Better Care Fund
ANNEX 1 – Detailed Scheme Description

Ref	Schemes
Bury BCF 01	Staying Well
Bury BCF 02	Extended Access to Primary Care
Bury BCF 03	Integrated Health and Social Care Team
Bury BCF 04	Care of Vulnerable Adults
Bury BCF 05	Review Programme - Integrated Intermediate Care , Reablement and other related services

Appendix 1	Impact of schemes - Metrics Mapping An exercise was undertaken to calculate the benefits on a scheme by scheme basis and to apportion the benefits to the different schemes. This is detailed in the table.

ANNEX 1 – Detailed Scheme Description

SCHEME 1

Scheme ref no.
Bury BCF 01
Scheme name
Staying Well
What is the strategic objective of this scheme?
The Staying Well Scheme is an early intervention scheme which aims to improve health, wellbeing and quality of life for older people, reducing the risk of future health and social care need and preventing future crisis. The scheme has the following key objectives: • To develop a systematic method of identifying those at high risk of developing future health and social care needs • To support those identified to take action to reduce their future risk e.g. by planning for their futures, helping people access relevant support and making the most of their personal and community assets • To reduce dependency on secondary health care and specialist social services in the medium to long term • To support a cultural shift towards a prevention focused system based on a social model of health • Support implementation of the Care Act 2014 Staying Well supports Bury's overall vision of enabling people to live well and remain independent for as long as possible. It is a key prevention service for older people that promotes citizenship, self-care, independence and wellbeing.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Staying Well is a targeted prevention and early intervention offer to older people that will increase their opportunities to enjoy long healthy lives, feeling safe at home and connected to their community. Far too many older people only come to the attention of health and social care services when they reach crisis point and then begin a downward spiral of decline and dependency. There is also a wide range of 'preventative' support available within Bury but this offer often fails to reach and connect with everyone who could benefit most. This scheme will adopt a systematic and proactive approach to identifying those at high risk of future care need and supporting

people to maintain their health, wellbeing and independence.

A review of the literature and consultation with older people, their carers and front line professionals suggest that the following are key risk factors for future health and social care need:

- Social isolation and loneliness
- Common conditions of older age that limit independence (e.g. mobility problems, foot health, chronic pain, visual or hearing impairment, incontinence, malnutrition, oral health)
- Housing and fuel poverty (affordability, changing housing needs)
- Practical support needs (e.g. minor household repairs, cooking, transport)

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The Staying Well scheme seeks to intervene as early as possible to minimise the need for more complex and costly interventions later on by its preventative, proactive, person-centred and community orientated approach.

Many minor needs can often be met by existing services and support commonly available in the community but awareness and access is low in the very group that needs them. Therefore, the key principles underlying the proposed model are:

- Proactive, systematic identification of those at high future risk utilising the Combined Predictive Model (CPM) and GP Practice Registers
- An asset based approach, promoting maximum independence and self-determination of older people
- Holistic approach considering the wide range of factors that contribute to health, wellbeing and independence
- A place based approach to use and develop community assets/resources
- Integration within a whole system of care, community and place
- Encouraging people to self-care and consider, plan & prepare for their futures

The cohort for this intervention will be all those aged 65 and over deemed moderate to low risk after application of the CPM Stratification to that population. It will exclude those in receipt of formal social care and those under the care of the Multi-disciplinary Locality Team. The prime basis for proactive systematic targeting of this intervention will be through GP practice registers. Further criteria for prioritising within this cohort are being considered e.g. having one or more long term condition, living alone. The intervention will also be offered opportunistically e.g. by the social care team if assessed as in-eligible for formal social care. It is expected around **2,444** people aged 65 and over will receive a Staying Well offer in Year 1 (see impact of scheme section for further details).

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The Staying Well intervention comprises the following elements:

- A person-centred conversation about needs and assets using an holistic, evidence based Staying Well Conversation Checklist Tool
- Individual goal orientated action planning to ensure patient/service user activation
- Facilitation, beyond sign-posting, to help people build the confidence, knowledge, skills and trust to enable them to make the most of the support available and take steps to improve their current and future circumstances

- Identifying, building on and making the connections between the assets & strengths of individuals and their communities
- Support, information or advice to encourage self-care and self-management
- Provision of a feedback loop to support service improvement in the wider system

The intervention will be delivered by 'Health and Wellbeing Co-ordinators' recruited and trained to deliver the holistic Staying Well intervention described below. Co-ordinators will use a range of knowledge and skills to support these steps and encourage a self-help approach. The service will also maximise the opportunities for self-management, peer support and support from local community, voluntary and faith sector groups. Our recently launched, web-based Bury Directory will support this function.

The Staying Well Conversation takes place in the client's home or another venue if they prefer. This provides the opportunity to have in depth face to face discussion and to take account of observations to ascertain the underlying and important issues that people may face now or in the future.

The Staying Well Conversation is supported by a number of tools, as an aid to identify client risk & protective factors for future health and social care need. The tools are centred around the core principles of a client centred holistic intervention. They promote an integrated approach to working and supporting individuals to live and stay well.

The Staying Well Check Tool consists of:

- Client consent form
- Quality of Life Wheel, covering 12 key dimensions of health and wellbeing
    1. Health (i.e. memory, healthy eating, screening)
    2. Carer Support (i.e. break from role, emotional well-being)
    3. Emotional Wellbeing (i.e. thinking clearly, making decisions, feeling sad)
    4. Getting Out and About (i.e. driving, managing stairs, shopping, going to the bank)
    5. Personal Care and Daily Tasks (i.e. feeding, dressing, cleaning home)
    6. House and Home (i.e. home repairs, minor and major adaptions, moving home)
    7. Managing Medication (i.e. taking the right dose at the right time, reading labels)
    8. Managing Money (i.e. debt advice, heating costs, benefits advice)
    9. Friends, Family and People (i.e. trust, relationships, loneliness)
    10. Communication (i.e. hearing, seeing, reading)
    11. Volunteering and Work (i.e. skills, training, working hours)
    12. Hobbies and Interests (i.e. shopping, puzzles, eating out)
- Visual communication cards
- Trigger questions
- Algorithms to guide referral/ signposting opportunities

The service will offer a co-ordinated response to identified needs, utilising key assets within people's communities. Our enabling workstream around community engagement seeks to stimulate and develop community capacity to support older people's health and well-being and is integral to the development and delivery of the Staying Well scheme.

Our local 'Bury Directory' provides an online hub of community assets within the Borough to support a range of potentially identified needs.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

There are two potential models for delivery:

- A commissioned model, where Bury Council will initiate a procurement exercise to identify an appropriate provider
- A directly provision model, with the Staying Well Service located within Adult Social Care within Bury Council,

A Business Case is in progress, which will present an options appraisal of both models of delivery, for consideration and decision by the Joint Commissioning Group.

Either option will require the recruitment of Health and Wellbeing Co-ordinators' who will be trained to identify those patients within GP practices and deliver the holistic Staying Well intervention described above to all eligible clients. The Health & Wellbeing Coordinators will be part of the emerging locality based health and social care teams.

GP practices will also form a key part of the delivery chain as GP practice registers will form the basis of cohort identification. We will also be exploring how GP practice read codes can be used to record social as well as clinical circumstances and interventions to help refine the identification of the target group over time, support monitoring and evaluation and help support the wider integration agenda.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Within the NHS Forward View is a clear articulation of the need to radically ramp up the focus on prevention and public health. Adopting healthier lifestyles in old age and learning how to self-care is shown to yield significant benefits and it is estimated that over half of the burden of disease among people aged over 60 is avoidable through changes in lifestyle such as regular exercise, not smoking, reducing alcohol consumption and healthy eating.

Whilst public services are challenged with meeting the needs of a growing and more dependent older population, many services struggle to provide support to people's lower or 'minor' needs. In addition, there are many older people who are not known to health and social care services who have lower level needs. Needs classed as minor can have significant effects on independence, well-being, social engagement and loneliness, social isolation and social exclusion and are known to be important risk factors for ill health and mortality in older people (Kings Fund, 2014, Making ouR health and care systems fit for an ageing population).

A significant proportion of activity within adult health and social care services can be described as ‘failure demand’ which is demand caused by a failure to do something or do something right for the customer at the right time and in the right place. It has been estimated that this can account for up to 80% of demand into health and social care services. Failure demand includes re-presentation with the same problem, re-screening and reassessment, all creating high volumes of work for health and social care services.

As social care eligibility alters, an increasing number will fall below defined thresholds. This can result in service users presenting in crisis where an earlier intervention may have averted the situation (Year of Care Programme, NHS IQ, 2014). Staying Well presents an alternative for these clients and addresses this gap. The scheme aims to ‘shift the curve’ from high cost reactive care to an approach that is preventative, proactive, based close to people and their homes and optimises self-care.

We know that maintaining independence is a key priority for older people. The ability to remain in one's own home which is clean, warm and affordable;

- to remain socially engaged; to continue with activities that give their life meaning
- to contribute to their family or community
- to feel safe and to maintain independence, choice, control, personal appearance and dignity
- to be free from discrimination
- to not feel a ‘burden’ and continue as a caregiver where appropriate are all important to older people

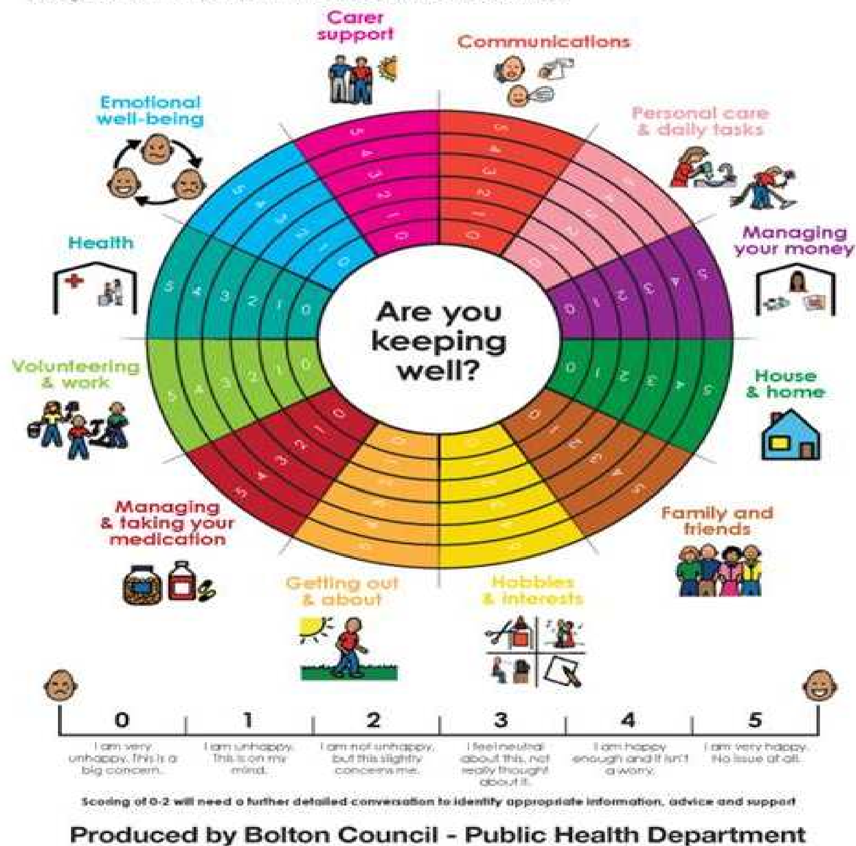
This scheme focuses on wellness and the factors that our residents value.

The service model has been shaped by evidence, national policy direction, learning from practice and evaluation from a pilot Staying Well project delivered in a neighbouring economy Bolton, an Older People’s Health Screening Pilot Project in Bury, and a Health and Wellbeing Check for older people delivered in Stockport. The Bury Staying Well Project combines elements of all these and builds upon them to develop a model and approach that fits with the Bury context.

The model will adopt a range of tools in its implementation. For example, it will utilise an evidence-based Staying Well Quality of Life Wheel (see overleaf). This was developed following a comprehensive literature review which sought to identify modifiable factors that were associated with an increased risk of entering residential or nursing care. The Wheel was also informed via a stakeholder consultation which sought the views of older people and professionals working with older people on the most important themes. It is designed in a visually appealing way to provide a tool to enable the client and Wellbeing Coordinator to engage in a holistic conversation about the client’s current quality of life, with the view of preparing the client to think about their potential future needs. The Wheel is currently being piloted as part of a 'social prescribing' offer for older people in our early demonstrator site at Radcliffe.

Evaluation of a pilot in our a neighbouring area of Bolton showed the take up rate for the service was 69%, which suggests significant customer demand. The greatest level of unmet need was around health-mainly pain, multiple physical health needs, sleep, breathing, physical activity and skin issues. The most positive impacts in terms of outcomes were around

improving confidence and feeling better able to cope with life. 98% of clients rated Staying Well as either good or very good. A total of 67% of clients said the project had helped them to maintain their independence. Through review of actions around goals set, 38% related to health or healthcare including referral to GP, long term conditions team, IAPTs, audiology and dental services. Contacting voluntary groups was involved in 16% of actions such as CAB, Age UK, and Carers Support thus demonstrating the utilisation of community assets rather than statutory services. A previous Older People's Health Screening (OPHS) Project in Bury showed merits in screening for hearing, foot problems, visual impairment and depression. Whilst the cost benefit analysis of the Bolton Pilot has yet to be published, the emerging evidence suggests this form of early intervention will have a significant impact on Adult Social Care and Health Service demand in the medium to long term. This scheme seeks to build the local evidence base around impact and outcomes and a model for identification and implementation that is locally focused.



Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Borough wide costs estimated at £374k for targeted Early Intervention Scheme - Staying Well.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Given the medium term nature of this scheme, its impact is assumed to be low in relation to BCF metrics for 2015/16 and is identified below.

This scheme has potential to impact on reductions in residential care admissions, avoidable emergency admissions, injurious falls, support reablement and improve patient experience as detailed in the table below. The metrics mapping exercise that relates to all of the schemes is available in part 1, appendix 1.

		Metric 1 - Residential Admissions		Metric 2 - Reablement		Metric 3 - Delayed Transfers of Care		Metric 4 - Avoidable Emergency Admissions		Metric 5 - Patient experience	Metric 6 - Local metric - Falls	
Scheme ID	**Scheme Description**	%	Nos of people	%	Nos of people	%	Nos of people	%	Nos of people	%	%	Nos of people
BCF01	Staying Well	10%	1	0%	0	0%	0	5%	49	20%	5%	2

At a population level, this scheme will support a range of measures variously across the NHS, Adult Social Care and Public Health Outcomes Frameworks. These include:

- Health related and social care related quality of life (NHSOF/ASCOF)
- Proportion of people feeling supported to manage their own condition (NHSOF)
- Proportion of people still at home 91 days after discharge from hospital into reablement/intermediate care (NHSOF/ASCOF)
- Improving people's experiences of integrated care (NHSOF/ASCOF)
- Proportion of people who use services who report they had as much social contact as they would like (ASCOF/PHOF)
- Permanent admissions to residential and nursing care (ASCOF)
- Fuel Poverty (PHOF)
- Perceptions of safety (PHOF)
- Falls and falls injuries in over 65s (PHOF)
- Flu Vaccination coverage (PHOF)
- Excess winder deaths (PHOF)
- Dementia and its impacts (PHOF)

Previous research from meta−analysis has demonstrated that Comprehensive Geriatric Assessment applied to the general older population followed by multi-factorial intervention leads to a mean 14% reduction in nursing and residential care home admissions (Beswick et al, 2008). It is expected that Bury's Staying Well Scheme will prevent avoidable emergency admissions and subsequent episodes of social care and reablement, including permanent

admissions of older people to residential and nursing care. Prevention of falls is integral to the Staying Well Check utilising an evidence based Falls Risk Assessment Tool (FRAT) which assesses risk of falls in the next 12 months on the basis of the FRAT score.
This will further support delivery against our local metric of a reduction in injurious falls in our 65+ population.

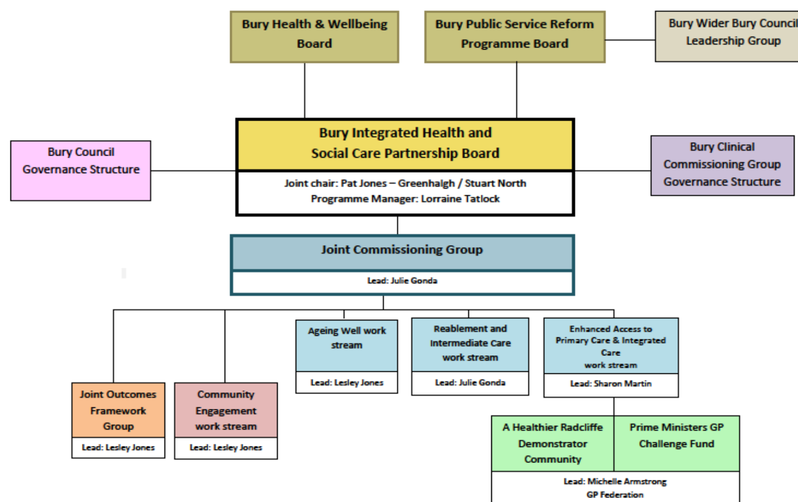
In Bury, there are 31,602 people aged 65 and over registered with a Bury GP practice. Our approach to population segmentation using the CPM applied to the 65+ population shows that 93% sit within the low or moderate risk categories. This scheme seeks to reach this cohort. In year 1 it will target 9 GP practices where >20% of their list are aged 65 and over - a total 65+ population of 13,141. Around 7% of Bury's over 65 population, falls within the high to very high CPM risk categories and would be excluded from this scheme. Applying this exclusion criteria to the registered 65+ population of those GP practices, would result in a sample frame of 12,221, prior to the application of further exclusion criteria. Based on capacity, we estimate that in Year 1 a Staying Well offer will be made to 20% of this eligible cohort - a total of **2,444.**

As a preventative scheme, Staying Well will impact on the projected 3.5% reduction in non-elective admissions. Although this is difficult to quantify, the likely impact across all metrics is articulated on page 8.

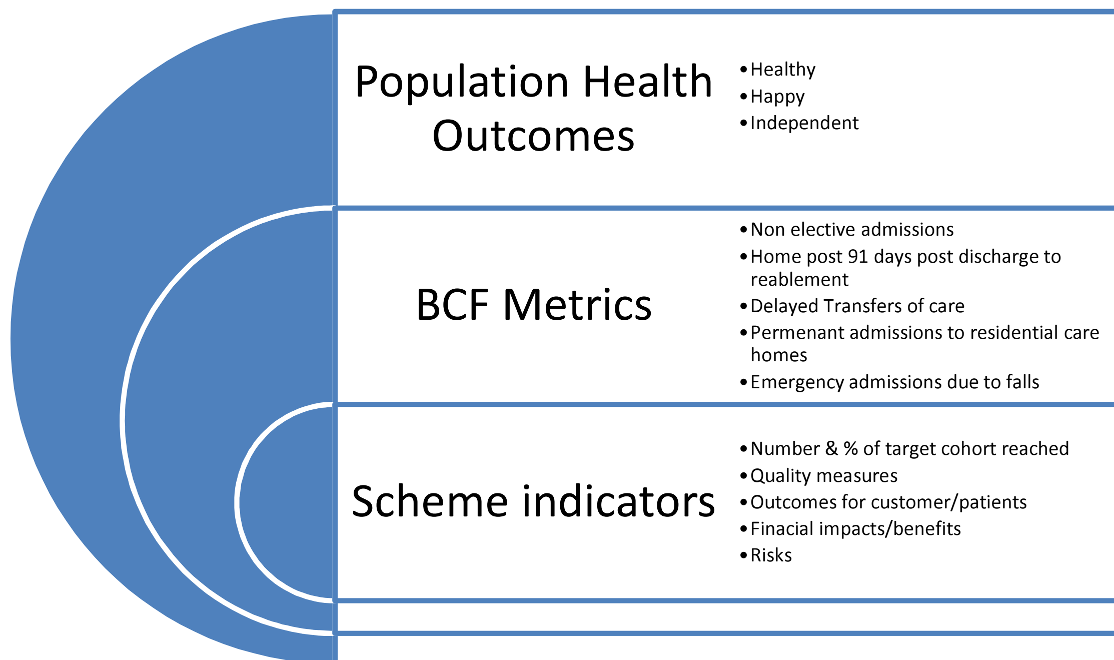
Further likely impacts include:

- More uptake of screening
- More pharmacy reviews for new medicines
- More people losing weight, stopping smoking and reducing alcohol intake
- Fewer people admitted to hospital due to alcohol
- Increased percentage of eligible people being vaccinated
- Better availability and access to psychological therapies
- Less loneliness & social isolation among older people
- More carers who are able to maintain their quality of life
- More homes meeting the decent homes standards in each borough
- Increased knowledge and awareness about keeping healthy and maintaining good wellbeing Increased personal responsibility and independence
- People will experience improved physical and mental health and wellbeing
- Increased utilisation of community assets as appropriate

Evidence from the Bolton pilot of Staying Well showed that the greatest level of unmet need was health-related. In addition, 67% of clients stated the programme had helped them to maintain their independence.

Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Governance Structure This Better Care Fund scheme is project managed by a scheme lead who reports to the Joint Commissioning Group via the ageing well workstream. The Joint Commissioning Group reports to the Integrated Health and Social Care Partnership Board and subsequently to the Health and Wellbeing Board as shown in the structure below. **Bury Integrated Health & Social Care Governance Structure**    Bury Health & Social Care Partnership Board are in the process of developing a Joint Outcomes Framework through which to monitor the impact of work-streams including the Better Care Fund Schemes on the health and social care system and ultimately on the health of our population. This work is being taken forward by the Joint Outcome Framework Group comprising performance and intelligence specialists from Public Health and Adult Social Care within the Local Authority and the CSU on behalf of the CCG.

The Outcomes Framework



Population Outcome measures

We are clear that health and social care integration is a means to an end and not an end in itself and that whilst there is an immediate focus around creating a financially sustainable system, this can only be achieved in the longer term if we create a system which improves the health and wellbeing of our local population and reduces the need for treatment services.

We have therefore agreed a set of indicators through which we can determine whether our work has a positive impact on people's health, wellbeing and independence.

The embedded document outlines the measures agreed and associated data sources and gives the current picture for Bury against each indicator.

JOF overarching indicators June 14 v2

Better Care Fund Metrics

The Better care Fund metrics provide us with more immediate feedback on whether the work we are doing is driving the system changes that we are aspiring towards. We are building on work undertaken by Greater Manchester CSU on developing a performance dashboard for the Healthier Radcliffe Demonstrator and the Non Elective Story Board (see embedded document) to develop a single whole Borough , whole system dashboard incorporating the BCF metrics using software recently purchased by the Local Authority.

As an interim whilst the dashboard is developed, we will be collating current performance reports on the different metrics to create a single monthly report provided to the Joint Commissioning Group, Provider Partnership Group and Health & Social Care Integration Partnership Board.

NEL.xls

Scheme indicators
The indicators for this scheme are set out below. The key indicators on progress will be incorporated into the above dashboard in time. Meanwhile monthly progress reports will be collated and provided to the Joint Commissioning Group and Provider Partnership with exception reporting to the Health & Social Care Integration Partnership Board. This robust governance structure is described in part 1 section 4b.

A service database will capture a range of data for a monitoring and evaluation framework. Monthly results in terms of activity and outcomes will be presented to a Project Steering Group which will oversee the progress of the scheme and consider its effectiveness. Specific components to support monitoring and evaluation will be:

- **Uptake of the scheme will be monitored, including demographics**

- **Results from the Health and Wellbeing Check Questionnaire**

- **Outcomes: Quality of life Wheel Scores**
    - The Wellbeing Coordinator helps the client to identify areas of concern for them, and they jointly agree and set actions intended to improve these areas of concern. The Staying Well Check tools, including the Quality of Life Wheel, are used to inform this discussion. The Quality of Life Wheel is then repeated on client sign off to check for changes, together with an evaluation questionnaire asking about changes that have happened to clients since they have been involved with Staying Well.

    - To focus on the clients who were in need of further support, the initial and sign off Wheel Scores of those clients who rated at least one theme as 0-2 (indicating a potential cause for concern) will be examined to determine a positive improvement across all the categories in which they initially had concerns or otherwise.

- **Outcomes: Exit questionnaire**
    - On sign off, clients will be asked to complete a questionnaire asking about the impact they feel that Staying Well has made on their lives across a range of potential outcomes, as relevant to individual clients

- **Outcomes: Client Actions**
    - The co-ordinators and clients set goals together. Reviewing their completions or otherwise will also enable assessment of outcomes. Referrals to voluntary and community sector services can also be monitored through this method.

Risks

Risk associated with the delivery of the Better Care Fund Plan and associated schemes have been identified in the Risk Log in Part 1 Appendix 3.

Any risks that may affect the delivery of this and other Better Care Fund Schemes will be raised with the Joint Commissioning Group as part of the regular reporting of the performance of the schemes. Mitigating actions will be undertaken to reduce the likelihood of the risk arising or to address the risk. If this is not possible and potentially means that plans could go off track, then this will be escalated to the Integrated Health & Social Care Partnership Board.

What are the key success factors for implementation of this scheme?

- Engagement of GP practices
- Information sharing agreements for Health and Wellbeing Co-ordinators with GP Practices to enable access to practice registers
- Employing the right people with conversational, engagement and motivational skills
- Taking time to engage and form a relationship with clients and support for their behaviour change

ANNEX 1 – Detailed Scheme Description

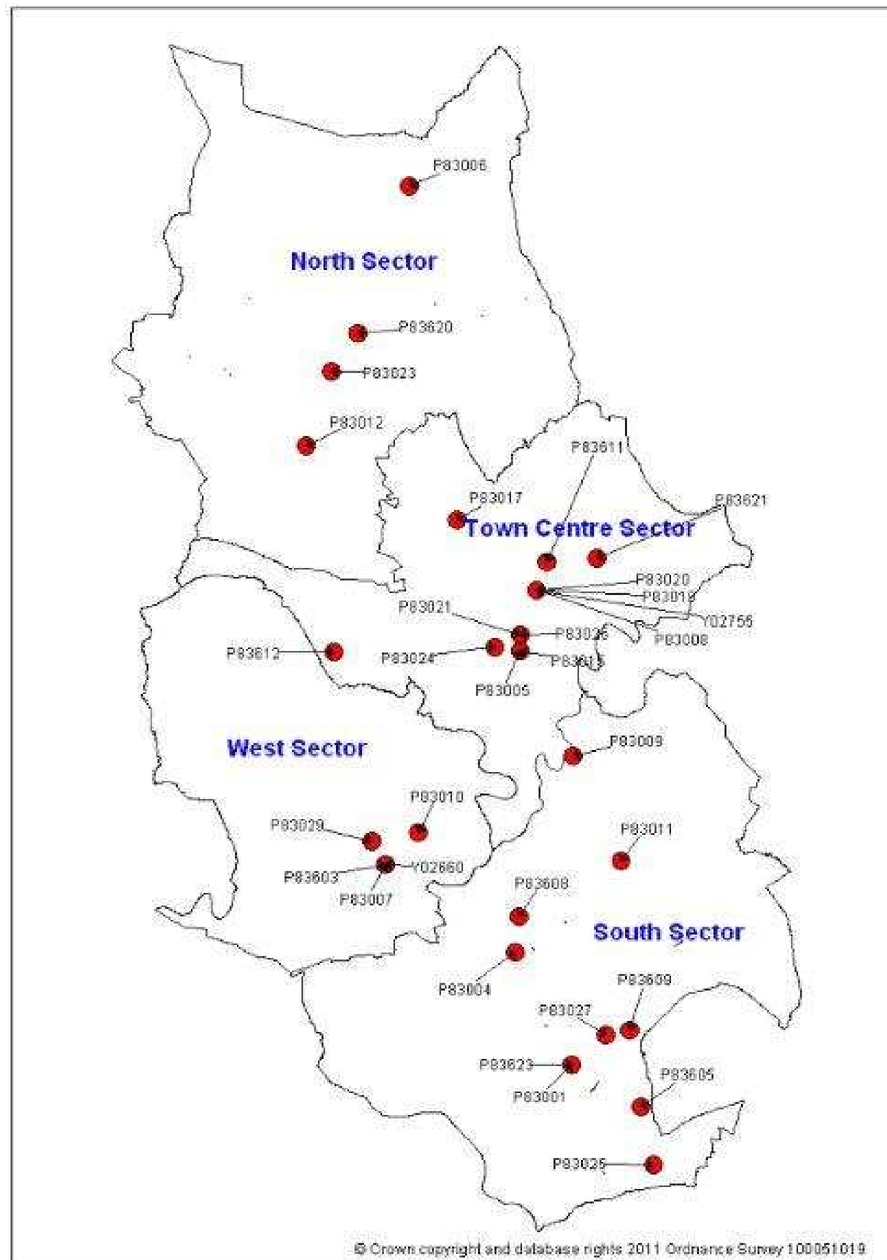
SCHEME 2

Scheme ref no.
Bury BCF 02
Scheme name
Extended Access to Primary Care
What is the strategic objective of this scheme?
The key strategic objectives for this scheme are: • To extend access to General Practice over 7 days a week. This will be achieved via the roll out of the Prime Ministers Challenge Fund. • Place greater emphasis on primary and community care and reduce risk and incidence of crisis or emergency admissions to hospital As explained in Part 1, our Health & Wellbeing Strategy is underpinned by 4 key principles which are at the core of all we do. This scheme directly links to each of these core principles: • Promoting prevention, early intervention and self care • Reducing inequalities in health and wellbeing • Developing person-centred services • Planning for future demands The strategic objectives for this scheme also support the delivery of the Better Care Fund's five priorities: • Ensuring a positive start to life • Encouraging healthy lifestyle and behaviours in all actions and activities • Helping to build strong communities, wellbeing and mental health • Promoting independence of people with long term conditions and their carers • Supporting older people to be safe, independent and well

Overview of the scheme
This is a good example of co commissioning between the GP Federation, NHS England and Bury CCG. **Extending Access to Primary Care** Bury is one of 20 Prime Ministers Challenge Fund national pilot sites. Led by the GP Federation the 6 practices that form Bury CCG west sector are currently delivering extended access as part of the national pilot. Bury CCG in partnership with the GP Federation and GP practices has defined a structured model for the roll out of extended access across remaining three sectors in Bury. Through a staged approach all 192,000 registered patients in Bury will have extended access to General Practice by 2015/2016.
This will be complemented by a further Better Care Fund Scheme, BCF 03 which aims to develop integrated health and social care services that complement and wrap around extended access to General Practice. Given the extended opening of GP practices this will also increase the ability for opportunistic falls screening for older people. The structured approach across Bury sees the extended access to General Practice scheme being delivered via four specific projects:- **Project 1 - Extended Hours** Extended access to General Practice in Bury will deliver: • Extended weekday opening (8am to 8pm) • Saturdays and Sundays (8am to 6pm) • All services available locally but not in every GP practice • Every patient's notes available to the GP providing cover during extended hours • Reducing likelihood of people needing to go to hospital • Making it easier for those who work or have school age children to avoid disrupting their working/school day • Easier for families to attend with elderly relatives From December 2014 this project rolls out to all 33 GP practices in Bury as shown in the list of practices below. The project was initially rolled out in the West Sector of Bury. The West Sector of Bury encompasses six GP practices covering 3 local authority wards that make up the local authority Radcliffe Township of Bury. The GP registered population for these six practices is 34,162. Extended access in Radcliffe commenced in September 2013, the six GP practices are currently delivering extended access to General Practice, weekday opening (8am to 8pm) and Saturdays and Sundays (8am to 6pm). The service is delivered from a central point in Radcliffe, the Radcliffe Primary Care Centre. From December 2014, additional practices in Bury will be offering a similar service, weekday opening (8am to 8pm) and Saturdays and Sundays (8am to 6pm). The service will also be delivered from central points in each locality.

North (North Sector)	South (South Sector)
P83006-Ramsbottom Medical Practice	P83001-Fairfax Group Practice
P83012-Tottington Medical Practice	P83004-The Uplands Medical Practice
P83017-Woodbank Surgery	P83009-Blackford House Medical Centre
P83023-Greenmount Medical Centre	P83011-Unsworth Medical Centre
P83620-Garden City Medical Centre	P83025-St Gabriels Medical Centre
East (Town Centre Sector)	P83027-Greyland Medical Centre
P83005-Ribblesdale Medical Practices (Subbiah)	P83605-Whittaker Lane Med Centre
P83008-Minden Medical Centre Practice No.1 (Shekar)	P83608-The Elms Medical Centre
P83015-Ribblesdale Medical Practices (Woodcock)	P83609-The Birches Medical Centre
P83019-Minden Medical Centre Practice No.2 (Deakin)	P83623-Longfield Medical Practice
P83020-Minden Medical Centre Practice No.3 (Saxena)	**West (West Sector)**
P83021-Peel GPs - Dr Jackson	P83007-Radcliffe Medical Practice
P83024-Knowsley Medical Centre	P83010-Monarch Medical Centre
P83026-Peel GPs - Dr Cleary	P83029-Spring Lane Surgery
P83030-Peel GPs - Dr Chacko	P83603-Red Bank Group Practice
P83611-Walmersley Road Medical Practice	P83612-Mile Lane Health Centre
P83621-Huntley Mount Medical Centre	Y02660-The Rlc Surgery
Y02755-Rock Healthcare Limited	

Please also see sector map on the next page.



The model for extended access sees the sector practices working together to provide a sector based service from central locations within each sector as follows:

- West Sector: Radcliffe Primary Care Centre
- North Sector: Tottington Medical Centre
- South Sector: Prestwich Walk-in Centre
- East Sector: Townside Primary Care Centre & Moorgate Primary Care Centre

Project 2 - Tele-consultations
The Tele-consultation project will:

- Assure that all patients who request an appointment are offered the option of a telephone consultation
- Increase the number of General Practices, currently about 35%, offering telephone consultation to patients
- Make better use of GP and patient time
- Offer patients choice as to whether they need to see the clinician face-to-face
- Release GP time for more appointments and reduce waiting times for appointments

Via the GP Federation, telephone guidance has been issued to all member practices. Practices are now enabled to start to operate / change procedures to offer alternatives to 'face to face consultation'. An incentive scheme has been agreed which aims to encourage practices to offer patients greater choice and flexibility in how they access/interact with GP services.

To further support the roll out across Bury a practice 'buddying scheme' has been introduced to support the adoption and implementation of the new telephone consultation guideline. The 'buddying scheme' aims to bring practices across Bury together to share/promote good practice in the delivery of telephone consultations.

Project 3 - Increased Online Access
The increase online access project will:

- Increase the use of online services
- Enable patients who register to make appointments or re-order prescriptions online
- All practices in Bury are enabled for online access
- Improve online registration. Increasing registration will significantly widen access
- Extend services available to patients over time including having access to health records and the ability to 'email' their GP

'How to guides' have been developed to aid practices to run targeted initiatives and to manage the new vision online system (VOS) process effectively.

Project 4 - GP Comparison Website
The GP comparison website project will deliver:

- A website to enable patients to make better choices about GP services
- Enhancement to current websites which offer limited information to patients
- A website which will offer information in a detailed and searchable form, modelled on successful comparison-style sites used elsewhere
- A website which will enable patients to search for staff availability, service availability, staff expertise, etc will show information for all relevant practices in Bury

The delivery chain
Bury Clinical Commissioning Group and NHS England are lead commissioners for ensuring delivery of extended access to General Practice over 7 days a week. Bury CCG are the lead commissioners for ensuring reductions in emergency admissions to hospital. The CCG has a lead clinician for Urgent Care and the reduction of emergency admissions is within the Urgent Care work plan. In order to deliver this there are a host of local providers that all have a part to play, these include: • Bury CCG Clinical Lead • Bury GP Federation • All Bury GP Practices • Bury Local Authority • Pennine Care Foundation Trust (Community) • Pennine Care Foundation Trust (Mental Health) • BARDOC • Pennine Acute Hospital Trust • North West Ambulance Services • Bury Pharmacists • Bury Carers Centre There is also an infrastructure of reporting and meetings to support delivery which is described in the feedback loop section of the document. The other key components in the delivery chain for this scheme are the other schemes detailed in this plan, in particular, Integrated Teams and Care of Vulnerable Adults.
The Evidence Base
National Evidence The national direction of travel for extended access in GP services has seen a £50m investment in pilot sites via the Prime Minister's Challenge Fund. NHS England commissioned the National Institute for Health Research to perform an interim evaluation which reported in June 2014. This evaluation focussed mainly on the progress of sites in establishing arrangements. The 20 national sites are currently being nationally evaluated by the company MotMacDonals for NHS England to assess impact. **Greater Manchester Evidence** The 5 year strategy for primary care in Greater Manchester states a commitment to: • commission quality health services delivered as close to home as possible • delivering transformed out of hospital care for all • improving access to General Medical Practice and • delivering services that support people to retain independence It also sets key primary care commitments to: • the production of transparent, publicly available benchmarking data

- services where patients have choice, access to their own records and to accessible information in order to work as partners with professionals to manage their health
- easy access to high quality, preventative primary care including rapid response to urgent needs so that fewer patients reach crisis

The scheme moves the health community in Bury closer to all of the above aims and either directly or by the creation of a firm platform on which to build more integrated services, thus preparing the way for a much greater shift of services from hospitals into our community.

A more flexible offer around general practice offers particular benefits to older people enabling them to have quicker appointments and making it easier for family members to attend them when visiting their General Practice.

Through greater use of online access, people will have a greater stake in their own care and will move towards the ambition of sharing with professionals. They will be able in time to access their care records and to have greater access to online services as these are developed centrally. More accessible information on care options will empower patients to make informed choices about their general practice service provider.

Local Evidence
As Bury is one of the national demonstrator sites for Extended Access, the emerging impact in Bury is already beginning to be evidenced. Whilst the national evaluation is important, Bury CCG has worked with the GP Federation to agree a set of monthly measures. These local measures will be extended to track progress in more detail for the other three sectors in 2015/2016.

The extended hours sessions are being well utilised and the latest available monthly measurement performed by the CCG, as at November 2014, is beginning to evidence an impact on Non Elective Activity in Radcliffe as follows:

- A&E attendances down by 2.52%
- A&E minor attendances down by 2.87%
- Non elective admissions down by 3.16%

Full details can be seen in the Healthier Radcliffe Dashboard attachment in the feedback loop section below. Although not all the local measures are currently achieved it is anticipated that further improvements will be reported.

By April 2015 it is planned to have the same level of local monthly measurement in place for all four sectors.

Bury CCG are in discussions with NWCSU to develop a local extended access evaluation. This will incorporate the current local monthly measures. The full parameters for the evaluation are currently being discussed. It is planned to see this evaluation presented to the CCG no later than November 2015. This will then inform future commissioning plans for extended access into 2016/17.

It is anticipated that this evidence will become more sustained and substantial when the BCF projects, BFCO3 and BCFO4 are fully operational.

Investment requirements

Extended access to Primary Care - £1,240K per annum.

Impact of scheme

The Extended Access to Primary Care scheme will help to deliver against each of the six Better Care Fund Metrics. The impact is most significant for reablement, avoidable emergency admissions and patient experience as detailed in the table below. The metrics mapping exercise that relates to all of the schemes is available in part 1, appendix 1.

		Metric 1 - Residential Admissions		Metric 2 - Reablement		Metric 3 - Delayed Transfers of Care		Metric 4 - Avoidable Emergency Admissions		Metric 5 - Patient experience	Metric 6 - Local metric - Falls	
Scheme ID	**Scheme Description**	%	Nos of people	%	Nos of people	%	Nos of people	%	Nos of people	%	%	Nos of people
BCF02	Extended access to Primary Care	10%	1	25%	2	5%	13	30%	296	20%	5%	2

As illustrated above in the six Radcliffe practices the following reductions have been seen:

- A&E attendances down by 2.52%
- A&E minor attendances down by 2.87%
- Non elective admissions down by 3.16%

There is an expected significant impact on avoidable emergency admissions as patients in Bury become increasing confident in evening and weekend primary care services. Equally the enhanced confidence in local services should flow through to improve patient experience scores. When fully operational across all sectors extended access will deliver an additional 1,425 appointments per week and equity of access, available to all Bury residents.

As extended access will be supported by a number of wrap around schemes via the Integrated Health and Social Care Teams scheme it is expected that this will also significantly help to deliver against the reablement metric

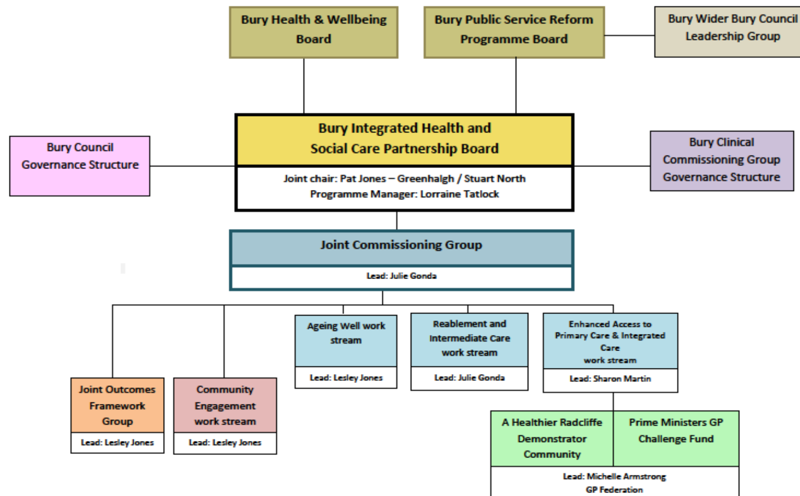
Feedback loop

Governance Structure

This Better Care Fund scheme is project managed by a scheme lead who reports to the Joint Commissioning Group via the Enhanced access to primary care and integrated care

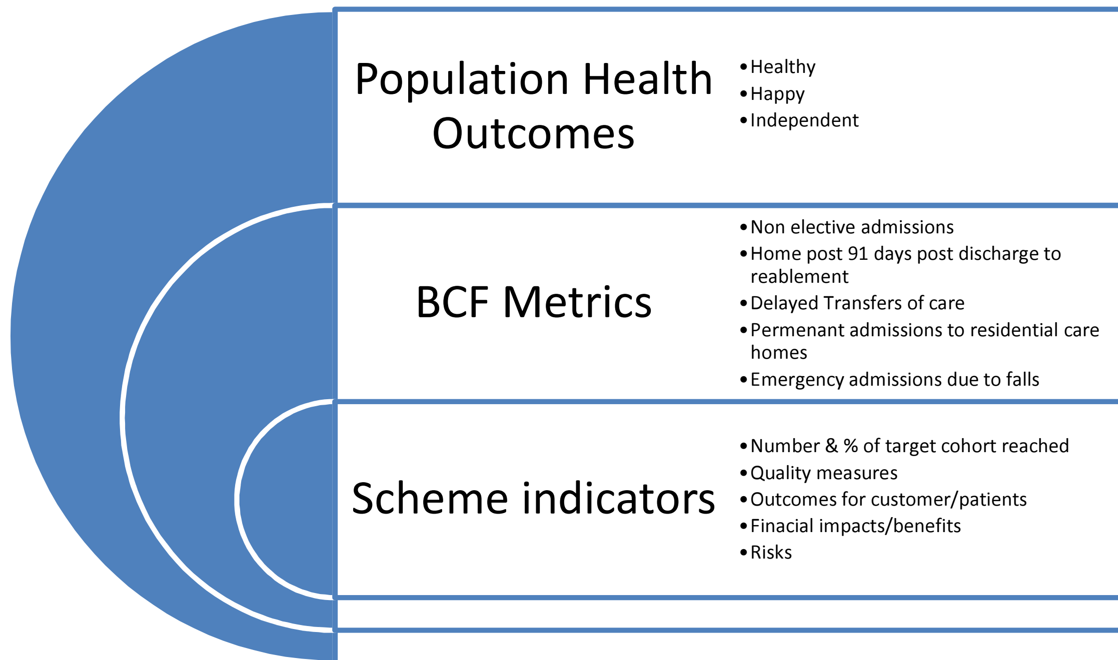
workstream. The Joint Commissioning Group reports to the Integrated Health and Social Care Partnership Board and subsequently to the Health and Wellbeing Board as shown in the structure below.

Bury Integrated Health & Social Care Governance Structure



Bury Health & Social Care Partnership Board are in the process of developing a Joint Outcomes Framework through which to monitor the impact of work-streams including the Better Care Fund Schemes on the health and social care system and ultimately on the health of our population. This work is being taken forward by the Joint Outcome Framework Group comprising performance and intelligence specialists from Public Health and Adult Social Care within the Local Authority and the CSU on behalf of the CCG.

The Outcomes Framework



Population Outcome measures

We are clear that health and social care integration is a means to an end and not an end in itself and that whilst there is an immediate focus around creating a financially sustainable system, this can only be achieved in the longer term if we create a system which improves the health and wellbeing of our local population and reduces the need for treatment services.
We have therefore agreed a set of indicators through which we can determine whether our work has a positive impact on people's health, wellbeing and independence.

The embedded document outlines the measures agreed and associated data sources and gives the current picture for Bury against each indicator.

JOF overarching indicators June 14 v2

Better Care Fund Metrics

The Better Care Fund metrics provide us with more immediate feedback on whether the work we are doing is delivering the system changes that we are driving towards. We are building on work undertaken by Greater Manchester CSU on developing a Performance dashboard for the Healthier Radcliffe Demonstrator and the Non Elective Story Board (see embedded documents) to develop a single whole Borough , whole system dashboard incorporating the BCF metrics using software recently purchased by the Local Authority.

As an interim whilst the dashboard is developed, we will be collating current performance reports on the different metrics to create a single monthly report provided to the Joint Commissioning Group, Provider Partnership Group with exception reporting to the Health & Social care Integration Partnership Board.

Healthier Radcliffe Pilot Dashboard - as a

NEL.xls

Scheme indicators
The indicators for this scheme are set in the attachments above and in the impact of the scheme section also above. The key indicators on progress will be incorporated into the above dashboard in time. Meanwhile monthly progress reports will be collated and provided to the Joint Commissioning Group, Provider Partnership with exception reporting to the Health & Social Care Integration Partnership Board.

As identified in part 1 section 4b, there is also a robust project level governance structure in place to receive reports and updates and to then develop mitigation plans where required for the extended access to General Practice schemes

With reference to this particular BCF scheme there are also additional board/meetings as follows:

Prime Minister's Challenge Fund Contract Board Meeting

- Chaired by NHS England, this board is attended by the GP Federation and the Bury CCG. This forum holds the GP Federation to account against delivery of the Prime Ministers Challenge Fund.

Bury Integration Group – A Healthier Radcliffe

- Chaired by the GP Federation, this group is attended by all the local stakeholders including the CCG Urgent Care Lead and the CCG Better Care Fund lead. The group receives updates and progress from the four stage two projects.

Bury GP Sector Meetings

- The local sector infrastructure will be the vehicle through which the roll out of the extended access and integrated health and social care teams will take place.

The Healthier Radcliffe Demonstrator Performance Dashboard will be further developed for the rest of Bury moving forward. There will also be a national evaluation of all PMCF schemes and Bury CCG is seeking a more detailed local evaluation for Bury.

Risks
Risk associated with the delivery of the Better Care Fund Plan and associated schemes have been identified in the Risk Log in Part 1 Appendix 3.

Any risks that may affect the delivery of the Better Care Fund Schemes will be raised with the

Joint Commissioning Group as part of the regular reporting of the performance of the scheme. Mitigating actions will be undertaken to reduce the likelihood of the risk arising or to address the risk.If this is not possible and potentially means that plans could go off track, then this will be escalated to the Integrated Health & Social Care Partnership Board.

What are the key success factors for implementation of this scheme?

The delivery of extended access in Bury is being driven by Bury CCG, the GP Federation and supported by NHS England via the Prime Minister's Challenge Fund. The key success factors are:

- Delivery of extended access to GP Services over 7 days a week
- Robust governance in place
- GP engagement
- Patient awareness
- Changes in traditional behaviour patterns
- Management of risk via risk register and regular contact with schemes in-between meetings

ANNEX 1 – Detailed Scheme Description

SCHEME 3

Scheme ref no.
BURY BCF 03
Scheme name
Integrated Health and Social Care Team
What is the strategic objective of this scheme?
The integrated care system will support frail older people, children and people with Long Term Conditions in their own homes to manage their long terms conditions effectively providing care closer to home and a coordinated multi-disciplinary response for a targeted population. Linking to the extended access scheme, this scheme will place greater emphasis on primary and community care and reduce risk and incidence of crisis or emergency admissions to hospital. As explained in Part 1, our Health & Wellbeing Strategy is underpinned by 4 key principles which are at the core of all we do. This scheme directly links to each of these core principles: • Promoting prevention, early intervention and self-care • Reducing inequalities in health and wellbeing • Developing person-centred services • Planning for future demands The strategic objects for the Integrated Health and Social Care scheme also support the delivery of the four of the five Better Care Fund priorities: • Encouraging healthy lifestyle and behaviours in all actions and activities • Helping to build strong communities, wellbeing and mental health • Promoting independence of people with long term conditions and their carers • Supporting older people to be safe, independent and well
Overview of the scheme
Four bespoke schemes are being piloted via A Healthier Radcliffe, Stage Two. Scheme 1 - Prevention and early intervention task team Scheme 2 - Targeted Frail Elderly MDT with care co-ordination and reablement Scheme 3 - Community Paramedic Service

Scheme 4 - Domiciliary medicines optimisation service

It is intended that the learning from these four pilots will help to inform the wider roll out of Integrated Health and Social Care Teams across Bury. These schemes will deliver coordinated health and social care services that will wrap-around the extended hours GP practices in Radcliffe with GPs holding accountability for all aspects of care. The model will facilitate the further development of integrated services and care plans and provide the blue print for the roll out of Integrated health & Social Care across the other three sectors.

Scheme 1 - Prevention and early intervention task team
Commenced in Radcliffe in November 2015, the provision of an Early Intervention Task Team identifies and supports families who do not meet the criteria for existing community services support. By having earlier contact it is hoped that the team will reduce the likelihood of needing support from statutory services. The team will include a Social Care Officer, Housing Officer and Health Trainers who will actively seek referrals through GP surgeries and make contact with families. At a Radcliffe scoping session it was identified that there are a number of families and individuals who would benefit from information, advice or signposting into other preventative services. This could include services such as health trainers, or the local “I will if you will” initiative, taking an active part in self-care etc. as well as other services such as IAPT and Age UK provision to support the social isolation agenda. The objectives of the team fit exactly to the aims of A Healthier Radcliffe in that they will:

- Ensure people take responsibility for their own health and well-being through self-care, ownership and accountability for their lifestyles
- Provide access to information and advice to help people understand what is available in the community and facilitate them taking ownership and accountability for their lifestyles
- Provide support which will involve the person's/family's natural circle of support and maximise the use of community assets
- Integrate to help facilitate services by providing the right workforce in the right place, at the right time
- Identify and sign post carers for assessments and support services to enable them to continue in their role
- The team will be focused specifically on frail older people and people with long term conditions as well as children in complex families
- They will work flexibly over seven days to support the community and individuals to understand what is available and access services to support self-care
- Through social prescribing, GP’s will signpost patients and their carers onto Health promotion services within the community. This in turn helps people manage their own health conditions and reduce the burden on GP’s and potentially A&E
- The team will have a co-ordination role for 3rd sector organisations in the patient’s community, to sign post and assess the difference these services are making

Scheme 2 - Targeted Frail Elderly MDT with care co-ordination and reablement
Commenced in Radcliffe in November 2015, this team will aim to support frail elderly people to manage their LTCs effectively in the community, reducing the risk and incidence of admission or crisis. This multi-disciplinary team led clinic for Frail Older People will assess the needs of

patients on an individualised basis, ensuring that both primary, secondary and NWAS care plans are in place and are linked. The aim is to make every attempt to maximise the health and self-management of the patient, and therefore reduce the risk of potentially avoidable A&E presentation and emergency admissions. If these are unavoidable the MDT clinics will ensure that secondary care interventions are targeted, appropriate and timely, and support the primary care plans in place, thus minimising the risk of further harm.

The scheme also sees the creation of an additional Reablement worker and the widening of reablement and community nursing teams which are aligned to the six GP practices in Radcliffe. The Reablement worker will work closely with the GP practices and current Care Coordinator to target individuals and their families who are at risk of their health deteriorating without targeted intervention. The Reablement worker and current Care Coordinator will work closely and proactively with the GP surgeries, NWAS and secondary care to target individuals and their families who are at risk of their health deterioration without targeted health and social care intervention.

It is also proposed that the MDT Frail Older People clinics will link into a pilot assessment scheme within secondary care (see Scheme 3 below) which will assess all 65+ Radcliffe patients who have been admitted as an emergency, against an agreed Frailty Risk Assessment Tool. This will be done with the Care Coordinator and Reablement worker so Frail Older People under the Care Coordinator and Reablement worker can be referred to the clinic. The Frailty Risk Assessment Tool will establish the patient's recent baseline, and agree, with all care agencies, a target status for the patient, when discharge is optimal. This agreed plan will link into the primary care management plan and will ensure that clinical care and diagnostic investigations are measured and appropriate for the target statuses of the patient concerned. This individualised approach will ensure that the clinical teams, the patient, family and other supporting agencies are all clear about the management plan for the patient in question and this will aid timely and appropriate discharge, and aim to reduce the potential of re-admission. Holistic assessment and care planning are an essential part of Scheme 2 which will see the Care Coordinator, Reablement worker and wider MDT working together as a team to provide targeted interventions which will aim to keep those frail elderly people most at risk of crisis at home and managing their health conditions.

Some of the proposed operational arrangements are as follow:

- All service users discussed at the MDT meetings and MDT clinic will have been assessed as appropriate for discussion, either by the GP, Care coordinator, secondary care clinician, Reablement worker, NWAS referral or Discharge Champion
- It is envisaged that this MDT clinic would involve partners for primary, secondary and social care with close links to other services such as crisis response teams, out of hours GPs, NWAS, care home providers, patients and next of kin/carers
- The MDT clinics could be virtual and make use of innovative technologies to aid the engagement of so many different sectors involved in patients care, or they could be face to face
- The MDT will review the management plans in place and assess, with the wider care community (including the patient and carers) the effectiveness of current plans,

assessing against provider activity data, and then agree any modifications to plans

- Once agreed, the management plans will be communicated to all relevant care agencies and involved parties and an on-going assessment and review process will check their effectiveness
- The MDT would be supported and managed through the Care Coordinator and dedicated administrative support worker. One of the reasons why the MDT approach has not worked in some areas is because of a lack of co-ordination and administration of the process. It is suggested that the lead for identifying key patients to be presented at the MDT is the Care Co-ordinator through an administrative support worker, with the support of the reablement worker
- For those service users deemed most at risk, Scheme 2 will see targeted health and social care interventions. These will be provided by the Care Coordinator and the Reablement worker. The Reablement worker, is trained to assistant practitioner level, and is able to provide therapy support to individuals, undertake health checks, assessments for equipment etc. It is felt that these skills will be beneficial to support the Care Coordinator for patients who are at risk of crisis or deterioration of their health condition but have presenting needs and factors impacting on their health that are predominantly social care
- Targeted intervention will include reablement support; facilitate access to Intermediate Care
- The process will also support the navigation and input of wider health and social care services to meet the individual's identified needs
- The out of hours Reablement worker will link with existing out of hours services for support if there is an urgent healthcare need, including OOH Community Nursing team and the Crisis response service
- The wider reablement and crisis teams will support the reablement worker and care coordinator and will work across the extended hours, seven days per week to complement the existing care co-ordinator for Radcliffe who works 9-5, Monday-Friday

Scheme 3 - Community Paramedic Service

By placing a Community Paramedic to serve a locality catchment area effective care will be tailored by a local Paramedic meeting the local population's health needs alongside health & social care partners, in effect bringing the Paramedic back to the Community.

The Community Paramedic in Radcliffe became operational on 5th January 2015, 10am – 6pm responding to the lower acuity green calls emergencies. These are the calls that are more likely to be dealt with leaving the patient safely at home with either a self-care pathway in place or by a GP attending the patient through the GP referral scheme.

The Community Paramedic works closely with other health and social care professionals in the area to help identify and implement individual community care pathways which can be left at home with the patient. These contain patient's normal baseline observations and professional

network providers contact details. If the patient safely fits the pathways referral flowchart the patient can avoid admission to hospital and get the right treatment and care in the comfort of their own home.

The Community Paramedic could support the health & social care needs of the local 'Frequent Callers' utilising best practice developed by the NWAS Frequent Caller Team. The local healthcare economy in Bury has agreed additional funding for additional capacity to support the NWAS Frequent caller Team via System Resilience Monies. With the development of integrated working the Community Paramedic could mirror the successes on a more local basis and hone the skills associated with this element much more quickly due to the concentration of the area and team work.

As the resource will be a Rapid Response Car, the patients who will be attending hospital would largely be conveyed by a requested ambulance and therefore ensure that the Paramedic remains in the area of their responsibility.

Scheme 4 - Domiciliary medicines optimisation service

The service will enable the GPs, several pharmacists and social care providers in Radcliffe to work in a collaborative partnership to provide an innovative service to patients who have 2 or more long term conditions, aged 65 or over, who would benefit from a medicines optimisation review. The pharmacist will arrange an appointment and visit the patient in the comfort of their home. In total 200 medication reviews will be performed in Radcliffe by 31 March 2015.

All reviews will be delivered by a qualified pharmacist. This will include a documented review which includes adherence, adverse drug reactions, knowledge of medication, medicine optimisation, prescription ordering, wastage of medicines, out of date medicines, hoarding of medicines, and the requirement of compliance aids or other adjustments under the Disability Discrimination Act (DDA) will be completed. Cognitive Abilities Test (CAT) score, inhaler technique and smoking status and referral, if appropriate will all be included. Other appropriate measures of wellness will also be included.

Patients with long term conditions who collect their medication and visit the pharmacy are able to access pharmaceutical services. Medication reviews take place and the pharmacist is able to provide support to the patient to ensure they manage their condition effectively. Patients who are housebound, often frail elderly and suffering from long term conditions receive a two tier service. Whilst the pharmacist is able to provide ordering and delivery service for repeat medication and also supply compliance aids where necessary, no face to face contact or formal review takes place. This is where the role of the social care professional could prove to be beneficial, through a joint service which monitors medication compliance.

Visiting the patient at home and carrying out a documented medicine optimisation review will support people by promoting self-confidence and self-care and will have a more outcome focused approach to the joint planning and reviewing their care plan. The pharmacist medication review will consist of an integrated approach which will include feedback from social care staff putting the patient and their carer at the heart of the service:

- Understanding the patient's experience of taking the medicines
- Checking on inhaler technique, CAT score if applicable, this could also include those

patients where Social Care administer medication

- Highlighting potential adverse drug reactions and what actions should be taken by either the patient or their formal care agencies in responding to these
- Ensuring medicines are used safely as prescribed and recommended
- Review medication and making recommendations to the prescriber
- Checking the storage of medicines
- Checking the expiry date of medicines
- Ensuring no hoarding or sharing of medicines is taking place
- Reviewing that the patient therapy is being monitored
- Providing advice and counselling to patient, carer or professionals involved in support as appropriate
- Reviewing the current ordering arrangements of repeat prescriptions
- Placing appropriate patients on a repeat dispensing service
- Identifying where synchronisation of medication is necessary
- Carrying out a DDA assessment and reviewing any reasonable adjustments being made
- Validating the approximate cost of any medicine wastage
- Healthy lifestyle advice
- Smoking cessation referral , if appropriate
- Referring into Public Health schemes where appropriate
- Enhance local relationships between healthcare and Social care professionals
- Information from reviews could form part of the NWAS community care plan

Patients would take more ownership of their condition and be empowered to self-care. Pharmacists would use shared decision making and motivational interviewing skills to help patients become more in control of their lives.

The delivery chain

In order to deliver this scheme there are a host of local providers that all have a part to vital play, these include:

- Bury CCG Clinical Lead
- Bury GP Federation
- All Bury GP Practices
- Bury Social Services
- Pennine Care Foundation Trust (Community)
- Pennine Care Foundation Trust (Mental Health)
- BARDOC
- Pennine Acute Hospital Trust
- North West Ambulance Services
- Bury Pharmacists
- Bury Carers Centre

There is an robust infrastructure of reporting and meetings to support delivery which is described in part 1 section 4b.

The governance structure includes The Bury Integrated Partnership Board, The Bury Joint Commissioning Group and The Health and Wellbeing Board for this particular scheme it also includes:

Prime Minister's Challenge Fund Contract Board Meeting

- Chaired by NHS England, this board is attended by the GP Federation and the Bury CCG. This forum holds the GP Federation to account against delivery of the Prime Ministers Challenge fund.

Bury Integration Group – A Healthier Radcliffe

- Chaired by the GP Federation, this group is attended by all the local stakeholders including the CCG Urgent Care Lead and the CCG Better Care Fund lead. The group receives updates and progress from the four Stage two projects.

Bury GP Sector Meetings

- The local sector infrastructure will be the vehicle through which the roll out of the extended access and integrated health and social care teams will take place.

The other key components in the delivery chain for this scheme are the other schemes detailed in this plan, in particular, Extended Access and Care of Vulnerable adults.

The evidence base

Bury CCG is currently designing a set of measurement with the GP Federation for the four pilots in Radcliffe. Each scheme will have a defined set of metrics. As schemes only became operational in November 2014 and January 2015 there is no actual, directly reportable, evidence to date.

Once developed these metrics for Radcliffe will be added to the local dashboard already developed and inserted below in the feedback loop section. Similar measurement will be developed for the other three Bury sectors to track the impact of Integrated Health and Social Care as implemented.

There is a lot of wider evidence detailed below to indicate the value of pursuing the schemes detailed above.

The evidence around individual care plans

A care plan is a document owned by the person receiving care and their general practice. It should be co-created with them and set out their agreed year of care. For long-term conditions or for people whose conditions need regular management, having a proactive care plan is vital. The care plan should be wellness focused and should cover a comprehensive and up-to-date understanding of the persons' needs and circumstances[1].

[1] North West London – Whole systems integrated care toolkit, 2014

North West London Integrated care toolkit highlights the following key principles of an individualised care plan[2]:

- Focus on patients most at risk of hospitalisation
- Patients and carers own care plans with agreed goals
- Access to single electronic health record
- Information sharing across health and social care
- 7 of 11 published reviews which were analysed found a positive impact of assessing care plans[3]. Other studies have shown a reduction in hospitalisations by ~23%3.

Further evidence on individualised care plans:
- Graffyetal, Primary Health Care Research & Development, 2009,10(3), 210-222
- NHS England, Transforming participation in health and care 2013, http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc- guid1.pdf

The evidence around care coordination
Care co-ordination is the practice of having someone (not necessarily a clinician) co-ordinate the care received by an individual that has been designated as needing additional support. Typically, these are older people and those with chronic conditions who often represent 10-20% of the population and 30-70% of costs in the health and care system. There are several essential steps that are required to implement care co-ordination including the identification of individuals who would benefit from care co-ordination, the enrolment of those individuals into a programme, the development of care plans for those individuals and then on- going follow-up in line with the plan.

The evidence base highlights the following techniques:

- A holistic focus supporting self-care at home
- Single entry point to provide continuity
- Shared electronic health records
- Coordinating care at the neighbourhood level with engagement of local community
- Prioritising engagement with GPs and links with secondary care

8 out of 13 reviews, which were analysed, assessed care co-ordination and found a positive impact. Other reviews of literature have concluded that hospitalisations may be reduced by approximately 37%[4] Interventions involving care co- ordination have shown to reduce HbA1c (in patients with diabetes) by 22% more than interventions without care co-ordination[5]

[2] Ibid.
[3] North West London – Whole systems integrated care toolkit, 2014, pooled estimate only reported in 2 relevant reviews
[4] North West London – Whole systems integrated care toolkit, 2014, pooled estimate only reported in 2 relevant reviews
[5] Shojana et al, JAMA, 2006, 296(4), 427-440

Further evidence on care co-ordination:

- 'Case management: what it is and how it can be best implemented'
- 'South Devon & Torbay: Proactive case management using the community
- Virtual ward and the Devon predictive model'
- Goodwin N, SonolaL,Thie IV, Kodner D (2013).Co-ordinated care for people with complex chronic conditions. London: The King's Fund.

The evidence around case management

Case management focuses on the small proportion of the population (e.g. <5%) with much more intense needs than the population addressed by care co- ordination. Given these needs, a case manager is required who can help to actively manage the condition of a person. The evidence base highlights the following techniques:

- A focus on early action and prevention, targeted at particular communities to mobilise local people

- Community-based multi-professional teams based around general practices or groups of practices that promote close working and communication between staff in different organisations, for example, through co-location

- A single point of access, single assessment and shared clinical records

- Targeting individuals who are at high risk of future emergency admission to hospital, before they deteriorate, which requires access to good quality health and social care data

- The evidence base for case management is "promising but mixed' (Purdy, 2010). This is in part due to difficulty in attributing any positive changes to case management when there are multiple factors at play (for example, how to disentangle the effect of case management from any specific interventions that might be planned e.g. falls prevention, reablement, self-care)

Further evidence on case management:

- Ross S, Curry N, Goodwin N (2011). Case management: what it is and how it can best be implemented. London: The King's Fund.
- Challis D, Hughes J (2011) Intensive care / case management, PSSRU, Manchester
- Graffy J, Grande M, Campbell J(2008).' Case management for elderly patients at risk of hospital admission: a team approach'. Primary Health Care Research and Development, vol 9, no 1, pp 7–13

The evidence around multidisciplinary teams

Multidisciplinary teams (MDTs) bring together the relevant professionals needed to care for someone with complex needs. MDTs should include everyone required to look after the physical, mental and social health and care needs of the individuals they serve. The aim is to manage the complexity of individual cases and facilitate the delivery of the best possible care.

The evidence base highlights the following techniques:

- Multi-disciplinary teams
- MDT meetings about every person admitted to hospital
- Hire specialists to work in community settings rather than hospitals
- Expanded hours for GPs and coordinators
- Dedicated housing workers for SEMI/vulnerable groups
- Allow nurses or nurse practitioners to prescribe certain drugs
- Mental health liaison teams
- Direct phone/email access from GPs to Mental Health experts

Further evidence on MDTs:

- Hollandetal,Heart,2005,91,899-906
- Proactive care partnership
- http://www.sussexcommunity.nhs.uk/Downloads/services/proactive_care/proactivecare_coastal_leaflet.pdf
- Case study examples: NHS North West London, Torbay, Towers Hamlets

The evidence around community paramedic service
NWAS alongside Clinical Commissioning Groups (CCGs) has spent time putting provisions in place to safely manage patients in their home environment. These include Paramedic Pathfinder pathways, GP referral schemes and Community Care Pathways. In spite of this the average A&E attendance to admission ratio in urban areas across the North West is higher than the national average (Information from Ambulance CQI Data). The challenge is to reduce A&E attendances for those patients appropriate for treatment by alternative services.

Across Greater Manchester the team have identified 286 frequent caller patients since its inception in November 2013. 23 of those identified are resident in the Bury CCG yet due to the team's capacity only 10 of those patients are receiving interventions to support their needs. The success associated with those receiving interventions has been really positive, in both improving the patient's quality and reducing ambulance & A&E attendances. Data relating to April identify 10 identified Frequent Callers in the Bury catchment area that generated seventy-nine 999 calls in the preceding 28 days. Following intervention from the team the same group of patients generated twenty nine 999 calls, a 63% reduction in 999 calls.

The evidence around domiciliary medicines optimisation service
Medicines remain the most common treatment offered to patients, and dispensing prescriptions and supplying medicines safely is at the heart of what community pharmacy does and what patients expect.

The NHS spends over £13 billion on medicines with 80% of this in primary care. However, avoidable medicines wastage in primary care is estimated to be in the region of £150 million annually, an unacceptable situation that needs to be addressed.

- A partnership for Older People Project (POPP) financed by Dept of Health provided a reduction in overnight hospital stays by 47% and reduced A&E usage by 29% amongst the target group

- A US PACE (Programme for all inclusive care of the elderly) targeting frail older people and involving a multidisciplinary team , found a 50% decrease in hospital use, 20% decrease in nursing admission, patients used 16 fewer bed days. Patients took ownership of their health with 43% reporting good health and 72% a more satisfying life
- A pharmacy Domiciliary Review Service in Croydon conducted 2012/13 involving Medicine Use Reviews to 230 patients resulted in the avoidance of 130 emergency admissions. The cost avoidance cost was calculated at over 400k
- NICE reports that 30-50% of medicines are not taken as the prescriber intended, which means the patient does not get the full benefit of the treatment and the NHS does not get the full value of its investment

Apart from medicines wastage, not taking medicines correctly can have serious consequences for patients, as studies have found that up to 15.4% of hospital admissions were drug related and preventable; the commonest causes were prescribing and monitoring problems (53%) and non-adherence (33%). Waste medicines result predominantly from patients not taking medicines as intended (non-adherence).

Investment requirements

Integrated Health & Social Care - £2,372k per annum across all four sectors.

Impact of scheme

The Integrated Health Social Care scheme will help to deliver against each of the six Better Care Fund Metrics. This scheme will have a significant impact on residential admissions, reablement and avoidable admissions as detailed in the table below. The metrics mapping exercise that relates to all of the schemes is available in part 1, appendix 1.

		Metric 1 - Residential Admissions		Metric 2 - Reablement		Metric 3 - Delayed Transfers of Care		Metric 4 - Avoidable Emergency Admissions		Metric 5 - Patient experience	Metric 6 - Local metric - Falls	
Scheme ID	**Scheme Description**	%	Nos of people	%	Nos of people	%	Nos of people	%	Nos of people	%	%	Nos of people
BCF03	Integrated Health & Social Care	35%	2	30%	2	15%	39	30%	296	20%	20%	8

Bury CCG is currently designing a set of measurement with the GP Federation for the four pilots in Radcliffe. Similar measurement will be developed for the other three sectors to track the impact of Integrated Health and Social Care as implemented.

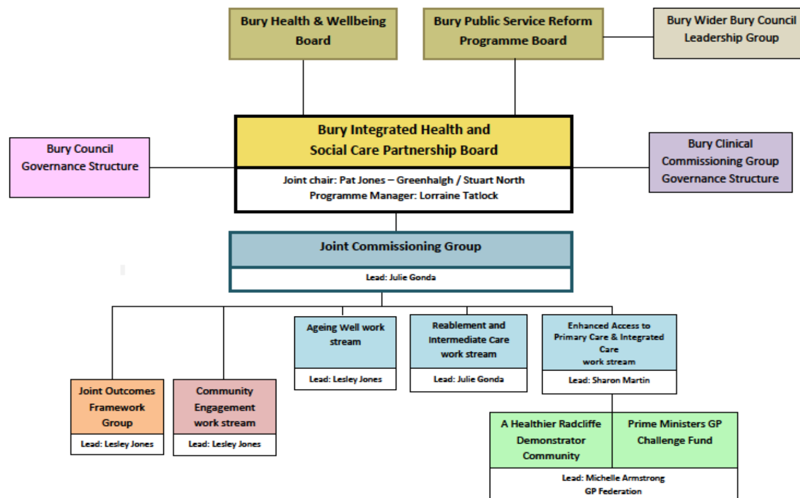
There is an expected significant impact on residential admissions as patients in Bury become increasingly supported by the additional services in the community. Equally as schemes begin to mobilise around extended access there is expected to be significant improvements against the reablement measure and reductions in avoidable admissions.

Feedback loop

Governance Structure

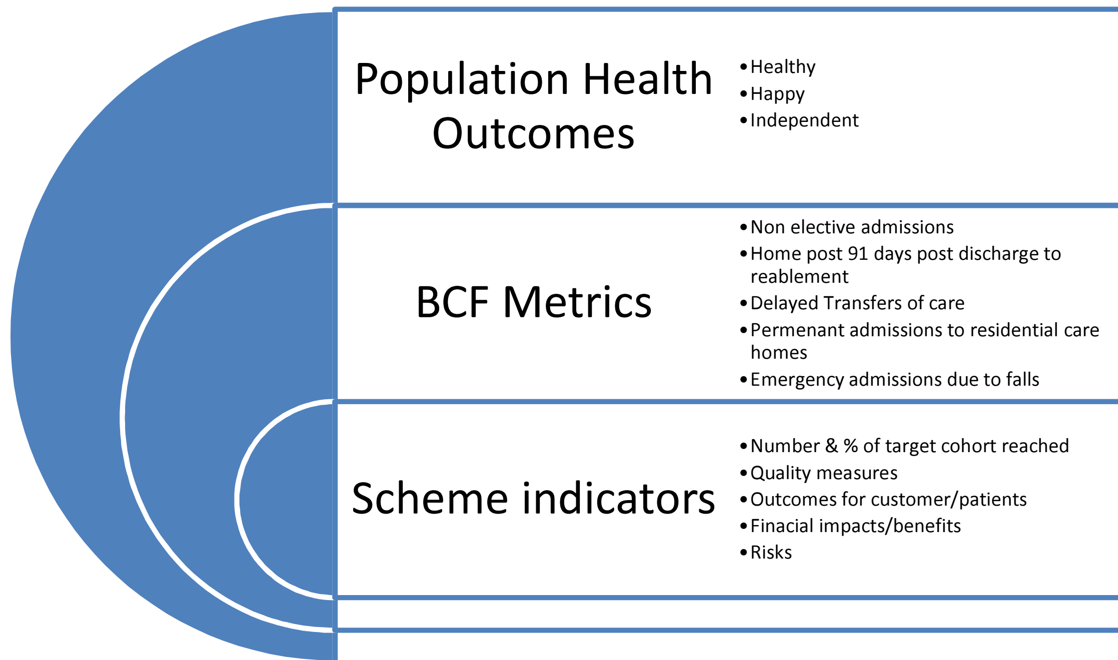
This Better Care Fund scheme is project managed by a scheme lead who reports to the Joint Commissioning Group via the Enhanced access to primary care and integrated care workstream. The Joint Commissioning Group reports to the Integrated Health and Social Care Partnership Board and subsequently to the Health and Wellbeing Board as shown in the structure below.

Bury Integrated Health & Social Care Governance Structure



Bury Health & Social Care Partnership Board are in the process of developing a Joint Outcomes Framework through which to monitor the impact of work-streams including the Better Care Fund Schemes on the health and social care system and ultimately on the health of our population. This work is being taken forward by the Joint Outcome Framework Group comprising performance and intelligence specialists from Public Health and Adult Social Care within the Local Authority and the CSU on behalf of the CCG.

The Outcomes Framework



Population Outcome measures

We are clear that health and social care integration is a means to an end and not an end in itself and that whilst there is an immediate focus around creating a financially sustainable system, this can only be achieved in the longer term if we create a system which improves the health and wellbeing of our local population and reduces the need for treatment services.

We have therefore agreed a set of indicators through which we can determine whether our work has a positive impact on people's health, wellbeing and independence.

The embedded document outlines the measures agreed and associated data sources and gives the current picture for Bury against each indicator.

JOF overarching indicators June 14 v2

Better Care Fund Metrics

The Better Care Fund metrics provide us with more immediate feedback on whether the work we are doing is delivering the system changes that we are driving towards. We are building on work undertaken by Greater Manchester CSU on developing a Performance dashboard for the Healthier Radcliffe Demonstrator and the Non Elective Story Board (see embedded documents) to develop a single whole Borough , whole system dashboard incorporating the BCF metrics using software recently purchased by the Local Authority.

As an interim whilst the dashboard is developed, we will be collating current performance reports on the different metrics to create a single monthly report provided to the Joint Commissioning Group, Provider Partnership Group with exception reporting to the Health & Social Care Integration Partnership Board.

Healthier Radcliffe Pilot Dashboard - as a

NEL.xls

Scheme indicators
The indicators for this scheme are set out in the attachments above and in the impact of the scheme, section, also above. The key indicators on progress will be incorporated into the above dashboard in time. Meanwhile monthly progress reports will be collated and provided to the Joint Commissioning Group, Provider partnership with exception reporting to the Health & Social Care Integration Partnership Board. Scheme risks are captured in the risk log in part one.

A specific set of measurements has been developed for Healthier Radcliffe, as detailed in the above attachments, and is currently being used to measure the impact of extended hours in Radcliffe. This model will be further developed to include measurement for the four integrated Health and Social Care Schemes.

As identified in part 1 section 4b, there is then robust project level governance structure in place to receive reports and updates and the develop mitigation plans where required. The governance structure includes The Bury Integrated Partnership Board, The Bury Joint Commissioning Group and The Health and Wellbeing Board for this particular scheme it also includes:

Prime Minister's Challenge Fund Contract Board Meeting
- Chaired by NHS England, this board is attended by the GP Federation and the Bury CCG. This forum holds the GP Federation to account against delivery of the Prime Minister's Challenge fund.

Bury Integration Group – A Healthier Radcliffe
- Chaired by the GP Federation, this group is attended by all the local stakeholders including the CCG urgent care lead and the CCG Better Care Fund lead. The group receives updates and progress from the four stage two projects.

Bury GP Sector Meetings
- The local sector infrastructure will be the vehicle through which the roll out of the extended access and integrated health and social care teams will take place.

Risks
Risk associated with the delivery of the Better Care Fund Plan and associated schemes have been identified in the Risk Log in Part 1 Appendix 3.

Any risks that may affect the delivery of the Better Care Fund Schemes will be raised with the

Joint Commissioning Group as part of the regular reporting of the performance of the scheme. Mitigating actions will be undertaken to reduce the likelihood of the risk arising or to address the risk. If this is not possible and potentially means that plans could go off track, then this will be escalated to the Integrated Health & Social Care Partnership Board.
What are the key success factors for implementation of this scheme?
The delivery of an Integrated Health and Social Care system in Bury is being driven by all the local stakeholders. The key success factors are: • Stakeholder engagement • Releasing capacity across stakeholders to support delivery • Delivery of extended access to GP Services over 7 days a week • Robust governance in place as schemes cut across the whole health and social care economy • GP engagement • Patient awareness • Changes in traditional behaviour patterns • Management of risk via risk register and regular contact with schemes in-between meetings

ANNEX 1 – Detailed Scheme Description

SCHEME 4

Scheme ref no.
Bury BCF 04
Scheme name
Care of Vulnerable Adults
What is the strategic objective of this scheme?
To reduce the number of avoidable admissions within secondary care by improving the coordination and quality of care for those who need it most. The scheme aligns with the core principles underpinning Bury's Health & Wellbeing Strategy: • Promoting prevention, early intervention and self-care • Reducing inequalities in health and wellbeing • Developing person-centred services • Planning for future demands
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
All 33 practices have signed up to deliver the following modules of care: **Module 1 – Increased Awareness/Administration of Flu Vaccinations** This module has two components that are targeted at over 65s: 1. Localised flu campaign • All patients over the age of 65 to be invited to receive their flu vaccination 2. Increased vaccination levels • Targeted payment rewards based on a higher level of achievement (80%, 85%, 87.5% and 90%) **Module 2 - Quality Improvements via Coordinated Care** This module has three key components which by the nature of their remit will cover all ages (197,376 registered population) but in particular those aged 65 and over (33,751) (as of June 2014). 1. Comprehensive care plans to be offered to the following cohorts of patients: • All patients within a residential establishment (Nursing/Residential (est no. 1,297),

Mental Health & Temporary residences) and registered with a Bury GP
- All patients on the practice's dementia register (currently 1,490)
- Any other patients as identified using local intelligence (e.g. those with co-morbidities or multiple A&E attendances/admissions). All care plans will be uploaded to the patients Summary Care Record (SCR) and Electronic Referral and Information Sharing System (ERISS) which is web-based application, designed to enhance information sharing and collaborative working between the North West Ambulance Service (NWAS) and its key stakeholders.

2. Increasing access to General Practice (general enabler supporting all ages):
   - All patients cohorts will benefit from practices delivering a minimum threshold of appointments per 1000 patients based on the average from benchmarking data (5.4 per 1000 patients)
   - Measured/monitored using bespoke software

3. Delivery of Multi-Disciplinary Teams for those who need one (all ages)
   - Coordination of appropriate attendance
   - Ensuring actions are documented and acted upon
   - Monitoring of outcomes/evaluation

Module 3 - Dementia identification and management
- Named dementia lead in every practice
- Localised training on dementia identification/assessment/investigation and management
- Increased prevalence recording (68% of predicted being the target)
- Implementation of a practice based pathway for dementia and alzheimer's disease
- Patients on the practices dementia register to be offered a comprehensive care plan (under Module 2)

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The services described will be delivered by the 33 practices within Bury through the use of a Locally Commissioned Service (LCS) contract which has been funded under the BCF. How general practice deliver the core expectations of this contract within their own practices will be for them to determine (i.e. staffing/skill mix) although cross stakeholder working will be required if the overall scheme is to be successful as illustrated on the next page.

Within the LCS Contract is the requirement for practices to deliver against a specific set of key performance indicators (KPIs) which will be measured and reported against on a monthly basis as shown in the table below:

Performance Indicator	Threshold	Read Code	Method of Measurement	Frequency
Delivery of a stretched target for flu (age 65 and over)	=>80% =>85% =>87.5% =90%		Extracted via vision by Sector Analyst	Monthly
Equitable access to appointments across the CCG to be achieved by 31 March 2015 (all ages) Practices should be able to demonstrate that they have sufficient capacity to match demand	By 31st October 2014 practices will have undertaken the initial run of software By 12 November 2014 the CCG will present an initial benchmarking analysis and agree a minimum threshold per 1000 patients By Jan 2015 practices will re-run the appointment software to validate any increase needed has been implemented	N/A	The use of agreed appointment software (Monitoring will continue to ensure any required increase is maintained) Practices will not be penalised where deadlines have not been met due to CCG capacity	Once as per deadlines
Increased identification and management of patients with dementia (all	68% of the practices estimated prevalence identified		Extracted by vision by Sector Analyst	Monthly
	A named dementia lead has been identified	N/A	Practices must be able to demonstrate compliance	On request
	Dementia lead has attended	N/A		

ages)	training on identification, assessment, investigation and management of dementia			
	A practice based pathway for identification, assessment, investigation and management of dementia and Alzheimer's Disease has been implemented	N/A	Practices must be able to demonstrate compliance on request (see Dementia Resource Pack)	On request
Care Plans (all ages)	100% of dementia diagnosed patients to have been offered 90% received a standardised care plan	13F6 "nursing / other home"	Practice Search / submission	Monthly
	100% of patients within Nursing/Residential Establishments including other care facility settings/respite settings (this includes temp residents) and mental health establishments to be offered, 90% received a standardised care plan	13F6 "nursing / other home"	Practice Search / submission Consideration for 13F6 – which is "nursing / other home"	Monthly
	100% of Quarterly reviews have been conducted	8CMG.00	Practice Search / submission	Monthly
	Where patients may be suitable but do not fall into the above categories (for example => 75 or on 4+ medications and 4 GP appointments /admissions in the last 12mths or local intelligence)	13F6 "nursing / other home"	Practice Search / submission	Monthly
MDTs (all ages)	Appropriate patients to receive the benefit of an MDT attended by relevant Health and Social Care professionals, the outcomes of which are clearly documented and acted on.	#3876 multidisciplinary assessment #6AE multidisciplinary review	Practice Search / submission Standardised MDT outcome template submitted to CCG	Monthly
Quality assurance	undertake/submit a random sample of care plans as part of a quality assurance process	N/A	Random sample of care plans by CCG (No. dependent on findings)	as requested
Overall Measure Performance Indicator	**Threshold**	**Read Code**	**Method of Measurement**	**Frequency**
A combined reduction which against (all ages) • NEL Admissions • A&E attendances	Baseline achievement against plan Further 5% reduction against plan	N/A	Practice/Sector and CCG reductions will be monitored through SUS/SLAM by the sector analyst and presented to Sectors and PMO on a monthly basis.	Monthly

This will not only give assurance to the Health & Social Care Governance Structure that measureable outcomes are being achieved but will also support general practices to have peer to peer discussions around the implementation of each module in order to share any good

practice and identify areas were further additional support may be required at the earliest opportunity.

Key milestones:

Vulnerable Adults	Start Date	End Date
Overall Project	**10/2/2014**	**30/9/2015**
Stakeholder Engagement	10/2/2014	19/6/2014
Specification Development	18/4/2014	1/10/2014
Financial modelling	14/3/2014	15/8/2014
Performance/Outcome Monitoring	15/7/2014	30/9/2015
Ongoing Support	1/10/2014	30/9/2015

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Local evidence

General overview of local intelligence

The Joint Strategic Needs Assessment for Bury states that, by 2022 the population in every 5-year age band over 50 years old is expected to increase by at least 20% :

- The over 65 year olds population is expected to increase by 29% (9,000 more)
- The over 85 year olds population is expected to increase by 54%. (2,000 more)

The demographic data in the report gives a clear indication of the ageing nature of the population with an estimated 10,000 more people over the age of 65 by 2025 (a 35% increase on 2010 levels). In addition, these people will be living longer. Females will continue to live longer than males although this gap is set to close due to increased life expectancy of males over the age of 80. In the next 15 years, there will be 79% more very elderly men compared to only 38% more females. The combined effect equates to 55% more over 80s by 2025.

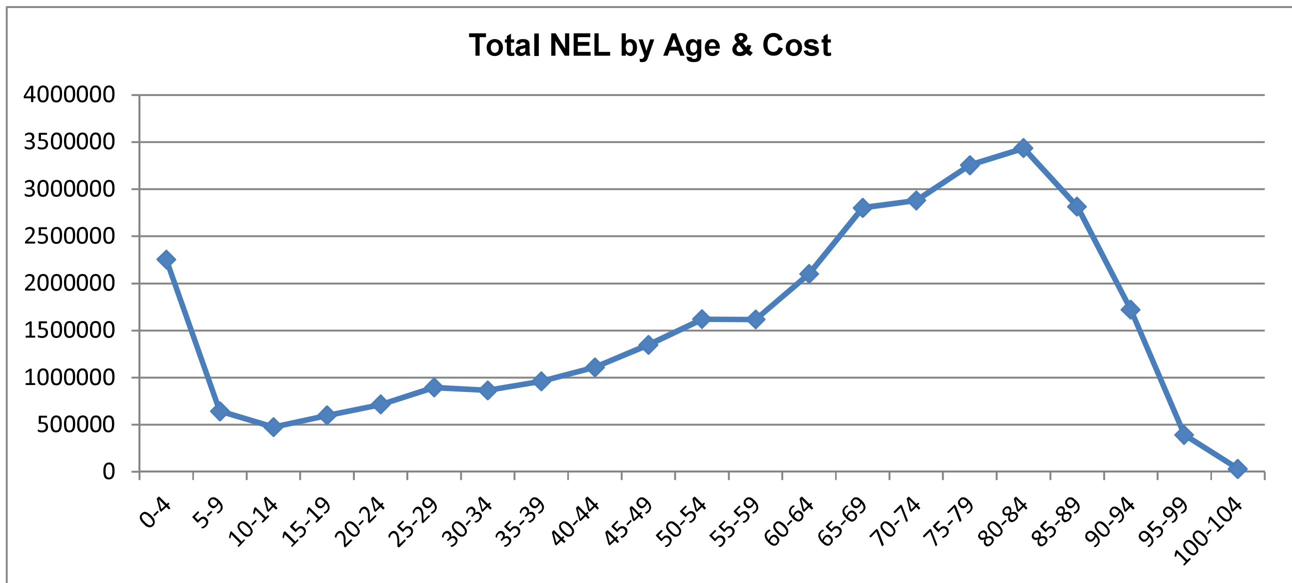
Current projections suggest that by 2025:

- 5,000 more people will have long term limiting conditions (+35%)
- 10,000 people are likely to have some form of continence problem
- 8,500 will have some problem getting around (+40% on current levels)
- Some 10,000 older people will be classed as obese with almost 5,000 people suffering from diabetes
- There will be 1,000-1,500 more people with dementia
- Other limiting condition such as visual and hearing impairment are also expected to rise by between 35% and 45%

Of particular concern is the number of falls amongst older people. In Bury admission rates for fractured femurs are already higher than average and with falls predicted to increase by up to 3,000 (+38%) by 2025, this could result in around 1,000 people per annum (10% of the total)

being admitted to hospital.

On looking at the total spend of non-elective admissions against all ages it is clear to see that this age band of patients are the most resource intense population; it is therefore imperative that any schemes delivered must be aimed at this cohort of patients.



Module 1 – Increased Awareness/Administration of Flu Vaccinations

Bury historically underperforms against a 75% target for the administration of Flu vaccinations for those aged 65 and over:

Year	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14
% uptake	71.9	72.3	72.2	71.4	72.1	74.5	72.3	72.6

Module 2 – Quality Improvements via Coordinated Care

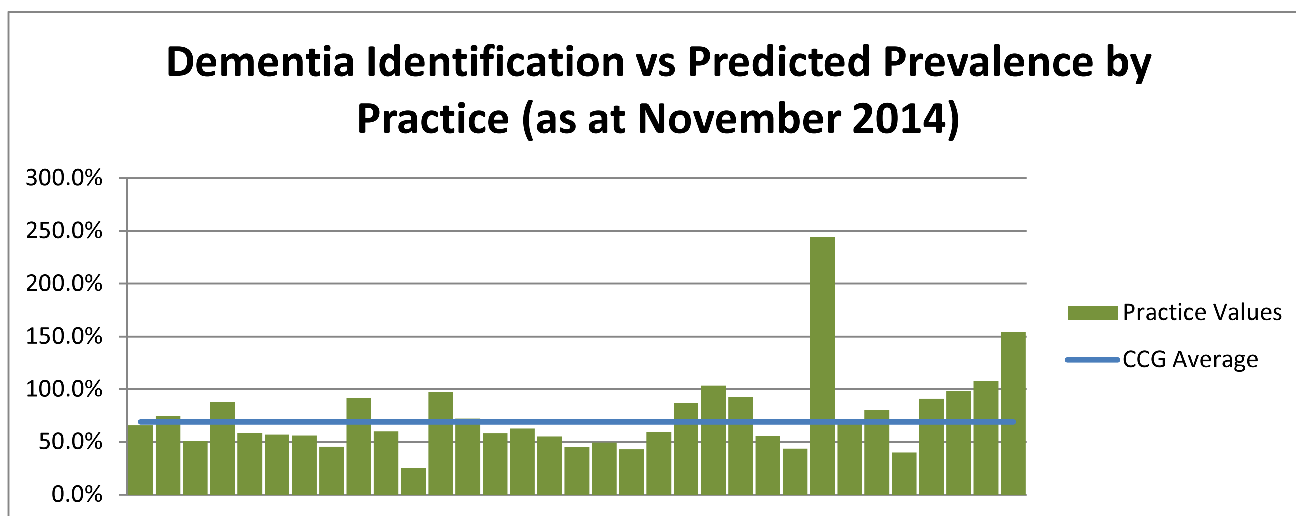
Local Schemes Already in Delivery - Care Home LCS

Proactive coordinated care planning is already in place for a specific cohort of patients through the Care Home LCS which has 18 out of 33 practices providing a dedicated GP role to specific homes within the borough. It hoped that by expanding the ethos of this model we will replicate the positive outcomes already seen which include:

- 22 out of a possible 30 homes covered (although not all patients within the homes have chosen to change GPs)
- Improved patient/carer experience
- Improved quality of care
- Reduction and prevention of non-elective admissions -86 compared to a 22 rise in those homes not covered (2012/13 verses 2013/14)
- Reduction in A&E attendances -30 verses a 39 increase in homes not covered by the LCS (2012/13 verses 2013/14)
- Promotes self-care and carer confidence

- Up-skilling of existing care home staff
- Alleviate pressure within Primary Care services
- An EOL evaluation and ADASS data indicates that Bury has moved from a national regional position of 42, to the third best performing region for death in usual place of residence (DiUPR.) Between 2009 and 2012, the proportion of people in Bury dying in their usual place of residence improved from 36% to 44%

Module 3 - Dementia Identification and Management
There is significant clinical variation across practices in terms of prevalence identification (Predicted versus actual, current highest 244%, lowest 25%)



National Evidence

Module 1 – Increased Awareness/Administration of Flu Vaccinations
- http://www.evidence.nhs.uk/search?q=flu+jabs

Module 2 – Quality Improvements via Coordinated Care
- Admission Avoidance Direct Enhanced Service (DES) http://www.nhsemployers.org/~/media/Employers/Publications/Avoiding%20unplanned%20admissions%20guidance%202014-15.pdf
- Delivering better services for people with long-term conditions - Building the house of care the Kings Fund 2013 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf
- A collaborative process of personalised care between the clinician, patient and if applicable the patient's carer(s).“My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes.” (National Voices)
- Health policy has consistently advocated personalised care and care planning, emphasised within ‘Our health, our care, our say’ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/272238/6737.pdf

- Personalised Care Plans for long term conditions - Quality and Productivity http://www.evidence.nhs.uk/qipp
- Shared Decision Making - http://sdm.rightcare.nhs.uk/
- NHS England, Transforming participation in health and care 2013, http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf
- Graffy et al, Primary Health Care Research & Development, 2009, 10(3),210-222
- Graffy J, Grande M, Campbell J. (2008) Case management for elderly patients at risk of hospital admission: a team approach. Primary Health Care Research and Development, 2008: 9 (1): 7-13.
- Care Planning "Putting Patients first." http://www.england.nhs.uk/wp-content/uploads/2013/04/ppf-1314-1516.pdf

Increasing Access To General Practice (General Enabler):

- GP Survey Results http://www.gp-patient.co.uk/results
- Improving General Practice – a call to action http://www.england.nhs.uk/wp-content/uploads/2013/09/igp-cta-evid.pdf
- Daly JM, Buckwalter K, Maas M. Written and computerized care plans. Organizational processes and effect on patient outcomes. J Gerontol Nurs 2002;28(9):14-23.

Module 3 - Dementia Identification and Management

- Dementia CG42: http://www.nice.org.uk/guidance/CG42/chapter/1-Guidance
- Improving the identification and care of patients with dementia has been prioritised by the Department of Health through its mandate to NHS England and by NHS England through its planning guidance for clinical commissioning groups (CCGs) .The commitment to improving patient care and early diagnosis in primary care is in the NHS England business plan "Putting Patients first." http://www.england.nhs.uk/wp-content/uploads/2013/04/ppf-1314-1516.pdf

How We Used National and Local Evidence

A series of events were held and 100% of Practices were represented (clinicians and managerial staff). A number of evidence based interventions (provided by the Kings Fund) were presented under the following broad headers:

- Healthy active ageing and supporting independence
- Living well with simple or stable long-term conditions
- Living well with complex comorbidities, dementia and frailty
- Rapid support close to home in crisis
- Good acute hospital care when (and only when) needed
- Good discharge planning and post-discharge support
- Good rehabilitation and reablement after acute illness or injury
- High-quality nursing and residential care for those who truly need it
- Choice, control and support towards the end of life

(King's Fund, 2013)

Practices were asked to pick their top four initiatives under these headers likely to achieve the desired outcome (to reduce NEL admissions) which were:

1. Influenza and pneumococcal pneumonia vaccination

2. An identified key worker who acts as a case manager and coordinator of care across the system
3. Expert decision makers are available at the front door of the acute hospital from 8am to 8pm, seven days a week. Specialist assessment should be available within 12 hours of admission, seven days per week
4. There should be a multi-disciplinary team located at the front door of the hospital integrated with the community team focused on the facilitation of discharge

Through a further series of meetings all initiatives where scoped into a project initiation document which took into account:

- Ease of implementation
- Delivery model (including potential financial envelope needed)
- Enablers
- Likely timescales for delivery and key milestones (by when and by who)
- KPIs for success
- Local/National Evidence
- Stakeholders
- Risks and possible mitigating actions
- Commissioned Provider (i.e. from practice/alternate provider)
- Outcomes / incentive payments for achievement of KPI's

This enabled a rationalisation exercise to take place and the main areas for implementation then agreed as:

Module 1 – Increased Awareness/Administration of Flu Vaccinations
Module 2 – Quality Improvements via Coordinated Care
Module 3 – Dementia identification and management

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

A budget allocation of £1,215,620 has been made available to the practices. This figure includes the national recommendation of £5 per head as well as an additional sum of funding to ensure 100% coverage of registered patients within care facilities (such as Nursing/Care Homes, respite facilities, mental health establishments etc. The following table explains how this investment will be deployed. It should be noted that only the performance element of the scheme is being funded through the BFC pool (in green) and that the remaining elements are funded by the CCG (in yellow).

Area	Target	Financial Reward
Module 1 – Increased Awareness/Administration of Flu Vaccinations (Incremental increases up to a total of 140K achievable)	Advertisement	£10,000
	80%	£77,000
	85%	£7,000
	87.5%	£14,000
	90%	£42,000
Module 2 - Co-ordinated Care (expectation that practices deliver all KPIs i.e. care plans/appointment software MDTs etc.)	KPIs	£397,029
Module 3 - Dementia Identification and Management	68%	£60,781
Overall Reward Payment (based on a financial saving against a planned practice budget)	Baseline	£486,248
	5% Reduction on baseline	£121,562
Total Budget		**£1,215,620**

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The main impact of this scheme is to reduce the number of non-elective (NEL) admissions, as shown in the table below and in part 1, appendix 1, both general and acute (estimated as a reduction of 328 with an average spell cost of £1,765).

		Metric 1 - Residential Admissions		Metric 2 - Reablement		Metric 3 - Delayed Transfers of Care		Metric 4 - Avoidable Emergency Admissions		Metric 5 - Patient experience	Metric 6 - Local metric - Falls	
Scheme ID	Scheme Description	%	Nos of people	%	Nos of people	%	Nos of people	%	Nos of people	%	%	Nos of people
BCF04	Care of Vulnerable Adults	35%	2	5%	1	15 %	39	30%	296	20%	20 %	8

The wider impact of the scheme will include:

Module 1 – Increased Awareness/Administration of Flu Vaccinations

- Reduced clinical variation for the administration of flu vaccines (89% highest practice, lowest practice 55.9%)
- Increased administration of flu vaccinations for over 65s (baseline 13/14 72.6%)
- Reduction in the number of respiratory classified admissions

Module 2 – Quality Improvements via Coordinated Care

- Reduced NEL admissions, general and acute
- Reduced length of stay
- Reduced Excess bed days
- Encourage collaborative working across the whole health care system (including other primary care providers, secondary care, community care, social care, third sector, out of hours medical services, ambulance, and 111 services) in order to ensure patient care is delivered in a 'joined up' manner
- Emergency re-admissions within 30 days of discharge from hospital
- Amenable/preventable mortality
- Improving people's experience of integrated care
- Health-related quality of life for carers/carer-reported quality of life
- Health-related quality of life for people with long-term conditions/social care related quality of life
- Reduce the number of minor A&E attendances
- Increased (equitable) access provision within General Practice (5.4 appointments per 1000 patients across all practices)
- Enhance the patient experience in terms of responsiveness and improved access

Module 3 - Dementia identification and management

- Reduced clinical variation across providers for the identification of Dementia (Predicted versus actual with 68% being the target – current highest 244%, lowest 25%)
- Dementia effectiveness of post-diagnosis care in sustaining independence and improving quality of life
- Provide clinicians with the skills and knowledge to detect assess and manage patients at potential risk of dementia

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Governance Structure

This Better Care Fund scheme is project managed by a scheme lead who reports to the Joint Commissioning Group via the Enhanced access to primary care and integrated care workstream. The Joint Commissioning Group reports to the Integrated Health and Social Care Partnership Board and subsequently to the Health and Wellbeing Board as shown in the structure below.

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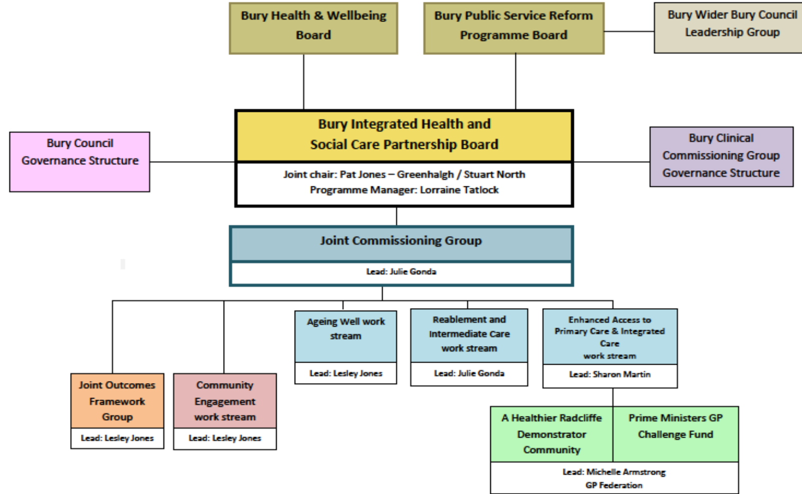

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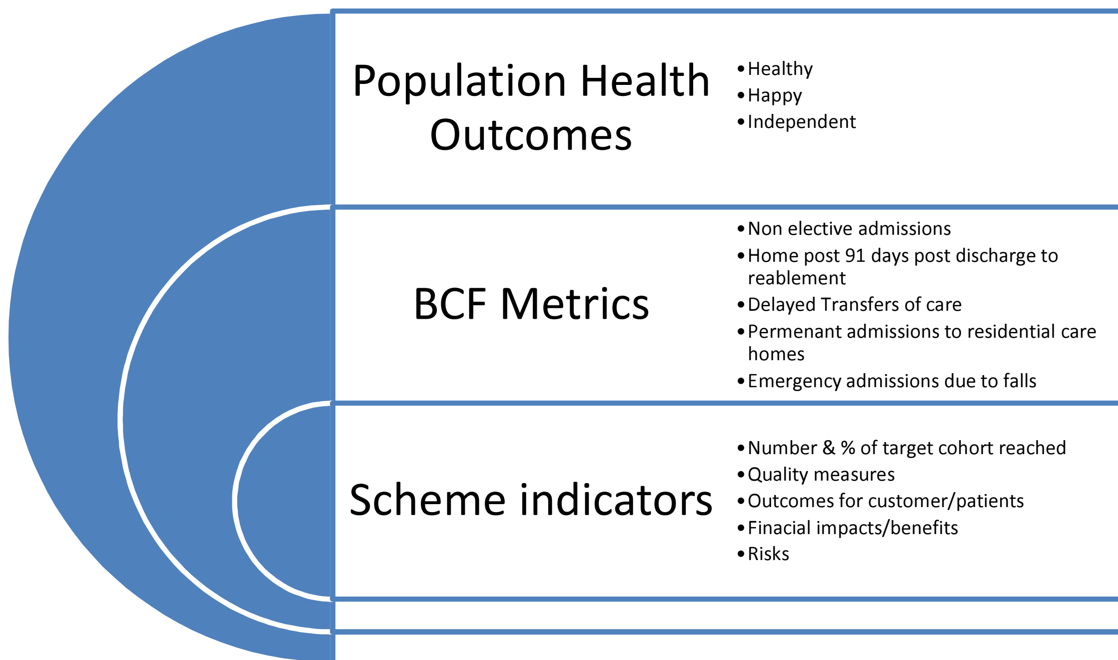
The Outcomes Framework



Population Outcome measures
We are clear that health and social care integration is a means to an end and not an end in itself and that whilst there is an immediate focus around creating a financially sustainable system, this can only be achieved in the longer term if we create a system which improves the health and wellbeing of our local population and reduces the need for treatment services.

We have therefore agreed a set of indicators through which we can determine whether our work has a positive impact on people's health, wellbeing and independence.

The embedded document outlines the measures agreed and associated data sources and gives the current picture for Bury against each indicator.

JOF overarching indicators June 14 v2

Better Care Fund Metrics
The Better Care Fund metrics provide us with more immediate feedback on whether the work we are doing is delivering the system changes that we are driving towards. We are building on work undertaken by Greater Manchester CSU on developing a Performance dashboard for the Healthier Radcliffe Demonstrator and the Non Elective Story Board (see embedded document) to develop a single whole Borough, whole system dashboard incorporating the BCF metrics using software recently purchased by the Local Authority.
As an interim whilst the dashboard is developed, we will be collating current performance reports on the different metrics to create a single monthly report provided to the Joint Commissioning Group, Provider Partnership Group with exception reporting to the Health & Social Care Integration Partnership Board.

NEL.xls

Scheme indicators
The indicators for this scheme are set out below. The key indicators on progress will be incorporated into the above dashboard in time. Meanwhile monthly progress reports will be collated and provided to the Joint Commissioning Group, Provider Partnership with exception reporting to the Health & Social Care Integration Partnership Board.

- Avoidable emergency admissions
- Permanent admissions of older people to residential and nursing care
- Effectiveness of Reablement for people 65 and over
- Delayed transfers of care
- Patient/service user experience
- Falls

A project dashboard which pulls together all of the key outcomes/KPIs intended to be delivered is reported to practices on a monthly basis in order for them to assess the impact of schemes and address any concerns at an early stage in the project via the Sector Support Groups which meet on a monthly basis.

Vulnerable Adults

Risks
Risk associated with the delivery of the Better Care Fund Plan and associated schemes have been identified in the Risk Log in Part 1 Appendix 3.

Any risks that may affect the delivery of the Better Care Fund will be raised with the Joint Commissioning Group as part of the regular reporting of the performance of the scheme.

Mitigating actions will be undertaken to reduce the likelihood of the risk arising or to address the risk. If this is not possible and potentially means that plans could go off track, then this will be escalated to the Integrated Health & Social Care Partnership Board.

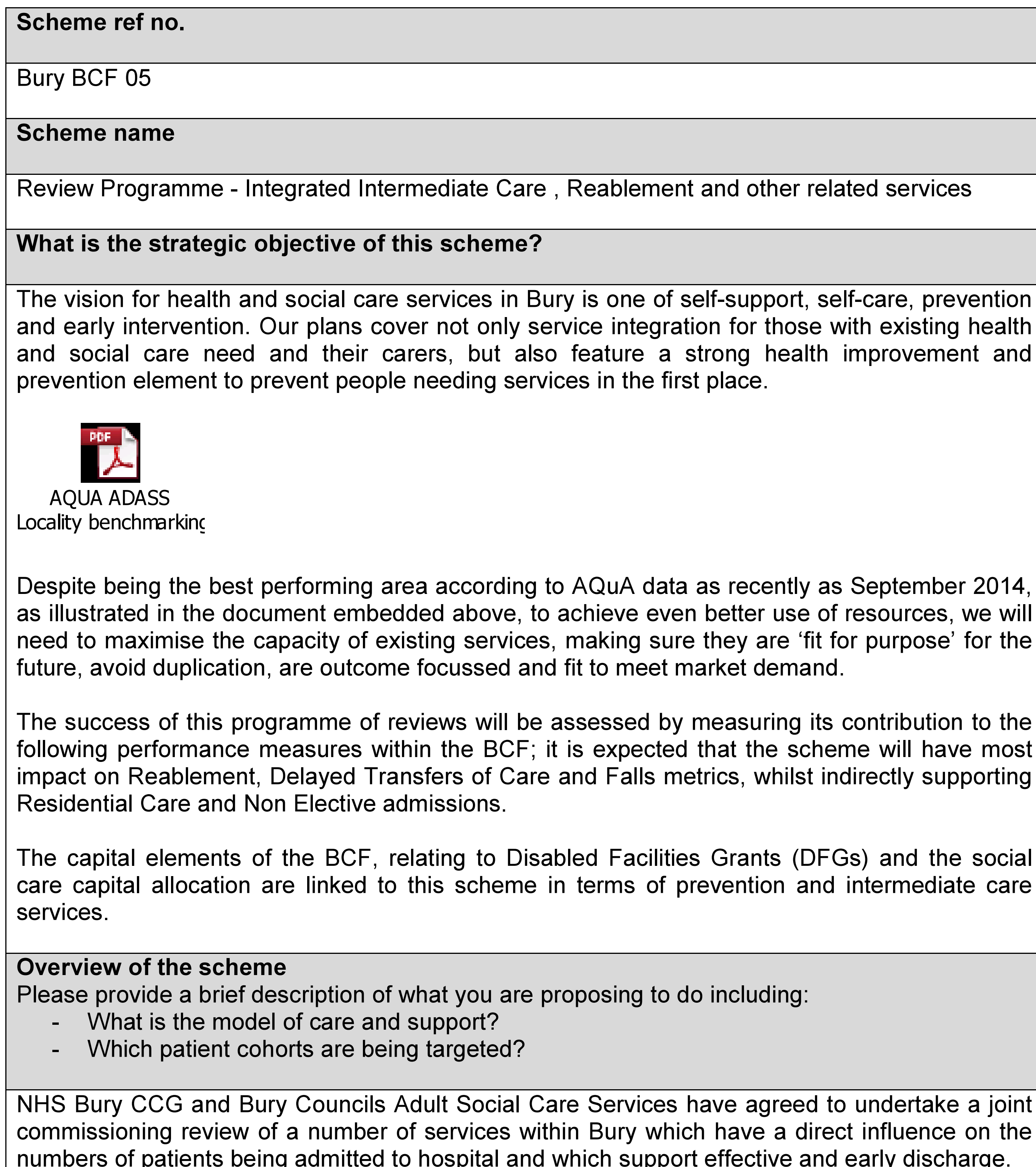
What are the key success factors for implementation of this scheme?

- Clinical leadership
- 100% sign up to the Locally Commissioned Service Contract
- Clear targets/objectives for the provider
- A coordinated approach to care delivery across providers
- Effective communication across wider system stakeholders
- Utilisation of all resources available within the community
- Regular reporting/monitoring of outcomes

As a result of this achievement of the specific targets referred to above which will ultimately lead to improved care for vulnerable people.

ANNEX 1 – Detailed Scheme Description

SCHEME 5



Scheme ref no.

Bury BCF 05

Scheme name

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

What is the strategic objective of this scheme?

The vision for health and social care services in Bury is one of self-support, self-care, prevention and early intervention. Our plans cover not only service integration for those with existing health and social care need and their carers, but also feature a strong health improvement and prevention element to prevent people needing services in the first place.

Despite being the best performing area according to AQuA data as recently as September 2014, as illustrated in the document embedded above, to achieve even better use of resources, we will need to maximise the capacity of existing services, making sure they are 'fit for purpose' for the future, avoid duplication, are outcome focussed and fit to meet market demand.

The success of this programme of reviews will be assessed by measuring its contribution to the following performance measures within the BCF; it is expected that the scheme will have most impact on Reablement, Delayed Transfers of Care and Falls metrics, whilst indirectly supporting Residential Care and Non Elective admissions.

The capital elements of the BCF, relating to Disabled Facilities Grants (DFGs) and the social care capital allocation are linked to this scheme in terms of prevention and intermediate care services.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

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

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

The significant majority of customers within these services are older people, latest reports (at Q2, September 2014) showing in Reablement 75% of customers are aged 75 or over, in Crisis Response 80% and in Intermediate Care 82%. It is expected that this demographic will continue for the foreseeable future.

The services also deal with a significant proportion of people who are referred into services due to falls/mobility issues, again with September 2014 reports showing Reablement at 68%, Crisis Response at 32% and Intermediate Care at 44%.

Outcomes from current operation of the schemes are expected to continue until the review is completed; At Quarter 2 (Sept 2014) some of the successful outcomes are:

Reablement – 50% of customers completed reablement and were discharged without a care package; 19% received a reduced (are package)

Crisis Response – 39% of customers were discharged and supported at home with a social care package; 19% of customers were discharged with no further actions; 27% of customers were transferred to short term residential or nursing care, indicating their need could not be met at home in the short term.

Intermediate Care – 72% of customers were discharged home, but 14% were discharged to hospital, indicating a deterioration in condition during the Intermediate Care episode of care

The services in scope and current investment levels are shown in the table below; those highlighted in green will form part of the Better Care Fund from 2015/16 whilst those in yellow complement the BCF schemes and are therefore included in the wider review, but not at this point in the BCF. Once the review is complete, the wider schemes may also be included within the BCF in future.

Service Name	Commissioned by	2015/16 £000
BCF schemes		
Integrated intermediate care	CCG	820
Integrated intermediate care	LA	315
Crisis response	LA	254
Crisis response	CCG	400
Discharge liaison	CCG	354
Reablement Service	LA	2,300
Total - included in BCF		**4,443**
Related schemes		
Bealeys - bed	CCG	
Access to beds (crisis response)	CCG	
Access to beds (50:50 beds)	CCG	
Access to beds (50:50 beds)	LA	
Access to beds (spot purchase)	CCG	
Access to beds (assessment)	CCG	
Schemes currently outside BCF but to be reviewed		

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

These services sit within the current patient / customer pathway as illustrated in the diagram below, with the discharge liaison service being a key referral point into service hence the inclusion of this team within the review.

IMC & REABLEMENT services.pdf

The current delivery chain in respect of the scheme is detailed below; changes to this will be identified clearly as part of the review programme. However, the main providers of Intermediate Care, Reablement and other related services in Bury are Pennine Care Foundation Trust and the Local Authority.

Intermediate Care Residential Service - a 36 bed service, social care rather than clinical model.	Provided by the Local Authority, majority commissioned by CCG
Crisis response – a joint service comprising social workers	Provided jointly by LA and Pennine Care Foundation Trust (PCFT) under line management from the LA; commissioned by CCG and LA
Discharge Liaison Team	Provided by PCFT but under line management from the LA Commissioned by the CCG
Reablement – this is a service that is both provided and funded by the Local Authority, under the same senior line management as IMC. It works closely with the hospital social work team, and with Domiciliary Care Brokerage Team in respect of on-going placements.	Provided by the LA; funded in full by the LA
• Assessment beds • crisis response • 50/50 beds • assessment beds • spot purchase beds	Commissioned directly from independent providers by the CCG
Bealeys Community Hospital	Provided by PCFT, commissioned by CCG

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Strong national evidence exists to show that intermediate care and reablement services are a significant part of the Government's agenda around prevention, aimed at keeping people independent and free from long term support for as long as possible; research demonstrates that a reablement approach also has a positive impact on people's own perception of quality of life.

SCIE (Social Care Institute for Excellence) have published a number of research items, including Social Care TV videos, between 2011 and 2013, ranging from cost effectiveness of such services to engagement with families and carers around reablement.

http://www.scie.org.uk/topic/careservices/preventionreablement/reablement

Section 2 of the Care Act provides a statutory framework for focussing on 'Preventing, reducing or delaying needs'. It outlines the duty for local authorities to 'identify and target those individuals who may benefit from particular types of preventative support'. The expectation of building strong links with health professionals such as GPs and community nurses to undertake some of the identification is clear, and there are projects underway in Bury to support this approach , such as Staying Well, which is part of the BCF programme.

Intermediate Care has been evidenced by the King's Fund as a positive way of supporting people moving through the health and wider care system
http://www.kingsfund.org.uk/publications/intermediate-care

and more recent King's Fund evidence pertinent to this cluster of services indicates that reablement forms a key component of effective integrated care which focuses on effective co-ordinated care and reduced delays for patients moving around the care system.

http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population

However, it should be noted that this BCF scheme is not only about reviewing and reshaping the Reablement Service and the Intermediate Care Service, but wider services which provide short interventions to support people's recovery on discharge from hospital, as well as shifting the emphasis to a 'step up' model of prevention. The case for change is strong – whilst Intermediate Care Services are a good example of collaborative working across the NHS and social care in Bury and the positive contribution that these services have made to the health and social care economy is positively acknowledged, both Local Authority and CCG commissioners' vision for services is a better integrated one, albeit with the recognition that the range of services may continue to be run by different partner agencies.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Service Name	Commissioned by	2015/16 £000
BCF schemes		
Integrated intermediate care	CCG	820
Integrated intermediate care	LA	315
Crisis response	LA	254
Crisis response	CCG	400
Discharge liasion	CCG	354
Reablement Service	LA	2,300
Total - included in BCF		**4,443**

As outlined above, the funding from BCF is £4.443m currently spent on these schemes, it is expected that this will continue until the review is completed.
The capital element of the BCF totals:

Capital element of BCF	£
Disabled Facilities Grants	781,000
Social Care Capital	455,000
Total Capital	1,236,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Specific targets have not yet been identified in terms of the reviewed services, but the following outcomes will be delivered by the review:

- Service model which ensures self-care and self-support – the aim of these services is to bring people up to baseline ability, then either discharge with no further support or minimal long term support. The review will assess how well do services meet that objective, how could they be improved, and measurements for success
- Delivery of the Better Care Fund measures – Four of the key measures within the Better Care Fund are:
  - Avoidance of emergency admissions to hospital;
  - Reduction in admissions into permanent residential care
  - Maintenance of an individual at home 90 days after discharge.
  - Delayed Transfers of Care

  It is expected that this review will provide a series of recommendations that are evidence based as to how the services in scope could be re-designed to contribute more effectively to the measures, in particular prevention of hospital admission
- Delivery of the CCG Commissioning Intentions 15/16, it is expected that the services in scope form Stage 4 of a procurement exercise in which decommissioning notice is served in October 2015, with new services live from October 2016. The outcomes from this review will develop the specification which the CCG will use to tender or re-design
- Support to the Integrated Health & Social Care model– the CCG and Council want to commission community based services supporting people in their own home, linked to primary care and other community based services to promote better wellbeing for the residents of Bury. The review will assess how well do services meet that objective now, how could they be improved, measurements for success against this objective
- Efficiencies - The review will identify potential savings through avoidance of duplication, system wide efficiencies and reduction in hospital admissions which will be outlined in a Business Case
- In addition, without going into detailed operational re-design, the review is expected to provide an overview of changes needed in respect of referral points in and out of these services to ensure that we adopt a ‘tell us once’ approach for the patient / customer, identify potential blockages within the customer journey and provide proposals on how providers can work together to resolve any issues.

This scheme will contribute towards the following metrics and financial benefits realisation as detailed in the table below and also in part 1 appendix 1

Scheme ID	Scheme Description	Metric 1 - Residential Admissions		Metric 2 - Reablement		Metric 3 - Delayed Transfers of Care		Metric 4 - Avoidable Emergency Admissions		Metric 5 - Patient experience	Metric 6 - Local metric - Falls	
		%	Nos of people	%	Nos of people	%	Nos of people	%	Nos of people	%	%	Nos of people
BCF05	Integrated Intermediate Care, Reablement and other related services	10%	1	40%	2	65%	167	5%	49	20%	50%	21

Action Plan

The high level action plan for this scheme is as follows:

Workstream	Activity	Key Milestone	Start Date	End Date	Owner	Status
A	**Review of Services**		**01/08/2014**	**30/09/2015**		On Target
1	Development of key material to support review process (prioritisation matrix/ joint processes/review template)		01/08/2014	31/12/2014	**Tracy Minshull**	**On Target**
2	Review to be completed and clusters of services identified	Y	31/12/2014	31/12/2014	**Tracy Minshull**	**On Target**
3	Data analysis (identification of trends/gaps ion services) Risk log maintained and existing metric reviewed.		31/12/2014	31/03/2015	**Liz Hodgkinson**	**On Target**
4	Review of existing practice and research around innovative models		31/12/2014	31/03/2015	**Zena Shuttleworth**	**On Target**
5	Emerging models developed for discussion		01/03/2015	30/04/2015	**Review Team**	**Not Started**
6	Options appraisal developed (where appropriate) Future metrics finalised.		01/04/2015	30/04/2015	**Review Team**	**Not Started**
7	Future service design to be finalised	Y	30/04/2015	31/05/2015	**Review Team**	**Not Started**
8	Implement findings of IMC review		01/06/2015	30/09/2015	**Review Team**	**Not Started**

The review team is a joint team made up of staff from both the CCG and the LA. The team members are:

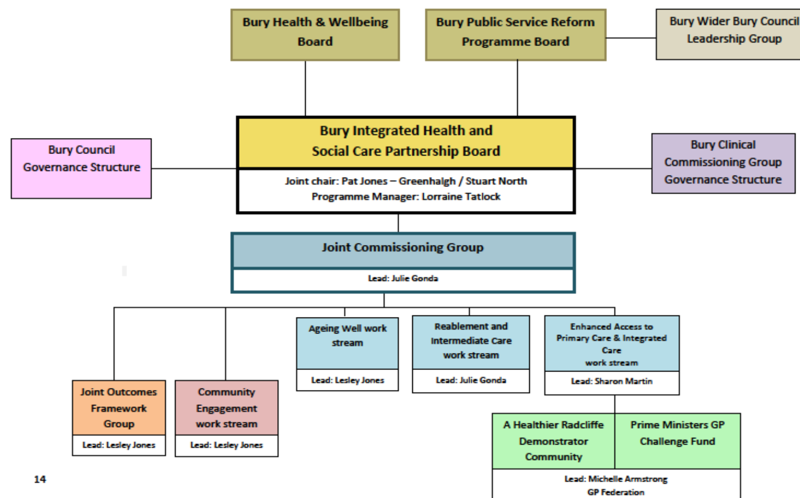
Tracy Minshull – Strategic Project Lead, Head of Commissioning & Strategy, Bury Council
Zena Shuttleworth – Strategic Planning Officer, Bury Council
Liz Hodgkinson – Economist, Bury Council

Sally Deaville – Deputy Head of Commissioning - Bury CCG
David Latham – Programme Manager, Bury CCG

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

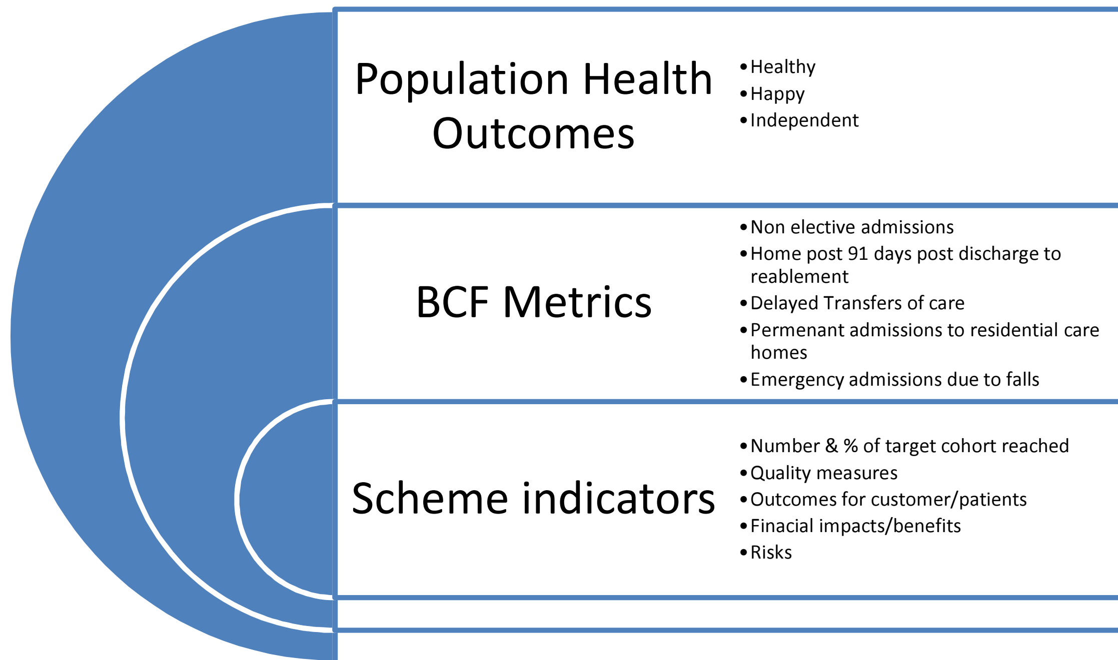
Governance Structure
This Better Care Fund scheme is project managed by a scheme lead who reports to the Joint Commissioning Group via the reablement and intermediate care workstream. The Joint Commissioning Group reports to the Integrated Health and Social Care Partnership Board and subsequently to the Health and Wellbeing Board as shown in the structure below.

Bury Integrated Health & Social Care Governance Structure



Bury Health & Social Care Partnership Board are in the process of developing a Joint Outcomes Framework through which to monitor the impact of work-streams including the Better Care Fund Schemes on the health and social care system and ultimately on the health of our population. This work is being taken forward by the Joint Outcome Framework Group comprising performance and intelligence specialists from Public Health and Adult Social Care within the Local Authority and the CSU on behalf of the CCG.

The Outcomes Framework



Population Outcome measures

We are clear that health and social care integration is a means to an end and not an end in itself and that whilst there is an immediate focus around creating a financially sustainable system, this can only be achieved in the longer term if we create a system which improves the health and wellbeing of our local population and reduces the need for treatment services.

We have therefore agreed a set of indicators through which we can determine whether our work has a positive impact on people's health, wellbeing and independence.
The embedded document outlines the measures agreed and associated data sources and gives the current picture for Bury against each indicator.

JOF overarching indicators June 14 v2

Better Care Fund Metrics

The Better care Fund metrics provide us with more immediate feedback on whether the work we are doing is delivering the system changes that we are driving towards. We are building on work undertaken by Greater Manchester CSU on developing a Performance dashboard for the Healthier Radcliffe Demonstrator and the Non Elective Story Board (see embedded document) to develop a single whole Borough , whole system dashboard incorporating the BCF metrics using software recently purchased by the Local Authority.

As an interim whilst the dashboard is developed, we will be collating current performance reports on the different metrics to create a single monthly report provided to the Joint Commissioning Group, Provider Partnership Group with exception reporting to the Health & Social Care Integration Partnership Board.

NEL.xls

Scheme indicators
The key indicators on progress will be incorporated into the above dashboard in time. Meanwhile monthly progress reports will be collated and provided to the Joint Commissioning Group and Provider Partnership with exception reporting to the Health & Social Care Integration Partnership Board.

Risks
Risk associated with the delivery of the Better Care Fund Plan and associated schemes have been identified in the Risk Log in Part 1 Appendix 3.

Any risks that may affect the delivery of the Better Care Fund will be raised with the Joint Commissioning Group as part of the regular reporting of the performance of the scheme. Mitigating actions will be undertaken to reduce the likelihood of the risk arising or to address the risk. If this is not possible and potentially means that plans could go off track, then this will be escalated to the Integrated Health & Social Care Partnership Board.

What are the key success factors for implementation of this scheme?

- Integrated pathway
- Improved patient journey
- Effective Navigation service in the Acute Trust both in A&E and Discharge
- Robust pathway development
- Efficient collection and analysis of data
- Buy-in of external stakeholders

Appendix 1 - Impact of schemes Metrics Mapping

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Scheme	Scheme Description	Metric 1 - Residential Admissions %	Metric 1 - Residential Admissions Nos of people	Metric 2 -Reablement %	Metric 2 -Reablement Nos of people	Metric 3 -Delayed Transfers of Care %	Metric 3 -Delayed Transfers of Care Nos of people	Metric 4 -Avoidable Emergency Admissions %	Metric 4 -Avoidable Emergency Admissions Nos of people	Metric 5 - Patient experience %	Metric 6 - Local metric - Falls %	Metric 6 - Local metric - Falls Nos of people
BCF01	Staying Well	10%	1	0%	0	0%	0	5%	49	20%	5%	2
BCF02	Extended access to Primary Care	10%	1	25%	2	5%	13	30%	296	20%	5%	2
BCF03	Integrated Health & Social Care	35%	2	30%	2	15%	39	30%	296	20%	20%	8
BCF04	Care of Vulnerable Adults	35%	2	5%	1	15%	39	30%	296	20%	20%	8
BCF05	Integrated Intermediate Care, Reablement and other related services	10%	1	40%	2	65%	167	5%	49	20%	50%	21
Total		100%	7	100%	7	100%	258	100%	986	100%	100%	41
		Annual change in admissions - 7 Annual change in admission % -3.2		Annual change in proportion 1.3 (equate to 7 people) Annual change in proportion % 1.5%		Annual change in admissions - 258 Annual change in admission % - 10.7%		P4P annual change in admissions - 986 P4P annual change in admissions % -5%			Annual change in emergency hospital admissions for injuries due to falls (65+) -41 Annual change in emergency hospital admissions for injuries due to falls (65+) -6.7%	

2015-16 change (from 2014-15)

Low = up to and including 10%

Moderate = 11-20%

Significant = greater than 20%