Team Bury
Working Together For A Better Bury

Bury Locality Plan

'Bolder, Braver Bury – Towards GM Devolution'

2016 - 2021

Version – Final (Updated)

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OUR APPROACH

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

Our approach is a simple one (See Appendix 3 for a graphical representation) - in order to achieve a narrowing of the potential financial gap at the same time as delivering consistent or improved outcomes for our population, there will be four key themes to our work locally:

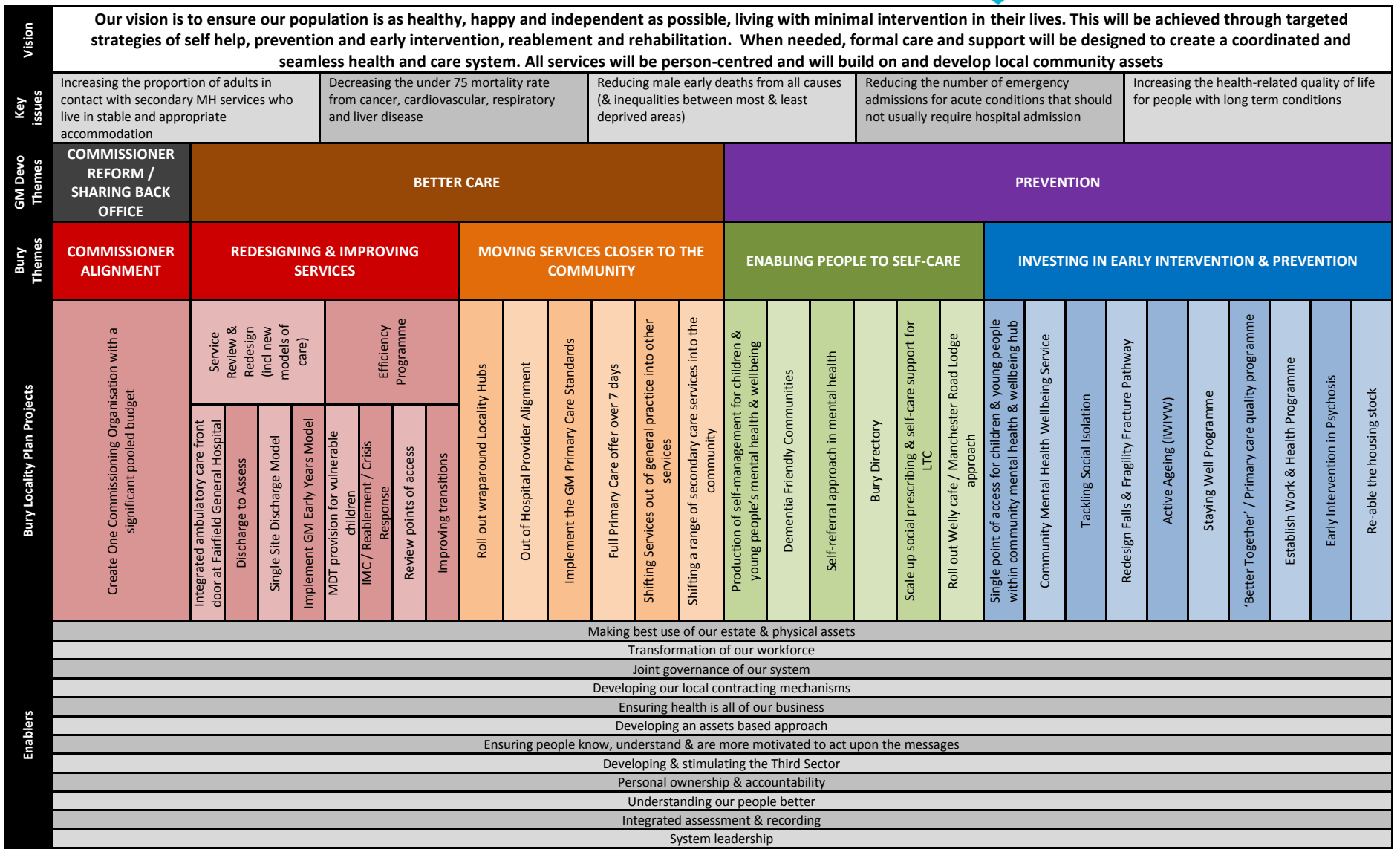
1. **Redesigning & Improving Services**: Our intention is to maximise the use of the Bury pound to support the citizens of Bury to live longer, happier lives, ensuring that everything we do is fit for purpose and as efficient and effective as it can be. We will quickly develop and upscale a number of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

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

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

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

This can be represented diagrammatically as shown over the page, including how these link to the Greater Manchester thematic work and our local vision.


Vision
Our vision is to ensure our population is as healthy, happy and independent as possible, living with minimal intervention in their lives. This will be achieved through targeted strategies of self help, prevention and early intervention, reablement and rehabilitation. When needed, formal care and support will be designed to create a coordinated and seamless health and care system. All services will be person-centred and will build on and develop local community assets
Key issues
Increasing the proportion of adults in contact with secondary MH services who live in stable and appropriate accommodation
Decreasing the under 75 mortality rate from cancer, cardiovascular, respiratory and liver disease
Reducing male early deaths from all causes (& inequalities between most & least deprived areas)
Reducing the number of emergency admissions for acute conditions that should not usually require hospital admission
Increasing the health-related quality of life for people with long term conditions
GM Devo Themes
COMMISSIONER REFORM / SHARING BACK OFFICE
BETTER CARE
PREVENTION
Bury Themes
COMMISSIONER ALIGNMENT
REDESIGNING & IMPROVING SERVICES
MOVING SERVICES CLOSER TO THE COMMUNITY
ENABLING PEOPLE TO SELF-CARE
INVESTING IN EARLY INTERVENTION & PREVENTION
Bury Locality Plan Projects
Create One Commissioning Organisation with a significant pooled budget
Service Review & Redesign (incl new models of care)
Integrated ambulatory care front door at Fairfield General Hospital
Discharge to Assess
Single Site Discharge Model
Implement GM Early Years Model
Efficiency Programme
MDT provision for vulnerable children
IMC / Reablement / Crisis Response
Review points of access
Improving transitions
Roll out wraparound Locality Hubs
Out of Hospital Provider Alignment
Implement the GM Primary Care Standards
Full Primary Care offer over 7 days
Shifting Services out of general practice into other services
Shifting a range of secondary care services into the community
Production of self-management for children & young people's mental health & wellbeing
Dementia Friendly Communities
Self-referral approach in mental health
Bury Directory
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Roll out Welly cafe / Manchester Road Lodge approach
Single point of access for children & young people within community mental health & wellbeing hub
Community Mental Health Wellbeing Service
Tackling Social Isolation
Redesign Falls & Fragility Fracture Pathway
Active Ageing (IWIYW)
Staying Well Programme
'Better Together' / Primary care quality programme
Establish Work & Health Programme
Early Intervention in Psychosis
Re-able the housing stock
Enablers
Making best use of our estate & physical assets
Transformation of our workforce
Joint governance of our system
Developing our local contracting mechanisms
Ensuring health is all of our business
Developing an assets based approach
Ensuring people know, understand & are more motivated to act upon the messages
Developing & stimulating the Third Sector
Personal ownership & accountability
Understanding our people better
Integrated assessment & recording
System leadership

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

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

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

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

- Key Greater Manchester wide devolution programmes focussed on mental health, primary & social care transformation, prevention & early intervention, IM&T, public estate, workforce, organisational development (see Appendix 1)
- Wider work around public service reform
- The Public Health Memorandum of Understanding programme
- The plans developed by providers to take account of opportunities to deliver better care with higher levels of productivity and more effective use of their combined estates
- The work delivered locally and regionally by the 'Transformation Prospectus'
- The impact of the Healthier Together programme, reorganising and improving the care delivered by hospitals in the Greater Manchester area and changing the way in which Bury residents are treated across the sub-region
- The transformation plans of Pennine Acute Hospitals Trust
- Local and regional responses to the NHS 5 Year Plan

We recognise that acute hospital services provide a key component of the care pathway for patients experiencing acute illness and / or whose condition cannot be managed safely in the community. Bury patients attend a range of hospitals for their secondary care and each of these have transformation proposals; however most of our patients receive their hospital care from Pennine Acute hospitals.

Pennine Acute Hospital NHS Trust provides a range of hospital, specialist, integrated and community services to the localities of Oldham, Bury, Heywood, Middleton and Rochdale and North Manchester (covering a population of around 820,000). Services are delivered from four major sites: Royal Oldham Hospital, North Manchester General Hospital, Fairfield General Hospital in Bury and Rochdale Infirmary, together with the Floyd Unit.

Services are operated using a single service model which balances locally based services, close to the patient's home, with a range of consolidated services eg: Stroke services for the north east locality are consolidated at Fairfield General Hospital, Gastroenterology at Royal Oldham, etc. Consolidated services have higher volumes, standardised approaches and

less variation, which in turn offers better outcomes for patients and economies of scale in terms of delivery.

The Royal Oldham has been designated as a specialist hospital under Healthier Together, supported by North Manchester and Fairfield General Hospital as local hospitals. Healthier Together changes enhance the current single service model with Acute Surgery and Acute Medicine at the Royal Oldham.

Building on Healthier Together and working in partnership with commissioners, the Trust has commenced a clinical service transformation programme that covers its full range of services and aims to deliver clinical and financial sustainability by 2019/20.

Most of the ill health suffered by our local population is not inevitable but can be seen as a consequence of how we organise and manage our society. The local health profile is shaped not only by our local actions but also by regional, national and global influences beyond our direct control. However, devolution offers a massive opportunity for us to gain more control locally over some of these wider determinants of health and to attempt to re-create a system and society that does more to promote and enhance health and well-being.

We already recognise, through the wider public services reform work, that creating investment in jobs and housing will not only improve the infrastructure of the town, but will also create better prospects for the population through increased wealth and opportunity for individuals and localities; with this comes greater wellbeing and better health.

Much of the demand for health and social care is driven by the wider determinants of health: economic security, housing, and criminal justice manifesting themselves in complex needs and poor health and well-being - for example mental ill-health, substance misuse and multiple long term conditions. The health & social care system cannot therefore act in isolation – if we are to secure good wellbeing for our citizen's than many other agencies and teams have an active role to play.

Lifestyle Choices (eg: smoking, alcohol, drugs, diet & exercise)

- Continuation of the multi-agency working to tackle incidents of domestic violence which will help to reduce the number of emergency admissions and episodes of acute care, as well as reducing issues related to mental health
- The Early Years Services changing the current model of early help support (moving from targeted interventions to a self help approach and empowerment model, using the assets within the community of its people and resources) to continue their work on improving the quality of life of the youngest members of society, so that they can grow up healthily, have better health in later life, have better educational achievement and improve their future life chances
- Continuation of the multi-agency Supporting Communities, Improving Lives (SCIL) (Troubled Families) programme, targeting those families requiring the greatest levels of intervention from public services, helping to stabilise chaotic lifestyles and improve the health of those affected, such as through tackling dependency on alcohol or drugs
- Continue the work with sport and leisure providers to expand the reach of their programmes, such as I Will If You Will, and facilities are utilised to ensure that people are kept active and enabled to interact with a wider community

Social & Community Networks (eg: family, friends, wider social circles)

- Maximise the socialisation opportunities presented by physical activity programmes such as I Will If You Will
- Support for Third Sector will help support the development & maintenance of groups for people to attend or volunteer

Education

- Work with Adult education to ensure courses on self care and health lifestyles are on offer and targeted at those most in need of support
- Work with education providers to offer services via social prescribing
- Develop self-care offer at Children's Centres, Youth Service, Connexions, within schools, within Fostering Services and within providers such as Pennine Care, Pennine Acute, Persona and Six Town Housing

Training & Employment

- Investment in projects such as 'Working Well', Backing Young Bury (apprenticeships) and access to adult learning for people with mental health issues is all geared to enable people to move people closer to the jobs market. Finding stable employment will also allow people the means to enjoy better quality housing and lifestyles

Welfare

- Maximising the impact of affordable warmth initiatives by targeting 'hot spots' to raise awareness and that schemes are targeted at those most in need, seeking to reduce excess winter deaths, and that take up is maximised
- Work with a range of agencies to see if assessment process can include welfare / benefits and debt
- Link debt advice & welfare services to Children's Centres

Housing

- Strategic Housing Services, housing providers and Six Town Housing utilising 'troubled families' principles to address the needs of complex individuals, increase homeless preventions and reduce the health impacts of rough sleeping
- Continue to work with housing providers to establish new models of housing which support self care which will inevitably involve the use of technology such as telecare and telehealth
- Working with house builders and housing providers to develop communities by ensuring that people can have 'homes for life' and can be enabled to remain in their own homes for as long as possible
- Working with house builders and housing providers to ensure housing is dementia friendly
- Working with the Fire Service to improve the quality and safety of properties

Transport

- Working with Transport for Greater Manchester to develop the transportation infrastructure in a way that promotes the use of walking, cycling and public transport use
- Working with Transport for Greater Manchester to ensure that public transport access to localities and facilities is good, especially during evenings and weekends
- Working with Transport for Greater Manchester to ensure no communities become isolated through lack of access to public transport
- Work with Transport for Greater Manchester to support uptake of subsidised and specialised travel (eg: travel cards, ring & ride)

Amenities

- Working with the Planning function of the council to ensure that our outside spaces are inclusive to all, conducive to health and are designed to take into account the needs of all of our population
- Working with council departments such as Licensing & Planning to ensure that town centre environments are safe and usable by all throughout the day and night and that they help to create an 'environment' that nurtures health
- Working with Planning and Building Control to ensure that dementia friendly environments are created wherever and whenever possible

General Socioeconomic, Cultural & Environmental Factors (eg: wages, income, availability of work, taxation, prices, food, clothing, etc)

- Work with welfare and debt support agencies to ensure people's income is maximised
- Work with Bury Third Sector Development Agency (B3SDA)to develop a volunteering offer to support third sector groups / agencies and to support people to connect with communities / form support networks
- Maximise use of volunteering opportunities by Museums, Libraries, Children's Centres, Youth Services, Connexions, Adult Education, Parks & Countryside & social inclusion services
- Explore use of spare land and food recycling schemes to get people growing their own food and eating healthily

Justice

- Continue to take a more preventative focus on reducing first time entrants to the criminal justice system and reducing re-offending, as this will not only improve the life chances of offenders and potential offenders but also improves the lives of victims of crime and the wider community, though improved perceptions of safety and cohesiveness in communities

FINANCIAL CONTEXT

Bury CCG, and its predecessor, Bury PCT, have experienced significant financial challenges over the last 5 years and were in formal financial turnaround until 2012/13. Bury CCG's revenue allocations in 2014/15 are £17m behind the calculated target for the size and need of its population and whilst it is on a gradual trajectory to target in accordance with the NHS England pace of change allocations policy, it is expected to be significantly behind target for the foreseeable future.

For the CCG, recent investment in the Better Care Fund also requires corresponding reductions in expenditure elsewhere eg: non elective admissions.

The local authority has been equally challenged, with council wide savings of £16m required for the financial year 2015/16, of which adult social care's share is £4.2m, some 9% of net budget. This scale of saving may well be similar in coming years, although future financial settlements are currently unknown.

Bury also suffers from underfunding in primary care, which is at an average of £109 per head of population, compared to £136 nationally - using the Mid-2013 population estimate of 187,000 people in Bury, this equates to an annual shortfall of around £5 million.

The implication of such constrained funding regimes in both social care and health is the lack of resources available to pump prime new, innovative schemes to provide local evidence towards improved outcomes. This is a significant risk for the Bury locality, both in terms of achieving reductions in acute activity, but also in terms of capacity within both organisations to review, reshape or decommission existing services.

Reducing resources, coupled with the rising demand for services, means that standing still is not an option for Bury; in order to ensure the future sustainability of the system, our principles of change must be underpinned by an approach to self care, leading to changes in the behaviour of both staff and the population of Bury, and ensuring that people have access to information and advice and can use community assets to help to keep themselves happy and healthy.

The Council's budget setting process is well underway, with engagement from Executive Directors and Elected Members over possible savings proposals. There remains considerable uncertainty of the level of cuts given the lack of funding detail from the Government, however we hope this to be firmed up by the Comprehensive Spending Review on 25th November and, ultimately, the Settlement itself in December. We feel we have been cautious in our estimates as to Government funding levels.

The next step will be public consultation, due to commence early December 2015 where budget options will be outlined.

The budget will be formally set at the Council Budget Meeting on 24th February 2016.

SNAPSHOT OF THE LOCALITY

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

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

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

- The consequences of the growth and profile of our population will increase demand for services, particularly from older people
- The effect of social deprivation on poorer health outcomes for some of our population compared to others
- Social exclusion is both a cause and consequence of poor health outcomes and often results from limited rights, resources and opportunities
- The impact of lifestyle choices which are increasing the demand on services, increasing inequalities and will result in higher levels of ill-health and lower levels of wellbeing
- Premature mortality is higher than expected given our levels of deprivation

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

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

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

This will be achieved through targeted strategies of self help, prevention and early intervention, reablement and rehabilitation, which will support reductions in activity in acute services – supporting financial sustainability. When needed, formal care and support will be designed to create a coordinated and seamless health and care system. All services will be person-centred and will build on and develop local community assets.

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

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

In order to achieve a narrowing of the potential financial gap at the same time as delivering improved outcomes, there are four key themes to our work:

1. **Redesigning & Improving Services**: Our intention is to maximise the use of the Bury pound to support the citizens of Bury to live longer, happier lives, ensuring that everything we do is fit for purpose and as efficient and effective as it can be. We will quickly develop and upscale a number of services/projects in order to save money and to create an investment fund for our longer term work, whilst maintaining or improving outcomes for the people of Bury. We will also be changing the way we commission services and from whom. Health and Social Care will work together as if one commissioning organisation with aligned commissioning intentions, a significant pooled budget and shared back office functions.
2. **Moving Services Closer to the Community**: Here we will start to move services out of acute settings and into appropriate community ones. Some of this will require investment / pump-priming.
3. **Investing in Early Intervention & Prevention**: We will invest in evidence led interventions which will be designed to reduce the prevalence and severity of health conditions over the short, medium and longer term.
4. **Enabling People to Self Care**: Here we will work to engage people in being part of the solution and ensuring they take a significant and active part in living longer and more healthily.

All of our Locality Plan work will need to reference and take account of the wide range of workstreams that are being led at and delivered by Greater Manchester wide thematic groups (See Appendix 2) – eg: Estates; Primary Care Transformation; Mental Health and Children & Young People's Mental Health; Information Management & Technology; Learning Disability; Early Years; Housing; Dementia; GM Leadership within New Society; and GM Specialised Services Transformation Programme.

REDESIGNING & IMPROVING SERVICES

In order to obtain maximum value for the poor levels of funding that Bury receives and in order to close the financial gap as much as is safely possible, we need to ensure that all of our services are fit for purpose and as efficient as possible. With the provision of excellent outcomes at the heart of what we will do, there are also a number of short term gains that can be made in terms of known projects or service redesigns that we can get on with immediately. This will not only contribute to the closure of the financial gap, but will also help us to create an investment fund for use to further develop / implement this area or to progress work in the other three areas.

WHERE ARE WE NOW?

- An uncoordinated arrangement of services and programmes which needs rationalisation
- Very little funding available for investment
- Services commissioned in isolation / silos
- Services provided in isolation / silos
- Multiple hand-offs for service users

WHERE DO WE WANT TO BE?

- Aligned / Integrated commissioning of services across both the health & social care economy, as well as wider wellbeing services
- Greater alignment amongst providers and more partnership working across public, private and third sectors, for health and social care provision.
- A deeper and broader set of integrated services
- Service users treated for the minimal amount of time in the most appropriate place
- Reduce the number of excess bed days
- Increased capacity within the intermediate care and reablement services

WHAT WILL WE DO TO GET THERE?

- Create one Commissioning Organisation with a significant pooled budget, in shadow form initially from April 2016, bringing council and CCG commissioners together as one organisation is to ensure that joined up commissioning of health, social care and wellbeing services is undertaken, through the whole pathway from asset based early intervention to acute hospital services. This will reduce duplication and facilitate holistic, person-centred approaches to service design and development, supporting financial sustainability of the health and care economy in the longer term. It will also help to drive a variety of forms of provider alignment. For this to be successful there are a number of other linked areas of work that need to happen:
  - Fostering a more collaborative approach to working with providers as well as fostering collaboration between providers across all sectors
  - Fostering innovation and having a system that is responsive to opportunities and that can change quickly without being hindered by bureaucracy
  - Adopting a whole population approach rather than commissioning for an age group or a particular disease
- Undertake a risk based, programme managed review of all commissioned / delivered services to understand if they are efficient, effective and focused on delivery of the new vision. This will lead to a programme of service review / redesign / (de)commissioning activity that will deliver savings and better outcomes in the short (Yrs 1 & 2), medium (Yrs 3 to 5) and longer term (Yrs 6+).
- Develop an integrated ambulatory care model, which acts as a primary care front end at Fairfield General Hospital Accident & Emergency Department. This will ensure that people are cared for in the right place at the right time. Services will include GP services, all age Crisis

Response services and palliative care provision which will be provided on the hospital site, as this is where people are attending to access help and support. The service will reduce the number of non-elective admissions and inappropriate attendance at A&E.

- Leading on behalf of the North East Sector, establish a single discharge service at the Fairfield General Hospital site to support improved performance around this key acute target, by freeing up beds within the hospital in a timely manner for people who are medically fit for discharge (MFFD). We will work towards a 'trusted assessor' model making most effective use of limited health & social care resources within the locality and across localities.
- Develop a ward-based 'Discharge to Assess' model within the hospital environment that cohorts MFFD patients and supports the in-reach of community services in support of discharge arrangements. Over time, we will look to move this into a community setting.
- Merge the Intermediate Care and Reablement Services across health and social care to have one clear pathway for intermediate care provision and ensure that specifications and admission criteria are aligned with hospital sub-acute rehabilitation services to ensure that there are no service gaps. The redesign of the intermediate care pathway will include Crisis Response services to improve the flow of service users through these services. In addition to streamlining the 'step down' intermediate care provision, we will also look to develop the service as a 'step up' one to reduce hospital admissions and ensure that people are cared for in the right place at the right time.
- Implement the Greater Manchester Early years New Delivery Model - A new model of integrated provision for 0-5s across healthcare, children's services and early years education providers. It is an eight stage assessment model supported by evidence based universal and targeted interventions to improve health outcomes and school readiness for children. This will lead to reduced complications of pregnancy, reduced demand on GP Practices and reduced childhood admissions to hospital.
- Merge the services focused on vulnerable children into a single multi-disciplinary team, rationalising processes and systems, where possible, and improving capacity within the service. We will explore the possibility of making this an 'all age' service, further improving efficiency and addressing issues around transition
- Review and make clear the access points to the health and social care system across Bury, rationalising where possible and streamlining to common processes where possible. We will also explore the role of Third Sector organisations in this, which is linked to our work on locality hubs, the primary care front door at Fairfield General Hospital and our proposed work around alignment of out of hours hospital provision.
- Undertake a review of points of transition, either between health and social care or between children's and adult or between services to understand and address any common points of failure. This will improve transition as a process and potentially stop service breakdowns and the need for high cost interventions at a later stage.

HOW WILL WE KNOW WE HAVE BEEN SUCCESSFUL?

- Reduction in the number of emergency admissions for acute conditions that should not usually require hospital admission
- Reduction in the length of acute stay by patients who are medically fit for discharge
- Reduction in readmission rates
- Reduction in the level of excess bed days
- Reduction in the level of acute bed stock
- Increased numbers of service users seen by the IMC / Reablement services
- More effective use of commissioning funds, especially where services are joint commissioned or have singly been commissioned in the past.

MOVING SERVICES CLOSER TO THE COMMUNITY

To support the closure of the financial gap, we will look to develop community based/community focused services which support the movement of care out of an acute setting and into a community one. In order to do this, there may be an element of investment required to cover capital costs, pump priming or double running.

WHERE ARE WE NOW?

- Large numbers of services are delivered from an acute setting, using high cost medical models
- Traditional service models
- Fragmented services delivered across a range of sectors and locations

WHERE DO WE WANT TO BE?

- Larger proportion of services delivered in the community
- Greater horizontal and vertical integration of services

WHAT WILL WE DO TO GET THERE?

- Roll out wraparound locality hubs, which build upon the successes of the Healthy Radcliffe project and provide a full range of primary and non-specialist healthcare services alongside social care and voluntary, community and third sector services. This will allow for a holistic, locality-specific wraparound service offering to be developed which will include appropriate secondary care services. Our ambition is for them to be a 'one stop shop for care'.
- Push for greater provider alignment, using our new aligned commissioning arrangements, across all sectors, for out of hospital provision. If providers engage in effective partnership, then we can genuinely make shared budgets a reality. For this approach to be successful, new accountability and joint working arrangements will be essential elements of delivering our local vision. This will include alignment of local authority social care provision with Pennine Care's community provision. This work will mean that there are more seamless services from a customer perspective and efficiency savings for commissioners
- Fully implement the Greater Manchester Primary Care Standards, ensuring consistent quality delivery offer
- Expand the seven day GP offer to include a wider primary care offer, such as diagnostics and pharmacy to ensure that people receive seamless care and treatment regardless of the day of the week.
- Encouraging groups of GP practices to work together to offer some specialisms within communities and shifting some services out of general practice into other services - this will free up capacity within the general practice sector, make best use of the skills in general practice and the wider primary care sector and ensure that primary care services work in partnership (rather than in competition)
- Take a range of secondary care services out into the community, using a range of different providers and delivery models. This will mean that services can be provided in a more seamless manner at a venue closer to the patient. Whilst this list will grow and change over time, initial areas to explore include:
  - Secondary mental health services
  - Children & Young People's Mental Health (CAMHS) services
  - Eating Disorder services
  - Some diagnostic services
  - Pain management services
  - Cardiology services
  - Audiology services
  - Routine outpatient appointments
  - Paediatric services

HOW WILL WE KNOW WE HAVE BEEN SUCCESSFUL?

- Reduction in acute sector spend
- Reduction in admission rates
- Reduction in the level of excess bed days
- Reduction in the level of acute bed stock

INVESTING IN PREVENTION AND EARLY INTERVENTION

In order to reduce demand upon acute and high costs services, we will invest in evidence led interventions which will be designed to reduce the prevalence and severity of health conditions over the short, medium and longer term.

WHERE ARE WE NOW?

- An uncoordinated arrangement of small-scale services and programmes which needs rationalisation
- Very little funding available for investment
- Services commissioned in isolation / silos
- Services provided in isolation / silos
- Traditional approach by organisations within the third sector, in general
- Lack of appropriate infrastructure and capacity within the system
- System oriented towards 'see & treat' rather than 'detect & prevent'

WHERE DO WE WANT TO BE?

- Joint commissioning of services across wellbeing and preventative services
- Integration of services to address a common set of service users
- Greater focus on prevention and early intervention in services
- Creation of a whole system, place based approach to improving health and wellbeing

WHAT WILL WE DO TO GET THERE?

- Implement a community mental health wellbeing service for adults.
- Implement a single point of access for Children & Young People's services within a community based emotional health & wellbeing hub.
- Develop a range of interventions that tackle issues of social isolation amongst older people, ensuring people understand and can access the support networks in their own communities and that the community looks out for people who are at risk of social isolation. This will keep people engaged with their own local community, support them to remain well and to remain in their own homes for longer.
- Redesign our Falls and Fragility fracture pathway and commission a primary care and acute fracture liaison service. We will also look to embed physical activity support across the pathway and provide a greater focus on prevention, ensuring appropriate interfaces with relevant services and maximising all opportunities for falls prevention across the system. This will lead to reduced outpatient appointments, reduced hospital admissions, reduced complications from surgery and reduced demand for community services, social care, IMC & reablement services.
- Implement an 'Active Ageing' strand of the I Will If You Will programme, our nationally significant work to create a social movement for health and physical activity. This will focus on keeping people in later life active and support their continued mobility and social engagement.
- Implement a 'Staying Well' service across Bury, 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. Evidence suggests that this form of early intervention will have a significant impact of health and social care demand in the medium to long term - reducing social care costs, reducing nursing and residential care costs, reducing hospital admissions and reducing demand on primary care.
- Re-able the housing stock – aligning new build schemes to local needs, streamlining access to adapted properties, working with energy suppliers to reduce fuel poverty, working with private landlords to reduce hazards and develop housing options to increase the number of homeless preventions and minimise the need for rough sleeping.

- Scale up and expand the 'Better Together' / Primary care quality programme (LTC health checks) with an emphasis on CVD, Diabetes, COPD, Asthma, Blood Pressure, Cancer, Arterial Fibrillation & Osteoporosis, the physical health of those with mental illness and those with learning disabilities. This is an incentive & support programme to drive up identification of the missing thousands from high risk and disease registers in primary care and ensure systematic best care for all patients. Currently there are a significant proportion of population with unidentified and therefore unmanaged disease; identification and effective management in primary care will reduce the progression of these diseases and reduce costs of more complex, expensive treatment and hospital admissions. It will include a range of medical and healthy lifestyle interventions where appropriate. This will help to find and treat people earlier, will prevent future prescribing costs by intervening with those at high risk CVD and pre-diabetes, reduce hospital admissions, reduce hospital outpatient appointments and mean there are fewer complications from surgery.
- Establish a work and health programme in Bury to support those at risk of falling out of employment due to ill-health to remain in work. This will build upon the pilot undertaken by Greater Manchester Public Health Network and will ensure access to assets such as employment, decent housing and social support in order to help reduce recovery times and prevent increased in co-morbidity. This will lead to reduced demand on primary, community, social and secondary care services and reduced demand on mental health and substance misuse services.
- Ensure that adults experiencing a first episode of psychosis start treatment in early intervention in psychosis services within 2 weeks of referral. Early intervention in psychosis services are multi disciplinary community mental health teams that aim to provide a full range of pharmacological, psychological, social occupation and educational interventions for people with psychosis. This will support the prevention of relapses and reduce long term impacts.

HOW WILL WE KNOW WE HAVE BEEN SUCCESSFUL?

- Improved health behaviours
- Shift in balance of resources between acute and community based services
- Increased health related quality of life for people with long term conditions
- Reduction in admission rates
- Reduction in relapses for people with a first episode of psychosis
- Reduction in referral to treatment times

ENABLING PEOPLE TO SELF CARE

In order to embed a longer term reduction in demand for services and to support a change in behaviour by people around health and care, we will work to engage people in being part of the solution and ensuring they take a significant and active part in living longer and more healthily. We will also need to review what we are going to stop doing in order to enable people to take individual ownership for their health and wellbeing.

WHERE ARE WE NOW?

- Historically an area that has been under-funded / neglected
- Previously, no strategic approach to developing this area - it has emerged piecemeal up until now

WHERE DO WE WANT TO BE?

- People take responsibility for their own health and social care
- We recognise that there should be a 'peer to peer' relationship between people and professionals, rather than a 'parent-child' relationship
- People recognise they have an integral role to play in supporting their own health, care and wellbeing and can bring their own assets and resources to be part of the solution

WHAT WILL WE DO TO GET THERE?

- Further develop our dementia friendly communities initiative. Broadly, we want a society where the public thinks and feels differently about dementia, where there is less fear, stigma and discrimination, more awareness of how to live a healthy life to reduce the risk of developing dementia in later years; and more understanding of people living with dementia in the community. A society where every person diagnosed with dementia and those around them:
  - Has access to meaningful care following their diagnosis, which supports them and those around them
  - Receives information on what post-diagnosis services are available locally and how these can be accessed
  - Has access to relevant advice and support to help and advise on what happens after a diagnosis and the support available through the journey
  - Is given the opportunity for advanced care planning early in the course of their illness, including plans for end of life.
  - Is given the opportunity to access relevant assistive technology to enable then to continue to live well

  We will continue to raise awareness of dementia by ensuring all of our staff receive the appropriate level of training required to carry out their responsibilities and by working with schools and within communities. Our aim is for Bury organisations to achieve the BSI standard for recognition as a Dementia Friendly Community. To achieve this we will work towards developing dementia friendly environments in hospitals, GP surgeries, public buildings, dentists, pharmacists, opticians, care homes, local businesses and dementia friendly public transport and taxis. We will continue to engage in regional and national initiatives to enhance local services.
- Develop a self referral process in mental health services for children and young people to align with the self referral process that has been successfully implemented within adult mental health services
- Production of self management materials for mental health and wellbeing, funded through the Children & Young People Local Transformation monies.
- Optimise use of the Bury Directory, expanding it to cover the wider health and wellbeing economy. The Bury Directory is a key tool to support people to make people aware of and so access local services. The Bury Directory lists the community assets and support networks available across the borough, together with details of how these services can be accessed.

- Scale up social prescribing and self-care support for people with long term conditions. This will put patients in the driving seat of their own care and could reduce demand upon primary, community, social and secondary care services.
- Roll out of the Welly Cafe / Manchester Road Lodge approach to providing support for people with disabilities wishing to enter / re-enter the employment market.

HOW WILL WE KNOW WE HAVE BEEN SUCCESSFUL?

- Asset based approach embedded across health and social care
- People recognise and value their role in their own health and wellbeing
- Improvement in user satisfaction rates re: access to advice and information

There are a number of local enablers that underpin this work and support the delivery of this change. These include:

- **Use of the estate and other physical assets**
  - Over the last few years public sector organisations within Bury have been working successfully to remodel and achieve efficiencies from their estates. However it is recognised that a more collaborative and innovative approach is now required to be able to break down historic barriers and to pool resources more effectively for the wider system benefit. This approach aligns fully with the Greater Manchester 'one public estate' initiative. Bury has formed a Strategic Estates Group (SEG) which will play a critical role in ensuring the public estate can support the delivery of commissioning and service redesign plans for the benefit of patients, staff and the taxpayer.
  - Bury's SEG will maintain a 'service led' rather than 'asset led' approach that fits with the 'Place' agenda for local services and supports partner organisations to remodel their estate more effectively at a central and local level. In general terms, the vision is for partners to effectively collaborate in relation to strategic asset management and to rationalise the property estate currently used leaving one that is:
    - In the right place, in the right condition, at the right time
    - Flexible and sustainable in use now and in the future
    - Able to deliver value for money in terms of service benefit, operating costs and financial return
    - Able to contribute to the reduction in the combined carbon footprint of Bury
  - Our approach will encompass primary care alongside the broader health and social care system, linking also to the Healthier Together programme and the Greater Manchester Devolution Programme.
  - The proposal is to pilot the service led approach to Estates through the new Whitefield Health centre development. This NHS England funded integrated health and social care facility will open in 2017.
  - Areas to explore which can complement our current proposals or act as a catalyst for change include: looking at using buildings as 'hubs' for multi-agency teams to work from; use of buildings as a single 'front door' to a variety of services or agencies; and the potential for community ownership.
- **Transformation of our workforce**
  - In developing the integration agenda we need to reshape the workforce to one that is able to deliver coordinated care in new ways, focusing on the person as an equal partner in their care and support and promoting self-management to improve community resilience. The key implication is that more of the health and care workforce will also have to work more within the community.
  - Whilst having a clear values-based driver, the self-management support agenda is also identified as a pragmatic enabler for services to manage an increasing demand on services, with an ageing and increasingly complex population. With people supported to manage their health and wellbeing, this creates capacity to target resource to areas of greatest need.
  - A critical barrier to this is eliciting behavioural change across the workforce to support better self-management. It has been recognised nationally that services are traditionally delivered in a paternalistic culture, which creates dependency on services/practitioners, and limits the extent to which people are supported to be empowered to take responsibility for their own health and wellbeing. Shifting towards a much more enabling, co-produced, person-centred culture is the aspiration for Bury. The challenge for us in Bury is how we do this on a system wide basis ensuring effective workforce leadership to support behavioural change so that we can deliver the right care in the right place at the right time.
  - We will need to explore how staff can be facilitated to work in multi-disciplinary teams, exploring and addressing issues around single

line management, governance and professional support, breaking down barriers between the traditional tasks undertaken by certain roles, the changing training and development needs of this new breed of staff and issues around seven day extended working.
    - We will also need wider considerations around the implementation of the living wage, the skills availability within the labour market, the labour market's vibrancy, the fee rates paid to contractors and our payment mechanisms.
    - We have a number of very distinct organisational cultures within the health and social care economy and so, as we integrate a number of organisations, services, functions and teams, we should celebrate that diversity and ensure that the best of each culture is retained and given prominence in the new world.
- **Joint governance of our system**
    - We currently have 3 separate governance systems for the health and social care economy - political, clinical and operational/ organisational. Whilst we have joint governance arrangements in place across the locality, this will need to build in a further level of 'locality' governance and so we need to review our current arrangements and ensure that they are fit for the future.
- **Developing our local contracting mechanisms**
    - We need to ensure that our contracting mechanisms allow us to develop and embed the range of services and skills that we require from providers in the future. Whilst not an exhaustive list, there are several key enablers that we feel need addressing in the short term if change is to be both rapid and sustainable. These include:
        - Allowing the flexibility to move away from set nationally driven tariff rates to something that rewards innovation and delivery of our local key outcomes
        - Having contracting mechanisms that support and reward partnership; rather than ensuring providers are in strict competition with each other
        - Moving to a contracting for outcomes basis as opposed to one that rewards activity as well as having flexibility within contracts that allows for innovation at pace in order to take advantage of opportunities as they present themselves
        - Having a contracting system that does not place any unnecessary barriers in the way of third sector organisations being able to win contracts
        - Adopting a wider, more holistic definition of 'value'
- **Ensuring that health is all of our business**
    - This is an understanding that the key players are many and diverse, from the individual's role in maintaining their own health to non-traditional partners' contribution to health and wellbeing. There is a separate work stream planned around engaging individuals in their own health and wellbeing, but there also needs to be a another work stream around some of the wider determinants of heath and the active role they can play to create an 'environment' that nurtures health (eg: planning, roads and infrastructure, licensing, procurement, etc).
    - We will also look to develop a 'health in all policies' approach to strategy and policy making which can help to stimulate and maintain some of this change.
- **Developing an asset based approach**
    - We have identified the need to roll out an asset based community development approach as part of our locality place-based approach to service provision. We have also identified some of the mechanisms that will make this possible - expansion of the Bury Directory; mobilising personal (skills, knowledge) and social (connections and relationships) assets among staff and their customers/ service users; establishing community development programmes in our most deprived neighbourhoods; and developing our neighbourhood assets (eg: parks, leisure centres etc) as resources for community wellbeing.

- Staff who undertake 'assessments' of individuals will need to take an asset or strengths based approach to these, linking people to the skills, physical assets, communities and connections that they already have, ensuring these work in harmony with any planned health & social care interventions or services.
- This co-production approach also needs to be embedded within all of the major agencies that work within the health and wellbeing sector.

- **Ensuring people know, understand and are more motivated to act upon the messages**
  - For people to understand how the new health and social care system hangs together, what services are provided by whom and where, what our expectations of them are in terms of self-care, keeping well and using personal assets and what assets there are out in the community, we need to be able to get effective messages to people, in a manner that ensures they are heard and understood and using a delivery method they will engage with. We will develop a structured programme of marketing and communications alongside this programme of change and a social marketing approach to making sure key messages are targeted at those people we need to target them at.
- **Developing and stimulating the third sector**
  - There is a large element of using personal and community assets to stay healthy and to use self-care and preventative services to maintain your health or condition. At the same time, professionals need to think differently about how to address health conditions in a non-traditional manner (eg: social prescribing) and so it is vital that we have a vibrant and entrepreneurial third sector and that we stimulate volunteering activity in support of this.
  - We are also looking for a far more diverse range of health and social care provision within the market if we are to be able to reduce the levels of activity within the acute sector and to reduce the cost of services - one potential area to explore is provision of a larger array of services, either by third sector organisations or in partnership with them.
  - We therefore need to rethink the way in which we engage with the third sector in general and also with individual organisations. We also need to rethink how we support this sector to be 'match fit' to take on some of the opportunities that may present themselves and how some of our processes can act as barriers to this happening.
  - The use of volunteers is key to the delivery of community / social networks and also provision of many third sector services. We will work closely with the sector to stimulate and harness the volunteering capacity in a coordinated way locally
  - We need to signal clearly to the Third Sector what the size and makeup of the sector needs to be in the future in order to deliver on the local aspirations and ambitions. This will help the Third Sector to self organise and mobilise to deliver on this agenda and will allow us to work collaboratively with the Sector to ensure that organisations and services are developed in areas of most need, recognising that there is a risk to organisations at present from the lack of funding available to them.
- **Personal ownership and accountability**
  - Part of the new 'health deal' for Bury has to be that people recognise their own key role in living healthy lifestyles, remaining healthy and returning to good health as soon as they can. At the same time, they have a key role to play in solutions to their own ill health when it comes to the skills, experiences and assets that they can bring to bear in support of efforts by health and social care services.
  - This will need to be enforced at an individual level by the way in which assessments and conversations are undertaken; at a community level by engaging with groups and organisations to explain the approach and to reinforce this individual level messaging; and at a population level by marketing and communications activity.

- **Understanding our people better**
  - We currently have a whole host of person, community and population level data, with some key information that allows for this to be brought together in a more cohesive picture, which is reflective of the inconsistent level of intelligence within the JSNA. Individually, we have been good at leveraging the intelligence we each hold, but have been less successful as a health and social care economy. If you then add the wider intelligence available across other public services and agencies, there is a clear opportunity to produce a step change in the intelligence that all partners produce and how this intelligence is used to stratify risks within our communities and deploy our resources more effectively.
  - Whilst sharing and combining our data and sharing the skills and resources we have within our data / intelligence teams is one potential benefit, having a shared view of the world and the issues that need to be addressed means that all of the combined resources of the various agencies, and teams involved can be brought to bear on it in a more coordinated and effective way. This will also support the strategic development of both the third sector in general and particular provider organisations or sectors.
  - The Joint Strategic Needs Assessment (JSNA) for Bury is being redeveloped and has recently been through a phase of consultation and engagement. An operational group is being brought together to support the delivery of intelligence and insight to partners and agencies across Bury. The agreed purpose of the JSNA is to provide a centralised, valid and reliable data source which offers key information, analysis and interpretation to provide a detailed overview of the health, wellbeing and social care situation in Bury. The vision is for the JSNA to be a web based dynamic document used by a range of key stakeholders for the following reasons:
    - Developing policies and strategies
    - Commissioning services
    - Redesigning pathways/services
    - Putting in bids for services
    - More effectively focusing / targeting services
    - Working together with our partners in a more integrated way
  - As part of the development of the JSNA there is a workstream which is scoping out the availability and appropriateness of various customer insight and intelligence software and tools. It is recognised that we now need to explore, further than using standard segmentation, the characteristics of our residents and cohorts of residents to understand and target services effectively. For example looking at the geo-demographics of the non-elective admission cohort to understand what people are being admitted for and length of stay. Such research can only be possible by utilising the established relationship between the CCG and the council. Further work is underway to explore options on how both the intelligence functions within the council and the CCG can work in a more integrated way, share resources, tools and software and access to data.
  - If we are to truly address common issues in an integrated way then we also need to be bold about having integrated health and social care intelligence and performance, establishing a common language and set of geographies, sharing and aligning any insight and addressing any associated barriers.
- **Integrated assessment & recording**
  - For us to develop a truly integrated offer around health and wellbeing, we firstly need to understand the individual as a whole. Once we do, we can then offer holistic services that build upon the assets available to an individual and pulls upon our collective strengths and abilities. A single joint holistic assessment if therefore key and we will also look to work towards a trusted assessment model.

- We also need to use the IT systems available to us to be able to produce an integrated record, with access to appropriate parts available to the various professionals and organisations involved.
- We need to ensure that we effectively share data at an individual and at an aggregate level (for planning purposes) and develop a robust information governance framework.

- **Leadership**
  - We know we need to reshape the workforce to one that is able to deliver coordinated care in new ways, focusing on the person as an equal partner in their care and support and promoting self-management to improve community resilience. The self-management support agenda is also identified as a pragmatic enabler for services to manage an increasing demand on services.
  - A critical barrier to this is eliciting behavioural change across the workforce to support better self-management. It has been recognised nationally that services are traditionally delivered in a paternalistic culture, which creates dependency on services/practitioners, and limits the extent to which people are supported to be empowered to take responsibility for their own health and wellbeing.
  - The systems leadership activity that we propose to take forward is whole system workforce self-assessment of their service offer with regard to self-management support across Bury. This is a complex and demanding responsibility, especially in the context of changing services and financial pressures. We see it is a combination of four interrelated activities:
    - Workforce intelligence - analysing and managing information about the resources, capacity, skills and knowledge available to meet the demands of people using current services in Bury and the ability to promote self-management and state of readiness
    - Feedback from people who use our services - what are their future needs around workforce
    - Workforce planning - analysing population projections and estimating future numbers of people who are likely to need care and support
    - Workforce development - establishing a common vision and shared sense of purpose across partners, engaging with and motivating staff at all levels, and driving strategic changes such as the development of integrated workforce strategies and a self-management strategy

Much of the engagement around the development of the locality plan priorities has already been done as part of the original development of the individual elements of our plans; however, we plan to undertake some engagement as part of the development of this locality plan as a whole. This will include:

- Discussion at a range of partnership groups, such as the Health & Wellbeing Board, the Health & Social Care Strategic Partnership Board, the Joint Commissioning Group, our (health & wellbeing) Provider Partnership and our Community Engagement for Health Group
- A range of one to one / group meetings with key staff from a range of organisations, for example:
  - Chair of our strategic public sector estates partnership
  - Commissioning leads within the council and the CCG
  - Partnership leads within Children's Services
  - Clinical Commissioning Group Leads
  - Director of Public Health
- The senior management teams of the Communities & Wellbeing Department, the Children, Young People & Culture Department, the council as a whole and the Clinical Commissioning Group
- The Clinical Cabinet of the CCG
- Locality Plan development workshops with a range of stakeholders, including providers.

In order to ensure support for the new ways of working that are being proposed, it is important that people understand the need for change and effectively contribute to the design and re-shaping of health and care services through a co-production approach wherever possible. Examples of where this has been successful include:

- The CCG's Patient Cabinet and the Urgent Care Patient Focus Group involved in the development of the urgent care plan
- The council's engagement with local people as part of the 'Our Place, Radcliffe' project, which included the use of participatory budgeting to allocate grant resources locally
- The council's Customer Task Force group in the remodel of Advocacy Services and user testing of The Bury Directory
- Customer and Carer Engagement through meetings, workshops and questionnaires

A multi-agency 'Community Engagement for Health' group has also developed a number of locality plan proposals:

- Development of proposals around asset based community development
  - Allowing communities to drive the development process themselves, responding to and creating local economic opportunity
  - Driving the community development process and leverage additional support and entitlements
  - Building social capital
- Adoption of participatory budgeting as a means of allocating resources and influencing resource allocation decisions
- Examining and reducing the 'red tape' that creates barriers to communities self organising and doing things for themselves and presents an unnecessary administrative burden on third sector organisations
- Developing a strong and vibrant Voluntary and Community Sector which is resilient to funding challenges, providing services which meet the needs of local people and build on the strengths and opportunities of grass root organisations
- Development of a network of engagement mechanisms and further development of service user groups and community groups to share and spread best practice
- Developing a comprehensive approach to self care

THE FINANCIAL CHALLENGE

As stated previously, the Bury locality has a history of significant underfunding across health and social care. As a result, significant inroads have already been made in the efficiency and change agendas – many of the 'easy wins' have already been taken.

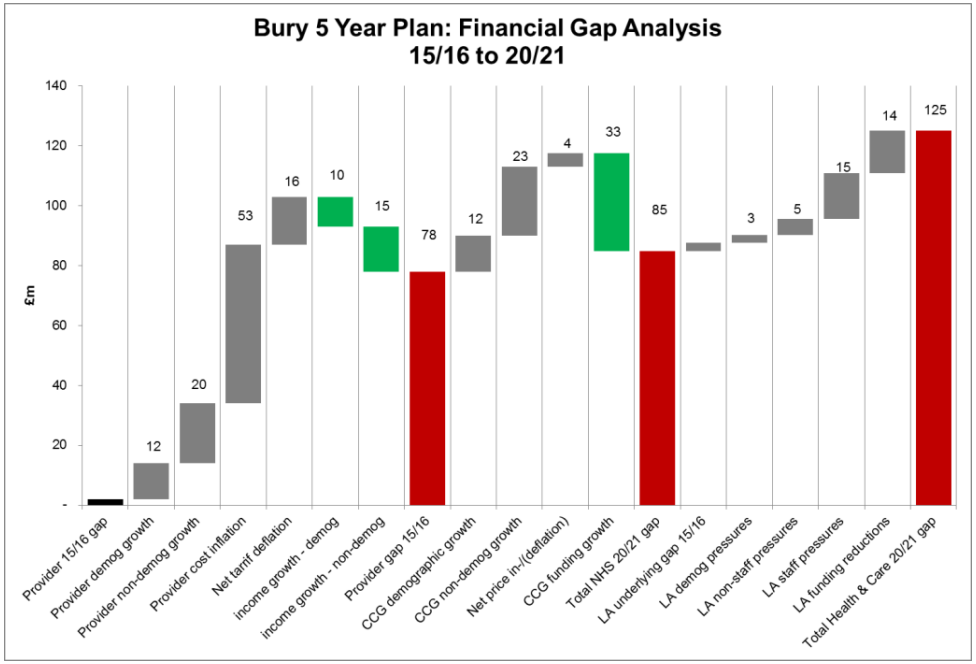
Financial modelling has been undertaken at a local level in order to assess the financial challenge facing the locality over the next 5 years. This shows:

- Commissioning resources are projected to be £379.3m per annum by 2020/21
- Without reform, commissioners would need to spend £426.1m each year by 2020/21 to meet health and care requirements.
- This leaves a joint financial challenge for commissioners of £47m per annum
- NHS providers face a financial pressure building up to £78m per annum without any further cost improvement and transformational changes.
- As a result the total financial challenge facing the health and care system in Bury by 2020/21 is forecast to be £125m per annum.

There are a number of key assumptions that have been used in these calculations:

- NHS provider figures have been taken from GM-wide analysis provided by the devolution team in order to allow for consistency and aggregation.
- CCG figures are based on the GM Five Year Forward View assumptions with the following adjustments:
- The baseline used is the 2015/16 forecast outturn as at month 6 (rather than 14/15 outturn used by GM)
- GP and directly commissioned Primary Care services have been included at an estimated baseline expenditure of £43m
- We have included additional recurrent pressures, over and above the standard GM assumptions, for the local impact of Mental Health Payment by Results (£1.5m) and other structural issues (£1m)
- We have assumed an additional £3.5m funding, over and above the standard GM assumptions, to reflect the NHSE commitment to bring all CCGs to within 5% of distance from target (DFT).
- The social care baseline spend figures are set based upon the 2015/16 position and include all adult and children's social care services.
- We have included estimates of known social care pressures and council funding reductions based on LGA projections applied to Bury Council's baseline spend.

The bridge chart below shows the components of this gap at the end of the 5 year period (2020/21).



CLOSING THE GAP

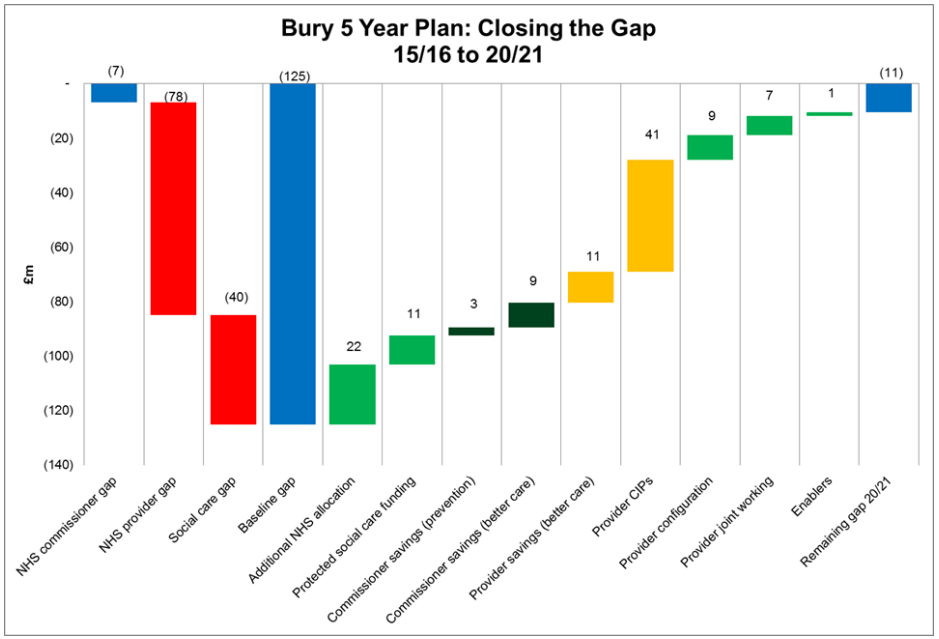
There are a number of key assumptions that have been used in these calculations:

- Bury locality receives an additional £22m as its share of the nationally agreed additional £8bn NHS funding (being the CCG and primary care element of this for Bury).
- Demographic growth is assumed at the GM level of 0.7% pa, but this may understate Bury's local position due to significant growth in the over 50s
- Council non-staffing inflationary growth is set at 2% in line with local assumptions
- Council staffing inflationary growth is estimated at 2% in line with local assumptions
- We believe that the growth in cost for commissioned services due to the impact of the Living Wage is vastly understated and so have used detailed local modelling.
- We have assumed that Bury Council will receive its share of the £255m to protect spend on adult social care services in support of the locality plan. This equates to £10.7m for Bury. If and how any protection would be received is very uncertain and will not be known until the time of the local government settlement. It is also unclear if this funding will be ring-fenced. We see this as a high risk assumption and need to continue work on local contingency plans should this not be agreed in order to ensure that the local authority financial position is balanced.
- In line with the CSR 'ask', we have assumed no reduction in social care funding.
- We do recognise that we need to continue to redesign, redevelop and reshape social care services to make most effective use of the Bury pound and ensure no negative impact on health services.
- £4.5m of prevention savings are targeted over the period. It is assumed that reinvestment is required at 40% and so the net saving is £3m over the period. We believe that savings will increase beyond this over a 10 year period as the lead in time for prevention schemes will extend beyond 5 years in some cases.
- Better care savings targets are £13.5m for commissioners. It is assumed that reinvestment is required at 40% and so the net saving is £9m over the period.
- NHS provider savings have been taken from GM-wide analysis provided by the devolution team in order to allow for consistency and aggregation. However, this assumes high levels of annual CIPs are delivered by providers. This is a high risk assumption for the locality given that our main local acute provider is currently not delivering its CIP target this year. More work will be needed with our providers in order to gain assurance over the CIP plans development as any CIPs provided through income generation will be a risk to the locality's overall financial plan.

The table over the page provides further detail on the assumptions used to calculate the financial gap over the next 5 years:

	16/17	17/18	18/19	19/20	20/21	15/16	16/17	17/18	18/19	19/20	20/21
						£m	£m	£m	£m	£m	£m
Acute Services	1.4%	0.5%	0.5%	0.5%	0.5%	129.8	131.6	132.2	132.9	133.6	134.3
MH services	1.4%	0.5%	0.5%	0.5%	0.5%	21.9	23.7	23.8	23.9	24.1	24.2
Community services	2.6%	1.7%	1.7%	1.7%	1.7%	26.9	27.6	28.1	28.5	29.0	29.5
Continuing Care services	5.4%	4.5%	4.4%	4.5%	4.5%	12.1	12.8	13.3	13.9	14.5	15.2
Primary & Prescribing services	6.0%	5.9%	5.9%	6.2%	6.2%	35.0	37.1	39.3	41.6	44.2	47.0
Other Programme services	2.6%	2.6%	2.7%	2.7%	2.7%	7.6	7.8	8.0	8.2	8.4	8.7
CCG Running Costs	1.9%	1.9%	2.0%	2.0%	2.0%	4.2	4.3	4.4	4.4	4.5	4.6
CCG Reserves & Contingency	1.9%	1.9%	2.0%	2.0%	2.0%	3.2	4.3	4.3	4.4	4.5	4.6
Business Rules						1.2	2.9	3.0	3.1	3.1	3.2
Non Recurrent Items							1.6				
GP services	5.8%	4.7%	4.7%	4.7%	4.7%	22.9	24.2	25.4	26.6	27.8	29.1
DC - Primary Care services	3.6%	3.6%	3.7%	3.7%	3.7%	20.2	20.9	21.7	22.5	23.4	24.2
Total CCG Expenditure						**285.0**	**298.8**	**303.5**	**310.1**	**317.2**	**324.6**
Funding - standard uplifts	1.9%	1.9%	2.0%	2.0%	2.0%	241.9	246.5	254.7	259.8	265.0	270.3
Funding - DFT adjustment	1.4%						3.5	0.0	0.0	0.0	0.0
Funding - national budgets	1.9%	1.9%	2.0%	2.0%	2.0%	43.1	43.9	44.8	45.6	46.6	47.5
Total CCG Funding						**285.0**	**293.9**	**299.4**	**305.4**	**311.5**	**317.8**
CCG Surplus/(Deficit)						**0.0**	**(5.0)**	**(4.1)**	**(4.6)**	**(5.7)**	**(6.9)**
Adult and Childrens Social Care Expenditure	7.5%	5.2%	4.9%	4.6%	4.4%	78.3	84.2	88.6	92.9	97.2	101.5
Adult and Childrens Social Care Funding	-7.5%	-6.0%	-2.1%	-3.4%	-1.0%	75.6	69.9	65.7	64.3	62.1	61.5
						(2.7)	**(14.3)**	**(22.9)**	**(28.6)**	**(35.1)**	**(40.0)**
Overall Commissioner Gap											**(46.9)**
Add Provider Gap											**(78.0)**
TOTAL ECONOMY GAP											**(124.9)**

The bridge chart below provides a high level analysis of current plans to close the £125m financial gap over the 5 year period.

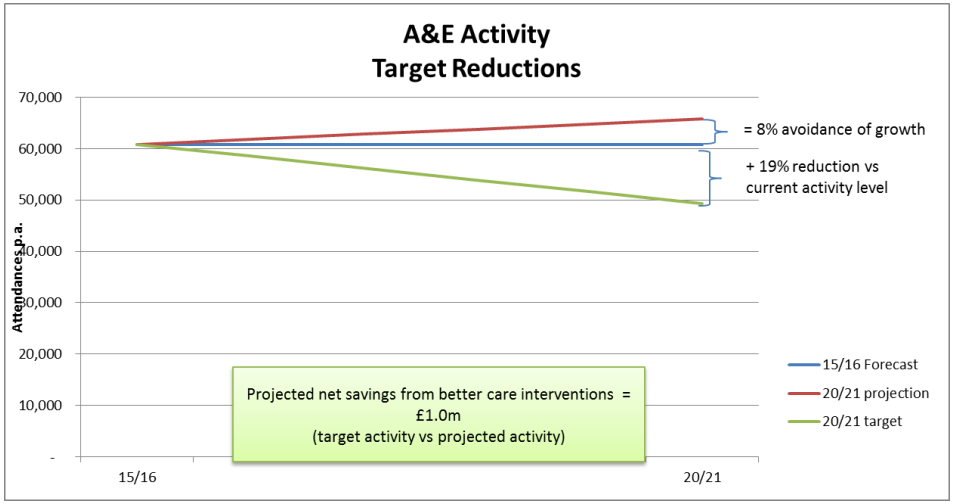


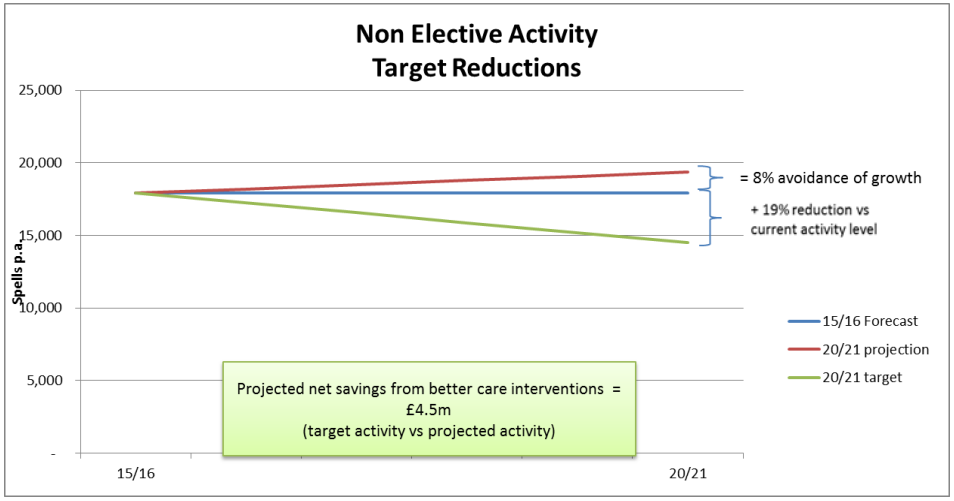
COMMISSIONER BETTER CARE SAVINGS

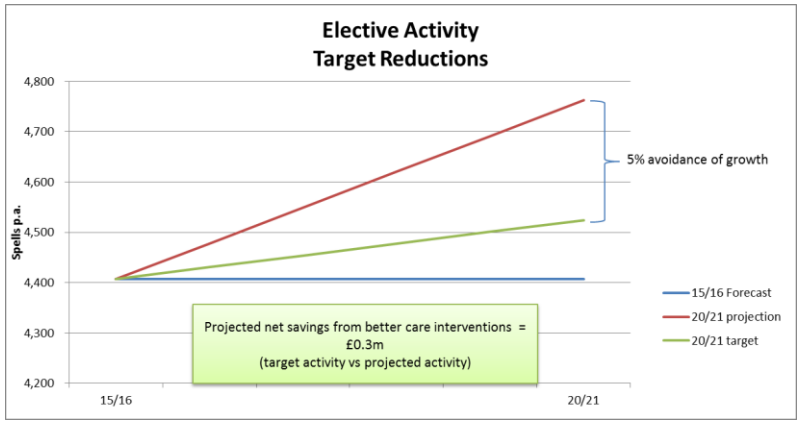
We estimate, at this point, that of the £9m net savings, £7.9m is achievable from the following areas – A&E, Non-Electives, Electives, Day Cases, Outpatients and Excess Bed Days. A further £1.1m is projected from independent sector activity, high cost drugs and devices, etc, giving a total saving in this area of £9m.

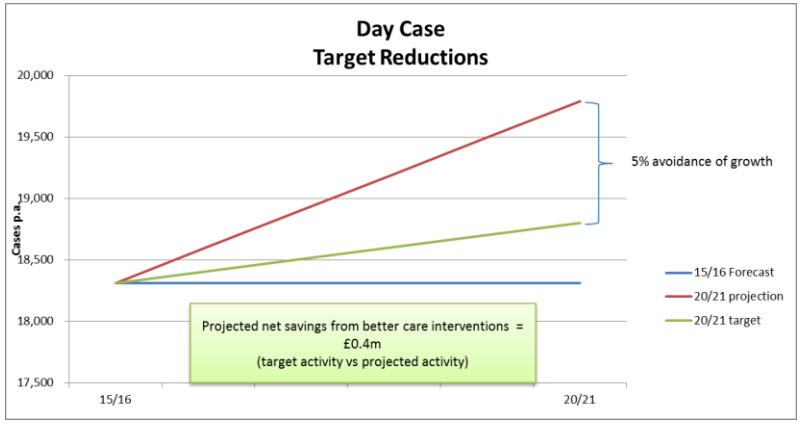
The following graphs show the levels of reductions in hospital activity being targeted over the period in order for reinvestment in care in out of hospital settings. The graphs show:

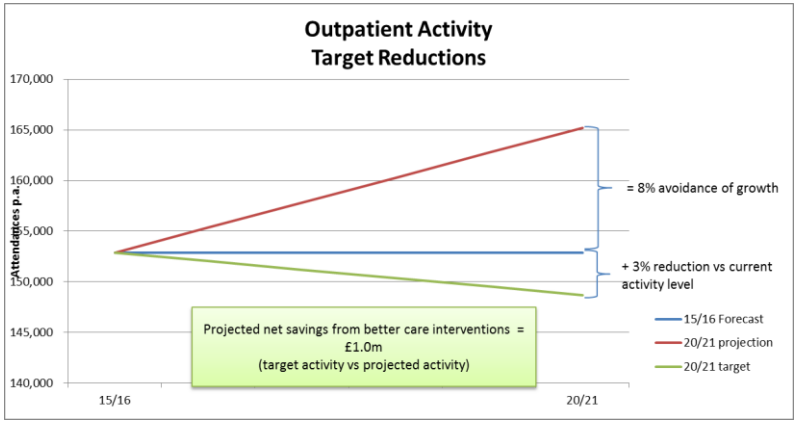
- Current activity levels by point of delivery grouping
- Target activity reductions from Better Care interventions
- Savings, net of 40% re-provision reinvestment costs

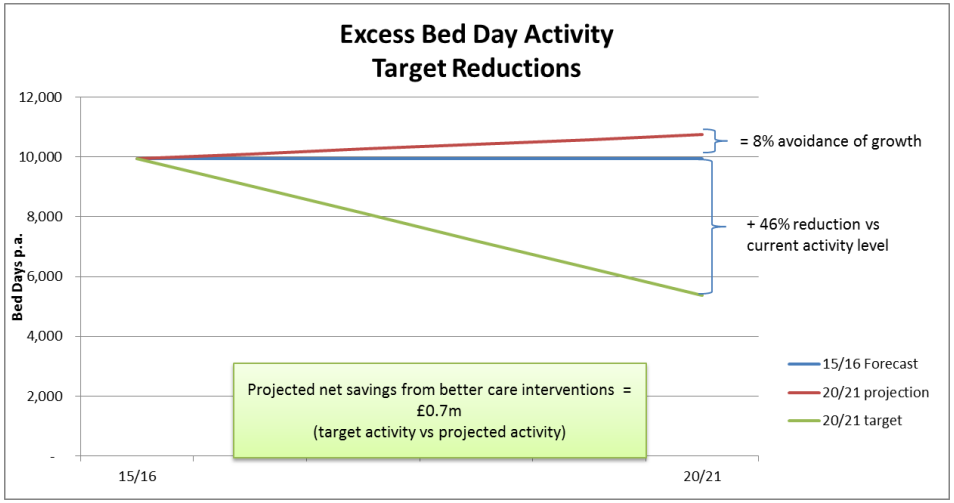












TRANSFORMATION FUNDING

We anticipate that for many initiatives there will be a non-recurrent transitional costs incurred, for example, in double running services whilst new services are developed. These costs are still being calculated but it is anticipated that they will be a call on the GM transformational funding received and are not included in the financial plan presented here.

We see this as the beginning of a process that will culminate, after the budgets have been agreed for the respective organisations, in a series of detailed transformation programmes for the locality.

This will allow us to work through the detail in terms of aspirations, detailed project plans, outcomes and detailed savings plans and ensure that the transformation programme is phased correctly and takes full account of the system interdependencies. This is represented graphically below:

October 2015

- Locality Plan, drafted, agreed & signed off
- Locality Plan submitted - 30/10

November 2015

- Locality PLan reviewed & aligned to GM Strategic Plan
- Development of Locality Plan to include work on 'Wider Determinants'
- Final version of Locality Plan submitted - late Nov
- Special Health & Wellbeing Board meeting - mid Nov

December 2015

- Council Cabinet Meeting - 16/12
- Health & Wellbeing Board meeting - 17/12
- National Council Settlement announced - late Dec
- Development of Locality Transformation Programme - Detailed Workstreams

January 2016

- CCG Budget Holder meetings
- CCG contract negotiations
- CCG high level budget & financial outlook for 16/17 to CCG Governing Body
- Development of Locality Transformation Programme - Detailed Workstreams

February 2016

- CCG Budget Holder meetings
- CCG contract negotiations
- CCG Budget sign off (EMT)
- Cabinet Budget Setting meeting - 10/02
- Council Budget Setting Meeting - 24/02
- Development of Locality Transformation Programme - Detailed Workstreams

March 2016

- CCG Finance Committee
- CCG Governing Body - 23/03
- Development of Locality Transformation Programme - Detailed Workstreams
- Wider Comms & Engagement - General Public

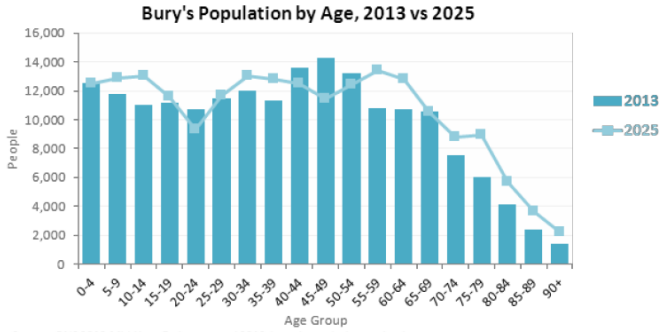
Appendices

Appendix 1: Detailed Snapshot of the Locality

Appendix 2: Greater Manchester Thematic Workstreams

Appendix 3: Quadrant Diagram

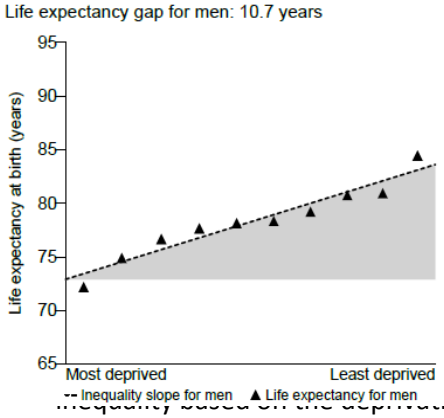
There are a range of diverse health and wellbeing challenges that Bury faces:

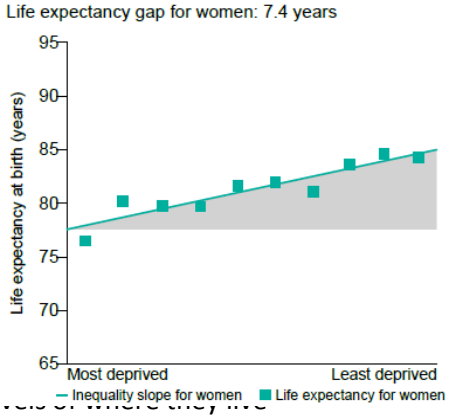


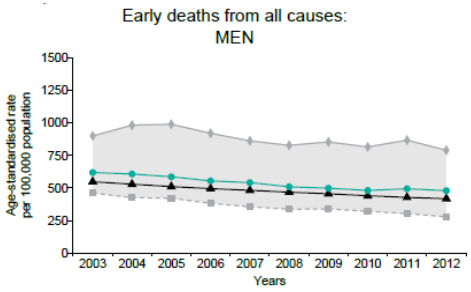
Source: ONS 2013 Mid-Year Estimates and 2012-based population projections

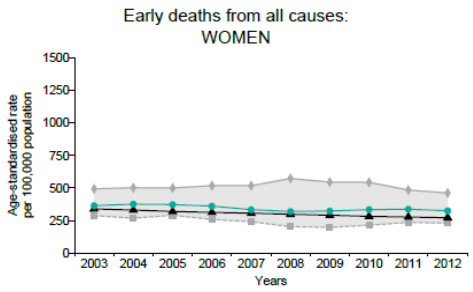
- By 2025...
  - ...the proportion of the population aged 65 or over is expected to rise (from 17% to 20%)
  - ...the proportion of the population aged 80 or over is expected to increase by 46% on the 2013 figure (from 4% to 6%) - This means there will be 11,500 people aged 80 and over living in Bury
- Whilst deprivation in the borough is lower than average, about 16.9% (6,400) children live in poverty
- The number of children in care is high
- The proportion of children who are considered school ready at the age of 5 is below average
- Breastfeeding rates are below average, with a significant drop off between initiation and 6-8 weeks
- Whilst Bury's educational results remain significantly higher than the England average, there are educational attainment gaps between ethnicities, for those on free school meals and for looked after children
- Nearly 1 in 5 five year olds and 1 in 3 ten year olds are overweight or obese. In Year 6, 20.4% of children are classified as obese
- Teenage pregnancy rates are higher than the national average
- Local levels of smoking in pregnancy are high compared to the England average
- Smoking related deaths in Bury are significantly higher than the England average, although adult smoking rates are slightly lower than the England average
- Bury has a high cancer incidence rate and the early death rate from cancer is higher than the average for England
- It is estimated that 18,300 adults aged between 18 and 64 have a mental health problem
- Over two thirds of the adult population are overweight or obese
- Only 11.6% of adults were undertaking recommended levels of physical activity, with a correlation between areas of high deprivation and low levels of participation
- The rate of self-harm hospital stays was worse than the average for England
- One in five of Bury's adult population is living with a long-term health condition. Those with long term conditions are also two to three times more likely to experience mental health problems
- The 2011 census tells us that, in Bury, 11% of the population (20,000 people) were providing some form of unpaid care. Carers providing support for 50 hours a week or more are twice as likely to be in poor health as those not in a caring role. Only around 15% of carers are known to the council's Carer Service Team or the Carer's centre
- Fewer adults who are in contact with secondary mental health services live in stable and appropriate accommodation than the average of our statistical neighbours
- The number of people living with dementia (and who are aged 65 and over) will increase by 34% over the next 10 years
- Around 35% of people aged 65 and over living in the community fall each year and this increases with age; around 20% of those who have a hip fracture (often due to a fall) will die within four months

- Life expectancy in the borough is still below the England average and this gap is widening, despite steady and lasting improvements in how long people can expect to live, partly due to a significant reduction in cardiovascular deaths - Life expectancy is 10.7 years lower for men and 7.4 years lower for women in the most deprived areas of Bury than in the least deprived areas (these areas are as little as four miles apart!)

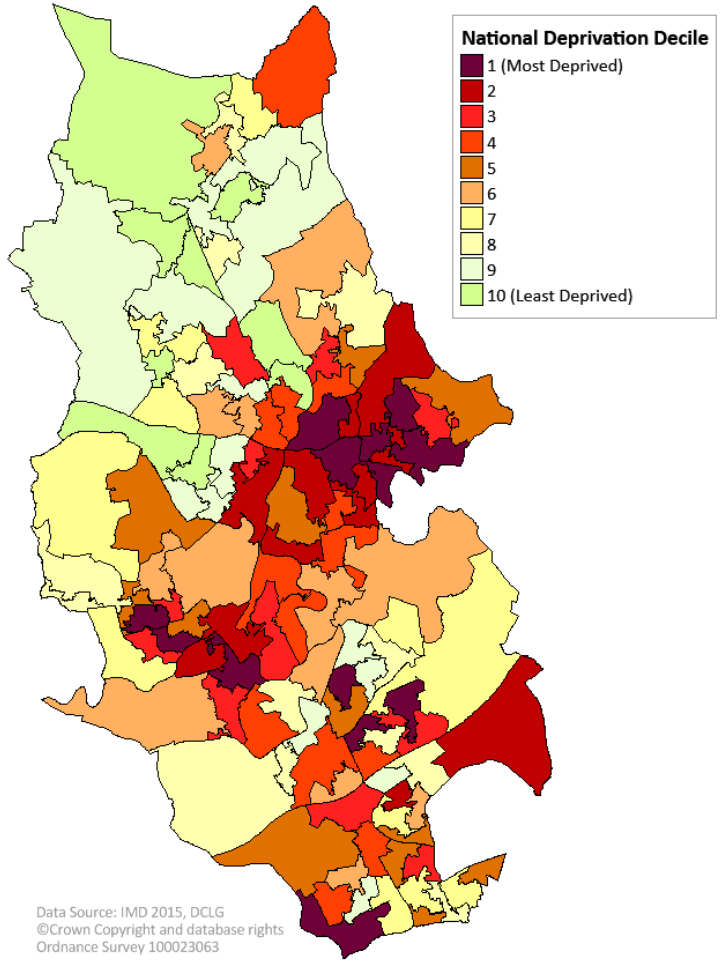








Deprivation in Bury
Index of Multiple Deprivation 2015



All of our Locality Plan work will need to reference and take account of the wide range of workstreams that are being led at and delivered by Greater Manchester wide thematic groups.

Estates

Creation of a city-wide Devolution Estates Task & Finish group, with membership from across the public sector, to work on a number of key challenges:

- Making most effective use of significant public sector assets
- Agreeing capital investment priorities
- Agreeing disposal of surplus land and properties
- Managing estates on a GM footprint

Work is also underway to provide more detailed analysis and work to support the assumptions included in the GM financial model. In particular it focuses on:

- The potential revenue and capital implications of reconfiguring estates in line with a redesigned approach to health and social care delivery
- Engage each of the 10 localities in the development of this analysis and use case studies to provide a deeper "dive" into how estates may change and the potential financial implications of such change
- Improve the data available to GM around estates and agree protocols for developing a single database going forward
- Provide the foundations for estate change beyond December and set out the steps needed to implement change

Information Management & Technology

The aim of this workstream is:

- To establish a GM vision for IM&T within the context of health and social care devolution
- To build on an understanding of IM&T requirements of the other devolution workstreams
- Identify GM standards for IM&T required to deliver devolution
- Respond to the requirements of CCG areas to develop a digital roadmap

Mental Health and Children & Young People's Mental Health

This is a revised version of the group that already existed and has overall responsibility for the GM Mental Health Work. The aim of the workstream is the development of an all age GM strategy for mental health. The strategy will:

- Set the priorities for GM Mental Health services
- Identify those things that need to be delivered at the GM level
- Provide the context for the development of locality plans
- Define the standards of service individuals and families can expect across GM – driving consistency
- Identifying best practice from localities
- Identify priority cohorts for GM and our collective response
- Facilitate cross border working and reduce out of borough placements

Primary Care Transformation

- The development and implementation of a new primary care strategy for Greater Manchester, ensuring it is aligned with the Greater Manchester Health and Social Care Devolution strategic plan and individual locality plans.
- Engagement with key stakeholders is planned for early November.

Early Years

- A small reference group was established to consider the re-development of the early years workstream in the context of start well. This was a task and finish group rather than an ongoing governance group. The aims of the workstream are:
- Develop a single programme of activity for early years across GM
- Inform the early years implementation programmes across GM
- Undertake workforce development activity across GM

Learning Disabilities

The initial aim was to bring together the GM bid for funding following the announcement of being a Fast Track area. This includes the GM vision and key objectives for learning disability including future targets. Following the bid and announcement of the funding, the aim of the workstream is now to develop and oversee the implementation of the GM vision and delivery of targets. Current progress and next steps:

- Vision developed including key objectives and targets
- Bid for funding submitted – this had two elements; one around the GM system capacity and another around the approach to Calderstones
- Implementation planning started

Housing

Housing's role in early intervention and prevention is key. Poor housing, unsuitable housing and precarious housing circumstances affect both physical and mental health. The health of older people, children, disabled people and people with long-term illnesses is at greater risk from poor housing conditions. The right home environment can:

- Protect and improve health and wellbeing and prevent physical and mental ill-health Enable people to manage their health and care needs, including long-term conditions, and ensure positive care experiences by integrating services in the home
- Allow people to remain in their own home for as long as they choose

And in doing so can:

- Delay and reduce the need for primary care and social care interventions, including admission to long-term care settings
- Prevent hospital admissions
- Enable timely discharge from hospital and prevent re-admissions to hospital
- Enable rapid recovery from periods of ill-health or planned admissions

•We need to engage with the housing sector in the transformation of health and social care to maximise their community asset base for engaging with communities to improve health and wellbeing.

Dementia

The programme will focus on improvements which directly impact on the 'lived experience' for people with dementia. Through broad stakeholder engagement, they will continue to narrow the focus during the outline planning phase, developing the thematic focus of 'connectedness' and enabling work streams. The programme will be designed in two distinct parts. 1) a description of the 'early win' commitment to the Devolution programme before March 2016, and 2) a 5 year dementia programme for Greater Manchester.

The early win has the following deliverables:

- Developing a transparent GM dashboard of metrics which will be updated monthly by January 2016.
- Determining and agreeing an improvement goal for GM to achieve.
- Offering support, for example by learning from the best, peer coaching, collating and building resources to spread learning.
- Establishing a governance structure to provide oversight to the early win and 5 year programme, September 2015.
- Pilot the key worker programme (developed by the Alzheimer's society) using the Salford Centre of Contact, with a view that people who are newly diagnosed with dementia will have access to a key worker who can support them.
- Launch the 5 year dementia programme for Great Manchester in March 2016.

The 5 year strategy will focus on three core elements: Monitor my Health; Enrich my World; and Connect me to my Support System.

GM Leadership within New Society

This work is designed to:

- Develop leaders across GM who can lead not only within and behalf of their organisations and professions, but increasingly can work beyond this to lead within and on behalf of 'place'. This new approach will be flexible enough to accommodate different spatial levels of place such as city region, district or neighbourhood.
- Develop a more coherent approach to leadership development that is not organised through professional disciplines (eg: health, social work etc.), or is structured around organisations (eg: local authorities, etc.).
- Develop an approach which will incorporate skills and behaviours identified by places and through GM work streams as essential to the delivery of our ambitions for GM.

GM Specialised Services Transformation Programme

- The purpose of this operational group is to develop the GM Specialised Services strategy, implement a transformation process for Specialised Urology and OG Cancer Surgery, identify and manage programme risks and provide assurance on delivery to the GM Specialised Services Oversight Group (GM SCOG).
- The workstream aim is: the development and implementation of a Specialised Services strategy for Greater Manchester, ensuring it is aligned with the Greater Manchester Health and Social Care Devolution strategic plan and individual locality plans; Oversight of on-going specialised services transformation programmes; and Oversight of the day to day commissioning and performance of GM Specialised Services.

BURY LOCALITY PLAN

REDESIGNING / IMPROVING SERVICES

- Create one commissioning organisation with a significant pooled budget
- Integrated ambulatory care front door at Fairfield General Hospital
- Discharge to Assess
- Single Site Discharge
- Implement GM Early Years Model
- MDT provision for vulnerable children
- IMC / Reablement / Crisis Response Step Up
- Review Points of Access
- Improving transitions

(INVESTING IN) PREVENTION & EARLY INTERVENTION

- Single point of access for children & young people within community mental health & wellbeing hub
- Community Mental Health & Wellbeing Service
- Redesign Falls and Fragility fracture pathway
- Active Ageing (IWIYW)
- Staying Well Programme
- Re-able the housing stock
- 'Better Together' / Primary care quality programme
- Establish work and health programme
- Early intervention in psychosis
- Tackling social isolation

MOVING SERVICES CLOSER TO THE COMMUNITY

- Roll out wraparound Locality Hubs
- Full Primary Care offer over 7 days
- Shifting services out of general practice into other services
- Implement the GM Primary Care Standards
- Shifting a range of secondary care services into the community
- Out of Hospital Provider Alignment

ENABLING PEOPLE TO SELF CARE

- Production of self-management for children & young people's mental health & wellbeing
- Self-referral approach in MH
- Bury Directory
- Scale up social prescribing & self care support for LTC
- Roll out of Welly Cafe / Manchester Rd Lodge approach
- Dementia Friendly Communities