Pre Consultation Business Case

Part 1

Appendix number: 5

Title of Appendix document:
Future Model of Community Based Care
<table>
<thead>
<tr>
<th>Title</th>
<th>Future Model of Community Based Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>GM Integrated Care Programme Team</td>
</tr>
<tr>
<td>Target Audience</td>
<td>Healthier Together Consultation</td>
</tr>
<tr>
<td>Version</td>
<td>Final</td>
</tr>
<tr>
<td>HTP Reference</td>
<td></td>
</tr>
<tr>
<td>Created – date</td>
<td>30th August 2013</td>
</tr>
<tr>
<td>Date of Issue</td>
<td>9th April 2014</td>
</tr>
<tr>
<td>Document Status</td>
<td>Final</td>
</tr>
<tr>
<td>File name and path</td>
<td>S:\Transformation\SERVTRAN\HealthierTogether\KeyDocs\Pre-consultation business case\Main Report\Appendices\Part 1\Word versions</td>
</tr>
</tbody>
</table>

**Document History:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Author</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>30/08/2013</td>
<td>0.1</td>
<td>Melissa Surgey</td>
<td>1st draft created</td>
</tr>
<tr>
<td>30/08/2013 – 09/04/2014</td>
<td>0.2 – 0.13</td>
<td>GM Integrated Care Team Programme members</td>
<td>Further drafts created based upon feedback and input from localities</td>
</tr>
</tbody>
</table>

**Approved by:** Lisa Stack and Damon Palmer (March 2014)

**Governance route:**

<table>
<thead>
<tr>
<th>Group</th>
<th>Date</th>
<th>Version</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Table of Contents

1.0 **Scope** ........................................................................................................................................... 5  
1.1 *Scope of ‘Community Based Care’* ......................................................................................... 5  
2.0 **The Need to Improve Community Based Care** ........................................................................ 6  
2.1 *National need* ......................................................................................................................... 6  
2.2 *Greater Manchester need* ........................................................................................................ 8  
2.3 *The need to align changes to community based care with proposed changes to hospital based care* ...................................................................................................................... 9  
3.0 **The Evidence Base** ..................................................................................................................... 11  
4.0 **The Vision for a Future Model of Community Based Care** .................................................. 14  
4.1 *The vision for primary care* ...................................................................................................... 14  
4.2 *The vision for integrated care* .................................................................................................. 14  
5.0 **Developing the Future Model of Care** ...................................................................................... 16  
5.1 *Primary care* ............................................................................................................................ 16  
5.1.1 *How the GM Primary Care Commissioning Strategy was developed* ................................. 16  
5.1.2 *The content of the GM Primary Care Commissioning Strategy* ........................................ 16  
5.2 *Integrated care* ....................................................................................................................... 17  
5.2.1 *How the integrated care plans are being developed* .......................................................... 17  
5.2.2 *The process for signing off the plans* .................................................................................. 18  
5.3 *How the single system view is being developed* ..................................................................... 19  
5.3.1 *Community based care standards* ..................................................................................... 19  
5.3.2 *Process for consolidating the plans* .................................................................................... 21  
6.0 **Summary of Each Locality’s Approach to Community Based Care** ..................................... 22  
6.1 *Bolton Plan on a Page* ............................................................................................................. 22  
6.2 *Bury Plan on a Page* ................................................................................................................. 23  
6.3 *Manchester (North) Plan on a Page* ........................................................................................ 24  
6.4 *Manchester (Central) Plan on a Page* ...................................................................................... 25  
6.5 *Manchester (South) Plan on a Page* ........................................................................................ 26  
6.6 *Oldham Plan on A Page* .......................................................................................................... 27  
6.7 *Rochdale Plan on a Page* ......................................................................................................... 28  
6.8 *Salford Plan on a Page* ............................................................................................................. 29  
6.9 *Stockport Plan on a Page* ........................................................................................................ 30  
6.10 *Tameside and Glossop Plan on a Page* .................................................................................. 31  
6.11 *Trafford Plan on a Page* .......................................................................................................... 32  
6.12 *Wigan Plan on a Page* .......................................................................................................... 33  
6.13 *Summary of GM-wide Approach to Improving Community Based Care – Primary Care* ..... 33
7.0. Pan-Greater Manchester Services ........................................................................................................... 35

7.1. NHS 111 .................................................................................................................................................. 35

7.2. North West Ambulance Service (NWAS) Paramedic Pathfinder .............................................................. 35

7.4. Children’s Community Based Services .................................................................................................. 35

7.5. Reconfiguring Hospital Social Care ........................................................................................................ 36

7.6. End of Life Care ...................................................................................................................................... 37

7.6.1. The Gold Standards Framework ......................................................................................................... 37

7.6.2. The Six Steps to Success in Care Homes ............................................................................................. 37

7.6.3. Electronic Palliative Care Co-ordination System .................................................................................. 38

7.6.4. Liverpool Care Pathway Review ......................................................................................................... 38

8.0. How Community Based Care will be Different for Service Users .............................................................. 39

8.1. Manchester Practice Integrated Care Team Case Study .......................................................................... 39

8.2. Salford Case Study .................................................................................................................................. 41

8.3. Dave from South Manchester .................................................................................................................. 41

8.4. Skype Appointments in Manchester ....................................................................................................... 42
1.0 Scope

1.1 Scope of ‘Community Based Care’

The term ‘community based care’ is a broad term used to describe all of the care that people receive outside of the hospital setting. This includes a range of different types of services, commissioned by a range of different commissioners as summarised below:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Commissioner(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care (general practice, pharmacy, dental and optometry services)</td>
<td>- NHS England</td>
</tr>
<tr>
<td></td>
<td>- CCGs</td>
</tr>
<tr>
<td>NHS community health services</td>
<td>- CCGs</td>
</tr>
<tr>
<td>Local public health services</td>
<td>- Local authorities</td>
</tr>
<tr>
<td>Social care</td>
<td>- Local authorities</td>
</tr>
</tbody>
</table>

How these services are commissioned and delivered in the future will play a critical role in improving the health and wellbeing of local populations and reducing dependency on acute services. Therefore, within the Healthier Together programme, care has been taken to ensure that the plans for creating a safe and sustainable hospital system are developed within the context of broader discussion around ensuring people have access to the right type of care, at the right time, in the right care setting.

Whilst the breadth of ‘community based care’ covers all the areas in the table above, the summary presented here focuses primarily on two key transformation programmes aimed at significantly improving the provision of and access to services in non-acute settings and therefore enabling the planned reconfiguration of hospital services. These are:

- Transformation of primary care
- The integration of health and social care services

It is widely acknowledged that despite examples of excellent primary care services being delivered right across Greater Manchester (GM), there is significant scope for reducing variation and ensuring that all residents have access to consistently excellent primary care services, irrespective of where they live. The Primary Care Transformation programme is aimed at supporting localities in developing innovative, robust and viable models for delivering primary care services to a consistently high standard across GM. In parallel, a programme of health and social care reform is also underway bringing together local health and social care commissioners and providers across GM to design and implement innovative ways of delivering care in a ‘joined up’ manner, giving their local populations access to the best possible care and leveraging the full breadth of resources available locally. Whilst governed separately, both programmes are in reality delivered jointly, with extensive efforts made to align plans, activities, aspirations and outcomes.

The summary provided in this document focuses on these two programmes, giving an overview of the breadth of work underway locally to create the appropriate health and social care infrastructure needed to improve the health and wellbeing of local populations. The nature, pace and scale of the transformation has also provided a firm basis upon which the proposals for reconfiguring acute services have been developed. Care has been taken to ensure these synergies are recognised and aligned, ensuring the ultimate outcome is a robust, stable and viable health and social care system for GM.
2.0 The Need to Improve Community Based Care

2.1 National need

A high quality, efficient and sustainable health and social care system has a breadth reaching beyond the traditional hospital. It should unite primary, secondary, community, social and preventative care to deploy professionals from these specialities in multi-disciplinary teams, working seamlessly together with local communities to tackle the health and social inequalities on the frontline and to support people to be as independent and in control of their own lives as possible.

However, users of health and social care services currently face a multiplicity of access points for services and often uncoordinated and fragmented services across the public sector. A report by the National Collaboration for Integrated Care and Support notes:

Too often, we don’t communicate properly with each other, don’t work together as a team or don’t treat people as whole individuals. As a result, care and support is often fragmented, delayed or duplicated, which can result in missed opportunities to prevent needs from escalating and intervening early. This leads to poorer outcomes and experiences for the people who use our services.

(National Collaboration for Integrated Care and Support– Integrated Care and Support: Our Shared Commitment - 2013)

Rising life expectancy, demographic change, medical advances, and increasing expectations all create new demands. A system largely designed for episodic care is now required to address the ongoing care of people with multiple long term conditions. People with long term conditions account for 70% of overall health and care spend. They are disproportionately older and higher users of health services, representing 50% of GP appointments, 60% of outpatients and A&E attendances and 70% of inpatient bed days.\(^1\)

In a report primarily focused on the organisation of care within hospitals, the Royal College of Physicians noted:

Despite patients over 65 making up the larger share of the hospital population, the system continues to treat older patients as a surprise at best, or unwelcome at worst. Much more can be done to prevent unnecessary hospital admission and readmission, shorten length of stay, and ensure the smooth and effective transfer of care for patients ready to leave hospital. Areas with integrated services for older people have lower rates of bed use – these areas also tend to have lower admission rates and deliver good patient experience.

(RCP – Hospitals on the edge? The time for action - 2012)

The case for change in the health and social care system (as fully outlined in appendix 1) draws heavily on the financial and quality challenges of the future.

The potential consequences for the individual of a continuing failure to integrate both commissioning and provision are clear – disjointed care, more hospital admissions, later discharge and poorer outcomes. The consequences for the health and social care systems are just as stark ...the NHS will fail to deliver on (its financial) challenge unless it achieves greater integration between health and social care.

(The Health Select Committee Report - 2012)

\(^1\) Department of Health (2012) Long Term Conditions Compendium (3\(^{rd}\) edition)
However, there are also opportunities to shift greater control towards citizens, patients, carers and communities.

We all have to recognise the limited resources of the state, and communities will increasingly need to look at what they can offer to promote well being locally. For those in need of social care the last few years have seen a significant change in the balance of choice and control over their own lives. There is now a clear expectation that people needing care... will take on at least part of the responsibility for defining their needs and shaping the support required to meet those needs

(ADASS – The Case for Tomorrow – Shaping the Change – 2012)

Evidence is a key challenge, however, expert consensus points strongly to the unaffordability of the current system; that joint working can improve outcomes; and that there is enough evidence of costly unplanned and reactive interventions to suggest that different ways of working are required. In summary, for older people we need:

- a level of localised care that can keep them out of hospital, empower them to care for themselves where possible, and give them the comfort that we would all wish upon our own loved ones. Warehousing them on medical wards in busy hospitals is not an option

(Peter Carter – RCN General Secretary for www.nhsmanagers.co.uk, 24th Sept 2012)

For the reasons set out above, there is broad national cross political party consensus on the scale of change required to the health and social care system.

Never in its history has the NHS had to face such a profound shift in our needs and expectations. An ageing population, rising costs of treatments, and a huge increases in the number of us with long term often multiple conditions are rewriting our relationship with health and care, all at a time of acute pressure on public finances.

Jeremy Hunt Secretary of State for Health– NHS Mandate – November 2012

If we leave things as they are, our (hospitals) will be like warehouses of older people – lined up on the wards because we failed to do something better for them. But it gets worse. Once they are there, they go downhill for lack of whole-person support and end up on a fast-track to care homes – costing them and us even more. We could get much better results for people, and much more for the £104bn we spend on the NHS and the £15bn on social care, but only if we turn this system on its head.

- Helping people with daily living, staying active and independent, delays the day they need more expensive physical and mental support.
- A truly integrated service not just battling disease and infirmity but able to aspire to give all people a complete state of physical, mental and social well-being.
- A service which affords everyone’s parents the dignity and respect we would want for our own.

Andy Burnham – Shadow Secretary of State for Health – Speech to the Kings Fund 21st January 2013
2.2 Greater Manchester need

Greater Manchester consists of 10 very distinct and diverse districts. GM seeks to become an economically sustainable city region, where all can benefit from success. The health and wellbeing of the residents of Greater Manchester is crucially important to the achievement of this ambition.

However, as set out in the Greater Manchester Case for Change (appendix 1), GM as a whole has some of the poorest health outcomes in the UK. 11.1% of residents have sub-optimal general health, with 20.4% living with a long term condition\(^2\). Although significant progress has been made over the last century in reducing the burden of disease associated with urban social deprivation, the health gap between GM and the rest of England is widening as the region is unable to keep pace with improvements elsewhere in the country. 9 out of 10 areas in GM have a standardised mortality rate that is equal to or higher than the national average, which is estimated to represent 5300 years of life lost annually.

There is also disparity in the health and wellbeing of individual districts, with gaps in health outcomes between the most and least deprived populations. Analysis of life expectancy patterns\(^3\) within Greater Manchester show that:

- 6 of the 10 Greater Manchester local authorities have significantly higher levels of internal inequalities in life expectancy than the England average; no Greater Manchester CCG has lower than average levels of internal inequalities.
- The male life expectancy gap in Greater Manchester is 14.9 years – the difference between the most deprived area in Heywood, Middleton & Rochdale CCG (68.9 years) and least deprived area in Stockport CCG (83.8 years).
- The female life expectancy gap in Greater Manchester is 12.5 years – the difference between the most deprived area in Bolton CCG (74.8 years) and least deprived area in Trafford CCG (85.7 years).

Internal inequalities across GM are also clear for key health and wellbeing indicators:

**Figure 1: Internal health inequalities in Greater Manchester**

<table>
<thead>
<tr>
<th><strong>1. Liver disease</strong></th>
<th>Those in the most deprived areas are 8 times more likely to die prematurely than those in the least deprived areas</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2. Mental health and wellbeing</strong></td>
<td>Those in the most deprived areas are 6 times more likely to experience extreme anxiety and depression as those in the least deprived areas</td>
</tr>
<tr>
<td><strong>3. Diabetes</strong></td>
<td>Those in the most deprived areas are 4 times more likely to die prematurely than those in the least deprived areas</td>
</tr>
<tr>
<td><strong>4. Quality of life</strong></td>
<td>Those in the most deprived areas are 3 times more likely to be experiencing extreme pain and discomfort than those in the least deprived areas</td>
</tr>
<tr>
<td><strong>5. Infant mortality</strong></td>
<td>Babies in the most deprived areas are 3 times more likely to die than those in the least deprived areas</td>
</tr>
<tr>
<td><strong>6. Coronary heart disease</strong></td>
<td>Those in the most deprived areas are 3 times more likely to die prematurely than those in the least deprived areas</td>
</tr>
<tr>
<td><strong>7. Lung cancer</strong></td>
<td>Those in the most deprived areas are 3 times more likely to die prematurely than those in the least deprived areas</td>
</tr>
</tbody>
</table>

\(^2\) 2011 Census Data
\(^3\) Source: 2006-10 Slope Index of Inequality, PHE
8. Stroke  Those in the most deprived areas are 3 times more likely to die prematurely than those in the least deprived areas

9. Child health and wellbeing  Those in the most deprived areas are 2.5 times more likely to die than those in the least deprived areas

10. Accidents  Those in the most deprived areas are twice as likely to die as those in the least deprived areas

Source: Local Health Profiles, April 2012, AHPO

On top of these significant health inequalities, there is a ‘burning platform’ for health and social care reform in GM. Local Government has had to deliver budget reductions of 25-30% and there are clear messages that future spending settlements will be similarly challenging. On current projections, it is estimated that by 2025, the whole of each local authority budget may be spent on social care. The NHS also faces huge financial pressure; in GM the NHS has faced a Quality Innovation Productivity and Prevention challenge of nearly £1bn to 2014 (as its share of the national £20bn target). It is unlikely this will ease, with reports that a total of £50bn of savings may be required by 2020.

The funding challenge is compounded by an increase in demand for health and social care services. In line with the national picture, this is in part driven by an aging population. Older people, many with multiple long term conditions, account for 62% of total bed days, 68% of emergency bed days, and 75% of council funded registered nursing and residential care home funding in GM. We estimate that about 750,000 bed days a year are occupied by older people with multiple long term conditions, costing £800m - £1.2bn annually.

Some communities are already benefiting from a holistic approach to community based care, but the reality is that for the majority, their health and social care experience is confusing, fragmented and difficult to access. Health and social care across the region therefore needs an innovative model to adapt to the changing needs of the population and reduce inequalities. Radical transformation at the pace and scale of the Healthier Together programme is therefore essential to improve community based care both in its own right and as support to the hospital reconfiguration programme. The reformed model of community based care outlined in this document has the potential to make sustained, rapid progress towards this. The identified programme outcomes are clear that all GM residents should have greater parity of access to high quality, safe and sustainable services to improve health outcomes and life expectancy.

2.3  The need to align changes to community based care with proposed changes to hospital based care

Our current healthcare model is reliant on services provided in an acute hospital setting. These services are experiencing avoidable pressure, with the region’s hospitals continuing to see over 1million A&E attendances per year. Data analysis shows that 27% of A&E attendances in Q4 2009/10 – Q2 2011/12 were discharged under usual GP care, and had no investigations undertaken. It seems reasonable to assume that these patients may have not required the support of the A&E Department if they had known how to / been able to access alternative community services.

---

4 GM PSR Team (2012) Health and Social Care: Narrative Report
5 Healthier Together (2012) A Greater Manchester Case for Change for Urgent and Emergency Care
Acute hospital care is not provided in a vacuum and there are interdependencies with a wide range of services across multiple organisations, including NHS community services, social care, primary care, rehabilitation services and the voluntary sector. More broadly, our requirements for a safe and sustainable hospital system need to understand the pressures on an interdependent care system, and our collective intentions for prevention, independence and wellbeing.

The reconfiguration of hospital-based urgent care and general surgery under the Healthier Together programme provides a unique opportunity to take a whole-system approach to improving health and social care in GM, both in hospital and in the community.
3.0 The Evidence Base

Section 2 demonstrates that there is a need to change community based care to ensure that it can:

- Maximise health and social care outcomes, reducing variation and health inequalities
- Improve service-user satisfaction of healthcare services
- Support the shift of activity away from hospitals and in to more cost-effective settings, closer to home
- Meet the pressures of rising demand for health and social care
- Make better use of existing resources, reducing duplication and streamlining services

We believe that transforming primary care and integrating health and social care services will make a significant contribution to addressing the identified challenges.

Two examples of the evidence that supports this approach can be illustrated in the work from Torbay and the Total Place pilots:

Torbay

Torbay is one the initial and high profile trail blazers of integrated care across health and social care *(Integrating health and social care in Torbay. (2011), Peter Thistlethwaite, The Kings Fund)*

Achievements for the year 2009/10 included:

- 17% reduction in elderly acute length of hospital stay;
- Reduced acute admissions for people over 65 yrs by 1/3;
- Maintaining emergency bed days for over 65s at the lowest rate in the South West region per 1000 population;
- Reduced over 75s emergency bed days by 24% and 32% for over 85s between 2003-08;
- 144 fewer people aged 65+ were admitted to residential and nursing homes aged 65+;
- Integrating health and social care management costs saved £250K in the first year (albeit home care services were double the regional average)

Key outcomes include improved patient experience, reducing acute admissions and unnecessary hospital admissions, and more care services closer to home. Central to the Torbay success is the philosophy and strapline 'Improving care for 'Mrs Smith'. This approach has now been replicated across numerous sites in Greater Manchester.

Fundamentally, the key message of the need to reduce the size of acute hospitals (wards/beds) and expand community based options for older people's care is central and critical to the Greater Manchester reforms.

Total Places Pilots: Place Based Approaches

Under the previous Labour Government an initiative was launched to explore the benefits of ‘place based approaches’ bringing together Public Sector Partners to work closer together to improve local public services. Greater Manchester was one the national pilot schemes *(Place-based approaches and the NHS: lessons from Total Place, (2010) Richard Humphries and Sarah Gregory, The King’s Fund)* and this work, along with the recent Coalition Government Community Based Pilots for Total Place, has provided the spring board to the Healthier Together reforms.
In Bournemouth, Poole and Dorset, their plan was to divert 15% people of avoidable admissions and meet or treat their needs in their homes or closer to home. Annual saving were forecast to be £18 million excluding £6.6 million on preventive services and £1 million on social capital investment.

In Birmingham, their Complex Families programme involved the city council forecasting savings of around £400 million by investing another £40 million over the 15 years in early intervention, but only 25 per cent of that would accrue back to the local authority.

Early evaluations, for example the Bradford District Partnership 2010 indicated improved discharge planning and by providing appropriate community support this could reduce the number of discharges direct into residential care by 50%, savings £1.8 million per year.

Publications such as the Care and Support White Paper, King’s Fund, Future Forum and The Common Purpose Framework also recognise that the evidence base for community based care and integration achieving major cost savings is emerging, patchy and inconclusive. However, the evidence is stronger for improving outcomes, quality and patient experience. Now the case has been made even stronger for more integrated care with a seminal publication by National Voices, a patient-user forum. It has identified the lack of joined-up care as a source of huge frustration for patients, services users and carers and that “achieving integrated care would be the biggest contribution that health and social care services could make to improving quality and safety”.

National Voices has produced, and government and local GM partners have signed up to, a narrative and definition for person-centred coordinated care:

“My care is planned with people who work together to understand me and my carer(s), put me in control, coordinate and deliver services to achieve my best outcomes. ”

Greater Manchester programmes and localities have commissioned their own evidence. This includes conversations with service users, carers, and health & social care workforce across the whole system. Formal and informal evidence has also been commissioned from national and local academic and national partners, clinical and professional peers as well as reviews of national and international good practice. We have worked with and continue to work with many of the leading national authors advocating for new models of community based care and integration at ‘pace and scale’.

In the main, the evidence we have used reiterates the national picture that integrated care is inherently the right thing to do. It is about patients seen as a ‘whole person’ rather than a medical condition, and that services should flex to ensure the experience is a good one from end to end. But it is complex, sensitive and time consuming. Only few areas in the country have achieved it and it is potentially costly.

Healthier Together will embark on the largest reconfiguration of hospital services in the history of the NHS. This will be in the context of new models of care outside of the hospital setting. We understand that developing new models of community based care is not about structures, organisations or pathways; it is about better outcomes for service users.

So, our reforms will ensure that GM health and social care services will truly put people at the centre of their care. The NHS and local government will need to better understand their communities and citizens and provide services that maximise independence, quality of life, ability to self-manage and empowering service users with choice and control.

The new models of care that are being designed and developed across GM will seek to address the historical challenges that exist in our current services. The new models will need to be more efficient and provide
better value for money than the expensive model of using hospital-based services for a significant proportion of care. Services will be more embedded in local communities, nearer to where people live and work. Community based care services, provided by social care services, community and primary care services in partnership with local people and the voluntary sector will need to provide a more responsive service, with better access, experience, quality and outcomes. These new models will complement hospital services, providing a valuable and credible alternative for a significant proportion of people.

The GM reforms are hugely ambitious. We acknowledge there is much work to be done and the ‘burning platform’ of unprecedented financial and service pressures facing health and social care cannot be tackled by making incremental adjustments to existing services and ways of working. So, our programmes of reform are seeing new models of care being introduced from 2014-15, building on the evidence base we have built.

We will seek to reform our services at ‘pace and scale’, continuing to build on our local evidence base. GM is committed to improving services for our local population. The evidence indicates this alone is critical to success.
4.0 The Vision for a Future Model of Community Based Care

4.1 The vision for primary care

High quality, responsive and accessible primary care is the cornerstone of an effective health and social care system. NHS England Greater Manchester has developed a Primary Care Commissioning Strategy in partnership with the primary care community including Dentistry, Optometry, Pharmacy and General Practitioners.

The traditional experience of the majority of primary care being available Monday to Friday during working hours will make way for extended opening and enhanced out of hours services in a range of locations, both face-to-face and virtually. Patient access to care will be quicker and more convenient; in the right place, at the right time. Patients will also be able to assess the quality of care they are receiving by easily accessing benchmarked data which describes the performance of their local primary care providers. We anticipate this level of visibility will, in time, reduce unwarranted variation and drive up quality.

This new model of care will be delivered by multi-disciplinary staff teams with enhanced training to work seamlessly across primary, secondary and community care. Staff will be highly skilled in public engagement and communicating healthcare knowledge to motivate patients to make healthy lifestyle choices, participate in preventative and early detection initiatives and self-manage their conditions. Patients and their families and carers will be empowered to make informed decisions about their care and discuss these openly and confidently with health and social care professionals. The use of modern technological advances, particularly in telehealth and telemedicine will be commonplace to further aid continuity of care and convenience throughout the system. It is anticipated that this approach will nurture improved health outcomes, independence and social responsibility.

4.2 The vision for integrated care

Building upon this premise for primary care, our vision for integrated care in Greater Manchester is to create a sustainable, person-centred health and social care system which supports the population to live longer, healthier and more independent lives. The boundaries between the different organisations providing this care and support; including the NHS, local authorities and the third sector; will be removed, facilitating a seamless and straightforward care experience for our patients and service users. The remit of these services will reach beyond helping people recover when they are unwell. They will actively engage with the population to promote good health and wellbeing, both physically and mentally, to prevent the onset of conditions that are hugely detrimental to our quality of life. Education and support programmes will be available for those chronically unwell to aid their understanding and self-management of their conditions. We aspire to create a more resilient, engaged and empowered population who are active partners in the health and social care system, rather than passive recipients.

We envisage the delivery of this care across a diverse range of settings, embedded in the local community and convenient and close to home wherever possible. Certain elements of care traditionally delivered in an acute hospital, such as outpatient appointments, diagnostic tests and investigations, physiotherapy and minor surgical procedures will be available in GP surgeries, local communities and patients’ own homes. Admission to an acute hospital will become a rarity for the majority of the population, with lengthy hospital stays a thing of the past.
Whilst we want to ensure this vision will become a reality for everyone in Greater Manchester; regardless of where they live or choose to receive care; we understand and respect the diversity and individuality of each district. The delivery of this vision will therefore be driven by health and social care partners (in collaboration with the local community) in each locality area, enabling the vision to be adapted to local needs and circumstances.
5.0. Developing the Future Model of Care

5.1. Primary care

5.1.1. How the GM Primary Care Commissioning Strategy was developed

The NHS England Greater Manchester Area Team has led the development of a Primary Care Commissioning Strategy: ‘Our 5 year strategy for improving primary care within Greater Manchester, supporting the development of community based care 2014 – 2018’ (Appendix 5). The development of this strategy was overseen by a Primary Care Commissioning Strategy Group with representation from all primary care contractor groups (dentistry, general practice, optometry and pharmacy), social care, Health Education England and CCG co-commissioners. Acknowledging that involvement and engagement are integral to the successful reconfiguration of services, there was wide engagement in the development of the strategy, including with patient and carer panels and representatives, all GM Local Medical Committees and two GM wide Primary Care Summits with participation from primary care contractors.

5.1.2. The content of the GM Primary Care Commissioning Strategy

The Primary Care Commissioning Strategy centres on 5 key themes which are shown below:

**Figure 2: Primary Care Commitments**

- **Multidisciplinary Care**
  - Identification of Long Term Conditions
  - Best care pathways
  - Medicines optimisation
  - Integrated care teams
  - GP as co-ordinator of care

- **Involvement in Care**
  - Access to care records
  - Promotion of self care
  - Primary prevention
  - People die in the place of their choosing

- **Access and Responsiveness**
  - Digital technology; range of access mediums
  - Continuity of care
  - Increased access to primary care services

- **Increased out of hospital services**
  - Locally based enhanced services
  - Smooth primary/secondary care interface
  - Inter-practice referrals

- **Quality and Safety**
These commitments form the basis of the primary care strategy and state:

- **Quality and safety**
  Primary care providers will provide consistently high quality and safe care as evidenced by appropriate quality assurance systems and the production of transparent, publicly available benchmarking data. All providers will be expected to participate in incident reporting and peer review.

- **Involvement in care**
  We will provide clear evidence informed preventative advice, understandable care pathways with the patient always at the centre. Patients will have choice, access to their own care records and be provided with accessible information in order to work as partners with professionals to manage their health.

- **Multidisciplinary Care**
  Patients with long term conditions including those with multi morbidities will have access to an integrated care team designed around their own needs to ensure their conditions are managed effectively.

- **Access and responsiveness**
  There will be easy access to high quality, responsive, preventative primary care including a rapid response to urgent needs so that fewer patients reach crisis and need to access hospital emergency care.

- **Increased out of hospital services**
  We will ensure patients can access a greater range of local health services within their communities easily and those services will work well together to ensure care remains in the community wherever clinically appropriate and safe.

NHS England will commission outcomes; it is up for localities to determine how services will be provided in order to meet these outcomes.

### 5.2. Integrated care

#### 5.2.1. How the integrated care plans are being developed

The development of integrated care models has been locally led by health and social care partners in each of the 10 areas of Greater Manchester; however, there has been a common approach to this development process (Figure 3). All 10 localities have focused on establishing partnerships between the stakeholder organisations; defining the scope of what is to be delivered; developing and testing a new model of care; and planning for the successful implementation of the new service model. Enabling workstreams have been established to support the delivery of new models of care. All localities have considered IT, workforce, estates, contracting models, service user engagement and primary care development as a minimum. Practice sharing events with representatives from across the region’s health and social care system have provided valuable opportunities for localities to come together, learn from one another and seek advice concerning model development. A Practice Sharing Event in September 2013 highlighted the need for collaboration at a Greater Manchester
level to tackle some of the more difficult aspects of implementing integrated care, including legal advice and IT and data sharing solutions. These events have also benefited from expertise from national partners including the Department of Health and the Health and Social Care Information Centre.

Figure 3: Process for establishing new models of integrated care in Greater Manchester

 Whilst each locality has started work on developing models of integrated care at a different point over the last 2-3 years, attempts have been made to move towards a common timetable. This has been realised via the AGMA Executive and the Association of Greater Manchester CCGs sharing their integration plans in June and September 2013, which has served to generate some pace and debate as to whether the scale of the plans is ambitious enough.

5.2.2. The process for signing off the plans

In the June 2013 spending review, the Government announced a £3.8bn Better Care Fund (BCF) – a pooled budget for local areas to access to support the closer integration of health and social care. The BCF supports the direction of travel that GM localities were working towards in the development of integration plans and will act as a catalyst for change at greater scale and pace.

The BCF is a critical part of, and aligned to, the NHS 2 year operational plan and the 5 year strategic plans, as well as local government planning. Local Health & Wellbeing Boards were asked to agree and submit a draft version of the BCF plan by 14th February 2014, with the final plan due on 4th April 2014. This will necessitate local plans for integrated care to have been signed off before this date.

This timeline also aligns to the GM timetable for integrated care plan implementation, where it is expected that localities will start to test their models of care from April 2014.
5.3. How the single system view is being developed

5.3.1. Community based care standards

The need for a Greater Manchester wide set of community based care standards

As outlined above, localities across GM are developing comprehensive plans for delivering the highest levels of care to their local populations and patient groups. These plans take into account:

- The current and future health and care needs of all population groups and patient cohorts;
- The recently launched Greater Manchester Primary Care Commissioning Strategy, which sets out the aspirations, principles and commitments governing the future provision of primary care services;
- The on-going work within each locality to create and implement models of integrated care – as part of wider Public Sector Reform; and
- The significant financial challenge that localities face due to increasing demand and reducing real budgets.

Whilst each locality is working to deliver the right ‘community based care’ services within their local communities and neighbourhoods; health and care leaders from across GM have expressed a need to ensure there is consistency in the aspirations and proposals put forward so that the local plans collectively lead towards a stable and sustainable health and care system across GM.

These standards are not entirely new. Localities across GM have long delivered services that reflect these aspirations. The standards create a framework through which localities can consistently
describe all the activities underway across GM to deliver high quality and sustainable care. The standards also help to ensure that everyone across every community in GM gains a consistent understanding of their personal responsibilities and expectations of community based care services, regardless of where they live.

The standards support and reinforce the local plans by:

- Setting future aspirations for better quality care upon which activity assumptions can be based;
- Providing a set of metrics for activity upon which the money flows can be determined;
- Providing a mechanism for reducing variation across primary care and measuring quality;
- Aligning primary care and integrated care into a coherent offer for community based services that people can understand; and
- Providing a consistent approach across GM to the quality and commitment to community based care which can then be implemented locally.

The process for developing a set of community based care standards

Stakeholders across GM have worked together to develop a common set of Community Based Care Standards that outline the key outcomes which all local plans for health and social care will seek to deliver. These standards are supported by all stakeholders across Greater Manchester and sit alongside the clinical standards which underpin the clinically led programme to reconfigure some hospital services across Greater Manchester.

An iterative process was undertaken, led by the GM Primary Care Transformation Programme and the GM Integrated Care Programme, to consider common themes emerging from local integrated care plans and the GM Primary Care Commissioning Strategy. Five core themes were defined as illustrated in Figure 5 below:

**Figure 5: Emerging community based care themes**
An extensive engagement process was then undertaken from August – October 2013, where these overarching themes were tested, analysed, refined and more accurately defined with a series of stakeholder groups as shown below in figure 6.

Following a series of workshops, an outline set of standards were developed by the end of August 2013 and further refined during September 2013. The standards were presented at the Primary Care Summit on 25th September 2013. A further engagement process was then carried out commencing October 2013 where the standards were presented to and shared with key stakeholder groups including local Health and Wellbeing Boards and patient groups.

**Figure 6: Process of engagement**

The process of engagement culminated in February 2014 when the standards were signed-off by the Association of GM CCGs. It was also agreed that the final version of the standards would be taken to all 10 GM Health and Wellbeing Boards and be reflected in local plans for community based care.

### 5.3.2. Process for consolidating the plans

As outlined above, plans for primary care and the integration of health and social care will be locally determined. However, for the purposes of the Healthier Together consultation on the reconfiguration of some in-hospital services, it was necessary to be able to describe local plans for community based care in a consistent and coherent way. Therefore, the GM Integrated Care Programme team has worked with locality integrated care programmes and CCG planning leads to develop and populate a series of community based care templates which summarise community based care plans, including the anticipated benefits and implementation plan. Section 6 of this document features the 12 locality community based care plans on a page which summarise the key initiatives being worked upon to transform care outside of the hospital setting.
6.0 Summary of Each Locality’s Approach to Community Based Care

6.1. Bolton Plan on a Page

<table>
<thead>
<tr>
<th>Case for Improving Out of Hospital Services</th>
<th>Key Proposed Initiatives for Delivering Better Care</th>
<th>Proposed Investment</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pilot project assessing potential value of integrated care model commenced August 2012. Specific learning from the Pilot commenced in 2012 was that the patient’s GP has to be at the centre of care planning and MDT working.</td>
<td>• “Staying Well” programme for early intervention and support those presently well but at risk of needing high-level health and social care in the future. Already in operation</td>
<td>• Joint CCG and Local Authority investment and savings already agreed for Intermediate Tier Redesign</td>
<td>• February - March 2014: Completion of the financial assessment of overall affordability of proposed model.</td>
</tr>
<tr>
<td>• Five tiers of care identified depending on intensity and volume of care needed</td>
<td>• “Ageing Well” programme to support those who have more than one long term condition and are generally functioning well to remain independent and self-managing</td>
<td>• CCG and council agreed to establish £1m Joint Transformation fund to support Integration in 2014/15</td>
<td>• March 2014: end of first run of “Staying Well” programme</td>
</tr>
<tr>
<td>• Includes end of life care, long term conditions requiring ongoing intervention, frail elderly and people with complex needs- approx 3,440 individuals; plus additional 16,000 individuals identified as &quot;LTC - Self Care&quot;.</td>
<td>• Intermediate care redesign with investment in 24/7 community services to commence April 14.</td>
<td>• Development of £2m primary care innovation fund</td>
<td>• March 2014: Organisation of the 10 GP clusters in to neighbourhood hubs that will accommodate three locality based integrated care teams (LBICs).</td>
</tr>
<tr>
<td>• The Service Model &quot;Complex Lifestyles&quot; includes management of anxiety, depression, alcohol dependence and drug abuse.</td>
<td>• Single Point of Contact (SPoC) for referral to rapid response services and intermediate care to be further developed into a SPA for all services delivering &quot;Integrated Care&quot;.</td>
<td>• Demonstrator site for primary care exploring the use of technology to permit access to patient records for individual and integrated teams and to test remote assessment using telehealth to promote early health and social care intervention in care homes.</td>
<td>• March 2014: Early first phase implementation of LBIC model</td>
</tr>
<tr>
<td>• Care in residential and nursing homes is referenced in the Service Specifications for &quot;EoL&quot;, &quot;LTC with Intervention&quot;, and &quot;Frail Elderly&quot; Service Models.</td>
<td>• Locality Based Integrated Care Teams (LBICs) put in place for risk stratification, care planning and delivery of care</td>
<td>• Active discussions in progress between partner organisations (BCCG, BMBC, BFT, GMW) on schemes for investment including Locality Based Integrated Care Teams, community admissions avoidance, 7 day hospital discharge, services for people with complex lifestyles and staying well.</td>
<td>• April 2014: Intermediate Tier Redesign commences.</td>
</tr>
<tr>
<td></td>
<td>• Core role for primary care in LBICs, prevention and development of care plans</td>
<td></td>
<td>• April 2014: Phased implementation of LBIC model to test assumptions commences in full for the remaining GP clusters. Continuous monitoring and reporting of agreed outcome metrics to evaluate impact.</td>
</tr>
</tbody>
</table>
6.2. Bury Plan on a Page

Case for Improving Out of Hospital Services

• Radical action is needed to deliver community-based care services as a result of:
  • rising public expectations
  • unprecedented demand
  • reducing funding
  • increasing numbers of older people
  • increasing numbers of people with long term and complex conditions
  • rising birth rates
  • need for improved experiences for people
  • cost of hospital based service
  • hospital acquired infections

Key Proposed Initiatives for Delivering Better Care

• The "Healthier Radcliffe" community demonstrator site will act as the first phase of the Bury-wide integrated care initiative. This will impact on all individuals in Radcliffe and will have a focus on frail older people, children and complex families
• Roll out of prevention and self care schemes, enabling people to take responsibility for their own health and well being through self care, ownership and accountability for their lifestyles
• Integrated care model with multi-disciplinary teams wrapped around GP practices
• Developing a model of integrated intermediate care & reablement support
• Increased support for carers as part of the implementation of a carers’ strategy which has been developed with the public
• Named GP for over 75s
• Focus on citizenship and community engagement with a commitment to co-production

Proposed Investment

• The Better Care Fund will be a major enabler in having a formal shared financial agreement over the use of the pooled budget - £11m
• Funding as part of the primary care demonstrator community programme in Radcliffe
• Investment of £5 per head - named GP
• Bid for PM GP Challenge Fund finance

Next Steps

• January 2014: Phase 2 of "Healthier Radcliffe" commenced
• Development of an agreed shared outcomes framework
• Risk stratification to identify cohort of people
• Whole system approach to delivering more home based care:
  • use of care plans
  • single care record
  • support for carers
  • access to professional advice
  • community engagement
  • communications
  • quality assurance
• Action plans being developed to drive the above
• Review of intermediate care and reablement services
### Case for Improving Out of Hospital Services
- Initial NM integrated care plans only cover 4.5% of the North Manchester population
- LLLB model segments whole population into priority groups
- 42,630 unpaid carers identified in 2011 Census – estimated to be closer to 60,000
- High numbers of those classed as “at risk” are not on GP disease registers
- Links between sub-optimal housing, low income, single parent families, complex lifestyles e.g. alcohol, substance misuse – need for greater prevention and intervention focus
- North Manchester has baseline of lower levels of investment in out of hospital services than other CCGs in GM
- Variation in quality of primary care

### Key Proposed Initiatives for Delivering Better Care
- "Living Longer, Living Better" programme of community-based co-ordinated care
- Implementation of new delivery models (NDMs) for the 6 priority population groups: Adults and children with LTCs, End of Life Care, Frail Older Adults and Adults with Dementia, Adults with Complex Lives
- Integrated intermediate tier comprising current intermediate care, reablement, crisis response and navigator services
- Peer support and education to promote self-care and prevention
- Use of technological advances e.g. tele-care and apps for efficient self-management of conditions
- Continuity plans should individuals require hospital care
- Vision of development of care campus in North Manchester
- Improving quality of care in primary care; reducing variation, agreeing minimum standards of care
- Community based long term conditions services, building on current diabetes and respiratory services

### Proposed Investment
- Significant investment already in place in NM for North Manchester Integrated Neighbourhood Care Model
- Investment in 24/7 district nursing
- Investment in Crisis Response Pilot
- Investment via Better Care Fund to support out of hospital services including intermediate tier, early supported discharge for stroke, end of life care, community nutrition, primary care support to frail elderly, consultant outreach to support frail elderly, Manchester Homeless Pathway, supplement NMINC teams with mental health practitioners

### Next Steps
- Better Care Fund submission March 2014
- Implementation of first 3 LLLB NDMs (frail older adults and dementia, adults with LTCs and end of life care) during 2014-15
## 6.4. Manchester (Central) Plan on a Page

### Case for Improving Out of Hospital Services
- Current integrated care plans only cover 2% of the Manchester population
- But 20% of the population identified as “at risk” of needing hospital admission including those with long term conditions, older people, people with complex lifestyles
- 42,630 unpaid carers identified in 2011 Census – estimated to be closer to 60,000
- High numbers of those classed as “at risk” are not on GP disease registers
- The three highest risk categories represent 5.5% of the overall population, but account for 58.3% of urgent care costs
- Links between sub-optimal housing, low income, single parent families, complex lifestyles e.g. alcohol, substance misuse — need for greater prevention and intervention focus

### Key Proposed Initiatives for Delivering Better Care
- "Living Longer, Living Better" delivered through the CICB, and Provider Partnership Board.
- Implementation of (NDMs) Adults with LTCs, End of Life Care, Frail Older Adults and Adults with Dementia, Adults with Complex Lives.
- Mental Health Improvement Plan
- Integrated care within health and social care through the NDM
- High quality consistent primary care - Increasing services offered by primary care
- New models of contracting
- Building infrastructure in communities
- Peer support and education to promote self-care and prevention

### Proposed Investment
- Significant investment (£3.4m) in out of hospital care, focused on the NDM for LLLB, and developing primary care.
- New investment agreements will be agreed by CMCCG in February and presented to the Health and Wellbeing Board in March 2014, for implementation through 2014/15.

### Next Steps
- April 2014: Agreement of new delivery models, investment propositions and initial implementation plan for 2014/15.
6.5. Manchester (South) Plan on a Page

<table>
<thead>
<tr>
<th>Case for Improving Out of Hospital Services</th>
<th>Key Proposed Initiatives for Delivering Better Care</th>
<th>Proposed Investment</th>
<th>Next steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current integrated care plans only cover 2% of the Manchester population</td>
<td>South Manchester Integrated Care programme of community-based co-ordinated care</td>
<td>Significant investment already in place across South Manchester (1.7m) funding integrated care teams for adults with LTCs, and specific integrated care pathways (examples include: respiratory disease, stroke, dementia diagnosis and residential care patients)</td>
<td>March 2014: HWBB sign off of Business cases for Population Groups Frail Older Adults, Adults with Dementia and EOL New delivery models for the population groups have been developed through locality provider partnership group</td>
</tr>
<tr>
<td>But 20% of the population identified as “at risk” of needing hospital admission including those with long term conditions, older people, people with complex lifestyles</td>
<td>Creation of new delivery models (NDMs) for the 6 priority population groups: Adults and children with LTCs, End of Life Care, Frail Older Adults and Adults with Dementia, Adults with Complex Lives</td>
<td>Going forward, investment propositions will be scaled up to support the five priority population as agreed within the wider Living Longer Living Better Manchester wide programme. New investment agreements will be presented to the Health and Wellbeing Board in March for implementation through 2014/15 and beyond.</td>
<td>April 2014: Agreement of new delivery models, investment propositions and initial implementation plan for 2014/15.</td>
</tr>
<tr>
<td>42,630 unpaid carers identified in 2011 Census – estimated to be closer to 60,000</td>
<td>NDMs will incorporate integrated pathways with shared care plans across organisations and identified Key Worker 24/7 health and social care on-call, triage and rapid response service, (inclusive of geriatrician and specialist medical, nursing, and AHP support for palliative and EOL care)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A number of those classed as “at risk” are not on GP disease registers</td>
<td>Shared risk registers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The three highest risk categories represent 5.5% of the overall population, but account for 58.3% of urgent care costs</td>
<td>Peer support and education to promote self-care and prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Links between sub-optimal housing, low income, single parent families, complex lifestyles e.g. alcohol, substance misuse – need for greater prevention and intervention focus</td>
<td>Use of technological advances e.g. telecare and apps for efficient self-management of conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity plans should individuals require hospital care</td>
<td>Continuity plans should individuals require hospital care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Case for Improving Out of Hospital Services

- Seeking to enable equity of access across the locality
- Recognition of the broad spectrum of determinants of health and cross-cutting factors
- Need to improve Out of Hospital care feeds into wider reforms such as the Cooperative Public Services Model which aims to improve social value, autonomy and resilience
- Apropritate social care model needed to support wider public service reforms—developed via the Integrated Commissioning Partnership

### Key Proposed Initiatives for Delivering Better Care

- Community services re-specified and tendered, wrapped around the primary care medical home.
- Specialist and response services to support those with long term conditions
- High quality Primary Care supported by EQALS incentive scheme.
- Care home support model
- Joint review of reablement, intermediate care provision
- Falls prevention campaign overseen by public health, Age UK and Pennine Care
- Disease specific change programmes for pain, dementia and ophthalmology.
- Mobilisation of Integrated Respiratory and End of Life services.
- Development of of integrated services in Urgent Care, MSK, Mental Health, Diabetes, and implementation for Cardiology and Dermatology.
- Dementia partnership—develop support, awareness and services to support people with dementia.
- Cancer screening and prevention schemes.
- Carers Strategy
- Implementation of of recommendations following pain review

### Proposed investment

- As per Better Care Fund Submission
- EQALS £1m
- New investment in community services £1M
- Better Care Fund Intervention Investments
- Clinical programmes up to £3M (dependant on acheivement of QIPP)
- Dragons Den Innovation fund £600 K per annum non-recurrent. £300K recurrent
- £4.1M top up of established joint commissioning budgets

### Next Steps

- March 2014:
  - Launch of new model of care for Care Homes including EQALS 2b
  - Mobilisation of Community Services, integrated End of Life and Respiratory services
  - Implementation of recommendations from dementia, CAMHS and paediatric asthma needs assessment
  - Specification for integrated cardiology and dermatology services for procurement
  - Reablement and response review of community bed base
  - Implementation of Saturday GP surgeries
- April 2014
  - Go live of new community services
  - Commence roll out of Primary Care strategy
  - Assistive Technology strategy
  - Commence roll out of shared decision making and LTC platform
  - Launch of procurement for Dermatology and Cardiology
  - Implementation of Children’s integrated team.
- Investment in IAPT
- May 2015
  - Co-location for out of hours GP base and A&E
- July 2014
  - Implementation of Community bed base review recommendations
- January 2015
  - Mobilisation of Cardiology and Dermatology services
## Case for Improving Community Based Services

- Growing older population—predicted increase of a third by 2025
- Predicted increase of 40% in those living with long term conditions by 2030
- 10 year difference in life expectancy between individual areas in the locality
- High levels of deprivation in Rochdale, with 40% of the populations experiencing high levels of disadvantage
- 22% of the population at risk of becoming vulnerable
- Long term conditions use approx. 50% of GP appointments and 70% of inpatient hospital bed days
- Increased dementia prevalence and associated costs

## Key Proposed Initiatives for Delivering Better Care

- Integrated commissioning, building on the successes of joint commissioning in reablement services
- Creation of a well-known single point of access to care
- Primary care as the "front door" to identify the most appropriate services for the individual
- Provision of specialist expertise within the community
- Improved integrated of carers and voluntary organisations into the health and social care infrastructure
- Creation of a "hub and spoke" model with Rochdale Infirmary to support multi-disciplinary neighbourhood teams
- Range of different intensity packages to support children and young people
- Integrated sexual exploitation team

## Proposed Investment

- Potential release of £3m from reduction of emergency admissions with a £1m investment necessary for alternative care and a further £2m of savings or for further reinvestment
- Investment of £3.9m for 2013/14 transferred from NHS to Local Authority for social care development
- Further transfer funding tbc but predicted to be a joint investment of at least £4.3m

## Next Steps

- **Phase One:** HWBB sign off of Business cases for Population Groups Frail Older Adults, Adults with Dementia and EOL
  New delivery models for the population groups have been developed through locality provider partnership group
- **Phase Two:** Implementation of new delivery models and pathways
- **Phase Three:** Interim review of impact
- **Phase Four:** Redesign based on review
- **Phase Five:** Monitor and Formal Evaluation
### Case for Improving Out of Hospital Services
- 14% of population in Salford is aged over 65 with an expected increase of 28% by 2030
- Circa £18m of savings is needed in health and social care across all partners, with £7m relating to older people
- High number of falls-related A&E attendances, hospital admissions and admissions to nursing/residential care
- Older people most likely to benefit from integrated care (complex conditions and lifestyle, with highest use of health and social care services)

### Key Proposed Initiatives for Delivering Better Care
- Formal partnership between Salford CCG, Salford City Council, Salford Royal FT and Greater Manchester West Mental Health FT
- Promotion and increased use of local community assets for increased independence including local schools, businesses and voluntary groups
- Integrated centre of contact for navigation, monitoring and support throughout the system
- Multi-disciplinary care groups supporting those most ‘at risk’ and broader provision of screening and primary and community support
- Use of a fictional older person ('Sally Ford') to personalise initiatives and embody values
- Separate but linked programme for Primary Care improvement - increasing capacity, access and types of services. Development of a Quality improvement framework to measure impact

### Proposed Investment
- Non-recurrent investment made in 2013/14 through ‘reablement’ funds
- Supporting Greater Manchester bid from the national "Technology Fund" to create an integrated digital care record
- To pool existing health and social care resources for older people in 2014/15 of approx. £100M through an 'Alliance Agreement'
- Service & Financial Plan for Integrated Care (incorporating use of Better Care Fund) for 2014/15 to 2017/18 agreed
- Significant investment to increase primary care capacity & quality
- Investment in Primary Care based Long Term Conditions Programme
- Investment in community services, social services & third sector providers

### Next Steps
- Develop and implement Primary Care Development Programme (Apr 14 onwards)
- Undertake primary care extended opening and federation pilots (April 2014 onwards)
- Implement primary care based long term conditions scheme (commencing Sept 2014)
- Agree the primary care standards that will inform the development of our Salford Standard (commence April 2014)
- Interim review of impact of Integrated Care Pilots (January 2014 to March 2014)
- Extend the Integrated Care Model City-wide (July 2014 onwards)
- Formal Evaluation of Integrated Care Programme (April 2014 to March 2019)
- Review service specifications for community based services - agreeing KPI’s and quality measures that align to our work programmes (April 2014 onwards)
**6.9. Stockport Plan on a Page**

### Case for Improving Out of Hospital Services
- People want more services delivered closer to home and in a timely manner.
- Preventing ill health and social isolation, and preventing a crisis in an existing condition or situation will improve people's lives.
- Over reliance on acute services with much higher hospitalisation than similar areas.
- Individuals trapped in this cycle of unnecessary acute admissions.
- The capacity, capability and coordination of community services is less robust than other areas.
- Financial gap of approx £114m for both Health and Local Authority.

### Key Proposed Initiatives for Delivering Better Care
- GP Care planning at scale.
- Integrated teams supporting general practice to manage people on a complex care pathway.
- A dedicated GP led team supporting nursing homes.
- People Powered health team to address low level social isolation in the community.
- Improving uptake of population protection (E.G. Flu).
- Reducing variation in long-term condition management.
- GP federation to drive above and improve access to primary care 7 days per week.
- Stockport Integrated Health Record.
- A range of community based rapid response services to deflect need for admission including IV fluids, Intermediate care expansion, NWAS pathfinder scheme.
- Increasing IAPT support.
- New front end to urgent care system.

### Proposed Investment
- Making recurrent non-recurrent spend in 13-14 on acute deflection schemes £3m in 14-15.
- IAPT investment £0.8m across 14-17.
- Integrated Care - £0.6m in 14-15, up to £1.5m across 15-17.
- Making recurrent existing non-recurrent investment in primary care £1.2m.
- A further £1.5m into primary care to increase access and support nursing homes.
- IM&T c£0.8m.
- Total c£10m.

### Next Steps
- Jan 14 roll out of Integrated Care team in locality 1.
- June 14 Nursing Home project established.
- June 14 consultation on integrated care within Healthier Together consultation.
- Oct 14 roll-out of integrated care teams across 3 remaining localities commences.
- April 15 - integrated care teams established in all localities.
### Case for Improving Out of Hospital Services
- Feedback from local residents and service users supports the demand for a more joined up health and social care system which promotes independence and shared decision-making.
- Improvements in healthy life expectancy and reduced health inequalities will only be achieved if Health organisations and Local Authorities work together.
- Financial pressures for both the NHS and Local Authority.
- We need to reduce demand on more intensive health and social care services by investing in community based prevention and early intervention initiatives.
- Community and acute services are unsustainable if they continue to work in silo.

### Key Proposed Initiatives for Delivering Better Care
- Development of an Integrated Care Service called Care Together that will support a pathway approach across the following levels of care:
  - Building up the strength of individuals and communities
  - Integrated teams based in localities
  - Specialist pathways
  - Hospital Based Care
- A focus on wellness and not illness
- Identification and support of the most “at risk” people
- Improved access to health and wellbeing information, education and engagement to encourage healthy lifestyles
- Care delivered by multi skilled professionals who understand health and social care needs and provide support to keep people healthy and independent.
- Moving away from bed based care and investing in prevention and early intervention services to stop people becoming dependent on public services.
- When people become ill services will focus on getting people well enough to self manage their condition at home through rehabilitation and re-ability and reduce the need for more specialist or intensive support.
- Seamless continuity of care across specialist, community and primary care.

### Proposed Investment
- The financial challenge to the health and social care economy over the next five years is unparalleled.
- CCG has around £326 million to spend locally in 2014/15 and £337 million in 2015/16. The challenge particularly in the next two years is to use that money to develop community based prevention and early intervention initiatives and quickly reduce spend on more intensive health and social care services.
- The Better Care Fund is a key enabler to take integration agenda forward at scale and pace, acting as a significant catalyst for change.
- The financial allocations available in Better Care Fund are £3.673 million in 14/15 and £19.343 million in 15/16.

### Next Steps
- The Joint CCG/LA Programme Management Office is coordinating the following workstreams that will deliver the vision of the local health and social care community:
  - Integration Service Redesign
  - Communications and Engagement/Consultation
  - Finance
  - Workforce
  - Estates and Transport
  - Governance
  - IM&T
### Case for Improving Community Services

- Significant investment into mental health has improved access, with implementation of RAID services for all Trafford patients. RADAR business case being developed across GM with Trafford leading.
- Patient co-ordination centre currently being procured which will be single access for patients and carers. This will deliver improvements in patients experience and improvement in quality. This will include a BCF project which will develop a Health and Wellbeing Hub which will support early detection and intervention.
- Trafford’s Primary care strategy being developed to increase, additional enhanced services within primary care to support integrated care in the community.
- Better care programme to provide a focus on Frail and Elderly People which will identify the further developments for this group of patients and to bring greater connectivity across services.

### Key Proposed Initiatives for Delivering Better Care

- Aligned commissioning, building on integrated commissioning for children and young people
- Fully integrated Care Co-ordination Centre for single point of access
- Integrated Care model to be based on neighbourhood models aligning Primary and Community services
- Enhanced reablement and discharge teams and facilities
- Joint health and wellbeing strategy for early intervention as part of the Better care Funds.
- Better Care Funds to develop further Palliative care to increase the number of deaths in usual place of residence.
- Increased investment in tele-health as part of patients co-ordination
- The continuation of a number of deflections schemes to reduce pressure on A&E departments
- Co-production with third sector, residents, housing and leisure providers
- Comprehensive support package for carers

### Proposed Investment

- Investment in unscheduled care of £3.2m in community service development as part of urgent care review
- Patient co-ordination centre to be main investment for Trafford CCG, investment not yet known currently part of a procurement process.
- Better care funds to support 3 projects, Frail and Elderly, Palliative Care and Health and Wellbeing Hub. Investment tbc
- Further investment to be aligned to commissioning interventions for 2014-15 outlined in the CCG 5 year Strategy
- Review of investments to support acute Trusts following the implementation of New Health Deal for Trafford.

### Next Steps

- Post evaluation of The implementation of New Health Deal for Trafford to understand lessons learnt.
- Trafford CCG to continue with the NHD dashboard to track and monitor all Trafford patient activity Unscheduled care activity and associated schemes.
- Further develop the Primary Care Strategy (as part of the Prime ministers challenge if successful) or for the CCG to support practices with the development of the 4 neighbourhood teams. With practices moving to a confederated.
- Baseline assessment of Council and CCG joint pressures
- Operational integration between Adult Social Care and Community Health Service
### Case for Improving Out of Hospital Services

As with all health and social care economies, Wigan Borough is facing unprecedented demand upon its health and social care services at the same time as funding levels are reducing. These challenges will intensify in the next few years as our population gets older and the numbers of our residents with multiple and complex health and care needs grow. In addition, the birth rate is rising, particularly in our more deprived communities. In order to meet these challenges, we know that we must take radical steps now to safeguard the delivery of high quality services that can meet the needs of the residents of our Borough and reduce the cost of the care provided.

### Key Proposed Initiatives for Delivering Better Care

Integrated Health and Social Care programmes for the three cohorts of Start Well (Children to 19), Live Well (Adults of Working Age Population) and “Age Well” (Older People). The interventions will be different for different cohorts but they will have principles of promotion of independence, targeted presentation, and joined up service delivery between agencies. The programmes will be rooted to primary care and a developed risk stratification to ensure practice identification of residents at needs of targeted support. Key characteristics of the joined up services across all three cohorts will be:

- An identified first point of contact for their health and care needs;
- An integrated care plan, built around the individual, covering health and social care, and drawing on all of the assets available in the community;
- Full involvement in the development of this care plan, including self-care elements
- Where appropriate, the option of a personal budget;

For further information see the Wigan Integrated Care Plan

### Proposed Investment

The cornerstone of the new investment models for Wigan is the Better Care Fund – a formal agreement (subject to approval by NHS England) for £22m to invest in extended and strengthening services that will operate as part of the reformed programme

### Next Steps

A programme of work for integrated care for children’s services is already in place, and the Extended Integrated Neighbourhood Team programme for the older peoples programme was approved by the Joint Commissioning Group in January 2014. This is building on the Integrated Neighbourhood Teams that have been in place since April 2013 and have delivered a significant impact already, as highlighted in the recent King’s Fund report *Community Services: How They Can Transform Care*. Further work is being undertaken on the Living Well Integrated Care Cohort – in particular the link to the wider Public Service Reform agenda.
### 6.13. Summary of GM-wide Approach to Improving Community Based Care – Primary Care

#### Key Proposed Initiatives for Delivering Better Care

- Programme of awarding Demonstrator Communities to encourage locality based innovation and ownership of the need to change primary care provision.
- Disseminate across GM the learning and data from the Demonstrators and other areas of innovative practice.
- Creation of a GM primary care strategy and delivery plan; mobilisation of resource to create GM wide enabling workstreams in the following areas: Workforce, Governance, Estates, IM&T, Finance and Communications & Engagement.
- To provide access to robust data which enable primary care services to be benchmarked across GM thereby enabling the public to review their service offering and ultimately to reduce unwarranted variation and drive up quality.

#### Proposed Investment

- **2013/14**: £2M identified by NHS England Greater Manchester Area Team to support innovation in primary care; Demonstrator Community scheme launched.
- **Feb 2014**: 18 applications from GM localities to the Prime Ministers Challenge Fund and one application supplementary to these from the Area Team.
- **2014/15 Area Team to identify level of funding to support further round of Demonstrators.** CCGs to confirm their level of investment in supporting innovation and increasing accessibility / responsibility in primary care.
- **2015/16 onwards**: Due to secondary care reorganisation, additional investment available for primary and community based care.

#### Next Steps

- **Feb - March 2014**: Agree high level programme plan with agreed leads on all areas.
- **March - July 2014**: Develop clear, detailed project plans for all 5 commitment areas and the 7 enabling workstreams.
- **April 2014**: Finalise governance arrangements and recruit full Transformation team.
- **Feb - May 2014**: Review evidence from Demonstrator Communities and ensure lessons learnt are being shared across GM.
- **April - July 2014**: Expand Demonstrator programme via Prime Ministers Challenge Fund or alternative funding methods to increase population under demonstrators to 1M.
- **July 2014 - March 2014**: Achieve milestones as set out in programme plan.
7.0. Pan-Greater Manchester Services

There are a number of services / initiatives that are Greater Manchester-wide and so are common to all 10 locality models of community based care. Some of these services and initiatives are described below.

7.1. NHS 111

NHS 111 is a 24 hour telephone service introduced to make it easier for service users to access local health services when there is urgent need. When someone needs to contact the NHS for urgent care, there are only three numbers to know: 999 for life-threatening emergencies, their GP surgery, or 111. NHS 111 is staffed by a team of fully trained call advisers, who are supported by experienced nurses. The caller is assessed, given advice and directed straightaway to the most appropriate local service; that could be an out-of-hours doctor, walk-in centre, urgent care centre, community nurse, emergency dentist or late opening chemist; and booked an appointment where possible. If an ambulance is needed, one will be sent just as quickly as if the caller had dialled 999.

NHS 111 can support Greater Manchester health and social care services as it directs the public quickly and efficiently to most appropriate local service and therefore can help ease the pressure on the 999 service and local A&E departments, so that they can focus on emergency cases.

7.2. North West Ambulance Service (NWAS) Paramedic Pathfinder

When 999 is dialled and an ambulance requested, many cases do not require immediate treatment in A&E. Paramedic Pathfinder is part of the approach NWAS clinicians take to assess a person’s care needs when they first arrive on scene. It is designed to ensure that the public receive high quality, appropriate care, whether that is solely from the ambulance paramedics, a local hospital, a local community service, or simply where the person may be able to manage their own condition at home. This approach ensures people are treated in the right place, at the right time by healthcare professionals with the right skills.

In the past, the only option for NWAS was to take patients to hospital. As the local NHS has developed more services closer to home to support people with a range of less-severe conditions, NWAS has been able to avoid attendance at A&E and tap into this local provision. Paramedic Pathfinder works in tandem with these services and enables NWAS crews to easily identify the most appropriate care option for the individual.

Since June 2012, the Pathfinder Team has identified 151 potential Community Care Pathway initiatives in the North West, all of which are being utilised.

7.3. Children’s Community Based Services

Children’s community based care in Greater Manchester is currently delivered through a variety of means, with differing levels of integration, access and quality of service. The implementation of Children’s Community Nursing services following the Making it Better programme has been variable across the city in
both access and provision, with the anticipated benefits of reducing the number of A&E attendances not being sustainably delivered.

Much like adult care, there is a desire to see increasing proportions of children’s care delivered safely and efficiently in community settings. Whilst all localities within GM have reflected the needs of adults and in particular older/frail people in their community based care plans, the needs of children within the community has often not been detailed in the same way.

To support the development of integrated children’s services in locality plans, a strategic vision and set of standards for children’s community based care has been developed through the creation of a Children’s Out of Hospital Working Group. The overarching principle of this vision is that:

“No child or young person should be in hospital when care can be provided to the same or better standard in the community.”

Delivering the identified standards of inpatient care for children will only be achieved by delivering a joined up approach to shifting care out of hospitals to meet the changing needs of the population and to remove unwarranted variation in care now and in the future. The approach as developed by the Children’s Out of Hospital Working Group will meet the needs of the most vulnerable children and young people in our communities and will be a combination of moving hospital services into the community, changing how many children and young people access primary care and ensuring that there is an integrated approach to care with support available in every locality.

7.4. Reconfiguring Hospital Social Care

It has been recognised that each local authority in Greater Manchester has their own arrangements for supporting hospital patients with social care needs. Working practices are very different in each area, including difference in staffing, working hours, processes and the level of integration with NHS staff.

The majority of authorities (although not all) have a social work presence at the hospital site within their local authority boundary in order to facilitate transfers of care for their local residents. However, the geography of Greater Manchester and patient choice means that people don’t always attend the hospital within their local authority boundary to receive inpatient hospital care. Each local authority has their own arrangements for assessing out of area patients for their discharge requirements, including dedicated out of borough social workers, utilising community social care teams and requiring members of the hospital social care team to travel to other hospital sites. The Healthier Together reforms would result in more patients being treated at hospitals outside of their local authority boundary.

The GM Hospital Discharge Group has proposed a new model of hospital social care provision. The new model will reorganise existing resources to create new social care teams in every in-scope hospital in GM. The teams will support all Greater Manchester residents attending / admitted to that hospital, regardless of the authority in which they are resident. They will input into / co-ordinate:

- Admission avoidance
- Assessments for discharge
- Arrangements for step-down care (in accordance with the policies and procedures of the borough in which the patient is resident)
The aims of the project are:

- To ensure that social care services across GM can respond to increasing demand, despite reducing resources
- To respond to the changes arising as a result of major service reconfiguration in GM
- To improve the efficiency of hospital social care teams
- To improve equality of service provision so that all GM residents requiring hospital social care services receive the same high standard of service

Implementation will take place on a phased basis during 2014/15.

7.5. **End of Life Care**

Although End of Life (EoL) care is a cornerstone of many locality integrated care plans, there are also a range of Greater Manchester-wide initiatives targeted at individuals on this pathway coordinated by the local Strategic Clinical Network (SCN).

7.5.1. **The Gold Standards Framework**

The Gold Standards Framework (GSF) for EoL care is a national training programme with the objective of providing frontline staff with the skills and confidence to provide EoL care of a consistent high quality. The GSF works to promote coordinated care for EoL individuals by identifying them earlier, improving their care experience and increasing the efficiency of the health and social care system by reducing the need for hospitalisation wherever possible. The compliance of care homes and primary care providers in all 10 Greater Manchester localities against the GSF is facilitated by the SCN, who offer support and track progress across the region.

7.5.2. **The Six Steps to Success in Care Homes**

The Six Steps initiative sets out actions care home staff can take to improve end of life care, including dignity in dying. The ‘steps’ identified in the National End of Life Care Strategy (2008) are:

1) EoL discussions with the individual
2) Assessment, care planning and review
3) Coordination of care
4) Delivery of high quality care
5) Care in the last days of life
6) Care after death

Implementation of this programme in Greater Manchester is currently in progress, with local delivery plans in place.

There is also a ‘Six Steps to Success in Domiciliary Care’ programme which supports domiciliary care organisations to implement the structured organisational change to deliver the best end of life care. Some GM CCGs are giving consideration to planning for the delivery of the programme.
7.5.3. Electronic Palliative Care Co-ordination System

The Electronic Palliative Care Co-ordination System (EPaCCS) is an electronic solution to providing improved integrated care for individuals at end of life, enabling efficient and comprehensive sharing of information (including care plans, EoL wishes etc.) across all partners in the health and social care system.

It is being ‘rolled out’ within each CCG ‘locality’ area under the direction of an EPaCCS task group comprising IT and EoLC representatives from the various services involved in EoLC in that area. The approach is a standardised one, agreed at North West level, to use existing systems, a standardised NW EPaCCS dataset, information sharing agreements, and with the ability to share information across borders as well as services.

7.5.4. Liverpool Care Pathway Review

Following the independent review of the Liverpool Care Pathway and published report ‘More Care Less Pathway’ (2013), the National Leadership Alliance for the Care of Dying People was set up to lead and provide a focus for improving the care for this group of people and their families. The Alliance are holding consultation events across the country, addressing the recommendations from the report and plan to report the outcomes in spring 2014. The SCN have facilitated the creation of an interim set of principles which have been distributed across the network and set up a working group to support the national Alliance guidance locally.
8.0. How Community Based Care will be Different for Service Users

In developing models of community based care, many localities have developed case studies to show how services are changing for service users. Some of these stories are included here to demonstrate the impact that new models of care will have on health and wellbeing across Greater Manchester.

8.1. Manchester Practice Integrated Care Team Case Study

Background

Anne has multiple long term conditions and very complex health and social care needs. She has recently been in hospital in October and again in November and has been commenced on new medication. She has complained of feeling very tired and now mobilises with a stick. Her husband is her main carer and she has a very supportive family who she sees regularly.

PICT Involvement

Anne was known to her GP, but the case summary discussion within the PICT meeting showed that she was not known to other members of the core team. As it seemed that one of her primary needs would be to stabilise her health conditions Anne was allocated to an Active Case Manager (ACM) at the PICT multidisciplinary meeting.

The ACM contacted Anne and met with her at home with her husband. Through the care planning process together they identified a number of priorities:

- To reduce her risk of readmission to hospital through supporting her and her husband around her blood levels and physical condition
- To liaise with the diabetic team around monitoring of Anne’s blood glucose levels
- To make accessing outside her home easier due to there being steep steps at the front door and problems parking at the front of the house
- Support around monitoring weight, with a plan for what to do if her weight increased, due to the risk of fluid gain which may trigger a further unplanned admission
- Assistance in maximising benefits as Anne was not claiming her full financial entitlement.
- Education around the importance of foot care in diabetes, and the need to link in with podiatry services.
- To establish the cause of recent incontinence and to ensure support from the incontinence team to maintain dignity at home.

Together a plan was also put in place for what to do in a crisis situation, this included:

- For contact to be made with the ACM should Anne experience a 2kg gain in fluid over 2 days
- For a plan around Anne’s platelet levels to be put in place, with guidance given around a stable level and what action to be taken should levels decrease further.
What this means for Anne:

- Anne has avoided further admission due to the self-monitoring and professional monitoring she has received, putting her and her family more in control of her health.

- Anne’s crisis plan has been tested and action taken in a timely way to prevent her health deteriorating to the point where she needed to go to hospital when her blood glucose levels became unbalanced.

- Anne has been able to receive the support of a range of different core and specialist health and social care services via her keyworker.

- Both Anne’s needs and her carers have been recognised and planned around.

- Anne has had the opportunity to discuss and resolve issues not only around her crisis needs but also a number of less critical issues which were still of really high importance to her and her family, such as how to be able to get out and about more easily.

- Anne’s plan has been built around her and the support she receives from her family, giving her more opportunity to be in control of her health conditions and feel more empowered.

What this means for Practitioners:

- Better sharing of information to enable a rounded view on the issues Anne has been experiencing and the support she may benefit from receiving.

- The opportunity to ensure more easily that the right skills are brought in at the right time to support people.

- A more easily accessible network of support to help in resolving problems.

- Shared ownership of decision making around Anne’s plan, making sure that lost opportunities for support are minimised.

What this means for the System:

- An already tested care plan which has avoided admittance to hospital.

- Reduced duplication in support from different professionals.

- The promotion of self-management, with Anne being supported to have clear responsibility in taking forward many of her care plan recommendations.

- A plan which not only responds with guidance on what to do in an emergency, but also has a strong emphasis on preventing Anne’s condition from deteriorating in the first place.
8.2. Salford Case Study

The following case study is an example of the successful introduction of complex equipment as a test of change including automated turning equipment (TOTO) and the difference it makes to the outcomes for these patients.

This lady had multiple admissions to Intermediate Care and Hospital and it was felt that the only option was 24 hour nursing care. However, her family wanted to explore every possible solution prior to considering this option. Since the introduction of this turning equipment, this lady still had health issues. However, the GP has managed to treat her at home and she has not needed to return to hospital, has greater comfort, sleep at night and a reduction in staff costs to turn her on a regular basis.

Family comments:

“Mum has lived with me for over 6 years now and having her back home after several hospital admissions and a long stay in Heartley Green, has meant a lot to us as a family and to her wellbeing. Having carefully addressed all of Mum’s needs and with the help and support of Mum’s Social Worker and other professionals working together, we have been able to meet those needs.

Whilst Mum has been at home, she has experienced family barbeques and meals, sitting out in the garden and endless teasing from her Grand-Children!!! This has given her flexibility and allowed her to join in and take part in family gatherings, to give her the choice of meals and for family to spend time with her in the comfort of her own home where she can take part in conversation and humour, meeting her wishes.

Mum has a safe and happy home life making her happy and content. It has meant the world to us to have her home giving her the level of care and love she deserves, although it can be tiring to see the smile, it makes it all worthwhile. We are so pleased to have her at home to share life and love with Mum.”

8.3. Dave from South Manchester

Sixty-seven year old Dave has a history of alcohol dependency and has been sober for 30 years. He has a number of health issues, including epilepsy and myocardial infarction, and has a history of falls. He recently suffered a stroke and is experiencing chest pains, which he believes may be due to his heavy smoking. He is therefore trying to stop smoking and make positive lifestyle changes. Sadly, Dave has recently become a widower and he misses his wife greatly. This bereavement has impacted on his sleep patterns and significantly increased his levels of anxiety. Other family members have moved into with Dave to help support him in his bid to be as healthy and independent as possible.

Dave’s care history

Prior to the death of his wife, Dave was managing his health and social needs quite independently, despite suffering from epilepsy and a number of ongoing health complaints. A shortness of breath at night which led to his latest admission into hospital may be anxiety-related, but the underlying cause is difficult to diagnose due to his aortic aneurism. He has also experienced a number of falls over the years as a result of feeling disorientated and, following his recent bereavement, has lost a significant amount of weight. He has been
finding it difficult to relax and is restless during the day and unable to sleep at night. He feels comforted only when ‘talking’ to his late wife.

**A ‘single team’ approach**

Dave’s situation following his bereavement was discussed by the South Manchester Neighbourhood Team at its multi-disciplinary team meeting. As a first step, a review meeting was set up with the Team’s mental health practitioner. Dave was appointed a key worker and has begun a programme of anxiety and cognitive behavioural therapy to help him cope with his emotional distress after the loss of his wife. This key worker also worked closely with his GP to manage and monitor Dave’s day-to-day health needs. His recent falls have been highlighted to the GP and a referral made to the local Falls Service. Both the mental health practitioner and the Neighbourhood Team’s support worker regularly relay any concerns to the Team’s nurses so that they can ensure safe management and appropriate support of any issues as they occur. Dave’s recent weight loss has been addressed by the community dietician and he has been referred for physical activity through his local community services. Further counselling input has also been requested through Age Concern’s ‘Silver Service’ organisation.

**How has this helped?**

As a result of this integrated team approach, Dave now feels that he has the coping mechanisms in place to help him with his day-to-day care. He has an allocated key worker with mental health expertise who is helping him through this period of bereavement and he has regained the confidence he needs to continue to live independently. He is finding his therapy effective and has felt well enough to undertake a family holiday abroad since the intervention of the Neighbourhood Team. Dave has made a number of positive lifestyle changes, including a healthy eating regime, and is receiving ongoing support from the community dieticians, including regular weight reviews. Whilst he has not given up smoking entirely, he has significantly reduced from 60 cigarettes a day to three with support from his GP practice and remains motivated in continuing his journey to become a non-smoker. He has had no admissions to A&E since being with the NT.

**8.4. Skype Appointments in Manchester**

Manchester GP Doctor Sirfraz Hussain explains how video calls keep him in the picture about patients’ health.
“So many of the cues to a patient’s health are non-verbal,” says Dr Sirfraz Hussain, who is a partner at Moss Side Family Practice in Manchester. “So much can be conveyed by body language and behaviour and these details often paint a fuller picture of how a patient is feeling. For example, many older patients are from a traditionally stoic generation and will often tell you that they ‘feel fine’. However, when you can actually see how they are moving and reacting it’s often clear that they could be in a pain and need some help.”

For Dr Hussain this is the key advantage to using Skype, which his practice introduced a year ago, over traditional phone calls. “It allows us to give added value and helps us triage patients. We can spot things on Skype which may not be apparent in a conversation alone, and ask a patient to come into the surgery when necessary.”

The practice, which is in the heart of Moss Side, has a diverse, multi-cultural patient base – and many of the patients are used to using Skype to keep in touch with family or loved ones overseas.

“Our patients have been really receptive to it,” he says. “They know we are offering video calls as an additional service – it is not intended to replace face-to-face appointments, which are the gold standard.

“But, for those patients who would find it difficult to come into the surgery it can be a huge comfort. Take carers who are looking after a dementia patient; or a parent of a child with autism – actually getting into the surgery can be incredibly difficult and sitting in the waiting room can be hard.

“This is where Skype is really valuable. It means that we can keep in touch and see what’s going on in the patient’s normal, day-to-day setting.” On average, Dr Hussain will have around three video calls a week with patients. For those patients who have never used Skype before, but do have the facility on their home computer, he will also talk them through how to use it.

“Last week I had a Skype conversation with a patient who has multiple sclerosis. She was delighted to be able to see me this way because travelling is difficult,” he says enthusiastically. “She was so pleased – and even more so when I pointed out that it was free and meant that she could Skype her son, who lives down south. It was like she had found a winning Lottery ticket.”

This unintended - though very welcome - social consequence of using Skype at the practice is one that Dr Hussain is keen to acknowledge.

“Technology like this is can be a powerful tool in helping to reduce loneliness and associated depression. If we can show someone how to use it, their social circle is widened and they can be part of life which they may have been previously excluded from. They can join church groups, self-help groups – they could even petition the Prime Minister through Skype if they wanted.

The wider care benefits that video calls could have for hard-to-reach patients are also an area that he’s exploring. “We have around a hundred patients who are over 75 years old and many of them only come into the surgery once or twice a year.

“I don’t feel like we should be waiting for them to contact us just when there is an urgent need. We could be proactive in using video calls to keep in touch and spot any potential problems before they happen. This would greatly improve our patients’ quality of life and it would also reduce the chance of hospital admissions.”

And Dr Hussain also takes a virtual dose of his own medicine by using Skype to talk to colleagues within his practice. “It really helps with teamwork when we can talk to each other like this quickly, rather than going from room to room. Again, it’s about adding value. I can ask a colleague for their opinion and see the
reaction and feedback, which helps me. I can also do this while I’m doing my paperwork, so it helps to save time too.”

Looking to the future Dr Hussain is keen to embrace other new ways of working which will improve communications between doctors and their patients.

“As a doctor I feel like I’m in a very privileged position. Patients confide in me and tell me things they would not even mention to their families. As doctors we are able to make a difference in another human being’s life and we need to investigate at all the options that help with that.

“Just look at how technology has moved on in the last three years – and how we are now on the iPhone 5. We need to be part of that momentum and be ready for when TVs or phones have inbuilt video call access, so that we can make the most of it.

“There’s an old business mantra about how success is made up a series of little wins. Skype, for us, has been one of those little wins and made us more dynamic and motivated to think about new ways of giving the best service to our patients. And in turn, our patients are always the voice that guides us – we just need to listen to what works best for them.”