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AGENDA PAPERS MARKED "TO FOLLOW" FOR

HEALTH AND WELLBEING BOARD MEETING

Date: Tuesday, 4 February 2014

Time: 6.30 pm

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

	A G E N D A	**PART I**	**Pages**
2.	**MINUTES**		
	To receive and if so determined, to approve as a correct record the Minutes of the meeting held on Tuesday 3rd December, 2013.		1 - 6
5.	**GREATER MANCHESTER WEST MENTAL HEALTH FOUNDATION TRUST –HOME PROPOSALS AND CONSULTATION**		
	This item has been withdrawn from the agenda.		
9.	**DEPARTMENT OF HEALTH - TRANSFER OF RESOURCES TO SOCIAL CARE**		
	To record a decision taken by the Chairman and Vice-Chairman of the Health and Wellbeing Board.		7 - 20
10.	**PHARMACEUTICAL NEEDS ASSESSMENT CONSULTATION FEEDBACK**		
	To receive a presentation from the Director of Public Health.		21 - 28
11.	**TRAFFORD CLINICAL COMMISSIONING GROUP UPDATE**		
	To receive a report from the Chief Clinical Officer, Trafford Clinical Commissioning Group.		29 - 44

THERESA GRANT
Chief Executive

Membership of the Committee

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

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

Ruth Worsley, Democratic Services Officer
Tel: 0161 912 2798
Email: ruth.worsley@trafford.gov.uk

This agenda was issued on Friday, 31st January by the Legal and Democratic Services Section, Trafford Council, Trafford Town Hall, Talbot Road, Stretford M32 0TH.

HEALTH AND WELLBEING BOARD

3rd DECEMBER 2013

PRESENT:

Councillor Dr. K. Barclay (Executive Member for Community Health and Wellbeing) (In the Chair),
Councillor Mrs. J. Baugh (Shadow Executive Member, Community Health and Wellbeing),
Councillor Miss L. Blackburn (Executive Member for Supporting Children and Families),
A. Day (Chair, Healthwatch Trafford),
Dr. N. Guest (Chief Clinical Officer – Designate, NHS Trafford CCG),
G. Lawrence (Chief Operating Officer, NHS Trafford CCG),
M. Roe (Acting Chief Executive, Pennine Care NHS Trust),
A. Razzaq (Director of Public Health),
S. Webster (Bluesci),
Councillor M. Young (Executive Member, Adult Social Services).

Also present:
W. Heppolette (Director of Operations and Delivery, NHS England) (attending on behalf of Claire Yarwood),
A. Latham (Chief Officer, HealthWatch Trafford),
J. Pearce (Director Service Development - Children, Family & Education) (on behalf of D. Brownlee)
B. Postlethwaite (Chair of Children's Safeguarding Board)

In attendance:
I. Khan (Partnerships Officer),
R. Worsley (Democratic Services Officer).

APOLOGIES

Apologies for absence were received from D. Brownlee (Corporate Director, Children, Families and Wellbeing), B. Humphrey (Chief Executive, Greater Manchester West Mental Health Foundation NHS Trust), Dr. A. Vegh (Chief Executive, University Hospital South Manchester NHS Trust), C. Yarwood (Director of Finance, NHS England).

29. **MINUTES**

RESOLVED: That the minutes of the Health and Wellbeing Board held on 1st October 2013 be approved as a correct record.

30. **DECLARATIONS OF INTEREST**

No interests declared.

31. **INTRODUCING THE CHILDREN'S TRUST AND CHILDREN'S SAFEGUARDING BOARD**

a) Presentation from the Chair of the Children's Safeguarding Board

The Chair of Children's Safeguarding Board provided a presentation on the Children's Safeguarding Board (CSB) and introduced the Annual Report for 2012/13 and the

Business Plan for 2013/14. He outlined the roles and responsibilities of the Children's Safeguarding Board in protecting children and young people and highlighted the linkages between the CSB and the Health and Wellbeing Board.

RESOLVED: That the presentation and report be noted.

b) Memorandum of Understanding between the Health and Wellbeing Board, the Children's Trust Board and the Children's Safeguarding Board

Members also received a report of the Corporate Director, Children Families and Wellbeing which set out the expectations of the relationship and working arrangements between Trafford Children's Trust Board (CTB), Trafford Health and Wellbeing Board (HWB), and Trafford Local Safeguarding Children Board (TSCB), covering their respective roles and functions, arrangements for challenge, overview and scrutiny, and performance management. The report indicated that the Chair of the CTB, the Chairman of the HWB, the Chair of the TSCB and Corporate Director, Children Families and Wellbeing had formally agreed to the arrangements set out in the document.

Board Members were advised that the arrangements would be subject to review in three years (from the date of initial agreement) unless there was significant change in the central government advice about the Boards or any of the Boards felt the arrangements were not working satisfactorily.

RESOLVED: That the Memorandum of Understanding between the Health and Wellbeing Board, the Children's Trust Board and the Children's Safeguarding Board be agreed.

32. INTEGRATION TRANSFORMATION FUND

The Deputy Director, Children, Families and Wellbeing submitted a report which provided details of the health and social care Integration Transformation Fund (ITF). The report explained that the June 2013 Spending Round had announced a fund of £3.8 billion nationally to ensure closer integration of health and social care services from 2015/16. The Local Government Association and NHS England then published a joint statement in August 2013 about this funding, known as the health and social care Integration Transformation Fund (ITF), outlining how the fund could work and the next steps to be taken.

RESOLVED: That the Health and Wellbeing Board approve the report.

33. CHANGES TO MEMBERSHIP - GREATER MANCHESTER POLICE

The Board received an update from the Partnership Officer regarding extending membership of the Board to Greater Manchester Police and it was anticipated that a Police representative would join the Board in February 2014.

RESOLVED: That the update be noted.

34. WINTERBOURNE VIEW STOCKTAKE ACTION PLAN UPDATE

Further to previous updates, the Board received a report of the Executive Member for Community Health and Wellbeing outlining the latest position concerning the Winterbourne View Stocktake Action Plan.

Members were reminded that Trafford had undertaken a self-assessment stocktake exercise in June 2013 for NHS England to benchmark its position leading up to the resettlement of individuals identified as part of the Winterbourne Review. The stocktake was designed to enable local areas to assess their progress against commitments in the Winterbourne View Concordat, share good practice and identify development needs. The Review report, published jointly by the Local Government Association and NHS England, was an analysis that covered all 152 Health and Wellbeing Board areas. Trafford has since been identified as an area of best practice in relation to Choice and Control by the Local Government Association (LGA), NHS England and the Department of Health and a case study from Trafford will feature in the report in relation to how local authorities have responded to Winterbourne.

Attached to the report was an action plan update showing progress against the 'Amber' areas for action (as part of a Red, Amber, Green rating system on progress) which had improved from 10 Amber areas in October 2013 to 1 Amber area in December 2013.

RESOLVED: That the good progress in relation to the areas of the Winterbourne View Stocktake be noted and the efforts of individuals involved be acknowledged.

35. NATIONAL AUTISM STRATEGY SELF ASSESSMENT EXERCISE

Members considered a report concerning a self-assessment exercise in respect of the National Autism Strategy; a strategy aimed at improving the lives of adults with Autism. The report explained that this would be the second national self-assessment exercise of the Adult Autism Strategy entitled "Fulfilling and Rewarding Lives" and that local authorities would be playing a key role in implementing the recommendations of the Strategy and the statutory guidance that supported it.

Members were advised that the purpose of the self-assessment was:

- To assist Local Authorities and their partners to assess progress in implementing the 2010 Adult Autism Strategy;
- To see how much progress had been made since the baseline survey, as at February 2012;
- To provide evidence of examples of good progress made as well as acknowledging remaining challenges.

It was noted that the on-line assessment had been completed in September 2013 and that the national strategy was being reviewed and it was anticipated that the revised version would be published in March 2014.

RESOLVED:

(1) That the National Autism Strategy Self-Assessment Exercise and the contents of the report be noted.

(2) That an electronic link to the document be made available to Members via email.

36. TOBACCO CONTROL LOCAL GOVERNMENT DECLARATION

The Director of Public Health presented a report which sought endorsement of the Local Government Declaration on Tobacco Control. The report highlighted the facts that smoking was the single greatest cause of premature death and disease in Trafford, the single largest factor in health inequalities and a major driver of poverty. It stated that the move of public health to local government presented an opportunity for local authorities to lead local action to tackle smoking and to ensure that the tobacco industry was not able to influence local tobacco control policy. Members had a long debate regarding smoking and the degrees of success in relation to cessation campaigns and work being undertaken with children and young people, and there was a general consensus that there needed to be more innovative ways to deter people from smoking.

RESOLVED:

(1) That the Health and Wellbeing Board approve the report.

(2) The Health and Wellbeing Board endorse the Local Government Declaration on Tobacco Control as set out in Appendix 1 of the report.

(3) That the Director of Public Health be requested to co-ordinate all information and interventions regarding cessation campaigns, including work with schools, and report back to a future meeting of the Board.

(4) Noted that the Director of Public Health would be attending an event in London to mark the Council becoming a signatory to the Local Government Declaration on Tobacco Control.

37. JOINT HEALTH AND WELLBEING STRATEGY ACTION PLAN UPDATE

The Deputy Corporate Director of Children, Families and Wellbeing provided an update on the development of the Joint Health and Wellbeing Action Plan Framework and presented a final version for sign-off. The report also gave details of progress on the Health and Wellbeing Communications and Engagement Plan, including the current position and recommendations. It was noted that there would be a workshop in January 2014 to facilitate organisations represented on the Health and Wellbeing Board to work together to drive through the objectives in the action plan.

RESOLVED:

(1) That the Health and Wellbeing Board approve the progress of the Action Plan Framework and provide reassurance that key priorities reflected in the action

plan are being progressed via the new Health and Wellbeing Programme Delivery Board.

(2) That officers ensure that key priorities reflected in the action plan framework are developed in a timely manner.

(3) That the Health and Wellbeing Board noted the updated Joint Communications and Engagement Plan Summary document.

(4) That the Deputy Corporate Director, Children, Families and Wellbeing, Linda Harper, be requested to provide an update at each meeting of the Board and that the Board be given access to the live document.

38. NHS TRAFFORD CLINICAL COMMISSIONING GROUP UPDATE

The Board considered a report of the Chief Clinical Officer Designate, NHS Trafford Clinical Commissioning Group, which provided an update on the work of the NHS Trafford Clinical Commissioning Group and progress on key commissioning activities. The report highlighted locality specific issues and links to Greater Manchester and national issues where relevant. Board Members raised a number of questions in respect of items in the report which were responded to by officers. A particular issue was raised regarding childhood asthma and some potential causal factors such as schools near busy roads.

RESOLVED:

(1) That the update report be noted.

(2) That the Director of Public Health and the Director Service Development - Children, Family & Education liaise to analyse existing data, if possible, to see if there are any possible linkages between the prevalence of asthma in children and the proximity of schools to areas of poor air quality, and report back to a future meeting.

39. HEALTHWATCH UPDATE

The Chair of HealthWatch Trafford submitted a report which set out the recent activity of HealthWatch Trafford since the last meeting of the Health and Wellbeing Board in October 2013. Board Members were advised that Chief Officer, Andrew Latham, had now been appointed and, that as part of the business plan, there would be increased promotional work to raise public awareness of HealthWatch Trafford.

RESOLVED:

(1) That the HealthWatch update be noted.

(2) That all councilors receive an electronic copy of the HealthWatch newsletter which is currently being distributed to libraries, GP practices and Trafford hospitals.

40. **KEY MESSAGES**

The Board summarised the key messages from the meeting which it wanted to convey to the general public.

RESOLVED: That the following key messages be agreed:

- The Board welcomed the report on the Children's Trust and the Children's Safeguarding Board.
- The Board endorsed the Local Government Declaration on Tobacco Control.

41. **URGENT BUSINESS**

(Note: The Chairman allowed consideration of the following item as urgent business as it had not been possible to include the item on the agenda and the matter required a decision prior to the next meeting of the Board in February 2014.)

Social Funding

Board Members were advised that information regarding a report on Social Funding would be circulated to them for information, and agreement was sought from the Board to delegate approval of this item to the Corporate Director of Children, Families and Wellbeing, in consultation with the Chairman and Vice-Chairman of the Board.

RESOLVED: That approval of the report on Social Funding be delegated to Corporate Director of Children, Families and Wellbeing, in consultation with the Chairman and Vice-Chairman of the Board.

The meeting commenced at 7.05 p.m. and finished at 9.00 p.m.

TRAFFORD COUNCIL
CHILDREN, FAMILIES & WELLBEING

Report to:	**Health & Wellbeing Board**
Date:	**22/11/13**
Report for:	**NHS Support for Social Care 2013/2014**
Report author:	**Finance Manager**
	Director of Operations

Report Title

Joint Report of Trafford Council and Trafford CCG
NHS Support for Social Care 2013/2014

Summary

The report outlines the additional monies allocated to Trafford Clinical Commissioning Group (CCG) for NHS support for social care covering the period 2013/2014. The report indicates where the additional monies are allocated, the resultant increased activity and outcomes and outlines the reporting responsibilities attached to the monies.

Recommendation(s)

That the Health and Wellbeing Board
agrees to:

- the allocation of the NHS Support for Social Care monies 2013/14
- the outlined monitoring arrangements

Contact person for access to background papers and further information

Name: Jeremy Kay
Extension: 4321

Name: Joanne Willmott
Extension: 2710

Introduction

Additional monies have been allocated from the Department of Health to provide support for Local Authority Adult Social Care. NHS England will enter into an agreement with each Local Authority and individual arrangements will be administered by the NHS England Area Teams (and not Primary Care Trusts as in previous years). These funds will be transferred under a Section 256 agreement of the 2006 NHS Act.

The funding must be used to support Adult Social Care services in each local authority, which also have a health benefit. However, beyond this broad condition, NHS England will provide flexibility for local areas to determine how this investment in social care services is best used.

The joint local leadership of Clinical Commissioning Groups (CCGs) and Local Authorities, through the Health and Wellbeing Board, is at the heart of the new health and social care system. NHS England will require the Local Authority to agree with its local health partners about how the funding is best used within social care, and the outcomes expected from this investment. Health and Wellbeing Boards will be the forum for discussions between the Area Teams, CCGs and local authorities on how the funding should be spent.

Allocation

The allocation for Trafford is:

Year	£000's
2010/2011	649
2011/2012	2,595
2012/2013	2,478
2013/2014	3,385

Reporting Requirements

The Area Teams will ensure that the CCG and local authority take a joint report to the Health and Wellbeing Board to agree what the funding will be used for, identified outcomes and the agreed monitoring arrangements in each local authority area.

The report will be:

- presented to the Health and Wellbeing Board who will sign it off as an appropriate investment plan,
- agreed by the NHS Area Team who will recommend release of the monies due
- on receipt of the recommendation of the NHS Area Team, NHS England will pass over the money due after the signature of the Section 256 agreement.

Funding Areas

The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition, NHS England wants to provide flexibility for local areas to determine how this investment in social care services is best used.

The funding can be used to support existing services or transformation programmes, where such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to budget pressures in local authorities without this investment. The funding can also support new services or transformation programmes, again where joint benefit with the health system and positive outcomes for service users have been identified.

In Trafford funding in previous years has been spent on:

- Additional short-term residential care places, or respite and intermediate care;
- More capacity for home care support, investment in equipment, adaptations and telecare;
- Investment in crisis response teams and other preventative services to avoid unnecessary admission to hospital; and
- Further investment in reablement services, to help people regain their independence and reduce the need for ongoing care.

The funding provided for 2013/2014 is intended to develop;

- Older Peoples Rapid Response – to support urgent and enhanced care
- Short Term Beds – Ascot House
- Residential and nursing care
- Personal Budget capacity
- Reablement
- ICES
- Telecare

With the objective to;

- Improve and promote independence and quality of life
- Support integrated care, in the right place at the right time
- Prevent unnecessary hospital admissions
- Prevent unnecessary residential and nursing care admissions
- Prevent delayed discharges

Again this is a local decision, between the Council, CCG through the Health and Wellbeing Board as to how this funding will be spent.

Trafford Position
2013/2014 Allocation £3,385k

Funding Allocated	2013/2014 £000's
Older Peoples Rapid Response	412
Night Service	200
Short Term Beds – Ascot House	477
Residential and nursing care	477
Personal Budget capacity	406
Reablement	706
Equipment and Adaptations	270
Telecare	437
Total	**3,385**

Approval of the final allocation of this is required.

Increased Activity and Outcomes

Telecare

Indicator	12/13 out-turn	13/14 Q2 position	13/14 end year projection
Number of people receiving Telecare in Year	1,792	1,851	2,400 – 33% increase on 12/13 end year
Number of new people aged 65+ receiving Telecare	664	489	980 – 48% increase on 12/13 end year
Number of new people aged 18-64 receiving Telecare	82	90	105 – 28% increase on 12/13 end year

Outcomes

680 new people have benefitted from Telecare installations from April – end October 2013. The table below lists the outcomes that were expected at assessment. The overall total is more than 680 as more than one outcome could be identified for each individual.

As can be seen below, Telecare installation was intended to;

- Facilitate Hospital Discharge in 23.5% of cases
- Minimise risk of falls in 65% of people
- Reduce the likelihood of admission to hospital in 56% of cases
- Improve health and emotional wellbeing in 54% of cases

The expected outcomes are highlighted when a referral is made to the telecare provider (Trafford Housing Trust). The intention is that, on review, these outcomes would be discussed with the user to assess whether they felt they were met.

For example, the outcome “Facilitate hospital discharge” – these people would have been in hospital when referral to telecare was made so 23.5% of referrals (160 / 680) can be said to have facilitated hospital discharge.

Outcome Expected	Number	% of people
Minimise risk of falls	445	65.4%
Manage the effects of dementia	104	15.3%
Enable independent living	525	77.2%
Support carer	340	50.0%
Facilitate Hospital discharge	160	23.5%
Living safely in own home	574	84.4%
Reduced likelihood of admission to Residential/Nursing Care	273	40.1%
Overall improved health and emotional wellbeing	366	53.8%
Reduced likelihood of admission to hospital	379	55.7%
Reduction/change to Home Support package	64	9.4%

Below is case study evidencing the effectiveness of Telecare

Telecare in Action

Mr P was admitted into hospital due to increased confusion and falls, he was discharged from hospital to Ascot House.

Although Mr P had advanced dementia, he had a very good daily routine. Mr P was discharged from Ascot House back home with a falls alarm and “Just Checking”.

Mr P went to the local Newsagent every day at 10.00a.m.; his son monitored the “Just Checking” around this time as his father had fallen once before when going out for his newspaper. Mr P’s son phoned central control as he had not returned home. Mr P again had fallen while outside. Central control phoned the carers who were supporting Mr P at home, and they found him on the floor close to home and called an ambulance.

Mr P returned home that same day as he suffered no serious injury, but he and his family agreed that it would be better for the newspaper to be delivered from now on. Day care support was then arranged for Mr P as Mr P could soon begin to feel isolated.

“Just Checking” not only proved that Mr P had an excellent daily routine at home and slept well at night, it also identified instantly that he had not returned home from buying his newspaper and provided emergency care to minimise length of stay in hospital

Equipment and Adaptations

Indicator	12/13 out-turn	13/14 Q2 position	13/14 end year projection
Total number of equipment / minor adaptations provided	13,950	9,485	18,800 – 38% increase on 12 / 13 end year

In 2012 / 13 we were able meet 85.1% of our target for urgent waiting times (within 7 days to delivery) and 64.8% for those clients classed as 'non-urgent' (within 8 weeks to delivery).

In the year 2013 / 14, we have improved our waiting times for clients to 100% within agreed delivery times for both urgent and non-urgent clients.

Effective delivery of equipment and adaptations ensure the following outcomes:

- People able to remain living independently in their own homes
- Reduction in residential admission
- Reduction in hospital admission
- Timely discharge
- Diversion from more expensive and on-going health and social care services

A sample survey of people who had received equipment / adaptations in the last six months of 2012 / 13 was carried out in April 2013.

- 380 people were surveyed, from which we received 145 responses.
- 96% of respondents reported that receiving equipment / adaptations "had made their life better"

In relation to outcomes:

- 26% reported that it had reduced the likelihood of admission to hospital.
- 35% reported that it had reduced the amount of time they need help from people supporting them.
- 70% reported that it made them feel safer.

Below is an One Stop Resource Centre case study that was included within the Local Account for 2012 / 13

Integrated Care in Action – One Stop Resource Centre

Mrs X needed both equipment and adaptations in order to keep her safe in her own home. Joint assessments took place between Occupational Therapists and Adaptation Officers in order to identify and agree a plan of action. Both had to work closely with Social Workers and the Fire Service to meet Mrs X's needs.

Through this 'integrated' work which involved Occupational Therapists, Manual Handling and Nurses from Health, Majors / Building Control / Social Workers from the Council, Stakeholders including Trafford Housing Trust, Fire Service, Ambulance Service and Equipment Suppliers, we were able to ensure Mrs X was able to remain in her own home to receive very specialist and complex care

Reablement

Indicator	12/13 out-turn	13/14 Q2 position	13/14 end year projection
Total number of community reablement episodes provided in year	1,647	959	1918 – 12% increase on 12 / 13 end year
Total number of days community reablement provided in year	49,619	31,087	62,174 - 25% increase on 12 / 13 end year

Outcomes

We have 2 local indicators that monitor the outcomes from community reablement provision;

- Average % reduction in service hours following reablement intervention in year – as at Q2 (13 /14) this stood at 60% (against a target of 60%)

- % people receiving no on-going service following community reablement intervention - as at Q2 (13 /14) this stood at 46% (against a target of 50%)

Savings analysis of community reablement.

The table below provides an analysis of the potential savings that are being made via community reablement provision based on 2012 / 13 information.

Number of people successfully completing an episode of community reablement	789
Total hours received at the **start of reablement** for the 789 episodes	8,642
Average weekly hours at the **start of reablement** for the 789 episodes	10.95 / week
Total hours received at the **end of reablement** for the 789 episodes	1,809
Average weekly hours at the **end of reablement** for the 789 episodes	2.29 / week
Total hours saved per week for the 789	(6,833)
Average hours saved per person per week	(8.65)
Total cost of hours saved per week @ £12.62 / hour	£(86,230) / week
Potential Full year effect of the reduction in hours (hours saved / week X 52)	£(4,483,920)
Taking the above: Based on a normal distribution of people entering and leaving the service in a year the saving arising from the hours saved is estimated at	£(2,033,000)

Taking the above: Based on an assumption of 50% of people requiring an increase in services due to needs changing the notional saving is in the region of:	**£(1,016,500)**

For every person that successfully completes an episode of reablement, the reduction in their care package cost equates to £(109.29) / week or £(5,683) / year before adjusting for changes in needs after reablement.

The work of the reablement team in benefiting the whole health and social care economy is demonstrated through the following improvements in health related indicators

Information within the AQUA / ADASS report evidences clear improvement across a range of indicators that are intended to support the development and monitoring of integrated health and social care working with a particular focus on frail elderly.

The information below is based on a "rolling year" and compares the 2 most recent reporting periods; April 2012 – March 2013 and June 2012 - July 2013

Indicator	April 2012 – March 2013	July 2012 – June 2013	Improvement
Non-elective admissions aged 65+ per 1000 pop 65+	258	255	1.2%
Non-elective bed days aged 65+ per head of 1000 pop 65+	3092	2962	4.2%
Non-elective readmission rate within 30 days aged 65 and over	16.8%	15.8%	6%
Non-elective readmission rate within 90 days aged 65 and over	27.9%	24.9%	11%

The information below compares the Delayed Transfers of Care bed day's figures from March 2013 to September 2013.

Indicator	April 2012 – March 2013	July 2012 – June 2013	Improvement
Delayed transfers of care (Bed Days) per 100,000 population 18+	255	146	43%

The National ASCOF indicators relating to Delayed Transfers of Care have also seen a significant improvement since 2012 / 13 year end as evidenced below;

Indicator	April 2012 – March 2013	April – Sept 2013	Improvement
Delayed transfers of care (all) per 100,000 population 18+	7.6	6.2	18%
Delayed transfers of care (Adult Social Care responsible) per 100,000 population 18+	4.1	2.1	49%

Below is a reablement case study that was included within the Local Account for 2012 / 13

Promoting Independence in Action – Community Reablement

Mr A was referred to the Reablement team by Trafford General Hospital, for an assessment of his needs. Mr A had suffered from a stroke which had affected his mobility and speech. Prior to his stroke he was an independent man who was retired and lived with his wife. He didn't live in the local area but was planning to move here, to be near other family members.

Necessary arrangements were made, and he was registered with the local doctor. The hospital sent information Mr A had shared to the Reablement team. When he was discharged a member of the team met Mr A at his home. The Occupational Therapist in the hospital had assessed Mr A would require a range of equipment; these were in place and ready for him when he got home.
At this stage the Reablement team provided four calls a day with two carers to support Mr A with all his personal care needs.

The team continued to support Mr A in his new surroundings and helped him regain his confidence. Mr A was recovering well from his stroke and his abilities increased. Consequently a referral was made for an OT assessment for new equipment relative to his improved mobility.

New equipment was provided, which Mr A was supported to use. Again, as he grew more comfortable with these, and his strength and mobility increased, the Reablement workers reassessed him. Mr A's was now able and comfortable to use the equipment with minimal assistance from one carer.

The Reablement team worked with both Mr A and his wife, as Mr A's mobility improved both he and his wife grew more confident to manage certain aspects more independently. With the A's agreement, visits were staggered to allow them to try to things on their own, gradually, at their pace, services were reduced to one visit in a morning by one carer.

A Social Care Assessor (SCA) reviewed the assessment and long term options were discussed with Mr and Mrs A. They chose a commissioned service and Trafford Council arranged this support. When the SCA carried out the six week review, Mr and Mrs A felt confident that they could manage independently but were concerned that Mr A's needs might change in the future and they wouldn't have any support.

The SCA reassured Mr and Mrs A that they could refer themselves at any time for a reassessment through the screening team. With this information Mr and Mrs A felt comfortable to cancel the care completely, returning their independence and control over their lives.

LD Reablement

In 2012 / 13, we expanded our reablement provision to cover people with Learning Disabilities. Development of the service in 2013 /14 is evidenced by the information below.

Indicator	April 2012 – March 2013	13/14 Q2 position	13/14 end year projection
Number of episodes of community reablement (LD specific)	57	50	100 – 75% increase on 12/13 end year
Number of days LD specific reablement provided	4604	3169	6338 - 38% increase on 12/13 end year

The role of the Learning Disability Reablement Service is to increase individuals functioning, independence and social capital and reduce reliance on formal health and social care services.

Short Term Beds - Ascot House

Indicator	12/13 out-turn	13/14 Q2 position	13/14 end year projection
Number of episodes of residential reablement provided	197	110	220 – 12% increase on 12/13 end year
% of people returning home following assessment unit intervention	42.7%	47.1%	48% - 12% improvement on 12 / 13 end year

The unit at Ascot House has also incorporated 5 health funded beds since April 2013. In this period, 33 people have completed a period of reablement with 30 (91%) returning to their home address.

Savings analysis of residential reablement.

The table below provides an analysis of the potential savings that are being made via residential reablement provision based on 2012 / 13 information.

Number of people **accessing** the assessment unit	192
Number of people **returning home** following assessment unit intervention	82
Average **estimated cost of a care package** for those returning home (10 / hours / week)	£126.20
Average **cost of a residential / nursing care placement** / week	£400
Average **cost saving per week** for those diverted from residential / nursing care.	£(273.80)

Total weekly savings for those 82 people diverted from residential / nursing care in 2012 / 13.	£(22,452)
Potential full year effect of savings for those people diverted from residential / nursing care (weekly savings 52)	**£(1,167,483)**
Based on a normal distribution of people entering and leaving the service in a year the saving arising from people diverted from residential/nursing care is estimated at	**£(478,600)**

For every person that returns home from the assessment unit having been diverted from long term residential / nursing care, the reduction in their care package cost equates to £273.80 / week or £14,237.60 / year before adjusting for changes in need after leaving Ascot House.

Integrated Care in Action – Ascot House

Mr G was admitted to Ascot House for a six week assessment. When he arrived at Ascot House Mr G required maximum support in all areas of daily living. Mr G was determined to return home and worked with a range of health and social care staff, including Physiotherapists, Occupational therapists and Carers to improve his mobility. The social care assessor arranged a package of care and Telecare equipment including falls detector, bed sensor, pendent alarm and key safe.
Due to the progress he made and the improvement in his confidence and mobility Mr G was able to return home after four weeks. This case shows how joint working with partners can have a positive and successful outcome enabling individuals to return home maintaining independence and preventing the need for 24hr residential care/nursing care and reducing hospital admission

Rapid Response

Indicator	12/13 out-turn	13/14 Q2 position	13/14 end year projection
Number of episodes of Rapid Response provided	511	287	575 – 12% increase on 12/13 end year

The following case studies provide examples of the effectiveness of the Rapid Response service;

Rapid Response in Action

1. Mr L

Referred from Wythenshawe Hospital as palliative care, this gentleman had been given a poor prognosis and he and his family wished for him to return home to spend his last days. Hospital occupational therapist had organised the necessary equipment before discharge home. Senior Support worker visited on the first day with a support worker to carry out personal care needs and complete the risk assessments. Senior discussed with Mr L and his wife the service and confirmed the visits would meet his needs. During visit Senior noticed that the armchair that had been raised was too high as there was a pressure cushion on it. Mr L was then referred to our Occupational Therapists to rectify the problem. Over the subsequent few days Mr L deteriorated and was unable to mobilise and needed to be cared for in bed which meant the support staff needed to be increased from one to two carers. Mr L was at home for a total of 6 days when he passed away in the comfort of his own home which was his and his families wish.

2. Mrs N

Referral received direct from District Nurses as Mrs N was not coping at home. She was on the reablement waiting list but was now no longer able to wait for support. Mrs N had severe arthritis and had been experiencing falls due to restricted mobility. Senior visited to complete risk assessments with family also present. It was noted that Mrs N was struggling to get up from the chair and bed due to arthritis in her hips and had poor dexterity in her hands making the simple tasks such as wringing a cloth or dispensing her medication very difficult. Referral was made to the Occupational therapist to look at raising the bed and chair to a manageable height and provide a perch stool in both kitchen and bathroom so that Mrs N could sit while completing tasks. Advice was given to purchase either a sponge or lighter flannel that Mrs N could wring out. Blister pack was discussed and following agreement by Mrs N ordered with GP so that she could manage her medication independently. Mrs N was on our service for approximately 3 weeks when she cancelled all support as she felt she had regained her independence which our records also confirmed.

Waking Nights Service

The waking nights' team consist of 7 members of staff that each work 3 nights a week - 30 hours. They work from 10 pm – 8 am over 7 days.

The service started in October 2011 and was set up with the aim of reducing the number of admissions to Hospitals and, where possible, assisting service users to return back to their home within the community in the Trafford area. The team work alongside the district nurses and when they are not assisting service users in the community they are based in Ascot House Sale. The District Nurses contact the staff if they receive a call that a service user requires assistance in the community and the staff attend in two's.

Staff also pick up from referrals from A & E Departments at Trafford General and Wythenshawe Hospitals and assist with a "meet and greet" at the service user's home if they require assistance once back home. The team also assist with night sits that can be pre booked through the Rapid Response team if a service user requires an assessment of night time needs. Staff also assist with night sits for palliative care end of life service users or emergencies that might happen when on duty with the District Nurses. Night sits are a maximum of 3 nights.

The number of visits that the staff have made from the 1st April 2013 – 30th September is 414.

Outcomes include

- Diversion from A+E
- Prevention of hospital admission
- Support to carers
- Promoting independence and quality of life

Monitoring Arrangements

NHS England will require expenditure plans by local authority to be categorised into the following service areas (Table 1) as agreed with the Department of Health. This will ensure that NHS England can report on a consolidated position on adult social care expenditure.

Table 1:

Analysis of the adult social care funding in 2013-14 for transfer to local authorities

Service Areas- 'Purchase of social care'	***£000's***
Community equipment and adaptations	270
Telecare	437
Integrated crisis and rapid response services	412
Maintaining eligibility criteria	0
Re-ablement services	706
Bed-based intermediate care services	0
Early supported hospital discharge schemes	477
Mental health services	0
Other preventative services	0
Other social care: Personal budget capacity	406
Other social care: Residential and nursing care placements	477
Other social care: Night service	200
Total	**3,385**

Furthermore, as part of the agreement with local authorities, NHS England will require access to timely information (via Health & Wellbeing Boards) on how the funding is being used locally against the overall programme of adult social care expenditure and

the overall outcomes against the plan, in order to assure itself that the conditions for each funding transfer are being met.

Conclusion

The 13/14 funding allocation is intended to be invested in services that benefit the Trafford Health and Social Care economy and support our shared journey towards integrated care. The funding transfer will make a positive difference to Social Care Services, and outcomes for service users, compared to service plans in the absence of the funding transfer

The plan provides a robust foundation for the development of Integration Transformation Fund plans as it focuses on the five outcomes already identified as ITF priorities:

- Delayed transfers of care
- Emergency admissions
- Patient and service user experience
- Effectiveness of reablement
- Admissions to residential & nursing care

Recommendations

It is proposed that;

- Final allocations for the use of this money, as outlined above are agreed by the Health and Wellbeing Board
- Agreement of NHS England for the release of this money as outlined above is sought.

NHS

Greater Manchester
Commissioning Support Unit

Pharmaceutical Needs Assessment post consultation update

Project to date

Greater Manchester Commissioning Support Unit

- Project started in June 2013
- During July and August 2013
  - Pharmacy and appliance contractors and the public were surveyed
  - Data to inform the PNA collated by GMCSU
- September 2013 a draft PNA produced by GMCSU
- 3rd October 2013 draft PNA approved for 60 day consultation

60 Day Consultation

Greater Manchester Commissioning Support Unit

- Took place during October and November 2013
- Document sent for consultation to:
  - All pharmacy contractors
  - Dispensing appliance contractors
  - Trafford CCG
  - Trafford LPC
  - Trafford LMC
  - NHS England Greater Manchester area team
  - Local Health watch
  - Local acute trusts
  - Neighbouring Health and Wellbeing Boards
- Responses analysed during December 2013

Consultation Responses

Greater Manchester Commissioning Support Unit

- 35 responses received in total
- All 35 thought that the explanation of the PNA was sufficient
- 31 thought that the PNA adequately assessed the pharmaceutical service in Trafford
- 30 thought that the PNA gave a satisfactory overview of current and future needs for Trafford
- 32 agreed with the conclusion of the PNA

Area of Contention 1

Greater Manchester Commissioning Support Unit

The PNA indicated a need for improved access on Saturday and Sunday for Sale Moor and Brooklands wards

- After considering the patient survey responses and the views of, in particular, Healthwatch and the LPC the PNA has been amended to state:

'Two 100hour pharmacies (open Saturday and Sunday) in Priory ward are easily accessible, by public transport, for residents in Sale Moor and Brooklands and the patient survey showed no lack of access at weekends'

Area of Contention 2

Greater Manchester Commissioning Support Unit

The PNA indicated a need for improved access on Saturday afternoon and Sunday for Bucklow-St. Martins ward

- After considering the views of, in particular, Healthwatch and the LPC (there were no patient survey responses for this area) the PNA has been amended to indicate that:

'The conclusion drawn in term of the opening hours for pharmacies around Trafford is that all localities have some weekend access to pharmacy services but that it may benefit the area of Partington, where the opening hours are limited on Saturday and closed on a Sunday, if there were to be an to extension of the opening hours.' This would help address urgent care pressures in this area of high deprivation.

Approval

Greater Manchester Commissioning Support Unit

- The HWBB has two options:
  1. Agree the amendments and approve the PNA now, or;
  2. Take further time to consider the document and request any amendments by 14th February in order to approve a final document at their April meeting.

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NHS Trafford Clinical Commissioning Group

Agenda Item No. 18

Part 1 [X] Part 2 [ ]

NHS TRAFFORD CLINICAL COMMISSIONING GROUP GOVERNING BODY 28th January 2014

Title of Report	Chief Clinical Officer's and Chief Operating Officer Report
Purpose of the Report	This report provides an update to the Clinical Commissioning Group Governing Body of NHS Trafford. This report is in two parts **Part 1:** is an update to the Clinical Commissioning Group Governing Body on key commissioning activities undertaken since the update provided to the Governing Body in November 2013. This section considers locality specific issues referencing links to Greater Manchester and national issues where relevant. **Part 2:** is the Integrated Care Update and is in the form of a highlight report. It provides a position statement for the entire Integrated Care Programme. The highlight report breaks down each of the work stream detailing the progress made over the previous reporting period, highlight any issues and detail the planned next steps.

Actions Requested	**Decision**	**X**	**Discussion**		**Information**	**X**

Strategic Objectives Supported by the Report	1. Consistently achieving local and national quality standards.	
	2. Delivering an increasing proportion of services from primary care and community services from primary care and community services in an integrated way.	
	3. Reduce the gap in health outcomes between the most and least deprived communities in Trafford.	
	4. To be a financial sustainable economy.	

Recommendations	The Governing Body is asked to note the contents included in this joint report from the Chief Clinical Officer's and Chief Operating Officers report. The Governing Body is asked to agree to move the Project Initiation Documents (PID)/Green Papers identified in Part 2 (section 3) of this report from Phase 1 to Phase 2.

Discussion history prior to the Governing Body	Project updates provided to the Commissioning & Operations Steering Group on the 17th January 2014
Financial Implications	N/A
Risk Implications	Any risks relating to any of the issues are included in Trafford's CCG risk log.
Impact Assessment	All redesign services will have a full impact assessment completed.
Communications Issues	The CCG has a comprehensive communications plan for New Health Deal. Communications relating to Trafford's Integration plan is being expanded to include the comprehensive programme.
Public Engagement Summary	Trafford CCG has had a full and inclusive public engagement programme for New Health Deal and is commencing on a local conversation for Healthier together

Prepared by	Dr Nigel Guest, Chief Clinical Officer and Gina Lawrence, Chief Operating Officer
Responsible Director	Dr Nigel Guest, Chief Clinical Officer

CHIEF CLINICAL OFFICER'S REPORT

1.0 PURPOSE OF THE PAPER

1.1 The layout and content of this report has been changed. The report will be in 2 parts.

Part 1: is an update to the Clinical Commissioning Group Governing Body on key commissioning activities undertaken since the update provided to the Governing Body in November 2013. This section considers locality specific issues referencing links to Greater Manchester and national issues where relevant.

Part 2: is the Integrated Care Update and is in the form of a highlight report. It provides a position statement for the entire Integrated Care Programme. The highlight report breaks down each of the work stream detailing the progress made over the previous reporting period, highlight any issues and detail the planned next steps.

The Governing Body is asked to agree to move the Project Initiation Documents (PID)/Green Papers identified in Part 2 (section 3) of this report from Phase 1 to Phase 2.

2.0 PART 1: COMMISSIONING ACTIVITIES UPDATE

2.1 South Sector Work

Work continues within the South West Sector Board to consider how services can align under the Healthier Together programme. The emphasis is on locality reconfiguration being led by the CCGs and providers in the area. Several models have been looked at

2.2 Oxygen Services

One of Trafford leads for Oxygen has been asked to become a member the National Patient Safety Group. This recognises the work which the team from the North West has undertaken. Also the Cluster Headache Pathway/algorithm which has been developed one of the Oxygen Leads has been submitted for a NICE shared learning award in February.

2.3 Asylum Seekers

Trafford CCG and NHS England have worked collaboratively to implement primary care services for this new community. The services have been in place which includes full health checks to avoid where clinically appropriate the demand on acute sector. This service will be available until early February when this population will be moving out of Trafford.

2.4 Podiatry Procurement

Trafford CCG are progressing to ITT stage of its procurement for this service. The CSU are responsible for this procurement

2.5 Community Dermatology Service

Trafford have agreed to be part of the joint procurement for community dermatology services with South Manchester CCG services.

3.0 NHS GREATER MANCHESTER UPDATES

3.1 Healthier Together

The Healthier Together Committee-in-Common, Clinical Reference Group and Steering Group continue to meet regularly. The Chief Clinical Officer is a member of all of the groups.

A formal review of the Healthier Together programme by the National Clinical Advisory Team (NCAT) took place on Tuesday 17 December, to ensure clinical assurance of the proposed Future Model of Care in Greater Manchester. The CCG's Chief Clinical Officer was involved in the session of the review for the Clinical Reference Group. The NCAT panel members were unanimous in their support to the programme, and noted that they were highly impressed with the scale of ambition and excellent work that is taking place across GM.

3.2 Greater Manchester Commissioning Support Unit (GMCSU)

GMCSU launched a Change Programme in November 2013, covering several strategic areas, with the aim of securing its long-term future. In order for GMCSU to meet its clients' requirements to become more responsive and efficient, it is reassessing its cost base, internal structures and pricing. All CSUs are going through the same process, at the same time, and a national 45-day consultation with all CSU staff started the week of 6 January 2014.

Alongside this, GMCSU has announced a formal commitment that it will start to work closely with Cheshire and Merseyside CSU, a decision that was made following discussions in light of the Lead Provider Framework.

3.3 Better Care Fund

Full details of the Better Care Funds have been published. Trafford have had joint discussions between the Council and the CCG to agree the Trafford approach and the submission for the 14th February. It has been agreed for the Trafford's programme to focus and develop the following programmes of work to ensure reduced activity in the secondary health sector.

The Trafford's schemes are:

Scheme	Overview	Lead responsibility
Early years intervention	The development of a Trafford Wellbeing Hub. This would bring together a variety of services into a single, shared, ageless service model with the focus on the holistic health and wellbeing of the individual.	**Lead organisation :** Trafford Council **Lead Officer**- Deputy Corporate Director Children, Families and Wellbeing Directorate Director of Service Development, Adult and Community Services
Palliative Care	To improve the choice of death for Trafford residents. To ensure that families/carers have greater support in the choice of death. This will increase the number of individuals who choice home to be their place of death and for both organisations to ensure that the patients and family is given the appropriate support.	**Lead organisation :** Trafford CCG **Lead Officer**- Associate Director of Commissioning.
Frail and elderly	It is recognised that as people are living longer, both Health and Social care have an responsibility to support, provide the appropriate support to ensure these vulnerable individuals retain independence and have the appropriate health and social care support to avoid unnecessary admissions into hospital. This programme will ensure there are comprehensive services and connectivity across services working across Trafford especially linking Primary and community services to ensure the delivery of quality services	**Lead organisation :** Trafford CCG **Lead Officer**- Associate Director of Commissioning.

4.0 NATIONAL UPDATES

4.1 Planning Guidance for Commissioners

NHS England has circulated its planning guidance for the next five years, Everyone Counts: Planning for Patients 2014/15 to 2018/19. This document describes NHS England's ambition for the years ahead and its on-going commitment to focus on better outcomes for patients. It describes the vision for transformed, integrated and more convenient services, set within the context of significant financial challenge. The CCG has made progress by identifying the commissioning priritires for the next 5 years and ensuring that these fir with the Joint Assessment Needs and ensuring these deliver against the 7 Outcome Ambitions

4.2 CCG Funding Allocations

NHS England has published the funding allocations that CCGs will receive over the next two years (2014/15 and 2015/16). The allocations contain a new funding formula for local health commissioners that will more accurately reflect population changes and include a specific deprivation measure.

4.3 Plan for Seven-Day Services across the NHS

NHS England's National Medical Director, Sir Bruce Keogh, has published his plan to drive seven day services across the NHS over the next three years, starting with urgent care services and supporting diagnostics. The plan is informed by findings of his Forum on NHS Services, Seven Days a Week, set up in February this year.

4.4 Prime Minister's Challenge Fund: Extending Access to General Practice

The Prime Minister has announced that there will be a new £50 million Challenge Fund to help extend access to general practice and stimulate innovative ways of providing primary care services. The Government has asked NHS England to lead the process of inviting expressions of interest and overseeing the pilots.

4.5 Publication of GP Outcomes Data

Increased information about the standards and performance of primary care has been published on the NHS Choices website, as part of NHS England's drive for more transparency and public participation. The information, which is a data set of GP outcome standards and high level indicators, includes screening rates, Quality Outcomes Framework measures, prescribing items and patient survey data.

4.6 Winterbourne View Concordat

To ensure that the NHS is able to assure people with learning disability, their families and carers, the wider public and the Department of Health that its commitments in the Winterbourne View Concordat action plan are delivered, targeted data collection is being undertaken through bespoke quarterly returns to be completed by all NHS commissioners.

4.7 Extension of Leadership Alliance for the Care of Dying People (LACDP) Engagement

As part of the system-wide response to recommendations in More Care, Less Pathway, the LACDP is currently seeking views on what high-quality care should look like for people in the last days and hours of life, no matter where they are being cared for. The engagement has now been extended until Friday 31 January 2014 to allow as many people as possible to take part.

5.0 RECOMMENDATIONS

The Governing Body is asked to note the contents of the update.

The Governing Body is asked to agree to move the Project Initiation Documents (PID)/Green Papers identified in Part 2 (section 3) of this report from Phase 1 to Phase 2.

6.0 PART 2: INTEGRATED CARE PROGRAMME UPDATE

The next section is the Integrated Care Update and is in the form of a highlight report. It provides a position statement for the entire Integrated Care Programme. The highlight report breaks down each of the work stream detailing the progress made over the previous reporting period, highlight any issues and detail the planned next steps.

TRAFFORD INTEGRATED CARE PROGRAMME: HIGHLIGHT REPORT

January 2014

Integrated Care Update

Op Lead: **Adam McClure**
Exec Lead: **Julie Crossley**
Clinical Lead: **Michael Gregory**

Strategic objectives met by Programme	Integrated Care Programme
1. Consistently achieving local and national quality standards.	
2. Delivering an increasing proportion of services from primary care and community services from primary care and community services in an integrated way.	
3. Reduce the gap in health outcomes between the most and least deprived communities in Trafford.	
4. To be a financial sustainable economy.	

Integrated Care Programme Highlight Report

1. Introduction & Background

This highlight report provides a position statement for the entire Integrated Care Programme. The report will break down each of the workstream detailing the progress made over the previous reporting period, highlight any issues and detail the planned next steps.

2. Contents

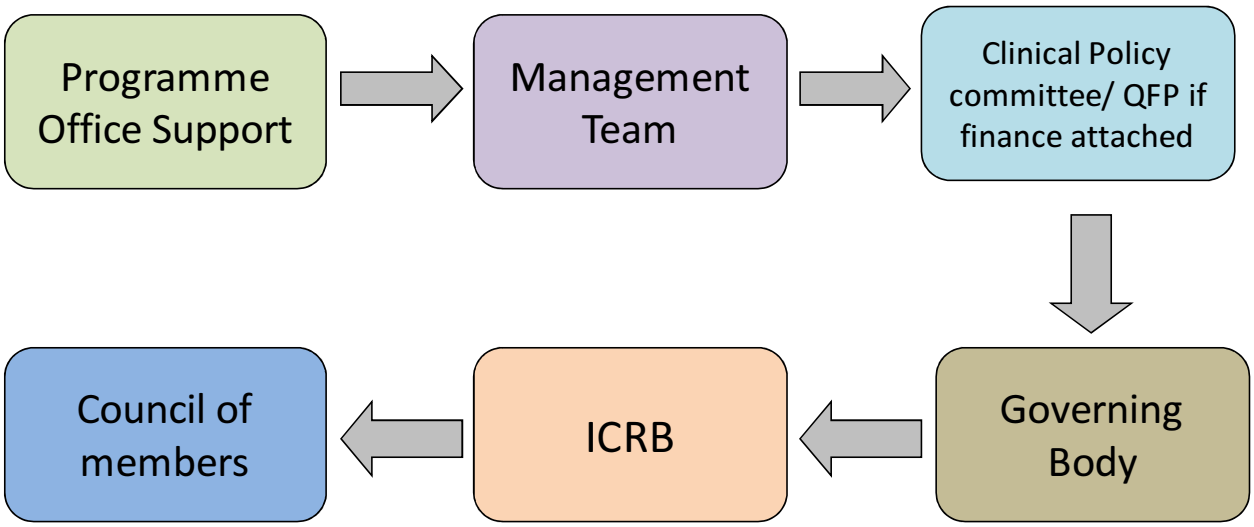
3. Programme Update

Phasing of projects
Each of the projects within the integrated care programme is managed on a phased basis. The four distinct phases are:

- **Phase 1:** Analyse (pre-design & review) – Project bank
- **Phase 2:** Plan (design & plan)
- **Phase 3:** Implement, test & assess
- **Phase 4:** Evaluate, sustain & Share

Phase 1 Project Initiation Documents (Green Papers) in development:
Phase 1 consists of analysing any proposed projects to gauge the potential benefits of the project and decide whether it is a priority for the CCG. During this phase a Green Paper or Project Initiation Document (PID) will be produced and presented to the CCG Governing Body prior to moving to phase 2.

Approval process for PIDs
In order to ensure that there is a robust sign-off process for all projects, the sign-off process below has been agreed with the Corporate Team.



1. All PIDs in development will be overseen by the Programme Office who will assist with ensuring that PIDs transition smoothly through the process;
2. Management Team will assess the PID in the context of capacity and assigning project managers and resources to the project;
3. Clinical Policy Committee will assess the clinical requirements of the project and provide approval. The Quality, Finance & Performance Committee will sign-off any financial commitment required;
4. The Governing Body will provide final approval of the project;
5. The ICRB is required to provide sign-up to the project on an economy footprint and ensure engagement from providers (as and where required); and
6. The projects will be shared with the Council of Members and agreement sought that the project is a priority for the CCG.

PIDs to be signed-off by the Governing Body
During December and January 2014, the Executive Management Team have signed off three Project Initiation Documents, these are:

1. Frail Elderly Programme;
2. COPD Early Supported Discharge Service (EDS); and
3. Palliative Care Programme.

An outline for these PIDs can be found in the table below and the full PID can be found in the Appendices at the end of this report. The Governing Body is asked to approve these documents in order for them to move to Phase 2 (Design & Plan).

Project	Description
Frail Elderly Programme	There are currently 18,500 people aged 75years and over in Trafford. Frail elderly patients with complex care needs represent the largest demand on adult health and social services. Many other frail elderly people are supported in their own homes or other community facilities and services (e.g. intermediate care, nursing and specialist care). Many of these people have complex needs and are susceptible to disease. This results in

Frail Elderly PID v3.2 20-12-13.docx	high admission and readmission rates to secondary care where in the community lack capacity and therefore the ability to use knowledge in managing diseases and complications. Consequently, pathways between levels of care are not targeted to support the delivery of specialist care and advice in the community. Admissions and readmissions of frail elderly patients could be avoided if there were greater support in primary and community services. There are alternative ways of supporting these patients in a community setting and further enhance primary care thereby reducing secondary care capacity. We define Frail and Elderly as: "Any patient over 75 years of age who enters intermediate care or who is a frequent flyer into acute services" This project will be clinically driven and will focus specifically on the pathway for frail elderly patients. It is not anticipated that the project will redesign, decommission or procure any services but rather will identify the potential need for these activities, making recommendations for the next steps and then passing these projects into the Integrated Care Project Reserve for assessment and prioritisation. The project will look at how services currently integrate and will work with services to ensure a smooth pathway, through education and changing working procedures in line with best guidance. In effect the project will perform an assessment/surveillance of the current frail elderly pathway, identifying issues, completing quick fixes (where appropriate), offering solutions to problems and ensuring education, development and communication plans are executed to improve the provision of care offered to frail elderly patients. Mission Statement: To improve the quality of care for frail elderly patients by looking at: • To identify any gaps in the current service provision and make recommendations for next steps • Ensure that services are designed to assist patient to remain independent and spend the majority of time in their own home • Supporting families/ carers through education • To ensure compliance with the Out of Hospital Standards • To ensure that health and social care pathways provide the right care, at the right time, in the right place Prevalence data for 2012-2013 informs that are currently 4,009 patients with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) within the borough, a figure which is expected to rise. In Trafford COPD admissions account for 13% of all respiratory disease spells to hospital, 85% of which are emergency admissions. COPD patients often experience an extended length of stay and a number of readmissions to hospital.
COPD EDS COPD ESDS PID v1.1 24-12-13.docx	To date Trafford does not have a specialist respiratory service that provides support to patients to manage their COPD within community or assist early discharge from hospital. The provision of commissioned respiratory services varies across Greater Manchester localities and following a review of current pathway it is evident that this variance extends to the support available to Trafford patients dependent on the Acute Trust they are admitted to. Central Manchester Foundation Trust (CMFT) has a well established COPD Team, based at Manchester Royal Infirmary (MRI), an element of which supports the early discharge of patients back into the community. Currently unavailable for Trafford patients, this proposal seeks to provide access by implementing the early supported discharge element of the service to Trafford General Hospital whilst also providing: • A reduction in admissions and length of stay • A reduction in readmissions

	• An improvement in patient experience and an increase in patients' independence and confidence to self care. The implementation of an COPD Early Supported Discharge Service (ESDS) at Trafford General Hospital as a one year 'test the concept' pilot will test assumptions and establish the impact and efficiencies a COPD early discharge service provides throughout the economy. Impacts of this service are expected across the COPD pathway and include: • Primary Care; reduction in prescribing and increase in the appropriate use of appointments • Secondary Care; Reduction attendances to A&E, length of stay and Readmissions; and • Community Services; increase in the enhanced care community offer and the increased management of Long Term Conditions (LTC) outside of acute settings. This approach will also facilitate greater coordination of care with Urgent and Enhanced Care during their first year of implementation and further scope the need for a specialist respiratory service in Trafford. A number of projects were initiated by Trafford Primary Care Trust and inherited by Trafford Clinical Commissioning Group (CCG), they are: • Multi Professional Education & Training (MPET) for care homes • MPET for professional and Clinicians • Trafford Advance Planning Portal (TAPS) • Electronic Palliative Care co-ordination System (EPaCCs) • Hospital Palliative Care Plan • Palliative care specification and community provision • MPET funding from NHS England • Management of St Ann's core contract
Palliative Care programme  Palliative Care PID v1.2 19-12-13.docx	This programme seeks to undertake a 'stocktake' of Trafford's current palliative care provision, to review project progress and identify areas for further development which are in line with the CCG's Integrated Care Strategy. It is important to note that following the national clinical change of the withdrawal of the Liverpool Care Pathway, there will be a significant impact on the pathway for many of Trafford CCG's patients and partners. Establishing an understanding of the impact of this change on commissioned services will be a part of the stocktake exercise. Trafford CCG's Palliative Care Programme will be developed to address areas for improvement to ensure a proactive, person-centred and integrated palliative care pathway exists which is based on best practice and delivers an improved patient and family experience. This programme will also establish efficient monitoring of commissioned services, through contract performance to ensure good clinical outcomes and value for money.

Phase 2 - 4 projects and programmes

The current numbers of projects and programmes at each stage is highlighted in the table below; this table will be used to highlight to the Governing Body the high level progress of the projects within the Programme as they pass into each stage:

Numbers of projects in each phase			
Phase 1 (Analyse)	**Phase 2 (design & plan)**	**Phase 3 (implement & test)**	**Phase 4 (Evaluate)**
Currently being agreed	14 *(+3 if agreed)* • *Frail elderly* • *COPD EDS* • *Palliative Care*	18 *(-1)*	4 *(+1)* • *RAID*

Integrated Care Measures

In order to measure the success and track the benefits to patients of the Integrated Care Programme the Programme Office have developed a set of integrated care measures for 2014-15 which have been agreed by all key stakeholders (external and internal).

This November report can be seen on the next page. In order to ensure that the measures are robust and to understand how these measures will be reported next year the table has been designed to show the month on month plan vs actual and the accumulative to date figure. It is important to note that a number of the programmes did not commence until November 2013.

The accumulative picture is showing a shortfall against the target, this information has been discussed with the project leads in a Commissioning Workshop and further details will be presented at the Commissioning & Operations Steering Group in February 2014.

The 'Deflections from Accident & Emergency' measure has shown improvement against the predicted target for October and November and the 'Reduction in re-admissions' and 'Reduction in Length of Stay' targets were achieved in November. Although not statistically significant it is believed that these measures have been impacted upon by the Urgent & enhanced Care Teams implementation in November 2013. Further updates on these measures will be reported through this report on an ongoing basis.

Integrated care measures, month on month breakdown and YTD accumulative: November 2014

Monthly movement - of Shortfall/(excess) achievement		Cumulative to M5	M6 only/cumulative	Oct'14 M7 only	Nov'13 M8 only	Dec'13 M9 only	Jan'14 M10 only	Feb'14 M11 only	Mar'14 M12 only	Shortfall/ (excess)	YTD cumulative
Unscheduled Care	Deflections from Accident & Emergency	864	125	-253	-159					577	577
	Reduction in admissions - Urgent care business case activity only	80	8	111	58					257	257
	Reduction in re-admissions	N/A	282	186	-58					410	410
	Reduction in length of stay - TGH only	N/A	2.23	0.34	-0.55					2	2
Scheduled Care	Reduction in procedures	411	122	90	418					1,041	1,041
	Reduction in out patients new	N/A	797	284	667					1,748	1,748
	Reduction in out patients follow up	N/A	1,437	503	197					2,137	2,137

4. Project Updates

Project updates are provided by exception. Due to the Christmas break the Commissioning & Operations Steering Group did not hold a full meeting in January 2014. This meeting was used to catch up with the wider integrated care agenda and a focus on business planning for 2014/15. Normal reporting will resume in this report from February 2014.

New Health Deal

Trafford CCG continues to monitor the post implementation of the New Health Deal for Trafford. An Operations group which has representatives from all partner organisations continues to meet on a weekly basis. This ensures all operations issues are resolved; it also reviews the weekly activity and performance data to ensure that all parties are aware of performance. A full pack of information is being collated to share and present at the Joint Overview and Scrutiny on the 28th January.

Trafford CCG continues to monitor the schemes which have been implemented to support the system and remove pressure from the secondary care Trusts.

From 20th December, the CCG introduced the Alternative to Trafford (ATT) Scheme. This scheme has been commissioned by Mastercall who work collaboratively with NWAS this scheme has to date reduced admissions to acute services by 96 since it was introduced. Mastercall are undertaking an audit to validate these patients was not admitted within 7 days.

There has been a small number of deflections from SRFT and UHSM back to practices from the GP deflection scheme.

As part of Trafford's CCG dashboard this now includes the utilisations of Trafford Intermediate Care services including the 18 beds at Trafford General. This unit has only received a number of patients from the acute units, the majority from UHSM. To date the maximums number of patients has been 10 out of the 18 beds available.

Patient Co-ordination Centre

The procurement has now progressed to the next stage with bidder's days being held with the providers. The information appertaining to the next stage has been shared with providers via the procurement software.

5. Programme Issues (Here and Now)

Issues are reported by exception, the project may have identified low level issues which do not require review by the Governing Body. Only those issues which may have an organisation impact will be reported.

The Programme Office and the Head of Governance, Planning & Risk are coordinating a piece of work to ensure that Risks and issues are reported in a robust and consistent way. In order to achieve this, the definitions of risks and issues were agreed at the Commissioning & Operations Steering Group in January 2014.

Issue definition: An **issue** is an event or condition that has already happened and has impacted or is currently impacting the project objectives. ***There is no uncertainty or probability aspect associated with an issue***

For example the probability of a **risk** may range between 0 and 100%, but it can't be either 0 or 100. The probability of an **issue** is 100% (Here and Now).
Further updates on Programme issues will be reported through this report once the work to tidy up the issues logs has been completed.

6. Programme Risks, 12 and above (Horizon scanning)

Risks are reported by exception and are recorded on the Board Assurance Framework, for the purposes of this report only risks which are 12 or above have been included. A project may have identified low level risks which do not require review by the Governing Body.

The Programme Office and the Head of Governance, Planning & Risk are coordinating a piece of work to ensure that Risks and issues are reported in a robust and consistent way. In order to achieve this, the definitions of risks and issues were agreed at the Commissioning & Operations Steering Group in January 2014.

Risk definition: The Programme Management Body of Knowledge (PMBOK) defines a risk as an ***uncertain event*** or condition that, if it occurs, has a positive or a negative effect on project's objectives.

The event has *not* happened yet but there is a chance it could occur (Horizon Scanning).

Further updates on Programme risks will be reported through this report once the work to tidy up the risk logs has been completed