TRAFFORD COUNCIL

AGENDA PAPERS MARKED 'TO FOLLOW' FOR

HEALTH AND WELLBEING BOARD

Date: Friday, 15 September 2023

Time: 10.00 a.m.

Place: Committee Room 2 and 3, Trafford Town Hall, Talbot Road, Stretford M32 0TH

	A G E N D A	**PART I**	**Pages**
3.	**MINUTES**		To Follow
	To receive and if so determined, to approve as a correct record the Minutes of the meeting held on 14th July 2023.		
8.	**SYSTEM WORKING TO ADDRESS HEALTH INEQUALITIES**		1 - 18
	To receive a report from the Director of Public Health.		
10.	**BETTER CARE FUND (BCF)**		19 - 68
	To consider a report from the Deputy Place Lead for Health and Care Integration for the Trafford Locality and the Corporate Director of Adults and Wellbeing.		

SARA TODD
Chief Executive

Membership of the Committee

Councillors L. Murphy, Wareing, J. Slater (Chair), K.G. Carter, R. Thompson, P. Eckersley, J. Brophy, H. Fairfield, E. Roaf, R. Spearing, P. Duggan, D. Evans, M. Hill, J. McGregor, E. Calder, James, M. Gallagher, Rose, Todd, J. Cherrett, M. Prasad, C. Davidson, Roe, C. Siddall and N. Atkinson.

Further Information
For help, advice and information about this meeting please contact:

Alexander Murray, Governance Officer,
Tel: 0161 912 4250
Email: alexander.murray@trafford.gov.uk

This agenda was issued on **Thursday, 7th September 2023** by the Legal and Democratic Services Section, Trafford Council, Trafford Town Hall; Talbot Road, Stretford, Manchester, M32 0TH.

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System working to address health inequalities

Trafford Health and Wellbeing Board

Trafford
Integrated Care Partnership

15th September 2023

Part of Greater Manchester Integrated Care Partnership

There's a lot of talk about health inequalities!

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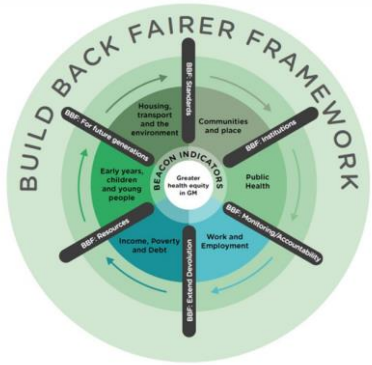
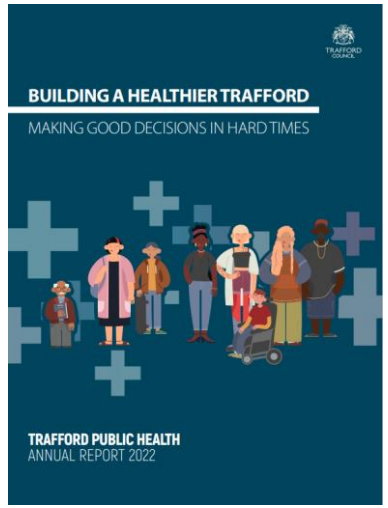
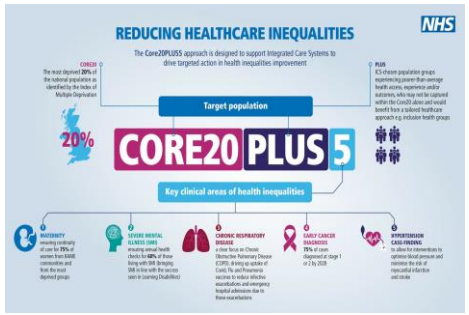
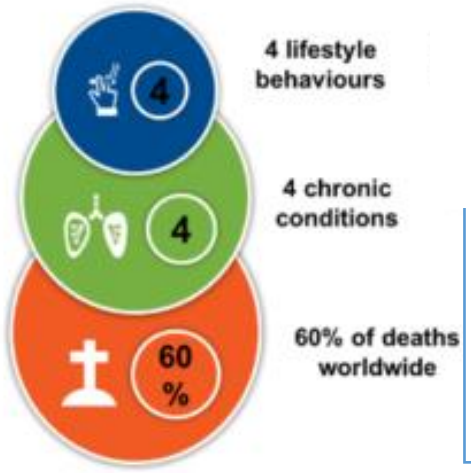






National → GM → Trafford

What makes us healthy leads to inequalities. Causes of the causes…



4 lifestyle behaviours

4 chronic conditions

60% of deaths worldwide

Socio economic conditions (~50%)

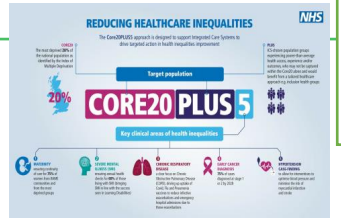
Education
Housing
Income and work
Relationships
Environment

4 health behaviours (~30%)

Physical activity
Nutrition
Smoking
Alcohol

4 chronic conditions (~20%)

Diabetes
Heart diseases
Lung diseases
Cancer
Mental Health
Maternity
Oral Health



Life expectancy

60% of deaths worldwide

+ Quality of life

The Vitality Institute (2016). Communicating Non-communicable Diseases: From 3Four50 to 4Four60. https://bit.ly/3nchaP5
World Health Organization. Global Status Report on Noncommunicable Diseases 2010. Geneva, Switzerland: WHO Press; 2011

Life expectancy has plateaued but the gap between the most and least deprived in Trafford is reducing, though still stands at 6.6 (male) and 5.1 (female) years

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Information on inequalities between the most and least deprived quintile of Trafford, 2014 to 2016 to 2020 to 2021

Male	2014-16	2017-19	2020-21
Life expectancy most deprived quintile	74.9	75.6	74.9
Life expectancy least deprived quintile	83.5	83.0	81.5
Gap	8.6	7.4	6.6

Female	2014-16	2017-19	2020-21
Life expectancy most deprived quintile	79.5	80.8	80.4
Life expectancy least deprived quintile	86.0	86.6	85.4
Gap	6.5	5.8	5.1

Source: Office for Health Improvement and Disparities based on ONS death registration data and mid year population estimates for the relevant years, and Department for Levelling Up, Housing and Communities Index of Multiple Deprivation 2019 (for 2017 to 2019 and 2020 to 2021 data) and Index of Multiple Deprivation 2015 (for 2014 to 2016 data). Where provided, results for 2020-21 are based on 2020 population data.

What are the (immediate) causes of that gap in life expectancy in Trafford (2020-21)?

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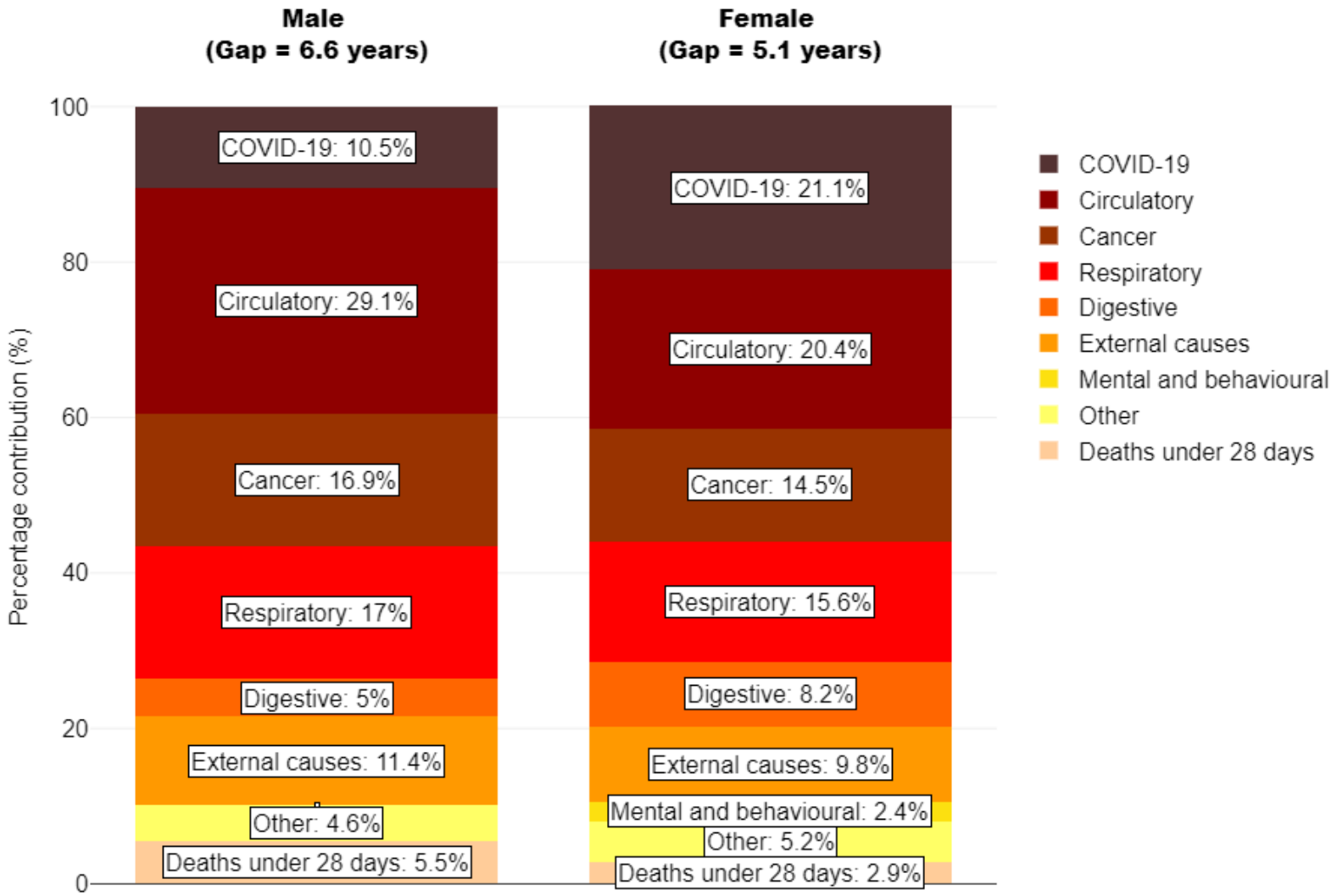

These conditions also lead to illness and poorer quality of life. They vary by geography…

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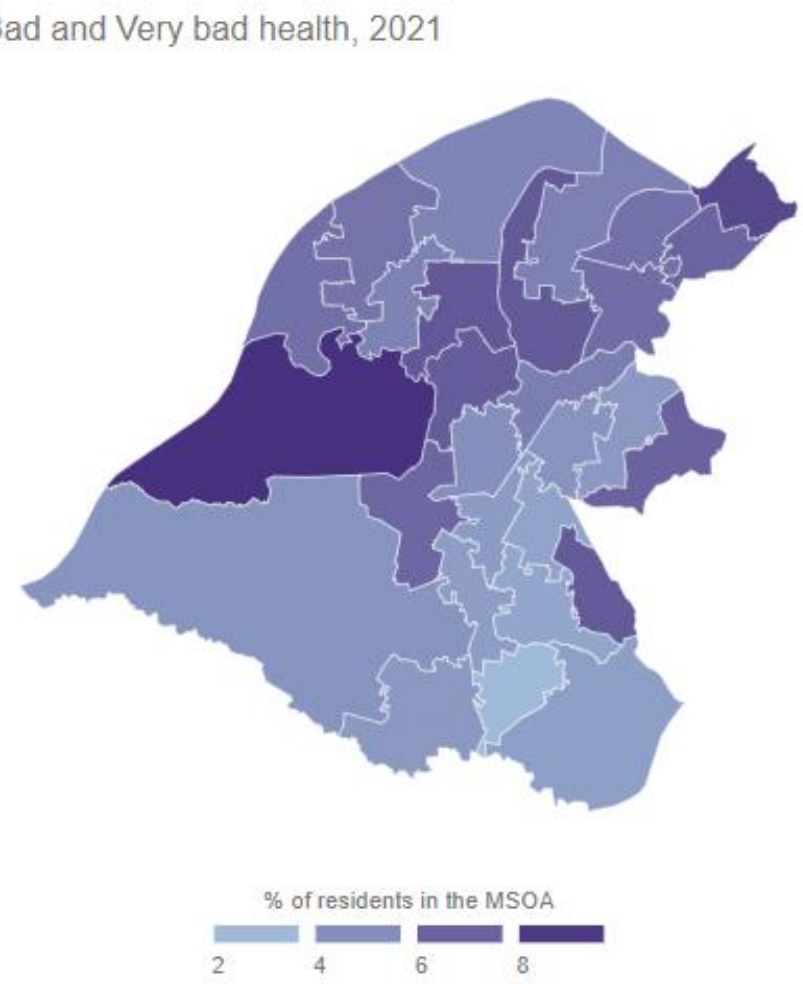
Self-reported health by area and by ethnicity (Census 2021)



Source: Census 2021

And they vary by different groups…

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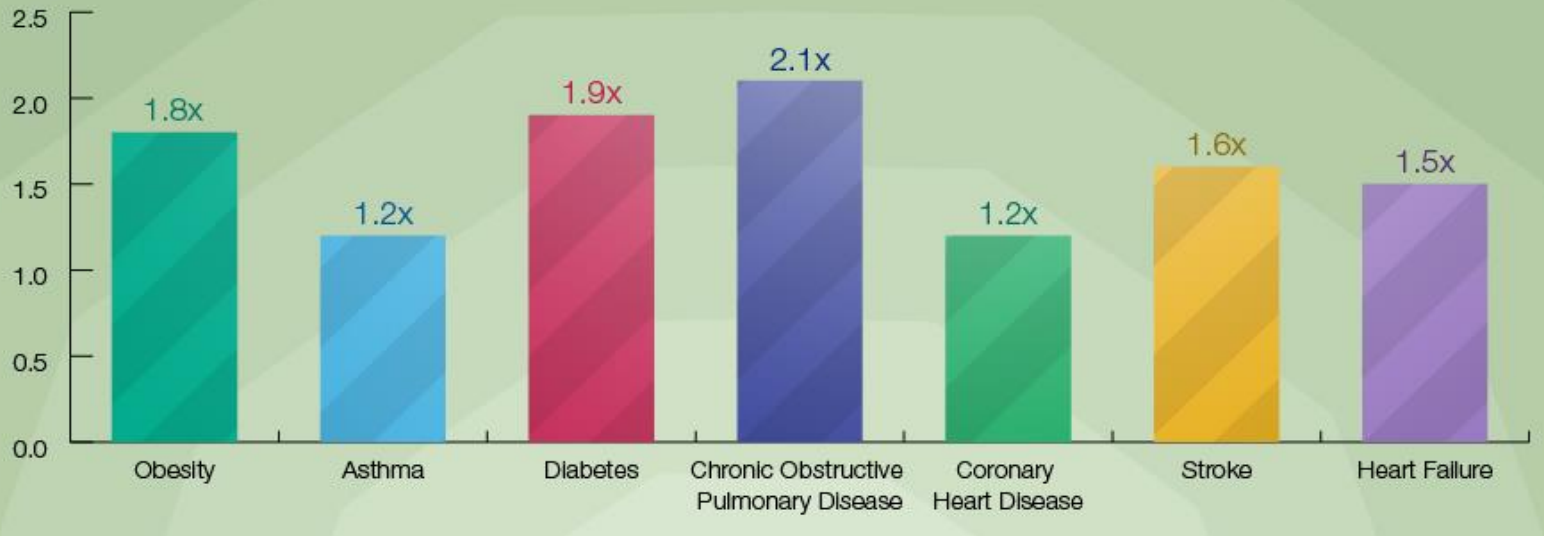
Public Health England

Health Matters

Adults with severe mental illness (SMI) are more likely to have physical health conditions

When compared to **the general population** of the same age group, **people with severe mental illness (SMI)* aged 15-74** are more likely to have:



*Sample of people with SMI registered with a general practice

Risk factors for ill health are not evenly spread…

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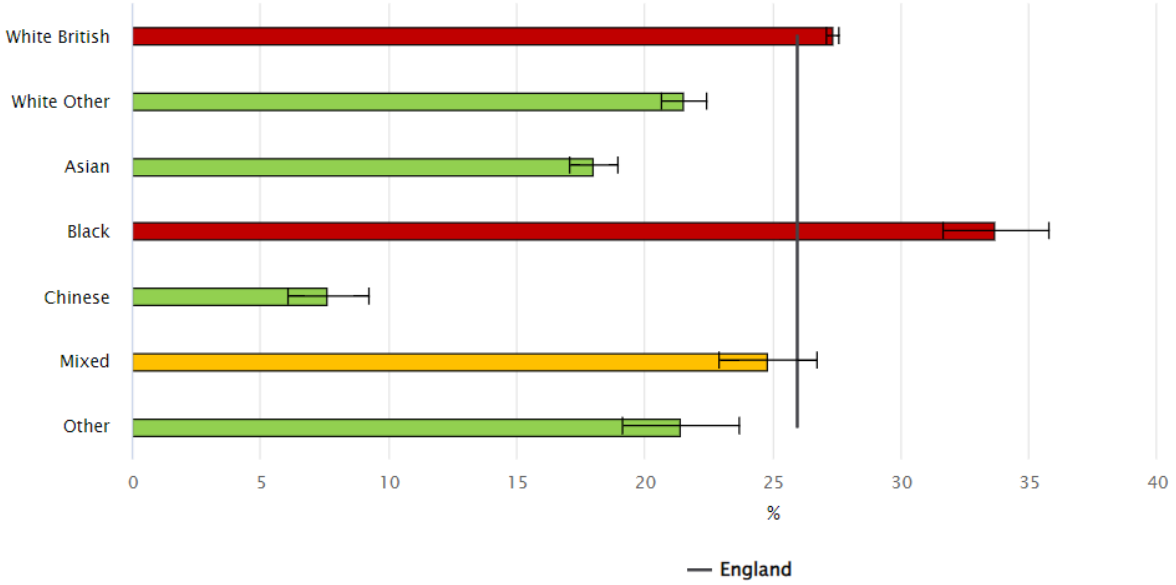
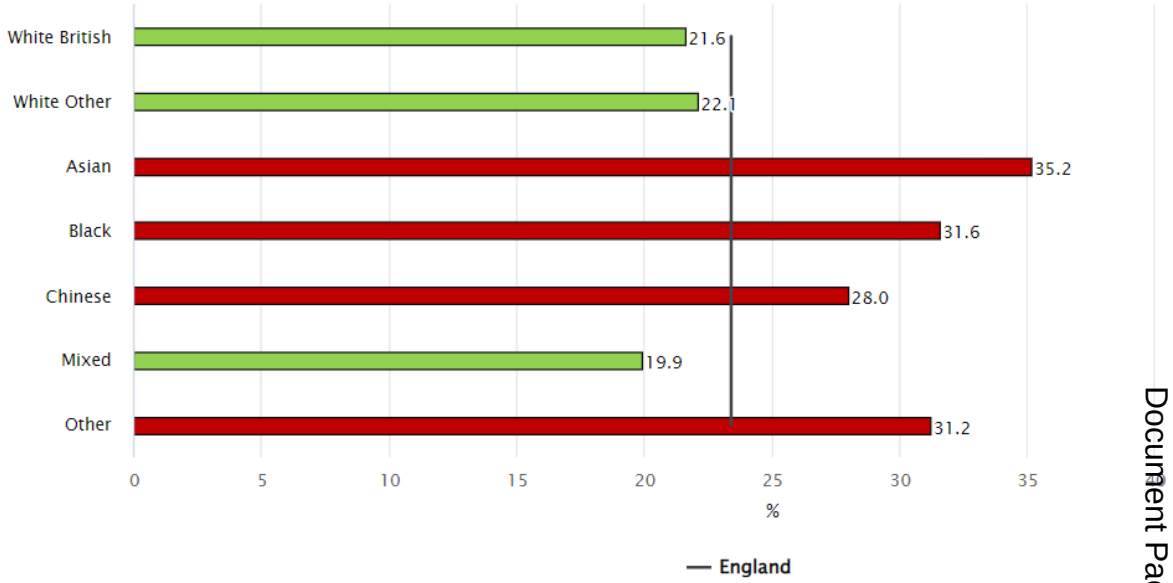
E.g. percentage of adults who are classified as obese and who engage in physical activity varies by ethnic groups

Obesity



Physical inactivity



Source: Active Lives survey, 2020/2021

Smoking is still the number one cause of preventable deaths

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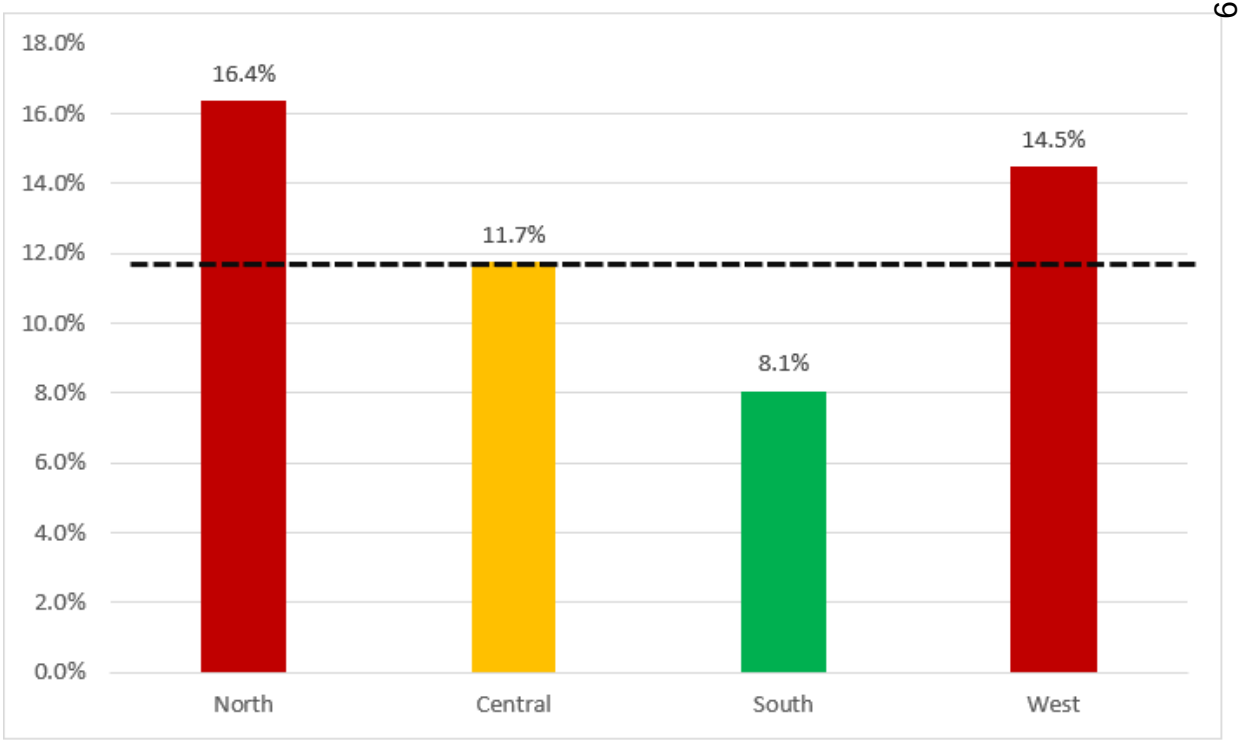
Overall smoking prevalence in Trafford estimated at 11.1% (2021 data) but much higher in some groups and communities e.g.:

- People with serious mental ill-health (SMI)

The national smoking rate for people with SMI is 40.5%. This is over 3 times the rate when compared to the general population. In Trafford, our SMI smoking rate is 35%, slightly below national average. This roughly equates to 880 SMI smokers in Trafford.

- 'Routine and manual' workers

Nationally the smoking rate is 24.5% for this population cohort, almost double the general population. In Trafford, our rate is almost in-line with the national average at 23.4%.



GP data on Trafford locality smoking rates 2023

The reasons people can't live healthier lives are complex and intertwined with their health…

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For example, less than a quarter of our adult carers have as much social contact as they would like*.

This ranks Trafford at the lower end among similar areas in 2021/22.

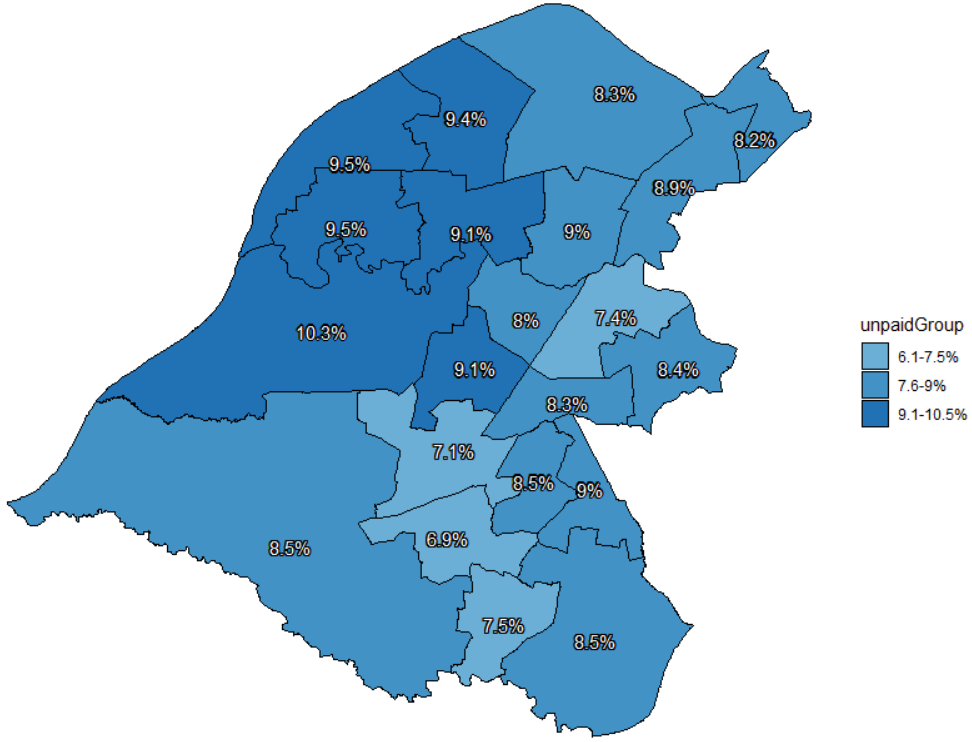
Carers UK, 2019b) found carers are more likely to report having a long term condition, disability or illness than non-carers.

Intense carers (at least 20-49 hours a week) were more likely to be physically inactive, smoke cigarettes, gain weight, and eat unhealthily.

They were more likely to self-report or have a diagnosis of depression or anxiety.

Carers who had given up work to care were more likely to be smokers and have common mental disorders (Future Care Capital, 2019; Tseliou, 2019).

Unpaid carers (2021 census breakdown by ward)



*Source: Adult Social Care Outcomes Framework (ASCOF) based on the Personal Social Services Survey of Adult Carers, NHS Digital

Different partners(hips) need to work at different 'levels' of the driver diagram to make sustainable changes – where do you have influence or direct responsibility?

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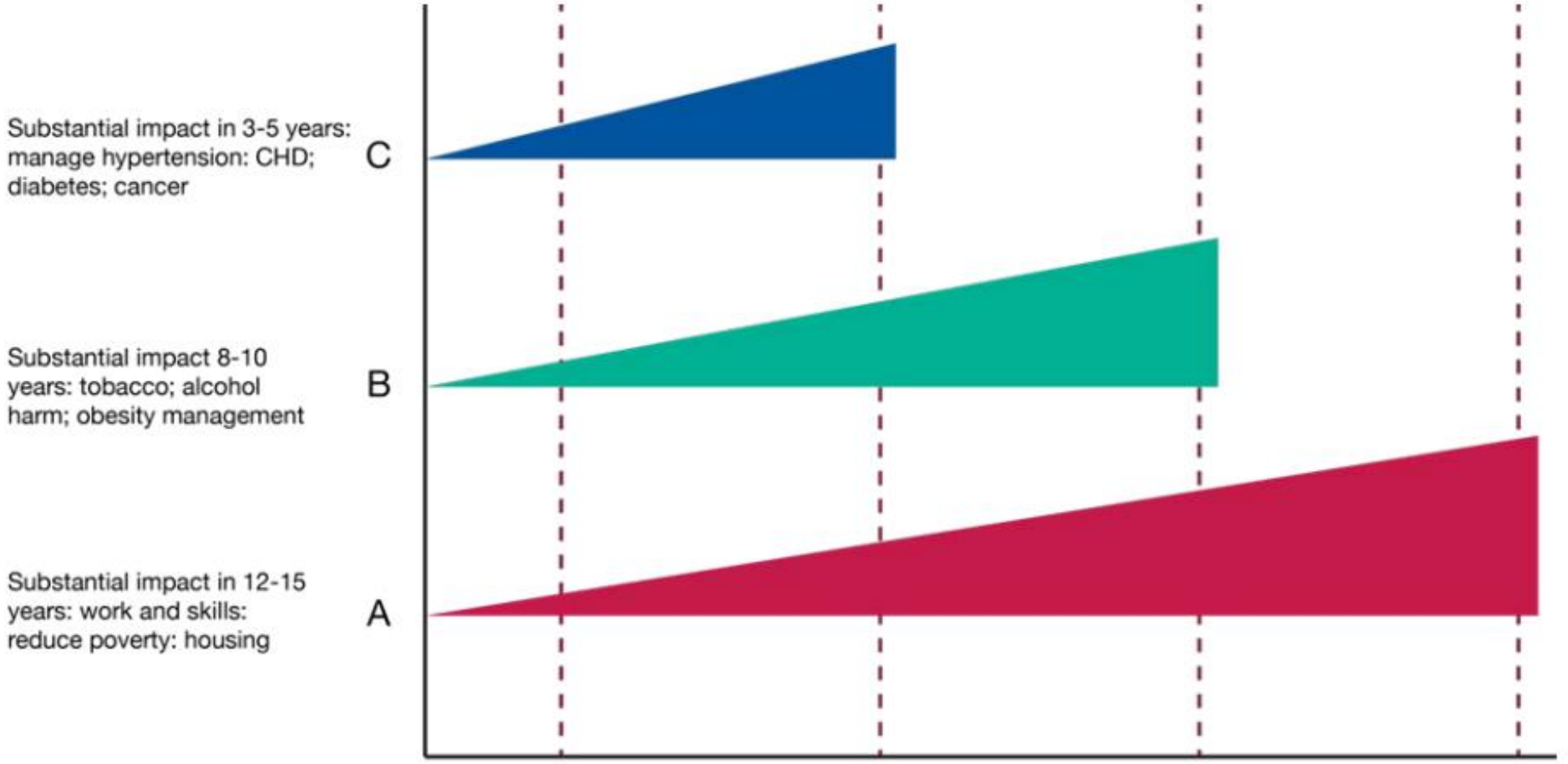

Reducing health inequalities: system, scale and sustainability (publishing.service.gov.uk)

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So what's happening in Trafford?

What's going on in Trafford…

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Primary Care Quality Assurance Group and Action Plan

Trafford Council Corporate Priority – Tackling Health Inequalities

Trafford Health and Wellbeing Strategy and priorities 2019-2029

Trafford Poverty Strategy

GM Primary Care Blueprint and PCN leads

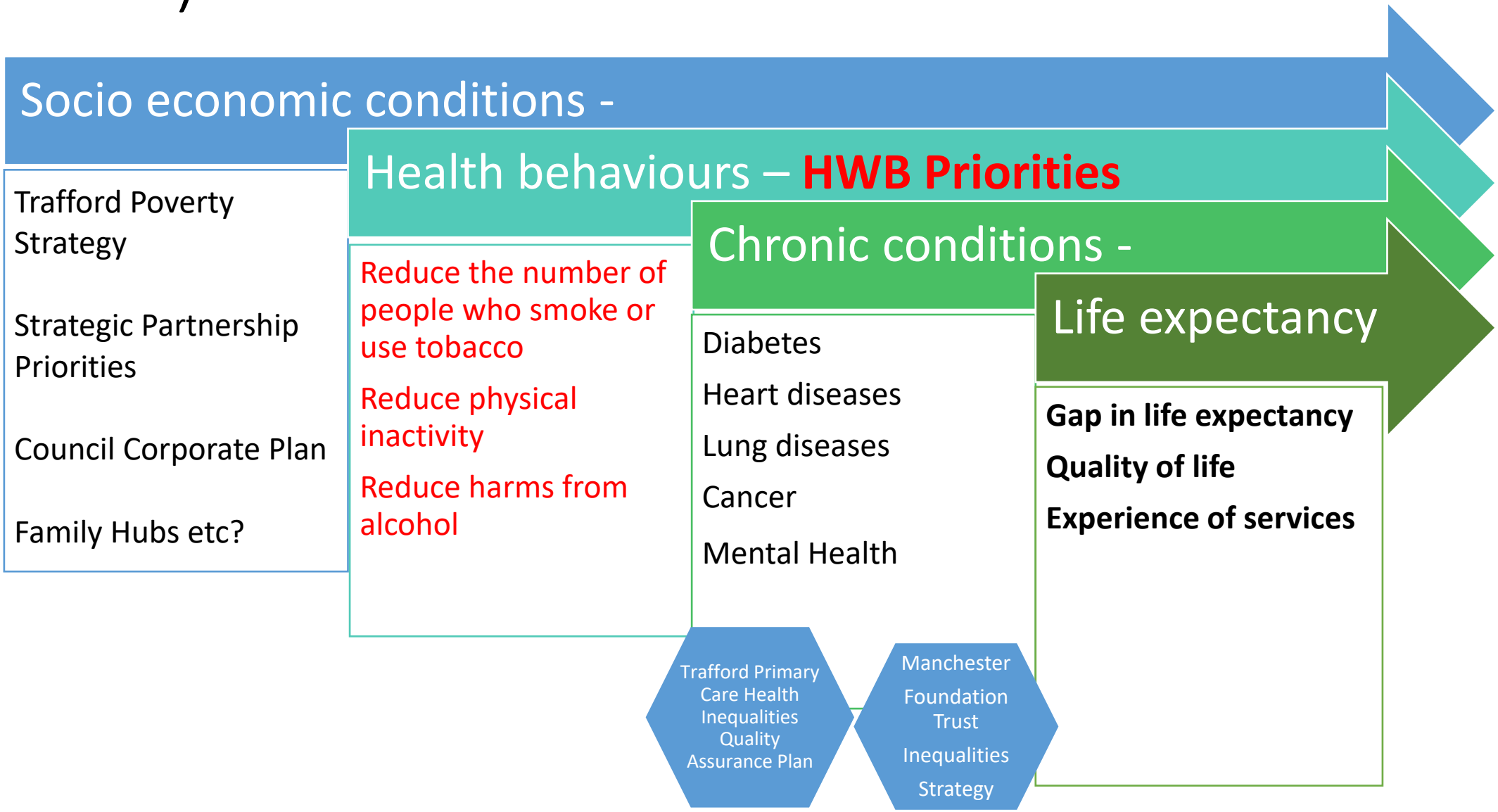
Manchester NHS Foundation Trust Inequalities Strategy

Build Back Fairer for Greater Manchester

Trafford Locality Plan 2019-24

Healthy Lives Services – voluntary sector

How does it all fit together for Trafford (a start)?



Our Draft Neighbourhood Model

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- Tackling neighbourhood health inequalities requires action in 4 key areas: Data quality, community engagement, access to services, risk identification and stratification (NHS Confed)

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So what approach should we take?

Things to consider….

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- Some interventions improve overall population health but risk widening health inequalities with **concerted effort,** particularly proactive universal interventions (eg cancer screening, NHS Health Checks etc)
- For many issues (e.g. obesity, alcohol misuse), biggest impact comes from intervening among group with highest overall burden of disease – this isn't necessarily the people at the highest risk and/or those with highest levels of inequality
- 'Proportionate universalism' often the favoured approach within services – how do we build this into specs etc and test if its right – are we brave enough?

Key Questions

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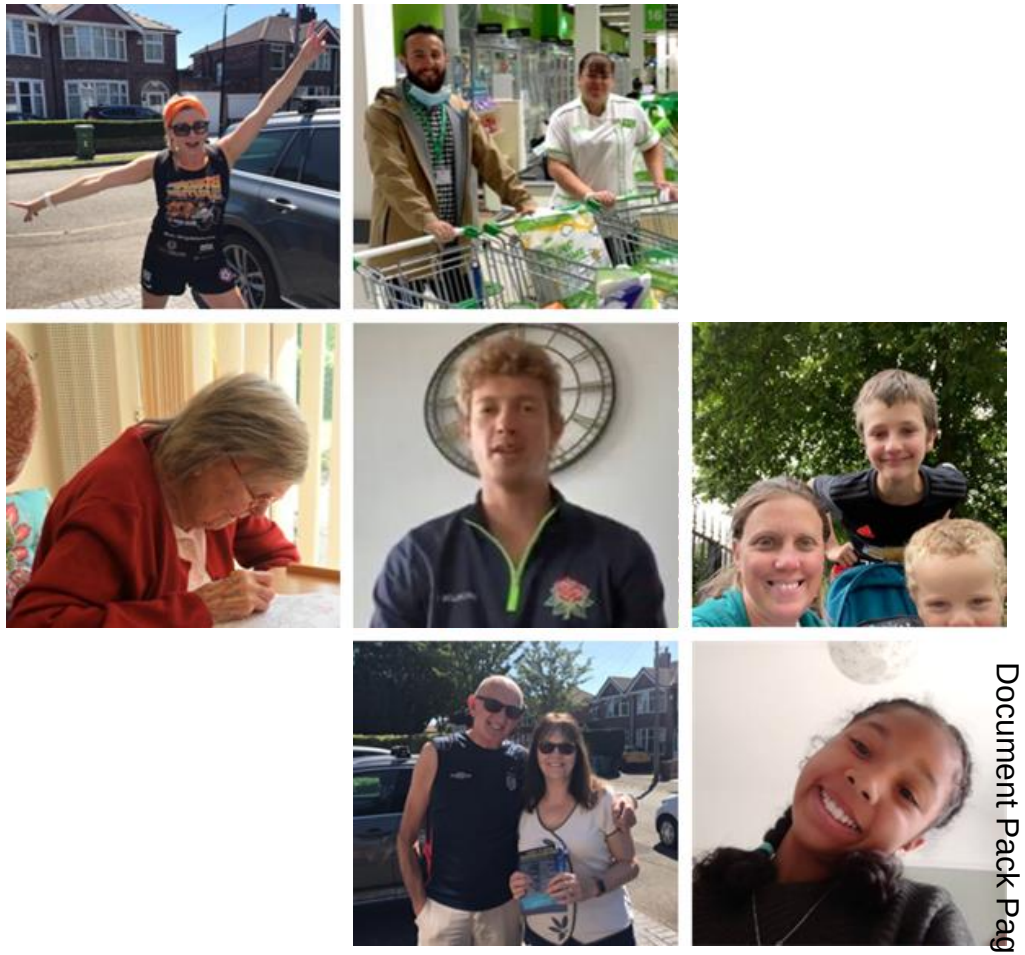
- Do we want to 'focus' on a few key population groups, causes or experiences, if so which or how do we decide?
- We have HW priorities and other system priorities, therefore do we identify specific inequalities / interventions to focus on?
- Do we need a tactical group to align programmes, provide challenge and identify opportunities / risks? Learning from Making Manchester Fairer.
- How do we capitalise on the planned refresh of the Trafford Locality Plan and ensure the collective efforts across our system have maximum impact on tackling health inequalities?



TRAFFORD COUNCIL

Report to:	**Health & Wellbeing Board**
Date:	**15th September 2023**
Report for:	**Decision**
Report of:	**Gareth James, Deputy Place Lead for Health and Care Integration, NHS GM Trafford & Nathan Atkinson, Corporate Director for Adults, Trafford Council**

Report Title

Better Care Fund Plan and Narrative 2023/25

Purpose

The report contains two documents for sign off by the Board:

- The BCF Plan 2023/25
- BCF Narrative 2023/25

These documents have already been submitted and approved through the regional assurance process and are currently with the national team for final sign off pending HWBB approval and notification thereof.

Recommendations

The Board is asked to:

1. Sign off the 2023/24 Better Care Fund Plan and Narrative

Contact person for access to background papers and further information:

Name: Thomas Maloney, Programme Director Health and Care, NHS GM Trafford and Trafford Council
Telephone: 07971556872

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HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Health and Wellbeing Board(s) :**Trafford Locality Board**

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils) .

- Trafford Council
- Trafford Locality of Greater Manchester Integrated Care
- Trafford Local Care Organisation (TLCO/Community element of MFT)

How have you gone about involving these stakeholders?

The Trafford BCF plan is a long-term plan which is developed and approved on a rolling annual basis via Trafford's Health and Wellbeing Board. All the relevant partners to the BCF are core members of all our health and social care governance in Trafford and have therefore been fully engaged in the curation and sign off the plan.

The activity within the BCF is a core component of the Trafford Locality Plan (2019-2024) which has been co-designed by system partners and formally adopted through Trafford's Health and Social Care System Governance architecture which is described in more detail under question 5. The Locality Plan was refreshed in 2021 and a further review is anticipated on completion of the GM and Local Operating Model following the transition to ICS arrangements – the BCF will form a fundamental component of the revised plan once actioned.

The BCF outcome measures are monitored and have been evaluated, with key indicators remaining stable or being reduced over the year which evidences positive progress.

Our 23/25 BCF plan will be aligned closely to the planning, design, delivery, and reporting arrangements that span Trafford Locality Board and the Health and Wellbeing Board ensuring a tight system grip on performance, enabling transparent system reporting on all related areas of the wider Section 75, BCF and wider aspirations of the Trafford Locality Plan.

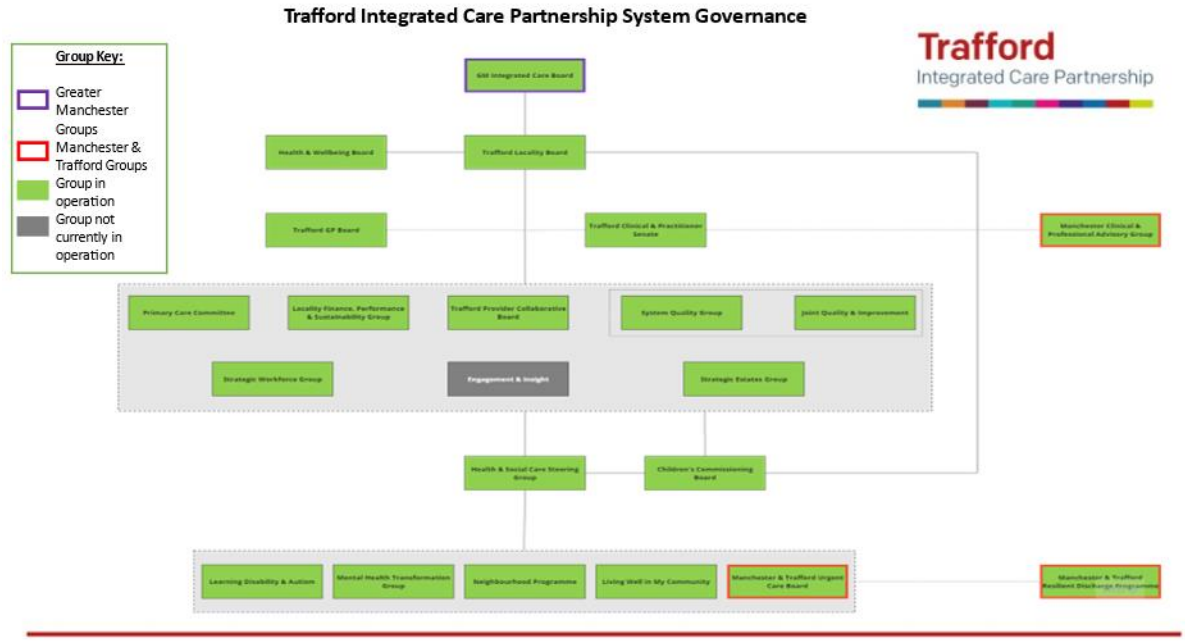
We have ensured that the BCF services/schemes are aligned to the three Trafford Provider Collaborative Board Strategic Priorities (23/24) and the more granular thematic priorities of the various partnership groups that drive forward the work of the BCF schemes are corralled via our regular (monthly) multi-stakeholder Health and Social Care Steering Group.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

The health and care governance structure has evolved significantly since the introduction of the ICS arrangements and disestablishment of Clinical Commissioning Groups. The current Trafford system governance is outlined in Figure 1 below and demonstrates our commitment to an inclusive set of governance arrangements across the Trafford system with full partner engagement/membership.

Figure 1:



The behaviours and ways of working which we aspire to have embedded in all our partnerships forums is encapsulated in our Health and Wellbeing Board (HWB), Trafford Locality Board and Trafford Provider Collaborative Board Terms of Reference, all which have been recently updated and formally signed off by partners (Terms of Reference available on request). The Boards function based on the following operating principles:

- Collaborative working
- Embedding a population health management approach
- Value for money
- Promoting innovation, and encouraging new ideas from patients/service users, carers and the workforce
- Champion both locality and neighbourhood service coordination through our integrated neighbourhood model
- Seek to avoid and identify any conflicts of interest

It is important to note the formalised governance that is operational in Trafford, particularly the arrangements of the Trafford Locality Board. The Locality Board incorporates three elements/'forums' and thus carries out three distinct roles:

1. Consultative forum
2. ICB Committee
3. Section 75 Committee

Of particular importance is the Section 75 Committee:

"A forum through which relevant section 75 arrangements are managed ("Section 75 Committee"). Section 75 arrangements will be managed, and decisions will be taken in accordance with requisite delegated authority given to core members of the Section 75 Committee by their respective organisations. Trafford Locality Board partners who do not have delegated authority in respect of section 75 arrangements will be able to participate in discussions regarding the section 75 arrangements, subject to conflict of interest rules, but will not be able to take de cisions in relation to section 75 arrangements."

The final sign-off of the BCF Plan is the responsibility of the Trafford Health and Wellbeing Board. It is also where assurance is sought that the BCF plan not only aligns to the wider aspirations of the Locality Plan but also contributes towards the Health and Wellbeing Strategy, specifically reducing health inequalities.

We committed in the 2019 Locality Plan to work with our partners on how we create together a culture of co-production that becomes our normal way of working – to plan, design and deliver services together with our partners and the Trafford public, where appropriate. The creation of our Locality Board and the Trafford Provider Collaborative Board as described above are the vehicles by which we will deliver against our system priorities, including the aims of the BCF. The Trafford Provider Collaborative Board has three strategic priorities which are refreshed on an annual basis and the detail of the BCF is operationally overseen through these arrangements with formal escalation to both the Health and Wellbeing Board and the Locality Board.

Below is a list of system partners who are active members of some/all of our locality governance arrangements:

- Trafford Council (Various Directorates)
- Manchester Foundation Trust (MFT)
- Trafford Local Care Organisation (Part of MFT)
- Greater Manchester Mental Health Foundation Trust
- Trafford General Practice Board
- Healthwatch Trafford
- MasterCall (Out of hours provider)
- Trafford Community Collective (VCFSE Representative)
- Thrive (VCFSE Locality Infrastructure Organisation)
- Independent Social Care Providers (Nominated representative)
- Trafford Leisure
- Greater Manchester Police
- Department for Work and Pensions

Executive summary

Trafford's BCF Plans this year are in some respects aligned to previous BCF submissions. However, we have built upon these foundations to create innovative and creative models which ensure our people can remain living well at home for as long as practicably possible.

The priorities for Trafford Locality include the following relevant outcomes to the BCF plan:

- Reduced proportion of admissions to long term care with increased proportion of people living independently at home for longer
- Reduced emergency admissions to hospital
- Increased proportion of people who return to living independently following a hospital admission
- Reduced 'No Criteria to Reside'

The targets agreed by system partners are detailed in the main BCF submission template and the following summarises how they will be achieved within the 4 KPIs are as follows:

- **Avoidable admissions- indirectly standardised rate of admission per 100,000 population**

- **Discharge to usual place of residence:** > % of people, who are discharged from acute care to their usual place of residence

- **Permanent admissions to residential & nursing 24 hour care: long term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes per 100.000 population**-< % of people being admitted to 24 hour care facilities across the Borough

- **Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services:** >% of people remaining at home following an episode of care/treatment.

National Condition 1: Overall BCF plan and approach to integration

Trafford has a long-standing commitment to integration across health and care. Our section 75 incorporates the BCF, Discharge to Assess (D2A) and Learning Disability provision. The section 75 gives lead commissioning responsibility to the Council for the sourcing of D2A beds and provision of homecare. The ICB leads on the clinical elements.

A joint Trafford Council and NHS GM (Trafford) finance group meets on a regular basis to discuss s75 activity, joint ventures and additional areas of work which may have more indirect impact. It is also pertinent to mention the standing up of a formal Finance, Sustainability and Performance Group which will report into the Trafford Locality Board on locally delegated resources. The Locality Board also receives reports on the s75 performance indicators and activity.

We have built our plan around our place and in Trafford this is our four neighbourhoods, our locality and working with other localities in Greater Manchester. We remain committed in Trafford to ways of working that put into practice, our principles and the difference these make to the people we serve. The principles in our 2019-24 Locality Plan remain a key focus as we recover from the pandemic;

- Together as Partners – co-ordinating across our health and social care system, thinking bigger and doing better using our combined resources to improve outcomes for residents.
- In a Place – being positive about our places and spaces, bringing people who live and work in an area together to build stronger communities.
- With People – putting residents at the heart of what we do, listening and working with people.
- Focusing on Prevention – commitment to taking action early and making every contact count.
- Continually improving – making the most of technology and using data and information to make shared decisions. We will continue to learn and develop our workforce and make the best use of our combined assets

The Age Well programme will focus on the delivery of an initial set of Neighbourhood le d services which are a combination of national must do's and gaps identified through our needs assessment , i.e.:-

- Crisis Reponses
- Case Management
- Enhanced Care in Care Homes

This will support the delivery of Core 20PLUS, to provide the right care and support reduces inequalities and address health needs improving outcomes.
New initiatives are described under the relevant headings to prevent duplication.

National Condition 2

Neighbourhood Working (Better Care at Home)

We aim to achieve the objectives set out in the NHS Long Term Plan, through an integrated neighbourhood model with system partners, looking to support individuals with multiple long-term conditions, including frailty to remain well at home.

With the support delivered by a multi-disciplinary team (MDT) , we are confident that our approach will contribute to reduced avoidable episodes of ill health which result in the need for the individual to access unplanned or emergency care. With holistic assessment, personalised care & support planning, coordinated care by the MDT agreeing interventions and support, people will be supported to stay at home, achieve better outcomes for their health & wellbeing while addressing and reducing health inequalities for this group.

Community including community nursing

In recent years, Trafford has placed great importance on the fundamental role of our Neighbourhood model in ensuring we have a social model for health – rather than a predominantly medical one – which focuses on the importance of people and communities as well as health and care services.

The Trafford Neighbourhood model is consistent with the Greater Manchester Model for Health which is based on core principles of co-production, working with people and communities rather than 'doing to'. The Neighbourhood model is the key to making our model for health a reality, ensuring that people are supported to live well with the support they need, whether they're diagnosed with a long-term condition, cancer, dementia, or they're at the end of their life and receiving palliative care.

Our model aims to bring about a shift in the culture of how people approach health and wellbeing, making it more person-centred and community based. It will allow residents and patients to build more personal resilience, increased confidence in self-management as well as addressing their health and social needs. People will be empowered and supported in their independence. Neighbourhoods will strengthen communities and networks to support individuals where required through localised, enhanced and faster access to services.

Trafford system is committed to work together across different partners and services to make the best use of our resources whilst encouraging collaboration. We want to create opportunities to support residents to prevent ill health. We will embed a population health management method and nurture a 'prevention-first' approach that builds on our community assets. It will be co-owned and designed with our residents to support their health and wellbeing needs now and in the future.

We champion locality and neighbourhood service coordination. We work on the principle that organising health and social care service delivery on Neighbourhood footprints creates opportunities for frontline staff to work together in places. This will improve the quality and integration of services and the extent to which they are joined up for residents. The outcomes will be reduced duplication and ensuring people are in control of their care

This will be delivered via:

- Four core Integrated Neighbourhood Teams (INT's) which consist of case management, children's services, adult social care, community nursing, communication and engagement and care navigators.
- Voluntary, Community, Faith and Social Enterprise sector (VCFSE) offer wrapped around the Core Integrated Neighbourhood Teams.
- Primary Care Networks (PCNs) are a key stakeholder within wider Integrated Neighbourhood Teams, with delivery underpinned by the priorities within the Primary Care Direct Enhanced Service (DES).
- Other services such as Palliative Care Nursing, Learning Disability and safeguarding specialists will also be reached out/brought into the integrated neighbourhood teams in a flexible and adaptive manner.
- Realignment of community nursing roles to support new models of Proactive Care (Anticipatory Care).
- Strategic Leadership will be provided by Neighbourhood Leadership Team which includes leads from; Social Care, District Nursing, Mental Health, General Practice and VSCFE.
- Introduction of Trafford Urgent Community Response Service

Technology and Equipment

Our ethos is to ensure that all our people can remain living well at home for as long as possible and to maximise the opportunities, we must use modern solutions. We are investing in our Technology Enhanced Care (TEC) offer and have explored several options include the using of robotics, sensors and connectivity through the Internet of Things to prompt self-care and support independence.

Age UK Passion for life and dementia

The aim of the service for the Dementia Advisors is to ensure that Trafford residents living with dementia and their carers receive high quality information, advice, advocacy and support which promotes independence, increases choice and focuses on social support, peer networks and community cohesion to enable them to live an independent and fulfilling life. Passion for Life is a Day Service that supports those with a Dementia Diagnosis in various sites across the Borough of Trafford.

1:1 Hours

During the Pandemic, the Trafford system witnessed significant changes in the way Health and Social Care operated, one significant change was that our Social Workers were removed from the hospital sites (except for a duty worker for increased complex situations including Safeguarding. This was mainly driven by the National requirement of all Health Social Care partners developing a Discharge to Assess (D2A) offer to meet increasing demand. We simply needed our resources in the

Community to ensure that we could ensure our residents needs were assessed in a timely manner and enabled to return home as soon as reasonably practicable.

As we witnessed the significant restrictions on our people's liberty being infringed with these high levels of intrusive care, it is important to note that the financial costs were also sizeable and reliant on a Social Care professional assessing our people to reduce/remove the 1:1 associated care.

Therefore, in 2021/2022, the Trafford system made the decision to commission our own 1:1 support with a local Care Agency called Cucumber, with a detailed contact which enabled the Local Authority to deploy & cease care when the person no longer needed it, operating this Trusted Assessor model.

- The benefits to our people meant that they only received the right care at the right time
- We were able to deploy our 1:1 workforce where required & not being reliant on the Care Homes sourcing their own 1:1, sometimes at £27-£30 per hour
- We were able to support more of our people who are 'more complex' quicker as the LA supplied the 1:1 care
- We are paying £17.86 per hour, which is currently less that our framework provider rate
- It was the Right thing to do!

Handy Person Service

We have invested in our practical services this year to support the speedy transition from Hospital to Home with a particular focus on making sure that the home is a safe environment to go home to, and meets the person's needs where these have changed as a result of needing care and clinical interventions. This will include filling service gaps such as the removal and moving of furniture, putting curtain rails up and preparing the home to ensure it is a safe environment to go home to from hospital. The Council have commissioned Helping Hands, a not-for-profit social enterprise to provide this service.

Home Care Capacity

Throughout the pandemic we accessed several centrally funded grants, one of which supported one of our providers to purchase a vehicle.

This has enabled the provider to delivery in excess of 500 additional homecare hours in areas of the Borough where transport links are extremely limited, and time restrained and where employees did not have access to their own vehicles.

We have agreed to extend this model through 2023/24.

Stroke Support Service

Stroke Association delivers Stroke Recovery Service for Trafford residents who have experience d a stroke, their families, and carers. The service works with local community stroke teams and other partner organisations to ensure the service is complements the local system and that together they improve people affected by stroke's long-term outcomes

- Coordinated support throughout your stroke journey
- Home visits and/or regular telephone calls

- Emotional support
- Tailored information including communication tools
- Assistance with accessing community-based support
- Support for carers and family members including monthly carers drop in at Trafford General Hospital for newly diagnosed stroke survivors.
- Living well after stroke groups
- Childhood Stroke Support Team has been supporting parents of children who have had a stroke

Ascot House

Ascot House is our 24 hour intermediate care facility within the Borough of Trafford for both community and hospital discharge.

Ascot House is the longstanding provider of Trafford's intermediate care provision, enabling the Trafford system to monitor changes in demand and capacity over a substantial period of time The utilisation of intermediate care beds at Ascot House has maintained relatively consistent levels over the last few years enabling the system to anticipate periods where demand will peak. The number of beds commissioned at Ascot House as been sufficient to manage demand and no additional capacity has been commissioned from alternative providers. Whilst temporary closures of units due to Covid outbreaks impacted on the number of beds open between 2020-2022, 35/36 beds have been consistently open at Ascot House (IMC Unit) between April 2022- March 2023, with the Year to Date (YTD) average occupancy rate of 79%, with a low of 59.3% (April 22) and a high of 92.3% (July 22).

Whilst beds were not up to full establishment of 36 beds in previous years, average YTD occupancy in 20/21 and 21/22 was 73%.

Through the efforts of service and improvements made with regards to patient flow, occupancy rates within Ascot House have improved over time however, utilisation remains under 80% which indicates there is an ability to drive greater utilisation or a review of the number of beds required.

Ascot House currently provides a therapy-led (rather than nursing) model of care. Working in partnership, Trafford system is undertaking a review of this model during 23/24 to identify if there is there is an unmet need for patients with nursing needs who would benefit from bed based intermediate care. Through the introduction of the Rapid MDT in Discharge to Assess beds, the service will identify any patients who should be stepped down from a Pathway 3 bed to intermediate care within the current criteria, and those we could have been supported within intermediate care setting if there was an increase in nursing provision.

This review is also considering the impact of the introduction of Trafford's Community Response service and whether this will enable more patients to be discharged directly home with support, thereby reducing the number of intermediate care beds required within the system.

The impact of introduction of new service offers and their impact on intermediate care bed-based utilisation will be monitored via the Trafford Resilient Discharge Programme and the D2A Assurance Dashboard with reports to Trafford Provider Collaborative on a quarterly basis.

Health Recovery Beds

Throughout 2022-23 it was identified that there was a relatively small number of patients who required a period of recovery prior to receiving rehabilitation or prior to long -term care needs being able to be assessed, taking them outside of D2A pathway 3 assessment period of 8 weeks. Prior to 2022-23 a patient would have experienced a long length of stay in hospital impacting on patient experience and flow through hospital sites.

Subsequently, in January 2023, the Trafford system introduced health recovery beds which are spot purchased in local care homes. This new pathway and provision are managed and commissioned via Trafford's Urgent Care Control Room, which is run and managed by Trafford's Urgent Care Integrated Health & Social Care Team within the Trafford Local Care Organisation (TLCO). To date, 8 health recovery beds have been commissioned and has included:

- Patients who require fractures to heal before rehabilitation can be delivered.
- Stroke patients who have received intensive rehabilitation within specialist stroke units and determined to require long-term residential or nursing care.

Trafford Community Response

Trafford Community Response (TCR) is part of the Trafford Local Care Organisation (TLCO) and provides assessment and short-term interventions including crisis intervention and supported hospital discharge with therapy / nursing input where required.

There are four main aims of TCR:

- Support people to remain at home
- Help people avoid going into hospital unnecessarily.
- Help people return home from hospital as soon as they are medically safe to do so
- Prevent people from having to move into a residential home until they really need to.

Services in the TCR will be integrated with health & social care colleagues forming specialist community teams. The service will provide the 2-hour crisis response, support hospital discharge with nursing and therapy input and will over the coming months work to integrate more community services such as Community IV.

The TCR is designed to be a short-term intervention with possible onward referral to another service if appropriate, including other parts of the Trafford Community Response (TCR) service or wider LCO.

The role of the service is to prevent hospital admission and attendance at urgent care services by assessing, diagnosing, and treating people experiencing a health and social care crisis that requires an inter-disciplinary intervention. The team supports a clinical triage process, supporting the point of entry into the Trafford Community Response service. This includes the Northwest Ambulance Service referral via 999 or 111 as well as via ambulance crews on scene. The team provides an intensive support service for up to 48 hours, before either discharging the person, or making onward appropriate referrals.

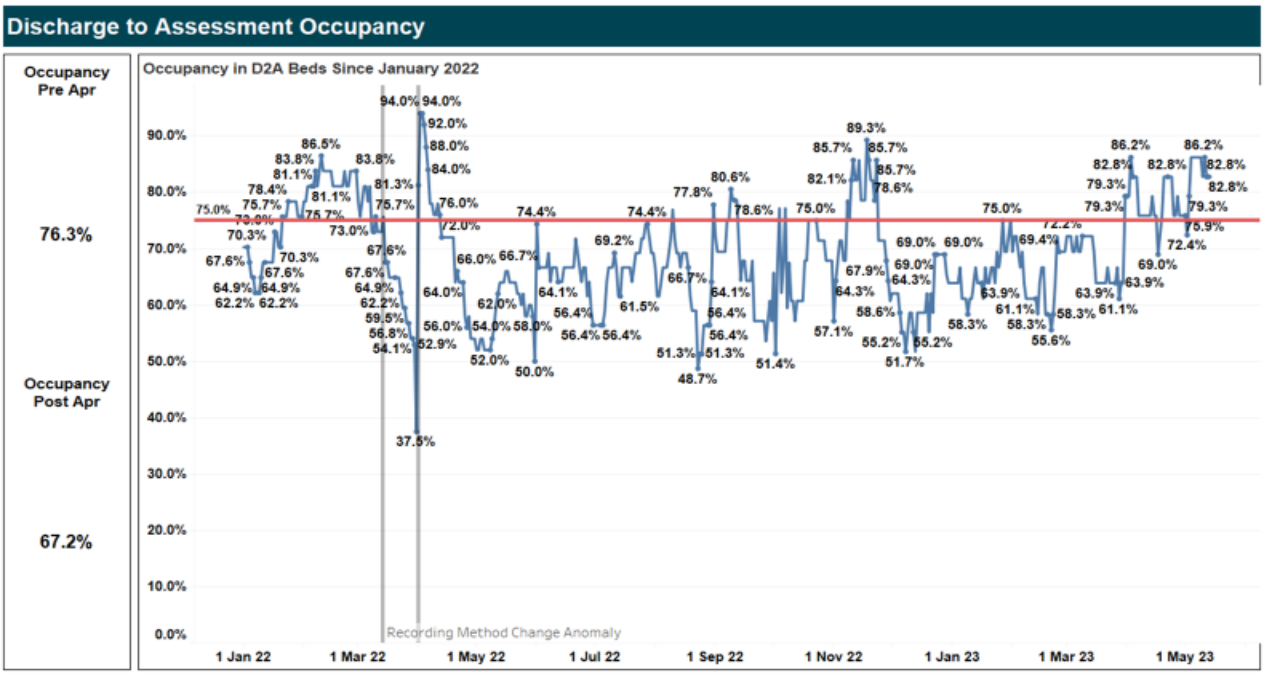
Trafford Resilient Discharge Model

Following the introduction of the hospital discharge guidance and the subsequent increase in residents being discharged for an assessment for long term care into bed-based care, we saw an increase in the complexity of health conditions being managed within a Pathway 3 D2A bed setting, and challenges regarding medications on discharge. This posed significant capacity challenges to General Practice, as these patients required timely review by a clinician. Without timely review and intervention there is an increased risk of patients being readmitted to hospital. Subsequently, the Trafford system commissioned a single GP provider, supported by pharmacists, to provide general practice support for block and spot purchased Discharge to Assess beds. This service provides:

- Temporary Registration of all people
- Provide 3 hours of medical cover per day 5 days per week
- Prescribe both repeat and acute medication as requested/in line with a consultation.
- Action any recommendations from the medicine's optimisation team.
- Service focused on ensuring a safe discharge, proactive care, supporting residents to get the medical care needed by working closely with the wider MDT team and being a single point of contact for primary medical care.
- Leading the MDT approach to care co-ordination.
- Ensuring optimal prescribing support by working in partnership with the dedicated medicines optimisation personnel
- Ad hoc requests from care homes
- Work with the Rapid MDT to D2A Team

Demand and capacity

We monitor capacity and demand across the system together with how we make use of the resources we have commissioned. We look at the number of people under Right to Reside who require support to be discharged, number of people who are discharged across the pathways and available capacity of those services to meet need.



This example shows the activity and use of block purchased D2A beds – we decommission if there is poor response by a provider and/or under use of beds, and spot purchase to increase capacity when there is limited resource.

Our demand predictions are based on the past 3 years level activity and have been in the main fairly accurate – however the key challenges for us is the need to respond to changing activity levels from partners, which is often unprecedented and changes in line with national policy – e.g. increased targets for hospital discharge.

Asset Based Community Capacity

We have employed several Community Link Officers across Adult Social Care to ensure our residents are supported from a preventative perspective. These roles are key to ensuring our people can access universal services and community resources to ensure their needs can be met at neighbourhood level.

Ageing Well Integrated Crisis and Rapid Response - Small team that provides rapid response to crisis in residential and nursing homes for over 65s

Trafford's urgent and emergency care systems have been under significant pressure for a sustained period. Within Trafford an aging population with comorbidities has contributed to increased levels of activity within urgent care across both Manchester and Trafford services.

Similarly, to other localities and areas around the country, Trafford urgent care services have all experienced significant challenges with rising activity levels, increased complexity of need, pressure on beds and in enabling safe and effective discharge. This has meant that the services within the community to support people at home and reduce the need for admission to hospital are becoming even more vital. Urgent Care community services are needing to manage higher levels of demand, acuity, and complexity than traditionally offered. People often have health and social care needs which means that the service offer needs to be provided through a multi-disciplinary approach, with teams working in collaboration with other services. This needs staff with different, developed, and enhanced skills.

Within Trafford our community response service consists of a range of specialists including; Nurses, Social Workers, Therapists and pharmacists.

Trafford Community Response (TCR)

Trafford Community Response (TCR) is part of the TLCO and provides assessment and short-term interventions including crisis intervention and supported hospital discharge with therapy / nursing input where required.

There are four main aims of TCR:

- Support people to remain at home
- Help people avoid going into hospital unnecessarily.
- Help people return home from hospital as soon as they are medically safe to do so

- Prevent people from having to move into a residential home until they really need to.

Services in the TCR will be integrated with health and social care colleagues forming specialist community teams. The service will provide the 2-hour crisis response, support hospital discharge with nursing, social work and therapy input and will over the coming months work to integrate more community services such as Community Intravenous Therapy service (CIV).

The TCR is designed to be a short-term intervention with possible onward referral to another service(s) if appropriate, including other parts of the wider Trafford system service.

The role of the service is to prevent hospital admission and attendance at urgent care services by assessing, diagnosing, and treating people experiencing a health and social care crisis that requires an inter-disciplinary intervention. The team supports a clinical triage process, supporting the point of entry into the Trafford Community Response service. This includes the Northwest Ambulance Service referral via 999 or 111 as well as via ambulance crews on scene. The team provides an intensive support service for up to 48 hours, before either discharging the person, or making onward appropriate referrals.

Integrated Crisis and Rapid Response – Alternative to Transfer (ATT)

The Trafford ATT Service is provided by Mastercall Healthcare. The service is for referrals directly from NWAS or from a Care Home. The service is for those patients where their condition is not life-threatening, but they may be at risk of admission that day due to a medical need. The service provides advice, guidance, and medical intervention where necessary. A senior clinical assessment takes place with a GP who can also arrange to visit the patient in their own home or refer on appropriately.

- Patients can be referred into the service via 999/111/NWAS pathways, GMCAS and Care homes directly
- The service is available 24 hours a day 365 days a year including Bank Holidays
- The ATT service triages all referrals and offer an appropriate response to the presenting issue. This may entail management digitally or through a face-to-face visit, verbal treatment advice, reassurance, or signposting.
- Urgent medical care resolution- potential follow up with Primary Care within the 2-hour response time
- All age all conditions Minimal exclusions
- Short-term assessments and interventions for people in their own homes or place or residence/on scene resolution (to be left in place of safety i.e. in a building)
- All ages in Trafford (no under 2 unless red refusal); any Trafford resident or Out of Area patient within the locality on scene
- GPs supported by wider MDT consisting of ACP/CP/TN/Pharmacist (meds management team)
- ATT/+ is Paramedic and Care Home referral 24/7. Referrals are also accepted from Greater Manchester Clinical Assessment Service (GMCAS) and LCAS directly booked.

The service also supports Red Refusals (unless under 2) within the community via NWAS.

The ATT service is a well-established service within Trafford. The developments taking place around the establishment of a Trafford Community Response also provides further opportunity to integrate and join up the different services available within the locality.

Integrated Crisis and Rapid Response – Trafford Patient Assessment Service (TPAS)

TPAS is the Clinical Assessment Service provided by Mastercall Healthcare who is the Out of Hours (OOH) provider for the Trafford locality. The TPAS supports the Urgent Treatment Centre (UTC) at Trafford General Hospital (TGH) for people who have been referred to the service via 111/999 or another alternative route such as GPs, OOH, ATT, Community Health & Social Care and received an outcome of attend the UTC at TGH.

Most cases that are referred to the TPAS are closed as advice and/or a prescription and do not need to see anyone face to face. Others are referred or booked into an appropriate service if they cannot be closed following initial conversation/consultation. This direct booking will also be undertaken by the TPAS and could be to a range of services across the system that are now interconnected because of the direct booking functionality including UTCs, Emergency Departments and Primary Care.

Clinical Assessment Service models are a key component mandated in the Integrated Urgent Care (IUC) service specification that turned the 111 signposting and referral service, primarily manned by call handlers with junior clinical support, into a full clinical service for Trafford.

Mastercall runs the TPAS service 8am-8pm in line with UTC operating times (note the TPAS operates 8am-8pm and is separate to the GMCAS).

All the service above will reduce the number of unplanned admissions to hospital for chronic ambulatory care sensitive conditions and emergency hospital admissions following a fall for people over the age of 65.

Falls

Within Trafford there are four priority areas in relation to falls:

1) Promote awareness of falls prevention to our residents and increase availability of strength and balance activity for older people.

2) Raise awareness and provide training for health and social care staff of the importance of falls prevention, and support them in delivering evidence based interventions

3) Focus particularly on preventing falls in Care Home and Social Care settings, including Home Care and unpaid carers, including exploring the increase of TEC and 1:1 additional support, additional training for the care home settings has also been provided including the encouragement of the adoption of the Safe Steps and Restore2 tools.

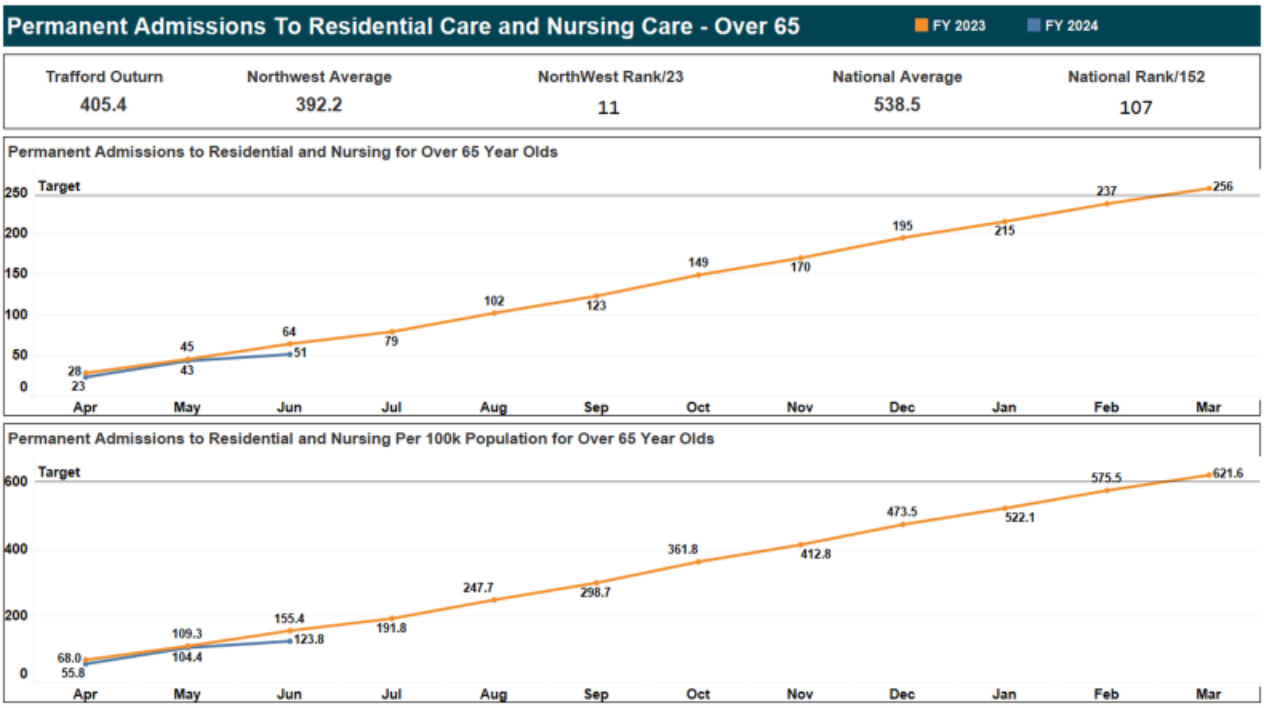
4) Review, revise and embed local falls prevention pathways. Trafford patients who experience a fall and are appropriate for lifting and support rather than conveyance to hospital are referred to the THT falls service via NWAS and will be lifted within their own place of residence.

In addition to this Trafford are also part of a wider GM Falls scheme provide s additional resilience to residents who may have experienced a fall.

Residential and Nursing Care Home admission

Our figures for long term admission continue to decrease year on year as more people choose to stay living at home with care and support . The reablement service we offer together with TEC builds peoples' confidence in making that decision. We only accommodate people in residential and/or nursing care homes where their needs cannot be met safely anywhere else. We have also funded a system Discharge to Assess (D2A) Programme non recurrently, which include GP an integrated assessment service to support discharge pathway choice for people in and out of D2A, therapy support as well as provision of beds and homecare. We continually review and skill up our reablement service to be able to meet the needs of people being discharged from hospital. Outcomes are continually monitored to look at how performance can be improved. Through our Section 75 we have invested in a crisis response service which will support this cohort of patients to stay well at home.

Long-term admission to residential care from D2A beds, is already low, and we are seeking to further reduce this through the expansion of the Rapid MDT which enables people to return home much more quickly. In addition, we have established a new post which will focus on ho using pathways where there is a barrier to someone returning directly home.



National Condition 3

Adults Discharge Fund (ADF)

We have six schemes funded through the ADF as detailed in the BCF Planning template (Excel). To maintain patient flow, the speed, complexity, and numbers of people being discharged has significantly increased along with the unit costs. Trafford has the highest bed cost in Greater Manchester. The cost of D2A beds is in keeping with these rates particularly as the speed with which people enter and leave D2A beds means that the care home staff have an average of 15 times the amount of assessment and discharge work that they have to do for every D2A bed as compared with an ordinary long-term bed. Our targets are 60 people per week which is an increase of 10 on last year. This is putting significant impact on our budget which is not fully offset by the ADF given that bed rates and homecare rates have increased considerably in line with the commitment to pay the Real Living Wage and inflationary increases which have hit the care sector particularly hard. In addition, many of our providers pay more than the Real Living Wage to attract and keep staff and maintain a safe service. We also commission Health D2A beds which are for people who require longer-term placements and support which cannot be provided at home, whilst they await a planned clinical intervention. Our GPs are unable to provide a comprehensive primary care service to our residents and the ADF has funded a contribution to the costs of the contract with a single practice to provide D2A cover. This arrangement enables the provision of complex support to the homes and facilitates the provision of continuity of support together with building close working relationships with the staff in the care homes. In addition, pharmacy support to people in D2A beds is also partially supported through the ADF. This alleviates the pressure on care homes and pharmacies due to the numbers being discharged and prevents the risk of people not having the right medication at the right time.

Trafford Resilient Discharge Programme

The Trafford system has reviewed our High Impact Change Model for transfers of care as part of our Strategic Locality Resilient Discharge Programme (RDP). This programme is aimed at ensuring compliance with; national guidance, clinical safety, providing quality care at the right time and meeting our ambition to ensure that our people can remain Living Well at Home or to a place of residence which meets their assessed needs and outcomes.

Our model of care delivers:

- Acute Trust 'Back to Basics' workstream is to develop a greater understanding of community resources to ensure people are discharged in accordance with our 'Home First principles' are at the point of discharge planning.
- Pathway 3 Discharge to Assess block and spot residential and nursing beds, commissioned within local Care Homes. Our demand modelling has developed since 2017, when we initially embarked on our D2A offer in Trafford.
- To support the timely assessment of residents within Discharge to Assess beds, a Rapid MDT Assessment Team has been established. This multi-disciplinary includes occupational therapy, physiotherapy, nursing, and social care to enable an initial MDT assessment to be undertaken within 48 of admission to a D2A bed. In addition to improving delivery of assessment within the 28-day target for D2A beds, this model ensures that people are on the correct pathway, enabling a change in pathways if clinically. Professionally appropriate

and wherever possible supporting residents to return home. This team subsequently acting as an additional safeguard to support the over prescription of long-term residential care.

- The Rapid MDT model and infrastructure is provided by the Urgent Care Control room as part of its wider system support to provide timely and effective discharge through joint working across the social and health system.
- A small pilot where we adopted the Rapid MDT methodology identified that our people were returning home sooner and between 10-20 days than would have typically been expected with Social Care only interventions.

Community IV Therapies – Delivery of IV in Community to avoid use of hospital capacity

Trafford has a dedicated Community IV service that is provided via the TLCO. This service was commissioned to provide support to 15 patients per month that otherwise would have been in an acute setting/hospital bed.

The IV service supports patients and the local system by:

- Increased patient experience;
- Providing care closer to home;
- Reduction in hospital acquired infection;
- Joined up integrated working between the hospitals and community teams;
- Improvement of patient choice;
- Facilitates early discharge
- Reduces patient admission waiting times by freeing up beds;
- Attendance and admission avoidance (for step up patients)

The Trafford Community IV therapy service aims to ensure the development of:

- An accessible and responsive service that provides patient-centred care either in a patient's home or in an ambulatory clinic setting.
- Provide a service to all Trafford GP registered patients requiring IV therapy in the community. The provision of service delivery for both step-up and step-down patients.
- A focus on outcomes To establish pathways to take patients from A&E, Ambulatory Care, GPs, and the Community Equitable access to the service across the whole of the borough.
- Integration with the local health and social care system.
- Manage patient and public expectations.
- Collaboration and engagement between providers.
- Consistent and proactive use of Shared Care records

Most patients that have been able to access the service have been stepped down from an acute setting; reducing length of stay and reducing the risk of hospital acquired infection/pneumonia whilst providing care closer to home. There is also a cohort of patients within the community who can be stepped up into IV via a community referral usually via a GP or Community service. This then supports both an ED attendance and hospital admission whilst also ensuring the patients can be treated or managed within their own homes where appropriate.

Trafford locality is working with the TLCO to scope the opportunity for enhancement of the service within the locality and the implications for the IV service with the development of the Hospital at

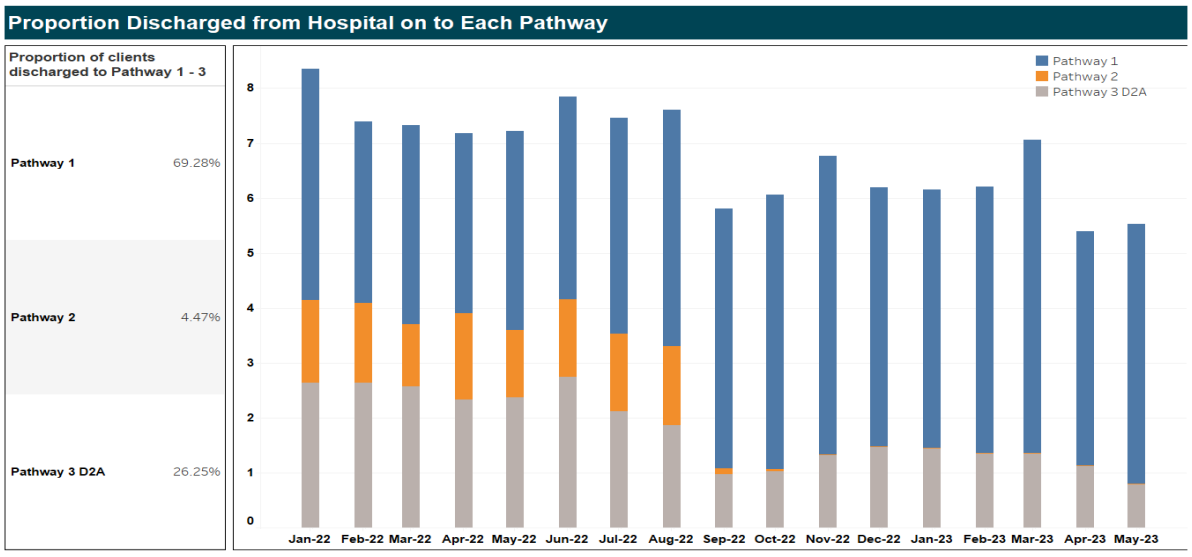
Home programme (incorporating virtual wards) and the enhancement of the Trafford Community Response service

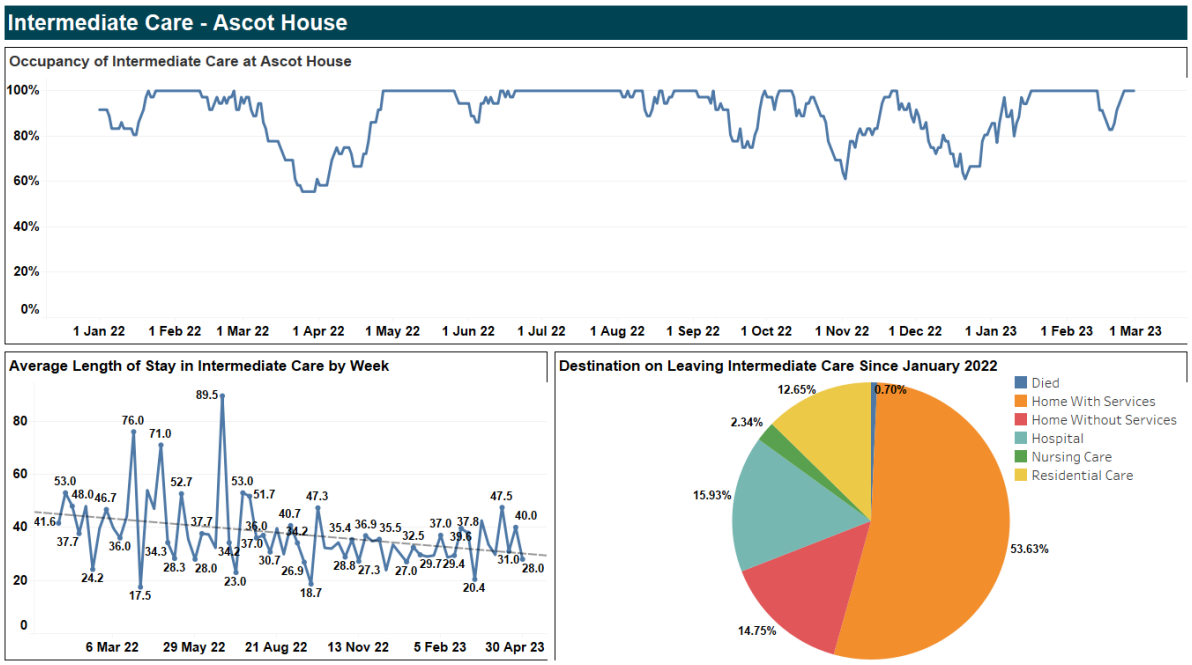
Voluntary Community Faith Social Enterprise (VCFSE) & Statutory Services

Statutory services and our commissioned care and support providers cannot possibly deliver everything for our residents. Consequently, we have decided to invest further in our V CFSE sector to deliver our Living Room projects where our people can attend to not only stay warm but also to engage in meaningful activities including; homework clubs, coffee mornings, afternoon tea, yoga, meaningfulness sessions etc. Further support for our 'Living Rooms' can be found at Trafford Community Hubs (traffordhubs.org)

For example, The Toy House is an inspirational community asset which provides local support to the residents of Urmston (West Trafford locality) and neighbouring areas. They provide a timetable of person-centred activities across an all ages from new mothers, people experiencing mental health associated needs ,older aged adults and adults with a learning disability. The Toy House have asked for additional support to 'grow' their volunteer workforce and we think by promoting our Personal Assistant (PA) offer for those in receipt of Direct Payments (DP's) or Personal Health Budgets (PHB's) is an opportunity to develop a structured approach into paid employment.

As detailed in response to National Condition 2, Ascot House is the long standing provider of intermediate care provision in Trafford. The monitoring of capacity and demand and utilisation of 36 bedded provision is monitored via Trafford's Discharge to Assess Assurance Dashboard which reports to Trafford Provider Collaborative on a quarterly basis. This demonstrates that the current 36 intermediate care beds commissioned are sufficient to meet demand, including periods of increase in demand such as over Winter. Please find current rates of discharges per discharge to Assess pathway and the utilisation of Ascot House below:





As 14.75% of people returning home from Ascot House with no further input from services, this may indicate that there is a over-prescription in the use of bed based rehabilitation and an opportunity for more people to return directly home from hospital with therapy support. This opportunity will be tested through the introduction of the Pathway 1 Discharge to Assess support within the new Trafford Community Response service and the additional community occupational therapy and physiotherapy this provides. The impact of the introduction of this service on the utilisation of Ascot House beds will be closely monitored over the next 12 months, with the outcomes considered within the current review of Trafford's Intermediate Care Model.

Additional Staffing in Care Hub & Control Room

We know that sometimes, people remain in hospital longer than necessary due to reasons which pertain to their accommodation related needs. It may be an environmental issue, health and safety or personal issue. Whilst the needs of the people which fall into the above category may not have 'eligible' care and support needs (under the Care Act, 2014 (Statutory Duty for Local Authority), ensuring people can leave hospital is the right thing to do.

Consequentially, we have secured additional capacity to address the complex housing related issues, our people face by employment of a dedicated Lead (fixed term contract 23/24). Further, we are working more closely with our Housing colleagues to ensure hotel capacity is brokered where required.

Social Work Resource in Emergency Department

We recognise that on occasion our residents are admitted to hospital due to non-medical reasons where they could be cared for at home. We have therefore agreed we will pilot the presence of a Social Worker in the Emergency Department of Wythenshawe Hospital to see if this model would be effective to support our residents more holistically as opposed to a hospital admission.

Early Supported Hospital Discharge-Rapid MDT

We know that once our residents are discharged from hospital and enter our D2A provision, more than 87% of people return home.

This may be because of several reasons, but we believe if we had a Health & Social Care model which met people on their first day this may improve our residents' outcomes even further.

The Council have developed this pilot in partnership with, Greater Manchester Integrated Care, Manchester University Foundation Trust (MFT), who will be providing Occupational Therapy & Physiotherapy assessments & interventions to support individuals during this assessment period.

Provision of Equipment to enable Single Handed Care

The purpose of this project is to ensure our people receive a dignified and less restrictive level of care where their assessed needs have been identified as requiring the support of two registered carers. This project has been delayed due to difficulty in recruiting Occupational Therapy support.

By maximising a modern approach to equipment, this will result in care only being required to be delivered by one carer as opposed to two: maximising our workforce capacity

We learnt prior to the global pandemic, that this approach worked effectively for both our residents and workforce, and we want to build on this through 2023/2024.

The BCF and the iBCF form part of our approach to discharging some of our Care Act (2014) statutory duties and functions.

Provision of Advocacy

Advocacy Focus delivers a range of statutory advocacy: Independent Mental Health Advocacy (IMHA), Independent Mental Capacity Advocacy (IMCA), Care Act Advocacy, NHS Complaints Advocacy, and Child Protection Advocacy (CPA). A recent addition of support delivered by Advocacy Focus is Peer Advocacy. There are 16 individuals that are members of the group. The service is also preparing for the introduction of LPS (Liberty Protection Safeguards), in the future, and is focusing on bringing the waiting lists down. The Trafford Advocacy Hub currently operates a waiting list due to high demand on services. They are fully staffed in line with our original budget and additional funding has been provided to extend capacity in line with demand. When Advocacy Focus took over the contract in 2018, 71 eligible cases were handed over and active within the service, today they work with an average of 211 people which is a 197% increase in demand.

Quality Assurance & Improvement

We have developed a Quality Assurance Lead to ensure that the care people receive of a high standard and is informed by our people's voice. The post holder also ensures that we have effective, safe, and good quality assurance to enable us to discharge our statutory duties and identify any subsequent learning. The Council commissioning team has co-produced an i-Tool with providers and this tool measures the quality of service. The team work closely with the providers to ensure best practice and develop and monitor improvement plans where there are concerns about the quality of a service. We have monthly meetings where the ICB, TLCO and the Council review the quality of commissioned provision across the system.

Urgent Care Control Room

We have temporarily increased our capacity across both Social Care and Health Assessment and Commissioning resources to ensure that we can support as many people as possible to return to their natural place of residence. The demands on data requests and greater assurance, visibility across the system has further increased, resulting in additional positions initially being tested as a 'proof of concept'.

Supporting unpaid carers

The Trafford system BCF plans and BCF funded services consider support for unpaid carers, and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Respite for Carers

The Trafford system is committed to ensuring that our people can receive the right care at the right time. In order to achieve this, we are developing in collaboration with a homecare provider an overnight support service for our residents during times of need (including overnight7 days a week). This usually occurs when their informal carer has become unwell or has been admitted to hospital.

This approach will ensure that the person being 'cared for' will be able to remain in their own home and will avoid any further distress/unrest or hospital admission. Our Social Care and Health workforce would then undertake an assessment of the person's needs the following working day.

Supporting Health & Wellbeing of Carers

The Carers Centre is a substantial resource for our informal carers, and they have requested support to ensure that our carers are aware of the support that is available to them specifically where their loved one is in a hospital setting. Our Carers Ambassadors will be available initially at our Wythenshawe hospital site and will provide additional resources to enable our carers to make informed decisions.

We believe that all carers have the right to be recognised, respected, valued, and supported both in their caring role and as individuals in their own right. Trafford Carers Centre support our carers through the provision of counselling, digital support, direct payments and information and advice. The Council and the ICS work in partnership with the Carers' Centre to ensure that where the independent assessments carried out by the Carers Centre recommend respite, that Carers breaks are available. Advice, information, and signposting is also provided by our Citizens Advice Bureau, in-house welfare services and our local community hubs.

From April to June 2023, the Centre achieved the following:

The Centre also offers Carers Awareness Training and support the roll out of our Employers for Carers initiative. We have funded a hospital discharge project to support carers of people who are being discharged from Trafford General Hospital. The outcomes are extremely positive at Q1 – A worker has been recruited to lead the work. Drop-ins have been established on each ward and awareness raising events held. The Hospital Discharge lead is now in the process of establishing carers' champions on each ward, together with establishing a carers' group. The lead has also raised awareness generally. The events have led to 28 new referrals for information and support.

Disabled Facilities Grant (DFG) and wider services

The Trafford system works collaboratively across health, housing and social care to maximise the availability of accessible housing to enable people to live for longer in their own homes. We consider all aspects of a person's life – not just the accessibility of their home, but also their access to local facilities and the community. We ensure that where possible, people are offered viable housing alternatives to adaptations, which are often extremely disruptive. We also offer grants to support the move. Where these are not available or desirable, we work with the family to develop a cost-effective solution to maintain independence. We consider the lifetime needs of the disabled person in designing an outcome. Our Older People's Housing Strategy outlines several actions to improve our range of housing choices from providing information to encouraging the development of more extra-care housing to support our population. The actions in this plan are regularly updated.

Older-Peoples-Housing-Strategy-2020-25-A-Plan-on-a-Page.pdf (trafford.gov.uk)

At a Greater Manchester level, we have developed a Healthy Homes initiative and we are seeking additional funding in order to implement the same offer of support across all GM boroughs. We meet regularly to share best practice at a strategic level. Managers of the Adaptations team also meet regularly to discuss operational issues.

GM Healthy Homes Final Report Jan 2023

We also have a number of Ageing Well initiatives to support people earlier on in their care journey, preventing hospital admission and maintaining optimum health for as long as possible. In addition, we also support older people to remain happy and healthy through our Age Well Plan which is based on the WHO Age Friendly Community approach. Age Well Plan (traffordpartnership.org) We work closely with the planning department and our Registered Providers to maximise the availability of

extra care provision within the borough which meets HAPPI standards and are in the process of developing our Market Position Statement for older people to provide a framework for this discussion. The number of adaptations requested are now increasing as we receive more OT assessments from an externally commissioned provider. We regularly review and report back on activity.

Adaptations Report May 23.docx

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

Yes - We agreed an RRO in 2018 to enable the provision of

- Moving Assistant Grant – this provides support to people who would live a better life if they moved to an alternative property. The take up of this grant has been very low and we are working with our Registered Providers to promote it again. There is no upper limit for this provision.
- The increase of the DFG upper limit to £50,000 – this particularly supported adaptations for families where there is a disabled child. The table below details those adaptations which are in excess of £50,000 – there is no upper limit in line with our statutory responsibility (and case law) to meet need.

E	F	G	H	I	J	K
details	gross_grant	certified	landlord (owners left blank)	Age		
a ground floor facilities	50,958.03	20-Jun-19	Irwell Valley Homes	47		
a ground floor bedroom and shower room facilities	61,769.60	26-Jul-19		55		
a ground floor bedroom and bathroom with hoist	56,730.05	30-Aug-19		12		
a ground floor facilities	63,549.43	26-Sep-19		35		
a ground floor bed/shower room	64,820.84	11-Mar-20		62		
a ground floor facilities, wheelchair access to property	58,878.13	02-Jul-20		68		
a aquanova scorpio 1800 bath, ramped access rear & fro	55,849.79	09-Mar-21	L&Q	65		
a ground floor bedroom/shower room	57,777.55	16-Mar-21	L&Q	6		
access to front/back garden & ground floor bed/shower ro	68,933.33	18-Jun-21		6		
a ground floor facilities bedroom & wetroom	51,513.36	14-Mar-22	L&Q	83		
a ground floor wheelchair accessible bedroom & shower r	81,804.71	14-Dec-22	L&Q	55		
a ground floor facilities	117,436.77	10-Mar-23	Irwell Valley Homes	12		
a ground floor facilites	84,759.64	14-Apr-23		6		
a ground floor facilities	69,853.40	25-May-23	L&Q	7		
a ground floor facilities	82,437.26	09-Jun-23	L&Q	44		
a ground floor wetroom and clos o mat	60,711.73	13-Jun-23	L&Q	38		
a ground floor facilities	78,796.75	16-Jun-23		6		
a ground floor facilities	66,915.80	11-Jul-23		5		

Equality and health inequalities

Via our established system governance, the Trafford system is working with people, communities and partners, particularly in deprived areas, to improve the physical and mental health of all our residents. The diversity of Trafford's population is one of our greatest strengths and we want all our neighbourhoods to have thriving and healthy communities. However, some groups are currently

disadvantaged – not just in life expectancy but in areas such as housing and poverty that can contribute to poorer health. The recent published Census and our local analysis has helped informed targeted support and activity in our neighbourhood model.

Our ambition to reduce health inequalities is driven by our Health and Wellbeing Board Strategy and Trafford Locality Board and operationalised through our Trafford Provider Collaborative Board which oversees effective delivery of the schemes contained within the BCF. These governance arrangements also ensure that organisational health inequality strategies are connected and that efforts to tackle inequalities across our Trafford Integrate Care Partnership are effectively deployed – including GM system Board efforts to address the priorities laid out in NHS Core 20 Plus 5.

Our Neighbourhood plans, which include priority pathways for change that address inequalities, are planned, designed, and delivered in our four Neighbourhoods. A series of 6 coproduction workshops in each neighbourhood with Trafford citizens and stakeholders have gathered local intelligence to reinforce the PCN, public health and census data which has informed the first iteration of neighbourhood plans – with outcome data being shared back through formal governance via our Locality Performance Framework.

Where applicable, the schemes within our BCF Plan have taken into account the NHS Core 20 Plus 5 clinical areas of focus (Maternity; Severe mental illness (SMI); Chronic respiratory disease; Early cancer diagnosis; Hypertension) and work to ensure these areas are addressed is governed through our Trafford Provider Collaborative Board, with wider support and scrutiny from the Health and Wellbeing Board and specific GM forums.

Conversations have started through Locality Board and Health Scrutiny on planning to support differential neighbourhood spend based on need, to improve outcomes and reduce inequalities. Engagement with the population at Neighbourhood level has commenced in our dedicated Long-Term Conditions and Mental Health programmes, so that services can be shaped to reduce inequalities and prevent the need for urgent care.

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BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.

4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

7. Please ensure that all boxes on the checklist are green before submission.

8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

HM Government

NHS England

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Trafford	
Completed by:	Natalie Foley	
E-mail:	Natalie.Foley@nhs.net	
Contact number:	07785 725 603	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no please indicate when the HWB is expected to sign off the plan:	Thu 20/07/2023	<< Please enter using the format, DD/MM/YYYY

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Jane	Slater	jane.slater@trafford.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Mark	Fisher	mark.fisher11@nhs.net
	Additional ICB(s) contacts if relevant	Trafford Place Based Lead	Sara	Todd	Sara.Todd@trafford.gov.uk
	Local Authority Chief Executive		Sara	Todd	Sara.Todd@trafford.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Nathan	Atkinson	Nathan.Atkinson@trafford.gov.uk
	Better Care Fund Lead Official	Joint for Trafford ICB	Gareth	James	gareth.james1@nhs.net
	LA Section 151 Officer		Graeme	Bentley	Graeme.Bentley@trafford.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Trafford

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£2,469,979	£2,469,979	£2,469,979	£2,469,979	£0
Minimum NHS Contribution	£19,396,441	£20,494,280	£19,396,441	£20,494,280	£0
iBCF	£8,224,415	£8,224,415	£8,224,415	£8,224,415	£0
Additional LA Contribution	£3,280,000	£500,000	£3,280,000	£500,000	£0
Additional ICB Contribution	£1,184,270	£1,184,270	£1,184,270	£1,184,270	£0
Local Authority Discharge Funding	£1,153,050	£1,922,000	£1,153,050	£1,922,000	£0
ICB Discharge Funding	£1,044,156	£1,606,278	£1,044,156	£1,606,278	£0
Total	**£36,752,312**	**£36,401,222**	**£36,752,311**	**£36,401,222**	**£1**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£5,511,918	£5,823,893
Planned spend	£11,928,113	£12,603,244

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£7,468,328	£7,891,035
Planned spend	£7,645,460	£8,091,035

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	193.2	169.8	185.3	135.9

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,067.9	2,003.0
	Count	936	917
	Population	41946	42394

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	91.5%	91.5%	91.5%	91.5%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	816	559

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	92.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Trafford

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	For predicted VCSE numbers, the BRC are currently carrying out a test of change where they are working closley with the interaarted discharge teams based in the acute hospital setting.we are awaiting the results of this project. The reablement numbers are based on the avergae number of clients we have accesing those services in a month. The capacity figures are for community reablement are based on the maximum number of people we have placed in a day and the D2A daily capacity has been calculated by using the average occupancy There is nothing included for Short term domicilary care (pathway 1) as we don't provide this, we operate a SAMS model and have included this demand/capacity under reablement at home (pathway 1).

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

(Select as many as you need)

Trust Referral Source	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	Social support (including VCS) (pathway 0)	12	12	12	12	12	12	12	12	12	12	12	12
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	Reablement at home (pathway 1)	40	40	40	40	40	40	40	40	40	40	40	40
	Rehabilitation at home (pathway 1)												
	Short term domiciliary care (pathway 1)												
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	Reablement in a bedded setting (pathway 2)												
(Please select Trust/s.....)	Rehabilitation in a bedded setting (pathway 2)	28	28	28	28	28	28	28	28	28	28	28	28
(Please select Trust/s.....)	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	36	36	29	29	29	30	30	34	36	36	36	36
Totals	**Total:**	251	251	244	244	244	245	245	249	251	251	251	251

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	18	18	18	18	18	18	18	18	18	18	18	18
Urgent Community Response	54	75	74	87	69	106	129	114	147	123	99	107
Reablement at home	6	6	6	6	6	6	6	6	6	6	6	6
Rehabilitation at home												
Reablement in a bedded setting	4	4	4	4	4	4	4	4	4	4	4	4
Rehabilitation in a bedded setting												
Other short-term social care												

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	18	30	30	30	30	30	30	32	33	33	32	30
Reablement at Home	Monthly capacity. Number of new clients.	76	76	76	76	76	76	76	76	76	76	76	76
Rehabilitation at home	Monthly capacity. Number of new clients.												
Short term domiciliary care	Monthly capacity. Number of new clients.												
Reablement in a bedded setting	Monthly capacity. Number of new clients.												
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	36	36	36	36	36	36	36	36	36	36	36	36
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	41	41	36	36	36	36	37	42	45	45	45	45

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	30	30	30	30	30	30	30	32	33	33	32	30
Urgent Community Response	Monthly capacity. Number of new clients.	216	300	296	348	276	425	516	456	588	492	396	426
Reablement at Home	Monthly capacity. Number of new clients.	15	15	15	15	15	15	15	15	15	15	15	15
Rehabilitation at home	Monthly capacity. Number of new clients.												

Reablement in a bedded setting	Monthly capacity. Number of new clients.	5	5	5	5	5	5	5	5	5	5	5	5
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.												
Other short-term social care	Monthly capacity. Number of new clients.												

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Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Trafford

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Trafford	£2,469,979	£2,469,979
DFG breakdown for two-tier areas only (where applicable)		
Total Minimum LA Contribution (exc iBCF)	**£2,469,979**	**£2,469,979**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Trafford	£1,153,050	£1,922,000

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS Greater Manchester ICB	£1,044,156	£1,606,278
Total ICB Discharge Fund Contribution	£1,044,156	£1,606,278

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Trafford	£8,224,415	£8,224,415
Total iBCF Contribution	**£8,224,415**	**£8,224,415**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
Trafford	£1,289,000	£500,000	Additional contribution to Hospital Discharge Costs
Trafford	£1,991,000	£0	Reserve carry forward
Total Additional Local Authority Contribution	**£3,280,000**	**£500,000**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Greater Manchester ICB	£19,396,441	£20,494,280
Total NHS Minimum Contribution	**£19,396,441**	**£20,494,280**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
NHS Greater Manchester ICB	£1,184,270	£1,184,270	Additional charitable grants and contracts identified in
Total Additional NHS Contribution	**£1,184,270**	**£1,184,270**	
Total NHS Contribution	**£20,580,711**	**£21,678,550**	

	2023-24	2024-25
Total BCF Pooled Budget	**£36,752,312**	**£36,401,222**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Trafford

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£2,469,979	£2,469,979	£0	£2,469,979	£2,469,979	£0
Minimum NHS Contribution	£19,396,441	£19,396,441	£0	£20,494,280	£20,494,280	£0
iBCF	£8,224,415	£8,224,415	£0	£8,224,415	£8,224,415	£0
Additional LA Contribution	£3,280,000	£3,280,000	£0	£500,000	£500,000	£0
Additional NHS Contribution	£1,184,270	£1,184,270	£0	£1,184,270	£1,184,270	£0
Local Authority Discharge Funding	£1,153,050	£1,153,050	£0	£1,922,000	£1,922,000	£0
ICB Discharge Funding	£1,044,156	£1,044,156		£1,606,278	£1,606,278	£0
Total	**£36,752,312**	**£36,752,311**	**£1**	**£36,401,222**	**£36,401,222**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£5,511,918	£11,928,113	£0	£5,823,893	£12,603,244	£0
Adult Social Care services spend from the minimum ICB allocations	£7,468,328	£7,645,460	£0	£7,891,035	£8,091,035	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No

>> Incomplete fields on row number(s):

58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

									Planned Expenditure						
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Expected outputs 2023-24**	**Expected outputs 2024-25**	**Units**	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding
29	D2A Beds	Temporary beds to expedite hospital discharges	Residential Placements	Short term residential care (without rehabilitation or reablement input)		4	12	Number of beds/Placements	Social Care		LA			Private Sector	Local Authority Discharge
30	Homecare (D2A)	Temporary homecare packages to expedite hospital discharges	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		50864	71211	Hours of care	Social Care		LA			Private Sector	Local Authority Discharge

31	Health D2A Assessments	Temporary beds to expedite hospital discharges	Residential Placements	Short term residential care (without rehabilitation or reablement input)		37	80	Number of beds/Placements	Continuing Care		NHS			Private Sector	ICB Discharge Funding
32	GP Cover	GP cover for residents in D2A beds	Residential Placements	Other		75	107	Number of beds/Placements	Primary Care		NHS			NHS	ICB Discharge Funding
33	Medicines Management	Pharmacy cover for residents in D2A beds	Residential Placements	Other		75	107	Number of beds/Placements	Primary Care		NHS			NHS	ICB Discharge Funding
34	D2A Beds	Temporary beds to expedite hospital discharges	Residential Placements	Short term residential care (without rehabilitation or reablement input)		4	4	Number of beds/Placements	Social Care		LA			Private Sector	ICB Discharge Funding
35	D2A Beds	Temporary beds to expedite hospital discharges	Residential Placements	Short term residential care (without rehabilitation or reablement input)		30	11	Number of beds/Placements	Social Care		LA			Private Sector	Additional LA Contribution
36	1:1 hours	Cucumber Scheme	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes	1:1 hours deployed by LA to support				Social Care		LA			Private Sector	Additional LA Contribution
37	Additional Staff ing in Care Hub and Control room	Additional capacity in the care hub and control and Adnin and analytical support	Workforce recruitment and retention						Social Care		LA			Private Sector	Additional LA Contribution
38	Handy Person service	Additional capacity in the adaptations service to prevent delayed discharges.	High Impact Change Model for Managing Transfer of Care	Housing and related services					Social Care		LA			Private Sector	Additional LA Contribution
39	Training	Enhanced Training to providers and Personal Assistants	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Private Sector	Additional LA Contribution
40	Trusted Assessor	Pathway 1 including overnight care and Trusted Assessment with Homecare	High Impact Change Model for Managing Transfer of Care	Trusted Assessment	Person centred trusted assesments				Social Care		LA			Private Sector	Additional LA Contribution
41	Homecare Capacity	Enhancing capacity in homecare through the provision of transport to care	Home Care or Domiciliary Care	Domiciliary care workforce development		26000	26000	Hours of care	Social Care		LA			Private Sector	Additional LA Contribution
42	Equipment	Provision of equipment to enable single handed care.	Assistive Technologies and Equipment	Community based equipment		106	0	Number of beneficiaries	Social Care		LA			Private Sector	Additional LA Contribution
43	Support for Care Homes	to provide one off support payments to care homes to assist with market	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes					Social Care		LA			Private Sector	Additional LA Contribution

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.

15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Trafford

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	194.3	170.8	185.2	166.0	The 22/23 outturn was 687.56 against a plan of 759 - so 11% better than plan. This is the 2nd best rate in GM and significantly better than the GM average of 907 and national average of 772. As such, I have added in a modest 1% reduction for 23/24.	We are continuing to develop and improve this indicator through a range of initiatives within the locality. This will be achieved through working with system partners and commissioned providers to ensure that where possible reductions are made in avoidable admissions. The Manchester and Trafford system are also focussing on a
	Number of Admissions	487	428	464	-		
	Population	236,370	236,370	236,370	236,370		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	193.2	169.8	185.3	135.9		

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,159.1	2,067.9	2,003.0	Target for falls in over 65's for BCF 23/24. The figures for the number of falls in 21/22 and 22/23 were 939 and 936 respectively. This gave age standardised rates per 100,00 pop of 2,162 and 2,068 – roughly in line with national average of 2,100. A further reduction of 2% is factored in for 23/24 resulting from the 4 priority areas for falls	Within Trafford there are four priority areas in relation to falls: 1) Promote awareness of falls prevention to our residents and increase availability of strength and balancy activity for older people. 2) Raise awareness and provide training for health and social care staff of the importance of falls prevention, and support them in delivering evidence based
	Count	935	936	917		
	Population	41,469	41946	42394		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal	Quarter (%)	91.6%	91.5%	90.9%	91.6%	Discharge to usual place of residence 22/23 - outturn of 91.1%, just below target but .6% point improvement on 21/22 figure of 90.5%. Rise from 8th to 6th	We have strengthened our VCSE and extended it to support a 7 day discharge process for people on Pathway 0. The funding is time limited. The pathways
	Numerator	4,288	4,247	4,256	4,286		
	Denominator	4,681	4,643	4,680	4,680		

		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	91.5%	91.5%	91.5%	91.5%	in GM. Aim for 22/23 is to further improve and reach the GM average of 91.5%.	home with reablement support have been streamlined, and work undertaken on ensuring correct referrals to make best use of limited resources - these actions should improve performance in these areas. MFT are also reviewing their internal
	Numerator	4,300	4,300	4,300	4,300		
	Denominator	4,700	4,700	4,700	4,700		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	815.6	552.0	580.3	558.6	We have commissioned a new suite of service responses to enable people to be discharged home with enhanced levels of support where required. We are currently reviewing this and enhancing our low level response and identifying how we can	Reduction of long-term admission to residential care from D2A beds, is already low, and we are seeking to further reduce this through the expansion of the Rapid MDT which eanbles people to return home much more quickly. In addition, we have
	Numerator	338	234	246	240		
	Denominator	41,443	42,394	42,394	42,962		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	92.3%	92.0%	91.9%	92.0%	As a system we have continued to work across all areas to ensure that timely assessment is undertaken either within hospital or within a D2A bed. The D2A beds have had further support through the alignment of Primary care to individual	We have a number of meaures to increase independence and support people to remain at home following discharge including,; enhanced training for carers, syringe drivers for safe and dignfied end of life care, increased use of TEC, services to
	Numerator	179	219	271	275		
	Denominator	194	238	295	299		

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.