanced Therapy Services
- Enhanced Community Based Services for Diabetes, Respiratory, and Cardiac Patients

Create an Integrated Community Based Care Programme

Streamline and Enhance Elective Care Service Provision

- Direct GP Referrals with direct access to diagnostics
- Improve access to Consultant led virtual clinics
- Develop an early supported discharge process
- Commission an Enhanced Recovery Programme
- Reduce unnecessary appointments

Future proofing Urgent Care Services in Bury

- Develop enhanced community based Urgent Care services
- Redirect appropriate Diabetes, Respiratory & Cardiac Services to Community
- Develop 111 Service
- Devise systems to inform and redirect the public

Enhancing Corporate Functionality

Commission for Quality

- Ensure Clinical and Public Engagement Programmes are Operational
- Implement strategies for Quality, Safeguarding, Equality and Diversity
- Procure OD, IMT, Estates, BI to facilitate all required work programmes

Governance arrangements:

- Weekly meetings between the Clinical work stream lead and service redesign manager.
- Monthly review of programme or project progress at CCG Clinical Cabinet Committee
- Monthly review of financial performance at the Audit Committee and Governing Body.
- Monthly review of performance issues at the Quality and Risk Committee
- Monthly review of the programme of Programmes jointly commissioned through the Better Care Fund through the Integrated Health and Social Care Partnership Board and the Director of Adult Care Services.
- Oversight and scrutiny of delivery through the Health and Wellbeing Board.

Measured using the following success criteria:

- Reduce the mortality Gap for patients with Dementia and Learning Disabilities
- Reducing mortality in CVD
- Reducing Alcohol attributable deaths
- Reducing deaths from COPD aged under 75
- Reduce Cancer deaths
- Reduce OP activity, EI & Non EI admissions

System values and principles:

- Reduce inequalities and improve outcomes
- Deliver transformational change
- Develop capability as commissioners and leaders
- Deliver improvements via QIPP to create high quality sustainable services
- Ensure citizenship, self-care and prevention is at the heart of what we do

Section 7 - The Vision for Bury

What will the health economy look like in 5 years time?

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 in 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 will influence how we commission and locate services too.

Vision to redirect care delivery over the coming five years in Bury

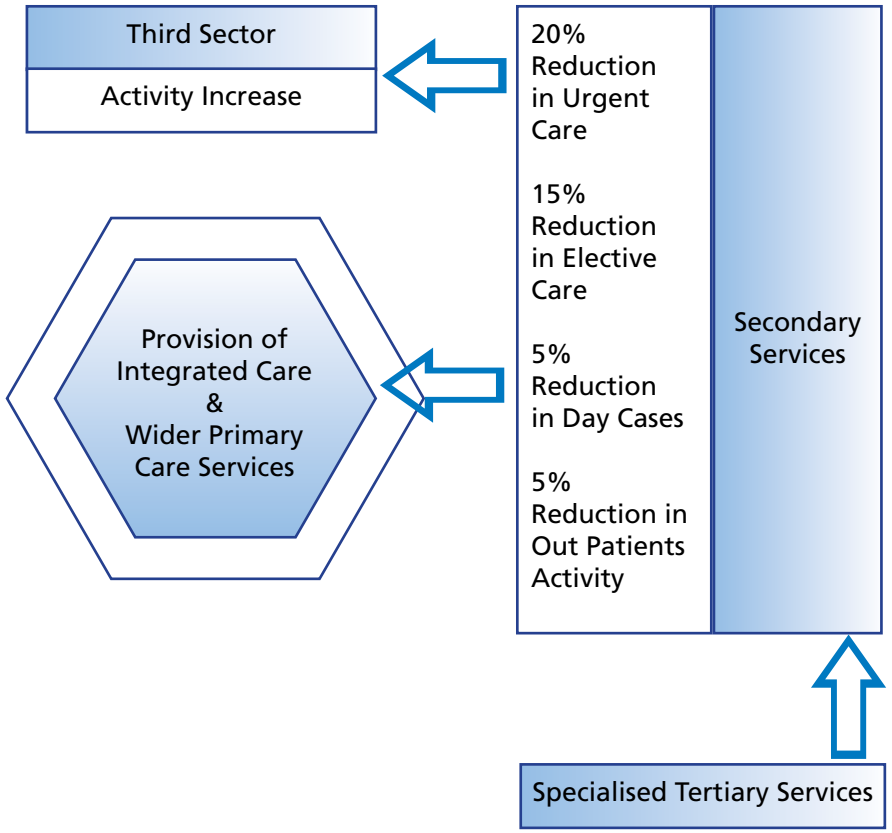


Figure 11 - Vision of Care Redirection in Bury

Section 7 - The Vision for Bury

7.1 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.

7.2 Primary Care

Primary care will continue to be the gatekeeper for patients' care. 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 continue to collaborate more effectively together in a more federated way.

7.3 Community and mental Health

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 the elderly 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.

7.4 Secondary care

Over the next 5 years we 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. Confidence from the local population in safe and effective care delivery will have been fully restored. Over the last 24 months, over twenty clinical congresses involving hundreds of clinicians have considered the issues facing our health system. They have explored the potential solutions to ensure services remain high quality, safe and cost effective for future generations. This work, which has been based on evidence and best practice from around the world has developed and contributed to this case for change. The proposals arising from these congresses are for services to 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

Section 7 - The Vision for Bury

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".

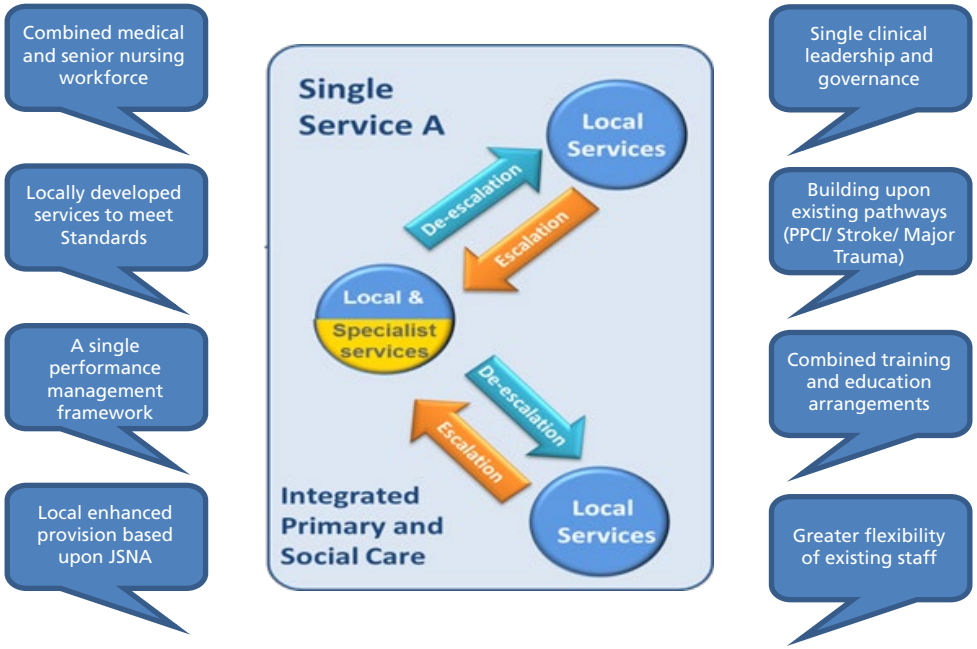


Figure 12 - Greater Manchester Proposal

The proposals to change hospital services will be subject to statutory public consultation, and must pass the requirements of the NHS Assurance process. Clinical assurance has already been secured for the model via the National Clinical Advisory Team (NCAT) – *"We unanimously support the Programme to proceed to Consultation. This is the most ambitious and well thought out work we have come across. We are highly impressed"*.

The determination of the viable options for consultation, are subject to a rigorous 9 stage process:

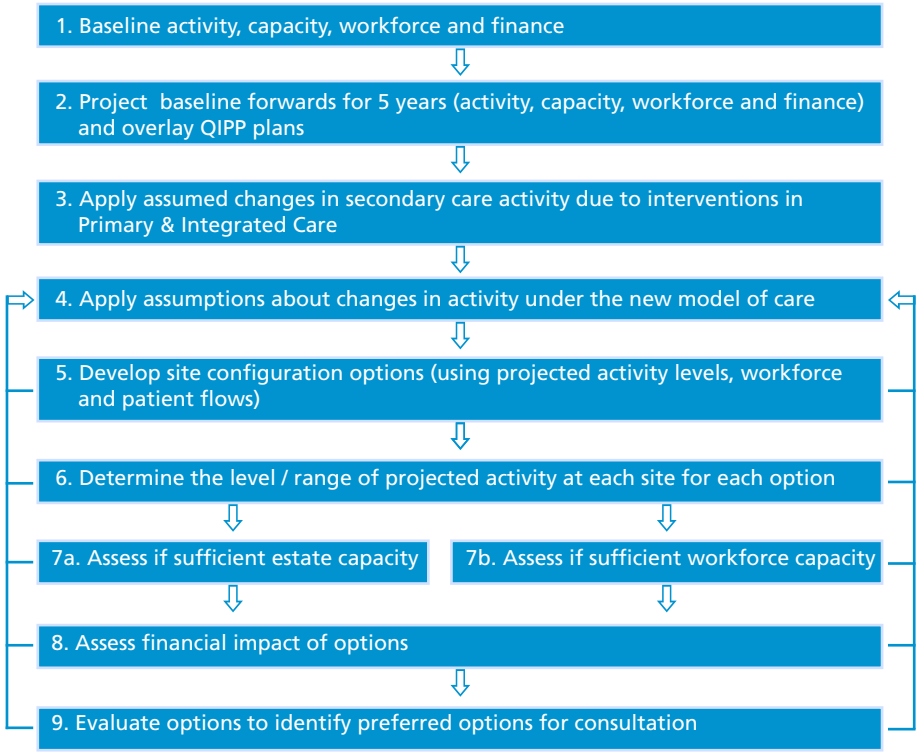


Figure 13 - 9 Stage Process

Section 7 - The Vision for Bury

Following extensive pre-consultation engagement, including with key partners such as the Association of Greater Manchester Authorities (AGMA), the Committees in Common of the CCGs will decide to proceed to consultation in June 2014. Subject to NHS Assurance, it is planned that formal consultation will take place in the summer of 2014, with a final decision at the end of 2014. There are considerable risks in a programme of this size and complexity, and given the proximity of a general election there is a possibility that the formal consultation and decision will need to be postponed until 2015 – this would clearly delay the programme and the delivery of the benefits expected to be realised.

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).

7.5 Social Care

We will continue to ensure integration with social care, both for children and older people. This will clearly focus on priority areas associated with the aging population (such as dementia and frail older people) and children and young people. There will be more integrated nursing and social care (e.g. short term intervention services and general domiciliary care) to support discharge from hospital and we will have drastically reduced delayed transfers of care. We will be jointly commissioning more services together (eg nursing and residential homes), for better value for money and market management and there will be more joint deployment of technology.

Section 8 - Our Ambitions and Goals

Section three of this document set out the context of health and needs in Bury. The NHS Outcomes framework describes five main Domains (categories) of better outcomes we want to see. NHS England has translated these outcomes into seven specific measurable Ambitions to be used by CCGs as indicators of success.

This gives rise to our Strategic Ambitions and Goals, which for the next 5 years are summarised in table 2:

Table 2

Domains	Ambitions	Outcomes Delivered By	Goals Set
1. Preventing premature death	1. Securing additional years of life for people with treatable mental and physical conditions	• Decreasing the potential years of life lost from causes considered amendable to healthcare • Decreasing the under 75 mortality rate from cancer, cardiovascular, respiratory and liver disease	PYLL (Rate per 100,000 population) Baseline 2660.5 to 2018/19 2261.2 3.2% applied year on year
2. Quality of life for LTCs	2. Improving health related quality of life for people with long term conditions	• Increasing the health-related quality of life for people with long term condition • Increasing the proportion of people feeling supported to manage their conditions • Reducing the unplanned hospitalisation for chronic ambulatory care conditions in adults and for asthma, diabetes and epilepsy in under 19's • Increasing the estimated diagnosis rate for people with dementia	Average EQ-5D score for people reporting having one or more long-term condition Baseline 70.4 to 2018/19 73.5 Aim to achieve the England rate by 16/17 The current England change rate of 0.2 applied each year thereafter. ii) Dementia % Diagnosis 2014/15 - 0.67 2015/16 - 0.68
3. Quick recovery from ill health	3. Reducing avoidable time in hospital 4. Increasing elderly people living independently at home on discharge (no CCG Measures set)	• Reducing the number of emergency admissions for acute conditions that should not usually require hospital admission • Reducing the number of emergency readmissions within 30 days of discharge from hospital • Increasing the total health gain as assessed by patients for both hip and knee replacements, groin hernia and varicose veins • Reducing the number of emergency admissions for children with Lower Respiratory Tract Infections	Emergency admissions composite indicator Baseline 2,874 2014/15 2,729 5% reduction 2015/16 2,298 15% reduction 2018/19 2,161 2% reduction year on year Activity Measures A&E Attendances - all types 15% reduction in first 2 years 2% for the years onward

Section 8 - Our Ambitions and Goals

4. Great experience of care	5. Increasing positive experience of care outside hospital	• Increasing the patient experience of primary (GP and Out of Hours)	The proportion of people reporting poor experience of GP and Out-of-Ours Services Baseline 6.2 to 2018/19 4.7 0.3 Reduction per year
	6. Increasing positive experience of hospital care	• Increasing the patient experience hospital care	The proportion of people reporting poor patient experience of inpatient care Baseline 115 to 2018/19 110 Reduction of 1 per year
		• Improving the findings of the Friends & Family Test for all relevant commissioned services	Do you plan to meet the nationally set objective for the Friends and Family Test in 2014-15 and 2015/16? - Yes
5. Safe care	7. Significant progress on eliminating avoidable deaths	• Reducing the incidence of healthcare associated infections in MRSA and C. Difficile	C. Difficile infection cases set at 63 for 14/15 as per National Directive for Bury MRSA Rate Set at 0 for 14/15

In addition NHS England has set out three further key measures:

Improving health – to ensure there is as much focus on health improvement as there is on treating illness by Commissioning for Prevention. The Bury Health & Wellbeing Board supports and encourages partnership arrangements for health and social care services. Its agenda includes the health and wellbeing of adults, children and families, as well as wider areas that impact on health such as housing, education and the environment.

Reducing health inequalities – to ensure he most vulnerable in our society receive better care through integration. The ambition in Bury is that in 5 years' time we will have fully integrated Health and Social Care neighbourhood teams wrapped around the patient and coordinated care through effective risk stratification.

Parity of Esteem – to ensure that there is as much of a focus on mental health as there is on physical health. The ambition in Bury is to reduce the gap in life expectancy of the population with mental health problems compared to the population without and ensure those with mental health problems do not suffer inequalities either because of their mental health problem itself or because they don't get the best care for their physical problems.

Section 8 - Our Ambitions and Goals

The Operating Framework also sets out the national expectations for quality and performance improvement against which CCGs are expected to deliver. Within this context, NHS England has set out a small number of key performance indicators. Whilst these may change in future as national priorities are met, for 2013/14 they were:

- Referral to Treatment
- A&E 4 hour wait
- Cancer - 62 day waits
- Stroke
- Mixed Sex Accommodation
- HCAI
- Ambulance Cat A.

Key measures are included alongside local outcomes in table 3; detailed targets for all required Operating Framework targets for 2012/13 are set out in Appendix 2.

Table 3

Performance / Quality Indicator	Target Performance	Performance 13/14
IAPT Recovery rate	50%	34.6%
IAPT Access rate	15 %	10.93%
Dementia Prevalence rate	67%	55.1%
Ambulance – Category A (Red 1) 8 minute response time	75%	NWAS 75.9% Bury CCG 71.4%
A&E 4 hour access standard	95%	95.4%
No. waits over 52 week wait	0	2
MRSA	0	2
Referral to Treatment wait over 18 weeks	Admitted - 90% Non Admitted - 95% Incomplete - 92%	Admitted – 92.2% Non Admitted – 96.4% Incomplete – 93.8%

The CCG will continue to ensure achievement of national standards through the contractual process, supported by CQUIN and other improvement initiatives, as well as the transformation programmes for Bury.

Section 9 - Quality Improvement Priorities

The duty of the quality agenda is that care will be clinically effective, safer and that patients will have an improved experience of health care. Bury CCG is committed to ensuring high quality underpinning all aspects of services from design through to delivery and a Quality Strategy has been developed, which is framed around five priorities:

Priority 1 - Patients will only receive quality health care because all commissioning decisions will be quality assessed and approved.

Bury CCG aims to ensure that any decision made regarding a health care service change has undergone a rigorous process to assess the quality impact of the change, prior to implementation. It is important that all commissioning decisions are evaluated for the quality impact and that risks have been adequately considered, to ensure an informed decision is reached. To do this a quality impact evaluation process, including the use of an appropriate tool will be developed.

Priority 2 - The quality of care will be improved by consistent scrutiny and challenge of all health care providers

This quality priority will ensure a consistent approach to quality surveillance of all healthcare providers, recognising that often our most vulnerable patients are cared for by small providers, providing low risk interventions, for example Care Homes.

Priority 3 - Patients will have a better experience of healthcare by ensuring providers are compliant with national recommendations

Bury CCG reviews national guidance as it is produced and seeks assurance from providers that plans are in place and they are progressing towards full compliance. The rationale for this priority is that the NHS continues to undergo wide reforms, systems continue to change and the quality agenda is a top priority, due to widespread failings over the past decade. Bury CCG must have assurance that providers deliver the nationally recommended standards of quality in all their services.

Priority 4 - The quality of health care will improve by working collaboratively with other commissioning colleagues

Bury CCG has close collaborative working arrangements with its partner CCGs across the NE Sector and with neighbouring CCGs in Stockport, Tameside and Glossop. NHS England Area Team has created effective lines of communication through their committees, called collaborative, for quality. Although the current working arrangements are established, they are not yet mature and it is vital that Bury CCG continues to effectively work with partners to deliver priorities 2 and 3 of this strategy, in order to ensure better outcomes for patients.

Priority 5 - 'No decision about me without me'. Patient experience will meet expectations by improved engagement

A fundamental value of the NHS Constitution is that patients and the public must have a say about the health care they receive. NHS Bury currently has a robust engagement strategy and has made good progress towards patient and public involvement. The focus of this priority is that engagement around the quality agenda is vitally important. Patients and the public demonstrate great interest in the quality of the services commissioned and what experience of healthcare feels like. The quality team will continue to build on the engagement work already in progress and find more consistent ways of engagement around the quality agenda.

Section 10 - The Public Voice

Over the past year NHS Bury CCG has sought to engage widely with stakeholders on 'Call to Action' related themes and the development of the Strategic Plan. The strategic plan addresses all areas of the feedback obtained.

From the public input the CCG has produced You Said We Will feedback:

You said you like……

Community Based Services
- Urgent Treatment Centres
- Ophthalmology
- Audiology

Same day GP appointments
Patient participation groups
Easy access to services
Support & Advice
Early discharge stroke team
Patient education

We will…..

Further enhance community services
Extend GP operating hours
Develop patient education
Improve ease of access to services
Aim for equitable services for all
Develop patient education programmes

What you said could be better…

Interlinking between education, health & social care
Community support services
Co-ordination of care, transport & appointments
Information sharing – telling your story only once
Continuity of services 7 days a week
Better services for chronic and long term conditions
Mental health services
Cancer and palliative care

We will…..

Create an integrated approach to health and social care
Collaborate to provide support
Implement extended hours for Primary Care services to operate 8-8 Monday to Friday and 8-6 at weekends.
Commission Consultant outpatients and pre-operative assessment clinics in Primary Care
Re-commission anticoagulant clinics in localities near to patients
Work on safe record sharing
Commissioning multi-disciplinary teams to support long term conditions
Improve access to psychological therapies and mental health services
Support people to die in their preferred place, implement training programmes

Your New Ideas Were…

To use alternative venues for health & care programmes e.g. libraries
To have one constant Bury approach at every contact
Encourage people to take responsibility for their own health
Simplify patient pathways
To improve communication, use text messages as reminders and phone calls to follow up.
Have immediate access to services on discharge from hospital

We will…..

Consider venue use within our integrated care programme
Engage in Partnership working for a consistent approach
Encourage self care
Work to improve patient pathways
Develop our communication processes and pass this message onto providers
Review access to community services following hospital discharge

Section 11 - The Membership Voice

Bury CCG has robust arrangements in place to facilitate two way engagement with colleagues within Primary Care, via monthly sector board meetings. The views and priorities of our members have been gathered and incorporated within the development of our plans.

Members have indicated:

Members say what works well……

We have good quality, personal, local services in Bury

Community based services e.g. anticoagulation service and incontinence service

The Care at the Chemist scheme

We will…..

Extend GP operating hours

Improve access to records for continuity

Re-commission anticoagulant clinics

Further enhance community services

Extend the care at the Chemist scheme

What members said could be better…

Growing demand is increasing pressure on the workforce

Community based care such as; paediatrics, mental health, alcohol services and physiotherapy

Communication across services and with social care

Integration with social care

Access for patients to:
The CRISIS Team; treatment rooms; the falls service; GP appointments.

Workforce issues:
Recruitment; training & development; sharing skill mix, appropriate use of resource

We will…..

Enhance the GP workforce

Develop speciality services in the community e.g. paediatrics

Improve access to psychological therapies and mental health services

Create an integrated approach to health and social care

Collaborate to provide support

Commission multi-disciplinary teams to support long term conditions

Enhance patient pathways to improve access

Collaborate on a whole systems approach to workforce

Your New Ideas Were…

To use alternative venues for health & care programmes e.g. libraries

To have one constant Bury approach at every contact

Encourage people to take responsibility for their own health

Simplify patient pathways

To improve communication, use text messages as reminders and phone calls to follow up.

Have immediate access to services on discharge from hospital

We will…..

Collaborate on the development of support for carers

Engage in partnership approach with public health initiatives where possible

Review the service offered in the Care at the Chemist Scheme

Encourage and promote wellness, self-care, and appropriate access to care

Work to improve patient pathways

Section 12 - Communication and Engagement Priorities

Good communication and engagement with all stakeholders is fundamental to the CCG achieving its strategic objectives over the next 5 years. Effective communication and engagement is essential to:

- Encourage our workforce to contribute fully so that the CCG can harness the knowledge, skill and experience we have in our team to achieve our vision
- Ensure a cohesive membership contributing to and supporting the delivery of the CCGs vision and objectives
- Enable the CCG to work with its strategic partners in the local authority and provider organisations to deliver true integration of health and social care services
- Empower patients and the public to have a voice in their own treatment and care as well as in wider commissioning decisions

To support the 5 year strategy the CCG has reviewed and refreshed its Communications and Engagement Strategy and in doing this invited feedback from some of our key stakeholders and our Patient Cabinet. The Strategy sets out our main priorities over the next five years. These include:

- Inform and support the significant transformation of health and social care that will take place locally, through service redesign, including the development of integrated models of care. The role for communications and engagement is to obtain and facilitate the transfer of views and opinions into the service redesign process and to promote information about changes to the community
- Help in the promotion of self-care within the community through a range of communications and engagement mechanisms
- Work with stakeholders and in particular the CCG's Patient Cabinet and Healthwatch, in understanding and responding to the needs of our communities and to make views and opinions obtained useful, by feeding into the commissioning process
- Utilise the experiences of our local patients in shaping future services
- Build, maintain and protect the reputation of the CCG with the public and stakeholders (both internal and external)
- Continue to work towards meeting best practice and delivering legal responsibilities
- Position NHS Bury CCG as the organisation able to improve the health of the people of Bury, improve the health services they receive and their experience of them and deliver this at good value for money
- Maximise the 'breadth' of engagement (the total number of patients and the public engaged) and maximise the 'depth' of engagement (reaching patients and members of the public who would not usually engage or who may face barriers to getting their voices heard).

The CCG is committed to listening, learning and acting on the views of our stakeholders and in this respect we are reviewing the outcomes of the latest NHSE commissioned 360o Stakeholder Survey and the feedback we have received from our engagement events with member practices and with local patients to inform our communications and engagement plans.

We are using 'Transforming Participation in Health & Care' to inform our approach so that we can ensure that our work on developing public and patient engagement is informed by best practice.

The CCG cannot achieve the priorities of the strategic plan on its own and the kind of whole system changes, which are necessary, require a genuine partnership approach. In this respect we will be building on early work with the local authority (adult social care and Public Health), key providers, Healthwatch and the 3rd Sector Development Agency to develop and implement a shared strategy to promote public and patient engagement in developing integrated care in Bury.

Section 12 - Communication and Engagement Priorities

Over the short term the CCG will be working on a number of priorities:

1. To use the 360o Stakeholder Survey and other feedback to work with our member practices at improving communication and engagement
2. Working with partners to promote public and patient engagement in the integration agenda
3. To develop and strengthen our Patient Cabinet
4. The development of a programme of work to broaden and deepen our public and patient engagement and build a 'community of interest' around the CCG. In particular we will be focusing on improving our engagement with protected groups in the Borough
5. The development of robust processes and associated governance arrangements to ensure that the CCG meets its statutory duties, in relation to engagement and consultation, when developing plans for significant changes in services

Section 13 - Financial Stability

The 5 year CCG Finance Plan has been developed, the summary of which is provided within table 4:-

Table 4

Revenue Resource Limit	2013/14 (£'000)	2014/15 (£'000)	2015/16 (£'000)	2016/17 (£'000)	2017/18 (£'000)	2018/19 (£'000)
Recurrent	213,060	221,360	231,326	231,604	235,470	239,401
Non-Recurrent	5,482	-	250	250	250	251
Total	218,542	221,360	231,576	231,854	235,720	239,653
Income and Expenditure						
Acute	124,462	121,792	119,812	120,866	120,768	120,557
Mental Health	22,861	25,117	24,525	24,696	24,972	25,231
Community	21,415	20,996	20,579	20,154	19,361	18,474
Continuing Care	11,602	11,133	11,515	11,524	11,533	11,542
Primary Care	32,038	31,872	32,315	32,560	32,807	33,056
Other Programme	3,710	4,422	17,220	16,442	20,646	25,141
Total Programme Costs	**216,089**	**215,333**	**225,966**	**226,243**	**230,088**	**234,002**
Running Costs	4,544	4,670	4,202	4,202	4,202	4,202
Contingency	-	1,107	1,158	1,159	1,179	1,199
Total Costs	**220,633**	**221,110**	**231,326**	**231,604**	**235,468**	**239,402**

This plan has been developed in light of the financial allocation for Bury. It reflects the notified financial allocations but, does not assume the increased levels that would be required, to bring the organisation closer to its allocation target.

The overall financial gap for Bury CCG is summarised in table 5:-

Table 5

	2013/14 (£'000)	2014/15 (£'000)	2015/16 (£'000)	2016/17 (£'000)	2017/18 (£'000)	2018/19 (£'000)
Recurrent (inclusive of full year effect)	4,600	505	1,238	3,678	1,101	942
Non-Recurrent		7,442	4,954	3,441	1,642	416
Total	**4,600**	**7,947**	**6,192**	**7,119**	**2,743**	**1,358**

13.1 QIPP Plan

The overall QIPP gap for Bury is outlined in table 6, which details the activity reduction assumptions within the acute sector that are the key to delivery of a balanced financial position moving forward for the CCG :-

Table 6

	2014/15 (£'000)	2015/16 (£'000)	2016/17 (£'000)	2017/18 (£'000)	2018/19 (£'000)
Total QIPP Required	7,947	6,192	7,119	2,743	1,358
Previous year over-achievement of recurrent QIPP target			-5,127	-2,205	-1,921
Total	**7,947**	**6,192**	**1,992**	**538**	**-563**
Strategic Plan - Acute Efficiencies					
Elective efficiencies - identified within strategic plan	-	-366	-426	-487	-548
Non-elective efficiencies - identified within strategic plan		-5,283	-300	-300	-300
A&E efficiencies - identified within strategic plan		-716	-30	-30	-30
Under / (Over) achievement of QIPP target	**7,947**	**-173**	**231,604**	**235,468**	**239,402**

The acute efficiencies have been calculated using planned activity reductions shown in tables 7 & 8

Section 13 - Financial Stability

A 15 % reduction in elective care activity is approximated to realise the following efficiencies:

Table 7

Year	% Deflections	Elective £	% Deflections	Day Case £
14/15	0	0	0	0
15/16	-3.0%	-£ 365,505	-0.5%	-£ 45,012
16/17	-3.5%	-£ 426,423	-1.0%	-£ 90,024
17/18	-4.0%	-£ 487,340	-1.5%	-£ 135,036
18/19	-4.5%	-£ 548,258	-2.0%	-£ 180,048
Total Deflection	**-15.0%**	**-£ 1,827,525**	**-5.0%**	**-£ 450,120**

A 20% reduction in urgent care activity and a 16.5% reduction in A&E activity; is approximated to realise the following efficiencies:

Table 8

Year	% Deflections	Non Elective £	% Deflections	A&E
14/15	-3.4%	-£ 1,317,170	-3%	-£ 179,079
15/16	-14.1%	-£ 5,282,770	-12%	-£ 716,319
16/17	-0.8%	-£ 299,732	-0.5%	-£ 29,847
17/18	-0.8%	-£ 299,732	-0.5%	-£ 29,847
18/19	-0.8%	-£ 299,732	-0.5%	-£ 29,847
Total Deflection %	**-19.9%**	**-£ 7,359,191**	**-16.5%**	**-£ 984,939**

The short term QIPP Plan centres on the completion of the integrated care initiatives, including the provision of seven day a week access to primary care, and implementation of integrated health and social care teams to support the most vulnerable patients.

These key initiatives will improve clinical quality and sustainability, integrate care for better patient experience and help to secure reductions in admission rates. The five year strategy is to reduce non-elective admission rates despite the increases in demand which we are expecting from an ageing population.

The CCG will seek to reduce paediatric non-elective admission rates by providing more accessible and child friendly, community based services. There will also be a reduction in elective referral rates which will be achieved through addressing procedures of limited clinical value and making available to GPs more effective decision making tools and providing referral management support. The long term condition strategy, which delivers pathway improvements in diabetes, respiratory and cardiac care, will also allow the CCG to achieve improved admission rates.

In addition to these plans there are a number of named transactional QIPP initiatives, such as continuing changes in GP prescribing practices and Continuing Health Care cost reduction.

An overall 4% efficiency target has also been built into contracts with all providers.

Most of the QIPP programme across the three years can be classified as transformational and more detail can be found in the transformational change delivery plan section 16.

Due to the range of transformational programmes and ongoing modelling the precise implcation of QIPP for acute and other sectors are not fully quantifiied. However a series of activity assumptions have been shared with the Local Authority and the Acute Trusts to guide development of five year plans. These reflect the actvity shift NHS Bury CCG expects to deliver through QIPP. The activity information and impact on provider bed days is outlined further in appendix 6.

Section 13 - Financial Stability

Work has been undertaken to identify an investment plan to resource schemes which will deliver Integrated Health and Social care and reduce admissions to hospital (Better Care Fund – see table 9 – the review and re-commissioning of these services will be key to the delivery of the CCG's required activity reductions. The impact of these investments will be collectively monitored across Health and Social Care using the programme's Joint Outcomes Framework (which is currently in development). This approach will allow the organisations to look at impacts across multiple organisations and projects, as it is not possible to isolate the impact of specific initiatives/investments upon whole systems. The business cases for each specific investment proposal will detail the method by which individual schemes will be monitored and evaluated.

We are currently working with the local authoirty to prioritise an iinvestment / disinvestment programme to support the Better Care Fund.

13.1 Better Care Fund

The financial plan and business case for the Better Care Fund have to be developed in the context of the anticipated financial position for the Council and the Clinical Commissioning Group over the next five years. The health and care sector challenge has been widely communicated across the Manchester health economies. The significant task of reducing and managing the CCGs and Councils financial pressures, together with delivery of Pennine Acute Cost Improvement Programme, is being addressed through a variety of inter-dependent programmes:

- Healthier Together
- Integration of Health and Social care
- Primary Care Strategy
- Other 'Quality, Innovation, Prevention and Productivity' (QIPP) schemes

Following the fundamental review of allocations policy commissioned by NHS England, Bury CCG is funded significantly below the target allocation. The pace of change moves Bury nearer to target but only in the last three years of the formula. As a consequence of these current uncertainties, the CCG has formulated a financial plan based upon a significant QIPP plan for years one and two.

For 2014/15, the finance plan identifies the specific measures that are being put in place to deliver the £7.9m QIPP gap in this financial year. It is recognised that some of these measures are non-recurrent actions to allow time for recurrent service redesign proposals and deflection schemes to be fully implemented. Moving forward, a variety of service design initiatives are being developed, to deliver the QIPP target in future years including £9.27m savings over the 5 year period relating to Healthier Together assumptions about changes in activity levels.

To achieve this level of QIPP the vision in Bury is that in 5 years' time there will have been a significant shift of activity and therefore funding, from secondary care into primary care services. The Better Care Fund, Healthier Together and Better Care programmes all support the development of an integrated wellness, prevention and care programme, which is to be developed in Bury. To date there has been recognition of required funding of £11.7 million to support this. The development of the integrated care plans are expected to realise; a 16.5% reduction in Urgent care activity; a 15% reduction in Elective Care; a 5 % reduction in Day cases and a 5% reduction in Out Patient activity. 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 admissions and by reduced length of stay (activity will decrease but average length of stay may possibly increase, as the acute sector deals with a more complex patient spectrum) and will therefore lead to bed reconfiguration and a related reduction in income and expenditure for the acute trusts. Bury CCG has issued commissioning intentions around Integrated Care to Pennine

Section 13 - Financial Stability

Acute Health Trust in October 2013 which highlighted the level of financial resource transfer that would be required from the acute to the community sector. Plans for year one reduction have been built into the contract for 2014/15 and the trust has plans to reduce its capacity accordingly. The CCG and PAHT are developing a programme of shared monitoring to ensure any risk to delivering activity reductions is identified immediately and can be acted upon.

A series of strategic financial planning assumptions have been agreed with key partners. These reflect the activity shift assumptions expected to be delivered through the above programmes over the planning period, as well as acknowledgement that reinvestment will be required in the community and other services to secure reductions in hospital capacity. Mitigation for non-achievement will be identified and agreed as part of this.

The timing and level of investments required (recurrent, non-recurrent and transition costs) will be driven by the pace of development of the Greater Manchester and Borough wide programmes. Pennine Acute Hospital Trust is developing its 5 year Business Plan to move to Foundation Trust Status. Across the North East Sector of Manchester the CCGs are working together with PAHT to ensure all known activity assumptions around the Healthier Together, Integrated Care, Primary Care and QIPP schemes are reflected within this plan. The reduction in activity PAHT will expect to see across the North East Sector of Greater Manchester is significant and will not be realised without a significant change in the way their services are delivered. Options for change are currently being considered by PAHT and the CCGs that deliver the activity reductions, whilst ensuring PAHT is economically viable. The Trust Development Agency and NHS England are partners in the planning and final decisions will be informed by the Greater Manchester Programmes. Due to the complexities referenced above it will be necessary to undertake much more detailed work with the Acute Trust over the next 2-3 months to understand the impact over 5 years. This commitment has been included in the Memorandum of Understanding that has been agreed for the 2014/15 contract. There will be a significant financial risk to the Commissioners and Health Economy if the ring-fenced resources in the fund cannot deliver change on the scale expected. Identified risks are outlined in appendix 3

Table 9

BCF Investment	2015/16 spend	
	Recurrent	Non-recurrent
Staying well – self-care and early prevention		£ 811,000
The schemes to be considered under this theme are: Carers Centre; Falls Prevention; Digital Inclusion for Older People; Sheltered Housing.		
Reablement and intermediate care		£ 2,773,000
The schemes to be considered under this theme are: Intermediate care; Crisis response; Reablement Service; Nursing Home beds spot purchase; Discharge Liaison services; Equipment; Discharge Liaison service.		
Integrated and community care services		£ 1,729,000
The schemes to be considered under this theme are: Transfer of care team, domiciliary care agencies, care home LES, health related support into residential and nursing homes; Cambeck Close; Excess Stroke Days; End of life care;		
Long Term Conditions - diabetes, cardiology, respiratory		
Mitigation of pressure on core social care services which already provide a health benefit	£ 5,828,000	
Capital - DFGs		£ 781,000
Capital - Council capital grant		£ 455,000
Contingency element		£ 586,000
A 5% contingency has been set, in case some of the schemes don't achieve their expected outcomes		
Total	**£5,828,000**	**£7,135,000**

Section 13 - Financial Stability

Work streams are in place currently to develop work plans within the areas identified in table 10.

Table 10

Bury Integrated Health and Social Care joint work programme key deliverables with timescales		
Ref	**Description**	**Timescale**
1. Prevention/ helping people staying well		
1.1	Better Together	April 2014 onwards
1.2	Integrated wellness services	April 2015
1.3	Staying well	April 2015
1.4	Self-care programmes	April 2014 onwards
1.5	Active ageing	April 2014 onwards
1.6	Falls prevention	April 2015
1.7	Affordable warmth	Sept – Feb Annually
1.8	Seasonal Flu uptake	Sept– Feb Annually
1.9	Dementia awareness	May 2014 onwards
2. Reablement and Intermediate care		
2.1	Data gathering	April 2014
2.2	Analysis and identification trends/ gaps	May 2014
2.3	Development of emerging models for discussion	June 2014
2.4	Development of business cases for discussion at board	July 2014
2.5	Implementation of new model	2016
3. Integrated community and primary care services		
3.1	Enhanced access to primary care	Oct 13 – April 15
3.2	Establish wider integrated health and social care team	July 14 – March 16
3.3	Admissions avoidance	July 14 – March 16
3.4	Enhanced discharge	July 14 – March 16
3.5	Integrated community services for children	April 14 – March 16

Section 14 - Our CCG Organisational Development (OD) Priorities

The OD Plan is designed to show how the CCG will grow and develop as an organisation, in order to deliver its key vision and objectives. Clearly the plan will change and evolve as the CCG develops and this early plan focuses on many of the issues any high performing organisation needs to have in place, in order to deliver its business aims effectively.
The plan is based around developing 6 areas:

- Clinical focus and added value
- Organisational capacity and capability
- Clear and credible plans
- Engagement with partners, patients and community's
- Leadership capacity and capability
- Collaborative organisation

The CCG OD Strategy is being currently refreshed.

Bury Clinical Commissioning Group
Delivery Plan 2014-2019

Section 15 - Achieving Our Ambitions

Ambition 1 - Securing additional years of life for the people of England with treatable mental and physical health conditions

This will be achieved through a reduction in mortality in the following areas:

- Reducing Mortality from Cardiac Disease
- Reducing Mortality from Stroke
- Reducing Mortality from Respiratory Disease
- Reducing Mortality from Cancer
- Reducing Mortality within the Mental Health and Learning Disabilities population
- Reducing Mortality from Liver Diseases

These areas have been selected a priority areas based on the evidence from the JSNA outlined in section 3.2 of this document.

The table 11 outlines modelled information which provides an estimate of the potential number of deaths that could be prevented in one year if the above are targeted by evidenced based interventions. There are lots of assumptions in this model, such as how well we are already doing in relation to the modelled interventions, how well we could potentially do (achievable coverage) leading to an estimate of the number of deaths we could prevent in one year. The theoretical maximum number of preventable deaths in one year is 229, with the biggest gains to be made (in the short term) from the optimal treatment and prevention of cardiovascular diseases. An achievable goal for Bury would be to prevent 100 premature deaths each future year. Better Together will provide the platform for this work and will include improving the accuracy of disease registers to establish a clear picture of the present position and the required scaling and targeting of the interventions in order to prevent 100 deaths. Whilst the modelled interventions will guide us in how to address the inequalities caused by circulatory and respiratory diseases it will also be crucial to focus on the gap attributable to mental health conditions in women.

The high impact interventions outlined will be implemented through

- NHS Health Checks with prioritisation of those at highest risk of Cardio Vascular Disease and a drive to continually improve uptake rates
- Integrated services for cardiology, diabetes and respiratory services, with a focus on greater uptake and completion of cardiac and pulmonary rehabilitation, will bring expertise into primary care and provide training and support to improve management of the conditions
- Implementation of GRASP-AF will improve identification and clinical review of patients with AF not presently anti-coagulated
- Anticoagulation services will be re-designed, to improve care delivered closer to home, which is cost-effective, with a focus on improving the amount of time patients are within the therapeutic range.
- Better Together', a collaboration between Public Health, the CCG and individual practices, will improve the management of long term conditions
- Integrated care planning for adults and children, integrated Physical and Mental Health approaches, collaborating with Bury council supporting people to live healthier lives including:
  - Shared decision making to empower patients to maximise self-care, self-management and choice
  - Telehealth.
  - Risk stratification and care planning
  - Reablement and Crisis Response services
- Promote implementation of the Alcohol Local Enhanced Service
- Alcohol liaison nurses working directly in A&E
- NHS Health Checks will include a mandatory dementia element to increase the rates and meet the National target
- Local RAID CQUIN and indicator, relating to reducing alcohol A&E attendance and hospital admission, and improved engagement with alcohol services
- A talk cancer program to further enable staff to engage in discussions around cancer awareness

Section 15 - Achieving Our Ambitions

Table 11 – Estimated potential postponed deaths in one year, life expectancy gain and 'Number Needed to Treat'

Assumed treatment coverage of eligible population (%)	Intervention	Potential postponed deaths in one year (based on 2006-08 data)			Estimated population eligible for treatment			Number Needed to Treat (NNT) to postpone one death	Life expectancy gain (for local authority)		Change in All Age All Cause Mortality (AAACM) rate per 100,000 from 2006-8 actual rate	
		Males	Females	Persons	Males	Females	Persons	Ratio	Males	Females	Males	Females
	Cardiovascular disease: Secondary prevention Four treatments (beta blocker, aspirin, ACE inhibitor, statin) for all patients with a previous CVD event											
	Currently untreated											
100%	CHD deaths averted	7	8	16	707	719	1,426	56	0.08	0.06	-6.57	-3.95
	Stroke deaths averted	3	7	10					0.03	0.05	-2.84	-3.08
100%	**Currently partially treated**											
	CHD deaths averted	14	15	30	5,373	3,854	9,227	189	0.16	0.12	-12.57	-7.52
	Stroke deaths averted	6	13	19					0.06	0.09	-5.43	-5.87
100%	**Additional treatment for hypertensives with no previous CVD event**											
	Additional hypertensive therapy	22	26	48	18,846	14,293	33,138	479	0.25	0.26	-20.15	-14.78
	Statin treatment for hypertensives with high CVD risk	10	11	21					0.13	0.12	-9.27	-5.86
100%	**Treatment for heart attack**											
	Primary angioplasty (PCI) for heart attack	2	1	3	-	-	295	107	-	-	-	-
100%	**Anticoagulant therapy (Warfarin) for all patients over 65 with atrial fibrillation**											
	Stroke deaths averted	5	9	15	293	257	550	38	0.04	0.06	-4.49	-4.02
100%	**Diabetes**											
	Reducing blood sugars (HbA1c) over 7.5 by one unit	8	3	11	1,830	893	2,723	245	0.08	0.03	-7.4	-1.72
40%	**Chronic obstructive pulmonary disease (COPD)**											
	Statins to address CVD risk among COPD patients	29	21	50	1,250	970	2,220	44	0.3	0.19	-26.22	-11.41

Section 15 - Achieving Our Ambitions

Assumed treatment coverage of eligible population (%)	Intervention	Potential postponed deaths in one year (based on 2006-08 data)			Estimated population eligible for treatment			Number Needed to Treat (NNT) to postpone one death	Life expectancy gain (for local authority)		Change in All Age All Cause Mortality (AAACM) rate per 100,000 from 2006-8 actual rate	
		Males	Females	Persons	Males	Females	Persons	Ratio	Males	Females	Males	Females
100%	**Reducing smoking in pregnancy**											
	Eliminating smoking in pregnancy (infant deaths averted)	0.3	0.4	0.7	-	-	451	684	0.26	0.32	0	-0.01
10%	**Harmful alcohol consumption**											
	Brief intervention for 10% of harmful drinkers	1.2	0.5	1.7	434	273	707	416	0.03	0.01	-1.44	-0.54
100%	**Lung cancer**											
	Increasing rates of early presentation	1.6	1.2	2.8	*	*	*	*	0.02	0.02	-1.52	-0.92
10%	**Smoking cessation clinics (setting a quit date)**											
	Results shows deaths postponed in short term (1-2 years)**	0.9	1	2	1,031	1,124	2,155	1092	0.01	0.02	-0.88	-0.62
	Total	**112**	**117**	**229**	**-**	**-**	**-**	**-**	**1.45**	**1.35**	**-98.77**	**-60.29**

Section 15 - Achieving Our Ambitions

Ambition 2 - Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions

Will be achieved through

- Ensuring equality of access to health services for all people within Bury
- A Clinical Leadership model with identified experienced clinical leads for LTC and Mental Health, having paid sessions to support the work of the CCG
- Patient Engagement supported by a robust Patient Cabinet, with identified leads for the Long Term Condition categories
- The CCG is actively participating in the LTC AQUA programme on risk stratification of patients, the development of MDTs and the promotion of shared decision making
- Development and implementation of an integrated community Diabetes Service
- Wider roll out of the pilot scheme 'Healthier Radcliffe'; an enhanced primary care 7 day service for the residents of Radcliffe to become 'Healthier Bury'
- Further development of the Care Home Local Enhanced Service will capture a large proportion of patients with LTC, reducing Non Elective Activity as a result of additional support from GP practices
- Establishing arrangements for Integrated Community Respiratory Services
- Establishing arrangements for Integrated Community Cardiology Services
- Winter Planning to prioritise the co-ordination of services and ensure support for those with LTC's
- Provision of a Crisis Response Service, to respond to referrals within 2 hours undertaking a comprehensive assessment, developing a package of care wrapped around the patient for up to 72 hours, to allow the patient to recover in their own home
- Develop of a blueprint for improving partnership working between GPs and third sector organisations, to provide support for patients with dementia and their carers
- Work with Bury IAPTS to further enhance partnership working with statutory and non-statutory third sector providers and expand the co-location of IAPTS in GP surgeries and community settings
- Promote the range of brief Cognitive Behavioural Therapy based interventions available to people of all ages
- Implementation of the Joint Dementia Strategy and Action Plan with the Local Authority

Ambition 3 - Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.

Will be achieved through

- Delivering the ambitions within the Better Care Fund Business Case
- Developing support for patients with LTCs
- Working with PAHT to develop pathways for in patients requiring IV therapy, to be discharged (stepped down) to community IV services
- Delivering primary care interventions to reduce the incidence of elective and non-elective admissions for patients with varicose veins
- Procuring an Integrated Community Respiratory service for Adults and Children
- Review the Stroke Early Supported Discharge service pilot programme, to identify any improvements realised and the benefit of continued investment
- Procuring an Integrated Community Cardiology Services
- Development and implementation of an integrated community Diabetes Service
- Wider roll out of the pilot scheme 'Healthier Radcliffe'; an enhanced primary care 7 day service for the residents of Radcliffe, to become 'Healthier Bury'
- Establishing a MDT Process- targeting regular attendees at A&E due to alcohol misuse
- Reviewing the End of Life and Palliative Care service, with a view to having improved co-ordination and communication

Section 15 - Achieving Our Ambitions

Ambition 4 - Increasing the proportion of older people living independently at home following discharge from hospital.

Will be achieved through

- Improved access to primary care service via Better Together (primary care health improvement programme)
- Provision of a Crisis Response Service, to respond to referrals within 2 hours undertaking a comprehensive assessment, developing a package of care wrapped around the patient for up to 72 hours, to allow the patient to recover in their own home
- Support for carers
- Rapid access to professional advice
- Multi-disciplinary teams aligned to GP practices to co-ordinate and plan care
- Integrated Reablement
- Self-care programme
- Integrated wellness service
- Staying Well programme, targeting older population at risk of dependency
- Helping yourself to health a self-care programme
- Active ageing programme
- Falls prevention intervention programme
- Affordable warmth
- Increasing seasonal flu jab up take, with a stretch target for the population aged over 75, to 90%

Ambition 5: Increasing the number of people having a positive experience of hospital care.

Will be achieved through

- The CCG aims to cultivate Learning Organisations by encouraging feedback, positive and negative, in order to review, assess and develop services to meet the needs and expectations of the patients and public who use them.
- PAHT obtains patient experience feedback across the 5 key domains:
  - Access and Waiting;
  - Safe, high quality, co-ordinated care;
  - Better information, more choice;
  - Building closer relationships;
  - Clean, comfortable friendly place to be.

  Using multiple techniques such as; Ward level – 'techno huddle' data, providing real-time patient feedback; The Friends and Family Test and Local Patient Surveys.
- Pennine Care Foundation Trust (PCFT) captures patient experience via a number of channels including; using 'Elephant kiosks'; email and telephone numbers on appointment cards; Patient Advisory Liaison Service (PALS) and Complaints.
- PCFT are completing a review to triangulate PALS, patient experience and complaints data
- Monthly feedback reviews to be undertaken at NE Sector Clinical Quality Leads Meetings – with CCG assurance sought around data capture
- Improvements in A&E performance
- Managing the discharge of patients if they are medically fit and a focus on delayed discharge
- Expansion of systems designed to capture patient satisfaction and experience e.g. patient Kiosks, SMS text messaging
- Enhanced therapeutic environments realised through a range of ward improvement schemes

Section 15 - Achieving Our Ambitions

Ambition 6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community

Will be achieved through

Monthly performance & quality reporting and monitoring for all Out of Hours providers

- Services to be targeted to at risk patient groups (Mental Health and Learning Disabilities) and move to a system of measuring outcomes and harm reduction.
- Physical health checks for people with severe and enduring mental health
- NHS Health Checks (Cardio Vascular Disease) – explore the possibility of expanding these to include Mental Health and Learning Disabilities
- Develop a community pharmacy questionnaire to encourage patients to ask questions about their medication and understand the implication on mental and physical health ('10 Questions to Ask Your Pharmacist'). Pharmacies to provide signposting/referral information for patients.
- End of life pathway for patients with Learning Disabilities – work with the Pennine Care Adult Learning Disabilities Team
- Health Trainers and developing pathways for people with Learning Disabilities
- Reducing A&E attendance for people with Learning Disabilities - work with Pennine Care Adult Learning Disabilities Team to develop pathways between providers to work with patients to reduce avoidable attendance at A&E and avoidable hospital admissions

Ambition 7: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

Will be achieved through

- Undertaking a monthly collaborative incident review management process, of root cause analysis and lessons learned

- Commissioning an infection control service, managed by the Public Health department for a further 3 years
- SLA to include infection control audit in general practice
- Monthly review of the HCAI action plan developed with Acute and Community providers and NES CCGs
- The medicines management team supporting prescribing and case management, to raise awareness of HCAI within General Practice and liaise with microbiology any issues and concerns
- The Provider Trust is undertaking triple testing for C-Difficile, the CCG aims to mirror the approach in the community and work with GPs to reduce Community retesting

Section 15 - Achieving Our Ambitions

Ambition 8 –Key Measure 3: Parity of Esteem

Will be achieved through

Developing an Outcomes Based Framework for Primary Care

- Move to an outcomes based framework - utilise 'Better Care' to develop measures to monitor reductions in the following areas in Years 1 & 2 amongst people with Learning Disabilities (LD) and Mental Health (MH) issues
- Practices to be benchmarked through 'Better Care'
- Services to be targeted to at risk patient groups and move to a system of measuring outcomes and harm reduction.

Adherence to Medications for Patients with MH and LD

- Develop shared care guidance and clinical correspondence between primary and secondary care – priority areas to be identified
- Develop a community pharmacy questionnaire to encourage patients to ask questions about their medication and understand the implication on mental and physical health ('10 Questions to Ask Your Pharmacist'). Pharmacies to provide signposting/referral information for patients
- Anti-psychotics and Dementia – reduction in the use of anti-psychotics

Ensuring Equal Access to Health services for People with MH and LD

- Equal access to health services for people with MH and LD; including comparable waiting times, equitable treatment for all in line with need and the same level of choice and quality of services regardless of conditions.

Embedding Mental Health and Physical Health Initiatives in Health Services

- GPs/Secondary Care and 3rd Sector - develop pathways to embed mental health/physical health services in relevant service specs e.g. IAPT services, links to LTC, links to challenging behaviour; and developing methods to measure patient health outcomes

Addressing Parity of Esteem Across The Life Course

- Training/Signposting - Making secondary care and primary care professionals aware of the range of physical and mental health services available in Bury and how to refer patients
- Review the Self-Care programme linked to Mental health and LD
- Mobilising communities (Citizenship/Patient Engagement)
- In reach into Lesbian and Gay Federation agenda
- BME Communities – Dementia, Carers and BME Communities pilot – sharing of blueprint for improved partnership working between GPs and third sector agencies.
- Embed parity of esteem across the life course – build into school nurse contract/health visitor contract/early years agenda
- Roll out of dementia friendly communities - via dementia action plan
- Map model from dementia friendly communities to create LD friendly communities model

Section 16 - Delivering Transformational Change in Bury

Our aim is to engage on a Health and Social care collaborative range of programmes, covering the life course aligned to the Health and Wellbeing Strategy. To maximise Patient participation in the NHS and care system, to develop a system that will truly put patients at the heart of both service planning and delivery and also put them in greater control of their own care.

Bury CCG has devised five Transformation Schemes to deliver the required changes, to fulfil our long term ambitions and support the significant shift in activity and resource that is necessary, from hospital into the community. The CCG aims to maintain a focus on quality, safety and improvement throughout all of these schemes.

The service improvement leads have worked in collaboration with clinicians to devise work plans for their individual service areas. The CCG now has a clear vision of how services should look in five years time and has begun to identify the steps required to achieve the vision. Work programmes have been developed and the CCG will undergo a prioritisation process to identify those with the greatest impact.

Transformation scheme initiatives linked to service plans, the Health & Wellbeing strategy life course and the NHS Outcomes Framework can be found in appendix 4. Work stream plans on a page can be found in appendix 5.

All work stream plans are expected to continue to evolve and become the basis of service development. The CCG recognises that collectively these plans are very ambitious and that achieving all the changes would take more resources than are available, however we are committed to ensure that output is maximised to deliver optimum improved outcomes for the public and patients in Bury.

16.1 Transformation Scheme 1 - Establish Collaborative Prevention, Wellness and Life Support Programmes - Living Well and Dying Well

Our ambition is to engage on a Health and Social care collaborative range of programmes, covering the life course aligned to the Health and Wellbeing Strategy. To maximise Patient participation in the NHS and care system, to develop a system that will truly put patients at the heart of both service planning and delivery and also put them in greater control of their own care.

Bury's Health and Wellbeing Strategy is based on the principles of promoting prevention, early intervention and self-care; reducing health inequalities and improving health outcomes across the life-course.

Delivery of the Health & wellbeing Strategy requires coordinated action at:

Population level: Developing strategy, policy and large-scale service reform to address the wider determinants of ill-health and health inequalities e.g. developing local poverty, housing and digital inclusion strategies; advocacy for policies on a minimum unit price for alcohol, food labelling and incentives for active travel; Implementation of Greater Manchester Public Sector Reform e.g. early years, troubled families/complex dependency, health & social care integration, working well, transforming justice.

Community level: Creating the conditions within education, health and care, workplace and neighbourhood settings that enable people to maintain and improve their health e.g. through a culture of wellbeing, equitable access to services, provision of healthy food choices, provision of shower and changing facilities

Individual level: Ensuring easily accessible information, advice and support to help individuals maintain and improve their health e.g. via digital, telephone and face to face methods.

Section 16 - Delivering Transformational Change in Bury

Bury Public Health have identified a number of work programmes to help take this agenda forward working closely with the rest of the local authority, the CCG, community and voluntary sector and other partners.

* Denotes programmes aligned to the Better Care Fund plans

Health & Wellbeing Strategy Priority 1: Ensuring a positive start to life for children, young people and families.

- To improve contribution of ante-natal and maternity services to public health outcomes
- Develop an early years health improvement strategy for Bury based on the Greater Manchester Public Service Reform New Delivery Model
- Re -establish a Healthy Schools Programme

Health & Wellbeing Strategy Priority 2: Encouraging healthy lifestyle and behaviour in all actions and activities.

- Advocate for a minimum unit price on alcohol
- Commission an appropriately scaled healthy lifestyle service supporting individuals with stopping smoking, weight management, safe alcohol consumption, healthy eating, physical activity and positive mental wellbeing.*
- Build on the Sport England funded 'I Will if You Will' programme to achieve a step change in participation in physical activity by the population of Bury *
- Establish a Healthy Workplace Programme
- To develop an adult sexual health promotion programme

Health & Wellbeing Strategy Priority 3: Help to build strong communities, wellbeing and mental health

- Implement the 'Community Engagement for Health' programme which aims to create the conditions for effective community engagement in health improvement and health care*
- Promote the 'Five ways to wellbeing' – Connect, Be Active, Give, Take Notice, Learn

Health & Wellbeing Strategy Priority 4: Promoting Independence of those with long term conditions and their carers

- Establish the 'Better Together' programme in primary care to ensure systematic implementation of primary and secondary chronic disease management in primary care. *
- Embed and expand the 'Helping Yourself 2 Health' self-care programme which builds confidence, motivation and health literacy to enable people to self-care.*
- Establish and evaluate a holistic 'Staying Well' service for older people who have high potential for developing a social care and higher level health need in the future to help maintain health, wellbeing and independence.*
- To review and redesign the falls prevention pathway from prevention, early identification and treatment of falls and osteoporosis through to management, treatment and rehabilitation of falls related injuries.*
- Develop a fuel poverty assessment tool to help systematic identification of households I or at risk of fuel poverty and target support to help keep people warm and well through winter.*
- To drive a step change in uptake of the seasonal flu vaccine*
- To build awareness among local people and the workforce of the preventable element of dementia, encourage early symptom recognition and support the national 'Dementia Friends' programme locally.*

Section 16 - Delivering Transformational Change in Bury

16.2 Transformation Scheme 2 - Create an Integrated Community Based Care Programme (covering the transformation areas of Primary Care and Integration)

Our aim is to create proactive, coordinated integrated community based care systems which anticipate, rather than react to need, that are accountable for overseeing care and empower the public to self-care and for service users to be actively involved in their care.

This will be delivered through the collaborative programmes identified in the Better Care Fund which will involve considering:

- New approaches to self-care, communications technologies and clinical collaboration
- Local systems of extended primary care that work to prevent unnecessary hospital admissions and support safe discharge seven days a week
- Shared decision making (addressing physical, mental and social care needs)
- Wider availability of community based diagnostics
- Improved patient access, including greater availability of consultations outside of traditional opening hours, and consultations outside of surgery
- Greater use of telephone, email and video consultations within Primary Care
- Closer working between OOHs and other community based providers, with a view to avoiding unnecessary secondary care activity
- One single shared Health and Social Care record
- Utilising the services of Community Pharmacists more effectively
- A Health and Social Care directory of services which asset maps all available resources so that all professionals know what assistance is available and a SPA to get into these services.
- Social prescribing that enables people with non-clinical needs to access voluntary services i.e. self-help groups, education classes, clubs and other hobby related activities

Our aim is to be a centre of excellence for elderly care and dementia. Through our integrated care model we will commission:

- **Wider Integrated Health and Social Care Team** – The team's initial focus will be on frail older people and children from complex families. The development of a new Integrated Community care model, leading to a whole system partnership, to deliver Risk stratification, neighbourhood teams, care planning, care coordination and case management.
- **Admissions Avoidance** – This will include standardised services provided to people in care homes by GPs for all patients, Named GP for all patients over 75, Admissions avoidance pathways, Unplanned Admissions DES for GPs, Implementation of Vulnerable Adults Local Enhanced Service.
- **Enhanced Discharge Pathways** – This incudes commissioned services which ensure that evolving multidisciplinary assessment for transfer of people back to the community is initiated soon after admission and prioritised and reduce injuries due to falls by reducing the number of falls in the community that result in decreased function and greater dependency.
- **Integrated Community Services for Children** – 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 plans to bring more services back into a community setting, by commissioning integrated community based services, which reduce avoidable emergency and non-elective admissions. Care Co-ordination and Care Plans to be put in place for the most complex children and increase out of hour's access. An integrated model will ensure early intervention and facilitate the health requirements of the Special Educational Needs and Disability agenda.

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Wider Primary Care, Provided at Scale

Our aim is for Primary Care services to operate 8-8 Monday to Friday and 8-6 at weekends. Access in core hours will improve through collaborative working between practices, in partnership with NHS England. There will be consistently high-quality care: removing unwarranted variation in effectiveness, patient experience and safety, in order to reduce inequalities and achieve faster uptake of the latest knowledge regarding best practice. To test this 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 (Healthier Bury) and enables us to focus on one geographical location.

The Demonstrator Community has adopted the Bury integration aims and principles, implemented by a multi-disciplinary partnership of health and social care providers working together in Radcliffe. The partnership is a coordinated network of Radcliffe people, carers and 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 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, complimenting and building on their assets.

The successful Prime Ministers Challenge Fund Bid will enable roll out of this service to all practices in Bury in 2014/15; therefore plans are now progressing for this to be delivered Bury wide which cover four main areas for development:

Extended opening hours - Weekday opening (8am to 8pm) and Saturdays and Sundays (8am to 6pm)

Have very patient's notes available to the GP providing cover during extended hours

Telephone consultation - Ensure that all patients who request an appointment are offered the option of a telephone consultation:

- Currently about 35% of practices offer telephone consultation to patients
- We believe that such consultations can be a better use of GP and patient time
- Patients are often capable of knowing whether they need to see the clinician face-to-face
- A higher proportion of telephone consultations would release GP time and reduce waiting times for appointments

Increased Online Access - from current 4% of patients to 60%+:

- Currently patients who register can make appointments or re-order prescriptions using online
- All practices in Bury are enabled for online access
- Registration is a difficult process which is not user friendly – we plan to change this significantly and offer help to patients to register and use online services
- More services should be available to patients over time including them having access to their own health records and the ability to 'email' their GP.
- Increasing registration will significantly widen access

Comparison website - Develop a "GP-Comparison" website to enable patients to make better choices about GP services:

- Current websites offer limited information to patients
- This website would offer information in a detailed and searchable form, modelled on successful comparison-style sites used elsewhere
- The website would enable patients to search for staff availability, service availability, staff expertise etc. and would show information for all relevant practices in Bury

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16.3 Transformation Scheme 3 - Streamline and Enhance Elective Care Service Provision

Our aim is to provide sustainable services to the local population by a workforce skilled in delivery, in an appropriate setting with the minimal disruption to their lives as possible. In order to achieve this, our aim is to reduce the need for elective care in the secondary care setting by 15%, day cases by 5% and out-patient activity by 5% over the next 5 years.

Our key objectives for elective care over the next 5 years are:

- To promote, commission and develop seamless integrated care, closer to home across the whole spectrum of elective care, commissioned with a sound evidence base
- To remove the inequalities in access to and delivery of services for the residents of Bury
- To ensure patients get access to the service they need, as close and as convenience to them as possible
- To reduce non-elective attendances and admissions for conditions that could be managed elsewhere
- To ensuring patients with a hospital admission do not stay longer than necessary. Day surgery, rather than inpatient surgery, will be the norm.
- Our clinicians will be of the highest calibre, supported in their role and developed to provide first class care, treating sufficient numbers of patients so to be experts in their field

The ambition in Bury is to become a centre of excellence for elective care and the initiatives identified to achieve this are in appendix 4.

16.4 Transformation Scheme 4 - Future proofing Urgent Care Services in Bury

For those people with urgent but non-life threatening conditions services need to be highly responsive, effective and personalised. These services should deliver care in, or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families. For those people with more serious or life threatening emergency needs we aim to ensure they are treated in centres with the very best expertise and facilities, in order to reduce risk and maximise their chances of survival and a good recovery.

In two years' time Bury CCG plans to have reduced Non Elective Activity by 15%, in five years' time the plan is to have extended this further and consolidated delivery of urgent care and care for those with Long Term Conditions (LTC), within a new integrated approach to primary care. The only way to achieve this is to grasp the opportunities that present themselves within the integration agenda and to refocus attention on better more integrated management of patients with LTC. The goal will be to have a system that delivers urgent care where access to secondary care based emergency care becomes a truly last option for those that need it due to the robustness of a co-ordinated and integrated care system for patients with LTC.

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16.5 Transformation Scheme 5 - Commissioning for Quality and Enhancing Corporate Functionality

The CCG aims to provide a robust sustainable corporate programme, which will facilitate commissioning processes of the highest quality. This can only be achieved with appropriate support, development and delivery mechanisms, operating within a transparent, risk managed organisation incorporating stringent governance arrangements.

16.5.1 Quality Priorities

Priority 1 - Patients will receive quality health care because all commissioning decisions will be quality assessed and approved

- A quality assurance tool will be developed, which will be used consistently when commissioning decisions are made.
- A Risk register will be maintained
- An evaluation of process will be undertaken after 12 months

Priority 2 - The quality of care will be improved by consistent scrutiny and challenge of health care providers

- A register of all providers will be held
- The process for measuring quality will be strengthened and consistently applied
- All forms of intelligence will be triangulated e.g. Performance, Incidents, Complaints
- All external intelligence will be reviewed
- An accurate, current database will be maintained, with information about safety, clinical effectiveness and patient experience for all of the services commissioned

Priority 3 - Patients will have a better experience of health care by ensuring that providers are compliant with national recommendations

- Current national recommendations: Francis, Berwick, Keogh, Cavendish, Winterbourne reports
- There will be an up to date CCG action plan for each report, both current and as they are published
- The Quality and Risk committee will support the Quality Team in producing an action plan and reviewing compliance against the plan
- The Governing Body will ratify all plans
- The Quality Team will seek assurance from all providers about their plans and compliance to national recommendations
- All plans from providers will be critically appraised for completeness and assurance will be sought that plans are embedded within the organisation and become usual custom and practice
- Walkarounds to clinical areas will provide a platform to test compliance to national recommendations
- Bury CCG Quality Team will contribute when appropriate to national guidance through membership of GM collaboratives, by working with academic institutions when opportunities arise and through national projects, discussion, webinars

Priority 4 - The quality of health care will improve by working collaboratively with other commissioning colleagues

- Bury CCG will work collaboratively with the following organisations:
  - HMR CCG, Oldham CCG
  - Other surrounding CCGs
  - Greater Manchester Area Team (GMAT)
  - Health and Well Being Board
  - Local Authority
- The Quality Team will support other organisations where able with the quality agenda
- The Quality team will support the current working arrangements with the NE Sector but be flexible to change working arrangements as the reforms continue

- The Quality Team will be members of the following bodies:
- GMAT Quality Collaborative
- GMAT Quality Surveillance Group
- GMAT Direct Commissioning Collaborative
- Bury CCG will participate in the quality agenda for not only Bury CCG but on a wider footprint, particularly participating in debate, process and learning from and sharing learning with GMAT

Priority 5 - 'No decision about me without me'. Patient experience will meet expectations by improved engagement with patients, partners and stakeholders

- A quality engagement plan will be developed considering current position and identified gaps
- Use of focused consultations with patients / service users / carers
- Use of 'citizen's jury' type methodologies to meaningfully involve patients and public in complex service redesign
- Use of patient reps (e.g. patient cabinet members) working directly alongside service redesign and clinical leads
- Use of patient / service user / carers groups to help specify quality & safeguarding related standards in service specifications
- Use of patient panels working alongside commissioner panels in assessing tenders / interviewing potential providers
- Triangulation of patient experience information through patient surveys and the like with PALs / Complaints information
- Use of patient / carers to support CQUIN development
- Patient / public involvement in service walkabouts
- 'Mystery shopper' type exercises
- Promotion of pals / complaints pathways (current low uptake by Bury patients)
- Critical analysis of current standard patient experience methodologies e.g. patient satisfaction surveys may be convenient to deliver but often provide little useful insight across a range of dimensions of quality (e.g. Access; Communication; Timeliness)

16.5.2 Safeguarding Priorities

The safeguarding priorities identified to be addressed during 2014-2016 are:

- To embed PREVENT within the CCG ensuring 80% of staff are trained
- To ensure provider uptake of PREVENT through monitoring systems
- To monitor training within provider organisations on child protection, adult safeguarding and MCA/DOLS via quarterly reports
- To embed the Designated Professionals for Looked After Children into the CCG and ensure expertise is available
- To ensure that the Early Help agenda continues to be embedded into the services for children provided by health
- To extend the work on Harm Free Care to encompass the data collected by our community care providers to enable analysis of the data to improve health outcomes for patients
- To continue the GP training and peer review programme
- To develop a process to ensure that all children with a CP plan or a Child in Need plan have a robust health plan that meets their needs
- To develop a process where each care leaver has a robust transition health plan which includes all the information needed to access effective health care

Safeguarding Priorities for 2016/17 to 2018/19

Priority 1 - Holistic Looked after Children and Care Leaver's Service
The aspiration is to review the pathways and providers and to provide an integrated pathway which will be seamless and delivered within a range of settings that are acceptable to the children and young people.

Priority 2 - Drop in provision for young people with tier 1 mental health difficulties
The aspiration is that the service will offer early intervention and peer support for young people who do not meet the threshold for young people's mental health service but may find themselves in need of advice and signposting at point of challenge or crises in their lives.

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Priority 3 - School/college health provision for post 16 year olds
The aspiration is that all young people up to the age of 18 and in some cases up to the age of 25 (in line with the SEND agenda) will have access to a school/college health advisor. The service would be a joint initiative with Public Health and it is expected that it would support a number of targets including reducing risk of Child Sexual Exploitation, pregnancy, STI's, self-harm etc.

Priorities 4 and 5 - Health services for children living with domestic abuse and adult victims of domestic abuse

The above priorities are linked but would potentially require different services to meet the needs or 2 separate arms to one service. A recent serious case review in Bury identified the potential impact of domestic abuse on the physical health of a child and it is well documented the impact on their emotional well-being.

Violence against women has serious consequences for their physical and mental health, and women who have experienced abuse from her partner may suffer from or chronic health problems of various kinds.
The aspiration would be for a targeted service, possibly from a 3rd sector provider to undertake work with the children identified as being at risk of significant harm due being exposed to domestic abuse and to provide support to adult victims.

16.5.3 Prescribing Priorities

The CCG has developed priorities for prescribing 2014 to 2019, this includes

- Managing patients' expectations and supporting ownership of their health
  - Ensuring people understand the limitations of the NHS budget and accept that some treatments need to be by individuals to allow for investment into newer drugs and newly identified conditions.
  - People access and utilise, preventative, self-care and treatment services, at community pharmacies –rebadged as 'healthy living pharmacies' aligning with national strategy
  - Addressing the increasing problem of dependence and addiction to prescribed and over-the-counter drugs
- Improving the patient experience
  - Enhanced 'shared care' arrangements to allow patients to receive drug treatments and monitoring closer to home
- Increasing access to prescribing support and medicines optimisation services - Enhanced pharmacist and pharmacy technician roles within general practices to:
  - Improve efficiency and safety of repeat prescriptions
  - Improve transfer between care settings
- Discharge information shared with Community Pharmacy
- Dedicated medication reviews post discharge (practice-based pharmacists/pharmacy technicians)
  - Include membership of multidisciplinary team supporting elderly and high risk patients and residents in Care Homes, for input into:
- Medication reviews
- System reviews in Care settings e.g. evaluation of bulk prescribing for commonly used medicines in care homes introduction of Homely remedy policies and other standard items that care homes should have in place as part of their care offer.
  - Educate and support practice staff to deliver on national and local priorities e.g. prescribing of antibiotics, benzodiazepine & z-drugs, NSAIDs, GM formulary and shared care arrangements

- Aligning prescribing responsibility to delivery of clinical care - Prescribing responsibility is owned by the most appropriate Healthcare professional for that aspect of the patient's care
  - The Stoma and Continence Prescribing Service which was commenced in November 2013 aligns prescribing responsibility to specialist clinicians to improve quality of care to patients via reductions in urgent care/ A&E attendances due to UTI/other catheter/ stoma related issues and aims to deliver efficiency savings to reinvest in the increased resource required in Continence & Stoma teams. It will mean that the service is accountable for its own prescribing budget.
  - Likewise, the prescribing of dressings and other items for wound care should be removed from GP practices and transferred to Community nursing staff that treat and monitor this group of patients.
  - Patients requiring enteral feeds (both 'sip feeds' and tube feeds) should be under the care of a dietician, and therefore the responsibility for prescribing/supply and monitoring of these patients should be removed from GP practices and transferred to Community dieticians. This does not remove the responsibility of all health and social care professionals to be cognisant of the risks of malnutrition and screen patients as part of routine care.
- Collaborative working and peer support - Bury practices develop a mature and supportive collaboration with their peers and with secondary care to share and promote good practice in prescribing.
  - Regular peer review meetings to:
  - challenge prescribing practice where data shows that practices are outliers
  - share difficult-to-manage cases and gain insight, advice and support from colleagues
  - Improve engagement with specialists and gain expertise in treating more complex conditions in primary care e.g. diabetes, dementia

16.5.4 Equality and Diversity Priorities

Priority 1 - Develop data to monitor, information to manage and knowledge to act

Readily available, up-to-date, accurate data, regularly analysed and presented, is vital for decision making, support in planning and commissioning dialogues. It improves the focusing of provision, the evaluation of outcomes and supports innovation:

- Develop better (more detailed and disaggregated) population data in partnership with local authorities and the third sector.
- Improve the collection, quality and disaggregation of population and public health data and demonstrate how this data is informing commissioning of services that meet the needs of the local population.
- Work towards an understanding of what the information means for both workforce and services, so that development and activity is focused on areas that are urgent and important, rather than where they have always been in the past.
- Ensure all strategies, plans and activities are subjected to equality analysis in accordance with national directives and equalities legislation.

Priority 2 - Develop the right services, targeted, usable, useful and used

Knowing who the population is and understanding the different health needs of groups and localities will improve precision of service delivery, lessen waste and could have a dramatic effect on the success of major health programmes. It will also facilitate the development and evaluation of focused development and pilot initiatives.

- Target health improvement initiatives to particular groups underpinned by robust and up to date intelligence
- Develop the relevant capacity, capability and knowledge for commissioners/ providers to meet the needs of the diverse population of Bury
- Assure that effective engagement and involvement models with equality groups are in place

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- Encourage high quality health services by ensuring the involvement and engagement of all sections of the population particularly vulnerable or marginalised groups.
- Improve the efficiency and targeting of health services and thus value for money, by ensuring commissioning meets the health needs of all sections of the population.
- Enable the development of local third sector provision.
- Develop robust contracts/service specs that make equality and diversity activities and responsibilities explicit.
- Ensure the integrated health and social care programme is underpinned by equality, diversity and health inequalities.

Priority 3 - Move beyond compliance to initiating best Practice

It is not enough to be legally compliant, although it is essential at all levels in all NHS organisations. Aiming for development and adoption of best practice will improve both working and service conditions; improving health outcomes whilst lessening wasted resources spent on litigation or high turnover.

- Develop Equality Objectives/EDS plans that are in line with existing legislation which are evidence based and outcome focused and where, commissioner and provider plans are reflective of each other's outcomes.
- An equality analysis framework is collaboratively developed, shared and adopted. The framework promotes evidence-based equality analysis carried out with and informed, by the different equality target groups.
- Integrate, where possible, analysis with other impact assessments e.g. health impact assessments.
- Improve collaborative working across organisational boundaries, particularly through third sector.
- Collaboratively develop a clear and consistent framework and guidance for procurement and commissioning locally to assure all contracts and service specs address equality and diversity.
- Develop capability of procurement, contracting and commissioning personnel in terms of equality and diversity requirements.

Priority 4 - Workforce and leadership

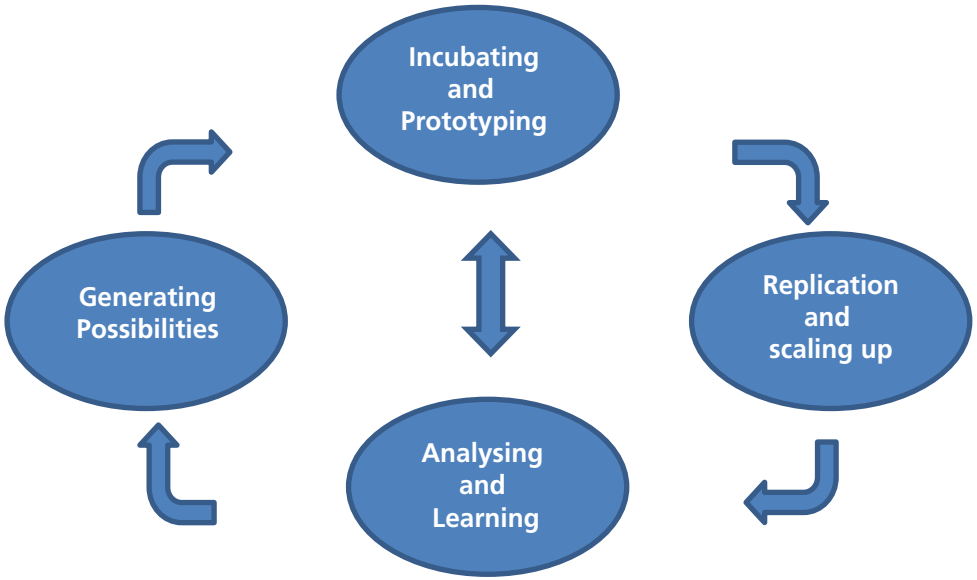
Managing and maintaining an inclusive, representative, knowledgeable and culturally competent workforce at all levels. The capability and capacity of clinical and non-clinical workforce within the CCG including wider membership is developed, at all levels to promote equality of opportunity and address health inequalities;

- Demonstrate year on year improvements towards developing a diverse workforce that reflects the local population, at all levels, through the setting of stretch targets (including the robust monitoring of provider workforce's and CSUs)
- Deliver an equality competent and diverse future workforce that can plan and deliver appropriate and accessible services through improved Education Commissioning.
- Develop equality awareness, capability of the existing workforce at all levels (including wider membership), in order to deliver equality competent services to all sections of the population.
- Organisations to provide evidence of a commitment to improve diversity at board level.
- CCG to become exemplar employer, with a focus on supporting staff achieve work life balance
- Full sign up of member practices to 'Pride in Practice'

Section 17 - Enablers

17.1. Bury CCG model of Innovation

A better understanding of the process of innovation can illuminate where there is room for improvement and where there are blockages[1]. NHS Bury **Clinical Commissioning Group** uses selected Mulgan and Alburys model to support the development of a culture which fosters innovation and creativity, in the figure below.



[1]Geoff Mulgan and David Albury (2003) Innovation in the Public sector

Generating Possibilities

NHS Bury Clinical Commissioning Group understands most innovations come from service users, frontline staff and middle managers. We will create an environment where ideas and suggestions are welcomed and all are explored for feasibility. Either through sector meetings, individual meetings with practice members, walking the wards on quality visits, clinical work stream meetings the NHS Bury Clinical Commissioning Group will take every opportunity to listen and allow teams, staff and patients the space to create innovation.

Incubating, prototyping and managing risks

When an organisation faces financial challenges it can stifle any innovation which needs small amounts of funding. NHS Bury Clinical Commissioning Group has committed to securing a budget for innovation for the clinical cabinet to utilise to fund small projects, test ideas and allow assessment of the impact which changes can have. This will include fostering development of the 3rd sector.

- Use of CQUIN – the NHS Bury Clinical Commissioning Group will utilise CQUINs to drive quality and innovation. This gives a 12 month window for assessment of impact before more innovative pieces of work are mainstreamed.
- Examples of where we have used a small amount of resource to pilot small changes and scale them up are outlined below.

Replication and Scaling Up

If a scheme demonstrates results the challenge is then to further improve results. In 2011/12, NHS Bury Clinical Commissioning Group was very effective in scaling up medicines management efficiencies, by stretching targets year on year. A clear project management system was in place for this; however the on-going success of the replication and scaling up was dependent on engagement of clinicians and practice staff and dedicated support to deliver the change.

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Analysis and Learning
Good Business Intelligence informs and supports an innovative organisation, providing the intelligence to support decision making and improve performance. The move towards a proactive, BI architecture will drive the development of the strategic plan.

There are a number of areas where the Business Intelligence service will be enhanced to support Bury CCG: -

1. Review of internal BI processes, identifying where reports can be automated. This will free up resource to support the move towards a business intelligence led service, rather than an information service.
2. Better use of monitoring tools. This will be a combination of centrally developed performance tools e.g. better care fund and local dashboards that monitor activity. These tools will help the CCG determine if a combination of QIPP schemes and service re-design are delivering the expected outcomes.
3. Business Plans
   i. To improve the data modelling behind business plans, with clinical input on the expected outcomes.
   ii. To move to a robust process for providing data for business plans. The new process should model different activity scenarios and include the methodology used to extract data.
4. Benchmarking data–a new Greater Manchester (GM) database has provided an opportunity to compare data across CCGs. This will help identify where the CCG are an outlier and where other CCGs have reduced activity, indicating possible areas for service re-design.
5. Providing drill down reports behind areas of over and under performance.

17.2. Information Sharing & Interoperability

A key enabler to all the CCGs work is to develop integrated records. The following requirements have been identified in order to support an integrated care programme in the North East Sector:

- A Clinical Portal: a single, integrated point of care system covering the entire continuum of care available whenever and wherever it is required. A clinical portal would allow information from multiple systems to be viewed and updated in a single view and would easily integrate with organisations' own source systems.
- A Patient Portal: an electronic window that will allow patients to actively participate in their own care. It will allow patients to review and update their health records, manage appointments and prescription renewals, access personalised information or discharge materials, and communicate in complete confidentiality with care providers.

These requirements are fully compatible with local IT and organisational strategies across the Sector and a gap analysis has been undertaken to ensure that current systems are compatible and have the capability of interacting with the Integrated Patient Care solutions investigated.

Clinical Portal

The clinical portal will be implemented in at least two phases:

Phase I would include a read-only view of patient information from GP, Social Care, Pennine Acute and Pennine Care systems and would contain Patient Consent Management, Patient demographics, Core Patient Clinical Details e.g. allergies, co-morbidities, Patient Letters and Electronic Discharge Summaries, Patient PACS Images and Test Results, Patient Activity, Messaging and Alerts to care providers when patient's status changes e.g. admitted, Care Pathway and Status Management (developed further in future phases)

Phase II and beyond would look to expand the user base further. It would see the development of the system to allow users to use the portal to update agreed information held in organisations' source systems. In addition the following information could be included in the portal:

- Care Pathway and Status Management (further development)
- Workflows and care plan management
- Booking and scheduling of appointments
- Ordering and Booking of Tests
- Imaging and Videos (non-PACS)
- Telehealth including review of discharged patients
- Diary Management
- Clinical Trial Results
- Prescription Tracking

Patient Portal

A patient portal will allow patients to carry out the following, ability to view pre-existing clinical records, monitor and track symptoms, alert clinicians when symptoms change, online consultations (messaging, Skype), ability to upload files, integrate with telehealth apps, personalised care plans, library of relevant resources, online journal for patients to keep a diary, smartphone compatible. All new systems will be NHS Number compliant and we are working with the LA to make the NHS number the unique identifier.

We have an on-going programme of migration of primary care systems to hosted environments. This is to improve business resilience and continuity as well as supporting information sharing at the detailed care record level. As a by-product this will also achieve efficiency savings in the longer term through improved support arrangements and the decommissioning of on-site clinical servers. Business intelligence is a by-product of high quality clinical data capture as well as good administrative practices. Our work with the Commissioning Support Unit is allowing us to design, build and implement a full data extract which, when blended with other administrative information, supports more effective analysis of this aggregated information.

17.3. Procurement

NHS Bury CCG is developing a robust system for the procurement of new and improved services. This will dovetail with the prioritisation process alluded to under 'transformational schemes' and will involve the strict adherence to a timeline. This timeline will include provision for:-

- Wider clinical and public involvement in service design
- Wider provider involvement and the facilitation of provider networking
- Wider public involvement in the evaluation process, aided by an increased use of out of area clinicians where local clinicians may have a conflict of interest.

Services will be ready to 'go live' 18 months after the start of this process.

The CCG is also working with partners in the Local Authority to better align procurement processes and to better realise the potential of joint working. This will be particularly evident in the procurement of integrated services.

The CCG is confident that these improvements will lead to a better delivery of the visions espoused in this document

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17.4. Estates

CCG Estates Strategy Development

We are currently working with NHS Property Company and NHS England to develop our Strategic Estates Plan. This will be finalised in line with the CCGs strategic plan.

It is critically important that property strategy is service led and directly supports the successful achievement of core Health Service priorities and the wider reform programme. The Estates strategy is service led and all property investment or divestment decisions must be able to demonstrate clear linkage to Health outcomes within each locality.

The drivers for this are that:

- CCGs and NHS England Area Teams have a duty to tackle health inequalities and are instructed to work together to develop 5 year strategic plans with 2 year operational plans. (CCG co-ordination will reflect the inter-relationships between local health systems)
- Primary Care provision is changing: reduction in single and double handed practices; improved access to services; 7 day opening.
- Drive to move services into the community from the acute sector.
- Integration with local authority services increasingly important and urgent.
- NHS needs to identify significant revenue savings that cannot be found through efficiencies alone, but need services to be fundamentally realigned.
- A sustainable funding solution for estate improvements is needed.
- There is significant revenue cost and capital tied up in poorly used estate.
- Identifying surplus land for housing is a government priority. Whilst not directly impacting commissioners, it will accelerate disposals and release the holding costs of unused assets that can burden commissioners.
- Strategically planning the estate is an essential element in enabling these objectives - whilst still delivering flexibility and without encumbering the system with long-term liabilities.

A more strategic service led approach is being taken to ensure the estate is fit for purpose, efficient and flexible to be able to meet the needs of frontline services. The approach that is being taken is based on a supply and demand model. The diagram below illustrates the approach being taken to identify opportunities and challenges that will underpin the local plans and priorities;

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A more strategic service led approach is being taken to ensure the estate is fit for purpose, efficient and flexible to be able to meet the needs of frontline services. The approach that is being taken is based on a supply and demand model. The diagram below illustrates the approach being taken to identify opportunities and challenges that will underpin the local plans and priorities;

From initial assessment and anecdotal evidence there is an oversupply of property in Bury but this will be more formally assessed in consultation with the CCG and other key stakeholders as a priority action for the early part of 2014. This exercise will establish surplus capacity within the estate then consideration will be given to how this could be better used or released.

It is also accepted that improvements in frontline services delivery, access to services and space utilisation can be achieved by increased collaborative working with partners within the District.

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The Council boundary and CCG boundary are identical which aids planning and co-ordination. Local Authorities are also seeking to identify and implement significant efficiencies from property and see collocation as an opportunity to save money and improve services at a local level. A cross public service strategic estates group (SEG) is already established and will have responsibility for the service led property strategy as its key agenda to progress over the next 3 to 5 years. It is proposed that the SEG's terms of reference, membership and work programme is redefined during April/May 2014 to ensure it is fit for purpose and has the mandate and support from the sponsoring organisations.

The SEG will maintain a public service led approach but with a specific focus on property and 'Place' within its widest sense. This will include but not be limited to;

- **Suitability** – is it fit for the purpose intended? Is it accessible for service users?
- **Sufficiency** – Is it the right size? How well is it utilised?
- Condition – Is it in a safe and in satisfactory condition for the purpose intended?
- **Running Cost** – Taking a lifecycle approach is it a cost effective solution when benchmarked against good practice. Consider opportunities gain economies of scale through combined FM supply chain procurement and management.
- **Investment** – When a requirement is identified could it be satisfied by making better use of an existing asset in the wider public sector estate. Could that single service investment be joined up with funding and requirements to make a greater impact at a local level? What impact will the investment have on the local 'Place' and wider regeneration?
- **Divestment** – Consider other public sector uses before going to the market. Consider marketing combined surplus asset to generate higher capital receipt. Consider the regeneration and place shaping opportunities.

To support this more strategic approach all buildings will be categorised based on an agreed standard and in consultation with the CCG and other key stakeholders. The categories will represent the importance or otherwise of each building within the estate and focus management attention on properties particularly at the top and bottom of the list.

Section 17 - Enablers

17.5. Workforce

Bury Health & Social Care Workforce

Consequences of the Health & Social Care reform will, inevitably, not only affect the current workforce but will have huge implications for future workforce. Whilst acknowledging this disturbance as a risk, it is essential to achieve the new service delivery models required.

A whole systems approach will be adopted within Bury and the wider North East sector through a multi-organisational, multidisciplinary workforce group. The workforce group will work in partnership with Health Education England (HEE) through the Greater Manchester Integrated Care Workforce Collaboration Group and ensure that plans are aligned to the wider workforce strategies including Healthier Together. Key stakeholders will be involved at all stages.

The workforce group aim to utilise and further develop current strong relationships within the health and social care system to mitigate disruption to the workforce and retain and appropriately reskill the valuable human resource within the Borough and sector.

Proposed work plan:

Table 12

Year	Actions	Status
2014-15	Integrated Care strategy	Completed March 14
	Collaborative aims & objectives agreed	Completed March 14
	Engage with GM Integrated Care Workforce Collaboration Group	Completed May 14
	Share agreed governance arrangements with stakeholders and staff	In progress June/July 14
	Link partner OD plans	Working group proposed May 14
	Develop cross-boundary working governance structures	
	Identification of risks/issues to collaborative working	Through workforce group
2015-16	Review current workforce position	
	Development of integrated pathways	All actions to be addressed through workforce group throughout 15/16
	Develop integrated leadership and management	
	Evaluate current integrated working to inform strategy	
	Engage and support carers	
2016-17	Develop innovative/general roles and plan and deliver appropriate education and training	

Section 17 - Enablers

17.6. Research

The CCG has the power to conduct, commission or assist the conduct of research into any matters relating to the causation, prevention, diagnosis or treatment of illness; and any such other matters connected with any service provided under the 2006 Act.

The CCG has within its duty to support and promote evidence based practice and research; and use the evidence from research when carrying out its commissioning functions.

The CCG is a partner of the National Institute for Health Research (NIHR) and the Greater Manchester Collaboration for Leadership in Applied Heath Research and Care (CLAHRC).

The CLAHRC presents an opportunity for partnership working across disciplines, organisations and sectors in carrying out high quality applied research and putting research into practice, as well as building organisational capacity for these activities.

CLAHRC is already engaged with the CCG via the Chronic Disease Management through the Long Term Conditions work stream lead. Our CLAHRC team is continuing to work with 5 practices not previously recruited to our heart failure (GM-HFIT) programme.

Additionally, the CCG actively supports the local Providers in their research projects, for example part of the Commissioning for Quality and Innovation (CQUIN) funding is for research initiatives. The CCG reviews and appraises research projects from our Providers in the Clinical Quality meetings as appropriate and the findings presented to a wider stakeholder audience.

The Academic Health Science Network

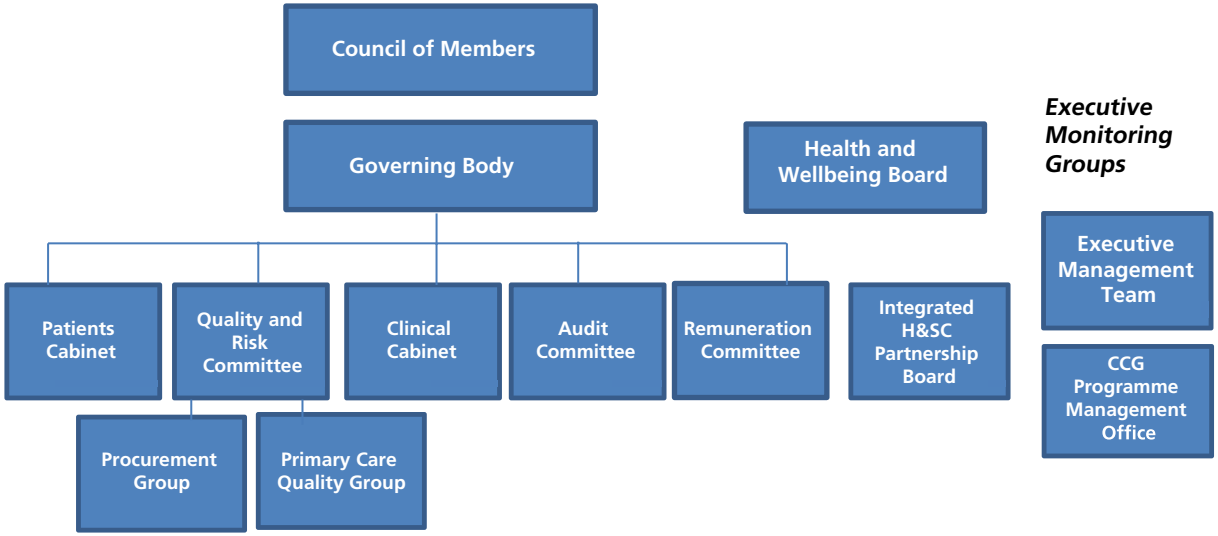
To support research and development Bury CCG are part of the greater Manchester Academic Health Science Network they are working with us on innovative solutions in the following areas:

- Cardio-vascular disease programme
- Vascular risk management.
- Improving patient safety.
- Shared patient data.

Importantly, they are forging relationships with universities and the corporate sector that are likely to bring innovations to the health care needs of our populations, and additional resource to our members as they pursue their health improvement goals.

Section 18 - Governance to Deliver

The CCG has a robust governance infrastructure, which is outlined below. Each of the subcommittees is chaired by a Non-Executive Director or Clinical Board Member.



The Executive Monitoring Groups ensure performance management of the Work stream / QIPP / Performance leads

To ensure that Bury CCG remains focused on delivery of its plans throughout 2014/16 and beyond it will implement the following tracking mechanisms.

- Weekly meetings between the Clinical work stream lead and service redesign manager.
- Monthly review of programme or project progress at CCG Clinical Cabinet Committee
- Monthly review of how the CCG is doing against its Quality Premium indicators at the Quality and Risk Committee.
- Monthly review of financial performance at the Audit Committee and Governing Body.
- Monthly review of performance issues and risks* at the Quality and Risk Committee (and the most significant risks (at the governing body).
- Monthly review of project progress at operational team meetings, run by the Deputy Head of Commissioning and Deputy CFO. Where possible, the benefits of each project should be tracked to monitor its effectiveness in achieving its objectives. The aforementioned fora will be used to check whether benefits have been realised. If they have not been realised, a decision will be taken about whether the project continues or is adapted.
- Monthly review of the programme of Programmes jointly commissioned through the Better Care Fund through the Integrated Health and Social Care Partnership Board which is chaired by the Chief Officer of Bury CCG and the Director of Adult Care Services.
- Oversight and scrutiny of delivery through the Health and Wellbeing

*Risks – recognised risks are outlined within appendix 3.

Section 18 - Governance to Deliver

18.1 Decommissioning and Disinvestment

To ensure that limited resources are consistently directed to the highest priority areas the CCG have identified the need to develop a Decommissioning and Disinvestment Plan that sets out the agreed principles for decommissioning services to allow funds to be redirected where appropriate. There is a need to ensure that when approval has been given to decommission, or disinvest from, a service, a clearly defined process is followed with clear lines of accountability and responsibility.

18.2 Conflict of Interest

The CCG takes conflicts of interest very seriously. Declarations of interest are published on the CCGs website http://www.hmr.nhs.uk/attachments/article/13/Governing%20Body%20Decs%20of%20Interest%20for%20Website.pdf.

When an interest has been declared the declarer will ensure that before they inform the chair of the meeting. The chair of the meeting will then determine how this should be managed and inform the member of their decision. Where no arrangements have been confirmed, the chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual will then comply with these arrangements, which must be recorded in the minutes of the meeting.

Get in touch

If you have any comments on the report, or questions on the information contained within it, we'd really like to hear from you:

- If you have an enquiry or would like to give us your feedback, you can do this through the 'We're here to help' section of our website www.buryccg.nhs.uk
- You can email us at buccg.communications@nhs.net
- You can give us a call on 0161 762 3106
- And you can reach us via our Twitter account www.twitter.com/NHSBURYCCG

NHS BURY CLINICAL COMMISSIONING GROUP
STRATEGIC PLAN 2014-2019
APPENDICES

APPENDIX 1

Armed Forces Health Commissioning (2014-2019)

Our vision is to obtain the best heath benefit from the available resources by commissioning high quality, safe and effective care for Armed Forces personnel and their families, in accordance with the Armed Forces Covenant and the NHS Constitution.

System Values

To achieve our vision we will:

- Work with Defence Medical Services to support them in their task of ***promoting***, ***protecting*** and ***restoring*** the health of the Defence population in order to maximise fitness for role. We will achieve this by commissioning a comprehensive core service.
- Make evidence based decisions
- Listen to and learn from patient experiences
- Ensure that Armed Forces personnel are not disadvantaged in their access to healthcare be that offer, access or outcome
- Ensure that special consideration is given to those injured as a proper return for their sacrifice

Objectives

System Objective One
Services for the armed forces are commissioned to achieve the best health outcomes, in line with the commitments of the Armed Forces Covenant

System Objective Two
We work in partnership with the MoD to commissioning healthcare in line with the partnership agreement and in support of DMS's objective to promote, protect and restore the health of the Defence population in order to maximise fitness for role.

System Objective Three
We will work with the MoD and CCGs to improve the model of integrated care that service leavers with mental health or complex physical health needs receive

System Objective Four
We will collaborate with CCGs and Health and Wellbeing Boards to develop and embed strong armed forces Networks to ensure that the armed forces community receives appropriate care regardless of commissioner

Interventions

Delivering better care through the digital revolution
(a) increase use of E-referrals, including advice and guidance functionality, within DPHC
(b) increase the use of telemedicine as an alternative to face to face care where appropriate;
(c) increase access to national screening programmes
(d) link DMS systems to Child Health Information Systems

Co-ordinated access to musculoskeletal pathway
(a) Improved use of E-referrals and its functionality within DPHC for access to secondary / tertiary referral for MSK conditions
(b) re-design MSK pathways to make best use of recognised good practice in rehabilitation

Improved access to mental health services
(a) Improve care co-ordination on service discharge
(b) Improve signposting to appropriate mental health services including crisis services
(c) Improve choice of recognised good practice services for mental health such as online counselling

WIS leavers to have an agreed health plan
Work with the MoD to ensure that all WIS service leavers leave with a personal health plan; designed to empower patients to take to take more control of their long term health and direct them to the most appropriate professional under the primary care team to manage their routine needs.

Overseen through following governance arrangements

- Area Team internal meetings
- Armed Forces Operational Group
- Joint Commissioning Group
- Armed Forces Oversight Group

Measurement

- Increased referrals made electronically
- Sustained RTT performance
- Co-produced workforce measures
- Access to screening programmes
- Number & % of agreed health plans
- Register of Armed forces champions
- Mental Health services directory

Sustainability

- We will consider sustainability and affordability in our approach to decision making.
- We will work with DMS to, where possible, standardise the approach to state funded items to help deliver affordability and sustainability.

APPENDIX 2

	Measure	Definition	Threshold	13/14	Plans to secure performance
PHQ 01	Ambulance quality - Cat A response times	Cat A response within 8 mins	75%	75.9%	
PHQ 02		Cat A response within 19 mins	95%	95.8%	
PHQ 03	Cancer 62 day waits	Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	85%	87.5%	
PHQ 04		Percentage of patients receiving first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	90%	89.3%	Immediate recovery plan in place. Transformational change outlined in section 16
PHQ 05		Percentage of patients receiving first definitive treatment for cancer within 62 days of a consultant decision to upgrade their priority status	85%	91.6%	
PHQ 06	Cancer 31 day waits	Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis	96%	99.2%	
PHQ 07		Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is Surgery	94%	98.2%	
PHQ 08		Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is a Radiotherapy Treatment Course	94%	99.5%	
PHQ 09		Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is an Anti-Cancer Drug Regime	98%	100.0%	
PHQ 10	Mental health measures - EI	The number of new cases of psychosis served by early intervention teams year to date	30.00	35.00	
PHQ 11	Mental health measures - CR/HT	Commissioner measure is number of episodes, provider measure is % of inpatient admissions that have been gate kept by CR/HT	408.00	391.00	
PHQ 12	Mental health measures - CPA	The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric inpatient care during the quarter (QA)	95%	95.3%	
PHQ 13	Mental health measures - IAPT	Proportion of people with depression who receive psychological therapy	n/a	n/a	Immediate recovery plan in plan, long term recovery plan being developed with the CCG by the National Intensive support team.
		Proportion of people who complete therapy who are moving to recovery	40.1%	34.6%	
PHQ 14	People with Long Term Conditions feeling independent and in control of their condition	% of people with LTCs who said they had enough support from local services/orgs	79%	66.0%	CCG has invested in enhanced care planning for people with LTC and elderly patients, including MDTs outlined in section 16

	Measure	Definition	Threshold	13/14	Plans to secure performance
PHQ 15	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)	Proportion of unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) per 100,000 population	908.94	809.36	
PHQ 16	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	Proportion of unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s per 100,000 population	495.86	380.30	
PHQ 17	Emergency Admissions	Emergency admissions for acute conditions that should not usually require hospital admission	2838.8	2480.4	
PHQ 18	Patient experience survey	Outliers identified using NHS PF approach + narrative & results of local surveys	n/a	n/a	
PHQ 19	RTT waits	RTT - admitted % within 18 weeks	90%	87.9%	Immediate recovery plan in place, Transformational change outlined in section 16
PHQ 20		RTT - non-admitted % within 18 weeks	95%	95.8%	
PHQ 21		RTT- incomplete % within 18 weeks	92%	93.9%	
PHQ 22	Diagnostic waits	% waiting 6 weeks or more	0.9%	0.79%	
PHQ 23	A&E	% of patients who spent 4 hours or less in A&E	95%	95.8%	
PHQ 24	Cancer 2 week waits	Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	93%	96.9%	
PHQ 25		Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected	93%	94.3%	
PHQ 26	MSA breaches	Numbers of unjustified breaches	0	2	Performance recovered 2014/15, on-going maintenance managed through contractual routes
PHQ 27	HCAI measure (MRSA & CDI)	MRSA bacteraemia	0	2	Robust infection control plan in place across all providers and managed through contractual routes.
PHQ 28		CDI	54	50	
PHQ 29	VTE risk assessment	% of all adult inpatients who have had a VTE risk assessment	95%	95.9%	

APPENDIX 3 – Risks

The table below provides an overview of some of the key risks identified through the Better Care Fund co- design process to-date:

Risk	Impact	Likelihood	Risk	Mitigating Actions
If resources are redirected to fund new joint interventions and schemes it may destabilise current service providers, particularly in the acute sector	5	3	15 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
If resources are reallocated within the BCF to fund integration initiatives it may destabilise the CCG and/or the LA	5	3	15 High	• A set of principles for the establishment of the BCF pooled budget will be agreed between the CCG and the LA as part of the BCF plan governance process by 4th April 2014 • The plan is to increase transparency between the CCG and the LA in budget setting and development of financial plans to ensure that any assumptions and changes made and the potential impact is assessed across both organisations • A new governance arrangement for the integrated commissioning between the CCG and the LA will has been established to monitor the Better Care Fund
If we do not have accurate data our financial and performance, targets for 2015/16 onwards are unachievable	4	2	8 Med	• 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
If operational pressures continue to increase across all agencies, this 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 reality	4	3	12 High	• Our 2014/15 schemes include specific non- recurrent investments in the infrastructure and capacity to support overall organisational development
If improvements in the quality of care and in preventative services do not translate into the required reductions in acute and nursing / care home activity by 2015/16 there will be an impact on the overall funding available to support core services and future schemes through Better Care.	4	2	8 Med	• We have modelled our assumptions using a range of available data • 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications

If the introduction of the Care Bill results in a significant increase in the cost of care provision from April 2016 onwards it will impact on the sustainability of current social care funding and plans	4	3	12 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 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
If there is insufficient clinical engagement in the transformation models they will be clinically un sound and not deliver the transformational change required	3	3	9 Med	• Clinical leads for each work stream has been identified • Clinicians will be involved within the steering groups and work stream groups. • Robust locality infrastructure to ensure Primary care Engagement • Provider clinicians engaged via local working groups.
If IM&T solutions to integrated care records are not available it will impact on our ability to integrate services.	4	3	12 High	• IM&T clinical lead to be integral to the development of the transformations models • The technology solution to be developed alongside the Academic Health Science Network to ensure the most innovative solutions. • Small changes to be tested across providers
If robust Information Governance processes policies are not in place, data sharing across agencies will be restricted	4	2	8 Med	• Information governance lead and Caldecott guardians to be involved in project from start and develop policies to support the service model.
If patients, customers and community are not involved and engaged in planning new models of integrated care they will not meet their needs	4	2	8 Med	• Proactive focus on development of range and effectiveness of service user, equality and wider public reference groups • Development of mechanisms to connect these to the strategic planning process
If patients, customers and community are not involved and engaged in sufficiently in maintaining and improving their own health & wellbeing we will fail to deliver the improvement necessary	4	4	16 High	• Adoption of a more systematic, evidence based and scaled approach to community engagement for health.
If activity does not reduce in line with projections, the Trust will not be able to reduce activity quickly enough to deliver the sustainability model required for their IBP. This will result in CCGs paying for the activity commissioned in the community and the activity delivered within PAHT	4	4	16 High	• The CCG will be looking for innovative funding models to support money following the patients, with some shared risk mitigation strategies with all providers. • The CCG and the council have set some short term contingency in the Better Care fund to mitigate this in year one but this is a long term strategic risk which will be better known once the detailed financial planning has been finalised
If PAHT remove the capacity which the CCG and Council say will be deflected into the community and the activity continued to go to the Trust. This will result in significant service risks.	4	4	16 High	• The CCG and Council will adopt a turnaround mentality in monitoring success of these schemes. Monthly cross-organisational monitoring sessions will be established and risks to non-delivery will be identified early and contingencies put in place. • Schemes will be piloted first and if they are not delivering they will be stopped and the resource used to fund the over performance in the acute trust.

If the delivery of a reduction in A&E activity results in patients with low level need being seen in Primary Care, this may on the Trusts ability to deliver the 4-hour target as they will have to reduce staffing, but the more complex cases will take longer to process through the department	4	4	16 High	• The CCG and Council will review ways to deliver services in an integrated way with A&E which continue to support deliver of the standard.
If transformational change disrupts services there could be a reduction of service, reduction in quality, continuity of care and performance.	4	2	8 High	• Current plans are aligned with Bury's strategic plans • Current plans are agreed with stakeholders including the Local Authority's Health and Wellbeing Board • Current plans are led by clinical work stream leads • Risk assessment methodology will be applied consistently to service redesign • Tactical groups in place to monitor system change impact on cancer, RTT and A&E targets to ensure we can swiftly act to any sign of variation from the norm. • NES approach to quality assuring Provider Cost Improvement Plans to ensure rigor and deliverability. • Dedicated CCG quality team to work with providers to ensure focus on the key priority areas i.e. Francis, Berwick Keogh.
If management costs reduce further or NHS England transfer responsibility for commissioning other services without adequate resource the CCG will be unable to deliver the breadth of transformation within this strategy	4	4	16 High	• CCG will not accept any delegation without appropriate resources • CCG will continue to use CSU for as many products as is feasible to maximise VFM.
If the CCG does not develop effective partnerships it will be unable to deliver the transformation outlined in this strategy	4	2	8 Medium	• CCG and LA have in place partnership infrastructure • CCG works with NES colleagues to meet with large providers every two weeks to ensure adequate planning is in place • CCGs across the NES have developed a leadership team, made up of CCGs Chief Officers and Chairs, Provider Chief Executives and Council Directors to work through the most difficult system issues.
If staff are not adequately skilled to deliver transformational change the CCG will not deliver the strategic intent.	4	2	8 Medium	• CCG OD plan being refreshed in line with the strategy • Programme of mentorship and coaching being developed for staff involved in transformational change • Development programme in place with CSU

APPENDIX 4 - Transformational Schemes

This contains the transformation scheme work programmes, which will continue to evolve over the duration of the strategy. It is not anticipated that resources will allow ALL to be delivered however the visionary plans for each work stream have identified areas where development may be of value.
The work streams are identified in the PLAN column where the lead plan for the initiative is in bold and associated plans, which also have input, appear alongside.

Plan Legend	**Driver Legend** - The drivers section outlines where the initiative is identified to be of value
C - Cancer I - Integrated Primary Care W - Women's & Children L - Public Health E - Elective Care U - Unplanned Care M - Mental Health/Learning Disabilities P - Palliative Care	Q - Quality Improvement CfV - Commissioning for Value JS - Joint Strategic Needs Assessment BCF - Better Care Fund HT - Healthier Together Programme BT - Better Together Programme NT - National Target

National Framework Legend - All initiatives are linked to the NHS Frameworks

Domains	**Ambitions**	**Transformation Characteristics**
1. Preventing premature death 2. Quality of life for LTCs 3. Quick recovery from ill health 4. Great experience of care 5. Safe care	1. Securing additional years of life for people with treatable mental and physical conditions 2. Improving health related quality of life for people with long term conditions 3. Reducing avoidable time in hospital 4. Increasing elderly people living independently at home on discharge 5. Increasing positive experience of hospital care 6. Increasing positive experience of care outside hospital 7. Significant progress on eliminating avoidable deaths **8. Key Measure 3** - Parity of Esteem	1. Including citizens 2. Wider Primary Care provided at scale 3. A modern model of integrated care 4. Access to the highest quality urgent and emergency care 5. Step Change in Elective Care 6. Specialised services concentrated in centres of excellence

Transformation Scheme 1 — Establish Collaborative Prevention, Wellness and Life Support Programmes

National Frameworks	Initiatives	Drivers	Plan(s)	Financial Impact	Timeline	Starting Well	Developing Well	Living Well	Working Well	Ageing Well
						Health & Wellbeing Strategy Life Course				
A1 A7 K1	Devise a cancer Risk Stratification system for age 24+	JS CfV	C		Y1-5	x	x	x	x	x
A1 A7 K1	Bury branded cancer communication programme	JS CfV	C		Y1-5	x	x	x	x	x
A1 A7 K1	Deliver cancer prevention & education initiatives	JS CfV	C		Y1-5	x	x	x	x	x
A1 A7 K1	Develop a programme to identify barriers to uptake of Cancer prevention initiatives	JS CfV	C		Y1-5	x	x	x	x	x
A1 D4	Provide Smoking cessation programme	BT BCF	U W M C		Y1-5	x	x			
A1 D4	Provide Flu immunisation programme	BT BCF	U							
A1 A2 D4	Provide Respiratory Technique Training Programme	BT BCF	U W	-£49,951	Y1		x	x	x	x
A2	Consider the implications of adopting EPACCS or other IT solutions	Q	P		Y1					
A2	Develop a Bury Wide EoL Integrated Pathway	BCF Q	P C M U	-£140,721	Y1				x	x
A2	Explore the use of CQUINs to support the EOL care agenda	BCF Q	P		Y1			x	x	x
K3 A2	Support stakeholder education and training use MPET funding to find the 1%	Q	P		Y 2-5					x
K3 A2	Scope LD Friendly Community Model	BCF	M		Y2-4			x		
K3 A1 A2	Ensure mental and physical health are given equal status in care pathways	Q	M		Y1-5		x	x		
K3 A6	Develop plans for offender and veteran health	Q	M		Y2			x		
K3 A1	Promote non-medication management approach in MH & reduce antipsychotics for dementia	Q BCF	M		Y1-5			x		
K3 A6	Embed parity of esteem principles for mental health across the life course including BME & LD groups	BCF Q	M L		Y1-5	x	x	x	x	x
K3 A1	Develop pathways to improve uptake of screening/health check for people with MH & LD	BCF Q	M		Y 1		x			
K3 A2 A6	Promotion of health trainers in mental health and LD population	BCF Q	M		Y 1		x	x		
K3 A1	Promotion of alcohol awareness and screening with clinicians	JS CfV	M		Y 1		x			
K3 A2 A6	Develop a community based, needs led cognitive impairment service & improve assessment detection and diagnosis rates	BCF Q	M		Y1-5		x	x	x	
D4 A1 A5 A6	Engage in a wellness programme around Maternity Care	Q	W L		Y1-5	x	x	x		

Transformation Scheme 2 Create an Integrated Community Based Care Programme

National Frameworks	Initiatives	Drivers	Plan(s)	Financial Impact	Timeline	Starting Well	Developing Well	Living Well	Working Well	Ageing Well
						Health & Wellbeing Strategy Life Course				
T3 A1	Ensure equity of access to services	Q BCF	W I L M	Better Care Fund 11.7 million joint investment	Y1-5	X	X	X		
T2 A2 A6	Increase community based MDTs	BCF	I U W M		Y1-2		X	X	X	X
T2 A1 A2 A6	Develop Integrated Community Cardiology Services	BCF CfV JS	I U E		Y1-2		X		X	X
T2 A6 D4	Increase access to GPs	BCF HB	I U W		Y1-2	X	X	X	X	X
T2 A1 A2 A6	Deliver the Stroke Support Programme	BCF JS CfV	U I		Y1		X		X	X
T3 A1 A2 A6	Deliver Integrated Community Diabetes Programme	BCF JS CfV	U W		Y1-2		X		X	X
T3 A1 A2 A6	Increase Integrated Community Respiratory Clinics	BCF JS CfV	U I W		Y1-2		X		X	X
T3 A2 K3	Identify Opportunities for a Shared Care Model for MH/LD e.g. ADHD	BCF CfV	M		Y1-2				X	
T2 K3	Undertake a Pharmacy Questionnaire MH/LD	BCF CfV	M		Y1-2		X			
T3 A6	Develop signpost and referral systems to available support programmes	BCF	M		Y1-2		X			
T3 A6 D4	Deliver the Crisis Response Service	BCF HT BT	I U		Y1-2				X	X
T4 A6 D4	Enhance the Care Home LES	BCF	I U E P		Y1				X	X
T3 A4 A6	Implementation of named GPs for the over 75's	BCF	I P U		Y1		X		X	X
T3 A6	Develop Gold Standard Framework accreditation in Care Homes	BCF	P		Y 2-3				X	X
T3 A2	Develop an Outcomes Based Framework to monitor lifestyle risk factors for MH/LD population	BT	M W		Y1-5	X	X	X		
T3 A6	Redesign CAMHS to develop a multidisciplinary, integrated children's MH Community service	BCF HT BT	M W		Y1 -Y2			X		
T2 A6	Provide improved access to Ophthalmology services	BCF	I E		Y1-5					
T2 A6	Provide improved access to community IV services	BCF	I E		Y1-5				X	X
T2 A2 A6 D2	Provide improved access to Continence Services.	BCF	E I							
T2 A6	Devise & Implement Paediatric Community workforce proposal	BCF	W		Y1-5	X	X	X		
T2 A6	Paediatric Service and pathway review & redesign	Q	W		Y1 -5	X	X	X		
T2 A6	Re procurement of Paediatric Community Services	Q	W		Y2	X	X	X		
T2 A6	Develop Single Point of Access Paediatric OOH care centre	BCF HT	W		Y1-2	X	X	X		
T3 A2 A6 D2	Establish cancer support groups with the voluntary sector	BCF	C							
D5 A7	Delivery of the Winterbourne Strategic Action Plan	Q	M		Y 1-5					
T3 A6 D4	Improve clinical correspondence between primary and secondary care	Q	M		Y 1					
T3 A2	Ensure IAPT services achieve prevalence and recovery targets and equality of access for LD	NT	M		Y 1			X		
T3 A2	Implementation of the SEND Agenda and integrated EHC plans	Q	M		Y1-5	X	X			

Transformation Scheme 3 Streamline and Enhance Elective Care Service Provision

National Frameworks	Initiatives	Drivers	Plan(s)	Activity / Measures	Financial Impact	Timeline	Starting Well	Developing Well	Living Well	Working Well	Ageing Well
							Health & Wellbeing Strategy Life Course				
T5 A3	Identify opportunities to transfer cancer services into the community	BCF JS CfV	C	15% Reduction in Elective Activity 14/15 - 0% 15/16 - 3.0% 16/17 - 3.5% 17/18 - 4.0% 18/19 - 4.5%	Year Value 14/15 £0 15/16 -£365,505 16/17 -£426,423 17/18 -£487,340 18/19 -£ 548,258 5 Year Total -£1,827,525	Y1	X	X	X	X	X
K3 A5 A6	Ensure the choice of Mental Health provider agenda is exercised	NT	M			YI			X	X	X
K3 A5	Embed parity of esteem principles for MH & LD across elective care	Q	M E			Y1-5			X	X	X
T5 D5	Reduce Caesarean Section Rate	Q	W			Y1	X	X			
T5 D5 D6	Develop direct GP referrals to secondary care	BCF	E			Y1	X	X	X	X	X
T5 D3	Develop and commission an enhanced recovery programme	BCF	E			Y2-5	X	X	X	X	X
T5 D5 A1 A7	Review pre and post-operative assessments services	Q	E			Y2-5	X	X	X	X	X
T5 D4 A1	Develop end to end condition specific pathways	Q	E			Y1-5	X	X	X	X	X
T5 A5 A6	Evaluate the Referral Gateway and EUR Process	Q	E	5% Reduction in Day Case 14/15 0% 15/16 -0.5% 16/17 -1.0% 17/18 -1.5% 18/19 -2.0%	Year Value 14/15 £0 15/16 -£45,012 16/17 -£90,024 17/18 -£135,036 18/19 -£ 180,048 5 Year Total - £450,120	Y1-2	X	X	X	X	X
T5 D4 A1	Improve access to Consultant led virtual clinics	BCF	E I			Y1-2	X	X	X	X	X
T5 D4 A3 A5 A6	Develop an early supported discharge process	BCF	E I			Y2-5	X	X	X	X	X
T5 D5 A7	Target workforce and retention issues in key areas	Q	E W			Y1-5	X	X	X	X	X
T5 T6	Improve links between specialist and generalist areas	BCF	E W			Y1-5	X	X	X	X	X
T5 D4	Reduce unnecessary appointments	BCF CfV	E			Y1-4	X	X	X	X	X
T5 A3 A6	Improve access to diagnostic and treatment services in the community, including re-procurement of the ISCATS contract	BCF	E			Y1-5	X	X	X	X	X

Transformation Scheme 4 — Future Proofing Urgent Care Services in Bury

National Frameworks	Initiatives	Drivers	Plan(s)	Activity / Measures	Financial Impact	Timeline	Starting Well	Developing Well	Living Well	Working Well	Ageing Well
							Health & Wellbeing Strategy Life Course				
T4	LTC AQUA	BCF AR	U I	20% Unplanned Activity Reduction 14/15 - 3.4% 15/16 - 14.1% 16/17 - 0.8% 17/18 - 0.8% 18/19 - 0.8%	LTC AQUA - £12,975 14/15 Baseline 15/16 -£5,282,770 16/17 -£299,732 17/18 -£299,732 18/19 -£ 299,732 5 Yr Total - 6,181,965	Y1		X		X	X
T4 A1 D5	111 Service Development	BCF	U			Y1-5	X	X		X	X
T4 A2 A3	Redirect Respiratory activity into the community	BCF CfV	U W			Y1-2	X	X		X	X
T4 A2 A3	Redirect Cardiology activity into the community	BCF CfV	U			Y1		X		X	X
T4 A2 A3	Redirect Diabetes activity into the community	BCF CfV	U W			Y1	X	X	X	X	X
T4 D4 A5	Minimum 95% A&E <4 Hour wait target	NT	U			Y1-5			X	X	X
T4	Review the Local Impact of RAID and enhance where appropriate	BCF	M U L			Y1-5			X		X
T4 A2 A3	Monitoring of Asthma presentations to A&E	HT CfV	U W	16.5% Reduction in A&E Attendance 14/15 - 3% 15/16 - 12% 16/17 -0.5% 17/18 -0.5% 18/19 -0.5%	14/15 Baseline 15/16 -£716,319 16/17 -£29,847 17/18 -£29,847 18/19 -£29,847 5 Yr Total -£805,859	Y1		X		X	X
T4 A2 A3	Undertake an audit of Paediatric respiratory presentations	CfV	W U			Y1				X	
T4 K3	Implement alcohol frequent flyers project across Bury	JS	M L			Y 1-2			X		
T4 K3 A2	Develop pathway with GP and Adult LD team to prevent unnecessary attendance at A&E	BCF	M			Y 1		X	X		
T4 K3 A2	Develop evidence based model to reduce admissions and length of stays for adults with acute mental health problems	BCF	M			Y3-5			X		

Appendix 5 – Work stream plans on a page

End of life

1

Our vision for Bury is to have an integrated and co-ordinated palliative and end of life pathway that supports patients and their families to have care that is tailored to their needs and allows them to live and die in their preferred place of care.

2

System Objective One Understand the totality and interdependencies across the EOL Pathway	Delivered through interventions: EOL Review due to report in Q1 2014/15 • Reflect the outputs from the Bury wide, January 2014 stakeholder scoping event.
System Objective Two Develop systems for the transfer of data across agencies	Delivered through interventions: • Review the implications for adoption of Integrated Electronic System and other potential IT solutions.
System Objective Three Review usage of DNACPR and promote service via eol Information pack	Delivered through interventions: • Develop a Bury wide Integrated Pathway building on the outputs from the January 2014 stakeholder scoping event. • Localise examples of best practice such as, Midhurst. • Review religious/ethnicity/social impact on EOL care • Develop a system wide Bury Patient Charter for EOL
System Objective Four Reduction NEL Admissions and XBDs for EOL patients. Increase deaths in preferred place.	Delivered through interventions: • Develop plans beyond the Rapid Transfer Pilot • Support proactive hospital in reach mechanisms • Encourage further uptake of the Care Home LES • Promote EOL care within the implementation of named GPs for the over 75's • Explore the use of CQUINs to support the EOL care agenda
System Objective Five Identify undiagnosed patients and support Education and Training across Bury	Delivered through interventions: • Support practice via MPET to 'find the 1%'. • Support stakeholder education and training through MPET
System Objective Six Develop GSF accreditation in Care Homes	Delivered through interventions: • Use MPET funding to support Care Homes

3

5

Overseen through the following governance arrangements:

Clinical Lead for EOL
LA & Joint (Health and Wellbeing Board)
CCG Governance (Cabinet, Patient Cabinet)
NES Commissioning Board
Altogether Better/Healthier Together
Bury CCG Sector Meetings
Sector Led Practice Liaison

4

Measured using the following success criteria:

Reduction in NEL Admission
Reduction in XBDS
Increase in death is Preferred Place of Care (PCC)
All key stakeholder are engaged in the early planning stages of commissioning, including providers and patients
Bury as a best practice in the national picture

6

System values and principles:

Reduce inequalities and improve outcomes
Deliver transformational change
Develop capability as commissioners and leaders
Deliver improvements via QIPP to create high quality sustainable services
Ensure citizenship, self-care and prevention is at the heart of what we do

Cancer

1 ***To improve health and wellbeing of the population and to enable people to live longer, healthier lives and feel supported to have best quality of life possible***

2

Prevention

Reduce preventable cancers by 2% each year

Detection

Increase screening uptake by 2% each year

Intervention/Treatment

Work with Providers to ensure treatments are delivered closer to home, which are safe, of high quality, and delivered within national performance targets and standards

Survivorship

Design, develop and embed a survivorship framework with protocols that help patients, carers and families to regain confidence to continue to live their lives

3

- Engage in partnership with Local Authorities, NHS England, Primary Care, Secondary Care, Patients, Public and Voluntary sector to deliver a creative, Bury branded, collaborative cohesive communication programme that is effective and fit for purpose and that uses a broad range of technologies, media and materials
- Expand current risk stratification systems to include risk profiling all adults 24 years and over

- Build on the outputs from prevention interventions ie – raised public awareness and risk stratification of patients, and additionally develop a programme that systematically identifies barriers to uptake.
- Shift monies from incentivising practices to motivating patients – work with commercial sector to explore opportunities for reward

- Commission high quality services, that have evidence based clinical outcomes, are local and forward thinking and that are compliant with national standards
- Scope and plan to shift appropriate interventions out of acute settings and into patient's homes on geographical footprints that provide adequate service volumes ie NES domiciliary Herceptin service
- Work with voluntary sector to establish local support groups ie practical support for frail vulnerable/single parents/carers

- Build on the existing National Action Plan for Survivorship to develop a framework that is recognised by and supports patient, family and carers
- Ensure clinicians are enabled to influence Local Authority strategies and develop models that are outcomes orientated
- Work with voluntary sector to establish local support groups ie practical support for frail vulnerable/single parents/carers

4 Overseen through the following governance arrangements

- North East Sector Cancer Board
- CCG Health and Wellbeing Board
- Cancer Leads

5 Measured using the following success criteria

- Year on year reduction in preventable cancers
- Increased screening uptake
- Improved outcomes
- Reduced mortality rates
- More patient and public involvement
- Reduced cost
- Compliant with standards as set out in the NHS Manual for Cancer
- Consistent achievement of national cancer targets ie 14/31/62 day

6 System values and principles

- Reduce inequalities and improve outcomes
- Deliver transformational change
- Develop capability as commissioners and leaders
- Deliver improvements via QIPP to create high quality sustainable services
- Ensure citizenship, self-care and prevention is at the heart of what we do

Women's and Children's

1 To provide world class health care to the children of Bury in the most appropriate setting with the most appropriate practit ioner. To reduce unacceptable variations in outcomes. To maximise opportunities.

2

System Objective 1
Reduction in avoidable emergency and non-elective admissions, especially non-elective admissions for Asthma, Diabetes and Epilepsy and Lower Respiratory tract infections

3

Delivered through intervention
- Review the community paediatric service & review the pathways commissioned
- Review and increase access to primary care through the emerging integrated primary care hubs and a Single Point of Access (SPA) paediatric out of hours care centre
- Develop a bespoke pathways to specific performance areas such as for Asthma, Diabetes and Epilepsy and Lower Respiratory tract infections

System Objective 2
Reduce inequalities and offer timely and equal access to all children closer to home via improved integrated pathways

Delivered through intervention
- Develop an integrated pathway for Children's services that links to all types of care with a SPA
- Act on the findings with regard to any inequalities identified in Maternity Service review
- Consider the impact of wider community procurements

System Objective 3
Provide OOH care with GPs switching to the front ending of ED with primary care triage and staffed with multi professional including GPs, CCNT and paediatric nurses

Delivered through intervention
- Develop paediatric urgent care centre as a coordinated approach, as a catalyst for whole system redesign of paediatric urgent care
- Consider the impact of wider community procurements

System Objective 4
Review knowledge base in primary care and assess variation in referral/outcomes. Upskill primary care team and assess skill mix

Delivered through intervention
- Stocktake of competency levels and skill mix across primary care in order to develop a Bury wide training and development plan
- Maximise current infrastructure to raise the profile of W&C across Bury
- Develop a proposal to secure a GPSI in each sector
- Consider the impact of wider community procurements

System Objective 5
To review local maternity provision benchmarked against best practice to inform future commissioning and redesign priorities

Delivered through intervention
- Conclude the maternity review
- Develop a midwifery led continuity model
- Consider the impact of wider community procurements

4

Overseen through the following governance arrangements
- Bury CCG Governing body (Clinical, cabinet and patient cabinet)
- NE Sector Commissioning Board
- NE W&C Board
- Covalent
- Clinical lead for Women and Children's
- Healthier Together

5

Measured using the following success criteria
- A set of robust KPIs (to be developed)
- Comprehensive benchmarking exercise
- Agree on good quality information/ data to be received from the Trusts

6

System values and principles
- Reduce inequalities and improve outcomes
- Deliver transformational and innovative change
- Develop capability as commissioners and leaders
- Deliver improvements via QIPP to create high quality sustainable services
- Ensure citizenship, self-care and prevention is at the heart of what we do
- Provide genuine Value for Money
- Comply with best practice and all relevant

Primary Care

1 To standardise the services available to patients within the community regardless of whom they are registered. Whilst ensuring that quality markers are met

2

System Objective One
Increased access to Primary Care Services

System Objective Two
proactive, coordinated care: anticipating rather than reacting to need and being accountable for overseeing your care, particularly if you have a long-term condition.

System Objective Four
health-promoting care: intervening early to keep you healthy and ensure timely diagnosis of illness – engaging differently with communities to improve health outcomes and reduce inequalities.

System Objective Five
onsistently high-quality care: removing unwarranted variation in effectiveness, patient experience and safety in order to reduce inequalities and achieve faster uptake of the latest knowledge about best practice.

System Objective Six
holistic, person-centred care: addressing your physical health, mental health and social care needs in the round and making shared decisions with patients and carers.

4

Delivered through intervention – Sector Based Integrated Care Models

- Each sector is currently working through what their local requirements for integrated care are; based on historic usage of both Secondary and Primary Care Services. This will include:
  - Extended opening
  - Integrated care pathways
  - Shared care records
  - Access to specialist advice from medical specialists without the patient needing to travel to hospital or have their care handed over
  - Enhanced access to care professionals and therapists. Mental health, occupational therapy, community nursing or social care staff are directly attached to practices

Delivered through intervention – Increased access to a wider range of services delivered in the community

- Local practices, pharmacies, community health services, voluntary agencies and the local authority work as a group to engage with their community, collaborating with them in asset-based approaches to improving health and wellbeing.
- increased use of technological solutions/interventions
- Standardisation of enhanced service delivery amongst practices
- Community diagnostic services. Local practices collaborate to arrange diagnostic services in the community, reducing travelling for patients and speeding access to results.

Delivered through intervention - Implementation of a Primary Care Quality Strategy

- Systematic review of performance using a suite of information sources to identify outliers
- Clinically led supportive practice visits and practice development programmes to reduce variation Peer-to-peer challenge and learning.
- Identification and dissemination of best practice
- Continual monitoring and support with potential problem areas

5 Overseen through the following governance arrangements

- Primary Care Quality Group
- Integrated Care Model Development group
- CCG Sector Meetings

3 Measured using the following success criteria

- Outliers brought in line with CCG average
- Increase in patient satisfaction of primary care services
- No. of patients over 75 with named clinical lead
- Reduction in emergency admissions

6 System values and principles

Reduce inequalities and improve outcomes
Deliver transformational change
Develop capability as commissioners and leaders
Deliver improvements via QIPP to create high quality sustainable services
Ensure citizenship, self-care and prevention is at the heart of what we do

Elective Care

1

Vision 18: Bury as a Centre of Exce llence for Elective Care

Through clinically led review and transformational change, we aim to deliver a productive and efficient elective care service that is safe and sustainable. By 2018, every patient will have excellent care delivered by the right person, in the right place, at the right time.

2

System Objective One
Seamless evidence based integrated care, closer to home across all specialities

System Objective Two
To remove the inequalities in access to and delivery of services for Bury residents

System Objective Three
Patients can access the service they need, as close and convenient to them as possible

System Objective Four
To reduce NEL attendances and admissions for conditions that could be managed elsewhere

System Objective Five
Patients are seen as a day case for all elective care surgery where appropriate

System Objective Six
Our clinicians are enabled to offer the very best care, and as such are of the highest calibre

3

Delivered through interventions:
Development of end to end condition specific pathways so that patients are seen <18 weeks and low volume specialities and procedures of limited value are on a downward trajectory
Working with primary and secondary care colleagues to develop GP direct referrals to secondary care
Improving access to and commissioning of additional community services such as ophthalmology, IV and continence

Delivered through interventions:
Utilise all providers equitably in meeting the diagnostic and treatment needs of the community.
An extension of the musculoskeletal single point of access, advice and guidance and community clinic model to include further services and specialities
Evaluate the function of the Referral Gateway and EUR process
Improve access to consultant led virtual clinics
Use specialist and joint commissioning to drive value for money

Delivered through interventions:
Undertake a review of evidence base and work with providers to commission an Enhanced Recovery Programme
To strengthen pre-and post-operative assessments to ensure patients are prevented from having a NEL and poorer outcome

Delivered through interventions:
Targeting workforce and retention issues in key areas
Improving the links between generalist and specialist areas
All specialities work together to reduce unnecessary

5

Overseen through the following governance arrangements:
LA & Joint (Health and Wellbeing Board)
CCG Governance (Cabinet, NES Elective Care Board, Patient Cabinet)
PAHT Contracting Board
NES Commissioning Board
Altogether Better/Healthier Together
Sector Led Practice Liaison

4

Measured using the following success criteria:
High levels of self-care and patient education
Reduction in conditions affecting health
Reductions of up to 20% in elective and non-elective admissions and resulting acute provider activity
Improved outcomes for patients
All key stakeholder are engaged in the early planning stages of commissioning, including providers and patients
Bury as a best practice in the national picture

6

System values and principles:
Reduce inequalities and improve outcomes
Deliver transformational change
Develop capability as commissioners and leaders
Deliver improvements via QIPP to create high quality sustainable services
Ensure citizenship, self-care and prevention is at the heart of what we do

1 Mental Health & Learning Disabilities

To ensure patients, families and carers are at the core of services and decisions relating to their health care. Services will empower patients to promote well-being, become aware of psychological distress and self-manage their conditions. Patients will have equal access to services and health outcomes will be comparable to the rest of the population. We will provide seamless services across a range of physical and mental health services and a wide choice of evidenced based services from voluntary and statutory organisations

2 Reducing the rate of unnecessary A&E attendance and hospital admissions for alcohol, dementia, LD and acute mental illness

A Whole system approach to patient care, which builds resilience and focuses on harm reduction

A whole community approach that includes integrated collaborative working

Promotion of self-care and prevention initiatives

4

Actions:

- Develop an Outcomes Based Framework to monitor and reduce lifestyle related risk factors e.g. smoking and alcohol benchmarked through Better Together
- Review the local impact of RAID and develop a business case for RAID
- Explore opportunities to enhance the RAID model
- Delivery of the Winterbourne Strategic Action Plan
- Improving detection, assessment and diagnostic rates for people with cognitive impairment
- Increase uptake of Health Checks for LD and SMI
- Improve clinical correspondence between primary and secondary care
- Implement alcohol frequent flyers project across Bury
- Develop pathway with GP and Adult LD team to prevent unnecessary attendance at A&E
- Develop plans for offender and veteran health
- Develop an evidence based model to reduce admissions and length of stay for adults with acute mental health problem

Actions:

- Review of IAPT services to achieve prevalence and recovery targets
- Joint training for LD and IAPT staff to manage LD referrals to IAPT service
- Developing a community based, needs led cognitive impairment service
- Identify opportunities for a Shared Care Model for MH/LD e.g. ADHD, Depot
- Work with primary and secondary care to reduce the use of antipsychotics for dementia patients
- Promoting non-medication approaches to the management of patients
- Embed mental and physical health initiatives into care pathways across a range of health services, starting with LTC and access to IAPT services
- Redesign of CAMHS (including ASD/ADHD services) to develop a multidisciplinary, integrated children's mental health service embedded within the community.
- Implementation of an identification and referral pathway to ensure all carers are signposted from GPs to

Actions:

- Scope and review equality of access to services for MH/LD population and address inequalities
- Implementation of the SEND Agenda and integrated EHC plans
- Map a Potential LD Friendly Community Model against Dementia Model
- Engagement and promotion of key stakeholders working together to improve patient outcomes
- Develop plans to access hard to reach groups e.g. BME using community resources/dementia alliance

Actions:

- Develop a community pharmacy questionnaire to encourage patients to ask questions about their medication and understand the impact on mental and physical health
- Scoping exercise to identify appropriate initiatives to embed parity of esteem principles across the life course e.g. early years
- Developing pathways with Primary care and Adult LD to improve uptake of cancer screening programmes for people with LD
- Explore with Public Health opportunities to develop the mental wellbeing agenda and work with minority groups and LD
- Promote physical and mental health checks for at risk groups
- Promotion of health trainers in mental health and LD population
- Promotion of alcohol awareness and screening with clinicians

5

Overseen through the following governance arrangements

- Clinical Cabinet
- CCG Governing Body
- Partnership Board
- Public Sector Reform Board
- HWBB
- PCFT Mental Health Contract Governance Arrangements

3

Measured using the following success criteria

- Achievement of outcomes in outcomes framework
- Reduced rate of hospital admissions, unnecessary A&E attendance and length of stay for alcohol related conditions, dementia, acute mental illness and LD
- Cognitive impairment service operational and managing patients in primary care
- Reduction in the number of inpatient cases for LD and an increase in people managed in community settings
- Increase in the number of people on prevalence registers
- Integrated pathways between mental health, social care and physical health services
- Audit trail to show shared care records
- Increase in the number of referrals entering into treatment for IAPT and increase in IAPT recovery rate
- Increased number of LD patients accessing IAPTS
- CAMHS service delivering reduced waiting times and better outcomes for young people through early intervention
- Integrated EHC plans in place
- Increase in people with LD accessing cancer screening
- Number of patients completing pharmacy questionnaire
- Number of referrals for health trainers/BEATS/know alcoholics
- Increase in number of health checks for LD and SMI
- Increased dementia diagnosis rate
- Evidence of work with 3rd sector

6

System values and principles

- Reduce inequalities and improve outcomes
- Deliver transformational change
- Develop capacity as commissioners and leaders
- Deliver improvements via QIPP to create high quality sustainable services
- Ensure citizenship, self care and prevention is at the heart of what we do
- Person centred and evidence based

Urgent Care and LTC

1 To provide an integrated urgent care model that is accessible in the right place at the right time through the development of a high quality, clinically safe system that is easy for both patients and professionals to navigate through and provides outstanding value for money. In order to facilitate this ensure LTC patients receive integrated co-ordinated care.

2

System Objective One
Minimum of 95% A&E patients seen within 4 hours

3

Delivered through interventions:

- Managed via the NES UC Network, daily monitoring and escalation process in place.
- Intergrated Primary care including the 7 day working.

System Objective Two
A 20% reduction in Urgent Care activity

Delivered through interventions:

- Care Home Les/LTC AQUA/Primary Care Integration/Better Care Fund/Reablement/Out of Hours/111/Self Care/Integrated Diabetes – Respiratory – Cardiology services/Paediatric Urgent Care Centre

System Objective Three
Realise a shift in appropriate urgent care delivery from secondary care to primary care

Delivered through interventions:

- Care Home Les/LTC AQUA/Primary Care Integration/Better Care Fund/Reablement/Out of Hours/111/Self Care/Integrated Diabetes – Respiratory – Cardiology services.

System Objective Four
Ensure the maximisation of national emergency department re-classifications

Delivered through interventions:

- Healthier Together outcomes delivery.
- Primary Care Integration/Better Care Fund
- 111 development
- LTC AQUA

5

Overseen through the following governance arrangements:

Clinical Lead for UC and LTC
Covalent reporting
LA & Joint (Health and Wellbeing Board)
CCG Governance (Cabinet, Patient Cabinet)
NES UCNB
NES Commissioning Board
Altogether Better/Healthier Together
Bury CCG Sector Meetings
Sector Led Practice Liaison

4

Measured using the following success criteria:

Reduction in NEL Admission
Reduction in XBDS
Increase in death is preferred place
All key stakeholder are engaged in the early planning stages of commissioning, including providers and patients
Bury as a best practice in the national picture

6

System values and principles:

Reduce inequalities and improve outcomes
Deliver transformational change
Develop capability as commissioners and leaders
Deliver improvements via QIPP to create high quality sustainable services
Ensure citizenship, self-care and prevention is at the heart of what we do

Appendix 6

Bed Reduction Impact from Proposed Bury CCG Deflection Plans - All Figures calculated using Pennine Acute Average Length of Stay

Pennine Acute	Elective				Non-Elective				No. Beds Reduced 100% Occupancy
Year	Activity Spells	Activity Bed Days	Bed Day Reduction	% Reduction	Activity Spells	Activity Bed Days	Bed Day Reduction	% Reduction	
13/14	3502	9876	n/a		16383	61436	n/a		
14/15	3730	10519	643	6.5%	15733	58999	-2438	-4.0%	-5.1
15/16	3600	10152	-367	-3.5%	13222	49583	-9416	-16.0%	-27.8
16/17	3460	9757	-395	-3.9%	13089	49084	-499	-1.0%	-2.5
17/18	3300	9306	-451	-4.6%	12958	48593	-491	-1.0%	-2.7
18/19	3128	8821	-485	-5.2%	12828	48105	-488	-1.0%	-2.8
									-40.9

Bolton	Elective				Non-Elective				No. Beds Reduced 100% Occupancy
Year	Activity Spells	Activity Bed Days	Bed Day Reduction	% Reduction	Activity Spells	Activity Bed Days	Bed Day Reduction	% Reduction	
13/14	232	654	n/a		904	3390	n/a		
14/15	234	660	6	0.9%	867	3251	-139	-4.1%	-0.4
15/16	227	640	-20	-3.0%	773	2899	-353	-10.8%	-1.1
16/17	219	618	-23	-3.5%	767	2876	-23	-0.8%	-0.1
17/18	210	592	-25	-4.1%	761	2854	-23	-0.8%	-0.1
18/19	201	567	-25	-4.3%	755	2831	-23	-0.8%	-0.1
									-1.8

CMFT	Elective				Non-Elective				No. Beds Reduced 100% Occupancy
Year	Activity Spells	Activity Bed Days	Bed Day Reduction	% Reduction	Activity Spells	Activity Bed Days	Bed Day Reduction	% Reduction	
13/14	505	1424	n/a		861	3229	n/a		
14/15	509	1435	11	0.8%	843	3161	-68	-2.1%	-0.2
15/16	494	1393	-42	-2.9%	850	3188	26	0.8%	0
16/17	476	1342	-51	-3.6%	857	3214	26	0.8%	-0.1
17/18	457	1289	-54	-4.0%	864	3240	26	0.8%	-0.1
18/19	436	1230	-59	-4.6%	871	3266	26	0.8%	-0.1
									-0.4