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AGENDA PAPERS FOR

HEALTH AND WELLBEING BOARD MEETING

Date: Friday, 2 February 2018

Time: 9.30 a.m.

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

	A G E N D A	**PART I**	**Pages**
1.	**ATTENDANCES**		
	To note attendances, including officers, and any apologies for absence.		
2.	**MINUTES**		1 - 6
	To receive and if so determined, to approve as a correct record the Minutes of the meeting held on 5 October 2017.		
3.	**DECLARATIONS OF INTEREST**		
	Members to give notice of any interest and the nature of that interest relating to any item on the agenda in accordance with the adopted Code of Conduct.		
4.	**PROGRAMME MANAGEMENT OF BOARD PRIORITIES**		
	To receive a verbal update from the Interim Director of Public Health.		
5.	**UPDATE FROM THEMATIC GROUPS; START WELL, LIVE WELL, AGE WELL, AND THE MENTAL HEALTH PARTNERSHIP**		7 - 14
	To receive a series of reports from the Interim Director of Public Health.		
6.	**CQC REPORT**		15 - 132
	To receive a presentation from the Corporate Director of Children Families and Wellbeing.		

7. **DELAYED NON URGENT HOSPITAL PROCEDURES**

To receive a verbal update from the Clinical Director of Quality & Performance, Trafford CCG.

8. **INTEGRATION UPDATE**

To receive a presentation from the Joint Change Director for Trafford Council and Trafford CCG.

9. **WIDER REFORM ACTION/INVESTMENT PLAN DEVELOPMENT** 133 - 150

To receive a presentation from the Head of Partnerships & Communities.

10. **NEW PHYSICAL ACTIVITY STRATEGY AND LAUNCH OF THE VISION** 151 - 164

To receive a presentation from the Chairman of the Trafford Sports and Physical Activity Partnership.

11. **KEY MESSAGES**

To consider the key messages from the meeting.

12. **URGENT BUSINESS (IF ANY)**

Any other item or items which by reason of special circumstances (to be specified) the Chairman of the meeting is of the opinion should be considered at this meeting as a matter of urgency.

THERESA GRANT
Chief Executive

Membership of the Committee

Councillors Levy, J. Lamb (Chairman), M. Colledge (Vice-Chairman), S.K. Anstee, J. Colbert, C. Daly, H. Fairfield, Dr. M. Jarvis, J. Lloyd, E. Roaf, M. Whetton, A. Worthington, Ahmed, Eaton, J. Harding, Miller, Nkwenti, Spearing, Ward, Bailey, Roe and Davidson

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

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This agenda was issued on **25 January 2018** by the Legal and Democratic Services Section, Trafford Council, Trafford Town Hall, Talbot Road, Stretford, M32 0TH.

HEALTH AND WELLBEING BOARD

5 OCTOBER 2017

PRESENT

Councillor J. Lamb (in the Chair).
M. Colledge (Vice-Chairman), Councillor S.K. Anstee, J. Colbert, H. Fairfield, Dr. M. Jarvis, B. Levy, Chief Superintendent W. Miller, M. Noble, E. Roaf, I. Tomlinson and Councillor M. Whetton.

In attendance

K. Ahmed	-	Director of All Age Commissioning
K. Purnell	-	Head of Partnerships and Communities
I. Cockill	-	Senior Democratic and Scrutiny Officer

Also Present

Councillor J. Harding.

Also in attendance

P. Blythin	-	Director of the Single Hospital Service Programme (for Minute No. 23)
E. Graves	-	Public Health Trafford
J. Rose	-	HealthWatch Trafford

APOLOGIES

Apologies for absence were received from M. Bailey, C. Daly, Councillor J. Lloyd and A. Worthington.

19. MINUTES

RESOLVED: That, subject to the inclusion of Chief Superintendent Wayne Miller in the list of apologies, the Minutes of the meeting held on 21 July 2017, be agreed as a correct record and signed by the Chairman.

20. DECLARATIONS OF INTEREST

No declarations of interest were declared by Members in respect of the business set out on the agenda.

21. TRANSFORMATION FUND BID - IMPLEMENTATION PLAN

The Board received a presentation from the Change Director Trafford Council and Trafford CCG.

Following the Transformation Fund submission, the clarification phase had been completed and all key lines of enquiry had been answered. Feedback had been positive, particularly the focus on primary care and neighbourhoods and also the level of detail and robustness of the Cost Benefit Analysis.

The integration of the CCG and Council continues with consultation to commence towards the end of October. Members considered it important that the Board was integral to the work and to ensure efforts were not duplicated.

RESOLVED

(1) That the work to deliver the mobilisation phase of the Transformation Programme be noted and supported.

(2) That the Board notes that detailed programme plan updates will be presented to future meetings as matters progress.

22. NEW STRUCTURES TO SUPPORT THE WORK OF THE HEALTH AND WELLBEING BOARD

The Interim Director of Public Health submitted a report on proposals for the future role and structure of Trafford's Health and Wellbeing Board.

The proposed structure provided for a thematic approach to the Boards' work, which would allow Members to obtain a better understanding of particular issues and the Board to develop system wide actions and priorities in subject areas.

Members commented upon the position, role and reporting arrangements of the Executive Group in the proposed structure. It was proposed that the Executive Group be strategically tasked and for example, have an oversight role of integration and implementation of the Transformation Fund Bid (discussed earlier on the agenda, Minute No. 23 refers). Cross party political representation and links to the voluntary sector would be considerations in the structure and it was emphasised that this should be an integral relationship rather than supplementing related arrangements.

RESOLVED –

(1) That the proposed new structure, as set out in the report, be approved in principle, subject to further consideration of the Executive Group's status and terms of reference.

(2) That the Working Group consider in more detail and report back on the proposed memberships of the Sub Boards and Executive Group.

(3) That the Interim Director of Public Health be requested to circulate the draft terms of reference for the Sub Boards to Health and Wellbeing Board Members.

23. SINGLE HOSPITAL SERVICE - HOSPITALS MERGER

The Board received a presentation from Peter Blythin, Director of the Single Hospital Service Programme outlining the progress to date and the next stages in the development of a service strategy and the ultimate aim of creating a truly single hospital service.

Communication and Engagement had been at the heart of the successful merger which had been achieved through the collaboration of all constituent members. The organisation now had the scope to be one of the largest employers in Greater Manchester, plus all the ancillary services.

The Board congratulated all concerned for accomplishing a merger over a 12 month period, itself a remarkable achievement. The Auditors KPMG had also provided unqualified opinions. Testament to success was that it was business as usual on 30 September without no big change or disruption.

The Service would evaluate progress over the first year and measure how it has delivered on its service strategy.

RESOLVED: That the presentation be noted and that the Board looks forward to working and aligning with the Single Hospital Service.

24. WORK AND HEALTH/EARLY HELP PROGRAMME UPDATE

The Head of Partnerships and Communities submitted a report providing updated information on the activity of the 'Greater Manchester Working Well Early Help' Programme being developed between the Greater Manchester Health and Social Care Partnership and the Greater Manchester Combined Authority.

Considering GP support for the new model, the Chief Clinical Officer supported a phased approach in order to secure meaningful commitment within the timescales suggested and proposed that one or two practices be approached in the first instance.

In terms of the membership of the Project Task Group, Trafford Leisure was also proposed.

RESOLVED –

(1) That the report be noted.

(2) That the Head of Partnerships and Communities be requested to progress a pilot scheme for GP referral, in consultation with the Chief Clinical Officer.

(3) That a Trafford Leisure representative be sought for the Project Task Group.

25. HEALTH AND WELLBEING PRIORITIES UPDATE

The Interim Director of Public Health presented a priorities update apprising the Board of the following actions and key areas of focus:

- Smoking and Tobacco Control: on the whole levels were reducing, however, smoking prevalence in adults in Routine and Manual groups was higher in Trafford (29%) than England or Manchester (27%).
- Alcohol: Alcohol Awareness Week 13-19 November focussing on families.
- Cancer Prevention and Early Diagnosis.
- Physical Activity: Play streets programme in development which would be a focus of the new Physical Activity Strategy and implementation plans – the Board was to have sight of an early draft strategy. The low level of physical activity in 15 year olds was considered a worry.
- Reducing impact of mental ill health.
- Work programme to re-commission Prevention, Wellness and Lifestyle services.

Responding to concerns expressed about the frequency of Mental Health Partnership Board meetings the Interim Director of Public Health confirmed that the matter was being addressed with the lead organisation.

Further Public Health Working Group meetings were to be timetabled and it was suggested that Health Impact Assessments be recommended for inclusion in Council reports.

RESOLVED: That the presentation be noted.

26. PROMOTING HEALTHY AGING IN TRAFFORD

The Interim Director of Public Health submitted a report on the role of the Health and Wellbeing Board in promoting healthy ageing in Trafford.

In order to progress the work, the appointment of a Programme Manager on an 18 month contract was proposed to plan, co-ordinate and deliver the changes required in Trafford, however, funding for the post was still to be confirmed. As GPs had been challenged to set up a provider organisation for the whole of primary care, a joint approach with links into their system was suggested as a means of securing support.

Delaying the appointment until the Ageing Well Board was established was suggested, however, funding was considered the priority with relationships and action plans being defined alongside the terms of reference and priority setting.

RESOLVED –

(1) That the report be noted.

(2) That the Interim Director of Public Health be requested to discuss with the Clinical Director of NHS Trafford Clinical Commissioning Group, the possible funding arrangements of a Programme Manager for Healthy Ageing.

27. TRAFFORD BETTER CARE FUND PROGRAMME 2017-19

The Director of All Age Commissioning submitted a report outlining the Better Care Fund (BCF) Programme for 2017-19 and seeking sign off of the BCF Plan by the Board in order to achieve National Condition 1.

Further to the report, the Board was advised that the current CQC Inspection may recommend areas for improvement and that the Plan had the ability to be amended to incorporate any changes. In relation to the CQC report, a new date for the meeting with Inspectors was to be arranged week commencing 4 December 2017.

Acknowledging in the previous period that nationally, most schemes had failed their targets, Members recognised that due to capacity and the absence of new money, existing schemes were to receive most investment. Concern was expressed about duplication and it was suggested that an analysis of the work undertaken and a record of those schemes that had narrowly missed the target could be of assistance. It was also noted that the Transformation Programme would be reviewing processes and the Plan in terms of adaptability.

Seeking to keep the Plan under review, Members were informed that updates would be included in the quarterly report presented to the Board

RESOLVED: That the Board signs off the Expenditure Plan for the 2017-19 Better Care Fund, with the assurance that it is an adaptive document that will evolve over the time period.

28. KEY MESSAGES

RESOLVED: That the Board notes the following key messages arising from the meeting:

1) Monitoring was an important aspect throughout all work streams and activities overseen by the Board.

2) Health and Wellbeing structural arrangements were to focus on delivery.

The meeting commenced at 3.30 p.m. and finished at 5.34 p.m.

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TRAFFORD COUNCIL

Report to: **Health & Well Being Board**
Date: **2nd February 2018**
Report for: **Discussion**
Report of: **Eleanor Roaf**

Report Title

Update on Thematic Groups

Purpose

To provide the Board with the draft ToR and suggested membership of the thematic groups

Recommendations

To agree the ToR and membership

Contact person for access to background papers and further information:

Name: Eleanor Roaf, Interim Director of Public Health

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Maternity, Children and Young People's Board
Terms of Reference
Draft 8th November 2017

Name of Committee	**Maternity, Children and Young People's Board**
Purpose	To oversee progress against the targets set by the Trafford Health and Wellbeing Board, especially in relation maternity, children and young people. This Board will subsume the work programme and objectives of the Public Health Delivery Group. The Maternity, Children and Young People's Board will clarify accountability for the delivery of national and local priorities for Public Health in relation to this aspect of the life course. The focus of the actions in this work stream is the conception-19 years, up to 25 years for SEND. The Board will cover general prevention and work on the wider determinants of health where appropriate. The Board will work closely with relevant boards including the Early Help Strategic Board. Aims and objectives are to:- • Achieve measurable improvement in health outcomes and reduction in health inequalities • Provide strategic oversight for the delivery of the national and local priorities for Public Health in relation to this aspect of the lifecourse. • Ensure that all relevant systems and structures are used to deliver public health priorities • To ensure a joint strategic approach to commissioning and that commissioning decisions reflect local priorities and targets including the Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategies and Public Health Outcomes Framework (PHOF) This will be a multi-agency Board.
Accountable to	Health and Wellbeing Board
Membership	Membership to include: • Councillor lead (Chair) • Consultant(s) in Public Health • Senior commissioner (Children and Young People's Services) • Senior commissioner (Early Help) • Education representative • Maternity Services Representative • CCG representative – clinical lead • CCG representative – commissioner • Pennine Care – Neighbourhood Strategic Lead • Senior Partnerships and Communities Officer • Public Health accountant (for specific items) • Public Health data analyst • Representative of the Community and Voluntary Sector
Chair	Lead Councillor
Frequency of meetings	Bi monthly
Quorum / Attendance	Lead Councillor, Director or Consultant in Public Health plus 4 other members
Key agenda Items	Standing items to include: Performance Outcomes – Public Health Outcomes Framework Progress on public health delivery plan priorities related to this theme
Agenda & Papers	The Maternity, Children and Young People's Board will be administered by

	Public Health Project Support Officer. Agenda to be agreed with the lead Councillor /Consultant in Public Health
Minutes	Action minutes will be taken by the Public Health Project Support Officer and circulated promptly to all members of the sub-committee

Live Well Board
Terms of Reference
Draft 11 January 2018

Name of Committee	**Live Well Board**
Purpose	To oversee progress against the targets set by the Trafford Health and Wellbeing Board, especially in relation to Healthy Life Expectancy. This Board will subsume the work programme and objectives of the Public Health Delivery Group. The Healthy Life Board will clarify accountability for the delivery of national and local priorities for Public Health in relation to healthy life expectancy. The focus of the actions in this work stream is the adult population, but the Board will cover general prevention and work on the wider determinants of health where appropriate. The Board will work closely with the Mental Health Partnership. Aims and objectives are to:- • Achieve measurable improvement in health outcomes and reduction in health inequalities • Provide strategic oversight for the delivery of the national and local priorities for Public Health in relation to Healthy Life Expectancy • Ensure that all relevant systems and structures are used to deliver public health priorities • To ensure a joint strategic approach to commissioning and that commissioning decisions reflect local priorities and targets including the Joint Strategic Needs Assessment, JHWS and Public Health Outcomes Framework (PHOF) This will be a multi-agency Board.
Accountable to	Health and Wellbeing Board
Membership	Membership to include: • Councillor lead (Chair) – Cllr John Lamb • Consultant(s) in Public Health – Julie Hotchkiss • Chair of the Mental Health Partnership • Senior commissioner (all-age with relevant portfolio 1) • Senior commissioner (all-age with relevant portfolio 2) • CCG representative – clinical lead • CCG representative – commissioner • Pennine Care – Neighbourhood Strategic Lead • Senior Partnerships and Communities Officer – Sarah Grant • Head of Public Protection • Public Health data analyst • Representative of the Community and Voluntary Sector in due course • Trafford Housing Trust • Trafford Leisure
Chair	Councillor Lamb
Frequency of meetings	Quarterly
Quorum / Attendance	Lead Councillor, Director or Consultant in Public Health plus 4 other members
Key agenda Items	Standing items to include:

	Performance Outcomes – Public Health Outcomes Framework Progress on public health delivery plan priorities and Healthy Life Expectancy priorities
Agenda & Papers	The Live Well Board will be administered by Public Health Project Support Officer. Agenda to be agreed with the lead Councillor /Consultant in Public Health
Minutes	Action minutes will be taken by the Public Health Project Support Officer and circulated promptly to all members of the sub-committee

Ageing Well Board
Terms of Reference
Draft 10th November 2017

Name of Committee	**Ageing Well Board**
Purpose	To oversee progress against the targets set by the Trafford Health and Wellbeing Board in reation to Ageing Well . The Ageing Well Board will clarify accountability for the delivery of national and local priorities for Public Health in relation to healthy life in older age. The focus of the actions in this work stream is the adults aged 65+, although some of the population will be suffering from poorer health from a younger age. The particular focus of the Board will be on preventing and addressing frailty, falls, dementia and end of life care, linking in with other Boards and strategic groups as appropriate. The Board will cover general prevention and work on the wider determinants of health where appropriate. The Board will work closely with the Mental Health Partnership and the Healthy Life Board.. Aims and objectives are to:- • Achieve measurable improvement in health outcomes and reduction in health inequalities • Provide strategic oversight for the delivery of the national and local priorities for Public Health in relation to Ageing Well • Ensure that all relevant systems and structures are used to deliver public health priorities • To ensure a joint strategic approach to commissioning and that commissioning decisions reflect local priorities and targets including the Joint Strategic Needs Assessment, JHWS and Public Health Outcomes Framework (PHOF) This will be a multi-agency Board.
Accountable to	Health and Wellbeing Board
Membership	Membership to include: • Councillor lead (Chair) • Shadow executive Councillor lead • Director of Public Health • Chair of the Mental Health Partnership • Senior commissioner (Health) • Senior commissioner (social care) • CCG clinical lead • Pennine Care – Neighbourhood Strategic Lead • Senior Partnerships and Communities Officer • Health Watch representative • Public Health data analyst • Carers Centre representative • Representative(s) of the Community and Voluntary Sector
Chair	Lead Councillor
Frequency of meetings	Bi monthly
Quorum / Attendance	Lead Councillor, Director or Consultant in Public Health plus 4 other members
Key agenda Items	Standing items to include:

	Performance Outcomes – Public Health Outcomes Framework Progress on public health delivery plan priorities and Healthy Life Expectancy priorities
Agenda & Papers	The Ageing Well Board will be administered by Public Health Project Support Officer. Agenda to be agreed with the lead Councillor /director/Consultant in Public Health
Minutes	Action minutes will be taken by the Public Health Project Support Officer and circulated promptly to all members of the sub-committee

Trafford Local System Review

***Professor Steve Field**, Chief Inspector of General Practice*

***Ann Ford**, Delivery Lead*

The focus

- How well do people move through the health and social care system, with a particular focus on the interface between the two?
- What improvements could be made?

The questions

- What is currently happening and what are the outcomes for people?
- What is the maturity of the local area to manage the interface between health and social care moving forward?
- What else needs to happen?

The approach

- Local ***system*** and people's ***experiences***

- 3 key points
  - Maintaining wellbeing
  - Crisis management
  - Discharge, step-down, re-ablement

- Preparation, engagement, site visit, communication

The outputs

- Report for each local system
- Interim report – before Christmas
- Final report – Summer 2018

What do people want from their local system?

Quality matters

www.penmendonca.com

Key Findings in Trafford- Peoples experiences.

- **Local People were not always seen in the right place, at the right time, by the right person.**
- There were missed opportunities to maintain people in their usual place of residence.
- Varied access to Primary Care services and no enhanced GP service to care homes
- People found it difficult to access information and support. Very few people were in receipt of Personal Budgets or Direct Payments.
- High numbers of people were referred to A&E from care homes and were being admitted to hospital with conditions that could be better cared for in the community.
- Hospital occupancy rates were high and A&E targets were not being met.

Key Findings – People's experiences

- Once ready for discharge, older people were often subject to delays.
- There was evidence that people had suffered avoidable harm or deterioration as a result of the delays and a lack of 7 day services.
- Due to market capacity issues there were delays in securing care packages or long-term care placements.
- The quality of social care was poor – a number of services are rated inadequate or requires improvement.
- If people received reablement services they achieved good outcomes and this had significantly improved since 2011.
- There had been significant improvements to CHC outcome data, but a negative perception of the process amongst people and staff still exists.

Key Findings – Staff Experiences

- System leaders and senior staff were visible and were clear about the direction of travel.
- The workforce across the system were committed to doing the right thing for people, but the degree to which they could articulate the vision and strategy varied.
- There were some examples of integrated team working, but front line staff were frustrated by the barriers, including multiple and confusing points to navigate the system and a lack of shared IT systems.
- Staff felt well supported by their organisation's leadership, but there was a lack of feedback both at organisational and system-level to escalated incidents or issues.
- Recruitment and retention were system-wide challenges.

Winter Planning

- Trafford's Winter plan was presented to the Greater Manchester Urgent Care Board and signed off during the week of our review.
- Some of the iBCF monies had been used to try and increase capacity in the community but with minimal success.
- There was some confusion amongst system partners, including providers and the voluntary sector, around the status of the plan. Some reported they had only recently been asked for their input, whilst others had not been engaged with at all.
- There were missed opportunities with Trafford's voluntary sector. They felt underutilised and more proactive engagement with them was necessary.
- With Winter approaching the system needs to remain focus on the here and now to achieve better outcomes for people.

Key Findings – Relationships

- Historically relationships across the system had been challenging, but recent changes at a senior level coupled with the Devolution Manchester agenda created a unique opportunity.
- There were clear lines of communication and accountability from the Greater Manchester Health and Social Care Plan to Trafford.
- Trafford's Locality Plan and Transformation Bid were aligned to priorities of the wider conurbation, whilst taking account of local variation.
- There was an openness and transparency amongst system leaders, facilitated by S75 agreements and the merging of the LA and CCG.
- The system was on a journey of transformation and integration was seen as the vehicle to achieve the vision.

Key Findings – The Health and Wellbeing Board and Scrutiny Board

- Although there were governance structures in place for health and social care**,** the challenge function of both the Health and Wellbeing Board and Scrutiny board were underutilised.

- Both recognised they were used as forums for reporting progress rather than a driver for change.

- The HWB was in the process of reviewing its role and developing a workplan.

- The Scrutiny Board reported they were given verbal assurances system improvements were happening, but a lack of data as evidence of impact.

Key Findings – System Working

- The context of Greater Manchester and the devolution of power provided a unique opportunity to transform the health and social care landscape.
- The was a system wide commitment to achieving positive outcomes for the people of Trafford.
- There was a compelling shared vision and strategy which was aligned to Greater Manchester's, *'Taking Charge of our Health and Social Care'.*
- Integration was seen as the vehicle to achieving the vision.
- A Local Care Organisation was due to go into shadow form in April 2018 and contractual arrangements were to be agreed upon.
- Governance structures were aligned to the Greater Manchester model, but feedback from staff and providers indicated they were not sure who was ultimately responsible for system performance.

Key Findings – System Working

- The Locality Plan, Transformation Bid and existing Section 75 agreements provided the foundations for inter-agency and multi-disciplinary working.
- Joint Strategic Needs Assessments had been carried out for each of Trafford's four localities to inform future commissioning plans and new models of care.
- Engagement and involvement of social care providers and voluntary sector organisations in strategic planning and delivery needed to be strengthened.
- There was transparent approach to sharing performance information amongst system partners and there were some agreed metrics in relation to flow. However, monitoring of health and social care was based on traditional performance indicators rather than universal outcome measures.

Key Findings – System Working

- The system was early in its journey to integration of health and social care. The CCG and LA had proceeded ‘at risk’ to implement some of the initiatives set out in the Transformation bid.
- There was a significant amount of monitoring and piloting of new initiatives, but there needed to be more evaluation to drive the transformation agenda forward.
- There was a single work-force strategy for Greater Manchester, but no single-level strategy for Trafford which incorporated social care, primary care and secondary care.
- System leaders were working to develop and future proof the workforce
- There was a shared view of risks, but responsibility for managing these depended on commissioning arrangements ie. homecare market capacity.

Key Findings – System Findings

- Future commission plans were focused on prevention and the person rather than services. However, current commissioning was traditional and reactive to pressure points within the system ie. delayed transfers of care.
- The prevention agenda and hospital avoidance schemes were underdeveloped:
  - GP provision was variable and there was no enhanced service to care homes at the time of our review.
  - There was a low-uptake of personal budgets and direct payments compared to Greater Manchester and nationally.
  - Whilst there had been plans to expand the Stabilise and Make Safe Service to provide ‘step-up’ care, the provider was already working at capacity and unable to recruit.
  - Only 10-15% of referrals to Ascot House were for ‘step-up’ care.

Key Findings – System Findings

- Whilst there had been some significant improvements made to delayed transfers of care since summer 2017 this was a from a low base.
- A&E attendances, hospital admissions, length of stay and delayed transfers of care remained high comparatively. We found examples where actual harm had been caused by these performance issues.
- The Trafford Co-ordination Centre was not working at capacity and there was mixed views on its effectiveness.
- Much of the High Impact Change Model was yet to be implemented with a lack of trusted assessments and 7 day working.
- A lack of shared IT systems, coupled with a complex landscape of pathways and services was a barrier to true integrated working.
- People living in Trafford encountered barriers to maintaining their health and wellbeing.

Emerging Messages

- The system needs to remain focus on the here and now to ensure improvements are sustained.
- The High Impact Change Model needs to be widely implemented and at pace.

Emerging Messages

- There must be a system-wide response to managing the social care market.
- The system needs to push ahead with the prevention agenda.
- The Health and Wellbeing Board and Scrutiny Board challenge functions need ot be strengthened.

Emerging Messages

- There needs to be a joined-up, structured approach to ensuring the voluntary sector and providers are true system partners.
- Learning needs to be more systematically shared and cultural barriers broken down.

Reflections

- The strategic vision is a compelling one, but the reality for people right now is not so positive.
- System leadership is strong and Greater Manchester provides a good support network.
- Trafford needs to ensure it local needs are met whilst being aligned with GM.
- Challenges in workforce recruitment across all sectors
- Harness the willingness and knowledge of frontline staff and the voluntary sector

Your questions please

CARE QUALITY COMMISSION SYSTEM REVIEW OF DELAYED TRANSFERS OF CARE 2017

TRAFFORD SYSTEM ACTION PLAN

OCTOBER 2017- OCTOBER 2018

16th January 2018

Background

Following the publication of the Care Quality Commission (CQC) Local Review of Health & Social Care Services in Trafford report on 18th December, 2017 (link:), this Action Plan has been developed in response to the issues highlighted in order to enable all partners to play their part in driving forward improvement in outcomes for the Trafford population of older people.

The joint action plan will be the mechanism by which partners are held to account, through the new governance structure, by the Health and Wellbeing Board for improving performance and ensuring effective monitoring and evaluation.

This joint action plan takes account of and cross-references the following plans that have been developed by partners:

Transfers of care plan 2017
Winter Plan 2017
Better Care Fund Plan 2017-18
Trafford Locality Plan 2016
Trafford Transformation bid 2017
All Age Health and Social Care Business Plan 2017-18

Partners are committed to system wide reform as expressed in the Trafford Locality Plan and work is well underway to implement the big ideas detailed in the Trafford Transformation Funding Bid. These include the Urgent Care project, the integration of the Council and the CCG into one new organisation, and the Trafford Local Care Organisation, the delivery model that we see as the future way of working in Trafford.

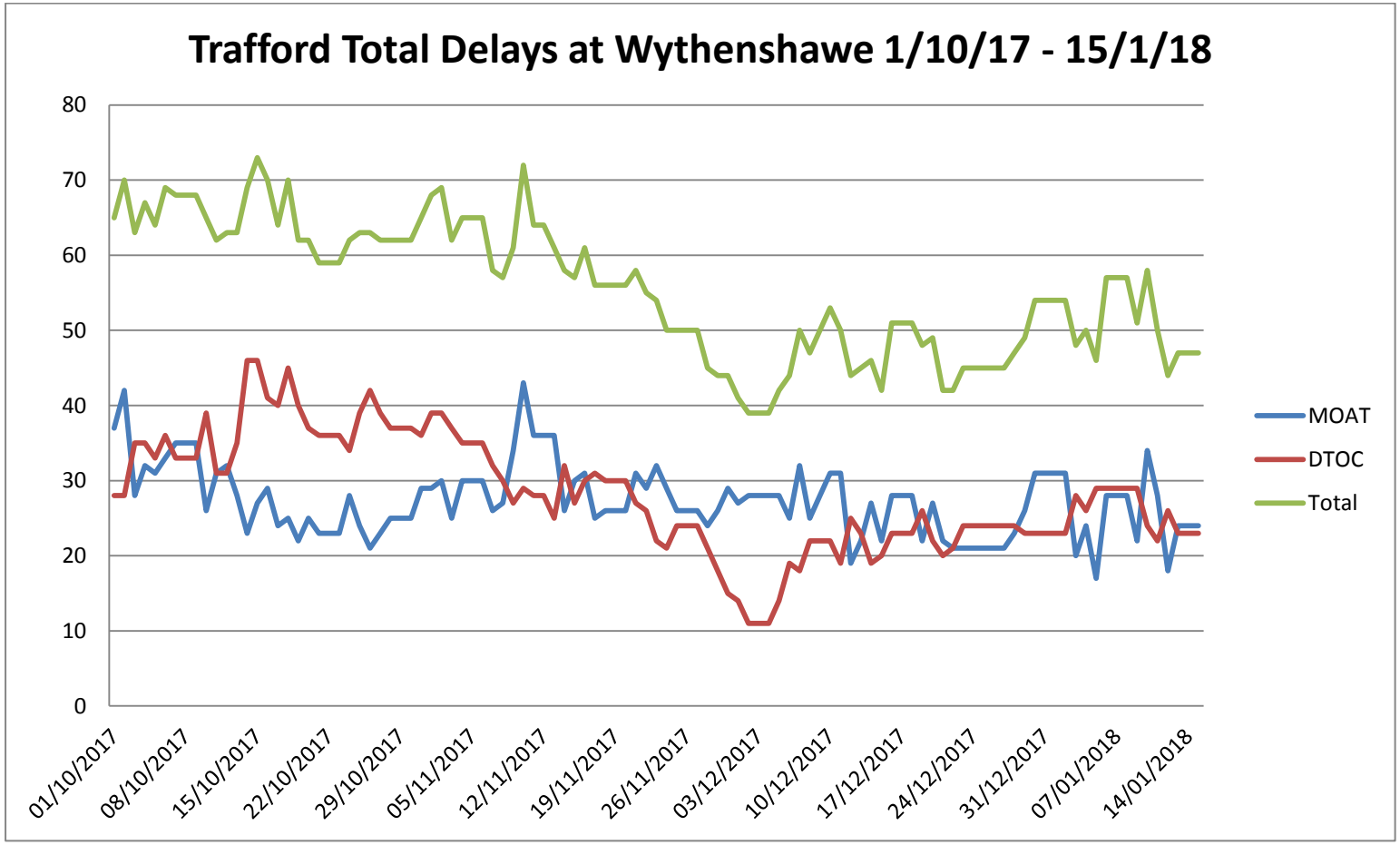
Trafford's plan for reform is ambitious as is its desire to improve performance around transfers of care. This plan tries to describe all relevant work required to improve that performance and as such cross-references areas of work that are already underway and subject to close monitoring.

Performance post-review

Post-CQC Review the Trafford system has continued to make significant improvement in reducing delayed transfers of care.

Significant improvement was demonstrated in November and December, and the 'Home for Christmas' campaign engaged the workforce and partners who continued to work hard to in achieving great performance in the run up to Christmas.

Our performance from 1/10/2017 to 14/01/18 is represented on this graph below and whilst variability remains the system almost achieved the 3.3% target the first week in December:



16th January 2018

Layout of the plan
The issues highlighted within the report have been reviewed and themed under the following headings:-

- Maintaining well-being in usual place of residence
- Crisis management: Preparation for winter & urgent care
- Step down, return to usual place of residence and/or admission to a new place of residence
- Challenge and scrutiny
- Market management/commissioning
- Intelligence and evaluation

It has been developed by the system as follows:

Trafford Council
Trafford Clinical Commissioning Group
Manchester University NHS Foundation Trust
Pennine Care Community NHS FT
Salford Royal NHS Foundation Trust
Healthwatch Trafford
Trafford Health and Wellbeing Board

1. Maintaining the wellbeing of a person in usual place of residence

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
1.1	Implement transfers of care plan and develop evaluation and performance metrics (this includes compliance with the High Impact Changes model) See APPENDIX 1	JC CW	October 2017	October 2018	Noted in full in the plan in Appendix 1 – to be updated monthly
1.2	Implement Primary Care/Care Home MDT project	CW	January 2018		Project goes live from 19.1.18 with 6 care homes and will continue to be rolled out cross Trafford over the next 3 months as new staff come on stream. Model has been developed as an integrated service offer between existing providers including Pennine Care, NMOPC and Mastercall with opportunities for further support through the voluntary sector.
1.3	Clarify investment via GM H&SC Partnership Transformation Programme into primary care	JC CW	January 2018	February 2018	An early TF bid was approved last year on primary care admissions avoidance schemes. Clarity sought from GM H&SCP as to what that was used for and any outstanding investment.
1.4	Engage VCS/Third Sector in discharge and planning processes at an earlier stage	KA & KP	November 2017	ongoing	To be considered through the engagement with providers by commissioners and the partnerships team
1.5	Refresh Seven Day Services Plan	DE RS MB	February 2018	April 2018	To be considered as part of the Cold Debrief from Winter.
1.6	Develop a transformation model for support at home underpinned by a new contractual framework	KA	April 2018	December 2018	- GM care at home work concluded and reported to GM H&SC partnership - Pilots underway in Partington and Sale to be evaluated at agreed point
1.7	Review impact of support at home prototypes	KA/UM	August 2018	September 2018	- In keeping with timescales above

1.8	Develop improvement programme for nursing and residential care	KA/MM	February 2018	February 2018 for review	- Adult Safeguarding Board briefed and supportive - Providers engaged and registered managers network agreed with support from Skills for Care
1.9	Develop comprehensive stakeholder & public engagement programme and strategy	CW TG	December 2017		- Engagement workshops underway - Existing work with Thrive to agree future model
2.0	Ensure new model of primary care addresses improvement required	Dr NG	January 2018	Ongoing	- Implementation of the MDT commences 19.1.18 and the Primary Care Organisation has a formalised Advisory Board in place though a MoU. Clinical pharmacist recruitment has been successful with commencement on 1.2.18.

2. Crisis management & urgent care

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
2.1	Implement Winter Plan – see APPENDIX 2	CW JC RS MB	October 2017	March 2018	Winter plan implemented, Cold Debrief to be undertaken early February 2018
2.2	Prepare and agree Easter plan	As above	March 2018	April 2018	In development
2.3	Primary Care prevention schemes for UTI and respiratory conditions (preventable admissions) to be considered	ER Dr NG	February 2018		Respiratory T&F group established looking at 'quick wins' to support admission avoidance, in partnership with PCO and community services provider. MDT incorporates an acute visiting element to manage exacerbations of LTC symptoms, acute infections and falls. Clinical review of respiratory pathway with MFT scheduled for Jan 18 to inform admission avoidance pathway in primary care.
2.4	Primary Care access and availability to be reviewed	Dr MJ	February 2018		Additional primary care access supported through winter resilience monies has been secured with go live date of 1.2.18. Full extended access model has been developed through the GP Fed with go live date 3.4.18 with provision through 4 neighbourhood hubs including Sat and Sun opening.
2.5	Engage VCS/Third Sector in Winter Plan	KA	October 2017		As per actions in section 1.
2.6	Ensure all acute providers have accurate and timely information relating to local services – TCC to be considered as the	DE SR SM	February 2018		• Issued through the winter plan and regularly updated

	delivery vehicle				
2.7	Reablement/Care at Home capacity to be reviewed and developed	KA SB	May 2018	July 2018	
2.8	Rapid implementation of single hospital discharge team at MFT Wythenshawe site with MCC	DE	Jan 2018	January 2019	In place
2.9	Early discharge planning to be improved	MB	February 2018		Underway through Integrated Discharge Team
3.0	Escalation channels and reporting to be made clear to all staff	MI	February 2018		This will be part of all escalation plans for clarity on roles and responsibilities. It will remain all system leaders role to ensure that each aspect of the system is contributing. This will be escalated to GM if there remain outstanding issues.

3. Step Down and return to normal place of residence

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
3.1	Discharge summaries and information sharing with community providers to be improved	MB DE	March 2018	April 2018	- Control hub established and up and running since November 2017 - Information sharing flowing more easily across providers via the control hub
3.2	Learning from critical incidents to be routinely shared with clear feedback to all professionals	TBC	January 2018		Discussed with Trafford Safeguarding Adults Board, processes and protocols to be considered by the Board and the relevant sub-group
3.3	Personalisation and personal health budgets to be more routinely considered	MM	January 2018	Ongoing	
3.4	1.1 Roll out of positive outcome for preventing admissions and reducing LOS for frail older people from Wythenshawe Hospital into Trafford General Hospital	Sally Briggs, Divisional Medical Director, Unscheduled Care	December 2017	November 2018	Over the last 3 years the Complex Care team based at Wythenshawe hospital have developed a well-recognised frailty service. This now operates seven days a week on AMU, as well as five days a week in the Emergency Department. There is also a robust orthogeriatric and surgical liaison service five days a week and discharge to assess beds. The service benefits from a continuous improvement approach and there is currently a plan to develop a separate frailty unit so that both the current AMU and ED services would merge to provide robust 7 day cover. Following the merger and creation of MFT there is now a desire to improve all sites to this standard, providing identification of frailty and access to timely comprehensive geriatric assessment. The Wythenshawe, Trafford and MRI teams have already met to discuss the setting of standards for their services and a further workshop is planned for

					February 2018. A key aim of the workshop is to identify which areas of frailty to prioritise as each site will have different cohorts of patients e.g. orthogeriatrics may be key for Trafford, whilst frailty support for surgical patients at MRI might be the more urgent need. Further aims of the workshop will include identification and sharing of resources and expertise and methodology for continuous development over the longer term.
3.5	Operational policies in place at Opal House should be reviewed to ensure they are not placing additional burdens on the wider system	Lauren Wentworth, Clinical Director	December 2017	April 2018	An audit is taking place to review appropriateness of patients transferred from OPAL House to the Emergency Department. The SOP will be reviewed to consider options for management of acutely unwell patients at OPAL House. The areas for consideration will be: 1. The admission criteria – depending on the outcome of the audit, it might be that patients with any outstanding medical should no longer be transferred to OPAL House. However this will be assessed against the risk of the benefits of early transfer for patients. 2. Medical staffing model – This is currently a therapy/nursing led unit with Clinical Fellow input 9-5 Monday to Friday. Out of hours medical cover is via GoToDoc and not by the hospital on call teams.
3.6	Review of Ascot House Intermediate Care facility	RS	February 2018		Routine review of capacity and flow is in place on a daily basis through the control hub and the daily monitoring report

4. Challenge and scrutiny

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
4.1	Aging well strategy, Dementia strategy, frailty strategy and falls strategy to be concluded and implemented	ER Cllr John Lamb	February 2018	July 2018	All strategies have been in development for some time and are progressing well. GM dementia work underway in Trafford
4.2	H&WB Aging Well group to be established	ER	February 2018		In hand
4.3	BCF reporting to include detailed analysis of urgent care performance system wide	JG TC	March 2018		The H&WB actions will also take account of this
4.4	Health Scrutiny Committee challenge function to be strengthened	JC Cllr Joanne Harding	January 2018	February 2018	Meeting planned in the diary accordingly.
4.5	Ensure Trafford has a clear role in the GM partnership and can draw on appropriate support where required	TG/CW			• Part of the Urgent Care network and support received via the GM urgent care approach. • Trafford input into the GM Transformation Board to share learning from others across GM • CCG CO part of the GM wide CCG CO group and CCG Association to ensure shared learning is received
4.6	Review role of the VCS/Third Sector in the H&WB Board sub-groups with a view to strengthening engagement	ER Cllr JL	Ongoing		• Progress underway to confirm vision/statement of intent of working with VCSE as an equal partner in the engagement of commissioning plans across Trafford. CCG (Rebecca Demaine), TC (Adrian Bates) and Thrive Trafford (Chris Hart on behalf of all VCSE in Trafford) to put in place additional infrastructure so that there is an effective two-way engagement between the public sector and VCSE on commissioning and delivery.
4.7	Ensure LCO development takes account of all relevant contracting and business continuity issues	CW JC			• Broad outcomes and design principles agreed for the LCO. Originating partners established a working group to determine operating model, service content and support to put in place shadow form Trafford LCO from

					1 April 2018. Likely to commence with MDT services and build in phases over the next three years. • All services (bar specialised) included, all age and all providers including VCSE, community, social care, primary care, mental health and acute.
4.8	Identify regional and national best practice in key parts of the system process and benchmark/compare against the Trafford system	Chair of HWBB, Chair Ageing Well Sub Board	Feb 2018	Feb 2019	

5. Market management/commissioning

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
5.1	System wide response to social care market and domiciliary care capacity to be developed and agreed	KA RD AB	March 2018	June 2018	- GM Care at Home workstream which Jill Colbert has led on in 2017 - Early discussions with Manchester CC regarding joint procurement of homecare
5.2	Construct a procurement model that engages service users in the process of selecting service providers/new service design	KA AB	June 2018		- Strong dynamic procurement framework in place
5.3	Agree routine reporting to Joint Commissioning Board on provider performance	RD KA	February 2018		- JCB sub group to be established to agree joint commissioning plan for 18/19 and workpplan for reporting provider performance.
5.4	Ensure all providers are making accessible information available to carers and residents to enable easy navigation through services	TBC			- The optimisation of the TCC to be considered as the vehicle to do this

6. Intelligence and evaluation (including Quality Assurance)

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
6.1	Develop a clear performance dashboard to report to H&WB the Joint Commissioning Board and Scrutiny Committee	IT PF MI			This will be a key role for the new CCG and Council integrated organisation. The new Joint Committee will need to ensure there is oversight on progress to adequately support the HWB.
6.2	CEC referral and activity data to be improved	RS	March 2018		
6.3	Accelerated work on single case records/case summaries for all providers to view on an individual basis	Integrated IT lead (to be announced)			- Optimisation of the TCC to be considered here
6.4	Develop improvement programme for nursing and residential care	KA/MM	February 2018		- Presentation to the Adult Safeguarding Board - Engagement with providers and agreement to support a registered managers network. Chair identified and funding agreed.

APPENDIX 1

Trafford Transfers of Care Plan

Version 10.0

16th January 2018

1. Introduction

As part of the refresh of the urgent care responses in Trafford, referenced in the Trafford 2020 plan, Trafford recognises that although significant work has been achieved over the last 2 years where we have seen a 50% reduction of delayed transfers of care, substantial challenges still exist to achieve the 3.3% target. This Transfer of Care Plan is a live plan which will be reviewed and updated by the Trafford Urgent Care Board on a regular basis. We will also engage with all our main Acute providers and with the Greater Manchester Mental Health NHS Foundation Trust regarding the implementation of the plan.

Over the next five years, the urgent and emergency care system, which supports residents of Trafford, needs to make radical changes to drive up efficiencies and reduce the numbers of people who are admitted to hospital, when they could be better cared for in the community.

In order to achieve this, both Trafford CCG and Trafford Council believe that it is essential to engage with patients and families to transform the urgent and emergency care pathway from end to end in line with Greater Manchester standards. By adopting this system wide approach together with the creation of this joint plan, our organisations believe that we can create a sustainable solution, not only to support people to stay at home but also to ensure that they spend the minimum amount of time in a hospital setting.

In keeping with Better Care Fund (BCF) requirements, Trafford Council, Trafford CCG and providers are working together to meet National Condition 4 (NC4) of the Better Care Fund. NC4 states that all areas should implement the High Impact Change Model for managing transfers of care to support system-wide improvements. As such, this plan uses the eight system changes which will have the greatest impact on reduced delayed discharge. Trafford CCG and Trafford Council have worked together to create this single plan, built on a foundation of close working, undertaking development workshops , understanding issues and barriers and recognising that all parts of the system have a part to play to keep delayed transfers of care to a minimum. By working together, and by developing this plan for Trafford, our organisations recognise that there is no single solution; rather there are several key projects which will need to be developed in order to effect change.

This document seeks to describe our joint plan for Trafford and the *'High Impact Change Model'* framework has been adopted as a framework to this end. Additionally, this plan has been drawn together with reference to the following national documents:

- Monthly Delayed Transfers of Care Situation Reports: Definitions and Guidance (NHS England, Oct 2015)
- NICE Guidelines [NG27]: Transition between inpatient hospital settings and community or care home settings for adults with social care needs (*NICE, December 2015*);
- High Impact Change Model – Managing Transfers of Care *(LGA, ADASS, TDA, NHS England, Monitor, December 2015*)
- Integration and Better Care Fund Policy Framework 2017 to 2019 (Department for Communities and Local Government and Department of Health, March 2017)
- Integration and Better Care Fund planning requirements for 2017-19 (*NHS England, July 2017*)
- NHS England: Urgent and Emergency Care Delivery Plan, April 2017
- Greater Manchester Health and Social Care Partnership, ratified the following policies at the Strategic Partnership Board on the 28th of July 2017;
    - Trusted Assessment
    - Patient Choice
    - Discharge to Assess

2. Our vision for older people in Trafford

"A sustainable health and social care system which aims to help older people be healthy, independent and enjoy living in Trafford."

Strategic aims:

- Older People should be able to stay at home, to support people to remain healthy and independent as long as possible, close to family until the day they die.
- Older people and their families should have access to good quality information and have increased skills and confidence to better manage any health conditions they have at home
- Older people should have access to high quality and personalised health care when needed
- **Older people should only be admitted to hospital when hospital is the only setting able to meet their health needs and at these times should expect that their stay is the shortest time needed for their treatment**
- **Older people using health and social care services are safe from harm**
- Older people should have access to high quality services. Dignity and respect remain key both for the older person and their carer. Investing in, protecting and supporting the ageing population and those who care for them are essential prerequisites for the wellbeing of our ageing society.

The voluntary sector and community groups should be key in supporting older people at the interface of health and social care

The two strategic aims highlighted (in bold) are the focus of this plan.

In order to deliver the vision of ***'Older people should only be admitted to hospital when hospital is the only setting able to meet their health needs and at these times should expect that their stay is the shortest time needed for their*** **treatment'** and **'Older people using health and social care services are safe from harm '** we will enact the strategic aims of**:**

- Further develop admission avoidance solutions linking GP activity to community responses
- Use risk stratification tools and the Trafford Coordination Centre (TCC)to further identify residents at risk of admission
- Develop early discharge planning in the acute sector

- Develop systems to monitor patient flow
- Further develop multi-disciplinary/multi-agency discharge teams including the voluntary and community sector
- Embed Home first/discharge to assess practice
- Develop seven day services
- Embed Trusted Assessors
- Develop focus on patient choice and ensure implementation
- Further enhance health in Care home

3. Accountability and governance

The Trafford Urgent Care Board is co-chaired by the Associate Director of Commissioning Trafford CCG and the Director of All Age Commissioning at TMBC. As such, the Board provides the practical arrangements to deliver the vision and strategic objectives and the assurance, capacity and resilience. Trafford Urgent Care Board monitors and reviews the Urgent Care project plan within agree project tolerances of budget, time and quality. If additional capacity and resilience are needed this will be escalated to the BCF steering group which ensures that BCF meets the national condition of reducing DTOCs.

The Trafford Urgent Care Board will report into the Manchester Urgent Care Transformation and Delivery Board, whose chair represents Manchester and Trafford at the Greater Manchester UEC Board.

4. Patient Engagement and Participation

Our organisations work collaboratively with local people to hold conversations which enable us to adjust and develop services according to local need. A plethora of actions take place to engage with local people and whilst these are not always transfers of care specific, the components which make up the plan, such as home care and care home placements, are a fundamental part of the discussions. Below are some examples of where we have engaged with local people.

4.1 The Council has developed engagement techniques through the Trafford Partnership structures to work with providers, partners and communities. Working in partnership with its commissioned VCSE infrastructure support provider, Thrive Trafford, we have established a VCSE Strategic Forum, that brings together larger VCSE providers (such as Age UK and Citizens Advice) with commissioners and other public service representatives, to explore key issues together, building positive relationships which will foster more effective contract delivery and create a space for coproduction and collaboration. There have been sessions on health and social care integration, isolation of older people and community cohesion. Its work in involving the VCSE sector at the earliest stage of development of our place-based working model proved particularly successful, engaging the sector in shaping plans and defining their role in these new ways of working.

Our Locality working programme bridges the gap between public services and communities, through a programme of work that empowers resident action through funding and support, and brings people that live and work in a place together as equals to build relationships, share ideas and create change. Our Locality partnership events have been on a range of topics, covering environment, safety, health and wellbeing. We have seen positive action emerge from them, such as health walks from GP surgeries and a new social isolation project delivered by the fire service. As part of the Trafford Vision 2031 we are undertaking a large community engagement programme in Carrington and Partington, empowering local residents to lead the engagement with people who live and work in the area, to develop a long-term vision which reflects their opportunities and challenges and shapes the health and social care offer of the future.

Trafford Council has used the Working Together for Change (WTfC) process to review the home care service. WTfC identified what is working well for people, what is not working so well and what might need to change for the future. The process helped us to shape the new Care at Home vision to provide the things people want and need in ways that make sense to them.

Additionally, the Joint Quality Team use engagement with residents and families to gain views to enable improved service delivery.

4.2 Trafford Talks Health events

NHS Trafford CCG commenced a series of interactive public events to kick-start conversation with the Trafford population around health priorities for Trafford. The events were co-designed with Healthwatch Trafford and were arranged for each of the neighbourhoods of Trafford (North, South, Central and West)

Public events were held as follows:

3 July 2017: 1pm-3pm at Broomwood Centre, Timperley (South)

4 July 2017: 6pm-8pm at Trafford CCG HQ, Sale (Central)

1 Aug 2017: 10-12.15 at St Matthews Hall, Stretford (North)

2 Aug 201: 6pm-8.15pm at Urmston Library, Urmston (West)

Trafford CCG also had a stall at a 'One Health' community marketplace hosted by Partington Family Practice in Partington on 13 September.

4.3 PEACH – Patient Experience and Continuing Healthcare

There isn't currently a standard measure to collect people's experience of Continuing Healthcare (CHC) and hence the impact on DToCs in England. Anyone over the age of 18 who has a complex medical condition and substantial/ongoing care needs may be eligible for NHS Continuing Healthcare.

A project to develop patient experience measures for adult Continuing Healthcare was awarded by NHS England to Tameside and Glossop CCG. The project is called PEACH which stands for Patient Experience and Continuing Healthcare.

Trafford CCG has worked with Tameside and Glossop CCG to extend the pilot to include Trafford, to hear about experiences of our CHC process and care provision and how we can improve ways of asking for feedback.

Trafford CCG and Patient Experience Matters have made a significant contribution to the compilation of these surveys to enhance usability. It has been confirmed that the changes that have been made will be taken forward as part of the PEACH Toolkit.

4.4 Public Reference and Advisory Panel (PRAP)

Trafford CCG's PRAP is a committee of local people established to represent the views of the Trafford population. Membership is sought from each of the different localities in Trafford (North, South, Central and West) and from various third sector/voluntary groups in Trafford, including Healthwatch.

The panel of volunteers meet monthly to discuss feedback and inform CCG programmes of work. This assurance group reports directly to the CCG Governing Body.

The panel is now in its third year and continues to grow in confidence to question, challenge and ultimately influence CCG commissioning plans and decisions.

PRAP representation is truly valued and we have extended PRAP involvement to other CCG meetings, including: Cancer Local Implementation Group; Locally Commissioned Services Group; Quality Walkaround Visits and Trafford Co-ordination Centre Implementation Board

4.5 Provider Quality Walkrounds

A quality walk around is a snapshot of how a service is performing on that day. It also captures how a service presents regarding: kindness, compassion, dignity and respect.

A walk around plan is shared with those who would undertake the walkaround several days prior to the visit to provide some background to the venue they were due to visit and will outline any current issues that would useful to check whilst on the

walkaround. Those undertaking the walkaround will often liaise with complaints and patient experience colleagues to check if any issues are raised with them around the service to be visited.

Dependent on the service, those involved in quality walkarounds could include: clinical audit nurse, chief nurse, pharmacists, commissioning managers, GPs and also members of Trafford CCG's PRAP.

Walkaround	Timeframe
➢ Ascot House	➢ Q3 16/17
➢ Trafford General UC Centre and MI Units	➢ Q1 17/18
➢ Community Enhanced Care Service	➢ Q1 17/18
➢ Wythenshawe F7 frail elderly/A7 Respiratory	➢ Q1 17/18
➢ Wythenshawe A1 vascular/A3 orthopaedics	➢ Q2 17/18
➢ Opal House	➢ Q2 17/18
➢ Patch 1 District Nursing	➢ Q2 17/18

Following on from the walkaround, a draft report will be produced with key suggestions for improvement. This will be shared with the provider for their comments and an action plan developed jointly.

4.6 Partners

We recognise the valuable contribution our partners make to inform the development and delivery of our local plans, eg, Healthwatch and the Carers Centre. The CCG and Local Authority hold regular contract development meetings with providers e.g.

Pennine Care Foundation Trust and homecare providers. We also hold a series of engagement events with providers e.g. annual engagement event with Homecare providers as part of winter resilience planning.

5. Situational Analysis

For the purposes of this Transfer of Care Plan, the table below provides a snapshot of activity at Manchester University NHS Foundation Trust (UHSM – Wythenshawe) for August+ 2017 and outlines the reasons for delayed transfers for both social care and NHS services in Trafford. We recognise that there will be seasonal variations and the data will be regularly monitored by the Trafford Urgent Care Board.

August 2017 – Manchester University NHS Foundation Trust (UHSM – Wythenshawe) Source; UHSM daily DTOC invalidated data

Reason For Delay		Number of bed days lost	% of total delays
A	Awaiting Completion of Assessment	8	1%
B	Awaiting Public Funding	64	8.4%
C	Awaiting Further Non-Acute NHS Care	12	1.6%
Di	Awaiting Residential Home Placement	66	8.6%
Dii	Awaiting Nursing Home Placement	131	17.1%
E	Awaiting Care Package in Own Home	331	43.3%
F	Awaiting Community Equipment and Adaptations	23	3%
G	Patient or Family choice	130	17%
H	Disputes	0	0
I	Awaiting Resolution of Housing Issues	0	0

Those delays classed as 'further Non acute NHS care' are delays in the main attributed to Intermediate Care at Ascot House. These will have been experienced when beds were full or delay in assessment/ transfer. The current criteria for intermediate care at Ascot House should keep these to a minimum.

The current criteria for the council funded step down-step out beds is intended to minimise the number of bed days lost due to 'Awaiting care package in own home'. It is also intended to utilise these beds to support a model of 'residential discharge to assess' by December 2017.

If the discharge to assess criteria and model were achieved it would target those who would contribute to the following delay reasons, however whether 9 beds is sufficient to meet the homecare **and** discharge to assess demand is yet to be quantified;

- Awaiting residential home placement
- Patient/ family choice
- public funding

The Patient/ family choice delays are attributed to both residential and nursing home (a rough estimate 50/50). Ascot House would only be able to influence the residential home delays due to its current CQC registration. In addition, the support of the Acute providers will be needed to implement the Greater Manchester Choice Policy.

In regards to community equipment and adaptations these delays are resolved quicker whilst the patient is on the hospital site and before they become a delay.

The largest number of delays for Trafford residents at Wythenshawe Hospital (UHSM) is due to the availability of homecare packages. The next largest cause of delays are reported as waits for nursing home placements and patients/family choice. This is reflected across both acute trusts – Manchester University NHS Foundation Trust and Salford Royal NHS Foundation Trust.
The tables below show the DTOC position for Manchester University NHS Foundation Trust for all their patients (irrespective of residents). This indicates the level of improvement required to deliver the DTOC target of 3.3%

TRAFFORD COUNCIL

Pennine Care NHS
NHS Foundation Trust

NHS
Trafford
Clinical Commissioning Group

DTOC Trajectory Analysis - 2017-18
16 October 2017

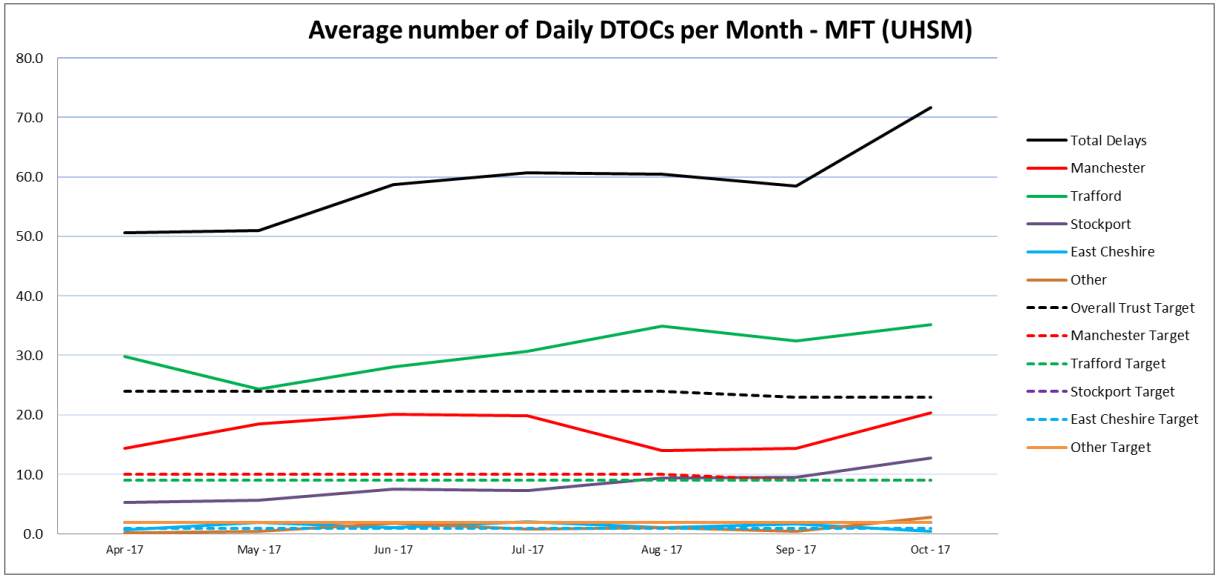
MFT (UHSM)	Description	April -17 Actual	May-17 Actual	Jun-17 Actual	Jul-17 Actual	Aug-17 Actual	Sep-17 Actual	Oct-17 Actual	Revised Monthly Target
	Average DTOCs Per Day	50.6	51.0	58.7	60.8	60.5	58.5	71.7	23.7
	Average Occupied Beds per Day	733	733	745	745	745	718	718	718
	% DTOC Rate	6.9%	7.0%	7.9%	8.2%	8.1%	8.1%	10.0%	3.3%

MFT (CMFT)	Description	April -17 Actual	May-17 Actual	Jun-17 Actual	Jul-17 Actual	Aug-17 Actual	Sep-17 Actual	Oct-17 Actual	Revised Monthly Target
	Average DTOCs Per Day	33.8	31.1	34.7	29.3	34.9	30.4	32.2	35.0
	Average Occupied Beds per Day	1,105	1,105	1,118	1,118	1,118	1,062	1,062	1,062
	% DTOC Rate	3.1%	2.8%	3.1%	2.6%	3.1%	2.9%	3.0%	3.3%

(Note: The 718 figure for UHSM and 1062 CMFT is based on the KH03 return which calculates quarterly the number of occupied beds and therefore this figure is used as the denominator for calculating the 3.3% target.)

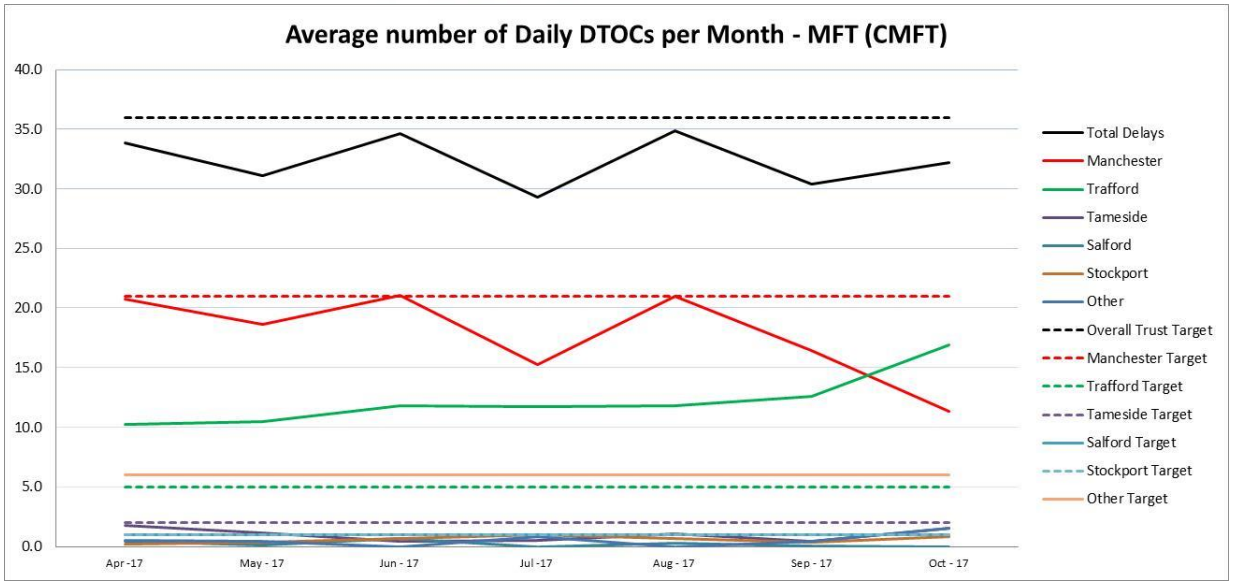
The Graph below shows the number of daily DTOCs for Trafford residents at Manchester University NHS Foundation Trust (UHSM – Wythenshawe) against the target.

Source; NHS England published Stats to end of August 2017, unvalidated local data (to 16/10/2017)



The Graph below shows the number of daily DTOCs for Trafford residents at Manchester University NHS Foundation Trust (CMFT – MRI & Trafford General Hospital) against the target.

Source; NHS England published Stats to end of August 2017, unvalidated local data (to 16/10/2017)


Average number of Daily DTOCs per Month - MFT (CMFT)
40.0
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
Apr -17
May - 17
Jun - 17
Jul -17
Aug - 17
Sep - 17
Oct - 17
Total Delays
Manchester
Trafford
Tameside
Salford
Stockport
Other
Overall Trust Target
Manchester Target
Trafford Target
Tameside Target
Salford Target
Stockport Target
Other Target

6. Trafford Transfers of Care Plan

The table below cross references each of the Programme Objectives against each of the reportable reasons for DTOC.

DTOC Key										
	A	A) Completion of assessment	**C**	C) Further non acute NHS care (including intermediate care, rehabilitation etc)	**Dii**	D) Care Home placement - ii) Nursing Home	**F**	F) Community Equipment/adaptions	**H**	H) Disputes
	B	B) Public Funding	**Di**	D) Care Home placement - i) Residential Home	**E**	E) Care package in own home	**G**	G) Patient or family choice	**I**	I) Housing - patients not covered by NHS and Community Care Act

Programme Objectives	**Projects and Progress**	**Time scale**	**Exec Lead**	**Mgmt Lead**	**Impact of DTOC** **(See Key pg 13)**	**RAG** **(As of Jan,18)**
1. Early Discharge Planning						
An integrated community health and social care team plan early discharges for all elective patient admissions.	1a. Elective discharge planning for hip and knees at UHSM New IDT manager commences at UHSM on 8th Jan. Social Worker to be involved in Pre-Ops	Sept'18	D Eaton	D Walsh/D McNicoll/IDT Manager	B, F	
Robust systems support the development of plans for the management and discharge of all emergency and unscheduled patient admissions, with EDD set within 48 hours.	1b. Integrated discharge team at UHSM, Salford and TGH – Full plan for patient track being developed for UHSM Length of stay group underway at Trafford general (reduced to below	Jan'18	D Eaton	D Walsh/L Lyons	A	

	100 days) District nurse liaison approach agreed for Salford and Trafford general					

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key pg 13)	RAG (As of Jan,18)
2. Systems To Monitor Patient Flow						
Robust patient flow systems and models are in place to support integrated teams and clinical decision makers to identify and manage problems and prevent bottlenecks 24/7	2a. Community flow manager recruitment **09/01/2017**; Started in post 21/11/2017	Oct'17	D Eaton	D Walsh/M Albiston	Maximise capacity throughout the system	
Transfers of care are planned around the individual and patient flow systems allow capacity to be automatically increased where demand (admissions) increases.	2b. GM Discharge pathway mapping project (complete mapping against process and identify gaps) **09/01/2017;** Mapping workshop took place on 16.11.2017. Revised Discharge Pathway documentation circulated and in test throughout the system and all four acute sites. 2c. Identify resources to meet increased demand (GM-Transformation Fund Bid) **09/01/2017;** Additional out of hospital capacity commissioned for D2A beds from 27/11/17.	Nov'17	T Cartmell	D Walsh S Morton	Maximise capacity throughout the system	

	Urgent Care Control Room established in November 2017, is monitoring capacity and demand throughout the system and informing commissioning intentions.					

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key pg 13)	RAG (As of Jan,18)
3. Multidisciplinary/agency Discharge Teams						
All discharge planning promotes a coordinated discharge to assess approach, through integrated MDTs, that is based upon joint assessment and discharge pathways, processes and protocols.	a. Discharge to assess project (To develop an agreed model and identify additional necessary capacity) **09/01/2017;** D2A beds commissioned from 27/11/2017. Admission criteria/spec letters etc.in use –review booked with homes this week Rehab /intermediate care process developed b. Procure discharge to assess nursing/ EMI bed(s) **09/01/2017;** 13 Nursing home beds commissioned including 2 EMI beds	Nov 17	K Ahmed	S Morton M Leslee J O'Donoghue S Morton M Leslee J O'Donoghue	Di, Dii, G	

	c. To identify agreed SW/DNL capacity required (GM – Transformation Fund Bid) **09/01/2017;** Interim community social work allocation process being monitored pending agency recruitment to track use of D2A beds and completion of social work assessments d. Training and development requirement for GPs in MDT **09/01/2017;** MDT due for initial rollout in late January.	**Nov 17** **Jan 2018**	K Ahmed M Jarvis	M Albiston J Telford		

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key pg 13)	RAG (As of Jan,18)
Integrated discharge MDTs have shared and agreed responsibilities, they include the third sector in discharge planning and they provide special arrangements for complex discharges.	e. Integrated discharge team at UHSM, SRFT, TGH (as per table section 1) **09/01/2017;** Integrated discharge team at - UHSM - SALFORD - TGH Integrated manager started at UHSM on 8th Jan 18. Discussions commenced with Salford and Trafford general re Integrated on site management arrangements	Jan 18	D Eaton	D Walsh/IDT Lead	A,G	
	f. Role of Trusted Assessors agreed and implemented for specific tasks eg funding decisions social care/CHC (As per table section 7) **09/01/2017;** Trusted assessors in place at UHSM AMU /IMC However we Review the Trusted Assessor role –due to D2A process -	Jan 18	D Eaton	D Walsh/D McNicol	A,G	

	g. Co-design of new model for Voluntary Sector home from hospital (As per table section 7)	March 18	K Ahmed	A Brown	E,I,G	

4. Home First Discharge to assess						
Patients always return home for assessment and reablement, where possible, after being deemed medically ready for discharge and are supported fully by integrated care and support teams.	a. Discharge to Assess Project (As per section 3) b. Increase in SAMS capacity procured – ongoing **09/01/2017;**Streamlined assessment introduced and tracking in place Daily availability included in the daily tracking sheet through the urgent care control room. Clear line of sight on numbers per day and expected availability and those waiting has supported commissioning to prepare for extension of SAMS with anew provider . Discussions re expanding SAMS with one provider with potential start date in January c. Develop capacity in Homecare market. **09/01/2017;**On-going- New homecare provider sourced	Jan'17 Jan 17 Ongoing	K Ahmed K Ahmed K Ahmed	S Morton M Leslee J O'Donoghue D Gent D Gent	Di, Dii, G E E	

	d. Develop single-handed care to provide more market capacity **09/01/2017;**Potential models being worked up. Business Case will be needed	Jan 17	D Eaton	D Walsh	E	
Where discharge home is not possible, step down beds will be utilised for assessment and additional care and support, where this is required.	e. Ascot House Step down beds **09/01/2017;**All beds know as discharge to assess. Patients requiring an interim 24 hour care placement will be processed through the D2A beds.	Nov'17	K Ahmed	D Gent Sue Burrell	E	
Care homes accept previous residents trusting Trust /ASC staff assessment and always carry out new assessments within 24 hours	f. New framework for nursing and residential homes **09/01/2017*;***Contract currently with solicitor. Meeting to be arranged with K Ahmed and Merry-Fair Price for Care	April'18	K Ahmed	D Gent J O'Donoghue	Di, Dii	

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key pg 13)	RAG (As of Jan 18)
5. Seven Day Services						
Patients receive seamless care provision that includes assessment and restart of care (within 24 hours) regardless of the time of day or week.	a. 7 day social worker and DN liaison provision for assessments at UHSM **09/01/2017;** 7 day SW/ DNL in place at UHSM/TGH and Salford	In Place	D Eaton	D Walsh	A, E	
Sustainable staffing rotas and new contracts are in place to deliver person centred seven day discharge to assess services.	b. 7 day social worker and DN liaison provision for assessments at UHSM (As above)	In Place	D Eaton	D Walsh	A, E	
6. Trusted assessors						
Single integrated assessments, carried out across the system, can directly access jointly pooled resources and funding (without separate organisational sign off) and are 'trusted' and accepted by all care providers within the system. In Trafford we expect this to include acceptance by core agencies eg CCG and TMBC	a. Implementation of Trusted Assessor policy within Trusts 24/7. See section 3f. b. Trusted Assessor trial project with Salford for CHC cases **14.11.2017** Monthly meetings in place. Monitor impact. Evaluation due January 2018.	Sept'17 Nov'17	D Eaton M Moore	M Albiston S Kass	A, E A, Dii	

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key pg 13)	RAG (As of Jan 18)
7. Focus on Choice						
Staff understand choice and can discuss discharge proactively, including the active involvement of patients and relatives at the point of admission.	a. Full Implementation of the choice policy including senior ownership of eviction process at each Trust **09/01/2017***;* Leaflets in redesign MCA processes been reiterated across all sites to ensure D2A options are used	Sept'17	K Ahmed D Eaton S Morton C Watts CMFT lead	Acute Trust leads	G	
8. Enhancing Health in Care Homes						
Care homes integrated into the whole health and social care community and primary care support	a. MDT for Care Homes; NMOC work, reliant on GM Transformation Fund bid **09/01/2017**; Pennine care, OOH Mastercall and CCG preparing implementation plans. First phase roll out planned by end January. Meadway office being prepared to accommodate care homes team initially	Jan 18	R Demaine	T Cartmell	Admission Avoidance	
	b. Scope Red Bag transfer System	Nov 17	M Leslee	New Commissioning Manager	Admission Avoidance	

There is no variation in the flow of people from care homes into hospital during the week	c. ATT Plus project **09/01/2017;** Service under review within OOH contract	Oct'17	T Cartmell	S Morton	Admission Avoidance	
Care home CQC ratings reflect high quality care	d. Implement Enhanced Health in Care Homes quality framework. **14.11.2017** – NHSE Vanguard work to build into MDT standards. Further review Jan 2018	Jan 18	M Moore	M Leslee	Di, Dii, G	
	e. Project to increase registered management capacity	April 18	K Ahmed/M Moore	J O'Donoghue	Di, Dii, G	
Programme Objectives	**Projects and Progress**	**Time scale**	**Exec Lead**	**Mgmt Lead**	**Impact of DTOC** (See Key pg 13)	**RAG** **(As of Jan 2018)**
9 Development of home care market						
There is a high quality home care market in place with sufficient, flexible capacity to meet local need.	a. GM transformational work stream for Support at Home Project	Sept18	J Colbert	K Ahmed	E	
	b. Partington Pilot active **09/01/2018**; pilot live in Partington and Sale	Nov 17	K Ahmed	D Gent	E	

10. Development of the TCC						
The TCC reviews and supports those at greatest need and prevents unnecessary hospital admissions by supporting primary care and linking to appropriate services	a. Deliver a Care Coordination service to 2,000 patients by April 2018, identified through a risk stratification tool. b. Discharge coordination service to prevent readmission 09/01/18; pilot underway with Wythenshawe site c. Agree referral protocols with Community Enhance Care (CEC) service d. Link TCC to Urgent Care control centre(the central point for the utilisation of commissioned services)	Jul 17 - Apr 18 Dec'17 Jan 18 Mar 18	T Cartmell M Jarvis	T Weedall	Admission Avoidance	

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key pg 13)	RAG (As of Jan 2018)
11. Development of Intermediate Care Services						
Increasing the utilisation of Intermediate Care (Ascot House) services in Trafford and reducing delays within the unit to ensure effective and timely response and efficient flow	a. Clinical model and pathway developed reviewed and confirmed b. The business model arrangements to reflect service model **09/01/2018;** Care at home taking dedicated step down from Ascot, CEC and MRI –working well and supporting flow New manager appointed in Care at home Electronic rota system being explored Pathway being reviewed further to develop trusted assessor /and three conversations as new senior prac started at Ascot house Pathway from CEC revised and working well with capacity available on a Monday to take step downs Available resource in community	Dec 17	R Demaine	S Morton D Eaton	C	

	showing successful improvements in community flow					
12. Public Funding decision making						
To ensure decisions for public funding are made appropriately and timely to avoid DTOC	a. CHC funding decisions b. Social Care funding decisions **09/01/2018;** All decisions up to £850 delegated to senior pracs on site in hospital teams being extended to include new IDT manager. New funding operating procedures written System changes completed Fast track decisions making in place for decisions above £850. Out of panel MH cases activated	Nov 17 Nov 17	M Moore D Eaton	Sally Kass/ Debra Peace TBC	B B	
13. CQC action plan						
To identify any actions from the CQC review of the health and social care system which are relevant to the Urgent Care Board.	a. Action Plan to be developed **09/01/2018;** plan in development to be integrated on completion.	Jan 2018	J Colbert	K Ahmed T Cartmell	A, Di, Dii, E, G	

7. Trafford Trajectory for DToCs

The table below summarises the projects detailed in Section 6, their mobilisation dates and the delayed transfer of care (DTOC) reason which they have an impact on;

	Reason for delay	% of delays in Q1&Q2 2017	Mobilisation dates of deliverables						
			Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
A	Awaiting Completion of Assessment	1%	6a	2a	2b - 2d, 6b		1b, 2c, 2d, 3e - f		3g
B	Awaiting Public Funding	5%			12a & b				
C	Awaiting Further Non-Acute NHS Care	2%				11a & b			
Di	Awaiting Residential Home Placement	11%	8d				4a - d		
Dii	Awaiting Nursing Home Placement	16%	8d		6b		4a - d		
E	Awaiting Care Package in Own Home	43%			4e, 9b	7b	4a - d		
F	Awaiting Community Equipment and Adaptations	2%	1a						
G	Patient or Family choice	20%	7a, 8d		6b		3a - f, 4a - d		3g
H	Disputes								
I	Awaiting Resolution of Housing Issues	0%							
		Note: admission avoidance and/or deliverables to be mobilised after 31st Mar 18 are omitted from the above							

Based the delivery of these projects Trafford have estimated the following trajectory to achieving the 3.3% DTOC target (based on the number of individuals reported as delayed on a given day). The table below details the current DTOC performance by site (MUFT & SRFT) against the Trafford trajectory.

	Trafford DTOC trajectory to achieve 3.3% in year Current month performance to 31/12/2017												
	Baseline*	Oct-17		Nov-17		Dec-17		Jan-18		Feb-18		Mar-18	
		Trajectory	Actual	Trajectory	Actual	Trajectory	Actual	Trajectory	Actual	Trajectory	Actual	Trajectory	Actual
Average month end number of reportable DTOCs at MFT: UHSM	30*	*30*	40	*30*	15	*28*	23	*25*		*15*		*9*	
Average month end number of reportable DTOCs at MFT: CMFT	13*	*13*	19	*13*	13	*10*	9	*8*		*7*		*5*	
Average month end number of reportable DTOCs at SRFT	2**	*2*	3	*2*	1	*2*	3	*2*		*2*		*2*	

At the end of March 2018, the target of nine delays at Manchester University NHS Foundation Trust (UHSM – Wythenshawe) are anticipated to be divided amongst the following reasons;

Reason For Delay		No. of individuals reported as DTOC
A	Awaiting Completion of Assessment	0
B	Awaiting Public Funding	0
C	Awaiting Further Non-Acute NHS Care	0
Di	Awaiting Residential Home Placement	0
Dii	Awaiting Nursing Home Placement	1
E	Awaiting Care Package in Own Home	8
F	Awaiting Community Equipment and Adaptations	0
G	Patient or Family choice	0
H	Disputes	0
I	Awaiting Resolution of Housing Issues	0

8. Enablers

Delivery of the above plan will support the achievement of 3.3% DTOC level for Trafford. However, there are additional enablers outside of the eight high impact change areas which will support delivery and these are identified below:

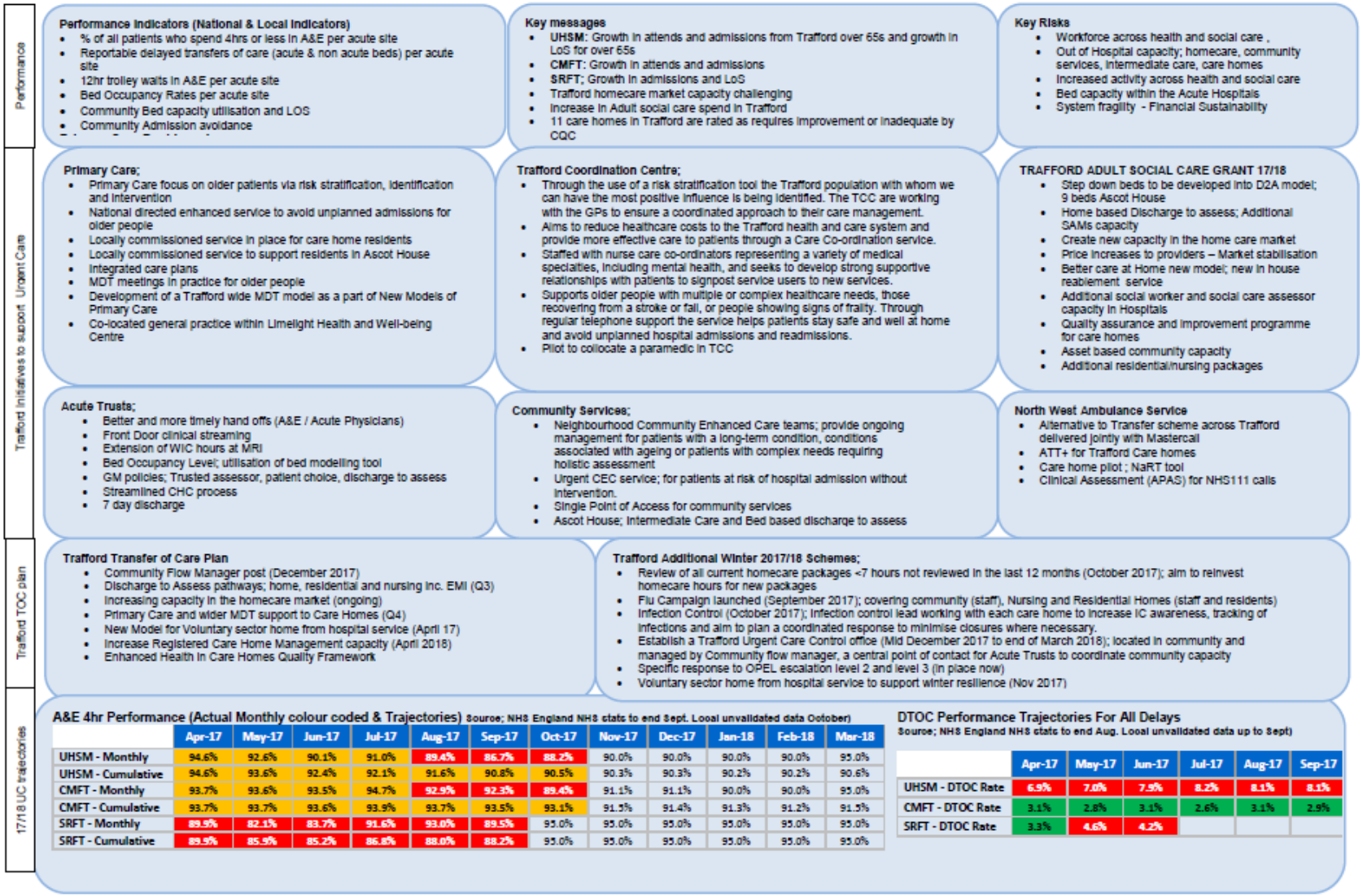
Programme Objectives	Project Dossier	Timescale	Exec Lead	Mgmt Lead
1. Escalation process				
There is a clear escalation policy and process in place in line with national OPEL reporting. Need to identify additional capacity i.e. additional community beds.	➢ Refresh escalation process and apply desk top testing pre winter'18	Nov'17	K Ahmed T Cartmell	S Morton
2. Performance dashboard				
There is clear data reporting in place in a single dashboard format which demonstrates the Trafford DTOC position on a daily basis	➢ Development of joint health and social care dashboard	Nov'17	K Ahmed T Cartmell	S Morton
3. Organisational development				
There is a clear plan, process and funding in place for organisations to develop capacity and capability to deliver the DTOC agenda	➢ TCC ➢ Health and social care integration ➢ Integrated commissioning function ➢ Care complex ➢ New models of care	April'18	C Ward T Grant	I Anderson K Ahmed R Demaine
4. Communication and engagement				
Excellent communication exists in our organisations to ensure that service users and providers understand the portfolio of services available to them	➢ Patient experience and engagement project ➢ Voluntary organisations ➢ TCC	Ongoing	M Moore A Schorah	L Collins K Ahmed D Eaton

9. Conclusion

Both Trafford CCG and Trafford Council recognise the significant challenges involved in reducing delayed transfers of care for Trafford residents. Joint working has enabled our organisations to develop a single joint credible plan to be managed via the joint Trafford Urgent Care Board. However, we do recognise the substantial challenges ahead, both national and local, seasonal variation coupled with the singular issues that impact on Trafford performance; such as high employment levels, the high numbers of self-funders, limited care home placements and the difficulties and challenges affecting the home care market. Nevertheless, our organisations are committed to developing sustainable solutions to topical issues and will work in partnership to offer high quality services to Trafford residents.

1. **Appendix 2 Winter Plan 2017**

DRAFT WORK IN PROGRESS: Trafford CCG & Trafford Council Provisional Winter Plan 2017/18 Across GM Acute Trust Sites v0.4



A&E 4hr Performance (Actual Monthly colour coded & Trajectories) Source; NHS England NHS stats to end Sept. Local unvalidated data October)

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
UHSM - Monthly	94.6%	92.6%	90.1%	91.0%	89.4%	86.7%	88.2%	90.0%	90.0%	90.0%	90.0%	95.0%
UHSM - Cumulative	94.6%	93.6%	92.4%	92.1%	91.6%	90.8%	90.5%	90.3%	90.3%	90.2%	90.2%	90.6%
CMFT - Monthly	93.7%	93.6%	93.5%	94.7%	92.9%	92.3%	89.4%	91.1%	91.1%	90.0%	90.0%	95.0%
CMFT - Cumulative	93.7%	93.7%	93.6%	93.9%	93.7%	93.5%	93.1%	91.5%	91.4%	91.3%	91.2%	91.5%
SRFT - Monthly	89.9%	82.1%	83.7%	91.6%	93.0%	89.5%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
SRFT - Cumulative	89.9%	85.9%	85.2%	86.8%	88.0%	88.2%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

DTOC Performance Trajectories For All Delays

Source; NHS England NHS stats to end Aug. Local unvalidated data up to Sept)

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
UHSM - DTOC Rate	6.9%	7.0%	7.9%	8.2%	8.1%	8.1%
CMFT - DTOC Rate	3.1%	2.8%	3.1%	2.6%	3.1%	2.9%
SRFT - DTOC Rate	3.3%	4.6%	4.2%			

Trafford

Local system review report

Health and wellbeing board

Date of review:
16-20 October 2017

Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and for Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives the Care Quality Commission (CQC) the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

The review team

Our review team was led by:

- Delivery Lead: Ann Ford, CQC
- Lead reviewer: Rebecca Gale, CQC

The team included:

- Three CQC reviewers
- One CQC analysts

- One Pharmacy Inspector
- Two CQC Inspectors
- One CQC Expert by Experience
- Four specialist advisors (two current Directors of Adult Social Services, one Clinical Commissioning Board member and a former National Director).

How we carried out the review

The local system review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on **older people aged over 65**.

We also focussed on the interface between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across three key areas:

1. Maintaining the wellbeing of a person in usual place of residence
2. Crisis management
3. Step down, return to usual place of residence and/ or admission to a new place of residence

Across these three areas, detailed in the report, we have asked the questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?

We have then looked across the system to ask:

- Is it well led?

Prior to visiting the local area we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We requested the local area to provide an overview of their health and social care system in a bespoke System Overview Information Request (SOIR) and asked a range of other local stakeholder organisations for information.

We also developed two online feedback tools: a relational audit to gather views on how relationships across the system were working, and an information flow tool to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care.

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as people who use services, their families and carers. The people we spoke with included:

- Senior leaders and managers from Trafford Council (the local authority), NHS Trafford Clinical Commissioning Group (the CCG), Manchester Health and Care Commissioning (MHCC), Manchester University NHS Foundation Trust (MFT – previously Central Manchester NHS Foundation Trust and University Hospital South Manchester NHS Foundation Trust), Salford Royal NHS Foundation Trust (SRFT) and Pennine Care NHS Foundation Trust (PCFT)
- Health and social care professionals including social workers, GPs, discharge teams, therapists, nurses and commissioners
- Healthwatch Trafford and voluntary and community sector (VCS) representatives
- Representatives of health and social care providers
- People using services, their families and carers at the Carers Centre, Fiona Gardens and a dementia day centre run by Age UK. We also spoke with people in A&E, the discharge lounge and visits to intermediate care facilities

We reviewed 20 care and treatment records and visited 11 services in the local area including acute hospitals, intermediate care facilities, care homes, domiciliary care providers, GP practices, extra care housing, the Urgent Care Centre, out-of-hours GP and the Trafford Co-ordination Centre.

The Trafford context

Demographics

- 16% of the population is aged 65 and over.
- 86% of the population is categorised as White.
- Trafford is in the 20-40% least deprived local authorities in England.

Adult Social Care

- 42 active residential care homes:
  - 23 rated Good
  - 13 rated Requires improvement
  - 2 rated Inadequate
  - 4 currently unrated
- 21 active nursing care homes:
  - 9 rated Good
  - 10 rated Requires improvement
  - 2 currently unrated
- 36 active domiciliary care agencies:
  - 16 rated Good
  - 13 rated Requires improvement
  - 7 currently unrated

GP Practices

- 32 active locations
- 2 rated Outstanding
- 28 rated Good
- 1 rated Requires improvement
- 1 currently unrated

Acute and community Healthcare

Hospital admissions (elective and non-elective) of people of all ages living in Trafford LA were almost entirely at the following NHS acute hospital trusts:

Central Manchester University Hospitals NHS Foundation Trust (RW3)

- Received 46% of admissions of people living in Trafford LA
- Admissions from Trafford made up 18% of the trust's total admission activity
- Rated Good overall.

The second main trust is University Hospital of South Manchester NHS Foundation Trust (RM2)

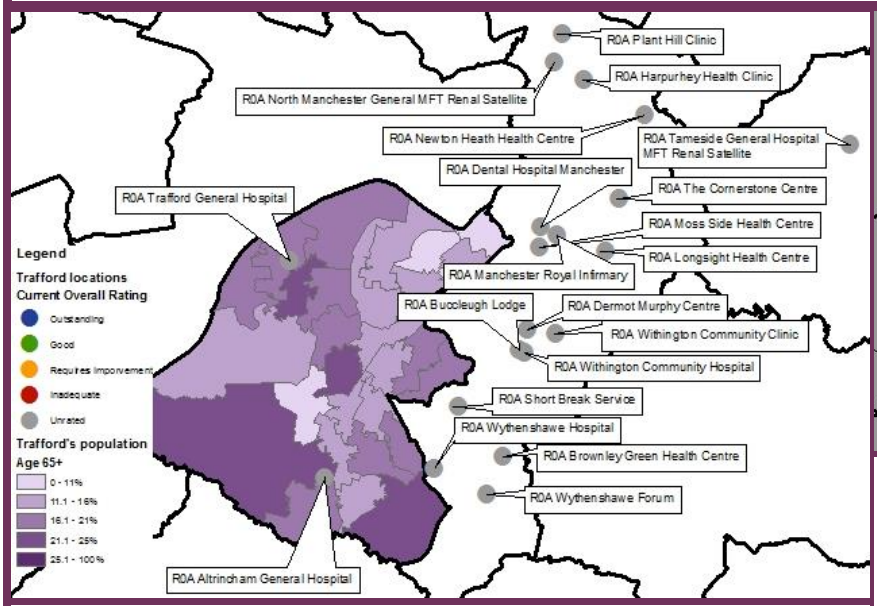
- Received 45% of admissions of people living in Trafford LA
- Admissions from Trafford made up 29% of the trust's total admission activity
- Rated Requirement improvement overall.

These two trusts have recently merged to create Manchester University NHS Foundation Trust (R0A).

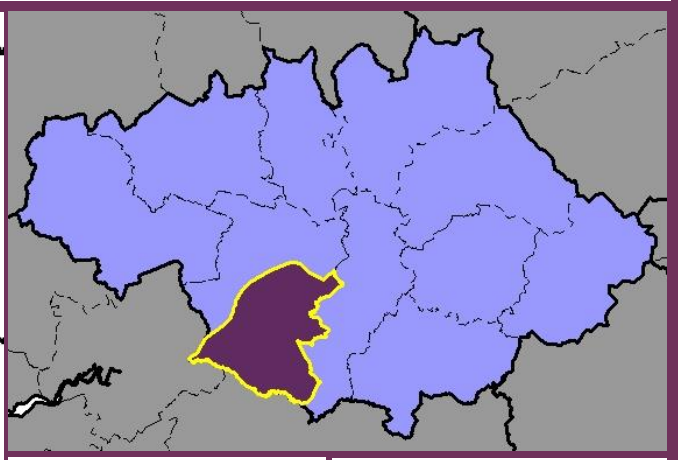
Community services are provided by:

- Pennine Care NHS Foundation Trust (RT2) - currently rated Requires improvement overall

All location ratings as at 29/09/2017. Admissions percentages from 2015/16 Hospital Episode Statistics.



Map 1: Population of Trafford shaded by proportion aged 65+ and location of services provided by the main acute trust for Trafford (R0A). Due to the recent merger, locations under this new trust are listed as Unrated. Community locations provided by RT2 aren't mapped as they cover a larger geographic area.



Map 2: Location of Trafford LA within Greater Manchester STP. Trafford CCG is also highlighted.

Summary of findings

Is there a clear shared and agreed purpose, vision and strategy for health and social care?

- There was system-wide commitment to serve the people of Trafford well. Trafford was on a journey of transformation and integration to achieve the strategic vision. The CCG and local authority were due to become fully integrated as commissioners by 1 April 2018 and there were governance structures in place to facilitate this transformation.

- The New Health Deal (NHD) for Trafford in 2012 was a programme of transformation of out- of-hospital services to ensure future viability. This incorporated the redesign of Trafford General Hospital (TGH) from an A&E site to a nurse-led urgent care centre and minor injuries unit, as well a site for day case surgery, some specialist elective procedures and an older person medical assessment unit.

- The context of Greater Manchester (GM) and the devolution of power provides a unique opportunity to transform the health and social care landscape. The Greater Manchester Health and Social Care Partnership is the vehicle for transformation across the GM-wide health and care system. The GM *'Taking Charge Implementation and Delivery Plan*,' set out a compelling and powerful vision for the future of health and social care services. This vision clearly set out what it would deliver for the people of Greater Manchester, and its localities including Trafford. Secondary care was also in transformation with recent hospital mergers and the vision for a single hospital service provided the opportunity for change.

- There was a clear line of communication and accountability from the Greater Manchester Health and Social Care Plan to Trafford. The Trafford Locality Plan and associated Transformation Bid (the Trafford case for transformation and associated transformation funding) were aligned to the priorities and strategic objectives of the wider conurbation, but were specific to the Trafford area, informed by the Trafford Joint Strategic Needs Assessment (JSNA).

- The Transformation Bid from Trafford set out the vision for a new model of integrated community care, mental health services, primary care and social care services to underpin the establishment of a Local Care Organisation (LCO), which would come into shadow form in April 2018. Trafford was earlier on in its journey compared to some other areas in Greater Manchester and system leaders should take the opportunity to see how contractual arrangements are being developed with other LCOs in GM.

Is there a clear framework for interagency collaboration?

- Historical relationships had been challenging across the system and there had been a significant amount of change among system leaders. Relationships were now improving and system leaders described the transformation agenda as the opportunity and accelerator for addressing systemic challenges and cultural issues. There was a shared understanding of the challenges, and a willingness to work together to achieve solutions.

- Manchester Health and Care Commissioning (MHCC) was the agreed GM lead commissioner for acute care, but Trafford system leaders felt their voice was heard in the wider system, despite their relatively smaller 'purchasing power'. To maintain influence, Trafford should continue to ensure that their relationships with secondary care providers remain collaborative and effective. This is critical for improvements to be realised across the system.

- A section 75 agreement had been in place between the local authority and Pennine Care NHS Foundation Trust since 1 April 2016 to provide all-age health and social care community services. Joint commissioning arrangements existed between the CCG and local authority with regards to the voluntary sector, Ascot House (intermediate care facility) and children's community services and they had developed joint working principles ahead of the planned merger when they would form a single commissioning function.

- There was evidence of some risk sharing between partners. For example, the CCG and the local authority had proceeded at risk to implement some of the proposals outlined in the Transformation Bid. However, commissioning was collaborative rather than joint and the system needs to push forward with the transformation agenda through joint commissioning.

How are interagency processes delivered?

- The challenge for this system was to transform services while also delivering improvements to ensure people were cared for in the right place, at the right time, by the right person. While there had been some significant improvements in performance over the past year, it was from a low base and the system's ability to cope with periods of surge in demand was uncertain.

- Governance structures were aligned to the Greater Manchester model and supported partnership working. A high level of scrutiny and challenge was provided by the Greater Manchester assurance process, but the role of Trafford's Health and Wellbeing Board and Scrutiny Board (the health overview scrutiny committee) needs to be strengthened.

- There was interagency collaboration at a high level, but frontline delivery of services was

still siloed. There was a complex service landscape and much of the High Impact Change agenda needed to be implemented, including seven day services and the use of trusted assessors. Strict admission criteria meant Ascot House was not working at capacity and some work was required to engage staff, provide clarity about the purpose of the service and encourage appropriate referrals.

- There were mechanisms in place to consult with wider system partners, including providers and voluntary sector organisations. However, the extent to which they felt like partners varied and there were missed opportunities to include and maximise providers' contributions.

What are the experiences of front line staff?

- System leaders and senior managerial staff were visible, engaged and had an overview of system performance. However, staff were not always clear who held the overall responsibility performance at a system level. Escalation channels were organisation-based and although issues were being escalated, there was mixed feedback from staff on whether this led to change.

- The degree to which frontline staff could articulate the system's vision varied and was often in the context of their own role rather than the wider system. There was a perception that staff were working to competing priorities, often dictated by sector-specific budgets and targets. There was a lack of trust across the health and social care interfaces, which was a legacy of historical cultural issues within the system.

- Front-line staff were committed to providing high quality, person-centred care. We saw some good examples of multi-disciplinary working. However, the system was multi-faceted and not yet working operationally in an integrated way across the health and social care interface. The capacity of individual teams was not always sufficient to keep up with demand.

- Staff reported there were multiple and confusing points to navigate the system and they did not always know who they could contact or which services they could refer into. There was limited evidence to date to demonstrate the effectiveness of the Trafford Co-ordination Centre (TCC). The TCC aimed to provide a single patient register of those identified most 'at risk' to remotely co-ordinate their care and keep them well in the community by anticipating any interventions required.

What are the experiences of people receiving services?

- The experience of people receiving health and social care in Trafford was varied.

- If a person received a reablement service they achieved positive outcomes and were more likely to remain independent and at home. There were effective arrangements in place to provide equipment to people swiftly and community-based therapy services were responsive to referrals.

- However, there were also missed opportunities to support people to stay in their usual place of residence and prevent admissions to hospital. Primary care provision and GP access varied across the borough and information and support was not always easily accessible. In the first quarter of 2016, A&E attendances and emergency admissions from care homes were higher than average. A recent data refresh showed that emergency admissions from care homes had moved to being lower than comparator areas and the England average. However, the actual numbers of admissions from care homes were as high as they were the previous year and an increase in national averages overall had reduced the gap. People were being admitted with conditions that potentially could be cared for in the community, such as urinary tract infections.

- If a person went into crisis, data showed they were likely to be admitted to hospital and experience longer lengths of stay due to a shortage of homecare packages and affordable, high-quality residential and domiciliary care.

- The implementation of the personalisation agenda was underdeveloped. Very few people were in receipt of direct payments or personal health budgets and while there were innovation sites using the 'three conversations' model, commissioning and contractual arrangements were traditional with a time and task focus.

- Providers and people who used services were extremely negative about the continuing healthcare (CHC) process in Trafford in terms of the assessment process and timely provision. There had been an injection of resource into the CHC team and data showed there had been some significant improvements to performance in recent months. Work was required to improve relationships and the negative perceptions.

Are services in Trafford well led?

Is there a shared clear vision and credible strategy which is understood across health and social care interface to deliver high quality care and support?

As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, multi-

agency and multidisciplinary working and the involvement of people who use services, their families and carers.

There was a shared clear vision and credible strategy for Trafford, which was aligned to the overarching vision for Greater Manchester. This was well articulated by leaders and there was a real commitment across system partners to deliver together; integration was the vehicle to achieve this. Historically there had been some challenging relationships, but these were improving. Staff at all levels were committed to achieving better outcomes, centred around the person and although there was a will to work more collaboratively they were frustrated by the number of barriers in the way. There were some missed opportunities to involve wider system partners in joint delivery plans, specifically around winter pressures which could have been addressed with a more cohesive, system-wide approach.

There were pockets of integrated working arrangements already in in place. The strategic vision for Trafford included establishing a Local Care Organisation to provide the foundations of integrated provision, consistent with the GM-wide vision. These needed to be built upon and expanded at pace with a shift of focus to delivery.

Strategy, vision and partnership working

- System leaders acknowledged that historically some relationships had been challenging, which had resulted in silo working, a culture of blame and a lack of shared responsibility in relation to performance. There had been some recent changes to senior personnel and organisational structures in the system. Relationships within Trafford and between statutory bodies were improving and integration was the vehicle to making the strategic vision a reality. However, we found varying progress in implementation of effective partnership working across different levels of the system. Leaders that we spoke to recognised there was work to be done to integrate delivery, through system transformation.

- The Greater Manchester Sustainability and Transformation Plan, *'Taking Charge Implementation and Delivery Plan'* set out a compelling and powerful vision for the future of health and social care provision and new models of care. Developed in partnership with 37 NHS organisations and local authorities, it clearly outlined what it hoped to deliver for the people of Greater Manchester. The GM STP was rated category 2 – advanced in the July STP progress dashboard.

- A key deliverable of the Greater Manchester Plan was the development of a single hospital service which saw the merger of Central Manchester NHS Foundation Trust and University Hospital South Manchester NHS Foundation Trust to form Manchester University NHS Foundation Trust on 1 October 2017. There was universal support for this change from the

senior staff, voluntary sector organisations and providers we spoke with in the hope it would improve performance and consistency in people's experiences.

- There was a clear line of sight between the Greater Manchester STP, set out in the *'Taking Charge Implementation and Delivery Plan',* and Trafford's vision and strategy, set out in the Trafford Locality Plan and Transformation Bid, which was well understood and articulated by system leaders. These outlined the approach to providing integrated, co-commissioned services with a place-based and community-asset focus to deliver on the vision of *"A sustainable health and social care system which aims to help older people be healthy, independent and enjoy living in Trafford".* The strategic vision for Trafford focused on prevention and early intervention, outlining proposals for new models of community care, underpinned by the Local Care Organisation which would be coming into shadow form in April 2018.

- A section 75 Partnership Agreement had been in place between the local authority and PCFT since 1 April 2016 to provide community services via integrated health and social care teams within each of Trafford's four localities. Feedback from front line staff and senior leaders about this service delivery model was positive. Leaders described how the partnership agreement had led to effective working relationships with high levels of trust and thought it was something to be replicated across the system.

- Partners had agreed and signed of a joint plan for the Better Care Fund (BCF) within the deadline and the Improved Better Care Fund (iBCF) submission for Trafford was aligned with the Transformation Bid. System partners were working together to begin to implement the changes in the High Impact Change Model, one of the national conditions for the BCF. The rate of delayed transfers of care had started to improve, but much more needed to be done. Commissioners told us they were modelling future commissioning arrangements around the High Impact Change Model, but the extent to which this had been achieved was limited. For example, trusted assessors were being piloted in pockets, but not used widely. Some discharge to assess beds had been established, but seven day services were not operating across the system.

- There was awareness among system leaders of the shared challenge to reduce the causes of delayed transfer of care (DTOC). Data showed the whole system had made improvements to the length of stay and number of DTOC, but the latter remained considerably higher than average. At the time of our review there were 11 empty beds at Ascot House (an intermediate care facility), but on 16 October 2017 there were 39 people at Trafford General Hospital waiting to be discharged. Ascot House had dedicated GP input for approximately five hours a day, yet the service was supposed to be for medically

optimised people. We were advised that a review of the admission criteria was underway, but this should be concluded as a matter of urgency to ensure that services across the system are being used effectively and that people are being cared for in the most appropriate facility for their needs.

- A review was carried out by the Emergency Care Improvement Programme in 2017. This is a clinically led programme provided by NHS Improvement to provide practical advice and support to improve patient care and flow. As a result, a Head of Patient Flow had recently been appointed at Wythenshawe Hospital. A Community Flow Manager was due to begin work in November 2017. Although there was a clear ambition, there lacked a robust, system-wide response to the contributing factors to DTOC, such as managing capacity issues in the Homecare market. People from across the system told us issues were not being tackled with sufficient urgency to prevent a potential crisis.

- Trafford's plan for winter was presented and signed off at the Greater Manchester Urgent Care Board during the week of our review. The Trafford plan was aligned to Manchester's and had been developed jointly due to shared resilience plans around acute care. However, there was some confusion evident at strategic and operational level relating to the status of the plan. Some groups reported they had only recently been asked for their input, some had been asked to submit their organisation-level plans and others reported they had not been involved at all. Some system partners felt the plan was late, had not been adequately stress tested and was not a systematic approach.

- The system reported that they worked collaboratively with providers, housing partners and voluntary sector organisations. They had commissioned Healthwatch Trafford to undertake a system-wide review of intermediate care and were in discussions with extra care housing providers regarding winter capacity. While there were structures in place to facilitate engagement, there was not a single, coherent approach to working with other partners. Providers and VCS organisations felt the system was well-meaning, but some felt their input was a 'tick-box exercise' and there was a top-down approach to issues such as winter planning and managing delayed transfers of care. Commissioners told us they recognised the potential of VCS organisations in preventative work and the need to learn from previous years and engage with them earlier on, in a more flexible way. However, the plan for winter had already been signed off by the Urgent Care Board, while a meeting with the voluntary sector to discuss winter resilience was planned, but had not yet taken place.

Involvement of people who use services, their families and carers in the development of strategy and services

- The Trafford Partnership, chaired by the leader of Trafford Council, brought together organisations across the public, private, voluntary, faith and community sector and local residents and was the system's Local Strategic Partnership to deliver on the 'One Trafford' vision which aims to make Trafford a place where residents achieve their aspirations and communities thrive. There was a clear line of communication and accountability to Greater Manchester through Trafford's governance structures and Health and Wellbeing Board.

- The response to the System Overview Information Request (SOIR) described the approach to public engagement to ensure commissioning and service planning was based on the needs of Trafford residents. The local authority's approach was underpinned by a strategy, *'Building Strong Communities'* and the Trafford Partnership. Engagement approaches varied from targeted events to help shape the Care at Home vision and commissioning priorities, Locality Partnership Events to empower communities through funding and support; to engagement of the VCS via an umbrella organisation. Thrive Trafford had been commissioned by the local authority to establish a voluntary/ community/social enterprise (VCSE) strategic forum to bring together VCS providers, commissioners and other public service representatives to discuss issues including health and social care integration and isolation of older people. Positive outputs from these events have included a social isolation project delivered by the fire service and health walks from GP practices.

- System leaders were committed to involving service users, carers and their families in the strategic approach and a series of public and partner engagement events had been held in relation to the Transformation Bid. However, it was acknowledged that more targeted engagement was needed going forward to ensure service design proposals were co-produced. While there were mechanisms in place to obtain feedback from people, these were often focused at service or provider level rather than capturing their experience of the entire pathway.

- We received mixed feedback from some VCSE providers on how valued they felt as system partners in the planning and delivery of services, including planning for winter pressures. They felt underutilised by the system and that they had a lot to offer in relation to keeping people well at home. The VCSE organisations reported there used to be regular meetings with the local authority, but these had become fragmented. Concerns were also raised about the tender process and a lack of transparency around funding decisions following several short-notice contract terminations two years ago. Following our review, the system told us these contracts had not been part of the delayed transfer of care agenda and were a historic procurement issue. The local authority led joint commissioning arrangements with the CCG, including the Carer's Centre and children's community services.

- It was recognised by the partnerships team at the local authority that there was a need to bring together health and social care contracts. We were told some 2017/18 VCSE winter resilience scheme monies were being used to work with VCSE organisations to develop innovative ideas.

Promoting a culture of inter-agency and multi-disciplinary working

- The Trafford Locality Plan, Transformation Bid and existing section 75 agreement between the local authority and community care provider PCFT, provided the foundations for inter-agency and multi-disciplinary working. The local authority and the CCG will be fully integrated commissioners by April 2018 and there were joint working principles already in place. We found some positive examples of staff working in an integrated way to commission and deliver services.

- All staff we spoke with during the week of our review expressed a will to work more collaboratively and although we saw some examples of staff working in an integrated way, these were often dependent on individual relationships and not always facilitated by the system. Frontline staff were frustrated by the barriers to inter-agency working. These included technological barriers, a lack of clarity about services available, duplication of efforts and a lack of trust or competing priorities between organisations. Frontline staff were highly focused on delivering high-quality care, focused on the needs of the person.

- Our analysis of 2015/16 Hospital Episodes Statistics (HES) data showed prior to the creation of Manchester University NHS Foundation Trust, 45.7% of admissions of people of all ages from Trafford went to Central Manchester NHS Foundation Trust (CMFT), 45.1% went to University Hospital of South Manchester (UHSM) and 6.9% went to Salford Royal NHS Foundation Trust. Additional information supplied by the system indicated that UHSM received a greater proportion of admissions of Trafford's older population. Admissions from Trafford made up 18% of CMFT's admission activity and 29% of UHSM's, so the system's purchasing power was less than others particularly as they did not commission services directly.

Learning and improvement across the system

- There were a variety of forums where quality and performance were monitored and discussed, but more evaluation and sharing of lessons learned across the system was needed. At the time of our review there were multiple pilots and concept testing programmes underway prior to system-wide roll-outs. Learning from these pilots was

shared with system leaders to demonstrate the impact they were having, but it was not systematically being cascaded to reach wider system partners or frontline staff at this stage. The system needs to work at pace to collate and implement the learning to drive improvement.

- Across the system, newsletters were used to share learning and feedback with staff. However these were for organisational news and there was not a system-wide mechanism for cascading messages to incorporate all partners. For example, staff reported they did not always receive feedback on incidents raised or whether there were common themes identified through safeguarding investigations.

- Social care providers reported there had historically been forums where they could feedback to the local authority, but all that existed currently were contract monitoring meetings. Following our review, the local authority told us there were fora available to providers, namely service improvements partnerships. Work was required to ensure these were well-known among commissioned services. There were plans in place to develop a Greater Manchester provider forum, but this had not been established at the time of our review.

- There were missed opportunities to ensure there was system-wide learning and improvement. The system could benefit from making sure there are opportunities to come together and discuss challenges, evaluate the effectiveness of initiatives and generate shared solutions.

What impact is governance of the health and social care interface having on quality of care across the system?

We looked at the governance arrangements within the system, focusing on collaborative governance, information governance and effective risk sharing.

Providers and commissioners across the health and social care interface had governance systems and processes in place to assess, monitor and mitigate risks. There were three levels of governance to support the planning and delivery of integrated care, reporting upwards from the local system to Greater Manchester Health and Social Care Partnership Governance structures within the Trafford system and with Manchester Health Care Commissioning were aligned with those of Greater Manchester and provided a mechanism to ensure consistency in performance monitoring.

System leaders felt the level of assurance required at both Greater Manchester and national levels was burdensome at times, but this was outweighed by the benefits of a shared

endeavour. Data and intelligence monitoring was shared across the system and reviewed daily at a senior level, but there needed to be more evaluation to drive improvements at pace. The Chairs of the Health and Wellbeing Board and of the Scrutiny Board acknowledged that the challenge functions of these bodies were not being used effectively. While risks were being escalated at every level, it was not always clear who held overall accountability for them.

Overarching governance arrangements

- There were three levels of governance to support the planning and delivery of integrated care:
    - the local level – locally commissioned services and BCF governed through local commissioning accountabilities, HWBB and CCG, and through local providers;
    - the wider system level (e.g. urgent care delivery board joint with Manchester, and Manchester Health and Social Care Commissioning as lead commissioner for acute care; and
    - the Greater Manchester level through the Health and Social Care Partnership Board (HSCPB) and Joint Commissioning Board.

- Governance structures within Trafford mirrored those across Greater Manchester with local representation on the GM Health and Social Care Partnership Boards and there was a clear line of communication and accountability between the two, with vertical and horizontal reporting structures. Trafford's Integration Board, Joint Commissioning Board and Urgent Care Board worked alongside each other and reported to the local authority's executive boards as well as through to GM assurance structures. Although the level of assurance submitted to the GM HSCPB felt burdensome at times, this was outweighed by the benefits. System leaders felt the collaboration and supportive network facilitated by GM provided a unique, innovative accelerator for change. Trafford system partners need to continue to ensure their voice in the partnership; that the priorities set by GM remain relevant to the Trafford local area and that support is drawn from other areas where local challenges are identified.

- The Trafford Urgent Care Board provided the practical arrangements to deliver the vision for integrated health and social care pathways relevant to urgent care across Manchester and Trafford and set out strategic aims via a jointly developed and agreed project plan, providing oversight for implementation progress. This was attended by key system partners.

- There was a transparent approach to sharing of management information across the health and social care interface. There were some agreed performance metrics set by GM in relation to flow and performance dashboards were in place. However, there were no integrated metrics between health and social care and monitoring was based on traditional performance indicators. We were told that work was underway to develop system-wide universal outcome measures. SRFT had developed a set of agreed, integrated metrics and Trafford could look to wider partners to see if these could be replicated within their system.

- Local authority leaders were visible and engaged. They were aware of the challenges faced by the system and were sighted on performance, but some were relatively new in post. Leaders reported positive working relationships despite political tensions in the past and there was a shared vision for the future.

- Although there was a significant amount of monitoring and measuring, there needs to be more evaluation. The Scrutiny Board's challenge function was underutilised; the Chair told us they were given verbal assurances by system leaders that performance was improving and pilots were producing positive outcomes, but there was a lack of data to evidence it. The Health and Wellbeing Board Chair had taken up the post two months prior to our review. There was an acknowledgement the Health and Wellbeing Board would benefit from a strengthening of its oversight and challenge function in relation to the transformation agenda. Work was already underway at the time of our review to facilitate this.

Risk sharing across partners

- There was a shared view of risks across the system. These were managed in different forums depending on commissioning arrangements. For example, primary care performance was monitored by the CCG Governing Body and social care risks and quality performance were overseen by Joint Quality Monitoring meetings. There was little evidence of shared risk management outside of these arrangements.

- The Trafford system was early on in its journey to integration of health and social care. At all levels it was acknowledged there was some isolated working, but there was a will by system leaders to respond to risks collaboratively. Prior to the Transformation Bid being approved, the CCG and local authority had proceeded 'at risk' to implement some elements of the proposed schemes to prevent delay. For example, increasing capacity of reablement services in the community.

- Staff at all levels had clarity about their roles and responsibilities, but this varied in relation

to inter-agency working. Staff were able to describe the governance structures in place to identify, record and escalate risks appropriately within their organisations. While system leaders were clear about their accountabilities, staff at other levels were not always aware of who was ultimately responsible for performance and risks at a system level. For example, in relation to DTOC or winter pressures.

Information governance arrangements across the system

- The Trafford Locality Plan outlined the importance of adopting a universal approach to sharing information across health and social care to meet its strategic objectives and there were a number of information sharing agreements in place across the health and social care interface.

- The Trafford Co-ordination Centre (TCC), described by the system as “air traffic control”, aimed to provide a single patient register of those identified most ‘at risk’ to remotely co-ordinate their care. The TCC had signed up all Trafford partners to an information sharing protocol to enable personal information to be moved through different agencies. However, at the time of our review not all partners could access the TCC clinical portal containing the shared patient data. This, coupled with the confusion around the role of the TCC and mixed feedback around its effectiveness, meant the benefits of a reciprocal information sharing arrangement were not being fully realised.

- Staff throughout the system reported that information sharing across the health and social care interface needed to improve and this was described as a key barrier to integrated working and improving outcomes for people. GPs and PCFT used the same electronic records system and the University Hospital of South Manchester site had permission to access GP records on a view-only basis, but this was not being put into practice by staff. We heard from GPs that a lack of access to primary care records by people working in the acute sector lead to people undergoing unnecessary diagnostic investigations, assessments and admissions. Eight of the of 15 Registered Managers of social care providers who responded to our survey in relation to information flows reported they received discharge summaries at least 75% of the time, but these were mostly in paper format and rarely electronic. Three respondents reported they rarely received discharge summaries.

To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?

We looked at how the system is working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource.

There was a system-wide understanding of workforce capacity and future needs. Workforce strategies were aligned to that of Greater Manchester, however there was not one whole-system workforce strategy for Trafford; there were separate arrangements at commissioner level. While these were aligned in terms of strategic vision, the system needs to ensure that operational priorities are addressed through a fully integrated workforce strategy. There had been some efforts to address domiciliary care capacity issues, but with limited success to date.

System level workforce planning

- There was not a system-level strategy for Trafford; Manchester, as lead commissioners, had developed a strategy for acute sector staff and Trafford CCG fed into the Greater Manchester workstream for acute workforce. The local authority and PCFT had developed a strategy for community health and social care, aligned to Greater Manchester, and had identified local workforce priorities:
    - Growing our own
    - Developing and promoting our brand
    - Developing our talent and a system wide approach to leadership

- The individual workforce plans were aligned with the strategic vision to move to multi-professional, place-based and asset-focused models of care. However, as the Trafford Local Care Organisation comes into shadow form, system leaders should ensure priorities are complimentary to each other and succession planning is considered.

- There was a Greater Manchester workforce strategy overseen by the Health and Social Care Partnership Board, which outlined the workforce challenges and proposed GM wide solutions in the context of new models of care.

Developing a skilled and sustainable workforce

- System leaders were working to develop and future-proof the workforce through partnerships at local and regional levels as well as with local further and higher education institutions. Workforce development was focused on “growing our own”, using apprenticeship levies, developing career paths and re-skilling and re-purposing existing teams. Some teams were already working in an integrated way in the four locality areas and pilots were being rolled out to empower staff at the frontline to make decisions.

- We heard from all system partners that competition with the retail sector and high educational attainment were key factors in recruiting domiciliary care staff. Analysis of Skills for Care workforce estimates for 2016/17 showed that the staff turnover rate in

Trafford was 35%, which was higher than the England average. However, 61% of new appointments were made to people who were already working in the social care sector in Trafford, which supported the view of providers who told us they were recruiting staff from the same pool as each other. Therefore, while employers were having to recruit to posts, the sector was retaining skills and experience. The local authority had tried several methods to increase workforce capacity, including recruitment days and a 'grow our own' salaried, homecare workforce in the Partington area. The outputs from these initiatives had been minimal to date, so whilst the social care vacancy rate in Trafford was in line with the England average, it had increased since 2013. While all system leaders recognised domiciliary care capacity was a significant issue, there was not a system-wide response to addressing this issue.

Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?

We looked at the strategic approach to commissioning and how commissioners are providing a diverse and sustainable market in commissioning of health and social care services.

Future commissioning strategies were aligned to the wider Greater Manchester STP 'Taking Charge Implementation and Delivery Plan' and Trafford's locality plan, based on a needs assessment which took account of variation within the borough. Funding for transformation had just been approved and although some initiatives had been set up using iBCF monies and some partners taking shared risks, these had had limited success. Commissioners did not take a proactive approach and remained traditional and reactive to pressure points in the system, notably delayed transfers of care. Trafford faced significant market challenges which were widely accepted by system partners. However, responsibility for resolving them was not collective. There was scope for longer-term gains to the wider system if investment was made now to get a grip on the market.

Strategic approach to commissioning

- The Trafford Locality Plan and Transformation Bid, involving the local authority, the CCG and acute care providers, set out the strategic approach to providing care within the four localities. This model was already being used by integrated community health and social care teams and some of the iBCF monies had been used to begin to implement some of the proposals. A needs assessment had been carried out for each of the localities to inform future commissioning plans and ensure local variation was considered.

- There were joint commissioning arrangements between the CCG and local authority with

regards to the voluntary sector, Ascot House (intermediate care facility) and children's community services. The two organisations were in the process of integrating to form a single commissioning function and a Joint Commissioning Board was already in place. Commissioning arrangements were collaborative rather than integrated at the time of the review, but a commissioning outcomes framework was being developed as part of the wider Greater Manchester devolution and staff were positive about future working arrangements. A strategic commissioning decision had led to putting a section 75 agreement in place between the local authority and Pennine Care NHS Foundation Trust (PCFT) since April 2016 in relation to community health and social care services.

Commissioning support services to improve the interface between health and social care

- Future commissioning plans were focused on prevention, and on pathways and the person rather than services, which was positive. At the time of our review these were still to be implemented; commissioning was still separate and based on meeting national objectives and targets rather than taking a coherent system-wide approach.

- Data from March 2017 on provision of extended access to GPs outside of core contractual hours showed that only 3.2% of the 31 GP practices in Trafford surveyed offered full provision of extended access over the weekends and on weekday mornings or evenings compared to the England average of 22.5% and the average across Trafford's comparators of 23.8%. Weekend appointments were provided by the GP Federation on Saturdays and the out-of-hours provider on Sundays. However, if a person needed a face-to-face appointment out-of-hours when the walk-in centre and Urgent Care Centre were closed, they had to go to a site in Salford. Data available at the time of our review showed hospital admissions from care homes were higher than average. A recent data refresh showed that although there had been a reduction in the number of admissions, improvements were not sustained and care home providers reported that GP provision was variable. CCG staff advised plans were in place to enhance the level of support to care homes with a multi-disciplinary team model and up-skilling of nursing staff, but these had not been implemented at the time of our review.

- Although there were 'front door' services commissioned to avoid hospital admissions, including the Older Persons Assessment and Liaison (OPAL) team, Community Enhanced Care (CEC) team, out-of-hours GP services and local pharmacies treating minor ailments; emergency admissions for over 65s in the first quarter of 2017 were higher at 75 per 1,000, compared to similar areas and the national average which were 69 and 64 per 1,000 respectively.

- The number of intermediate care beds had increased from five to 36 at Ascot House and the local authority had also commissioned nine discharge to assess beds at the same

facility. The response to the System Overview Information Request (SOIR) stated this increase in capacity had enabled the system to respond to seasonal fluctuations in activity and led to 30 delays in the summer of 2017 compared to 70 the year before. Published data showed there had been a reduction in DTOC across Trafford in recent months. While Ascot House could be used for 'step-up' care, 90% of referrals were for 'step down' care. In September 2017, the occupancy rate was 75% compared to a target of 85-90%. There was potential for this service to increase system-wide capacity and be utilised more effectively. An evaluation of the admission criteria had begun, but this needed to happen at pace and in collaboration with acute partners.

- Published data in relation to continuing healthcare (CHC) showed that Trafford CCG's performance in quarter one of 2017/18 was poor. High numbers of people were waiting longer than 28 days for their assessment and low numbers of people had been deemed eligible for Fast Track CHC (an indicator of end of life care performance). The response to the SOIR stated that the CCG had increased spending across CHC and Funded Nursing Care between 2013/14 and 2017/18 by approximately £5 million. There had been some changes to the CHC team and data provided by the system showed some positive improvements in performance; more people were receiving CHC funding, were being assessed quicker and not in an acute setting.

- Uptake of personal budgets was low at 5% and of 339 recipients of CHC, only 26 had a personal health budget or direct payment for all or part of their care. There were pilots ongoing with a focus around the 'three conversations' model, which aims to replace traditional assessments for services with three conversations or questions, identifying what financial and social assets a person has and how they can be best supported to use them. While there were pilots ongoing around 'three conversations' and building on assets in the community, there was no coherent plan to increase uptake of more personalised options for purchasing care and supporting the informal workforce. Current contracting arrangements were traditional and time and task focused.

- Voluntary sector organisations felt they were underutilised and there were concerns about the lack of provision for people with dementia. There were limited intermediate care facilities for people with dementia due to the admission criteria and while the local authority told us they commissioned dementia day care from Age UK on a spot-purchase basis, the provider told us they had not received any referrals since block funding was stopped by the local authority in July 2016. The cost of this service was prohibitive to many, often the most vulnerable groups. People we spoke with described some voluntary sector organisations as their "life line", but finding out about the services available to support them was difficult.

Market shaping

- Trafford faced significant challenges in relation to the social care market, both in terms of quality and affordable capacity. Forty-nine percent of care home beds and 35% of domiciliary care packages were purchased by people funding their own care, which created a buoyant market where providers were not reliant on local authority income to exist. In addition, as of September 2017, 53% of nursing homes in Trafford were rated as requires improvement, a figure much higher than the comparator (30%) and national averages (27%). The percentage of domiciliary care providers rated requires improvement was 45% compared to 13% in comparator areas and 16% nationally. This meant that people were at risk of receiving unsafe care and it limited the capacity of the market as the local authority would suspend placing people in homes rated inadequate.

- The system had explored the use of innovative options to exert greater control over the domiciliary care market through the Partington pilot and purchasing packages of care off framework at a higher cost, although the number was small. The iBCF was used to finance some of these initiatives, but as this was one-off funding the system hoped the recently approved transformation fund would help to stabilise the market. New models of care were included in Trafford's Transformation Bid, but were not established at the time of our review.

- The local authority felt supported by wider Greater Manchester workstreams which recognised workforce was an issue for the wider conurbation. While system partners in Trafford all recognised the challenge the market posed, there was not a shared response. Homecare providers were not paid a retainer by the local authority to keep packages of care open if a person was admitted to hospital; there was an informal expectation they would do so for 72 hours. Frontline staff reported that this lead to unnecessary delays while new packages of care were arranged and assessments carried out. It also impacted on continuity of care. In one case file reviewed a person experienced a 15-day delay because their previous long term agency had stopped their package of care and another provider had to be sourced. System partners should take a long term view and make short term investments for longer term gains. Traditional contractual arrangements with homecare providers with a time and task focus rather than flexible commissioning around the person, should be reviewed to create additional capacity and provide continuity of care for people.

Contract oversight

- Contract arrangements for health and social care provision were not joint, but were collaborative. As lead commissioner, Manchester Health and Care Commissioning had overall contract oversight for acute contracts. However, as an associate contract holder, Trafford system leaders told us they felt there was parity in the partnership and they had influencing power.

- Commissioners across health and social care had systems in place to monitor and respond to performance issues and there was evidence of partnership working to drive improvements. The CCG and the local authority worked together and had developed a virtual joint quality team to support providers which fed into joint quality meetings attended by key partners, including Healthwatch and CQC. Data showed this was having a positive effect as 46% of adult social care services were found to have improved following a CQC re-inspection compared to 33% in similar areas. However, 17% of all adult social care services had also declined on re-inspection, which was higher compared to 11% in similar areas. Commissioners had prioritised support to those services most in crisis and so this figure is perhaps not unexpected.

How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting people's independence?

We looked at resource governance and how systems assure themselves that resources are being used to achieve sustainable high quality care and promote people's independence.

There were governance structures in place which facilitated transparent and collaborative lines of reporting. There was a shared understanding of where resource gaps were, but the focus was on the transformation agenda and future projections. While there was high scrutiny of those financial pinch points within the system, current investments were not supporting people to remain at home and the personalisation agenda was underdeveloped.

- There was a shared understanding of where resource gaps were in the system, informed by activity data, quality monitoring reports and the Joint Strategic Needs Assessment for each the four localities. These gaps were articulated within Trafford's Transformation Bid which reflected the resource gaps in the context of the Greater Manchester Delivery and Implementation Plan and the move to a Local Care Organisation model.

- The planning and delivery of the BCF, including the delivery of the Section 75 agreement, was overseen by the Better Care Steering Group, which consisted of senior and middle commissioning managers from the local authority and the CCG. There were transparent reporting lines and evidence of positive working relationships between finance departments at the CCG and the local authority. However, system leaders told us it was difficult to pool budgets at the health and social care interface because of national conditions imposed on monies. System leaders felt that, as Trafford was not high on the deprivation index, they were not prioritised for funding in Greater Manchester despite having some of the most significant challenges in terms of performance.

- Governance structures were designed to provide assurance; commissioners monitored the outcomes for people through ongoing contract monitoring while finance teams assessed the value for money. Transformation Project leads attended the Transformation Board to present real-life case studies to demonstrate the impact pilots and interventions were having on individual people. However, many of the pilots and concept tests underway during our review had not yet been fully evaluated and any cost benefits were projected.

- There had been investment into the adult social care system, but system leaders acknowledged it was not as much as it should be while they were trying to transform it. There had been significant spend on tackling delayed transfers of care (SAMS and Ascot House), but no system-wide cost benefit analysis of the resource being spent on monitoring flow versus investment in managing the homecare market. The local authority had carried out a cost modelling exercise, which had assessed the current hourly framework rate for home care (£14.06) as value for money. Information provided after our review showed this rate was the third lowest out of the 10 local authority areas in Greater Manchester, which ranged from £13.50/ hour to £14.58/ hour. The local authority had paid a provider off the framework at a higher cost and they had subsequently been able to provide 24 packages of care. However, this had not addressed the wider issues and a feasibility study by the local authority estimated it would cost an additional £5.2 million per year to develop a local authority-owned homecare service. At the time of our review, there was no plan to proceed with this option.

- Our analysis showed that there were slightly fewer residential and nursing home beds per population aged 65+ in Trafford compared to comparator areas and the England average. However, data collected by the system and a recently published consumer report contradicted CQC's data and predicted an over-supply of 20% by 2020. Rates of admission to residential and nursing care homes to provide long term support for older people had declined in 2015/16 to 69 per 100,000 from 72 per 100,000 the previous year and were below the England average and that of similar areas. Avoiding permanent admissions is a good measure of delaying dependencies. However, with low uptakes of personal budgets, limited homecare capacity and high numbers of people waiting to be discharged from hospital, the system needs to assure itself that resources are being used most effectively to ensure good outcomes for people. Examples were provided of where high costs of care were agreed to meet the needs of the person, but it was reported that these were not sustainable in the longer term.

Do services work together to keep people well and maintain them in their usual place of residence?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in usual place of residence

Are services in Trafford Safe?

There was a system-wide commitment to keeping people safe in their usual place of residence and proactive prevention and intervention were key priorities in Trafford's strategic vision. However, the reality for people at the time of our review was that support was variable and disjointed at times; some people fell through the gaps and ended up in crisis. Although there was a shared view of who was most at risk, the Trafford Co-ordination Centre was not being used at full capacity and there was limited evidence it had reduced hospital attendances or admissions. There were shortfalls in support to care homes and we found evidence of people being admitted to hospital with conditions that could have been managed in the community.

- The system did not ensure people were consistently supported to stay safe and well at home and people's experiences varied significantly. Age UK held the overall responsibility for delivering the prevention and wellbeing contract for people aged 65 and over with the aim of reducing hospital admissions. They had jointly developed a falls pathway with system partners. Greater Manchester Fire Service conducted 'safe and well' visits and made minor adaptations following referrals from the community.

- However, when we spoke to a group of voluntary sector stakeholders and a group of carers, they felt the system was disjointed and there were gaps, particularly around support for people with dementia. There were no intermediate care facilities for people if they lacked capacity and there was a perception that people with dementia were unlikely to return home if they had a hospital admission. We were given examples of where people had been admitted to hospital with urinary tract infections (UTI) or pressure sores because of variable GP access and difficulties in obtaining specialised equipment. During our review of case files, we found an example where opportunities had been missed to respond to a person's social needs and they were later admitted to hospital following a fall in the community.

- Our analysis of HES data showed that in the first quarter of 2016/17, admissions from care homes in Trafford as a result of UTI were higher than similar areas at 189 per 100,000 aged 65+, compared to 171 per 100,000 aged 65+ across comparators, but in line with the England average of 190. During our review of case files we found an example of a person being admitted with a UTI and approximately two thirds of patients on the acute medical

unit (AMU) at Trafford General Hospital were referred by their GP. Staff felt that some of these people could have avoided admission to hospital if IV antibiotics could have been administered in the community, an opinion shared widely within the system. Care and nursing home providers were frustrated at the lack of response from commissioners to their suggestions. We were advised by system leaders that there was a programme of work in place to roll this out.

- System leaders told us partnership work was well established to safeguard adults at risk of harm. Safeguarding was monitored by system partners monthly, but with the merging of the CCG and the local authority commissioning functions there was an opportunity for these to become more integrated. The lead for safeguarding at the CCG had been in post for six months at the time of our review. They had begun to implement a series of safeguarding assurance and monitoring groups but these had not yet been fully embedded.

- Front line staff across health and social care providers and the voluntary sector were able to describe the process for reporting safeguarding concerns and other incidents. We were given examples of where action had been taken by commissioners to ensure areas of quality and safety concern were mitigated and monitored. While staff reported the system was responsive, they felt that there was limited feedback on any themes or lessons learned which could be cascaded widely across health and social care for future improvement.

- People who were frail, had complex needs or were at high risk of deterioration and/or hospital admission were identified at a system level using a risk stratification tool developed by the Trafford Co-ordination Centre, using primary and secondary care data. The information was shared with GPs and the Community Enhanced Care team (CEC) to provide a coordinated approach to managing their care. These people could be enrolled in the TCC, which aimed to reduce hospital admissions by providing telephone support and remote pathway tracking by managing referrals and preventing missed 'contacts' or appointments. It also provided a point of contact for carers or relatives if they felt the person's condition was beginning to deteriorate.

- Feedback from care home providers indicated there was a variable response from community healthcare services which was putting people at risk of avoidable harm. Some providers had their own contractual arrangement in place with GPs and were complimentary about the Alternative to Transfer initiative, a view which was supported by the Ambulance Service. However, others described a lack of support from some GPs and the out-of-hours provider, which led to some unnecessary admissions. HES data available at the time of our review showed in the first quarter of 2016 the percentage of older people that attended A&E from care homes in Trafford was higher at 11 per 1,000 people than in

similar areas and the national average at 9 per 1,000. A data refresh showed there had been some improvement in recent months. In the first quarter of 2017 the percentage of older people that attended A&E from care homes was lower than the national average at 955 per 100,000 people compared to 979, although it was still higher than the 866 per 100,000 in comparator areas. It was too soon to determine if these improvements were sustained. The numbers referred to A&E by a GP had fluctuated between 9% and 13% over a two year period up to the first quarter of 2017, but was consistently higher than the national average of 6%.

Are services in Trafford Effective?

The strategic vision for the future provided a compelling narrative and outlined how it could improve outcomes for the people of Trafford. Although pilots were showing promising outcomes and some proposals were entering the implementation phase, at the time of our review the landscape was fragmented and performance remained a challenge for the system. The system was not easy to navigate and hospital avoidance schemes were patchy.

- People's experiences were varied and they reported that the system was difficult to navigate and information about support was not easily accessible. There was not a single point of contact for people to access health and social care services. Those who thought they might need some social care support were triaged and either referred for an assessment or signposted to alternative services via the social services screening team. People, providers and voluntary sector organisations told us that information was not easily accessible or understood, particularly for people who funded their own care. Adult Social Care Outcomes Framework (ASCOF) data for 2015/16 showed only 69% people over 65 in Trafford found it easy to find information about support, the lowest of its comparator group.

- We received positive feedback from people who use services and staff about the One Stop Shop when low-level equipment (for example, raised toilet seats and grab rails) was needed and the 'safe and well' checks conducted by the fire service. However, we also heard about delays when waiting for more complex pieces of equipment, and individuals buying equipment themselves because of a lack of clarity about how the system worked. System leaders acknowledged there had historically been long waits for aids and adaptations. However, following a review and increase of resource, waits for major aids or adaptations had reduced from 18 months to nine months.

- While plans were in place for system-wide transformation, in the interim there was an inconsistent approach to assessments which was leading to duplication of work, referrals to services being refused and difficulties in planning care around the person. Care home and homecare providers reported the level of detail they received from commissioners to plan a package of care was poor. Case files we viewed supported this view; some assessments

contained repetitive standardised statements and very little about the person's needs or preferences.

- The Trafford Locality Plan and Transformation Bid outlined the shared vision for supporting people to stay in their usual place of residence, to remain healthy, safe and independent for as long as possible. Health and wellbeing priorities had been reviewed to reflect Trafford's local context and there had been a surge of activity around the public health agenda. Future service delivery was being planned around a locality model, where teams would use the Joint Strategic Needs Assessment (JSNA) to determine the care needs of the people in their local neighbourhood. However, some plans were not fully operational at the time of our review and the *Ageing Well* strategy, frailty strategy, dementia strategy and falls strategy were all in draft.

- The system had considered the wider determinants of health in future plans and had worked with partners in housing and leisure. For example, the falls rehabilitation programme had been expanded from an eight week to a 16-week course, through collaborative working between commissioners, PCFT and Trafford Leisure to incorporate prescribed exercise classes. There were four extra care housing facilities, some with primary care facilities co-located and commissioners were in discussion with Trafford Housing Trust about winter resilience.

- The strategic vision placed an emphasis on keeping people healthy and at home, but this was not being achieved in reality and the personalisation agenda was underdeveloped. Data showed the proportion of people who received personal budgets was low with only 5% of the local authority's total adult social care expenditure going on direct payments. There had been a downward trend in the number of people aged 65 and over whose long-term support needs had been met by admission to residential care, which was positive. However, a higher proportion of the local authority's adult social care expenditure was on nursing and residential care (60%), compared to services designed to maintain people in their usual place of residence (26% of expenditure was on homecare and 11% on reablement). Ascot House was designed to be used as a 'step-up' as well as a 'step-down' facility, but at the time of our review, 10-15% of referrals were from the community. Local authority commissioners had hoped to expand the Stabilise and Make Safe (SAMS) service to include 'step-up' provision but it was currently operating at capacity.

- Although frontline staff in acute and social care services had the skills to support the transition of people between health and social care services, their knowledge of the services available varied and there was a risk that people could fall through the gap. Information about the services available was not always consistent and staff reported they

did not know where and when they could refer people. For example, the CEC team was a 24/7 service, but the information available to staff at Wythenshawe Hospital stated it was available from 08:00 to midnight. Staff reported they felt confused by the different pathways, especially when different local authority areas had different systems or services in place. As a result, some people ended up being seen in the wrong place by the wrong person and at the wrong time.

- Voluntary sector organisations felt there were missed opportunities and that they could be better utilised by commissioners to support people to stay at home. One voluntary organisation told us they had been approached last winter about doing shopping and wellbeing visits in an effort to reduce admissions to hospital, but it had been too late to arrange. They have not been approached since and this was felt to be a short-sighted response by the system.

- There were some good examples of integrated working between health and social care staff delivering community services. However, staff across the system reported that the lack of digital interoperability impacted on their ability to share information effectively. Health and social care services used different IT systems and the lack of trusted assessors meant duplication of effort by services.

- There was an initiative being piloted in the northern locality, 'One Trafford Response'. Coordinated by Trafford Partnership, staff from different agencies including health, social care, police and housing were co-located in a central hub to see how working together to manage referrals and community issues in real-time could reduce the burden on other parts of the system. Initial findings were positive and there were plans to roll this out further.

Are services in Trafford Caring?

There was a commitment and desire from staff at all levels in the system to provide person-centred care and to empower people to make decisions and to remain in their usual place of residence. While we found examples of where people had been well supported and their preferences documented, they may have had to tell their story multiple times to multiple professionals. There was not a coordinated approach to assessments and information and support was not always easily accessible.

- The voluntary sector was extremely active in Trafford and provided a range of services designed to maintain and improve people's health, wellbeing and independence. These were targeted at specific groups, such as the BME community, people with Alzheimer's Disease and carers. Services offered included, support groups, yoga classes and advice lines. Voluntary sector organisations felt they could be better utilised by health and social

care partners to provide information and support to people and carers to prevent crisis episodes.

- During our review we visited an extra care housing facility where people were universally positive about their involvement in making decisions about their care and the information and support available to remain well.

- Some people felt there was a reliance on carers and relatives to navigate the system, particularly if a person was funding their own care. We were told that if a person had an advocate they could have a good experience and while there was an advocacy service in Trafford, this was not well known. Another person described how they had needed to reduce their working hours to care for their relative, and pay for equipment to keep them at home.

- Several carers reported that they had not been given information on how to access financial support until they had discovered the Carers Centre or had searched the internet themselves. According to a 2017 survey carried out by the Carers Centre, only 27% of 333 respondents had been signposted or offered information. ASCOF outcome data for 2015/16 showed the proportion of people over 65 in Trafford who find it easy to find information about support was the worst compared to comparator areas.

- ASCOF outcome data for 2016/17 showed the overall satisfaction score of adults in Trafford who use services with their social care and support (58) had improved from the previous year (52), but still remained below most of the comparator local authority areas where scores ranged from 55 to 68.

- Front-line staff were, without exception, committed to providing more personalised care. Assessments of need were not always coordinated effectively to ensure the person was at the centre of their care and support planning. We heard from people who use services and from staff that often multiple assessments would be carried out meaning the person would have to tell their story more than once. Our review of case files found examples of duplicated assessments where different conclusions were reached about the person's needs by different professionals. This was recognised by the system; for example, the local authority was piloting a neighbourhood-based scheme where referrals, assessments and interventions were managed by one local team to provide consistency and reduce duplication.

Are services in Trafford Responsive?

There were some good initiatives in place to respond to people's needs and prevent admission

to hospital, but the system was fragmented, over-complicated and not easy for people or staff to navigate. Therefore, people were not always seen in the right place, at the right time by the right person.

- People were not always seen in the right place, at the right time by the right person. People we spoke with described varied experiences. GP patient survey data showed there had been a decline in the number of people who felt supported to manage their long-term condition from 70.5% in 2011/12 to 65.1% in 2016/17, but this was in line with the national average of 64%. Case files showed some positive examples of where staff had carried out assessments and arranged packages of care to either support a person to remain at home or be referred to Ascot House for intermediate care. However, in two cases there had been missed opportunities to provide preventative interventions, which may have contributed to their hospital admission.

- The care coordination aspect of the TCC had been in operation for 12 months. At the time of our review, it was providing support to approximately 1,000 people, but had capacity for 3,000. We received mixed feedback from staff across the health and social care system about the purpose, efficacy and impact of the service. As it was a telephone-based service only, the perception from health professionals was that it did not reduce the burden on other professionals as they would be expected to carry out home visits if one was required. The Transformation Bid outlined plans to optimise performance but these had not been realised at the time of our review.

- The rate of emergency admissions in the first quarter of 2017 for over 65s was higher at 75 per 1,000, compared to similar areas and the national average which were 69 and 64 per 1,000 respectively. Performance against this indicator had worsened over a twelve-month period.

- Feedback on GP provision from people who use services, families and carers, staff and system partners was mixed. National survey data showed that satisfaction with GP opening hours was in line with national averages, but data from March 2017 showed that a low proportion of practices provided full extended hours provision. Analysis of HES data showed that in the first quarter of 2017 the percentage of older people that attended A&E as a result of being referred by their GP was 8% which was in line with similar areas and the national average of 8%. The percentage of those people who were then discharged from A&E without being admitted to hospital was lower in Trafford (12%) than similar areas (17%) and the England average (17%). Staff throughout the system felt a lack of support available in the community meant more people were being admitted to hospital.

- The response to the SOIR stated there was a Local Enhanced Service to encourage GPs to proactively manage their patients in residential care by producing individualised care plans to help reduce unnecessary admissions. Although A&E attendances from care homes had declined and were in line with England averages as were emergency admissions, care home providers reported a variable response from GPs and the out-of-hours provider, which meant that people were being sent to A&E unnecessarily. System leaders told us the aim was to provide an enhanced, multi-disciplinary level of support to care homes in two of Trafford's localities by Christmas 2017, but this timescale was ambitious with no contracts in place at the time of our review.

Do services work together to manage people effectively at a time of crisis?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management

Are services in Trafford Safe?

Systems, processes and practices did not always keep people safe when they were in crisis. There had been some improvements in performance in recent months, but data showed that more older people in Trafford were attending A&E, being admitted to hospital and staying longer compared to similar areas. While there was a positive risk reporting culture, risk-averse decision making may have contributed to more people going into crisis than necessary.

- Systems, processes and practices across the health and social care interface did not always safeguard people from avoidable harm. More older people in Trafford were going into crisis, being admitted as an emergency and staying longer than necessary. Our analysis of HES data in the first quarter of 2017 showed the rate of A&E attendances for people aged 65+ was 13,601 per 100,000 compared to similar areas with a rate of 9,724 per 100,000 and the England average of 10,534 per 100,000. The emergency admission rate for people aged 65+ in Trafford was 7,470 per 100,000 compared to a rate in similar areas of 6,922 per 100,000 and the England average of 6,391 per 100,000. While there had been a slight upward trend over the past year, performance had consistently remained worse than average and indicated a gap in community service provision.

- Risks to people were not always assessed, mitigated and monitored to support them to stay safe. Our analysis of HES data showed that in the first quarter of 2017, 33% of people aged over 65 had a hospital stay lasting longer than seven days, which was in line with similar areas with an average 32%, but a slight increase from 32.7% the previous year. Significant capacity issues in the homecare market were contributing to this, however there

were no systems in place to risk stratify people according to need once they became medically fit for discharge; the priority was around their length of stay. Longer hospital stays put people at risk. We were given an example where a patient who had waited a significant time to be discharged and had suffered a fall in hospital, resulting in a sub arachnoid haemorrhage.

- There was a positive risk reporting culture and frontline staff were able to provide examples of where they had reported incidents and safeguarding concerns. However, some staff shared their frustration about when they had escalated incidents or operational issues which presented risks and there was no evidence of any action being taken in response.

- There was a system-level escalation procedure to manage risks to service delivery; the Operational Pressure Escalation Levels (OPEL) framework. There had been some inconsistencies about when to trigger a Level 3 response, but system partners were agreeing the criteria at the time of our review.

- System leaders had a shared view around the reasons for high levels of A&E attendances and hospital admissions and were hopeful this would be addressed as part of the system-wide transformation. There was a shared view among front-line staff that social care market capacity and primary care support was a key factor. However, both acute and community staff described each other as “risk averse” when it came to decision-making. This was supported by the findings of our relational audit where one of the lowest scores was on the statement: people take organisational risks where it had the potential to serve wider system goals without fear of criticism or failure.

- There was a shared view of risks to delivery of services to people in crisis across the Greater Manchester landscape. Safeguarding dashboards were shared monthly and there were daily status update reports to system leaders on flow and system capacity. Working groups had been set up to respond to particular pinch-points, such as delayed transfers of care.

Are services in Trafford Effective?

During a crisis front-line staff demonstrated an awareness of assessing a person holistically in order to meet their needs. Where multi-disciplinary teams were co-located this was working well and they were supported to move through the system more effectively. However, the multiple and confusing pathways meant staff did not always know who to refer to, particularly out of hours. Communication and sharing of information varied and trusted assessors had only been piloted in parts of the system.

- In two case files we viewed there was evidence of holistic assessments of peoples' needs and effective multi-disciplinary working. There was a Choice Policy available to help support people in making decisions, but this was not being universally implemented.

- Services designed to improve flow through the health and social care system were evidence based, but there were multiple, disjointed pathways which meant they were not always being used effectively. The CEC team was designed to provide short term emergency care and where it was providing care to people we were advised it was having good outcomes. According to the CEC's key performance indicator dashboard, 49 people were referred to the urgent arm of the service in September 2017, but there was no measure of whether this was in line with the number of referrals they would expect and there was no break-down of where referrals had come from so targeted engagement could be done with system partners.

- Acute hospital staff showed us the different algorithms they were meant to use depending on where a person lived, but these were not used consistently. They found the system confusing and difficult to navigate and described how strict admission criteria and complex referral processes to services such as Ascot House, made them disinclined to refer.

- Where and when a person was treated had the potential to impact on how well they moved through the system. Multi-disciplinary teams were based at Trafford General Hospital and Wythenshawe Hospital five days a week. At Wythenshawe Hospital there was a geriatrician-led, multi-disciplinary team (OPAL) which worked in A&E Monday to Friday and the Medical Assessment Unit seven days a week. The team identified those people who could avoid admission who may be put on the frailty pathway and supported at home with a package of support. This model of care was producing positive outcomes for people and the system should review any outcome data available to determine whether rolling out the same model to Trafford General Hospital or in to the community would have wider benefits, building on the Community Enhanced Care team to avoid duplication.

- Trusted assessors had been piloted in parts of the system, but there was not widespread implementation at the time of our review. Each service would carry out their own assessments, which could cause a delay to care being delivered. There was little evidence of system-wide learning from pilots or incidents being disseminated across the workforce. Where staff could describe where they had achieved positive outcomes for people this was very much at team or location level.

- One of the strategic objectives of the Trafford Locality Plan was to have a universal approach to sharing information across health and social care. At the time of our review

there was limited interoperability of record systems to allow staff to share accurate, real time information and staff told us often the only piece of information available at the point of crisis was a person's DNACPR record. The senior executive team of the newly formed, Manchester University NHS Foundation Trust outlined the plans to have one IT system and one assessment process, but acknowledged this was in the early stages of development.

Are services in Trafford Caring?

Frontline staff understood the importance of involving people who needed support and their families in decisions in about their care and there was an innovative approach to supporting people in their discharges from Trafford General Hospital. However, we received mixed feedback from people and their families during our review. Some did not always know who was coordinating their support or feel they had been given sufficient information to make decisions.

- Our review of case files showed assessments of care were centred around the needs of the person and people we spoke with at the hospital knew the plan for their care and felt involved in making decisions. However, when we spoke to a group of carers and relatives they were less positive. They felt decisions had been made without their input even where they had Lasting Power of Attorney. Staff reported more advanced care planning in the community would prevent the person from having to tell their story multiple times.

- We found some innovative practices to involve carers, families and advocates in future plans. At Trafford General Hospital there was a purpose-built flat based on Ward Two where discharges could be simulated to determine what support was required and how the family or carers felt they might cope.

- Providers, voluntary sector organisations and carers raised concerns about the support for people with dementia when they went into crisis and felt that the right people were not always involved. They reported that staff were not able to provide the support they needed and the hospital environment often heightened a person's anxiety. Hospital staff told us that relatives and carers were encouraged to visit at all hours, especially meal times, and to stay overnight. Some specialist support was also available and dementia was observed to be a high priority for staff at all levels.

Are services in Trafford responsive?

People living in Trafford did not always receive the services they needed at the right time and in the right place. People were more likely to be admitted to hospital and were also more likely to stay in hospital for too long because of a shortage of care packages and affordable beds in the community.

- In July 2017 North West Ambulance Service (NWAS) treated 32% of 999 calls without transferring them to hospital, which was slightly below the England average. We were told there were few incidents where ambulances were diverted elsewhere, which may indicate that the transfers were appropriate or it may be there were shortfalls in community provision.

- During our review we identified an operational policy which directed staff caring for people within the OPAL unit at Wythenshawe Hospital to call 999 if a person became acutely unwell. System leaders should review the policies and procedures relating to the OPAL unit to ensure additional burden is not placed on the wider system and that people who are still under the care of the acute trust are seen by the right person at the right time.

- Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM) merged and as of 1 October 2017 formed Greater Manchester University NHS Foundation Trust. Published data was still at the disaggregated level. Between 2014/15 and 2016/17 both CMFT and UHSM failed to meet the national four hour A&E target of 95%. Unverified data, collated by the system as part of their on-going monitoring of performance showed performance had declined across both hospital sites in the last quarter.

- Older people in Trafford were more likely to end up being admitted to hospital and staying longer. Between 2016 and 2017, bed occupancy at CMFT was consistently above the optimal target of 85%. Bed occupancy at UHSM was slightly lower, but only dipped below 85% in one quarter.

Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: step down, return to usual place of residence and/ or admission to a new place of residence

Are services in Trafford Safe?

There was not a coordinated response to discharges, which meant some people experienced unnecessary delays and, in some cases their risk factors increased as a result. Once people were ready for discharge, there were some systems in place to ensure their safety was not compromised, including provision of equipment and reviews of their needs. However, these need to be strengthened to ensure information is provided to all partners in their care and is sufficiently detailed and accurate. Emergency readmission rates for older people in Trafford had

increased over time.

- The number of older people in Trafford requiring emergency readmission once discharged was in line with the England average at the time of our review, but had been higher for five of the last six quarters. Our analysis showed that over all of the financial year 2016/17, Trafford's emergency readmission rates occurring within 30 days of discharge for people aged 65+ was 19.5% compared to the England average of 18.7%.

- The systems in place to return people to their usual place of residence or a new facility did not always protect them from avoidable harm. In two case files we found examples where people had experienced hospital stays of over a year and their health condition had deteriorated as a result. Groups of voluntary sector organisations and carers we spoke with also described hospital acquired delirium as a barrier to people returning home and we saw an example of this in one case file we reviewed.

- At Trafford General Hospital, Ward Two was a 25-bedded 'complex discharges' ward and staff gave examples of where people had experienced falls or detriment whilst waiting for packages of care to be arranged. Although these were reported as incidents, there was no evidence of these incident reports effecting changes. There was a sense of learned helplessness among staff and that these incidents were a symptom of the wider flow issue within the system.

- Eight of the of 15 Registered Managers of social care providers who responded to our survey reported they received discharge summaries at least 75% of the time, but these were mostly in paper format and rarely electronic. Three respondents reported they rarely received them. Eleven said they usually received summaries within 24 hours, but there was mixed feedback on the quality of the information and whether it was sufficient to plan a package of care. Six respondents said there was sometimes enough information, five said there was not; eight said there was rarely information in relation to any mobility issues. This was supported by a group of care home and homecare providers we spoke with who also reported referrals often failed to include whether a person had a cognitive impairment.

- Once a person was discharged there were some systems in place to ensure they were reviewed to prevent a readmission. There was a Directed Enhanced Service in place to encourage GPs to review and amend care plans for those identified at risk of admission and if a person was in receipt of reablement, they received weekly reviews following discharge to ensure the package of care was sufficient to keep them safe. The One Stop Shop prioritised discharge referrals and aimed to provide equipment the same day (93% of urgent referrals were completed within 48 hours). Community pharmacies were informed by

Trafford General Hospital if a vulnerable person was discharged with a monitored dosage system, but there was no formal scheme in place to facilitate discharge information being sent from secondary care to community pharmacies. There was a pilot ongoing in Salford, but no concrete plans were in place to roll this out in Trafford.

- Our analysis of HES data showed that in the first quarter of 2017 emergency readmission rates occurring within 30 days of discharge for people aged 65+ from care homes in Trafford was lower, at 14%, than similar areas and the England average (21% and 20% respectively). This was an improvement from 21% the previous year (compared to an England average of 20%), but the system needs to ensure this is sustained.

Are services in Trafford Effective?

Whilst there had been some improvement in performance, the number of delayed transfers of care remained high and people were not always enabled to return to their preferred place of residence with a timely integrated approach. Those that did receive reablement had good outcomes, but the number in receipt of these services was below the England average and market forces were having an impact on the system's capacity to keep up with demand. The recent appointment of a Community Flow Lead was intended to provide a system-wide view of capacity and co-ordination, but they were not in post at the time of our review.

- Readmission rates had declined over recent months, but so too had the number of people receiving a reablement service from 3% in 2013/14. Analysis of ASCOF data for 2015/16 showed that the percentage of older people who received a reablement service was slightly lower compared to similar areas at 2.6% for Trafford and 3.0% for comparator areas. Where people did receive reablement, it had good outcomes; 93% of people over 65 were at home 91 days after discharge from hospital to a reablement service. This had improved significantly from 69% in 2011/12. The Stabilise and Make Safe (SAMS) service, commissioned from two homecare providers, was the preferred route out of hospital. For bed-based reablement, people could be referred to Ascot House and Wythenshawe Hospital. Patients could also be sent to Opal House, based on site.

- There had been a sharp decline in DTOC between February 2017 and July 2017 from 46.3 days to 25.5 days per 100,000 population (aged 18 and over). While this shows a significant improvement, it was still high compared to the average of 13.6 days for both comparator areas and England averages. A Community Flow Lead had been appointed to have a system-level view of capacity and was due to start in November 2017. Daily meetings were held at each hospital site to discuss delayed transfers of care and next steps. However, the sense of urgency varied and there was an attitude that delayed transfers of care were an accepted symptom of the system.

- There were multidisciplinary teams co-located at the four hospitals serving Trafford residents to facilitate timely, holistic assessments to promote a person's independence on discharge. While we saw some good examples of where teams worked together, the system was disjointed and not easy to navigate. A lack of in reach by community staff, shared records, trusted assessors and competing priorities were cited as barriers by staff to providing an integrated response to a person in crisis. We were told about a person who presented to A&E on a Friday evening and due to a lack of seven day services could not be discharged back out into the community. Their package of care was stopped over the weekend and they ended up staying in hospital for a month while a new one was arranged.

- The acute medical unit (AMU) at Trafford General Hospital no longer had any formal occupational therapy input following the retirement of member of staff, funded by PCFT. System leaders told us this change was made in 2013 as part of the transformation of community services. Hospital staff felt it had negatively impacted on delayed discharges with the AMU. This example was illustrative of the feedback from some staff who felt changes were made in isolation without wider consultation. Where referrals had been refused to Ascot House, referring staff were not always clear why and felt the criteria was too strict. Staff at Ascot House recognised a need to work more closely with their secondary care colleagues to ensure there was a shared understanding of the purpose of this service.

- Some private providers told us they had to ring hospital wards to find out when an existing client may be ready for discharge; often they were only contacted when the person was medically fit. For new packages of care, they were alerted via an email from commissioning teams. They were required to submit an 'Expression of Interest' based on the information provided, which was often limited. If their tender was accepted, they would be expected to assess and start delivering a package of care within 24 hours. Providers were concerned about the level of information supplied by commissioners and relied on their own assessments, so there was a reluctance to consider the use of trusted assessors. Furthermore, the practicality of this system did not encourage person-centred care.

Are services in Trafford Caring?

The extent to which people, their families, carers or advocates were treated as active partners varied. Where efforts were made to put the person at the centre, the extent to which they could make choices was limited to what care was available in the community, particularly if they were not funding their own care. There was limited use of voluntary sector organisations by the system to support people to return to their usual place of residence.

- The SOIR stated people and their families were engaged at each assessment in each

setting and choices offered between solutions to meet needs, providers to deliver care and commissioned care or direct payments. Our review of case files showed a person-centred approach was applied inconsistently and to varying degree. In one example, there was consistent support of the community social worker upon hospital discharge and a package of care was increased rapidly to prevent a carer breakdown. However, we also saw some assessments where there was little evidence to demonstrate the person's input. People we spoke with awaiting discharge or assessment felt they had been kept up to date and knew what the next steps were. However, a group of carers were less positive and did not feel like they had been treated as partners in care.

- There was a choice policy in place, but this was not understood by all staff or universally applied. We heard from various sources that due to demand outweighing supply in affordable, high-quality community care, it was less about choice and more about what was available. This was contributing to delays as people and their families refused placements. There was a common perception among different groups we spoke with that if a person funded their own care, they would get a better experience.

- Voluntary sector organisations told us they were rarely directly involved in supporting people to return home. The response to the SOIR stated that a volunteer-led support to hospital discharge service had been commissioned to work in partnership with hospital discharge teams, but this had delivered limited outcomes and a new service was being co-designed. Voluntary sector organisations we spoke with told us they were not involved in any discharge planning or support and felt this was a missed opportunity. A Carer Liaison Worker was based at Trafford General Hospital twice a week with the aim of providing information, advocacy and advice around admissions and discharges.

- We received negative feedback in relation to the CHC process. Unverified data from the system's latest submission showed there had been some significant improvements in the last quarter. However, work was required to alter this negative perception through positive engagement with staff, providers and people who use services. As of September 2017 only 42% of local resolution meetings were happening within three months of notification of an appeal compared to a target of 100%.

Are services in Trafford Responsive?

Systems processes and services were in place to support the transition of people to their usual place of residence or alternative setting, but there was insufficient capacity to meet demand. The system had made significant improvements in relation to delayed transfers of care, but the significant shortage of homecare packages meant people were still waiting too long in inappropriate settings and not always receiving continuity of care or choice.

- Services were commissioned to help improve the flow through the health and social care system, but there was insufficient capacity to meet demand. A reliance on the homecare market with its workforce capacity issues, a lack of Elderly and Mentally Infirm (EMI) beds and affordable residential care, meant people were not always being seeing in the right place, at the right time, by the right person.

- The SAMS service had seen a 68% increase in referrals between November 2015 and October 2017. Following a change in criteria in August 2017 to include more complex cases, the service quickly became full. System leaders told us they had hoped to use the SAMS for 'step-up' as well as 'step-down' provision, but the providers could not recruit to keep up with the demand. The service had recently been supplemented by the in-house Care at Home service to increase capacity. Between April 2016 and March 2017 out of 287 completed cases, 33% of people who had received the service were living independently and 12% were able to have their packages of care reduced. It was not clear how this compared with expectations and the system should review how performance is measured.

- Where there was a reliance on homecare staff to provide a service, there were bottle-necks in the system. This was demonstrated by data in relation to reasons for DTOC; between February and April 2017 'awaiting care package in the home' was reported as one of the main reasons for delay in Trafford, accounting for an average daily rate of 12.7 delayed days per 100,000 population, compared to an average of 2.6 days in similar areas and 3.1 days nationally. The system should consider its reliance on the homecare sector to provide its community rehabilitation service, considering the workforce challenges and inability to reduce capacity with winter approaching.

- Nine discharge to assess beds had been commissioned at Ascot House and Opal House and Ward Two were also using the same model. The response to the SOIR stated that there was flexibility to enable the SAMS service to provide additional capacity. However, as this service was already at capacity this seemed to be an unrealistic assertion.

- There had been significant improvements in performance of continuing healthcare (CHC) over the past quarter. NHS CHC data showed the conversion rate for people being referred and then assessed as eligible for CHC had stayed below the system's target of 23% (19.65% in September 2017), but the total number of people referred had increased from 63 in May 2017 to 173 in September 2017. More people were being identified by frontline staff. People were receiving timely assessments once in the most appropriate setting for their care; 83.3% of assessments were completed within 28 days compared to 10.8% in May 2017 and only 6% took place in an acute setting. One hundred percent of people referred for Fast Track CHC received it, meaning people at the end of their life were

supported to be moved to their preferred place of care.

- The High Impact Change model for managing transfers of care identifies seven day services as one of the changes that can support health and social care systems reduce delays. The Department of Health's analysis of activity between October 2015 and September 2016 showed that the proportion of older people discharged over the weekend in Trafford was slightly higher than similar areas at 20%. There was the potential for this number to increase through improved partnership working and further development of seven day working across the system.

Maturity of the system

What is the maturity of the system to secure improvement for the people of Trafford?

- Although the system had a clearly and consistently articulated vision across health and care agencies, which was aligned to the Greater Manchester STP *'Taking Charge Implementation and Delivery Plan'*, delivery and implementation was at an early stage. The CCG and the local authority commissioning functions were on track to become fully integrated and the Local Care Organisation would be coming into shadow form in April 2018. These foundations need to be built upon and expanded at pace to ensure the benefits are felt more widely across the system. Trafford's strategic vision for a Local Care Organisation is the vehicle to achieve this, and now that the Transformation Bid has been approved by the Greater Manchester Health and Social Care Partnership Board, the focus needs to shift to delivery

- Governance arrangements in Trafford facilitated transparent conversations, information sharing and some shared decision-making between statutory organisations. However, the challenge function of Trafford's Scrutiny Board and the Health and Wellbeing Board were underdeveloped and a lack of integrated outcome measures meant monitoring of performance was siloed and in accordance with traditional key performance indicators.

- Historically relationships within the system had been challenging, but these were improving. System leaders were united in a shared endeavour and there was a commitment to work together in a collaborative way. There were still some legacy cultural issues which were apparent among frontline staff, but these were recognised by system leaders and actions were planned to address them.

- Some funds from the iBCF had been used to stabilise and shape the adult social care market. However, market pressures remained a significant challenge for Trafford and the extent to which system leaders worked collaboratively to address them was limited and system partners recognised they had scope to improve.

- There was a shared understanding of where resource gaps were in the system. While the BCF had facilitated integrated working between health and social care, budgets remained separate. The use of personal budgets was low and commissioning was collaborative rather than integrated. The CCG and the local authority will form a joint commissioning function in April 2018.

- Trafford did not have a single workforce strategy, but were aligning to the strategy at GM level at GM level

- Information governance arrangements were at the early stages of integration. Health and social care used different records systems, but there was a shared use of NHS numbers.

- There was some evidence of multi-disciplinary team working for effective outcomes, but they were not system-wide. There were multiple pathways and a reliance on homecare to provide services meant people became stuck in the system and suffered poor experiences and outcomes as a result.

Areas for improvement

We suggest the following areas of focus for the system to secure improvement

- With winter approaching; the system should remain focused on the here and now to ensure improvements in performance are sustained while delivering transformational change. There should be a shift from monitoring and piloting to evaluating and implementing.

- The system should fully implement the High Impact Change Model.

- The challenge functions of the Health and Wellbeing Board and Scrutiny Board should be strengthened. Where there are shared risks these should be made explicit and managed through joint governance structures.

- There should be a proactive system-wide response to effectively managing the social care market and domiciliary care capacity.

- The OPAL multi-disciplinary team were producing positive outcomes in preventing admissions by providing an in-reach service. The system should endeavour to review outcome data and consider whether the model can be rolled out in other areas.

- Operational policies in place at Opal House should be reviewed to ensure they are not placing additional burdens on the wider system.

- Admission criteria to intermediate care services should reviewed to ensure consistency and efficacy of service provision. Acute hospital staff should be engaged in the evaluation process.

- The system should ensure there is a Trafford-wide workforce approach, which identifies current needs as well as predicting future requirements in alignment the GM workforce strategy.

- The system should continue to ensure that its voice is heard in partnerships with the wider conurbation to make sure priorities remain relevant to the Trafford area and that support is drawn from other areas where local challenges are identified.

- With the Local Care Organisation coming into shadow form, the system should learn from wider system partners to ensure that new contractual arrangements do not destabilise the system.

- There should be a joined-up, coordinated response to engaging with the voluntary sector and provider organisations as system partners.

- Work is required to share learning and experience between staff at the interface so there is shared trust and understanding and historical cultural barriers are broken down.

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Trafford Partnership
Working together for you

Trafford Public Service Reform

Strategic Assessment and GM Reform Investment Plan

January 2018

Transformation Strands

What stage are we at?

	Early	Developing	Maturing	Mature
Experience of the Citizen & Community				
Leadership				
Workforce Development				
Delivery Structures & Delivery Processes				
Culture				
Strategy				
Reformed Investment & Funding Structures				
Place Based Integration				

So what?: Challenges

- No single Reform Governance at present
- Some disjoint between Health and Social Care Transformation and PSR
- No single Reform Strategy or Statement of Intent
- Is the ambition to create a single operating model for delivery of frontline services in Trafford?..to include all areas of reform (health, social care, early help, housing, policing, offender management, employment and skills..)
- OTR key systems issues: Crisis accommodation; Impact of Welfare Reform; access to Primary care Mental Health services
- Reduction in Stronger Families funding.. How to sustain model as part of place based delivery?
- No single front door for both early help and safeguarding
- How to expand multi-agency, multi disciplinary, integrated placed-based working ethos, culture and practices across all areas and services in Trafford including VCSE providers?
- How to ensure all workers share culture, values and standards consistently about co-design, co-production and strengths-based delivery- What it means to be a public servant in Trafford…?
- How to improve communication about the Reform programme across the Partnership?

So what?: Challenges cont'd

- How to better connect people to people through increased community capacity?…to reduce demand on public service eg role of community connectors
- Leaders need to be more engaged in unblocking systems conditions
- How to ensure strategic commitment to reform filters down through middle management?
- How to equip our frontline supervisors to manage multi-disciplinary teams in a place/… and need to identify who these team leaders are in Trafford
- How to increase investment in preventative services?
- How to make more effective use of cost benefit analysis?
- No single business intelligence function for Trafford
- How to ensure co-location for integrated working wherever possible?- estates challenge
- How to develop a consistent approach to induction and training in Trafford for our place based workers?
- Early intervention/Early Help no universally understood definition
- How to ensure Reform programme is understood as part of Vision 2031?
- How to achieve pooled budget arrangements?
- How to make best use of technology?

Reform Action Plan Headlines

Theme	Intentions
Strategy	Develop a single Reform Strategy or Statement of Intent linked to Vision 2031
Governance	Review current arrangements. Create one Strategic Reform Board to align Health and Social Care transformation and wider PSR agendas
A Single Framework for 'The Way we Work in Trafford'	For the way we deliver frontline services. Development of a safeguarding and early help front door; Early Help model and integrated place based delivery across the spectrum of need on our 4 locality/NH footprint to include health and social care, offender management; Employment & skills services etc
Co-location of key staff and services	Defining the estates challenge to ensure key staff and services are co-located on a locality or sub-locality footprint wherever possible
Embedding Troubled Families approaches	Key workers, co-location, peer support etc. How to fund and use the skills in the Stronger Families team to help embed practice whilst also meeting TF national targets for 2018-19

Reform Action Plan Suggestions?

Theme	Intentions
Workforce Development and Leadership at all levels	Adopting shared values, attitudes, behaviours across workforce. Development of generic induction programme for all Trafford staff. Min. requirements for Manadatory training. Development offer in key practices to support staff working in core place-based delivery. Development of Trafford Leadership prog to improve lines of comms across/within organisations, systems leadership, leadership in a m-a place based teams
Critical Systems Blockages	Identified through OTR- homelessness & access to crisis accommodation; streamlining our offer to residents and raising skills and knowledge to navigate the benefits system; quicker access to mental health services through community wellbeing provision and primary care in each locality.

Reform Action Plan Suggestions?

Theme	Intentions
Building Community Capacity/ Capacity of Universal services	Develop a strategic vision, adopt principles for any community connector/navigator projects. Develop model and pilot different approaches. Empower/upskill place-based workers to know community offer and work with VCSE providers to build capacity to identify and reduce demand GMFRS Community Risk programme refresh and expansion?
Comms and Marketing	To develop and deliver a Marketing strategy and plan to support the Reform Strategy and AP
Business Intelligence, Evaluation, Financial Analysis, Pooled budgets and Technology	To progress towards single budget arrangements? To create a single business intelligence function across Trafford Partnership; To review and increase cba and financial modelling capacity to support the Reform Programme To maximise the use of technology to support the Reform programme

GM Reform Ask

- **Strategic Self-Assessment process =** increase the speed and scale of reform & integration locally- submitted our headlines

- **Reform Investment Plan-** clarified just before Xmas that the £1.4m funding is to embed the Stronger Families model in our wider Reform prog. Especially place based and early help models

Trafford Reform Investment Plan

1. Whole System Redesign

- a redesign of frontline service delivery (The Trafford Way)
- incorporate and embed the methods and ethos of our Stronger Families approach
- delivered in the place and at scale across the whole borough and all partners.
- Build on the foundations laid through our One Trafford Response (OTR) programme, (to roll OTR out at scale is less about creating new and separate teams, but about achieving a whole system, whole scale cultural change)

2. Workforce and Leadership Development

- a comprehensive workforce and leadership development programme to offer training, shadowing and upskilling opportunities to the existing Trafford workforce (circa 5000).
- equip staff from all agencies, including the VCSE, to provide whole family holistic case management at the earliest point in a service user's journey.
- provide a set of common values and understanding of Trafford the place and its 4 localities as part of a generic induction programme.
- ensure there are consistent standards for mandatory training such as Safeguarding and Domestic Abuse.
- equip leaders to manage in place, including systems leadership and matrix management.

Trafford Reform Investment Plan

3. Early Help Model and Place-Based Working

- expansion of our All Age Front Door to include early help referrals;
- expansion of our Early Help Panels;
- phased roll-out of our integrated place-based/neighbourhood working (OTR), firstly to the whole of the north locality and then the other 3 localities.

4. Community Navigators

- to de-escalate the families we work with
- to better harness our strong and vibrant VCSE
- ensure all frontline staff at all levels know 'place' and recognise the assets in families, neighbourhoods and communities.
- recruitment and training of volunteer "Community Navigators", to help families access VCSE or universal services before they require targeted intervention.
- support professional keyworkers to help their clients better connect with their community, increase resilience and stabilise their situations.

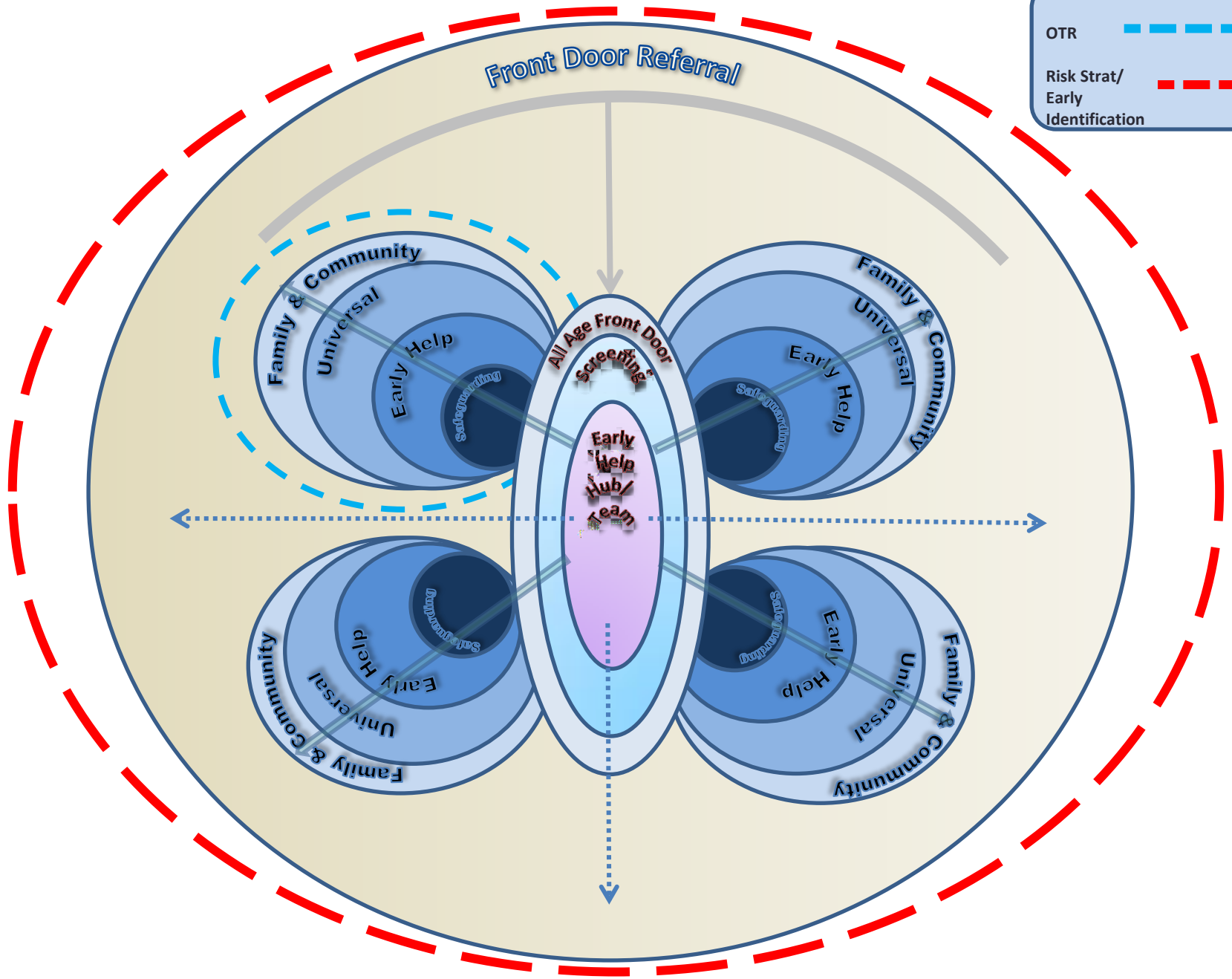
Trafford Reform Investment Plan

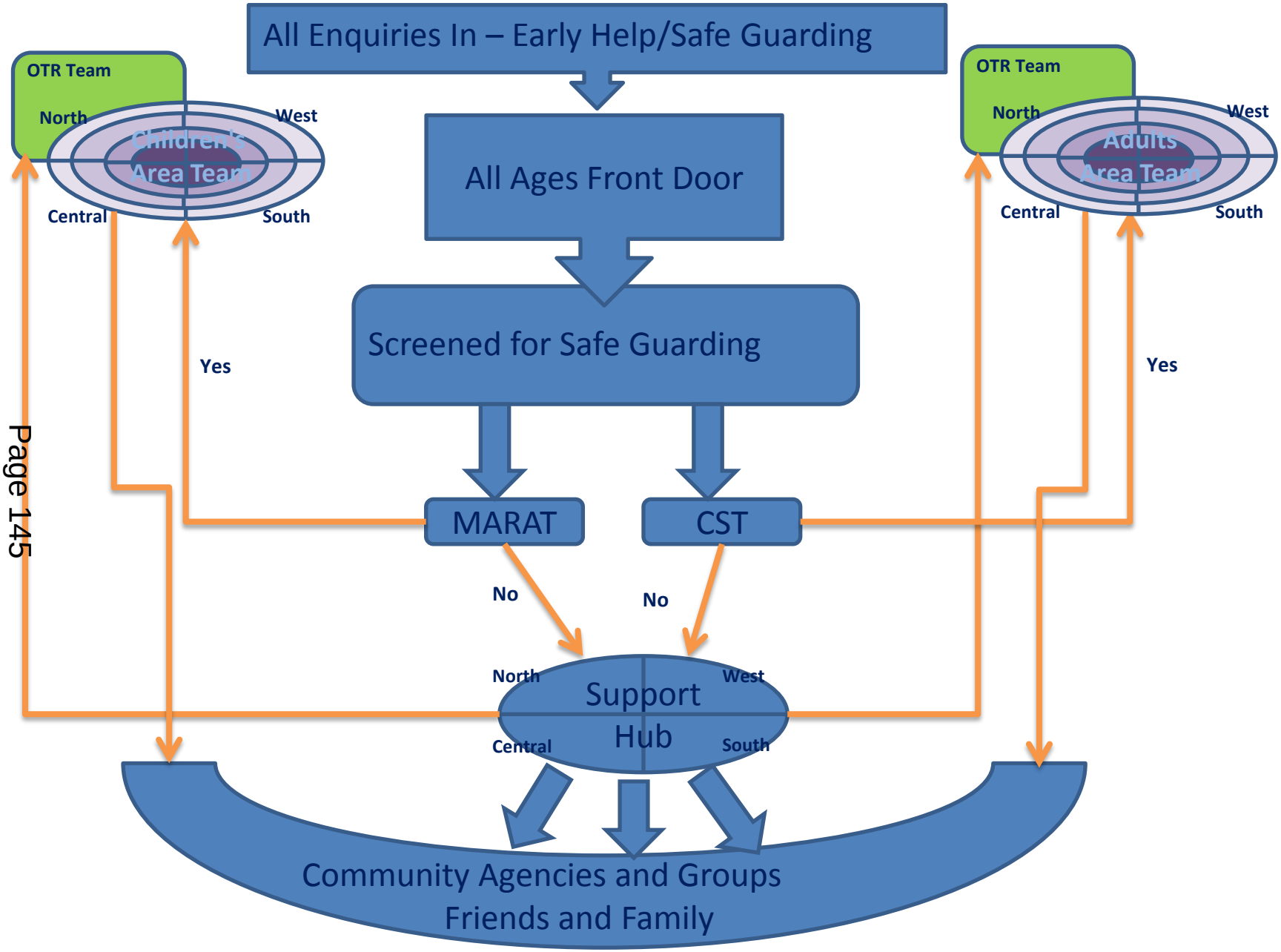
5. Comms/Marketing

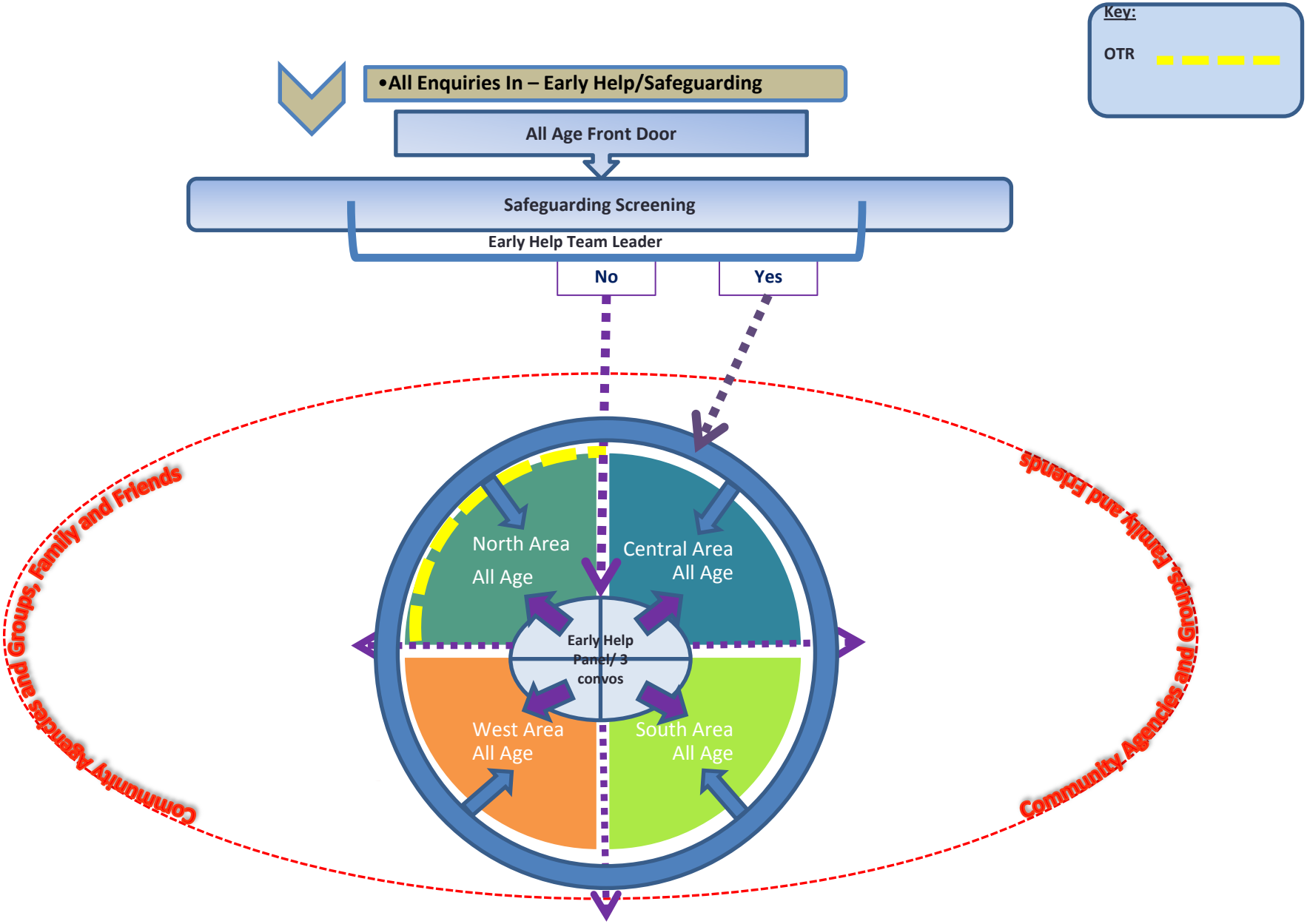
- a whole system and workforce/cultural shift requires a well-constructed and resourced Communications and Marketing Strategy and action plan for staff, referrers, service users and the public.
- increase and dedicate capacity in Comms and Marketing, on behalf of the whole Partnership, to our Reform programme.

6. Estates/ Agile Working

- 'One Trafford Estate' – our approach to gain knowledge and intelligence of all public sector owned assets. We have secured One Public Estate 6 funding to undertake a neighbourhood asset review across each of our 4 neighbourhoods.
- ambition is to co-locate as many of our Early Help keyworkers as possible & to be able to offer a range of accessible spaces in our communities where staff can see service-users. We do not have enough appropriate spaces for staff to have quiet conversations, where staff can also access the wifi networks needed to be agile workers. Need to invest in some adaptation of some spaces across our estate.
- intend to equip all Council employed staff in the place base teams with tablets and provide a bank of tablets for Partner staff.


Key:
OTR
Risk Strat/ Early Identification
Front Door Referral
Family & Community
Universal
Early Help
Safeguarding
All Age Front Door
Screening
Early Help Hub/ Team


All Enquiries In – Early Help/Safe Guarding
All Ages Front Door
Screened for Safe Guarding
OTR Team
North
West
Children's
Area Team
Central
South
OTR Team
North
West
Adults
Area Team
Central
South
Yes
Yes
MARAT
CST
No
No
North
West
Support
Hub
Central
South
Community Agencies and Groups
Friends and Family


Key:
OTR
•All Enquiries In – Early Help/Safeguarding
All Age Front Door
Safeguarding Screening
Early Help Team Leader
No
Yes
North Area
All Age
Central Area
All Age
Early Help
Panel/ 3
convos
West Area
All Age
South Area
All Age
Community Agencies, Family and Friends Groups
Community Agencies and Groups, Family and Friends

Trafford Reform Investment Plan- Financial summary

Summary Table: Proposed Utilisation of Investment

Theme	RIF	Reserve	LWIP/PBI	OPE	Trafford P'ship	Total
All Age Front Door Early Help Team Leader	25,212		24,000			**49,212**
Stronger Families Service Mgt & Change Champion	29,000					**29,000**
OTR Team Leader	49,212					**49,212**
Early Help Team Leader		49,212				**49,212**
Place Based & Complex Dependency Reform Programme Management	61,500		41,000			**102,500**
Business Support and Evaluation in OTR Pilot	32,565					**32,565**
Performance & Data Mgt		38,725				**38,725**
Trafford Way' Integration Champions OTR	80,834					**80,834**
Early Help Intervention Workers		121,251				**121,251**
Customer Service Advisor for the All Age Front Door- Safeguarding and Early Help Screening role	16,000					**16,000**
Workforce and Leadership Development	100,000		15,000			**115,000**
Building Community Capacity Community Navigator Project	40,000				40,000	**80,000**
Estates / Agile Working	100,269			85,000		**185,269**
Comm's and Marketing Capacity	55,000					**55,000**
Total for Year 1	**589,592**	**209,188**	**80,000**	**85,000**	**40,000**	**1,003,780**

Theme	RIF Yr 1	RIF Yr 2	RIF Yr 3	Total RIF
RIF Allocations as Summary Table Above	589,592	-	-	589,592
Comms and Marketing Capacity	-	55,000	-	55,000
Workforce Development	-	82,708	76,000	158,708
Customer Service Advisor for the All Age Front Door- Safeguarding and Early Help Screening role	-	32,500	-	32,500
Place Based & Complex Dependency Reform Programme Management	-	83,000	-	83,000
OTR Team Leaders (x 4 Neighbourhoods)	-	198,000		198,000
Trafford Way Integration Champions	-	123,000	-	123,000
Business Support and Evaluation in Front Door and OTR Pilot	-	36,000	36,000	72,000
Building Community Capacity Community Navigator Project	-	25,000	25,000	50,000
Total for Years 2 and 3	**589,592**	**635,208**	**137,000**	**1,361,800**

Trafford Reform Investment Plan- Next Steps

- Approval of outline Plan by PSR Board
- Taking to Council Corporate Leadership Team
- Other Partners may wish to share with their Leadership teams
- Resubmit our final Plan to GM Friday 26th Jan
- Outline to HWBB and the TP Executive Board 2nd Feb
- Composite report from all 10 to GM Reform Panel 6th Feb
- Reform Board for approval in March and GMCA 29th March
- Funding released
- We don't intend to wait to start implementing our plan

Trafford Wider Reform Action Plan - Next Steps

- **Convene partnership Workforce Development Group**
- **Convene partnership working group to look at wider Reform Plan**
- **Working Group to:**
  - **Work on statements of intent**
  - **Review Reform Governance structures**
  - **Map Vision 2031 and Health and Social Care Transformation activity against Reform Action Plan headlines**
  - **Identify existing resource commitments and any further resources required to deliver the Reform Action Plan**

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Trafford: Sports & Physical Activity Strategy

‘Vision for 2031- Intervention Two: Creating a national beacon for sports, leisure and activity for all, making Trafford a destination of choice.’

By 2031 every resident in Trafford will #BeActive everyday*.

** This will be measured via Sport England’s annual: Active Lives Survey*

Strategic Landscape;

2017-31 Trafford's Vision 2031 Programme
Trafford's Sports and Physical Activity Strategy

2017: Trafford's Physical Activity Vision

2017-21 #GM Moving: A Plan for Physical Activity and Sport

2016-21: Sporting England: Towards and Active Nation

2015: Sporting Future: A New Plan for and Active Nation

Current Picture;

Area	Inactive, *less than 30 mins a week*	Fairly Active, *30-149 mins a week*	Active, *150+mins a week*
Trafford	24.3%	12.2%	63.5%
Greater Manchester	27.7%	12.9%	59.6%
England	25.6%	13.8%	60.6%

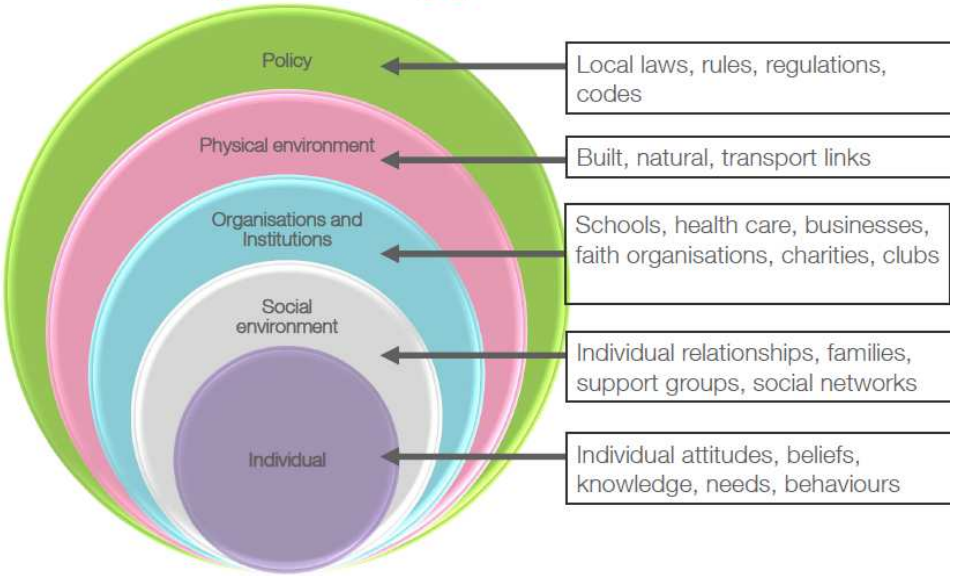
Table 2: Active Lives Survey Data: (Sport England, 2017)

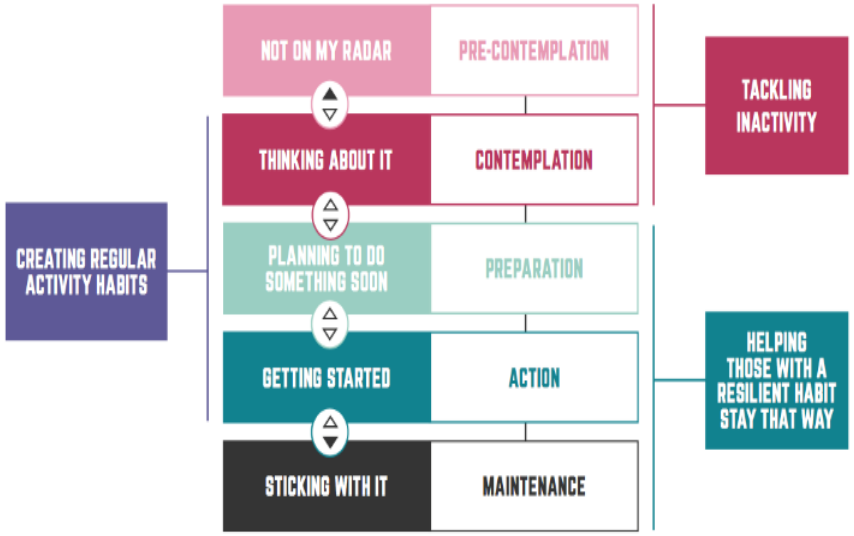
- Nationally inactivity costs £7.4 Billion a year, at a GM level this equates to £26.7 million and £4.8 Million in Trafford.

- WHO reports ~ 1 million deaths a year in Europe are as a result of inactivity.

Changing approaches;

Population level change requires 'whole system' approaches





- Population level behaviour change around physical activity requires broader, joined up approach.
- Physical Inactivity is everyone's business! Can't focus on traditional audiences and partnerships.

Priorities;

- Active People, across the life course
- Active Places, asset based
- Enablers, without barriers

Active People;

- Interventions for everyone across the life course

Start Well: Young children need to learn to value the importance of physical activity from as early an age as possible.

Develop Well: Children and young people need to be presented with the right opportunities in a style and setting that is appropriate.

Live Well: Physical Activity needs become interwoven into both work and life to create a lasting habit that can be enabled in others.

Age Well: Older people need to be encouraged and empowered to be physically active on their own terms.

Active Places

- Places and spaces accessible to all

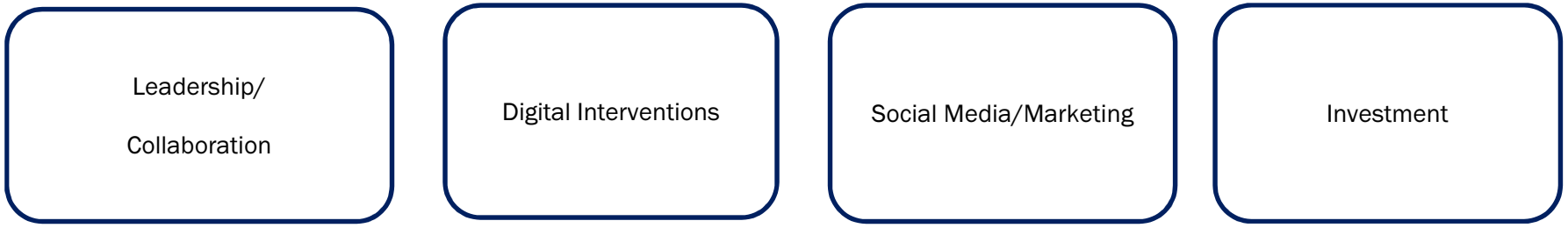
• Active Places

Public Realm/Leisure Facilities

• Active Spaces

Pitches & Parks

Enabling Change;



- Four key enablers for delivering change in Trafford
- Ensures and enables change is sustainable
- Connects with us with those who need support most
- Enables interventions to be current and timely

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TRAFFORD COUNCIL

Report to: **Health & Well Being Board**
Date: **2nd February 2018**
Report for:
Report of: **Thomas Haworth: Sports & Physical Activity Relationship Manager**

Report Title

Trafford's Sports & Physical Activity Strategy 2018-2025

Purpose

The Sports & Physical Activity Strategy sets out to interpret the Physical Activity Vision adopted by the Health and Well Being Board and the Council in 2017. The strategy, accompanied by the implementation framework, highlights the priorities and interventions the Strategic Sport & Physical Activity Partnership will lead with other partners and communities to support the Trafford Vision 2031 Program intervention;

'Creating a national beacon for sports, leisure and activity for all, making Trafford a destination of choice.'

To support this wider outcome the sports & physical activity strategy will aim to ensure that;

"By 2031 every resident in Trafford will #BeActive everyday"

Recommendations

The HWBB is asked to:
Endorse and adopt the strategy and implementation framework

- **Endorse the development of a strategic investment plan, targeted at areas of need**
- **Endorse the recruitment and deployment of ambassadors to focus on the following areas**

  - **Disability, Inclusion and long-term conditions**
  - **Women and girls in sport and physical activity**
  - **Active Ageing**
  - **Youth engagement**

Contact person for access to background papers and further information:

Name: Tom Haworth (Thomas.haworth@trafford.gov.uk)

1. Introduction

1.1 Following the conclusion of Trafford's Sport and Physical Activity Strategy 2013-2017 a broader vision was developed for sport and physical activity in Trafford which reflected significant changes in the way Leisure is delivered in the borough and the recognition that physical activity is a critical wider determinant of heath and wellbeing. The Vision was adopted by Trafford Council and the Health and Wellbeing Board.

1.2 This Vision is now being translated into a strategy and implementation framework. This will ensure the strategy remains current and reflects the changes in the way physical activity is measured through the introduction of Active Lives along with a sector shift to 'whole-system' working that focuses on the most inactive through broader physical activity initiates and community engagement.

1.3 The most recent Active Lives Survey indicated that 24.3% (~43,000 residents) of Trafford Population is 'inactive'. Inactive is 30 minutes of activity or less per week and also includes those that don't do any activity.

1.4 Those that are classed as inactive are putting their health at risk; not meeting this level of activity greatly increases people's prevalence of conditions, such as cancer, CVD and diabetes, all causes of early morbidity. The World Health Organisation estimated that 1 million deaths in Europe are as a result of physical inactivity. A lack of physical activity has also been shown to detrimental to people's mental health.

1.5 The emerging sports and physical activity strategy sets out how Trafford Strategic Sports Partnership will tackle the issues associated with inactivity through specific interventions and encouraging behaviour change. The aim is to make Trafford the most active borough in Greater Manchester and by 2031 and to ensure that all residents in Trafford are active every day.

2. Baseline – Current picture

2.1 The table below shows levels on activity for Trafford compared to Greater Manchester and England. This will be updated on an annual basis.

Area	Inactive, *less than 30 mins a week*	Fairly Active, *30-149 mins a week*	Active,*150+mins a week*
Trafford	24.3%	12.2%	63.5%
Greater Manchester	27.7%	12.9%	59.6%
England	25.6%	13.8%	60.6%

2.2 Another key outcome is developing and delivering interventions and behaviour change that increases the percentage of the population that are 'fairly-active' and 'active'.

2.3 The strategy and implementation plan will deliver this change through the following outcomes:

- Healthy life expectancy increases and there are less preventable deaths
- Less people are obese
- Less people suffer from mental health issues and dementia
- Less people live with long-term conditions
- Less people suffer from falls
- Less people suffer social isolation

- Less people suffer work related stress
- Workplace productivity is increased

2.4 The above outcomes will be achieved by focusing on the following thematic areas:

- **Active people:** focused on the behaviour change of our residents, employers and leaders
- **Active Places**: concentrating on the transformation of our places and spaces to make physical activity the easy choice.
- **Enablers:** the assets, technology, policy and platforms that will allow enable this ambition and marketing and communication to raise awareness.

3. Methodology

3.1 The strategy aim and outcomes will be delivered through the implementation framework.

3.2 The implementation framework focuses on delivering the interventions below, which are grouped in the thematic priorities identified in 2.4.

- The Impact of active spaces in public realm design, through the Trafford Leisure Strategy and Playing Pitch Strategy & Local Planning Policy.
- The impact of targeted interventions for the elderly, disabled and women and girls
- The Impact of social prescribing on physical activity levels, health outcomes and new models of primary care delivery for GPs. Through training and advocacy, making every contact count.
- The Impact of co-ordinated workplace physical activity on sickness levels and productivity for different cohorts of employees, through the Workplace Wellbeing Charter.
- The Impact of different uses of public realm and open green spaces such as the Mersey Valley and Sale Water Park. Through Trafford Green Space Strategy and initiatives like Play Streets.
- The Impact of Partner pledges to support the Physical Activity Strategy. Through coordinated engagement and workforce development.
- The Impact of increased activity with a focus on walking, running and cycling, through active travel and interventions such as ParkRun and the Greater Manchester Marathon.
- The Impact of accessible digital technology on levels of physical activity. Through the promotion of the PHE ‘One You, Active 10 App’.
- Impact of physical literacy and physical activity levels of children and young people. Through Let’s Play Toddler, the School Games, After School Clubs and opportunities outside of education.
- The Impact of Trafford’s clubs and volunteer physical activity champions on behaviour change at a locality level.

3.3 Baseline measures and KPI’s are being developed for each of these interventions and an output framework is being delivered to collect demographic data from across the strategic sports partnership.

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