TRAFFORD COUNCIL

Report to: **Health & Wellbeing Board**
Date: **6th April 2016**
Report for: **Health & Wellbeing Board**
Report of: **Better Care Fund Programme**

Report Title

Progress Report of Better Care Fund for Trafford, and overview of plan for 16/17

Purpose

This is to provide the Health and Wellbeing Board an update of the progress of the Better Care Fund for Trafford in 15/16, and an overview of the planning process, and the content for the plan for 16/17.

Recommendations

The Health and Wellbeing Board are asked to:

- note the progress outlined in the attached paper for 15/16
- note the schedule for 16/17 BCF planning and assurance

Contact person for access to background papers and further information:

Name: Julie Crossley, Associate Director of Commissioning at Trafford CCG.

Trafford Better Care Fund Programme

1. Introduction

1.1 The Health and Wellbeing Board have received previous reports which set out the schemes which contribute to the Better Care Fund programme for Trafford. This is the latest report which provides update on the individual schemes and areas which have been addressed by the Steering group.

1.2 The Better Care fund is set out in the CCG's strategic plan as this will be a main contributor to reducing unscheduled care activity and shifting activity from the acute sector into the community. As set out in 2015/16, Trafford commissioners are seeking to reduce activity by 3.5%.

1.3 All the schemes for 15/16 are focused on the Frail and Older people, with the schemes supporting this cohort of patients to keep their independence and to support individuals remaining in their own homes with services wrapped around them to support them in the community.

1.4 This report provides an overall summary of the 15/16 programme and details of the latest highlight report and financial position.

1.5 Also contained in this report are details of the 16/17 planning process, and an outline of the content for the 16/17 plan.

2. The Better Care Steering Group

2.1 The Steering group responsibility is to monitor progress, address any risks/barriers to improvement. Progress has been made in terms of collecting and analysing risks at both an individual scheme level and overall. Any significant risks (in terms of likelihood and impact) will be reported to the HWB.

2.2 The latest version of the live risks are shown in Appendix 2. Currently there are no significant risks to report at programme level. Individual scheme risks are reported in section 3 of this report.

2.3 There has been a change to the terms of reference for the BCF Steering Group. This group now reports via the Joint Commissioning Board to the HWB.

2.4 National Support for Logic Modelling – An event took place on 9th March 2016 which was arranged jointly by Trafford CCG / Council and the Midlands and Lancashire Commissioning Support Unit. The half day event was well attended, with 21 attendees from a mix of Council, CCG and Pennine employees. The event was essentially 'on the job training' to think in a logical way about how we plan and build models. There were very useful conversations had around integration of health and social care, delayed transfers of care, building a data dashboard across several organisations. The learning from this training is being taken forward and an initial version of a Logic Model is under development for the 16/17 Better Care Fund plan.

3. Update on Progress for 15/16

3.1 Scheme Performance Overview:

Scheme	Status
1. Integration of Health and Social Care	On-going
2. End of Life	Phase 1 – implemented
3. Community Nursing	Phase 1 to be implemented April
4. Falls	Phase 1 – April
5. ATT	Currently being implemented
6. Care Homes – Enhanced Primary Medical Services	Interim Implemented- phase 2 to be part of new models of care for Primary care
7. Intermediate Care	Phase 1 implemented – progressing phase 2

The latest highlight report that has been tabled at the BCF Steering group can be viewed in Appendix 1. This gives a narrative update on each of the existing schemes for 15/16.

4. Better Care Fund Planning 16/17

4.1 For 2016/17 Trafford have been allocated a total of £16,092K. This is made up of revenue funding from the CCG and from Disabled Facilities Grant. This makes up the minimum pooled fund that the CCG and Local Authority will have in place for the Better Care Fund.

4.2 In terms of the planning process for 16/17, the steering group have already submitted an initial planning template, and a draft narrative plan for 16/17. The full narrative plan is still being compiled, and the planning return template that reflects the finances and metrics for the plan will also need to be updated.

The high level timetable for returns for local Better Care Fund plans is as follows:

Date	Description	Status
2 March	Local areas to submit only the completed BCF Planning Return template detailing the technical elements of the planning requirements, including funding contributions, a scheme level spending plan, national metric plans, and any local risk sharing agreement.	COMPLETE
21 March	First submission of full narrative plans for Better Care alongside a second submission of the BCF Planning Return template.	COMPLETE
25 April	Final submission, once formally signed off by the Health and Wellbeing Board.	In progress

As the table sets out, there must be sign off from the HWB of the 16/17 Narrative Plan and Planning Return Template. The local timetable for sign off is set out below.

Date of Meeting	Group	Update / Planned
21st March	BCF Steering Group	Approval of submissions: 1. BCF planning spreadsheet 2. BCF Narrative plan Agreement of process for signing off the 16/17 plan, and document
15th April	Health and Wellbeing Board	Progress report to the HWB on 15/16 BCF performance Overview of process and outline of 16/17 BCF submission.
22nd April	Joint Commissioning Board	Approval of final version of BCF submission.
25th April	BCF Steering Group	Final day for submission – feedback from JCB, changes made and agreement reached.
25th April	Health and Wellbeing Board	Final approval of submission by HWB. Submission made.

4.3 Regional Assurance.

During this time period, there is also a regional based assurance programme. The outcome of this will be that the plan that is submitted will be scored according to a number of key lines of enquiry that are clearly set out in the planning guidance. The possible scores that can be achieved for the plans are:

- not approved
- approved with support
- Approved

5. BCF Plan for 16/17

5.1 The key components of our 16/17 BCF Plan are:

- A fully integrated Health and Social Care model
- Intermediate Care - phase 2
- Protection of Social Services
- Disabled Facilities Grant

The reduced number of schemes shows that Trafford has made significant progress with the schemes for 2015/16 with the majority of these now being managed as business as usual. These schemes will still be part of the BCF dashboard to provide evidence of improvement.

5.2 In terms of protection of social care, £5.5m was agreed for 15/16 and agreement needs to made in terms of the plan for 16/17.

6. Recommendations

6.1 The Health & Wellbeing Board are asked to note the contents of the Better Care Fund progress report for 15/16, and to note the schedule for 16/17 BCF planning and assurance.

6.2 To place an item of the next HWB agenda to provide approval for the 16/17 BCF Plan.

Appendix 1 – Scheme Highlight Summary Report as at 5th March 2016

1 Integration of Community-based Adult Health & Social Care
Summary Report 5th April 2016
A consultation process will be initiated with CEC staff: aligning the objectives of Phase 2 to reorganise the clinical leadership. The alignment of the Band 6/7 CEC and District Nursing roles has been scheduled for April 2016 onwards to take account of the delay in recruiting to the Band 8 and 7 posts in the Neighbourhood hubs. Interviews are now taking place for the 8a/Band 7 roles. All Age Integration will replace the 2015/16 project. A joint workshop is planned for March 2016 to agree new priorities. Work is also underway to align performance reporting and present on an All Age basis. Key performance indicators are being developed for All Age integrated delivery models. TMBC are progressing a broad partnership approach to address local requirements for adequate provision of community estate that facilitates co-location of integrated All Age services. This will be closely linked to the CCG's work on community hubs. Work is in progress to produce a harmonised Directory of Services (DoS) that reflects integrated All Age services covered by the Section 75 Agreement. Development of integrated performance monitoring/ reporting has been incorporated within a work-stream to support renewal of the Section 75 Agreement to be achieved by April 2016. This includes the review of the proposed benefits realisation model. Work has commenced on the development of a new model of care for the delivery of Intermediate Care including its alignment with CEC, ATT+, and NWAS responses. Phase 2 will align step up /down models for secondary care into Ascot House Intermediate Care. Reporting will be via the Intermediate Care group, priority workshop and FQP/Contract board. Work is also in progress to develop and implement the new Community Nursing model which will also incorporate End of Life Care. The model integrates new approaches to self-care, self-management and health improvement and opportunities for collaboration with TCCC and other partners.
Project Risk/Issues: • **Risk**: Failure to fully realise the benefits and financial efficiencies associated with fully integrated community health and social care service provision (Addressed on Risk Register)
Project Status

2 End of Life & Palliative Care
Summary Report 5th April 2016

The Governing Body have approved the continuation of this project supporting the work in Phase 1.

Phase 1
Using a Task and Finish Group approach; this group will progress the objectives by way of completing the agreed Action Plan, The Action Plan identifies opportunities against each of the current contractual agreements where direct improvement can be made which will achieve improvement in commercial value, improved access, improved utilisation, improved VFM without major contractual change at this time
In conjunction with Phase 1 the project team will continue to consider the Case for Change (Phase 2) should this ultimately be necessary to achieve the recognised best practise and to meet un-met service demand by the current models commissioned/ providers
However there needs to be a suitable time to also consider the impact of the changes made in Phase 1: Therefore the Case for Change will be considered at a more appropriate time in the year

Project Risk/Issues:

- Register being developed, none reported

Project Status	

3 Community Nursing & Ambulatory Care

Summary Report 5th April 2016

The CCG has issued Pennine Care with the revised Specifications and are awaiting the feedback from the provider..

Pennine will set out a mobilisation plan as part of their response.

It will then work to understand the timescales and financial implication of the full transition to the holistic community nursing care model; which will be mapped out for consideration in 17/18 aligning to the TCCC and Primary Care Locality Service model requirements.

Project Risk/Issues:

- **Risk:** Timeline – further revisions to the service specifications and response period may impact on implementation period
- **Risk:** Financial – Previous response from Provider was not financially viable as each option sought considerable financial recurrent investment
  Revised specifications minimise the financial exposure /investment expected

Project Status	

4 Falls

Summary Report 5th April 2016

Information to be collected from NWAS to understand demand for the service.
A scoping exercise is currently underway to map all services that support people who fall in the community.

NWAS will continue to operate the Falls referral scheme.

The project manager will continue to collate information and activity from those community services already in place supporting the full cohort of patients. This information will help identify areas of best practice to be expanded and shared.

Falls will be a high priority cohort classification to include in risk stratification once the TCCC expands its work streams and the TCCC will become the single point of referral (dates still to be agreed).

No additional services for Falls will be committed until there has been sufficient time to establish the number of services in existence; their performance/effectiveness; value for money; and impact is reviewed. This will report back in January 2017 on findings and proposals
This project will now only report by exception in the meantime.

Project Risk/Issues:

- **Risk:** The current delay to the TCCCs Go Live is having an impact on their capacity to commence the Falls Service evaluation period (data collection) and consequently the implementation of the project will be delayed.
    - It has been agreed by the Governing Body to extend the review /assessment period of this scheme in order to gain a full understanding of community provision and impact of deflection and support services. Reporting January 17

This Risk is now Closed – 04/03/16

Project Status	

5 ATT+

Summary Report 5th April 2016

This project is now considered to be Business as Usual and will continue to be monitored to ensure maximum utilisation.

Proactive engagement with Nursing Homes and Residential Homes will continue through regular attendance at their monthly forum.

The contract will be renegotiated with the provider (NWAS and Mastercall) to ensure improved value for money.
The Mastercall contract will link to any new contract terms agreed under the Out of Hours contract.

Project Risk/Issues:

- Register being developed, none reported

Project Status	

6 Care Homes - Enhanced Primary Medical Services
(previously named PC Model for Nursing and Residential Homes)

Summary Report 5th April 2016

Phase 1 – Enhanced Service – introduced in January and there is current take up of 13 practices across Trafford. An assessment is to be undertaken relating to the areas where there is no current service and how Trafford CCG will address these.

Phase 2 – This was to be the dedicated service for a Primary care for all nursing and residential care home patients. This is currently being considered as part of the CCG's priority of new models of care. The CCG is working on the model that will be submitted at the end of March.

The CCG are currently developing new models of care for Primary care and this may include this service . this is currently being considered by the CCG.
If a full service excludes this provision then the programme will be reconsidered in line with the original plan.

Project Risk/Issues:

- **Risk:** Resource capacity is currently a risk to the timescales of this project and delivery of the business case for the long term solution. This remains a risk and the Primary Care Interface team will continue to work with practices on the implementation of the interim scheme and the monitoring of this service.

Project Status	

7 Intermediate Care

Summary Report 5th April 2016

Two Senior Nurse positions commenced in post on 4th January, providing clinical leadership to the service model; developing standard operating procedures and processes. Further interviews took place for other posts mid-January. The recruitment drive successfully enabled the appointment of three Health Care Support Workers who will commence in post February and March 2016. However, further recruitment will be necessary for additional qualified registered nurses to deliver the full nurse lead model.

Outcome of Band 5 recruitment
2.5 WTE have been recruited

Status of GP recruitment
GP service provider has informed of the intention to commence delivery of service on 01/05/16 using 1 part time GP from original recruitment drive and GP partner from Washway Road in the interim until August 2016. Interviews for the remaining GP are scheduled for mid-March 2016 with an expected start date of August 2016.

Outcome of proposal of additional 5 assessment beds = total 23
18 beds incrementally increased to 23 full conversion anticipated by 15/03/16

Proposed model timescales
Proposed timescales for the full nurse led model still dependant on the outcome of the Band 5 recruitment if successful the intention will be to move to full nurse led model 01/06/2016 allowing for 3 month notice period. Timescales for full implementation of Phase 2 Early 2017

Activity
Intermediate Care service at Ascot has significantly reduced its length of stay since the new model has been implemented. This in turn has improved patient flow.
The LOS of more than 28 days
Baseline April - October = 61.1%
November – January = 15.4%

Percentage occupancy levels for intermediate care beds
Baseline April – October = 89.8%
November – February = 77.3%

Updated figures will not be available until mid-March.

Project Risk/Issues:

- **Risk:** Non-delivery of the nurse led model (Risk Register)
- **Risk:** Non-delivery of Primary Care enhanced model (Risk Register)
- **Risk:** Long-term availability of Ascot House (Risk Register)
- **Risk:** The GP provider has informed the CCG that it has been unable to recruit to the two vacancies and is going back out to advertisement January/February. This will impede the ability to deliver the nurse lead model in the way that it was described in the full business case. However, the number of beds in operation will remain at 18. Band 5 recruitment still an issue. On-going recruitment is in place.
    - The GP provider has informed that expressions of interest have been received from 2 of their current GP registrars and interviews will take place within the next couple of

	weeks; however if successful the candidates will not be in a position to take up post until August 2016. An interim solution is to cover the remaining session at Ascot House with one of the GP partners. This will commence in May. The Risk will remain until cover is in place
Project Status	

Appendix 2: Risk Register for Trafford Better Care Fund – Live Risks, Updated March 2016

Risk No.	Risk Description	Causes	Consequences	Current Controls	Current Risk Rating			Risk Owner
	What is the specific risk to business objectives?	What needs to happen for the risk to occur?	What are the consequences of this risk occurring?	What controls do you currently have to manage this risk?				
					Likelihood	*Impact*	*Likelihood x Impact*	
1	Operational risks which result in milestones not being achieved within the project plan.	1. Recruitment and retention challenges. 2. Sickness absence of key staff 3. IT Systems delivery 4. Lengthy assurance process delaying the start of critical projects	Delayed delivery of the project milestones	Identified risk should be dealt with at a project level if not escalated to Transformation Group for remedial action. Schemes which will impact on reduced A & E activity are also reported at Trafford's System Operational Resilience Group. Individual project risk registers, and new operational risks will be reported to the steering group.	3	2	6	Julie Crossley / Joanne Gibson
2	The reduction is emergency admissions is not achieved. .	There are too many factors affecting emergency admissions to describe causes.	If the reduction target is not reached, BCF initiatives dependent on the P4P payment cannot be supported. The financial risk to Trafford is £1,319	The Steering group will be responsible for monitoring the overall progress of BCF against the trajectories. Each of the work schemes will be providing highlight reports on a monthly basis. This risk is linked to risk 5- see commentary. Dashboard to monitor reductions.	2	4	8	Gina Lawrence / Jill Colbert

4	Provider organisations not understanding the impact of service changes on their own organisation	Poor quality communication with stakeholders, lack of understanding by stakeholders of consequences of change, messages not filtering through to senior leaders of organisations	Break down in relationships with providers, third sector organisations at risk of not changing to meet new needs	Provider organisations are involved in the redesign of services from an early stage through to the monitoring and review of service changes. Delivery of a number of dedicated sessions with Providers to ensure full engagement. This includes a dedicated Integrated care redesign workshop with all provider Health organisations. Separate sessions with CMFT, Pennine Care and the Resilience group with representatives including all acute Trusts, Primary care and NWAS.	2	2	4	Julie Crossley / Jill Colbert
6	A delayed reduction in A&E activity	The redesign of services resulting in increased demands being placed on community services may result in a delayed reduction in A and E activity	That performance target is missed.	A performance management framework exists, ensuring the BCF Steering Group have rigorous oversight of the performance metrics and can regularly review and monitor performance. Also monitor through the Trafford SROG where all stakeholders are represented. This is also monitored at The Pennine Care Contract Board. Regular engagement with Pennine in place. Pennine care to identify any risks around capacity issues	3	2	6	Julie Crossley
7	A successful Integrated Care model requires a skilled workforce to respond to new demands and clinical requirements	A workforce that has no access to training, and do not understand the overall new model for integrated care. Recruitment issues.	Workforce working in a non-integrated way, or not fully realising the benefits of the integrated care model.	For primary care the CCG has a dedicated team to oversee the primary care education development programme. This is also monitored at the Primary Care Strategy Group. Pennine Care are fully engaged with all redesign of services which impact on their staffing and workforce establishment. Individual scheme risk registers.	2	2	4	Julie Crossley & Diane Eaton
9	Lack of commitment from the voluntary and community sector to support the shift to early intervention and prevention activity.	Lack of knowledge from the VCS, poor engagement by programme, no funding available.	VCS unable to deliver EI and prevention.	BCF Steering Group to oversee and agree the direction of travel. Continue conversations with the voluntary and community sector about the strategic direction, utilising the Thought Chamber. Ensure appropriate contracts and service specifications are in place to facilitate this. Cyril Flint contract now in place.	1	2	2	Jill Colbert

11	Local authority cannot maintain social care and the voluntary and community sector to the level needed to support effective out of hospital integrated care.	Increase in demand, financial pressures, provider failure	Increased admissions and delayed discharges	Funds set aside within the BCF to protect social care and integrated community services. Close monitoring and reporting of social care budget and pressures by the council finance lead, reporting into the BCF Steering Group. Robust systems and tools in place for contract monitoring, provider failure.	2	4	8	Jill Colbert
12	The baseline for the older people permanent residential admissions measure included as part of the BCF metrics is calculated using the old methodology in the ASCCAR annual return. From 2014/15, this information will be generated from the new SALT return. There is no indication as to what the overall implications of this will be and the impact on the figures reported.	Change in definition of outcome measure.	Potentially a change in definition could lead to missing target performance.	The DH has been made aware of this change; the council's performance lead will keep the BCF Steering Group updated with any progress and monitor the impact once the first calculation has been done using the new methodology.	2	2	4	Jill Colbert