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TRAFFORD COUNCIL

AGENDA PAPERS MARKED 'TO FOLLOW' FOR

HEALTH AND WELLBEING BOARD

Date: Tuesday, 3 December 2013

Time: 7.00 pm

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

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5.	**INTEGRATION TRANSFORMATION FUND**		1 - 10
	To consider a report of the Corporate Director Children, Families and Wellbeing.		
6.	**CHANGES TO MEMBERSHIP - GREATER MANCHESTER POLICE**		To Follow
	To consider a report of the Partnerships Officer. This report will be tabled at the meeting.		
9.	**TOBACCO CONTROL**		11 - 20
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10.	**JOINT HEALTH AND WELLBEING STRATEGY ACTION PLAN UPDATE**		21 - 28
	To consider a report of the Deputy Corporate Director Children, Families and Wellbeing, Director of Service Development, Adult and Community Services.		
11.	**CLINICAL COMMISSIONING GROUP UPDATE**		29 - 52
	To receive for information a report of the Chief Clinical Officer – Designate, NHS Trafford Clinical Commissioning Group.		
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	To receive for information a report of the Chair of HealthWatch Trafford.		

THERESA GRANT
Chief Executive

Membership of the Committee

Dr. A. Vegh, B. Humphrey, M. Roe, D. Banks, Councillor Dr. K. Barclay (Chairman), Dr. N. Guest (Vice-Chairman), Councillor J. Baugh, Councillor Miss L. Blackburn, D. Brownlee, A. Day, G. Lawrence, A. Razzaq, Councillor M. Young and C.Yarwood.

Further Information
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This agenda was issued on **Thursday 28th November 2013** by the Legal and Democratic Services Section, Trafford Council, Trafford Town Hall; Talbot Road, Stretford, Manchester, M32 0TH

TRAFFORD COUNCIL

Report to: Health and Wellbeing Board
Date: 3rd December 2013
Report for: Decision
Report of: Deputy Director, Children, Families and Wellbeing

Report Title

Integration Transformation Fund

Summary

The June 2013 Spending Round announced a fund of £3.8bn nationally to ensure closer integration of health and social care services from 2015/16. The Local Government Association and NHS England published a joint statement on the 8th August 2013 about this funding known as the health and social care Integration Transformation Fund (ITF), outlining how the fund could work and next steps.

Recommendation(s)

The Health and Wellbeing Board approve the report.

Contact person for access to background papers and further information:

Name: Linda Harper
Extension: 1890

Background

1. The June 2013 Spending Round announced a fund of £3.8bn nationally to ensure closer integration of health and social care services from 2015/16. The Local Government Association and NHS England published a joint statement on the 8th August 2013 about this funding known as the health and social care Integration Transformation Fund (ITF), outlining how the fund could work and next steps.

What is the Integration Transformation Fund (ITF)

2. The Integration Transformation Fund (ITF) is "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities".

3. The intention of the ITF is to "provide an opportunity to transform care so that people are provided with better integrated care and support. It will help deal with demographic pressures in adult social care and is an opportunity to take the integration agenda forward at scale and pace – it is a catalyst for change". The ITF provides opportunity to create a shared plan for the totality of health and social care activity and expenditure that will have benefits way beyond the effective use of the mandated pooled fund.

4. The ITF will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work CCGs and local authorities are already doing, for example, as part of the integrated care "pioneers" initiative and Community Budgets, through work with the Public Service Transformation Network, and on understanding the patient / service user experience.

Details of the funding

5. The June 2013 spending review set out the following;

2014 /15 – an additional £200m transfer from the NHS to social care, in addition to the £900m transfer already planned (to enable CCG's and LA's to build momentum towards delivering the expected outcomes)

2015 /16 - £3.8 billion pooled budget to be deployed locally on health and social care through pooled budget arrangements.

6. <u>In 2015/16</u> the ITF will be created from the following:

£1.9 billion existing funding continued from 14 /15 - this money will already have been allocated across the NHS and social care to support integration	• £130 million Carers' Breaks funding • £300 million CCG reablement funding • c. £350 million capital grant funding

	(including £220m of Disabled Facilities Grant and funding for IT projects to facilitate secure sharing of patient data between NHS and local authorities) • £1.1 billion existing transfer from health to social care
Additional £1.9 billion from NHS allocations	• Funding to cover demographic pressures in adult social care and some of the costs associated with the Care Bill • £1 billion performance related, with half paid on 1 April 2015 (most likely based on performance in the previous year) and half paid in the second half of 2015 / 16 (which could be based on in-year performance)

7. As identified above, £1bn of the ITF will be dependent on performance and local areas will need to set and monitor achievement of these outcomes during 2014 / 15 as the first half of the £1bn, paid on 1st April 2015, is likely to be based on performance in the previous year. Assessment of performance is likely to be based on a combination of national and locally chosen measures.

8. It is important to note that most of this funding does not represent new money. The money to be invested in the ITF will have to be found by CCG's from budgets which will scarcely have grown from the previous year in real terms. The LGA and NHS England point out that the fund does not in itself address the financial pressures faced by local authorities and CCGs in 2015 /16, which remain very challenging. The £3.8bn pool brings together NHS and Local Government resources that are already committed to existing core activity. (The requirements of the fund are likely to significantly exceed existing pooled budget arrangements). Councils and CCGs will, therefore, have to redirect funds from these activities to shared programmes that deliver better outcomes for individuals. This calls for a new shared approach to delivering services and setting priorities, and presents Councils and CCGs, working together through their Health and Wellbeing Board, with an unprecedented opportunity to shape sustainable health and care for the foreseeable future.

Accessing the funding

9. To access the ITF each locality will be asked to develop a local plan by March 2014 covering the 2 years 2014 /15 and 2015 /16. This will need to set out how the pooled funding will be used in 2015 /16 and the ways in which the national and local targets attached to the performance-related £1 billion will be met.

10. This plan will also set out how the £200m transfer to local authorities in 2014 /15 will be used to make progress on priorities and build momentum.
11. Plans for the use of the pooled monies will need to be developed jointly by CCGs and local authorities and signed off by each of these parties and the local Health and Wellbeing Board.
12. The ITF will be a pooled budget which can be deployed locally on social care and health, subject to the following national conditions which will need to be addressed in the plans:
    - plans to be jointly agreed;
    - protection for social care services (not spending);
    - as part of agreed local plans, 7 day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends;
    - better data sharing between health and social care, based on the NHS number;
    - ensure a joint approach to assessments and care planning;
    - ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
    - risk-sharing principles and contingency plans if targets are not met and
    - agreement on the consequential impact of changes in the acute sector.

Approval of plans and timetable

13. Plans will need to be developed by local authorities and their respective CCGs, based on the joint strategic needs assessment, CCG commissioning strategies and local authority business plans. They will also need to reflect national priorities set out in the NHS Mandate and the NHS Planning Framework.
14. The intention is that local Health and Wellbeing Boards will sign off the plans ensuring that they are the best for the locality; the plans will then go through an assurance process involving NHS England to assure Ministers.
15. A broad outline timetable has been agreed for 2013/14 for developing the pooled budget plans as follows;

August to October 2013	Local planning discussions. Nationally further work to define conditions
November/December 2013	NHS Planning Framework issued
December 2013 to January 2014	Completion of local plans
February 2014	Sign off by Health and Wellbeing Boards

Next steps on implementing the ITF

16. On the 17th October 2013, further guidance was issued by the Local Government Association (LGA) and NHS England regarding next steps in implementing the ITF. This covered the following issues;
    - How the ITF will be distributed
    - How councils' and CCG's will be rewarded for meeting goals
    - Required changes to statutory frameworks
    - How should councils' and CCG's agree and develop a joint plan
    - More detail on the National Conditions.

A summary of this advice is outlined in Appendix A

Copies of all relevant documents to date and a link to further information on the LGA website are included in Appendix B.

November 19th 2013

APPENDIX A

Summary of further advice on the Integration Transformation Fund issued by LGA / NHS England on 17th October 2013.

How the ITF will be distributed

- Councils will receive their detailed funding allocation following the Autumn Statement in the normal way. When allocations are made and announced later this year, they will be two-year allocations for 2014 /15 and 2015 /16 to enable planning.
- In 2014 /15 the existing £900m s.256 transfer to Local Authorities for social care to benefit health, and the additional £200m will be distributed using the same formula as at present.
- The formula for distribution of the full £3.8bn fund in 2015/16 will be subject to ministerial decisions in the coming weeks.
- In total each Health and Wellbeing Board area will receive a notification of its share of the pooled fund for 2014 /15 and 2015 /6 based on the aggregate of these allocation mechanisms to be determined by ministers. The allocation letter will also specify the amount that is included in the pay-for-performance element, and is therefore contingent in part on planning and performance in 2014/5 and in part on achieving specified goals in 2015/6.

How councils' and CCG's will be rewarded for meeting goals

- In summary, 50% of the pay-for-performance element will be paid at the beginning of 2015/16, contingent on the Health and Wellbeing Board adopting a plan that meets the national conditions by April 2014, and on the basis of 2014 /15 performance. The remaining 50% will be paid in the second half of the year and could be based on in-year performance. LGA / NHS England are still agreeing the detail of how this will work, including for any locally agreed measures.
- In practice there is a very limited choice of national measures that can be used in 2015 / 16 because it must be possible to baseline them in 2014 /15 and therefore they need to be collected now with sufficient regularity and rigour. For simplicity we want to keep the number of measures small and, while the exact measures are still to be determined, the areas under consideration include:
    - Delayed transfers of care;
    - Emergency admissions;
    - Effectiveness of re-ablement;
    - Admissions to residential and nursing care;
    - Patient and service user experience.
- When levels of ambition are set it will be clear how much money localities will receive for different levels of performance. In the event that the agreed levels of performance are not achieved, there will be a process of peer review, facilitated by NHS England and the LGA, to avoid large financial penalties which could impact on the quality of service provided to local people. The funding will remain allocated for the benefit of local patients and residents and the arrangements for commissioning services will be reconsidered.

Required changes to statutory frameworks

- The Department of Health is considering what legislation may be necessary to establish the Integrated Transformation Fund, including arrangements to create the pooled budgets and the payment for performance framework. Government officials are exploring options for laying any required legislation in the Care Bill. Further details will be made available in due course.

How should councils' and CCG's agree and develop a joint plan

- To assist Health and Wellbeing Boards LGA / NHS England have developed a draft template which they expect everyone to use in developing, agreeing and publishing their integration plan. This is attached as a separate Excel spread sheet.
- The template sets out the key information and metrics that all Health and Wellbeing Boards will need to assure themselves that the plan addresses the conditions of the ITF. We strongly encourage Councils and CCGs to make immediate use of this template while awaiting further guidance on NHS planning and financial allocations.

- Local areas will be asked to provide an agreed shared risk register, with agreed risk sharing and mitigation covering, as a minimum, steps that will be taken if activity volumes do not change as planned. For example, if emergency admissions or nursing home admissions increase.

More detail on the National Conditions.

National Condition	Definition
Plans to be jointly agreed	The Integration Plan covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Well Being Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and Local Authorities should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.
Protection for social care services (not spending)	Local areas must include an explanation of how local social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with the 2012 Department of Health guidance on transfer of funds from NHS to social care.
As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends	Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The forthcoming national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England will provide guidance on establishing effective 7-day

	services within existing resources.
Better data sharing between health and social care, based on the NHS number	The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. Local areas will be asked to: □ confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to; □ confirm that they are pursuing open APIs (i.e. systems that speak to each other); and □ ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place. NHS England has already produced guidance that relates to both of these areas, and will make this available alongside the planning template. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health).
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Local areas will be asked to identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning.
Agreement on the consequential impact of changes in the acute sector	Local areas will be asked to identify, provider-by-provider, what the impact will be in their local area. Assurance will also be sought on public and patient engagement in this planning, as well as plans for political buy-in.

How will preparation and plans be assured?

- A shared approach to supporting local areas and assuring plans will be developed. This process will be aligned as closely as possible to the existing NHS planning rounds, and CCGs can work with their Area Teams to develop their ITF plans alongside their other planning requirements.
- LGA / NHS England will establish in each region a lead local authority Chief Executive who will work with the Area and Regional Teams, Councils, ADASS branches, DPHs and other interested parties to identify how Health and Wellbeing Boards can support one another and work collaboratively to develop good local plans and delivery arrangements.
- Where issues are identified, these will be shared locally for resolution and also nationally through the Health Transformation Task Group hosted by LGA, so that the national partners can broker advice, guidance and support to local Health and Well Being Boards, and link the ITF planning to other national programmes including the Health and Care Integration Pioneers and the Health and Well Being Board Peer Challenge programme. LGA / NHS England will have a first review of readiness in early November 2013.
- LGA / NHS England will ask Health and Well Being Boards to return the completed planning template by 15 February 2014, so that they can aggregate them to provide a composite report, and identify any areas where it has proved challenging to agree plans for the ITF.

APPENDIX B

Relevant Documents / Links

Original Statement on the ITF from LGA / NHS England (8th August 2013)	Statement on ITF (Aug 13).pdf
Next Steps on implementing ITF (LGA / NHS England 17th October 2013)	Next Steps on ITF (Oct 13).pdf
Draft planning template	ITF Draft plan template (Nov 13).xls
Kings Fund article on ITF (31st October 2013)	ITF Kings Fund article (31st October

Link to ITF information on LGA website	http://www.local.gov.uk/home/-/journal_content/56/10180/4096799/ARTICLE

TRAFFORD COUNCIL

Report to: Health and Wellbeing Board
Date: 3rd December 2013
Report for: Decision
Report of: Director of Public Health

Report Title

Local Government Declaration on Tobacco Control

Summary

Smoking is the single greatest cause of premature death and disease in Trafford, and the single largest factor in health inequalities. It is also a major driver of poverty. The move of public health to local government presents an opportunity for local authorities to lead local action to tackle smoking, and to ensure that the tobacco industry is not able to influence local tobacco control policy.

Recommendation(s)

The Health and Wellbeing Board approve the report.

Contact person for access to background papers and further information:

Name: Abdul Razzaq, Director of Public Health
Extension: 0161 873 9692

1. Summary

Smoking is the single greatest cause of premature death and disease in Trafford, and the single largest factor in health inequalities. It is also a major driver of poverty. The move of public health to local government presents an opportunity for local authorities to lead local action to tackle smoking, and to ensure that the tobacco industry is not able to influence local tobacco control policy.

The council provides good services towards reducing smoking prevalence, including:

- Social marketing campaigns such as Stoptober; Smokefree Homes;
- Stop smoking support that is easily accessible through commissioned smoking cessation services;
- Campaigns about illegal tobacco and shisha smoking.

2. Issues for consideration / Recommendations

The Health and Well Being Board is asked to consider the Local Government Declaration on Tobacco Control and to recommend its adoption with an amendment on 'future' commercial and vested interests'.

3. Background

3.1 **The Impact of Smoking.** Every year in England more than 80,000 people die from smoking related diseases. This is more than the combined total of the next six causes of preventable deaths, including alcohol and drugs misuse. Smoking accounts for one third of all deaths from respiratory disease, over one quarter of all deaths from cancer, and about one seventh of all deaths from heart disease. On average a smoker loses 10 years of life. The earlier you quit, the less life you lose.

3.2 **Reducing smoking in our communities significantly increases household incomes and benefits the local economy.** The annual cost of smoking to the UK national economy has been estimated at £13.7 billion. A smoker consuming a pack of twenty cigarettes a day will spend around £2,500 a year on their habit. Based on 2009 prices, poorer smokers proportionately spend five times as much of their weekly household budget on smoking than do richer smokers. If poorer smokers quit they are more likely to spend the money they save in their local communities.

3.3 **Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities.** About half of all smokers in England work in routine and manual occupations. Workers in manual and routine jobs are twice as likely to smoke as those in managerial and professional roles. The poorer and more disadvantaged you are, the more likely you are to smoke and as a result to suffer smoking-related disease. Ill-health caused by smoking is therefore much more common amongst the poorest and most disadvantaged in society**.**

3.4 **Smoking is an addiction largely taken up by children and young people** Two thirds of smokers start before the age of 18, and across the UK more than 200,000 children aged between 11 and 15 start to smoke every year, even though it is illegal to sell cigarettes to anyone below the age of 18. Two thirds of smokers say they began before they were legally old enough to buy cigarettes. Research shows that by the age of 20, four fifths of smokers regret they ever started. Growing up around smoke puts children at a major health disadvantage in life. Children exposed to tobacco smoke are at much greater risk of cot death, meningitis, lung infections and ear disease, resulting in around 10,000 hospital admissions each year.

3.5 **Smoking is an epidemic created and sustained by the tobacco industry.**
The tobacco industry (outside China) is dominated by four multinationals, Japan Tobacco International and Imperial Tobacco (which together account for 85% of the UK market), British American Tobacco and Philip Morris International. These firms are some of the most profitable in the world: the global tobacco market is worth about £450 billion a year.

The tobacco industry needs to recruit 200,000 smokers a year in the UK to maintain current levels of consumption, replacing those smokers who have quit or who have died from diseases related to their addiction. The great majority of these new smokers will be under 18 years old. Although tobacco advertising is now banned in the UK, the tobacco multinationals use packaging of their products to try to attract young people in general, with specific brands aimed at target groups such as young women.

3.6 **The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco.** HM Revenue and Customs estimate that in 2010/11, the illicit market in cigarettes accounted for about 9% of the UK market, and the illicit market in hand-rolled tobacco accounted for about 38% of the UK market. The total amount of revenue lost to the Exchequer was estimated at £1.20 billion for cigarettes and £0.66 billion for hand-rolled tobacco. (All figures are mid-range estimates).

4. Framework Convention on Tobacco Control

The Framework Convention on Tobacco Control (FCTC) is the world's first public health treaty, negotiated through the World Health Organisation. It has been ratified by more than 170 countries, including the UK. Key provisions include support for: price and tax measures to reduce the demand for tobacco products; public protection from exposure to tobacco smoke; regulation of the contents of tobacco products; controlling tobacco advertising, promotion and sponsorship; measures to reduce tobacco dependence and promote cessation; tackle llicit trade in tobacco products; and end sales to children. Article 5.3 commits Parties to protecting their public health policies from the commercial and vested interests of the tobacco industry and the UK has explicitly committed to live up to this obligation in chapter 10 of the Tobacco Control Plan for England.

It is also necessary to protect local policy from the tobacco industry.

Under the World Health Organisation Framework Convention on Tobacco Control, countries have pledged to protect health policy from the commercial interests of the tobacco industry. Local authorities are also subject to this treaty, but policies on how to ensure local compliance are rare. By signing the Declaration councils are reinforcing their existing obligations and sending a message that they will protect policies from tobacco industry lobbying.

5. Local Government Declaration on Tobacco Control

The Local Government Declaration on Tobacco Control (Appendix A) is a response to the enormous and ongoing damage smoking does to our communities. It is a commitment to take action and a statement about a local authority's dedication to protecting local communities from the harm caused by smoking.

Further, it is an opportunity for local leadership. The best way to tackle smoking is through a comprehensive approach working with all partners. The Local Government Declaration on Tobacco Control can be a catalyst for local action showing the way for partners both inside and outside the local councils.

There is strong cross party consensus on tobacco control with every major party signed up to a comprehensive approach to reduce smoking. Everything contained in the Declaration has previously been committed to at a national level by all political parties. The Declaration is also strongly supported by the wider public health community including The Trading

Standards Association, Chartered Institute of Environmental Health and the Association of Directors of Public Health as well as Public Health England, the Public Health Minister and the Chief Medical Officer.

6. Implications

Councils which sign up to the Declaration are committing to taking action on smoking, and will develop plans in partnership to reduce smoking prevalence, monitor progress and publish the results. They will also need to ensure that the tobacco industry is not able to exert direct or indirect tobacco company influence through lobbying or other means.

In particular the Council is committing to:

- Act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Develop plans with our partners and local communities to address the causes and impacts of tobacco use, according to our local priorities and securing maximum benefit for our communities;
- Participate in local and regional networks for support; and
- Monitor the progress of local tobacco plans against our commitments and publish the results.

7. Recommendation

The Health and Well Being Board is recommended to endorse the Local Government Declaration on Tobacco Control (as at Appendix 1).

Appendix 1: Local Government Declaration on Tobacco Control – Trafford Council

We acknowledge that:

- Smoking is the single greatest cause of premature our communities;
- Reducing smoking in our communities significantly increases household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely taken up by children and young people, two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the 80,000 people its products kill in England every year; and
- The illicit trade in tobacco funds the activities of organised criminal gangs death and disease in and gives children access to cheap tobacco.

As local leaders in public health we welcome the:

- Opportunity for local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;
- Commitment by the government to live up to its obligations as a party to the World Health Organization's Framework Convention on Tobacco Control (FCTC) and in particular to protect the development of public health policy from the vested interests of the tobacco industry; and;
- Endorsement of this declaration by the Department of Health, Public Health England and professional bodies.

We commit our Council from this date …….. to:

- Act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Develop plans with our partners and local communities to address the causes and impacts of tobacco use;
- Participate in local and regional networks for support;
- Support the government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities;
- Protect our tobacco control work **from future** commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- Monitor the progress of our plans against our commitments and publish the results; and
- Publicly declare our commitment to reducing smoking in our communities by joining the Smokefree Action Coalition, the alliance of organisations working to reduce the harm caused by tobacco.

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Signatories

Leader of Council **Chief Executive** **Director of Public Health**

[Signatures to be inserted]

Appendix 2: Local Government Declaration on Tobacco Control: Briefing Note

(Text in bold is taken from the Declaration)

Smoking is the single greatest cause of premature death and disease in our communities

Every year in England more than 80,000 people die from smoking related diseases. This is more than the combined total of the next six causes of preventable deaths, including alcohol and drugs misuse. Smoking accounts for one third of all deaths from respiratory disease, over one quarter of all deaths from cancer, and about one seventh of all deaths from heart disease. On average a smoker loses 10 years of life. The earlier you quit, the less life you lose.[1]

Supporting information and resources on smoking and tobacco control, by English region and down to local authority level, for use by Councillors, officers and local decision-makers, can be found at **www.ash.org.uk/localtoolkit.**

Information on the burden of illness and disease caused by smoking, for each local authority in England, can be found at **http://www.tobaccoprofiles.info/tobacco-control**

Reducing smoking in our communities significantly increases household incomes and benefits the local economy

The annual cost of smoking to the UK national economy has been estimated at £13.7 billion. A smoker consuming a pack of twenty cigarettes a day will spend around £2,500 a year on their habit. Based on 2009 prices, poorer smokers proportionately spend five times as much of their weekly household budget on smoking than do richer smokers. If poorer smokers quit they are more likely to spend the money they save in their local communities. [2]

Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities

About half of all smokers in England work in routine and manual occupations. Workers in manual and routine jobs are twice as likely to smoke as those in managerial and professional roles. The poorer and more disadvantaged you are, the more likely you are to smoke and as a result to suffer smoking-related disease. Ill-health caused by smoking is therefore much more common amongst the poorest and most disadvantaged in society**.** Smoking rates are also higher among particular ethnic groups, the prevalence rate among Afro-Caribbean men is 37% and among Bangladeshi men it is 36%. [3]

Smoking is an addiction largely taken up by children and young people

Two thirds of smokers start before the age of 18, and across the UK more than 200,000 children aged between 11 and 15 start to smoke every year, even though it is illegal to sell cigarettes to anyone below the age of 18. Two thirds of smokers say they began before they were legally old enough to buy cigarettes. [4] Research shows that by the age of 20, four fifths of smokers regret they ever started. Growing up around smoke puts children at a major health disadvantage in life. Children exposed to tobacco smoke are at much greater risk of cot death, meningitis, lung infections and ear disease, resulting in around 10,000 hospital admissions each year. [5]

1 ASH, *Facts at a Glance*, http://www.ash.org.uk/files/documents/ASH_93.pdf (Accessed 11th April 2013)

2 ASH, *The Economics of Tobacco*, http://www.ash.org.uk/files/documents/ASH_121.pdf (Accessed 11th April 2013)

3 ASH, *Smoking Statistics Who Smokes and How Much*, http://www.ash.org.uk/files/documents/ASH_106.pdf (Accessed 11th April 2013)

4 Office for National Statistics, *General Lifestyle Survey 2011, Chapter 1 Smoking*, http://www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2011/rpt-chapter-1.html (Accessed 11th April 2013)

5 *Smoking: Children*, http://www.ash.org.uk/localtoolkit/docs/cllr-briefings/Children.pdf (Accessed 11th April 2013)

Smoking is an epidemic created and sustained by the tobacco industry

The tobacco industry (outside China) is dominated by four multinationals, Japan Tobacco International and Imperial Tobacco (which together account for 85% of the UK market), British American Tobacco and Philip Morris International. These firms are some of the most profitable in the world: the global tobacco market is worth about £450 billion a year. Between 2006 and 2011 Imperial Tobacco increased its UK operating margins from 62% to 67%. [6]

The tobacco industry needs to recruit 200,000 smokers a year to maintain current levels of consumption, replacing those smokers who have quit or who have died from diseases related to their addiction. The great majority of these new smokers will be under 18 years old. Although tobacco advertising is now banned in the UK, the tobacco multinationals use packaging of their products to try to attract young people in general, with specific brands aimed at target groups such as young women. [7]

The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco

HM Revenue and Customs estimate that in 2010/11, the illicit market in cigarettes accounted for about 9% of the UK market, and the illicit market in hand-rolled tobacco accounted for about 38% of the UK market. The total amount of revenue lost to the Exchequer was estimated at £1.20 billion for cigarettes and £0.66 billion for hand-rolled tobacco. (All figures are mid-range estimates).

Recent research in the North of England showed that over half of smokers aged 14 to 17 have been offered illicit tobacco, and that buying rates amongst these age groups are higher than amongst older smokers.

Local authorities are key players in tackling the illicit trade, through trading standards departments and through their local partnerships with police, customs and health professionals. Regional partnerships to tackle illicit tobacco include the North of England Tackling Illicit Tobacco for Better Health Programme, the South of England Partnership and the East of England Partnership. [8]

As local leaders in public health we welcome the:

Opportunity for local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;

As you will know from 1st April 2013, the public health function has been transferred from the National Health Service to local authorities. Each top tier and unitary authority has its own health and wellbeing board and a Director of Public Health, and these local authorities are responsible for commissioning stop smoking and other relevant services. [9]

Commitment by the government to live up to its obligations as a party to the World Health organization's framework convention on Tobacco control (FCTC) and in particular to protect the development of public health policy from the vested interests of the tobacco industry;

The Framework Convention on Tobacco Control (FCTC) [10] is the world's first public health treaty, negotiated through the World Health Organisation. It has been ratified by more than 170 countries,

6 ASH, *The UK Tobacco Industry*, http://ash.org.uk/files/documents/ASH_123.pdf (Accessed 11th April 2013)

7 Plain Packs Protect Campaign, *Smoking Facts for Kids*, http://www.plainpacksprotect.co.uk/plain-packaging-children-teenager-smoking-facts-infographic.aspx (Accessed 11th April 2013)

8 All Party Parliamentary Group on Smoking and Health, *Report on the Illicit Trade in Tobacco Products*, http://www.ash.org.uk/APPGillicit2013 (Accessed 11th April 2013)

9 Department of Health, *A Short Guide to Health and Wellbeing Boards*, http://healthandcare.dh.gov.uk/hwb-guide/ (Accessed 11th April 2013)

10 World Health Organisation, ***Framework Convention on Tobacco Control***, http://www.who.int/tobacco/framework/WHO_FCTC_english.pdf (Accessed 11th April 2013)

including the UK. Key provisions include support for: price and tax measures to reduce the demand for tobacco products; public protection from exposure to tobacco smoke; regulation of the contents of tobacco products; controlling tobacco advertising, promotion and sponsorship; measures to reduce tobacco dependence and promote cessation; tackle Ilicit trade in tobacco products; and end sales to children. Article 5.3 commits Parties to protecting their public health policies from the commercial and vested interests of the tobacco industry and the UK has explicitly committed to live up to this obligation in chapter 10 of the Tobacco Control Plan for England.[13]

We commit our Council to …

Act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;

Develop plans with our partners and local communities to address the causes and impacts of tobacco use, according to our local priorities and securing maximum benefit for our communities;

Participate in local and regional networks for support; and

Monitor the progress of our plans against our commitments and publish the results.

It is for local authorities to decide on their priorities. The CLeaR model developed by ASH in partnership with the regional offices of tobacco control, CIEH and the TSI amongst others, provides a structured process for building a local tobacco plan. http://www.ash.org.uk/CLeaR
More information can be obtained from Hazel Cheeseman at ASH hazel.cheeseman@ash.org.uk

Any Council wishing to take a systematic approach to tobacco control will of course need to monitor and measure progress against agreed plans, and it is strongly recommended that this be done through publicly accessible reports, discussed and agreed in a public forum.

Join the Smokefree Action Coalition (SFAC)

The Smokefree Action Coalition is an alliance of over 100 organisations including medical royal colleges, the British Medical Association, the Trading Standards Institute, the Chartered Institute of Environmental Health, the Faculty of Public Health, the Association of Directors of Public Health and ASH. The Coalition was created during the successful campaign for legislation ending smoking in enclosed public places (Health Act 2006), and has also engaged with Government on a wide range of tobacco control issues, including the introduction of standardised ("plain") packaging for tobacco products. [11] More information about the Coalition and how to join can be obtained from Hazel Cheeseman at ASH, which provides the secretariat for the SFAC. Email: hazel.cheeseman@ash.org.uk

Protect our tobacco control strategies from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees

Article 5.3 of the FCTC states that: *"in setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law"*. WHO guidelines on implementing Article 5.3, which were also supported by the UK Government, state that the obligations under this Article apply *"to government officials, representatives and employees of any national, state, provincial, municipal, local or other public or semi/quasi-public institution or body*

11 Smokefree Action Coalition, http://www.smokefreeaction.org.uk/ (Accessed 11th April 2013)

within the jurisdiction of a Party, and to any person acting on their behalf". They also recommend that public bodies covered by Article 5.3. should introduce *"measures to limit interactions with the tobacco industry and ensure the transparency of those interactions that occur; reject partnerships and non-binding or non-enforceable agreements with the tobacco industry; and avoid conflicts of interest for government officials and employees".* [12]

The Declaration does not contain specific commitments in relation to Councils' pension fund investments in the tobacco industry. Councils may wish to review these investments and may conclude that the tobacco industry is not an appropriate investment. Decisions of this kind must be made by trustees on advice and in accordance with their legal duties.

Support the government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities;

"Healthy Lives, Healthy People: A Tobacco Control Plan for England" was published by the Department of Health in 2011. It included commitments to implement legislation to end tobacco displays in shops; consult on "plain" (standardised packaging of tobacco products; use tax to maintain the high price of tobacco products to cut smoking prevalence; promote effective local enforcement of tobacco legislation, particularly on the age of sale of tobacco; encourage more smokers to quit through local stop smoking services; and publish a 3-year marketing strategy for tobacco control. [13] The Government has consulted on standardised packaging and is awaiting further evidence before future implementation.

12 World Health Organisation, *Guidelines for implementation of Article 5.3 of the WHO Framework Convention on Tobacco Control*, http://www.who.int/fctc/guidelines/article_5_3.pdf (Accessed 11th April 2013)

13 Department of Health, *Tobacco Control Plan for England* (2011), https://www.gov.uk/government/publications/the-tobacco-control-plan-for-england (Accessed 11th April 2013)

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TRAFFORD COUNCIL

Report to: **Health & Wellbeing Board**
Date: **3rd December 2013**
Report for: **Information**
Report of: **Health and Wellbeing Manager**

Report Title

Update regarding the progress of the Health and Wellbeing Action Plan.

Summary

- This paper is to update the Health and Wellbeing Board (HWBB) on the development of the Joint Health and Wellbeing Action Plan Framework and present a final version for sign off. This paper also presents the progress of the Health and Wellbeing communications and engagement plan, our current position and recommendations.
- Communications and Engagement Summary document is also attached

Recommendations

- Seek approval and consult the Health and Wellbeing Board regarding the progress of the Action Plan Framework and provide reassurance that key priorities reflected in the action plan are progressed via the new Health and Wellbeing Programme Delivery Board.
- Ensure key priorities reflected in the action plan framework are developed in a timely manner.
- That the Health and Wellbeing Board approves the draft Joint Communications and Engagement Plan Summary document.

Contact person for access to background papers and further information:

Name: Helen Darlington. Health and Wellbeing Manager
Extension: 0161 912 1220

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1.0 Background

The Health and Wellbeing Strategy Communication and Engagement Plan was presented to the Health and Wellbeing board on the 1st October, since then it has been updated and developed into a Health and Wellbeing Board Communication and Engagement Strategy and Action Plan, with the key dates for activities identified now added in as requested by the Joint Strategic Commissioning Group.

Communication/Engagement of Health and Wellbeing Strategy presentation and Action Plan Framework has been shown at SLT, Cllr Young/ Barclay, CMT, HWBB, CCG Board, Partnerships and performance team, Ageing well Partnership, TLAP, Home care, Information and Advice away day. Trafford Housing Trust, including providers, West Locality partnership inject, Homecare Service Improvement Partnership, IOM (Offender Health). Trafford Cultural Partnership, Dementia Strategy Group and the Health and Wellbeing Delivery Programme Board.

2.0 Establishment of the Health and Wellbeing Delivery Programme Board.

The Health and Wellbeing Action plan group had been disestablished and a new Health and Wellbeing Delivery Programme Board has been developed.

The Delivery Programme Board aims to include partners that support the wider determinants of health that are reflected in the green colour coded sections of the action plan, e.g. Greater Manchester Police and Trafford Housing Trust). Some mirror the new provider organisations that have become new members on the Health and Wellbeing Board (e.g. Pennine Care NHS Foundation Trust and Greater Manchester West Mental Health NHS Foundation Trust).

The embedded diagram illustrates the organisational membership of the Delivery Programme Board.

Health and Wellbeing Delivery Programme E

New Terms of Reference have been produced in consultation with the Delivery Programme Board that include members positions. Key responsibilities of the Programme Board are included in the TOR, including the production of a summary/easy read action plan that focuses on collaboration and integration and the Monitoring Framework. The first introductory meeting took place on 1st November 2013.

TOR REDRAFT (Post mtg).doc

3.0 Structure/governance.

The governance structures of the Delivery Board were discussed at the introductory meeting and this structure chart illustrates the eight priority areas and leads.

Stucture Chart HWBDPB.doc

4.0 Progress

- Communication and Engagement: Children, Families and Wellbeing newsletter: Regular (Monthly) articles are in this newsletter including HWBS update position and New Year, New You.

HWB Strategy Communications Sept

- Members/Director/Staff/Partnership Briefing reports are written to update on progress, e.g. The Warehouse Project. Co-branded Website set up regarding Drugs/Alcohol/Health/Safety. Report submitted is available on request. Other programmes of work are being progresses e.g. Alcohol awareness week in November.

- Additional actions added to priority 7 via the Dementia Strategy group and other strategies are being developed to evolve and align to the Health and Wellbeing Strategy and Action Plan Framework, e.g. Tobacco Control Strategy.

- North West Joint Health and Wellbeing Strategy Leads workshop, 11/11/13 Widnes. Discussion regarding development of Trafford Monitoring Framework and gathering qualitative intelligence about outcomes. Written request regarding how Trafford are developing these ideas requested by Policy Lead, Strategic Intelligence and Planning (JSNA and JHWS).

5.0 Recommendations

- Seek approval and consult the Health and Wellbeing Board regarding the progress of the Action Plan Framework and provide reassurance that key priorities reflected in the action plan are progressed via the newly developed Health and Wellbeing Programme Delivery Board.

- Ensure key priorities reflected in the action plan framework are developed in a timely manner.

- That the Health and Wellbeing Board approves the draft Joint Communications and Engagement Plan Summary document

Priority	Lead Officer	Big Idea	Actions	Short term Action	Completion date	Milestone	Outcomes	Key Measures	Timescale	Governance / Partnership (Partners Involved) Monitoring Board.	Proposed Outcome Champions
1. Reduce Childhood Obesity	**Lisa Davies**	We will maintain or increase the number of children who are a healthy weight, through the provision of a range of healthy weight interventions and the promotion of physical activity and healthy eating.	Increase the number of primary schools participating in FFL in the four localities with particular focus on schools with high levels of obesity	Apr-14		Apr-14	Reduce levels of year 6 childhood obesity in Trafford and in areas where currently childhood obesity levels are high.	PHOF 2.2 Breastfeeding PHOF 2.6 Excess weight in 4 - 5 and 10 - 11 year olds	Mar-16	**Maternity and Child Health Advisory Forum Joint commissioning Managements Board (Children and Young People) Children's Trust Board**	**Deborah Brownlee**
			Agree a collaborative programme of activity for childhood obesity including healthy eating and physical activity across all agencies in Trafford using the life course approach								
			Support new mothers to breastfeed by using universal services, peer support groups and targeted follow up								
			Work with planners, local food outlets and other agencies to ensure healthy food is available and promoted, and that allotments and green spaces are utilised and developed								
			The LARCO (Locality Approach to Reducing Childhood Obesity) project will fund local groups in three areas of Trafford to provide innovative activities for primary age pupils around physical activity and healthy eating								
2. Improve the emotional Health and wellbeing of children and young people	**Jill Colbert**	Trafford will support children and families with emotional health issues to access the most appropriate services quickly and easily.	Work as a partnership to develop a single point of access (SPA) for emotional health services to provide a clear and easy to access system			Sep-14	Improved emotional Health and wellbeing of children and young people	PHOF 2.8 Emotional well-being of looked after children PHOF 2.10 Self-harm	Mar-16	**Emotional Health and Wellbeing Advisory Forum** **Joint Commissioning Management Board (Children and Young People) Children's trust board** **Children's Trust Board**	**Deborah Brownlee**
			Ensure voluntary and community sector providers are engaged with the SPA								
			Engage schools in developing the SPA as key supporters of children with emotional health issues								
			Develop clear communications and publicity to ensure that all relevant services, as well as the young people and families, understand how to access the SPA								
			Deliver targeted (National Institute Health and Care Excellence) behaviour change evidence based interventions for parents of 0-5 year olds								
			Work with schools to coordinate mental health services and promote emotional health for children and young people	Jan-14							
			A partnership task and finish group will work together to ensure that all services locally are evidence based (NICE) and of a high quality								
3. Reduce alcohol and substance misuse and alcohol related harm	**Mark Grimes**	We will reduce the harm alcohol and substance misuse inflicts.	Work collaboratively with partners to ensure messages relating to drugs/alcohol are promoted across the borough at events such as the Warehouse project	1st Phase Oct 12th 2013		Apr-14	Reduced alcohol and substance misuse and alcohol related harm	PHOF 2.18 Alcohol-related admissions to hospital PHOF 2.15 Successful completion of drug treatment. PHOF 2.16 People entering prison with substance dependence issues who are previously not known to community treatment PHOF 1.11 Domestic abuse PHOF 4.6 Under 75 mortality rate from liver disease* (NHSOF 1.3)	Mar-16	**Safer Trafford Partnership: Joint work with police, linking with the police crime commissioner and joint working on alcohol related harm**	**Gina Lawrence / Deborah Brownlee/ Mark Roberts**
			Implement the RAID model within Trafford to reduce the demand on A & E caused by frequent flyers								
			Ensure those with alcohol/drug misuse issues who are committing crime are subject to ATR or DRR to encourage them to address their addiction								
			Refresh alcohol strategy for Trafford and action plan	Nov-13							
			Deliver a programme of events in Trafford for alcohol Awareness week in November 2013 "Hair of the Dog"	Nov-13							
			Review and revise as necessary the care pathway for GPs to ensure early identification support people with alcohol problems - in line with national best practice Map of Medicine guidelines								
4. Support People with Long term health & Disability Needs to live healthier lives	**Julie Crossley**	We will deliver a transformational universal model of integrated care and support with people who have a range of long term conditions and disabilities, based on coproduction.	Commission a patient coordinated care hub in Trafford			Mar-16	We will build on this evidence based approach to commissioning. 1. Proactive and coordinated care seamlessly around the patient 2. Delivery of the right care and the right time in the right place 3. Can equate an appropriate level of care to care site. Best possible patient experience Greater focus on local issues i.e. health appointments and transport in Partington 4. Proactive Care Planning to maximise Self-Management Approaches 5. Multi-agency Training and Service Development Programmes	PHOF 4.3 Mortality rate from causes considered preventable** (NHSOF 1a) PHOF 1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services *(i-NHSOF 2.2) ††(ii-ASCOF 1E) **(iii-NHSOF 2.5) †† (iii-ASCOF 1F) Learning Disability Joint Health and Social Assessment Framework Outcomes	Mar-16	**Commissioning and Operations Steering Group**	**Gina Lawrence**
			For all provider organizations to develop single access point for all patients								
			Develop a hub and spoke model of information and advice services with partners, linked to locality working by March 2015.			March 2015					
			Increase the number of people in receipt of a personal budget to further promote choice and control by 10% by March 2014			March 2014					
			Increase the number of people in receipt of Telecare, to promote independence and resilience linked to the Trafford Telecare Pledge.	Mar-14							
			Implement the Winterbourne View Response Actions Plans and deliver on the identified areas for improvement in the Winterbourne submission stocktake	Mar-14							
			Deliver the Learning Disabilities Service Improvement Programme, including the Winterbourne View Response Action Plans	Mar-14							
			Deliver the Trafford Autism Strategy Delivery Plan	Mar-14							

5. Increase Physical Activity	**Helen Darlington/ Daniel Newall**	More People, More Active, More Often.	Ensure that strategic planning processes contribute to creating a local environment, including facilities for outdoor recreation, physical activity and play that supports an active lifestyle.			Apr-14	Increase numbers of people in Trafford physically active.	PHOF 2.13 Proportion of physically active and inactive adults PHOF 1.16 Utilisation of outdoor space for exercise/health reasons PHOF 2.12 Excess weight in adults Sport England Active People Survey	Mar-16	**The Trafford Strategic Sport and Physical Activity Partnership**	**Wendy Marsden**
			Work in partnership to increase participation levels and offer GP Referral pathways to progression.								
			We will identify gaps in provision and target interventions where they are most needed, e.g. women and girls', ethnic minority communities and young people between the ages of 14 - 24								
			Develop and extend/promote the Active Trafford and Junior Active Trafford Scheme to communities in most need.								
			Evaluate, then develop and expand/innovate the Healthy Hips and Hearts older peoples exercise programme throughout Trafford working with physiotherapists and Occupational Therapies and Housing.		Completed evaluation Sept 2013						
6. Reduce the number of early deaths from cardiovascular disease and cancer	**Abdul Razzaq/Julie Crossley**	Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)	Commission work to understand what lifestyle interventions will have the biggest impact on CVD/cancer in disadvantaged communities based on National Institute of Health and Care Excellence Public Health Draft			Apr-14	1) Patients with CVD will be better equipped to manage outcomes. 2) Patients at risk of CVD/Cancer will have information to reduce their chance of developing these conditions. 3) Clinicians in Primary care will have increased skills and knowledge to enable better management of patients. 4) Move towards reduced mortality rates from CVD/Cancer in disadvantaged communities reducing the between least deprived/most deprived areas	PHOF 4.5 Under 75 mortality rate from cancer* (NHSOF 1.4, 1.4i - 1.4iv) PHOF 4.7 Under 75 mortality rate from respiratory diseases* (NHSOF 1.2) 2.14Smoking prevalence – adults (over 18s) PHOF 2.22 Take up of the NHS Health Check programme – by those eligible PHOF 2.21 Access to non-cancer screening programmes 2.19 Cancer diagnosed at stage 1 and 2 2.20 Cancer screening coverage	Mar-16	**Commissioning and Operations Steering Group**	**Gina Lawence/Deborah Brownlee**
			Deliver NHS Health Checks programme and consider extending the programme (e.g. out of hours, non clinical venues) targeting disadvantaged communities	Jan-14							
			Design and implement a patient education programme for CVD and cancer awareness targeted at disadvantaged communities								
			Design and implement a clinical education programme in Primary Care								
			Develop and deliver primary care cancer & CVD strategies across whole population								
7. Support people with enduring mental health needs, including dementia to live healthier lives.	**Ric Taylor**	We will commission streamlined services which are joined up and have the person at the heart of what we do.	Review and refresh the council section 75 Partnership agreement with Greater Manchester West to further Transform the model of support based on personalisation, choice and control.	Jan-14		Apr-14	• Equitability of access for individuals referred • Clarity for referrers • Improved response times for assessment and treatment • Consistency of response • Reduction of multiple assessments • Promoting understanding of resources • Standardised information for service users • Increased service quality and efficiency.	PHOF 4.9 Excess under 75 mortality rate in adults with serious mental illness*(NHSOF 1.5) PHOF 4.10 Suicide rate PHOF 4.16 Estimated diagnosis rate for people with dementia* (NHSOF 2.6i) Standard mental Health Measures contained with in Everyone Counts	Mar-16	**Trafford CCG Quality Finance & Performance/Dementia Strategy Group.**	**Gina Lawrence / Deborah Brownlee**
			To facilitate the development of an integrated service model with shared performance indicators across the health and social care economy, following a partnership review of current spend and activity.								
			To review in partnership, all existing all-age mental health services								
			Deliver the Improving Access to Psychological Therapies Service Improvement Programme								
			Deliver the Trafford Dementia Kite mark for residential care and homecare services across the Borough.	Dec-13							
			Proposed: Develop Intergenerational work regarding Dementia to Principles: 5 Ways of Wellbeing. Connect, Be Active, Take Notice, Learn a new skill, Give . To link to the Trafford Dementia Kitemark.	*Develop principles Jan 2014*							
8. Reduce the occurrence of common mental health problems amongst adults	**Ric Taylor / Helen Darlington**	Developing workplace health by supporting Trafford employers to prevents/intervene early and support those experiencing common mental health problems.	We will work to deliver improved mental health in working aged adults through new and innovative Workplace Health programmes specifically through 'Healthy Workplaces' and 'Fit For Work' services. Therefore, we will develop the mental health in the workplace training for businesses and organisations including GMP and other support agencies.			Apr-14	Mental health is more than the absence of mental illness. It encompasses a state of wellbeing in which the individual realises his or her abilities and can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual wellbeing and the effective functioning of a community. The burden of poor mental health and mental illness in Trafford is substantial. Mental illness is consistently associated with deprivation, low income, unemployment, poor education, poorer physical health and increased health-risk behaviour. In addition there is a clear link between mental health	PHOF 2.23 Self-reported well-being PHOF 1.7 People in prison who have a mental illness or a significant mental illness PHOF 1.18 Social isolation (ASCOF 1I) Relevant CAMHS data - particularly wellbeing / IAPT measures	Mar-16	**Joint Strategic Commissioning Group. Proposed: Wellbeing Partnership.**	**Gina Lawrence / Deborah Brownlee**
			We will implement targeted, mental health and wellbeing programmes across Trafford that will then develop to inform evidence led commissioning. We will work with partner such as Trafford Housing Trust to address the wider determinants of health and wellbeing.								
			We will work across boundaries to develop and deliver a new 2014 Salford Bolton and Trafford Suicide Prevention Strategy Targeted approach to men	Jan-14							
			We will promote mental resilience and reduce the burden of mental illness through awareness raising programmes including interventions such as 'books on prescription' and through campaigns to reduce stigma relating to mental illness.								
			We will work with key stakeholders to address wider health inequalities and social determinants of health e.g. housing, social exclusion and income inequality and we will develop plans to mitigate the potentially negative impact of benefit changes and other economic changes linked to the economic downturn.								
			Manage provider performance against contract / KPIs								

Public Health Outcomes Framework 2013-2016	**Wider Determinants of Health**	**Health Inequalities**
Alignment across the Health and Care System	Housing, Employment, Leisure, Environment, Education, Living and Working Conditions	Targeted Vulnerable & Disadvantaged Groups

* Indicator shared with the NHS Outcomes Framework.

** Complementary to indicators in the NHS Outcomes Framework

† Indicator shared with the Adult Social Care Outcomes Framework

†† Complementary to indicators in the Adult Social Care Outcomes Framework Indicators in italics are placeholders, pending development or identification

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TRAFFORD COUNCIL

Report to: Health and Wellbeing Board
Date: 3rd December 2013
Report for: Information
Report of: Dr Nigel Guest, Chief Clinical Officer, NHS Trafford Clinical Commissioning Group

Report Title

NHS Trafford Clinical Commissioning Group Update

Summary

The report provides an update on the work of the NHS Trafford Clinical Commissioning Group and provides information and progress on key commissioning activities. It considers locality specific issues and references links to Greater Manchester and national issues where relevant.

Recommendation(s)

The Health and Wellbeing Board is asked to note the update report.

Contact person for access to background papers and further information:

Name: Gina Lawrence, Chief Operating Officer, NHS Trafford Clinical Commissioning Group

Extension: 0161 873 9692

COMMISSIONING UPDATE

1.0 PURPOSE OF THE PAPER

1.1 This report provides an update to the Health and Wellbeing Board (HWB) since the last update in September It considers locality specific issues referencing links to Greater Manchester and national issues where relevant.

2.0 COMMISSIONING UPDATE

INTEGRATED CARE PROGRAMME UPDATE

2.1 Reporting and Monitoring

The Programme office has established and implemented a governance and reporting structure which provide assurance to the CCG Governing Body that all integrated care projects are progressed and reported internally. Progress is discussed and challenged to a broad range of Clinical Commissioning Group (CCG) senior representatives and Trafford Borough Council (TBC).at the Commissioning and Operations group on a monthly basis. The CCG provides a comprehensive report on progress of this programme to the Integrated Clinical Redesign Board the following projects are reported through this structure:

Enablers
- Map of Medicine;
- Data sharing;
- Risk Stratification;
- Education & Development;
- Patient Voice.

Unscheduled Care
- Unscheduled care business case; and
- Palliate Care Redesign.

Scheduled Care
- Community MSK physiotherapy service business case;
- Community MSK pain management service;
- Stroke action plan;
- Podiatry procurement; and
- Clinical Referral Management.

Mental Health
- RAID;
- Dementia; and
- Alcohol Strategy.

Primary Care
- Commissioning of Out of Hours;
- Access & capacity within Primary Care;
- Enhanced services; and
- Quality Outcomes Framework (QoF).

Children's:
- Children's community equipment and wheelchairs; and
- Children's MSK physiotherapy service.

Programmes:
- Respiratory programme;
- Home Care service (Medicines Management);

- Patient Care Coordination Centre; and the
- New Health Deal for Trafford.

The structure of this paper groups the projects under the relevant heading. There is a comprehensive enabler programme which comprises of t a number of generic projects which impact across the whole of integrated programme. This programme is again monitored and report through the same reporting and governance structure.

2.2 Enabler Projects

The Enablers Steering group has representation from the programme office, the leads from each of the projects which are a combination of senior officers from Commissioning, Corporate Services, Finance, Commissioning Support Unit (CSU) and Primary care. The Clinical Director for Clinical Policy and Strategy is a member and vice chair.

This group is responsible for monitoring the progress of the enabling programme, to ensure project timescales are met, manage the risk around delivery and to measure the benefit improvements from this programme which should be a catalyst across a number of the operational workstreams to deliver improvement.

Map of Medicine (MoM)
Map of Medicine usage continues to average between 150-200 clinical pathway views by clinicians per month which is approximately a 50% increase on normal usage. The flowing pathways are being redesigned and will be available on the MoM once completed:

- Chronic Obstructive Pulmonary Disease (COPD); and
- Paediatric Asthma.

Moving forwards the Map of Medicine will continue identify opportunities to support integration in terms of the development of Trafford Localised Clinical Pathways.

Risk Stratification
The timeline for the risk stratification project had a milestone of implementation for October 2013. Due to an issue with the IT infrastructure within Trafford the GMCSU have delayed the roll out of this programme until early 2014.

The CCG has implemented a short term solution to assist practices with identifying patients with COPD who are at risk of admission. Once the IT issues have been resolved the CCG will pilot the GMCSU risk stratification tool at a small number of practices prior to full roll out from April 2014 onwards.

Patient experience
COPD:
A programme of work consisting of surveying the current experience of patients with COPD has been agreed with HealthWatch. The results of this survey will be collated by HealthWatch and presented back to the CCG in order to influence the redesign of the COPD pathway.

Paediatric Asthma

The Childhood Asthma Integrated Care group devised a general survey to find out about families experiences in Trafford. This questionnaire asked questions such as: how they were diagnosed, if they had an asthma plan and what would make it better for them. This is a key element of the work to improve patient experiences of asthma services and increasing the integration between services.

This survey was made available online and in hard copy and was sent out to providers working with families in Trafford, those who had had some involvement with the Children's Community Nursing Team and through the Family Services Directory. In total there were 45 responses returned.

Out of All of the 45 responses 43 stated that they had a child/young person with asthma with two of the responses being not sure as they were an asthma query rather than a confirmed asthma case, because they were too young.

2.3 Integration (Commissioning) Workshops

Trafford's Integration is a whole system programme. To support the development of the programme The Programme Office holds monthly workshops to further assist the integration of the teams within the CCG.

The October workshop focussed on the development of a set of Integrated Care measures, these have been in development throughout October and November and will be presented to the Commissioning & Operations Steering Group on Monday 4th December 2013 and the Integrated Clinical Redesign Group on Tuesday 18th December 2013.

The December workshop will focus on Health Profiles and will be facilitated by a Consultant in Public Health.

2.4 Wider Integration

It is important that Trafford CCG links with neighbouring Health economies to understand progress and to share good practice. Representatives from Trafford CCG have been members of ***South Manchester Integrated Care Delivery Board***

It has been agreed by the South Sector Leadership Board that the integration work in South Manchester will in future been over seen and governed by an Out of Hospital Care Delivery Board. As a result of this the Integrated Care Delivery Board will no longer continue to meet

This new Board will comprise of executive membership from South Manchester CCG, UHSM, the City Council and Trafford CCG. An Integrated Delivery Steering Group will continue to meet every 2 weeks and will report to the Board on integration progress.

PROCUREMENT

2.5 Procurement of the Patient Care Coordination Centre (PCCC)

The successful delivery of a Patient Care Coordination Centre is a key priority for the CCG and an essential element of the Integrated Care programme. The CCG, supported by TBC, is currently engaged in a formal Competitive Dialogue procurement process for the PCCC which ended at 5pm on Friday 22nd November 2013.

All submissions will be evaluated by a panel of experts from across the CCG, TBC and GMCSU. A maximum of 5 bidders will be taken through to the competitive dialogue phase of the process; these shortlisted bidders will be notified if they have been successful by 9th December. Those bidders who have not been successful will be provided with feedback.

The Competitive Dialogue process will allow the CCG to work with the shortlisted Bidders in order to develop the detailed final specification which will form the basis of the Invitation to Submit a Final Tender (ITSFT) which will allow the CCG to select the successful provider who will be awarded the contract. It is expected that the contract will be awarded during 2014/15.

The table below outlines the key dates as part of the dialogue process. These are provided for information.

Action	**Deadline**
Tender Published	**11th October 2013 – Completed**
Pre Qualifying Questionnaire Submission by Bidders Deadline	22nd November 2013
Invitation to Submit Outline Solution (ISOS) Published	16th December 2013
ISOS Submission by Bidders Deadline	10th February 2014
Invitation to Submit Detailed Solution (ISDS) Published	14th March 2014
Detailed Competitive Dialogue	15th March 2014
Invitation to Submit a Final Tender (ITSFT) Published	August 2014
Contract Award	October 2014
Service Commencement	1st April 2015

NB. Where possible, dialogue timelines will be shortened to enable earlier award / commencement

SCHEDULED CARE

2.6 Clinical Referral Management Programme

Recruitment for the vacant specialties has been complete.

A new GP referral proforma was launched on 1st October 2013. The aim of this proforma is to RAG rate all rate GP referrals, using the following criteria:

- Green - Good referral;
- Amber - Fair/could have been improved (may require additional medication being prescribed or watchful wait); and
- Red - Poor quality (Other services available outside of hospital).

The proforma is used by the GP reviewer to assess all referrals against the criteria set out within the Map of Medicine pathways. Referrals considered to be of poor quality will be assessed on a fortnightly basis, as part of the Clinical Referral Management Programme meeting. The GP reviewer performance will also be assessed on a monthly basis and monitoring of workload by speciality will be on-going and increase reviewer support will be provided when necessary. The outcomes and learning will be communicated to all GPs.

2.7 Community Dietetic Service

Trafford Borough Council is the lead commissioner for community dietetics. Trafford CCG is currently supporting a review of these services, including X-PERT, childhood obesity and diabetes.

The CCG, as part of the Healthy Weight for Children, Young People & Families Task and Finish Group, are involved in conducting a brief review of treatment services in order to reduce childhood obesity. The first task is to develop healthy weight care pathways for 0-4, 5-11 and 12-17 year olds. This task will be completed by December 2013.

2.8 Stroke Action Plan

The first quarter stroke performance has now been received; this demonstrated improved performance at the Trafford General Hospital.

Work continues to develop the best model for ESD for Trafford. Research has been undertaken to consider other models across Greater Manchester. The CCG are aware that as outlined in their commissioning intentions for 2014/15 that Central and South CCGs are to redesign their ESD services.

This redesign of this service is supported as part of the investment plan agreed internally; this investment will include a short term solution. The Commissioning team are working with CMFT and University Hospital South Manchester, specifically to avoid any discharge issues which would impact on the New Deal for Trafford site reconfiguration.

The CCG will receive a more detailed business case from the Stroke Association with regard to their Life After Stoke needs-led service proposal.

2.9 MSK Community Physiotherapy – Business Case

The business case to increase the community MSK physiotherapy resource for both adults and children was signed off by the Pennine Contract Development Board on the 18th November 2013. The development of the project plans and reporting will be monitored through Pennine Service Development Group.

UNSCHEDULED CARE

2.10 Unscheduled Care Business Case

Urgent and Enhanced Care teams have been established the through the development of the Unscheduled Care Business Case. All services have now been recruited to and went live on the 25th November parallel to the implementation of Model 2 of the NHD. The teams consist of:

1. Urgent Care Team;
2. Community Pharmacist;
3. Community Integrated Care Teams (Ascott House);
4. Intermediate Care AHP Team (incl. Respiratory Physician);
5. Community Matrons Team (incl. Dementia Specialist Nurse & Band 3 practitioners);
6. Community Geriatricians (incl. Admin Support & Includes Care Home Pilot); and the
7. IV Therapy Team.

KPIs for the delivery of the programme have been developed and signed off by the Pennine Contract Development Board on the 18th November 2013. These measures will be collected following go-live and will monitored through The Trafford Commissioning & Operations Steering Group from December 2013.

2.11 Respiratory

Following the Clinical panel held in September a Steering Group has been established to oversee the delivery of the projects within this Programme of work. The programme consists of:

- Exploration of the development of a COPD Early Discharge Team;
- Increasing the utilisation of Pulmonary Rehab Service;
- GP Practice Nurse Development for Spirometry;
- Links to the CYPS Paediatric Asthma project established;
- Respiratory priorities chosen as Member Practice local QP payments; and
- Understanding patient experience through HealthWatch (discussed earlier).

The measures for this Programme are currently under developed and will be presented to the Respiratory Steering Group in December 2013. Following agreement they form part of the formal reporting and monitoring through the Trafford Commissioning & Operations Group.

2.12 Personalisation

The Government's aim is by 2014, everyone in England, who could benefit, will have an option of choosing a personal health budget. This commitment includes parents of Adults and Children with special educational needs and disabilities. By April 2014, people eligible for NHS Continuing Health Care will have the right to ask for a

personal health budget, including a direct payment for healthcare. The NHS will also be able to offer personal health budgets more widely, for example to people with long term health conditions or people with mental health problems

To deliver this programme the CCG has appointed a Personalisation Lead who reports through the Head of Unscheduled Care. An overview of this programme including the challenges to delivery was presented to the Commissioning and Operations Steering Group and the Management Team in October.

A co-production group has been established to support and oversee the delivery of the programme's action plan. The group is chaired by the Personalisation Lead, NHS Trafford and has senior representation from the CCG, Trafford Council, the third sector, home health care providers, HealthWatch and carers of a patient with a long term condition. This Group will oversee the development of the following workstreams:

1. Information and Advice
2. Support Planning
3. Brokerage
4. Resource Allocation System
5. Health Outcome Monitoring
6. Review and Audit

MENTAL HEALTH

2.13 Rapid Assessment Interface Discharge (RAID)

The RAID Business Case was approved by the CCG Governing Body in March 2013. The Trafford RAID service will support Trafford registered patients aged 16 and over with mental health problems, alcohol misuse issues and dementia being cared for within Central Manchester University Hospitals NHS Foundation Trust (CMFT) Trafford Site and University Hospital of South Manchester NHS Foundation Trust Wythenshawe Hospital (UHSM) or presenting at either hospital's A&E department.

The RAID service will be provided by Greater Manchester West Mental Health NHS Foundation Trust (GMW) as extension of existing liaison services

The Raid team to consist of:

Post	Progress
Consultant	Interviews 29.11.2013
Manager Band	In Place
Team Leader	Recruited
Nurse Band 6	All recruited and 2 started
Admin Band 4	Recruited
Admin Band 3	Recruited

In addition £100K has been agreed by TMBC for 1 year to fund a further 2 alcohol nurses and another admin worker. The full service in place by 31.03.2014

The core KPIs for the project have been agreed as:

1. **CORE KPI – Reduction in Excess Bed Day Payments**
2. Reduction in Frequent Flyers
3. Reduction in A&E Breaches
4. Deflections from MAU (patients appropriately discharged from A&E or diverted directly to the appropriate ward)
5. Reduction in re-admissions
6. Reductions in LOS
7. Reduction in Admissions via A&E

PRIMARY CARE

2.14 Primary Care Strategy

As part of the Greater Manchester service transformation Healthier Together programme, NHS England GM local area team launched the GM Primary Care Strategy on the 25th September 2013 at Salford City Stadium at the 2nd Primary Care Summit. The strategy gives the case of change as

- Ageing population place increasing demand on the system that is not sustainable in the long term;
- Evidence shows that improved primary care with care outside of hospital settings costs less. This is the only way to increase quality in the face of rising demand and limited resources; and
- Variation in access to and the quality care across GM.

The GM Primary Care strategy gives 5 commitments for improving primary care with high level outcomes only, the assumption being that local CCG strategy will define how the CCG secures the outcomes for the population of Trafford.

The priorities are;

- Quality and safety;
- Involvement in care;
- Multidisciplinary Care;
- Access and Responsiveness; and
- Increased out of hospital services.

NHS Trafford CCG is engaging with member practices to develop the local strategy for primary care in Trafford. The Trafford CCG strategy will outline how the local model for primary care in Trafford will deliver the requirements of the population, and contribute to realising the outcomes outlined in the GM primary care strategy.

Challenges to delivery include;

- Single IT solution;
- Estates investment;

- Member relations/engagement;
- Contracts & Tendering;
- Provider developments;
- Information Governance issues;
- Integrated Care Model;
- Primary Care Pathways; and
- New out of hospital care standards.

MEDICINES MANAGEMENT

2.15 New Oral Anticoagulants (NOACs)

A pathway for the management of these patients has been discussed and agreed locally with UHSM, CMFT (including Trafford Division) and approved by the CCG. The commissioning of this pathway is almost complete at both sites.

Patients who are taking warfarin and are not stable will be identified and reviewed by the anticoagulant teams. Where it is considered that the patient could switch to a NOAC, and the patient has had an informed discussion as to the benefits and risks of switching, the patients GP will receive a preformed detailing the outcome of the review.

2.16 Practice Prescribing Budget

The practice prescribing budget is showing a projected under spend for the lat reporting period. The Medicines Management team are continuing their programme of work with practices which includes supporting medication reviews in care homes, repeat prescribing reviews, QiPP targets, specials medicines and maximising the use of generic medicines.

2.17 Patient Group Directions (PGDs)

The two new PGDs that have been developed by NHS England (NHSE) and GMCSU respectively, for two of the new vaccination schedules; Shingles vaccination (Zostavax) for 70 and 79 year olds & Fluenz Nasal Spray in 2-3 year olds, have been communicated to practices to allow the vaccination schedules to commence on the appropriate dates.

Additionally, the expired PGDs for travel vaccines have been updated by the Medicines Management team, signed by the appropriate lead clinicians and also communicated to practices to allow continuation of travel vaccinations within Primary Care.

2.18 Adult Service Model

At the recent Health and Wellbeing Workshop, the CCG shared the Adult Service model which is being developed .This is being developed further as part of the Primary Care Strategy, this is provided at Appendix A. for information Work has commenced on the Children's model and will be reported to the Board in a future update.

2.19 Integrated Care Plan

The Board will be aware that Trafford along with all other Health and Social Care Economies have been working on their Integrated Care plan. A copy of the June submission is attached for information. Further work in currently being progressed which sets out the plan changes up to 2016 together and implementation plans for each locality. Once these have been completed these will be shared with the Board.

2.20 New Health Deal

The Board will be aware that the JOSC supported NHS England in progressing the New Health Deal for Trafford. As part of the preparation for this service change there have been 3 key work streams which have been progressed by Trafford CCG to ensure all partner organisations are ready for the associated changes.

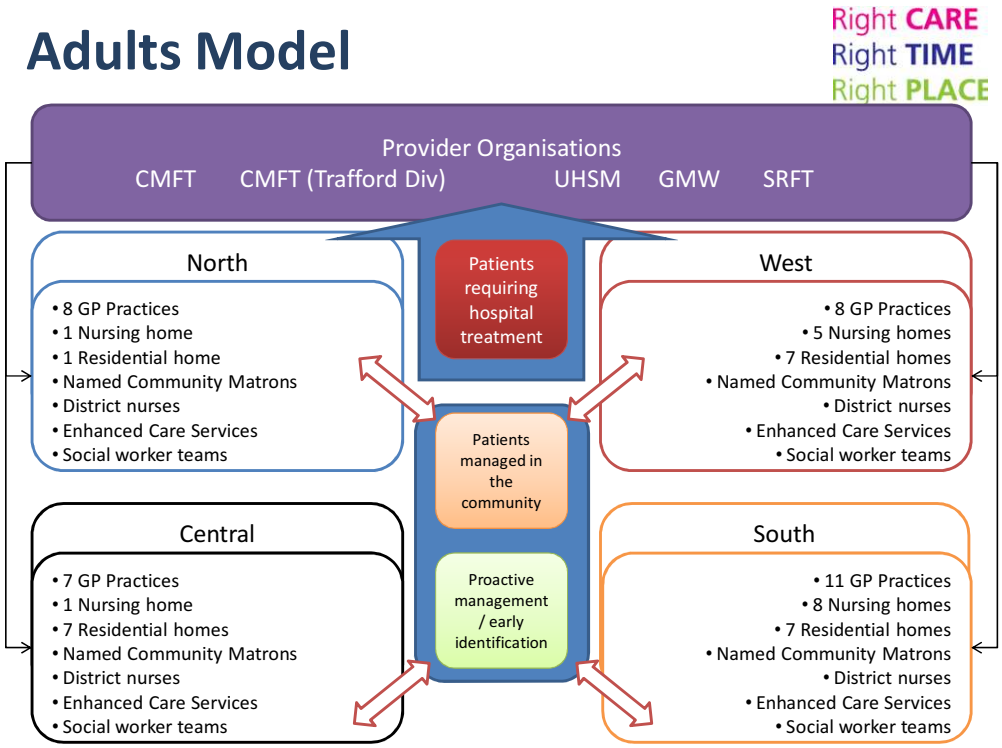
These include:

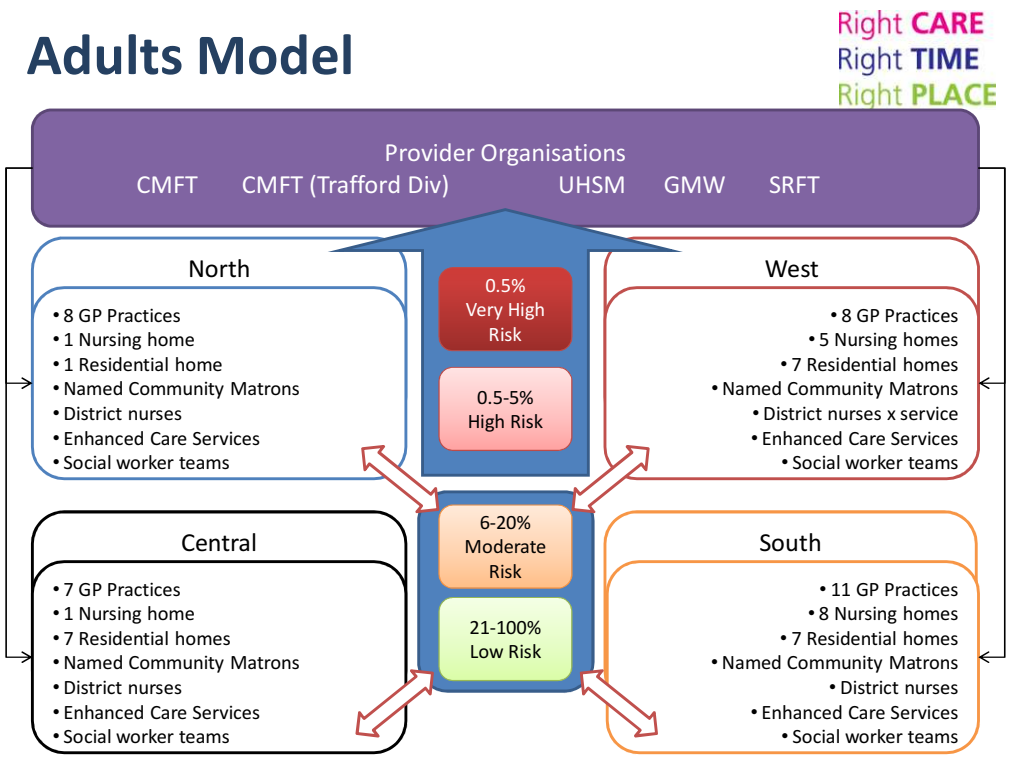
- **A comprehensive communications strategy** which includes communications internally, across organisation and to the public.
- An operations group has been established which includes representatives from all Health organisations including; UHSM, SRFT, CMFT, GMW, NWAS, Pennine Care and Mastercall. Together with Social Care. All organisations have developed new operations networks to ensure all Trafford patients are treated in the correct place by the correct clinical teams.
- A full monitoring dashboard which includes set of data to monitor all Trafford Patients and to monitor capacity, performance of all A&E departments which are impacted by the Trafford New deal.

3.0 RECOMENDATIONS

The Health & Wellbeing Board is asked to note the update provided regarding the CCGs key commissioning activities.

APPENDIX A: ADULT NEIGHBOURHOOD MODEL





APPENDIX B: AGMA INTEGRATED PLAN

Executive Summary
Integrated Care Model for Trafford Health and Social Care Economy
AGMA Informal Leaders Meeting 28th June

1) Overall Aim

The Trafford Health and Social Care economy is fully committed to whole system integration to deliver high quality, compassionate care, through person centred, cost effective and co-ordinated care and support – thereby improving all clients[1] experience and outcomes, and the effective use of resources across Trafford economy.

Our aim is to build resilience and sustainability across our economy by ensuring a whole system approach to population management and the delivery of cost effective, person centred, co-ordinated care. Together we will reconfigure structures, systems and pathways and align this with cross sector culture change to deliver meaningful transformation.

We see integration as the key mechanism to deliver high quality, compassionate care leading to improved health and well -being for Trafford residents:

- improving health and wellbeing being across the course of life rather than reacting to problems
- investment in keeping people well and able to live independently
- focusing on preventing and reducing illnesses such as cancers, cardiovascular disease and respiratory disease
- reducing inequalities in health and wellbeing between the most and least deprived neighbourhoods
- a strategic shift towards early intervention and prevention

Our overarching aims are:

- To integrate around, and deliver **better outcomes for patients as customers**, including experiences for individuals, families, carers and communities – aligning with the national outcomes frameworks and encompassing mental and physical health, social care and public health, as well as other public services, such as education, involving the community and voluntary sectors, as appropriate, across Trafford. **As set out in the Health and Wellbeing Trafford's ambitious plans are to focus on preventing and reducing devastating effects that illness have on our community. Trafford's priorities are to improve the clinical outcomes for reductions in; cancer, cardiovascular disease, respiratory disease and mental health. Improvement in clinical outcomes will narrow the gap in health and wellbeing between the most and least deprived neighbourhoods. Early intervention and prevention will be supported by the risk stratification which will highlight the clients which are most at risk, for these individuals to be carefully monitored at the earliest opportunity.**

[1] Throughout this document we are referring to patients and customers as 'clients' to ensure constancy across the whole of our integrated care plan.

- To **improve the care and support experience for all customers. Trafford wants to give local people choice and control to shape in the new integrated care model. The new care model will be seamless and less confusing for its user with improved communications. The model will "think family" and where appropriate have greater support and interventions from health and social care within the community. Clients' will be encouraged to maintain their independence with support provided to all including family and carers.**

- To **ensure efficient use of resources across the health and social care economy, by identifying potential financial efficiencies for reinvestment and measures of success**. **The strategy will be delivered throughout partnership working with greater emphasis focused on the use of resources and improved value for money. To integrate resources around children and young people, adults and older people Trafford will use a 'life course' approach which is recognised as the most effective way to address inequalities.**

The primary requirement within the Trafford economy is to continue to work with partners to improve the citizen's experience by delivering a 17% reduction in avoidable admissions to hospital and other care institutions. This will be achieved through the development of "integrated care services" – care which are wrapped around the needs of individual clients & carers. Clients will have choice in where they receive appropriate health and social care support. Clients will have seamless care delivered by multi agencies which are responsible for the delivery of improved health, social care and well- being outcomes.

Trafford is unusual in that its patients have access to multiple providers within the economy, rather than the usual 1:1 relationship between commissioners and providers. Due to this Trafford is committed to working in partnership with neighbouring CCGs, providers and the council to provide integrated care for its patients. **The planned changes to Trafford General Hospital underpin the integrated care model which supports investment into community and primary care services**.

Clients with long term conditions and those of high risk of frequent acute admissions will be known and will be monitored in the community as part of admissions avoidance. Patients will receive support to take responsibility to self-manage and monitor their conditions. **In essence integrated care will support the shift to the proactive, rather than reactive, management of health and well -being for residents of Trafford.**

2) Partners Involved and Governance

Trafford has a long history of working with the multiple providers within the economy through initiatives such as the New Health Deal for Trafford, with all key Stakeholders working together to deliver an integrated care model. This includes local executive and political leadership, staff groups, including clinicians, patient groups, people who use services, carers and families.

Trafford has **an established set of Integrated Care Principles**, produced by the health economy in 2008 when the initial integrated care Programmes commenced, these were refreshed in 2010 when the New Health Deal Programme work commenced and they have been successfully used as the foundation for all of the projects undertaken within the locality (see appendix A of the attached plan).

A robust governance structure which builds on pre-existing partnership which has historically been in place has been further developed within the locality. The health & social care economy is responsible for the commissioning of this new care model and will lead its full implementation through an Integrated Care Redesign Board (ICRB) which consists of providers and commissioners. The ICRB is responsible for removing any barriers to delivering integration and will agree and monitor integrated care plans.

In July 2013, Trafford will launch a revised governance structure designed to deliver integration within the locality. This is a joint venture with oversight from leaders within both Health & Social Care and ensures providers are included at Programme and project levels to ensure delivery of the Integrated Care system. This will enable robust governance frameworks for information sharing and engagement with local HealthWatch, people who use services, all staff groups (including clinician peer to peer promotion) and the wider public in local service reform.

The Integrated Care Governance structures and terms of reference for the Integrated Care System can be found in Appendix B of the attached plan; the following are key groups and organisations which form part of the partners and governance framework.

Group /organisations	Name	Members
Strategy Level – joint working	Health and Wellbeing Board	All public sector representative
	Joint Commissioning Group	Health & Social Care
	Trafford Clinical Commissioning Group	Health, Public Health, Social Care
	Trafford Council	Social care, Housing, Education
Acute Providers	University Hospital of South Manchester	
	Central Manchester Foundation Trust (Manchester and Trafford site)	
Mental Health Trusts	Greater Manchester West	
	Pennine Care	
Community Trust	Pennine Care	
Third party sector	Community and Voluntary sector	
Patient/Clients voice	Health watch	
	Carers	
	Public Health	
Others	NWAS	

3) The People (i.e. the population stratification)

Trafford's approach to integration is based on a whole population level, working at scale and pace. Focus will be on intensive users of services who have traditionally crossed organisational boundaries. **Integrated Care in Trafford includes both mental and physical health, and is founded on an ageless approach to service delivery and development.**

Integrated Care in Trafford builds on our well-established integrated Children and Young People's service (commissioning and provision), integrated Mental Health services and integrated services for people with learning disabilities.

We will include Public Health, a the community and voluntary sector, and our housing and leisure partners to ensure integration supports the overall health and well -being of Trafford residents.

Our Integrated care model is founded on the full continuum from prevention and early help to supporting people to manage very complex health and social care needs.

Trafford's Integrated Care Programme will be primarily focussed upon our patients who have long term conditions and are identified as being at risk through our risk stratification programme. This work will identify the health risks initially and incorporate social care data and risk identification at a later date.

Population and risk will build on stronger communities and troubled families work streams – whereby those who would benefit most from person-centred, coordinated care and support, such as intensive users of services and/or vulnerable individuals with complex support needs, who repeatedly cross organisational boundaries are recognised as disproportionately vulnerable and need of integrated care solutions.

This work will take into account how public services are integrated better with the unpaid contributions of families, carers and communities. This focus is essential as a key element of local public service reform programmes.

4) The New Service Model

Trafford has been at the forefront of areas in understanding and developing care for local people moving away from a reliance on traditional specialist services. Clients want to access services in a timely way and not have multiple referrals to different agencies and providers. **Teams have been working together and all are signed up to ensure this system wide approach to deliver health and social care is implemented.**

Trafford CCG is currently developing with provider organisations a Patient co-ordination centre. This will be the enabler for co-ordinated care. It will support patients, families, carers and all clinicians to have a clear view and understanding for all patients care. Appendix B illustrates referral flow .

Although the new model will operate across the whole of Trafford, **Trafford has identified 4 localities to focus coordinated service delivery models within the borough:**

- Central
- West
- North
- South

Within each of these localities multi agency integrated teams are being established to deliver joined up Health & Social Care. Each of these localities will have a multi agency Locality Partnership Board made up of Elected Members, Community Ambassadors and a range of statutory and voluntary agencies including the CCG and health and social care services. The Locality Partnership Board will work with their local communities to undertake an asset based assessment of the locality and will review locality specific issues to ensure the most appropriate interventions are implemented for our population. This will help to ensure that all our citizen's have a positive experience across both Health & Social Care.

Within the new service model Integration across physical and mental health, primary and secondary care and health and social care will be achieved through this focus on locality working.

Partnership working across the health and social care sector and co- production with citizens, patients/customers and carers will lead to seamless care and support built around the needs of the individual, their carers and family and the community within which they live.

People will be supported and cared for as close to home as possible with the new service model based on the right care in the right settings at the right time. The **model is centred on**

- **Prevention and the promotion of independence and the best use of resources across the system.**

- **Avoid unplanned hospital admission**

- **Use new technology and sharing data to deliver tailored services**

Building upon the successful track record of the Children and Young People's Service integrated commissioning and provision model – through joint governance and management from Trafford Council and Trafford CCG, together with our provider organisations. Trafford CYPS was formed in 2007, as a unique partnership between Local authority, Primary Care and Acute Hospital trusts. Its vision was based upon a determination to ensure better outcomes for children and young people by providing integrated commissioning and delivery services.

The positive outcomes from this work have been objectively validated as improving quality of life outcomes across health, social care and education through bringing the different agencies and services together and providing a more 'joined up' service for children, young people and their families.

The creation now of the Trafford Health and Social Care Service, which is made up of operational Adult Social Services and Trafford Community Health Services is a key delivery mechanism for integrated care in Trafford. This provider/provider integration, aligned with the overarching system wide integration plans will ensure the following:

- Trafford recognise the importance of the Public Health function to effective population and demand management. A joint strategic commissioning group, working to the Health and Well Being Board, ensures a place based approach to health and social care commissioning and the effective use of Public Health resources to support our newly developed health and well -being strategy.

- The Trafford Health and Social Care Service is committed to the principle of integrated self -care and building on Trafford's position at the forefront of personalisation. We already have a high proportion of customers using Direct Payments and a well embedded and successful Telecare strategy. This is being used as the foundation stone for the further development and roll out of Telehealth and the expert patient programme in Trafford.

- Integrated neighbourhood teams, made up of health and social care workers will be the main focus of translating effective risk stratification and the population management model into an operational reality. The teams will build on the current single assessment process and will deliver integrated care management on a locality level, closely aligned to GP practises. These teams will support early diagnosis and case finding, working to deliver our joint dementia and falls strategies. Effective data sharing and risk stratification will support the review of local populations to work proactively with customers at high risk of future dependency.

- Trafford has a well-developed approach to working with individuals and local communities to build additional social capital and community designed and owned solutions. We recognise the clear interdependency between an individual's sense community inclusion, the level of their social capital and their health, well- being and social care outcomes. Our reablement service already focuses on building individual's resilience and social capital, reconnecting people to their local networks, as well as supporting people to develop and maintain more practical skills of daily living. This will be used as a foundation stone for the roll out of integrated neighbourhood teams. Trafford have recently undertaken a place based, comprehensive review of information

and advice to ensure the provision of high quality, accessible information and advice and the effective use of resources across the system. This had led to the development of a locality based model of provision which is being implemented over the next two years.

- The Trafford Health and Social Care economy recognises the centrality of appropriate housing and housing related support to peoples overarching health and well -being. A well- established housing and support forum is driving forward the development of a wide continuum of support. Recent successes delivered on a partnership basis include the delivery of 2 Extra Care developments with a third in construction and a fourth in development.

- Integrated enhanced reablement team made up of health and social care workers supporting people to maximise their independence and diverting people away from formal health and social care services

- Trafford have recently undertaken a place based, comprehensive review of information and advice to ensure the provision of high quality, accessible information and advice and the effective use of resources across the system. This had led to the development of a locality based model of provision which is being implemented over the next two years.

- Integrated Urgent Care Team made up of health and social care workers ensuring effective diversion from hospital through the delivery of a 24 hour a day urgent response

- Integrated hospital discharge team, made up of health workers from the community health and acute sectors and social services staff. This team will build on the outcomes of the recently completed experience based design work on improving patient/customer experience of hospital discharge and will ensure effective and safe discharges where people are supported and empowered throughout.

- Integrated end of life care, delivered at home by health and social care staff who are part of a neighbourhood team, closely aligned with Primary Care

Shared accountability for performance will be delivered through our robust governance and quality assurance model, led by the Health and Well Being Board. A key ongoing work stream is data and information management which will ensure the effective, cross system capture and use of data. This will inform and improve the delivery of integrated care to individual clients, the targeting of care and support to at risk individuals and use of management information to improve quality and ensure full accountability to all stakeholders, particularly local users of services.

The development of an integrated provider organisation, Trafford Health and Social Care Service, and the close alignment of health and social care commissioning will ensure the embedding of best practise and effective care co-ordination across care pathways and traditional organisational boundaries. Individuals will experience joined up, seamless care rather than needing to navigate a fragmented and challenging system. Risk management mitigation strategies are in place, to maximise the likelihood of delivering our shared vision for integrated care and support across Trafford

5) The Investment Proposition/Money Flow

The local plans take into account the latest best practice evidence and guidance, and an assessment of the potential impact of the relevant local provider landscape in line with the planned outcomes and aims identified in section 1.

Trafford's strategy is to reduce the inefficiencies within the current system through service review, design and redesign. This will facilitate and create the opportunity to invest in the new model which will prioritise investment in health within primary and community services and within Social Care. This will support the joint and integrated commissioning intention to provide better, safer care, closer to home.

Trafford is currently completing a prioritisation process to understand which all initiatives will assist with achieving this outcome and assist with the delivery of integrated care.

One example of commissioning services closer to home is Trafford Clinical Commissioning Groups Urgent Care Business Case which contains extensive financial modelling of the new model of care and supports the foundations which are required for the full implementation of the New Health Deal. This will form the starting point for the development of a worked up investment proposition through the overlaying of social care information and data. Our model of integration is based on the principle that money follows the individual.

Service redesign in Trafford is on-going and is all at different stages, the new RAID service is one example which is at implementation stage which will be delivered within the financial year.

Enhanced reablement has now also been identified as a potential pilot area for developing a worked up and measurable investment proposition.

6) Evaluation/Review-

It is essential for the all changes to be reviewed and evaluated to ensure improvements are delivered. As part of the evaluation the governance structures has a robust review process in place which provides reassurances to both Trafford CCG and Trafford Council. This will ensure the overall aims set out in both the integrated strategy and the Health and Wellbeing strategy are met.

Evaluation and review of our success will be drawn from whether we achieve our overarching aims:

- To **improve better outcomes for patients as customers**
- To **improve the care and support experience for all people using services as customers**
- To **ensure efficient use of resources across the health and social care economy**

All this work will include as review as central objectives:

- **Constructive open analysis and review of all process and outcomes evidence**
- **Positive Public and professional opinion and engagement**
- **Sustained positive changes to the strategic/executive level culture**
- **Changed new ways of working and workforce flexibility matched assessed need**

This should be **demonstrated through customer and front line staff centred evaluations and review – with the system feeling better and different, and a focus on holistic person-centred care.**

External evaluations should also be able to note effective governance and programme management.

All the integrated care projects undertaken within the locality with are linked to the National Frameworks. This will ensure that the health& social care economy can accurately demonstrate the impact of any Integrated care initiatives/projects on a regular on-going basis and measure improvement.

Examples of the measures to be utilised are:

- Friends & family test;
- Patient experience of Primary Care;
- Emergency admissions for acute conditions:
- To reduce inappropriate scheduled and unscheduled admissions.

Each project will complete a project closure document which will detail lessons learned, benefits realisation and an analysis of true impact on performance indicators.

7) Next key milestones

Integrated care and partnership working is well established with Trafford, success has already been achieved and this will continue through the new governance and reporting structure. The following are the next milestones

Month	Task/milestone
June 2013	• Trafford CCG - prioritisation work to complete • Completive dialogue for Patient co-ordination centre
July 2013	• Implement the new governance arrangements. • Launch new initiatives , including: -Completion of Urgent care team implementation Palliative care redesign -Implementation of Integrated care teams health/ Social care • NHS England will review the CCG scorecards (repeated October 2013) • Full implementation of the Risk stratification Programme • Full implementation of
August 2013	• Establish neighbour teams, including community pharmacist, community matrons, community geriatricians, IV Therapy teams • Establish enhanced reablement including AHPs
September 2013	• Implementation of RAID
The New Health Deal for Trafford will commence if approval is received from the Secretary of State	

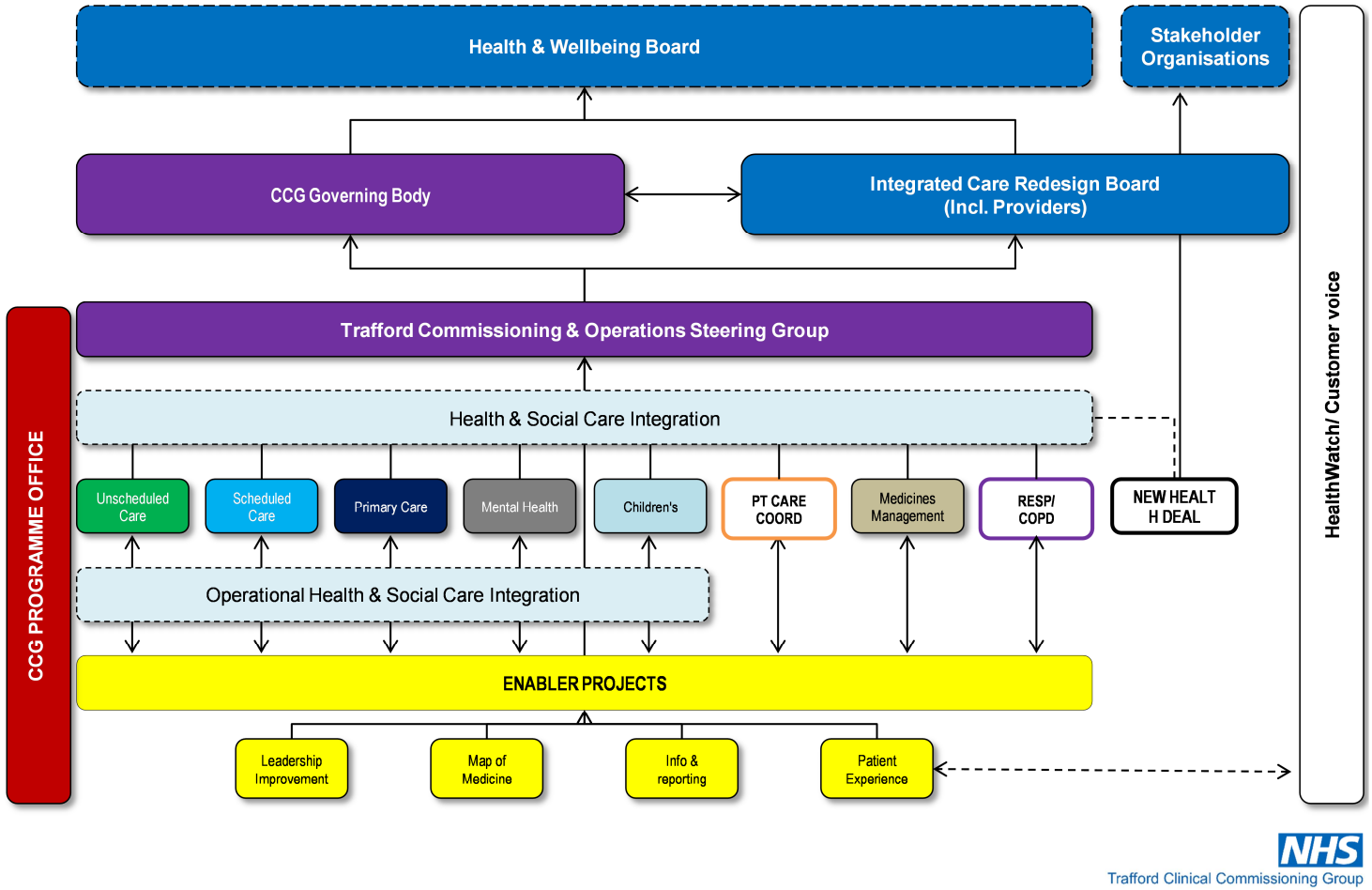
Please send to Will Blandamer w.blandamer@manchester.gov.uk, with the locality integrated care plan attached, by Monday 10th June

Appendix A: Principles of Integrated Care

Principle	Description
Principle One	**'Nothing about me, without me'** – the patient voice must be at the heart of all provision. This requires a cultural change in all services, with a new emphasis on the patient voice and patient experience, and the way in which this is incorporated into planning and ongoing evaluation of services.
Principle Two	**General practice should be the 'locus of integrated services'.** Integrated services are based on the practice-based registered list: a list of the population who may need NHS care, and the most complete record of their health care needs.
Principle Three	**Specialist expertise** is an essential component of effective integrated services. The unique authority of consultant specialists to identify a definitive differential diagnosis and plan care for patients remains central. Achieving a shift from consultant-based to **consultant-integrated services** requires new ways of working (such as specialists working more in the community) and an increase in their contribution to the overall management of clinical care provided to populations.
Principle Four	The delivery of integrated services will rest primarily on **extended roles for nurses and Allied Health Professionals (AHPs).** The development of integrated care across primary and secondary care requires a new relationship between nurses/AHPs working in general practice and community teams, and those associated with acute care. This involves changes to clinical education and training, and the establishment of more formal networks between locations of care to ensure the effective delivery of new pathways and the development of nursing/AHP leadership roles.
Principle Five	**Integrated services must incorporate social care**. Closer working between health and social care is needed to enable: more effective management of the risks of hospitalisation (leading up to and following admission, as well as preventing the need for admission); the delivery of better coordination between services to promote independent living; and to prevent illness and social isolation.
Principle Six	Future integrated services should **bring together the full range of primary care services. Incorporating new diagnostic technology, and developing further patient choice within a network of inter-linked services,** opens up the prospect of a greater role for pharmacy and optometry in the delivery of the future model of care.

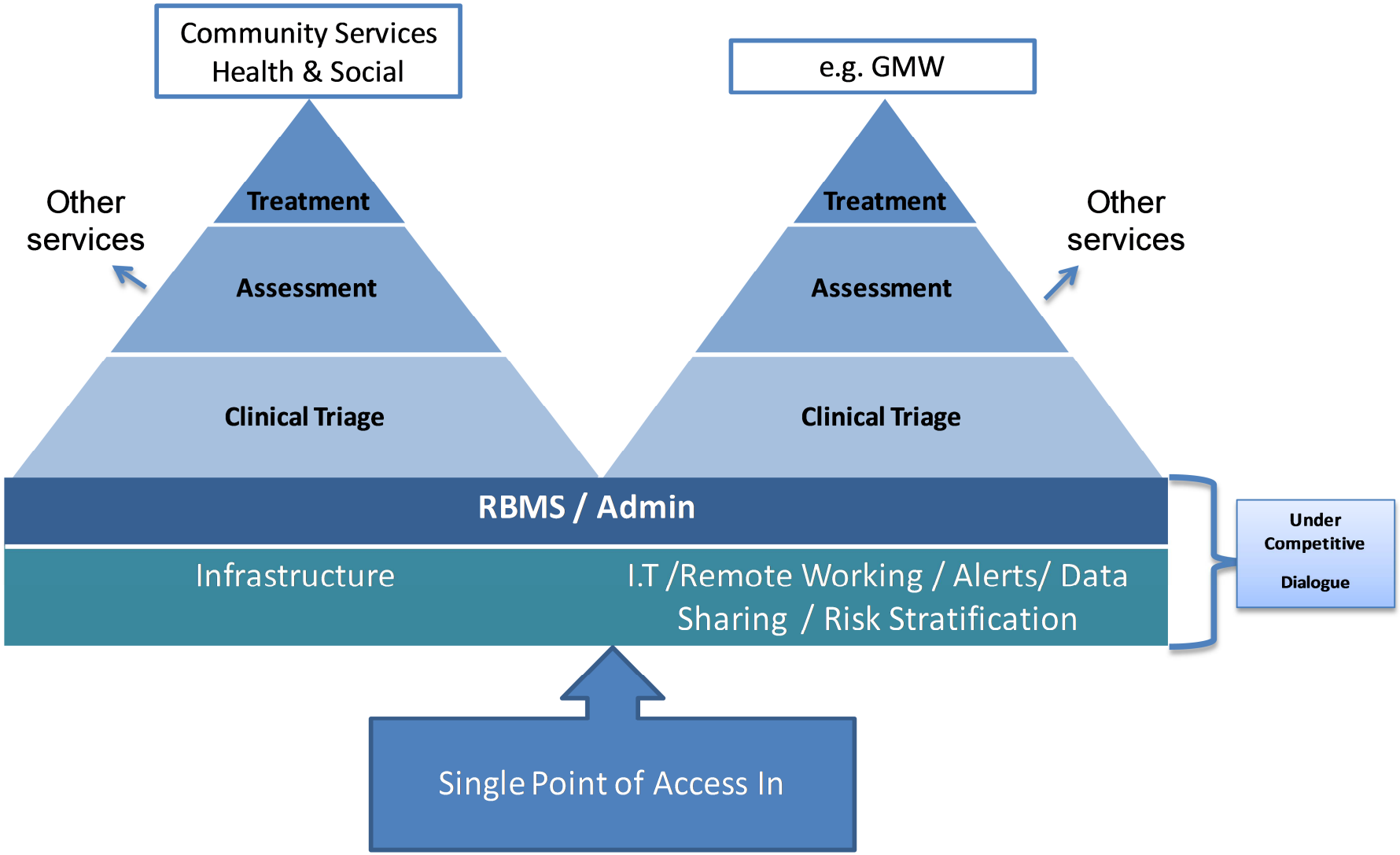
Appendix B: Governance Arrangements

Enablers and Joint Working - Governance



NHS
Trafford Clinical Commissioning Group

Appendix C: Care Coordination Centre



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TRAFFORD COUNCIL

Report to: **Health & Wellbeing Board**
Date: **3rd December 20132013**
Report for: **Information**
Report of: **Chair, Healthwatch Trafford**

Report Title

Healthwatch Trafford Update December 2013

Summary

The report provides an update on the work of the NHS Trafford Clinical Commissioning Group and provides information and progress on key commissioning activities.

Recommendations

1. The HWB notes the Healthwatch update

Contact person for access to background papers and further information:

Name: Ann Day, Chair Healthwatch Trafford

Staff and Board Recruitment.
Since the last Healthwatch Trafford Update we have appointed a new Chief Officer, Andrew Latham who commenced employment on 18th November. Andrew is a resident of Stretford and was previously Chief Officer of Citizens Advice in Accrington.

We currently have 5 vacancies for members of the Healthwatch Trafford Board. A recruitment campaign took place during September and October and interviews will be taking place in late November.

Activities.
We continue to meet with local groups and residents of Trafford as well as our scheduled meetings with stakeholders, local commissioners and providers of services.

We continue our involvement with the New Health Deal for Trafford and Healthier Together Programs.

The Healthwatch Trafford Development Worker has met with LMCP South Asian group to talk about Healthwatch Trafford and issues in the BME communities. She has also met with the Voice of BME in Old Trafford and will be attending the next BME service improvement partnership to talk about Healthwatch Trafford and its work.
Healthwatch also attends the Old Trafford Liaison Group monthly meetings.

The Older people's event in October was not well attended but those present felt that an older people's forum was needed but it was important to be clear about its structure and function. Another meeting is planned for January.

Mastercall
In November we met with Chief Executive and Marketing Manager of Mastercall. Mastercall provides the Walk-in-Centre at Trafford General and the Out of Hours Service for Trafford residents.

The Young People's health and wellbeing project.
We are continuing are work with the Trafford Youth Cabinet who have raised a variety of concerns that they feel impact on Trafford's young people's health and wellbeing. These include poor access to Child and Adolescent Mental Health Services (CAMHS), no access to dieticians for those with weight problems and lack of easily accessible health information for young people on GP websites.

Enter and View
Healthwatch Trafford Development Worker and the Chair of the Enter and View Panel attended the Enter and View training day hosted by Healthwatch England. DBS registration of the Enter and View team is now complete. A local training event will take place in January which will include dementia, DOLs and MCA training. This will be offered to existing and new members of the team.

North West forum for older people
We also attended the Northwest Forum for older people's conference at the Kings House Manchester. Guest Speaker at the event was Esther Rantzen promoting the "silver line" a help line for older people suffering from, isolation, loneliness and abuse.

Respiratory Work Program
We have been asked by the CCG to seek the views of patients with respiratory disease about their experience of care and treatment.
We are doing this by questionnaire, focus group work and interviews.

Healthwatch Website
We have added Browse Aloud to our website to make it more accessible to those with sight impairment and reading difficulties. It is a service which can do a number of things to assist with reading and understanding the text on our site, including speaking the text out loud, highlighting sections and words and offering a translation service. It is all done in high contrast colours and is free.
Our November newsletter is in circulation and includes information on the changes at Trafford General Hospital as well as other articles.

Information and Signposting Function
Since the last update there have been 20 instances of signposting or information requests from the public.
There have been 11 concerns / complaints in this time 7 of these are ongoing.
Example of concerns recently received:

- Elderly resident raised concern about care given after hip surgery. Felt care givers lacked compassion, food was "disgusting cold and inedible." On day of discharge was put into a chair at 6 10am, bed was stripped and not made up she had to remain in the chair until discharged at 6 15 pm. She was in pain and discomfort.

- Pregnant mum attending anti- natal clinic at 11weeks was unable to find parking space at the hospital and because of this was 15 minutes late for appointment. On arriving at the booking in desk and explaining the situation to the staff member another person on reception, without listening or looking at Mrs X, told her colleague to rebook Mrs X appointment. Mrs X returned home very upset as new appointment was made and she would by then be 15 weeks pregnant.

Both these concerns were reported to the Director of Nursing and Head of Midwifery at the hospitals concerned.

Ann Day
Chair Healthwatch Trafford.
Nov 2013

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