GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Stockport in Partnership

The Devolution Difference

CHANGE HERE

Pam Smith, Chief Executive
Stockport Council

STOCKPORT
METROPOLITAN BOROUGH COUNCIL

STOCKPORT. CHANGE HERE

OUR RESIDENTS AND COMMUNITIES

OUR LEADERSHIP

System-wide
Person centred
Place-base approach

STOCKPORT
METROPOLITAN BOROUGH COUNCIL

WE HAVE

- ✓Strong vision
- ✓**Passion** and **Ambition** for Stockport and our residents
- ✓Developing relationships with our Partners in Stockport and Greater Manchester

CHALLENGES

CHALLENGES

- ✓ Meeting the needs of residents
- ✓ Financial sustainability
- ✓ Workforce
- ✓ Performance – CQC
- ✓ Limited evidence of whole system response

STOCKPORT
METROPOLITAN BOROUGH COUNCIL

SHAPING THE FUTURE **TOGETHER**

- ✓ See the larger picture
- ✓ Short term reactive problem balanced with long term value creation
- ✓ Opportunities for innovation
- ✓ Shared understanding of complex problems
- ✓ Shared reflection
- ✓ From reactive problem solving to collective creativity –

SHAPING THE FUTURE

STOCKPORT
METROPOLITAN BOROUGH COUNCIL

STRONG GOVERNANCE

- ✓ Health and Wellbeing Board review underway
- ✓ Alliance Provider Board – 'engine room'
- ✓ Commissioning: single commissioning intention

STOCKPORT
METROPOLITAN BOROUGH COUNCIL

WORKING WITH YOU

- ✓ Shaping improvement
- ✓ Housing strategy for older people
- ✓ Reinvigorating our engagement with independent sector

STOCKPORT
METROPOLITAN BOROUGH COUNCIL

OUR WORKFORCE

- ✓ System-wide workforce strategy and implementation
- ✓ Developing innovative practices:
  - ❖ Teaching Care Homes
  - ❖ Housing/key-worker accommodation
  - ❖ 7-day working across the system
- ✓ Culture:
  - ❖ Creating the right environment for us all to thrive
  - ❖ Employers of Choice

STOCKPORT
METROPOLITAN BOROUGH COUNCIL

PERFORMANCE

- ✓ Person centred
- ✓ Neighbourhoods
- ✓ Effective Care Pathways
- ✓ Meeting National Standards

STOCKPORT
METROPOLITAN BOROUGH COUNCIL

What next?

STOCKPORT
METROPOLITAN BOROUGH COUNCIL

Commitment & drive to

MAKING IT HAPPEN

Thank you

STOCKPORT
METROPOLITAN BOROUGH COUNCIL

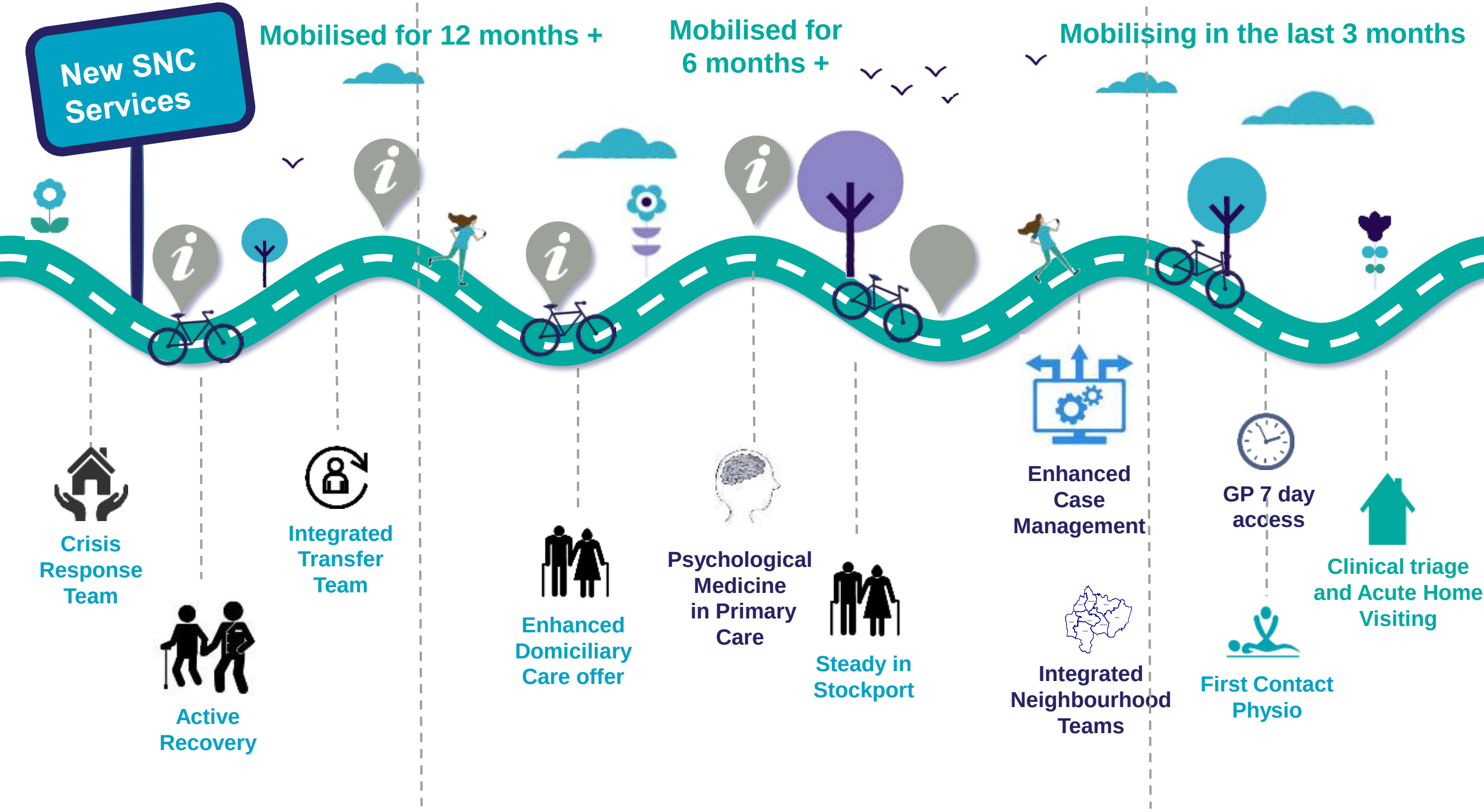
NHS

Stockport Together – Our Journey

Dr Liz Elliott, CEO Viaduct Care
Mark Fitton, Director of Adult Social Care
Stockport Neighbourhood Care

STOCKPORT
NEIGHBOURHOOD CARE

Stockport Together


New SNC Services
Mobilised for 12 months +
Mobilised for 6 months +
Mobilising in the last 3 months
Crisis Response Team
Active Recovery
Integrated Transfer Team
Enhanced Domiciliary Care offer
Psychological Medicine in Primary Care
Steady in Stockport
Enhanced Case Management
Integrated Neighbourhood Teams
GP 7 day access
First Contact Physio
Clinical triage and Acute Home Visiting

Our targets

What do we need to achieve?

For the 15% most at risk of hospital admission:

Reduce avoidable hospital admissions.

19 admissions per day

= 2 each day per neighbourhood

Reduce avoidable visits to A&E

33 visits per day

= 4 each day per neighbourhood

Reduce avoidable admissions to care and residential homes

3 admissions per month

Reduce average length of time people who are admitted have to stay in hospital.

1/2

SNC Triumvirate Leadership Teams

TRIUMVIRATE LEADERSHIP TEAM:
Dr Liz Elliot (Viaduct Care Neighbourhood Director)
Mark Fitton (SMBC Director of Adult Social Care)
Margaret Malkin (SFT Director of Integrated Care)

Neighbourhood Bramhall	Neighbourhood Cheadle	Neighbourhood Heatons	Neighbourhood Marple	Neighbourhood Stepping Hill	Neighbourhood Tame Valley	Neighbourhood Victoria	Neighbourhood Wernerth
Dr Dan Goldspink Lead GP	Dr Viren Mehta Lead GP	Dr Rebecca Locke Lead GP	Dr Maher Al-Ausi Lead GP	Dr Rukhsana Salim Lead GP	Dr James Higgins Lead GP	Dr Paul McGuigan Lead GP	Dr Abdul Ghaboor Lead GP
Jan Leeming SMBC Assistant Team Manager	Jo McLoughlin SMBC Assistant Team Manager	Mel Flint SMBC Assistant Team Manager	Jo Welch SMBC Team Manager	Marie Clavin SMBC Assistant Team Manager	Lynn Hagan SMBC Assistant Team Manager	Kirsty Jones Simmons SMBC Assistant Team Manager	Anna Jenkins SMBC Assistant Team Manager
Louise Birchall SFT District Nursing Lead	Louise Ball SFT District Nursing Lead	Tina Rosebuck SFT District Nursing Lead	Sharon Gardner SFT District Nursing Lead	Andrea Harris SFT District Nursing Lead	Tina Aspin SFT District Nursing Lead	Carina Schofield SFT District Nursing Lead	Angela McNalty SFT District Nursing Lead

Mental Health and Wellbeing Teams

WELLBEING PRESCRIPTION

NOTE

PART 1

- **Veg on prescription** - *Grow your own, cook your own !!*
- **Weekly Health Walks** - *Every Wednesday*
- **Coffee and Conversation** - *Feeling alone, fancy a chat?*
- **Social Events for New Mums** - *Don't feel alone*
- **Pram Pushers Walk** - *Bring along baby for a friendly walk*
- **Singing for Health** - *Singalong with the Champions*
- **Knit and Natter** - *Friendly banter with like minds*
- **Cook and Taste** - *Let us show you how to cook it*
- **IT Skills** - *Let's get you started with the basics*
- **Telephone Support** - *A friendly voice on the end of the line*
- **Practice Allotment** - *Come and help with our allotment*
- **Money Advice** - *Advice and guidance*
- **Evening Get Togethers** - *A friendly group gathering*

PART 2

PART 3

Name:

Contact Number/Email address:

Alvanley Family Practice
HEALTH CHAMPIONS

7 day Access to Primary Care

- Longer appointments
- Access outside of working hours within local community
- Ability to access the full record and ECM
- Bring a relative or carer with you
- MDT approach for Long Term Condition Management
- Phlebotomy and health screening
- Neighbourhood offer is expanding 7 days per week

Enhanced Pharmacy and Physiotherapy

- Addressing the workforce challenges
- Improving patient access 8-8pm, 7 days per week

Enhanced Pharmacy

- Service has seen 826 patients in August
- Service has delivered 2298 non patient contact activity (medication reviews, results review etc.) in August.

First Contact Physio

- 519 patients seen over July & August
- 14 GP practices covered to date
- Further 3 practices coming online by the end of September

Headline Case Studies – Enhanced Care Management

Person and context: 86yrs, female , lives alone, no previous care needs. Had a double hip replacement, discharged from hospital and had a fall at home.

How they participated in project: Better at Home (BAH) got involved after the person fell. BAH provided three weeks of support to the person in their own home, to help re-build their independence, at total cost of £420. Support included care, advice, and assessment / support around new mobility needs at home.

Impact and outcomes of involvement: The BAH support was available immediately, so the person could be discharged from hospital earlier to their home. After BAH support, the person was able to live independently at home without care after 3 weeks.

Lessons learned: Immediate and person-centred short term support in a person's home can help a person leave hospital sooner and support them to regain independence in their own homes, preventing the need for a longer term package of care**.** Joint working and trust between the social worker, in-house support workers, and external Care Provider is crucial to resolving external agency issues / concerns– preventing the breakdown of the care package, which is unsettling for the person, and resource-intensive for Social Care.

Care Homes

- Raising the standards – no inadequate care homes across Stockport
- Driving up the standards on the basis of improving CQC Ratings
- Pathfinder, EQIUP, Red Bag, Trusted Assessor (26 homes signed up)
- Care Home performance dashboard
- Older Peoples Accommodation Strategy
- Increased hourly rate for domiciliary care
- Exploring Care Institute to agreed by December 2018

Headline Case Studies – Red Bag

Person and context: Gentleman with dementia living in one of our Red Bag Pilot Care Homes in Stockport.

How they participated in project: As part of the Red Bag Pilot, the patient was supported by care home staff and family members to complete a “This is Me” sheet, which describes his likes and dislikes, and how to best support his needs. He became unwell, and needed to be admitted to Stepping Hill Hospital for treatment. Before he went to hospital, he was supported to pack his Red Bag, which would follow him through hospital – this included his “This is Me” sheet.

Impact and outcomes of involvement: Once placed on a ward, the patient became quite agitated and the staff were finding it difficult to support him.
One of the staff nurses read through his “This is Me” Sheet in his Red Bag, and found that he was a big Neil Diamond fan. The nurse sourced a CD player, and brought in a Neil Diamond CD from home, to play on the ward. The patient’s agitation reduced significantly, and staff also found it much easier to support him.

Lessons learned: This relatively small action provided much more person-centred care for the gentleman, greatly improving his experience of hospital, whilst also enabling ward staff to support the patient in a calmer environment.

Headline Case Studies – Trusted Assessor

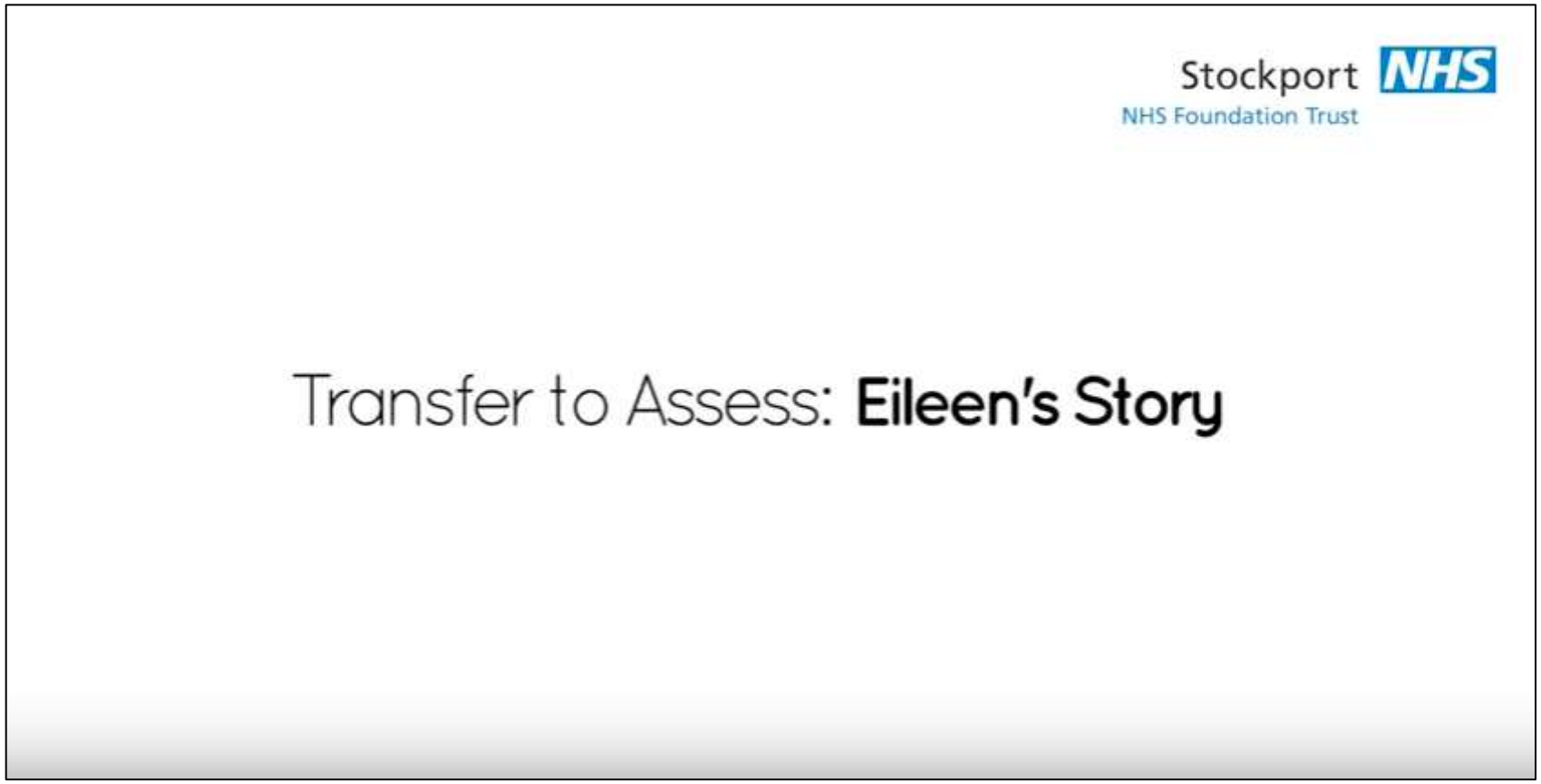
Person and context: male 70yrs, required a new EMI (Elderly Mental Infirm) nursing care placement to support safe and timely discharge from hospital.

How they participated in project: Trusted Assessor assessed service user before hospital discharge. Not having to wait for an assessor from care home avoided delayed discharge which could have lead to deterioration of his dementia and physical abilities such as eating and drinking. Home felt that without the assessment and advice from Trusted Assessor they would not have been able to care for the customer and they would have had to go back to hospital.

Impact and outcomes of involvement: Person transferred to appropriate placement in a timely and safe way. Person and home felt supported by Trusted Assessor team and prevented a readmission to hospital.

Lessons learned: Additional advice and support for home as well as accurate and through information passed on from hospital to care home makes transfer safe and a positive experience for all involved.

Transfer 2 Access



STOCKPORT METROPOLITAN BOROUGH COUNCIL

NHS

Our Journey Continues…

Thank You

STOCKPORT NEIGHBOURHOOD CARE

STOCKPORT
METROPOLITAN BOROUGH COUNCIL

NHS

Steady in Stockport

falls prevention and bone health improvement **pathway**

S Slippers, Shoes, footwear and clothing

T Tablets and Toilet

E Eyes and Ears

A Active

D Drinking and Diet

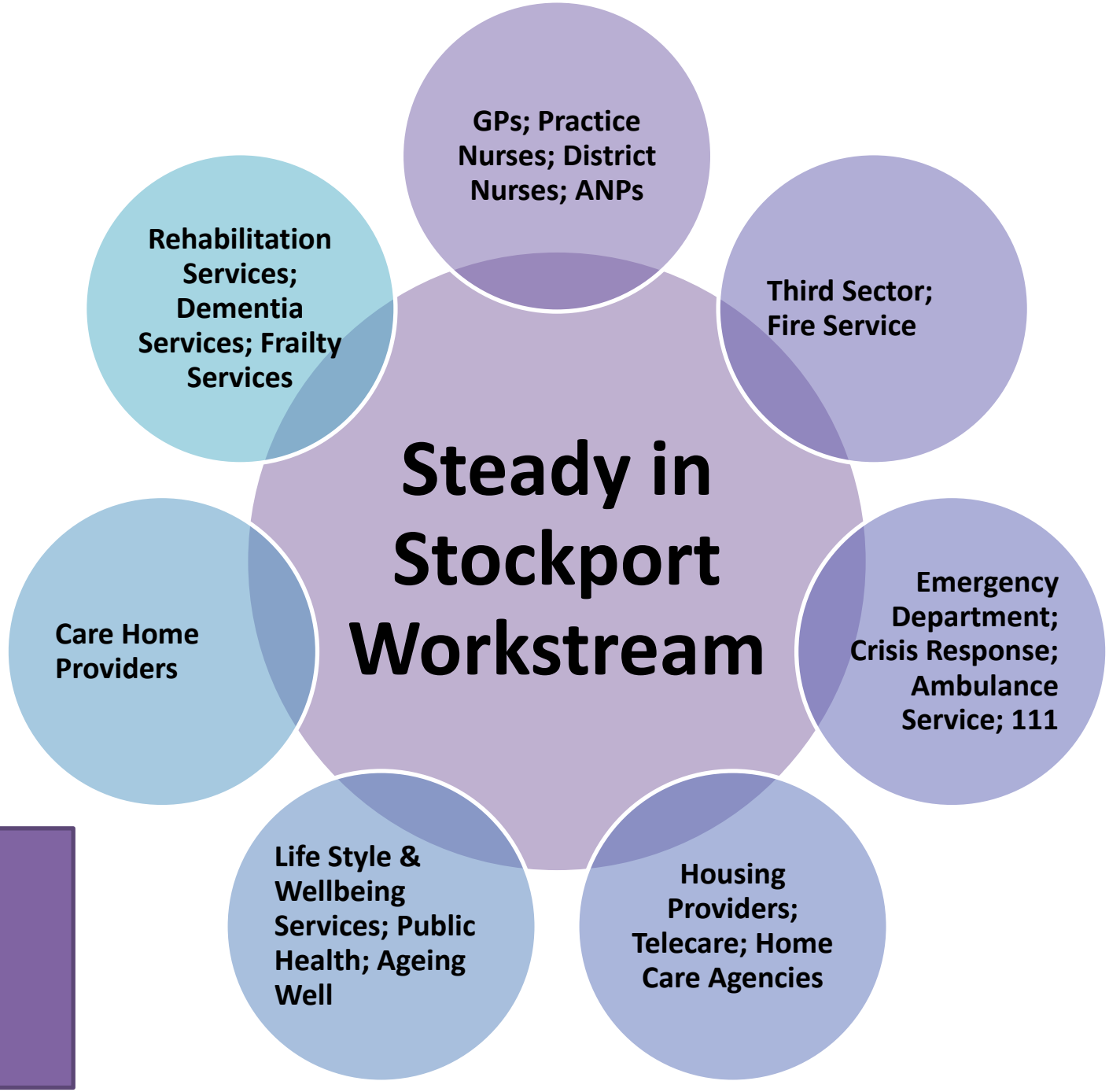
Y You and Your home

SYSTEM APPROACH:

- Falls Prevention & Risk Assessments (Falls Service)
- Management of Bone Health (Fracture Liaison Service)
- Falls Prevention Exercise offer (Strength & Balance groups / 1-1)
- Public Falls Awareness Raising
- Falls Prevention Care Homes
- Falls Experts Network

to improve quality of life & care and to reduce health & social care costs

Partnership approach



- Pathways
- Training & Education
- Partnership working
- Sharing expertise

Key Milestones

2017

- November — Falls arm of service live: assessments
  Falls prevention clinics / information sessions

2018

- January — Fracture Liaison Nurses in post (bone health)
- February — Launch falls experts network
  Greater Manchester Falls Workshop (Feb, July)
- March — First patients with fragility fracture assessed
- May — 2x Support Workers successfully completed Otago Exercise Lead Course
- June — Falls Clinic at Kingsgate commenced
  Bone Health Education & Peer Support sessions
  NWAS referrals commenced
- August — New band 5 Physiotherapist recruited
  Physiotherapist successfully passed PSI course

Next steps

- Patient Education Booklet
- Care Home Toolkit
- Introduce regular patient survey / feedback
- Increase number of clinics
- Closer working with Adult Community Therapy: joint triage/referrals

Steady in Stockport
Falls Prevention & Bone Health Service

Falls Prevention Arm

- **Primary prevention**

Falls prevention visits

Community sessions

- **Secondary prevention**

Multi-factorial assessments
1-1 mobility interventions

- **Education / Information sessions**

2 Physiotherapists
1 Occupational Therapist
2 Support Workers
1 Clerical Officer

Steady in Stockport
Falls Prevention & Bone Health Service

Bone Health Arm

- Bone Health Assessment for people with fragility fractures
- Treatment reviews
- ‘Newly Diagnosed’ groups for people
- Osteoporosis Peer Support Group
- Osteoporosis Information Sessions

2 Fracture Liaison Nurses

Stay Steady Activity Sessions

- ***A 6 month course to improve stability, strength and mobility using specially developed exercises***
- ***Free course with weekly group over 6 months***
- ***Fully qualified instructors who will monitor each persons progress***
- ***Advice on how to continue exercise at end of the course***
- ***Regular meetings with Life leisure and Steady in Stockport***

- History of falling
- Feeling unstable
- Has a fear of falling
- Must be able to stand(able to use a chair for support) for at least 30 seconds

lifeLEISURE
liveFITNESS liveSPORT liveLIFE

Smile

SIMPLE • MOVEMENTS • IMPROVE • LIFE • EVERYDAY

lifeLEISURE

liveFITNESS liveSPORT liveLIFE

Case Example: ‘Olga’

- Background: Becoming increasingly unsteady; leading to a fall in 2017. Lost confidence, socially isolated, difficulty with daily tasks, increased reliance on daughter.
- Referred to Steady in Stockport- Assessed by one of the SIS therapists with her daughter present.
- Several risk factors identified- Rails were provided and daily living equipment and she was also advised re purchase of an outdoor 4 wheeled walker.
- Physio advised on specific exercises for strength and balance and SIS Support Worker visited to practise these.
- Now much more confident and attending a community social exercise group.
- Her FES-1 score (fear of falling) reduced from 24/28 to 17/28.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

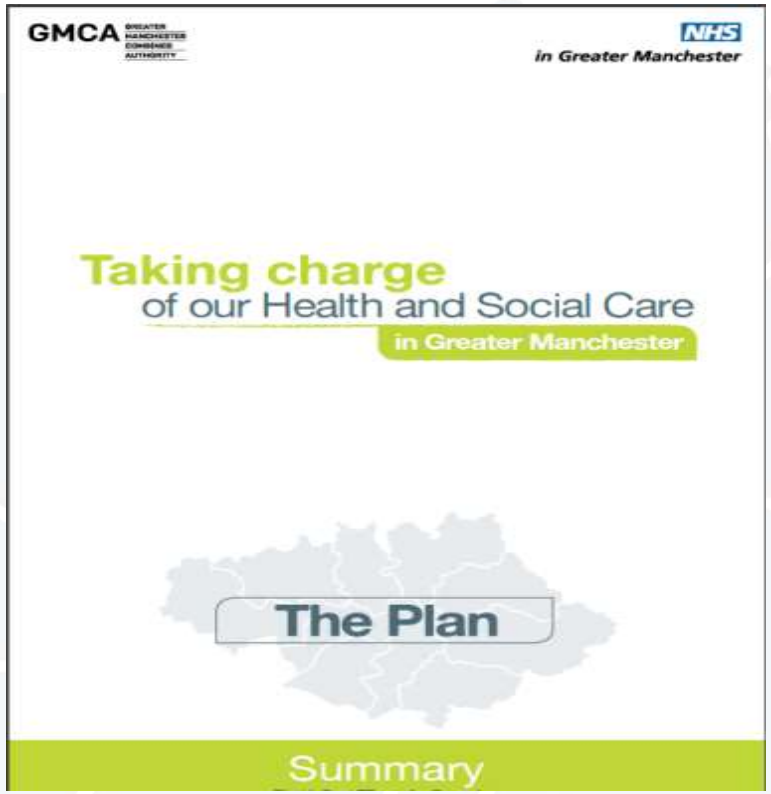
NHS in Greater Manchester

Devolution Difference –
meeting the health and care needs of our population

Jon Rouse, Chief Officer

Devolution - Taking Charge

- In 2016, Greater Manchester took control of the health and social care system.
- Giving us the opportunity to do things differently.
- At the same time we launched our five-year plan to improve health and social care, called ***Taking Charge.***



Greater Manchester Health and Social Care Partnership

Who makes the decisions?

Greater Manchester Health and Social Care Partnership is the body made up of the NHS, local authorities, charities, voluntary, community and social enterprise groups, Healthwatch and others.

Shaping what good care looks like using people's comments, local knowledge and expertise.

.

Greater Manchester Health and Social Care Partnership

Our Aims – by 2021

- **More babies being born a healthy weight** (over 2,500g) which makes a huge difference to their long term health
- **More children** reaching a good level of social and emotional development - **ready for school**
- **Fewer people dying** from cancer, heart and lung disease
- Supporting people **to stay well and live at home** for as long as possible.

Greater Manchester Health and Social Care Partnership

Here are just a few of the changes….

- We’re creating **better, more joined up public services in the community –**

Co-designed with local people.

Working in partnership:

GREATER MANCHESTER VCSE DEVOLUTION REFERENCE GROUP

Greater Manchester Health and Social Care Partnership

Supporting families to get children 'school ready'

- to have strong social skills
- to cope emotionally with being separated from their parents
- to be relatively independent in their own care
- have a curiosity about the world and a desire to learn.

Examples -

- **Speech, language and motor skills**
- **hygiene & toilet training**
- **confidence and self-esteem**
- **feeding and healthy eating**
- **immunisation**

Giving children a better start in life

- Such as, spending more on reducing tooth decay

Greater Manchester Health and Social Care Partnership

Improving lifestyles

- We want to **Make Smoking History** – reducing smoking by a third by 2021.

- working in partnership with GM Moving – **getting 75% more people active by 2025**

Health and Social Care Partnership

We’re tackling cancer

- **better access to tests**
- **Investing** in ground breaking technology and treatment
- **More ‘cancer champions’** supporting people affected by cancer

Greater Manchester Cancer Champions

Health and Social Care Partnership

Investing in mental health

- £74m on child and adolescent mental health – **supporting schools and improving crisis care**
- £50m on adult mental health services
- More people now receive ‘talking therapies’ - one of the ways supporting recovery within 6 weeks of referral.

Largest investment in mental health in England

Greater Manchester Health and Social Care Partnership

Investing in mental health

- Fighting fit - Jenny's story

Greater Manchester Health and Social Care Partnership

Investing in mental health

- Fighting fit - Jenny's story

Greater Manchester Health and Social Care Partnership

Increasing access to primary / community care

Such as,

- An extra £41m being spent in GP practices by 2021 to improve access and quality.
- making it easier to see medical professionals at convenient times, including online and language support.
- Before devolution, patients rated GP satisfaction below national average – now we are above average.

Examples

Health and Social Care Partnership

We’re investing more in technology, digital / online

Such as, £7.5m on electronic patient records

- secure, up-to-date health and social care information
- shared with staff and patients
- one of the biggest projects of its type in Europe.

Greater Manchester Health and Social Care Partnership

Improving social care

- personal care plans have helped people leave hospital - reducing delays by a third.
- Developing Teaching Care homes – sharing best practice and quality standards
- Lot more still to do, however **Greater Manchester is one of the most improved areas in the country.**

Greater Manchester Health and Social Care Partnership

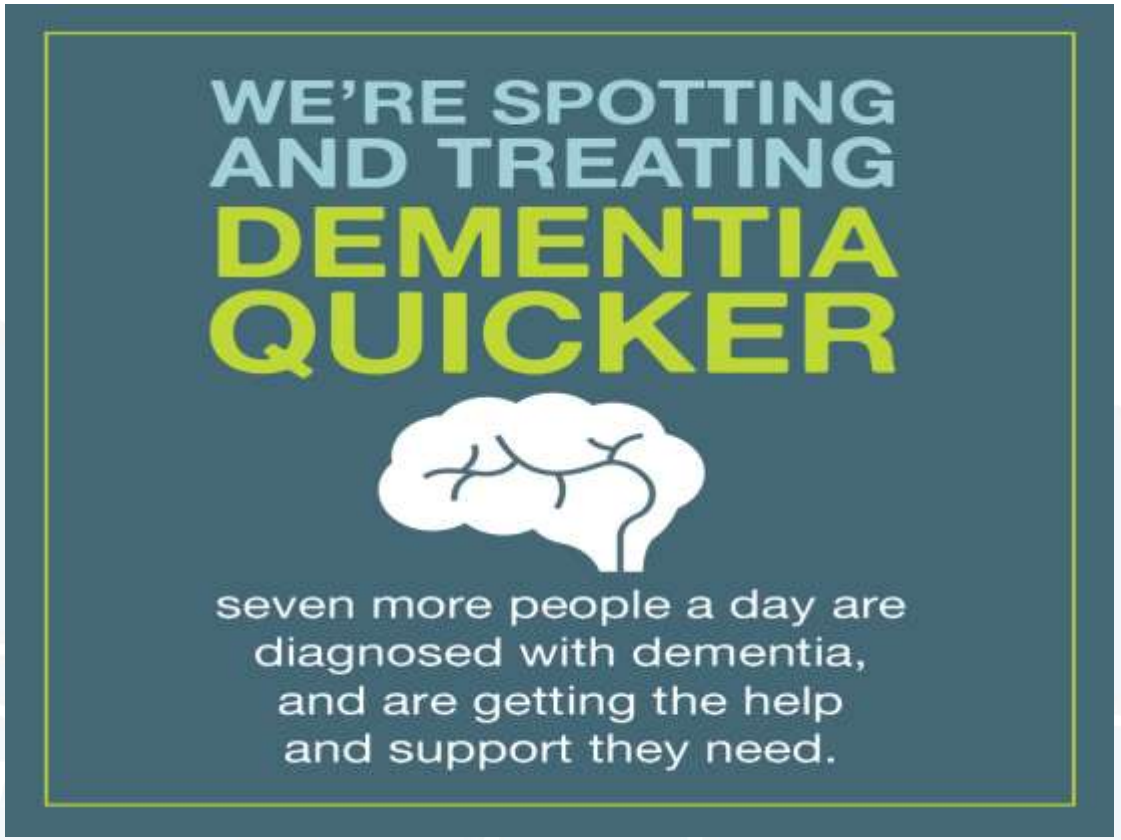
Our stroke centres are A-rated

- At least 200 lives have been saved because of the specialist care people have received in them.
- **This is the best rating anywhere in England.**

Greater Manchester Health and Social Care Partnership

We’re spotting and treating dementia quicker

- seven more people a day are diagnosed with dementia, and getting the help and support they need
- GM University’s investing in patient research
- Aiming to be the most dementia friendly city in the UK



Greater Manchester Health and Social Care Partnership

Better, more person centred health and care

- GPs spend at least fifth of their time on non-medical issues
- We're supporting other ways of improving health and wellbeing – otherwise known as social prescribing
- **See Roy's story**

Greater Manchester Health and Social Care Partnership

Better, more person centred health and care

- GPs spend at least fifth of their time on non-medical issues
- We're supporting other ways of improving health and wellbeing – otherwise known as social prescribing
- **See Roy's story**

Greater Manchester Health and Social Care Partnership

There are lots more examples of how **devolution** is **making a real difference in Greater Manchester**.

Changes do take time and we continue to have **big challenges** that are not always in our control.

All of us have a role to play
to make positive changes to
our health and wellbeing

What's next ?….

Greater Manchester Health and Social Care Partnership

The Partnership Business Plan 2018-19

- Continuing to roll out new models of joined up care.
- Sharing health and care resources – buying and managing contracts across Greater Manchester.
- Working with other organisations including universities and industry: sharing best practice, insight and resources.
- Working together to improve hospital care.

Greater Manchester Health and Social Care Partnership

The Partnership Business Plan 2018-19

- Investing in workforce e.g. nurse recruitment
- Improving maternity safety
- More flu vaccinations to include Year 5
- Preventing ill health – big alcohol debate
- Continuing to support schools with children's mental health
- Even more GP access at evenings and weekends

Greater Manchester Health and Social Care Partnership

GMHSC Partnership Business Plan 2018-19

- Specialist Children and Adolescent Eating Disorder service
- Dementia-Friendly Transport System
- Continuing to improve quality of Care Homes
- New Learning Disability Strategy
- More Urgent Treatment Centres
- Roll out of social prescribing

Greater Manchester Health and Social Care Partnership

Next Steps

- Working with all health and social care organisations and partners to **make sure these changes happen**.
- Continuing to work closely with the **Mayor of Greater Manchester** on how **all of the public services can help support and improve health and well-being**.
- Continuing to **develop our relationship with voluntary, community and social enterprise groups**.
- Agreeing the way forward - **big challenges remain** including finance and workforce shortages in key areas.

Greater Manchester Health and Social Care Partnership

Keep in touch

www.gmhsc.org.uk

www.facebook.com/GMHSCPartnership

Twitter @GMHSC **#gmdevodifference**

Greater Manchester Health and Social Care Partnership