TRAFFORD COUNCIL

Report to: **Health & Wellbeing Board**
Date: **5 October 2017**
Report for: **Health & Wellbeing Board**
Report of: **Better Care Fund Programme**

Report Title

Trafford Better Care Fund Programme 2017-19

Purpose

To inform the HWB about plans for 2017 – 19
For sign off of the plan in order to achieve national condition 1

Recommendations

To sign off the Expenditure plan for Better Care Fund for 2017 – 19

Contact person for access to background papers and further information:

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Trafford Better Care Fund Programme 17-19

1. Introduction

1.1 The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.

1.2 The BCF encourages integration by requiring CCGs and local authorities to enter into pooled budgets arrangements and agree an integrated spending plan. In 2016/17, £16,092,128 pooled in Trafford.

1.3 Each year NHS England publishes guidelines on how the BCF should be spent and managed. There have previously been strict national conditions that BCF plans need to meet in order to be approved by NHS England. This year, guidelines published span the next two financial years (2017/18 and 2018/19), and the number of national conditions have been reduced to 4. Please see Appendix 1 for National Conditions and a link to the published guidelines.

1.4 The Spring Budget 2017 announced an additional £2 billion to support adult social care in England. This money is included in the Improved Better Care Fund (iBCF) grant to local authorities (LAs) and will be included in local BCF pooled funding and plans.

1.5 The iBCF funding can be spent on three purposes: Meeting adult social care needs; Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; Ensuring that the local social care provider market is supported

1.6 In Trafford, the Pooled BCF allocations are made up of the Disabled Facilities Grant (DFG), the iBCF, and a minimum CCG contribution:

	2017/18 Gross Contribution	**2018/19 Gross Contribution**
Total Local Authority Contribution (DFG)	£1,852,822	£2,017,365
Total iBCF Contribution	£4,254,403	£5,725,357
Total Minimum CCG Contribution	£14,661,678	£14,940,250
Total BCF pooled budget	**£20,768,903**	**£22,682,971**

1.7 For 2017 – 19, a new plan and a section 75 agreement will be required that builds on the previous plans, and sets out how the BCF and the iBCF will be spent over the next two year period.

1.8 It is a national condition that the HWB agree this plan.

2. The Trafford Vision

2.1 Building on the BCF narrative from last year, the intention is to continue with the work that is ongoing in both the Council and the CCG. The vision is still articulated through the priorities set out in the 2020 locality plan. "*By health and social care working*

together we will improve the quality, range and access to services for the people of Trafford".

2.2 The shared vision, which is also a fundamental aspect of the joint Transformation Fund bid,also continues to promote and enable people to live at home and remain as independent as possible. By joining up services in the community and providing extensive step up and step down enablement it will reduce demand and the use of hospital care and residential/nursing home care, and deliver services closer to home in a community setting.

2.3 Trafford's health and social care economy will focus on ensuring that people stay healthy and well at home by intervening much earlier, promoting self-care and maximising people's independence and resilience.

2.4 The transformation of community health and social care to an integrated model is a critical ongoing development to enable this vision to be realised, and this forms part of the wider integration of Trafford Council and CCG. Please see Appendix 2 for a governance diagram of this integration.

2.5 Last year, priorities were set based on the issues that Trafford were facing, and these remain important for the next 2 years:

- High level of Delayed Transfers of Care (DTOCs)
- The need to reduce numbers of people attending A&E
- The need to prevent Non-emergency admissions
- Lack of step up and step down intermediate care beds
- The need to improve care taking place in the community by range of appropriate professionals that talk to each other

2.6 In terms of the protection of social care, Trafford Council have also identified issues around the capacity and quality of the homecare market.

3. **Expenditure Plan**

3.1 A full breakdown of schemes for both the CCG and Council can be seen in Appendix 3.

3.2 The protection of social care will support the continuation and enhancement of a number of social care services which is a national condition of the BCF. National condition 2 stipulates that in order to comply, there must be:

"A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum contribution to the fund in line with inflation;"

3.3 For Trafford this translates to a minimum spend of £5,645m in 17/18 and £5,753m in 18/19 on the protection of social care services. How this will be spent is detailed in Appendix 3 part B (i.e. Council Schemes), including brief scheme descriptions. In most cases, the amount spent is just a proportion of the total Council spend in this area.

3.4 In the face of rising demand and budget reductions the Council's ability to maintain its current provision and eligibility is an on-going challenge. The positive steps to protect social care under this joint fund do not provide a solution beyond 2019/20 for social care funding.

3.5 The Council and CCG have agreed in principle to the expenditure plan and this will be subject to further review as the 8 high impact changes plan has only recently been concluded and there may be alterations as a result of the CQC visit. The plan needs to be signed off by the HWB.

4. National Metrics

4.1 The BCF policy framework establishes that the national metrics for measuring progress of integration through the BCF will continue as they were set out for 2016-17, these are:

a. Non-elective admissions (General and Acute);
b. Admissions to residential and care homes;
c. Effectiveness of reablement; and
d. Delayed transfers of care;

4.2 Appendix 4 provides details on the targets that have been set for 2017 – 19, and an overview of 2016/17 performance.

4.3 The High Impact Change Model identifies eight system changes which will have the greatest impact on reduced delayed discharge. Of those eight work streams, Trafford already has a jointly commissioned and delivered integrated health and social care system provided by Pennine Care. This is an all age service which is now well established.

4.4 Hospital discharge teams are multi-disciplinary. The key issue from a local authority perspective is the high amount of inappropriate referrals from the hospital team to social work. The local authority and the CCG have focused on the areas described above and are working towards 7 day services.

4.5 The changes have seen a reduction in DTOCs but further work and embedding the improvements across the system with particular emphasis on pathways, flow and early identification of patients for discharge is required.The Trafford area continues to be a national outlier on the numbers of patients experiencing delayed discharge. A forthcoming Care Quality Commission (CQC) review will be used as an opportunity to consider other initiatives to address the long standing problem.

4.6 Capacity and quality in the homecare and residential and nursing market continues to be an on-going issue. This can impact on the capacity of reablement as there is nowhere to discharge patients to, as well as the availability of beds for patients with complex needs.

4.7 Appendix 5 shows the High Impact Change Model plan.

4.8 A risk share agreement is being negotiated as it is a requirement of the national guidance that a specific proportion of the area's allocation is invested in NHS-commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement Formal sign-off of the section 75 agreements will follow formal agreement of the finances and metrics.

5. Outcomes

5.1 The funding of social care will support the delivery of changes to the population of Trafford and deliver;

- Enhanced local health and social care services
- Safe and high quality health and social care services with a skilled workforce
- Alternatives to secondary care through community health and social care services
- Improved co-ordination of patient care

- A coordinated and supported network of community organisations providing preventative services

5.2 The following changes to patients and service user outcomes will be seen;

- Trafford residents will receive the right care, by the right person, when they need it, in the right place as patients will benefit from increased resilience and capacity in the community
- Residents and communities will be empowered to be more resilient and proactive about their wellbeing
- Locality services will meet the needs of patients and will better equipped to respond to their needs
- Through a proactive model, patients will be able to access support at an early stage which will reduce the need for more acute services
- Length of stay at hospital will be appropriate to the clinical need of the patient and no longer
- Patients will benefit from early care planning by multidisciplinary teams
- Patient and service users will have a positive experience of care
- Reducing duplication for people using services
- Improved support to carers and families

5.3 It will be necessary for close monitoring of the effectiveness of the various schemes to be considered by the Health & Wellbeing Board to ensure the expected outcomes are delivered. Alternatively consideration will need to be given to different schemes to achieve the desired results.

6. Graduation from the Better Care Fund

6.1 The planning requirements set out an opportunity for areas to apply for 'graduation' from the BCF. This is in recognition that some areas have a sufficiently mature system of health and social care. Greater Manchester were cited as an area that could potentially qualify for this given the ambition around devolution.

6.2 Whilst there has been no decision made regarding graduation, there has been agreement between the GMHSCP and NHS England that for 2017 – 19, the only planning document that needs to be submitted by GM areas is the planning template (excel spreadsheet describing funding and expenditure). A narrative plan is not required.

6.3 The benefits of graduation will be that there are less reporting requirements.

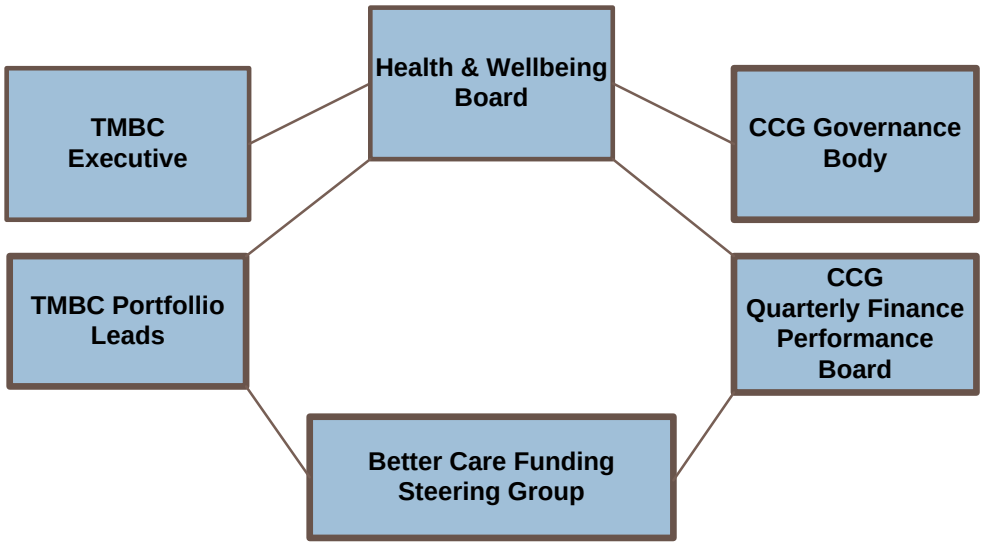
7. How will this be managed?

7.1 The governance structure below shows how the BCF will be managed. Both the CCG and the Council will need to ensure that decisions are made through their existing governance structures before then being jointly signed off and agreed at the HWB.

7.2 A steering group will be re-established to meet on a regular basis. The CCG are the lead organisation for the BCF.

7.3 The CCG and LA remain committed to agreeing the proposals, but there remains an issue surrounding a risk share agreement.

Better Care Fund / Section 75 Governance Arrangements



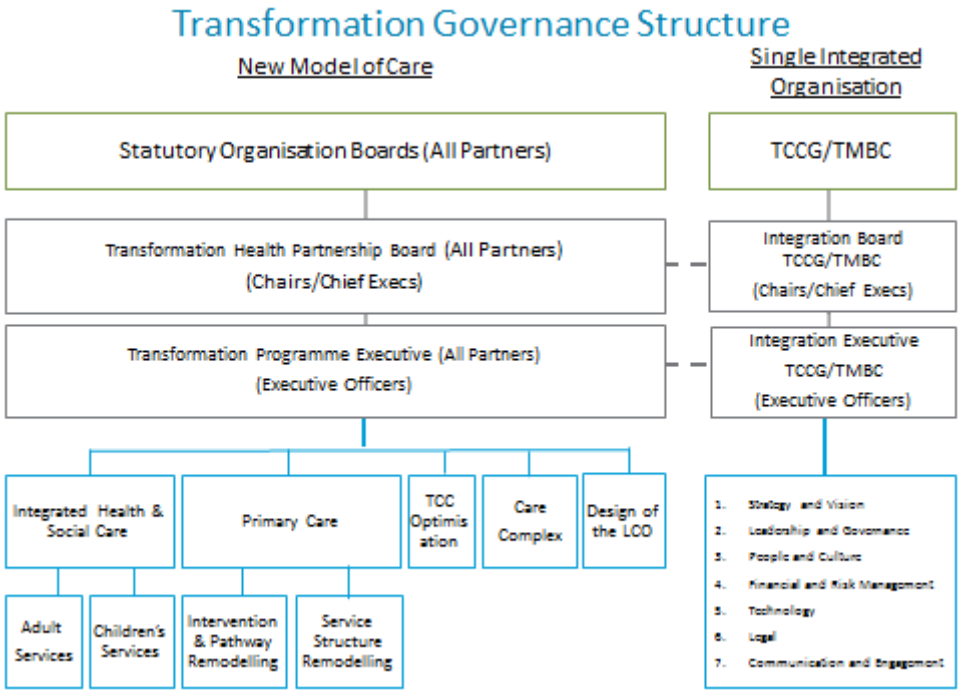
Appendix 1: BCF Guidelines

Link to the Integration and Better Care Fund Planning Requirements for 2017-19
https://www.england.nhs.uk/wp-content/uploads/2017/07/integration-better-care-fund-planning-requirements.pdf

National Conditions 2017 – 19

1. That a BCF Plan, including at least the minimum contribution to the pooled fund specified in the BCF allocations, must be signed off by the HWB, and by the constituent LAs and CCGs;
2. A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum contribution to the fund in line with inflation;
3. That a specific proportion of the area's allocation is invested in NHS-commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and
4. All areas to implement the High Impact Change Model for Managing Transfer of Care to support system-wide improvements in transfers of care.

Appendix 2:


Transformation Governance Structure
New Model of Care
Single Integrated Organisation
Statutory Organisation Boards (All Partners)
TCCG/TMBC
Transformation Health Partnership Board (All Partners)
(Chairs/Chief Execs)
Integration Board
TCCG/TMBC
(Chairs/Chief Execs)
Transformation Programme Executive (All Partners)
(Executive Officers)
Integration Executive
TCCG/TMBC
(Executive Officers)
Integrated Health & Social Care
Primary Care
TCC Optimisation
Care Complex
Design of the LCO
Adult Services
Children's Services
Intervention & Pathway Remodelling
Service Structure Remodelling
1. Strategy and Vision
2. Leadership and Governance
3. People and Culture
4. Financial and Risk Management
5. Technology
6. Legal
7. Communication and Engagement

Appendix 3:

A. CCG Scheme Details

	Scheme Name and Description	Funded from:	17/18	18/19	Existing or New?
1	Community Nursing	CCG Minimum Contribution	£3,203,000	£3,263,857	Existing
2	End of Life Services	CCG Minimum Contribution	£2,403,000	£2,448,657	Existing
3	Intermediate Care (Ascot House)	CCG Minimum Contribution	£1,012,405	£1,031,639	Existing
4	Trafford Care Coordination	CCG Minimum Contribution	£823,000	£838,637	Existing
5	Community Geriatrics	CCG Minimum Contribution	£412,000	£419,828	Existing
6	Nursing Homes	CCG Minimum Contribution	£723,000	£736,737	Existing
7	Alternative to Treat (ATT)	CCG Minimum Contribution	£440,000	£448,360	Existing

B. Trafford Council Scheme Details:

	Scheme Name and Description	Funded from:	17/18	18/19	Existing or New?
1	**Community Equipment and Adaptations** The provision of community equipment and adaptations is to support the person to achieve their desired outcomes and in doing so maximise their independence and improve their quality of life. The services provided are: • One stop resource centre - based in Sale, this provides community equipment and services for people living in Trafford, who may need assistance with daily living due to a disability. This is a joint venture between Pennine Care NHS Foundation Trust and Trafford Council. • External minor adaptations - an alteration or addition to a home that will allow greater safety or independence for a person/carer to access their home and its facilities. • Community alarms • Telecare equipment • Lift and repairs maintenance • Sensory equipment	CCG Minimum Contribution	£350,000	£350,000	Existing
2	**Integrated Crisis and Rapid Response Services** The Crisis Resolution Home based Treatment Team provides a 24 hour, 7 day a week service to adults with a serious mental illness, in an acute crisis that is so severe that, without intervention from this service, the service user would require hospitalisation. The Team aims to act as an alternative to hospital admission by providing intensive interventions in the community. The Rapid Response service provides a homecare service under emergency circumstances. This is to prevent unnecessary admission to hospital, residential or nursing care by providing an initial, short term package of care to people in their homes who are in urgent need of home care support.	CCG Minimum Contribution	£600,000	£600,000	Existing

3	**Reablement Services** The assessment and reablement team carry out holistic person centred assessments and implement outcomes focused support plans that aim to either support the individual to become completely self-managing or to reduce the level of intervention to the minimum level required. There is a focus on building on people's existing strengths, and ensuring that the maximum independence and quality of life are achieved. Trafford Council have a statutory duty to provide reablement services, free of charge for a period of up to 6 weeks. This team has now been re-structured – please see Better Care at Home.	CCG Minimum Contribution	£500,000	nil	Existing
4	**Early Supported Hospital Discharge Schemes** The hospital based screening teams complete assessment of need for adults over the age of 18. This is a statutory duty of the council under the Delayed Discharge Act 2005 and the Care Act 2014. There are time restraints which regulate the assessment period and the timely provision of services. The social workers offer advice and signposting, assessment of un-met need and thus provide community services where required. The assessment ensure that service have access to the correct funding streams which appropriately meets the needs of the service user, such as the Continuing Health Care funding. In addition the social worker carry out safeguarding activities including leading investigations and implementing the process as set out in Trafford's Safeguarding policy. The above activities support the Care Act Principles with the aim of supporting people for a limited time only (where possible) and that people therefore remain independent longer. This ensures that resources are targeted at the most vulnerable people and working with strategic partners to jointly utilise the funding available.	CCG Minimum Contribution	£450,000	£450,000	Existing
5	**Joint Health and Care Teams Working** Integration between health and social care is underway and locality teams are now in place. Work has commenced in the localities to look at preventative services working specifically with other professionals such as dentists, physios, GPs, and local community groups, churches and leisure centres. The impact of these on budgets will be longer term as people maintain their own health and wellbeing. Much of this work is being undertaken by the community teams as they have started to develop services within the communities.	CCG Minimum Contribution	£559,000	£559,000	Existing

6	**Social Care Client Packages Residential** The provision of external placements are an outcome of assessment under the Care Act 2014 and previously the Community Care Act to meet un-met need in the most effective and efficient way. This is a statutory duty under the Care Act and formerly the 1948 National Assistance Act. Services provided include residential and nursing placements. The service provision is proportionate to need and aligns to the reshaping offer in Trafford, offering choice, control and best value. The service provision aims to: • support people • keep people safe and well • promote health and wellbeing Trafford Council faces significant financial challenges due to demographic pressures (Trafford has a higher proportion of older people per 1000 head of population), people living longer and more with complex needs, at a time of reducing resources. The funding within the BCF for this area will support the continuation of essential services to the community.	CCG Minimum Contribution	£1,050,000	£1,050,000	Existing
7	**Carers** Trafford Council and CCG jointly commission a carers centre to ensure that carers are supported as early as possible to prevent carer breakdown. It is recognised that in Trafford, our carers are an important resource in ensuring that loved ones can be looked after at home and in the community. In order to make this caring role more sustainable, through the integrated assessment process, carers are considered and respite put in place in order to ensure that carers get a break from caring. This expenditure is for the cost of these respite packages. Whilst it is the cared for that receives this, the outcome is to ensure there is no carers breakdown, or that emergency cover is in place for when carers cannot carry out their caring role.	CCG Minimum Contribution	£499,273	£499,273	Existing
8	**Stabilise and Make Safe** The Stabilise and Make Safe (SAMS) model aims to bring a new approach to short-term/low-level (but possibly intensive) home care support. The key driver behind the service is to prevent service users entering reablement inappropriately, instead, clearly defined assessment processes will ensure that client's needs are identified and an appropriate care pathway is assigned. There are currently 2 providers of SAMS in Trafford. The core delivery model for SAMS	CCG Minimum Contribution	£496,000	£996,000	Existing

	involves letting care to the market in three-week blocks. Once a client is placed with a provider, the initial payment will cover a period of three weeks. If the provider can make the person safe before the three weeks are up, then that person can be discharged from the service and the provider will still receive a payment for three weeks care. To ensure that the service remains flexible, the client's progress is reviewed regularly. The main purpose of this is to ensure that service users can be discharged from the service at the earliest (but safest) opportunity. However, it is the statutory responsibility of the Council to undertake an assessment prior to care package removal; therefore a final assessment will be signed off by a Trafford Council Social Care Assessor.				
9	**Disabled Facilities Grant** This grant pays for essential housing adaptations to help disabled people to stay in their own homes. The amount awarded is dependent on household income and savings. There is a team working in council that manages the process, and works closely with our partners in Pennine (OT and Physios) in order to ensure that outcomes are met.	Local Authority Contribution	£1,852,822	£2,017,365	Existing
10	**Social Care Client Packages Homecare** The provision of external placements are an outcome of assessment under the Care Act 2014 and previously the Community Care Act to meet un-met need in the most effective and efficient way. This is a statutory duty under the Care Act and formerly the 1948 National Assistance Act. Services provided include residential and nursing placements. The service provision is proportionate to need and aligns to the reshaping offer in Trafford, offering choice, control and best value. The service provision aims to: • support people • keep people safe and well • promote health and wellbeing Trafford Council faces significant financial challenges due to demographic pressures (Trafford has a higher proportion of older people per 1000 head of population), people living longer and more with complex needs, at a time of reducing resources. The funding within the BCF for this area will support the continuation of essential services to the community.	CCG Minimum Contribution	£1,050,000	£1,157,261	Existing

11	**Bed Based Discharge to Assess** See 13 below.	Improved Better Care Fund	£875,091	£875,091	Existing
12	**Capacity and Flow in Hospitals** Our internal analysis of existing 'end to end' processes shows that there are further improvements that can be made that could reduce delays in the system and where additional capacity and/or specific expertise is needed. These require further changes to the pathways starting at hospital admission, moving through the discharge process and then how cases are processed and managed by providers. Changes here need to reduce the volume of administration, reduce the number of hand-offs in the system and aim to eradicate duplication between the roles of social workers and care providers. None of these initiatives alone will create the required improvements in flow unless the home care market remodelling occurs in line with GM initiatives. To deploy 1 x Senior Practitioner whose remit and responsibility is for ensuring flow and throughput and 1 x Brokerage Support Officer. UHSM - deploy 2 x Social Care Assessors to reduce admissions, sitting between A&E (UHSM Front Door) and the wards. Deploy 2 x Social Workers to facilitate speedy and safe discharge on complex cases on the premise that the primary detailed assessment will take place in the system post discharge (discharge to assess) TDH and Salford deploy 2 x Social worker (one at each site)	Improved Better Care Fund	£321,433	£321,433	Existing
13	**Discharge to assess** A combination of community and bed based discharge to assess models have been commissioned in order to provide a smoother and more timely discharge from hospital and an assessment in a place which will enable the skills and requirements of individuals to be accurately represented. 9 beds have been commissioned at Ascot House to support discharge to assess for people who may require residential beds or 4 homecare visits a day. Up to 10 beds will also be commissioned from nursing homes. 'Discharge to assess' approaches are being integrated into our externally commissioned intensive reablement service and our new internal Better Care at Home service.	Improved Better Care Fund	£141,367	£141,367	New
14	**Create New Capacity in the Homecare Market** Our approach to securing this additional capacity has been developed with providers under a form of guaranteed capacity to meet the shortfall in home care. So, rather than buying by the hour, a salaried workforce with enhanced terms and conditions will differentiate these roles in	Improved Better Care Fund	£388,950	£388,950	Existing

	order to address the issues of recruitment by making the roles more appealing as a career choice. It will be commissioned as a block contract on a geographic basis or linked to a hospital or intermediate care facility providing a level of certainty to the providers so they can recruit a skilled workforce and invest in their development and retention. There are additional costs associated with this approach compared to commissioning on an hourly basis which should be seen as investment into a better equipped and rewarded workforce better able to meet the assessed needs of residents.				
15	**Quality Assurance and Improvement** Two posts will provide capacity within the Quality Assurance remit of the team for Adults. These posts will play an integral role in pro-active, quality assurance visits and to provide ongoing support to ensure there is no negative impact on bed availability or quality.	Improved Better Care Fund	£71,882	£71,882	Existing
16	**Asset based community capacity**	Improved Better Care Fund	£491,668	£38,265	New
17	**Price Increases to Providers - Market Stabilisation** Capacity within both the residential and homecare markets is lower than required. The key market issues are the ability of providers to recruit and retain staff, and the quality of the provision (CQC ratings are very low for both Homecare and Residential Care). Significant delays are caused by the lack of available beds and the lengthy process involved in identifying and securing residential and nursing care. The scarcity of available beds and homecare capacity is exaggerated by the poor quality of this provision, and the consequent need to suspend referrals to those services. Trafford each year follow the fair price for care procedure, aiming to ensure that we pay a fair and sustainable amount to providers in the market to ensure they can make their businesses work. In 17/18, a 3% uplift was offered, however through negotiation, an eventual 3.54% uplift was agreed. (Average across homecare and residential and nursing).	Improved Better Care Fund	£681,359	£1,605,716	Existing
18	**Additional homecare Packages** See Scheme 10	Improved Better Care Fund	£400,000	£800,000	Existing

19	**Additional Residential / Nursing packages** See Scheme 6	Improved Better Care Fund	£400,000	£1,000,000	Existing
20	**Additional Stabilise and Make Safe** Please see Scheme 8.	Improved Better Care Fund	£100,000	£100,000	Existing
21	**Better Care at Home New Model** Given the lack of capacity in the market, our statutory duty to maintain market sufficiency is best met by retaining an in-house service as this ensures capacity within the system and builds on the skills of an already experienced workforce. This service will compliment the externally commissioned SAMS service. Better care at home will create two referral pathways into reablement support, both of which will help people to maintain or regain their health and independence. The services will help people avoid unnecessary hospital admissions or readmissions and reduce the need for costly high level health and social care services. Both services will provide 3 weeks of intensive rehabilitation support, with an option to extent for up to 6 weeks for those people with higher level needs. 1. The in-house Better Care at Home service will particularly focus on people who are being discharged from Ascot House, Manchester Royal Infirmary (MRI) and the Community Enhanced Service (CEC). 2. SAMS will take referrals from all other sources, including those new to social care and those being discharged from UHSM.	Improved Better Care Fund	£287,454	£287,454	New
22	**Programme Management**	Improved Better Care Fund	£95,199	£95,199	Existing
23	**Advocacy** A contribution is made to the contract that delivers our statutory independent advocacy services. This is to support people who do not have a suitable person to represent them in line with the guidance in the Care Act, the Mental Health Act, and the Mental Capacity Act.	CCG Minimum Contribution	£91,000	£91,000	Existing

Appendix 4: Metrics – Extract from Planning Template:

HWB NEA Activity Plan

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	**Total 17/18**	**Total 18/19**
HWB Non-Elective Admission Plan* Totals	7,031	7,030	7,044	7,032	6,997	6,996	7,010	7,004	28,137	28,006

16/17 Performance:

Performance against the NEL target for 2016 / 17 has proved extremely challenging – outturn of 27,775 was 7.2% above the required target of 25,915.

The increase in Non-elective emergency admissions is mainly due to a 64.1% increase in short stay activity, mainly at UHSM. The CCG has re-negotiated payment terms to encourage a higher level of activity to go through the Acute Medical Receiving Unit (AMRU) at UHSM to reduce overall costs.

Non-elective non-emergency admissions have increased by 3.9%.

The overall increase for both non-elective emergency and non-emergency activity is 8.1%.

Based on the block contract CMFT has had a 2.4% increase in all non-elective spells, based on PbR there is a -0.6% decrease.

Residential Admissions

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	735.2	702.4	600.3	585.2
	Numerator	292	284	246	243
	Denominator	39,719	40,432	40,976	41,523

2016/17 Performance:

Given the projected population increase in older people, the target for 2016 / 17 was to be no more than in 2015 / 16 (284 placements in year). The actual number of placements was 280, a decrease of 3% in the rate per 100,000 (from 715.1 to 694.5).

Reablement

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	93.4%	89.5%	90.2%	91.2%
	Numerator	171	179	157	165
	Denominator	183	200	174	181

2016/17 Performance:

The performance for this indicator for 2016/7 at 86.1% is below target (89.5%) and has fluctuated over the past few quarters. We are investigating the reasons for this. It should be noted however, that a small volume change (to the numerator or denominator) will result in a 5-10% fluctuation in percentage performance.

Delayed Transfers of Care

		16-17 Actuals				17-18 plans				18-19 plans			
		Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	3113.1	3238.3	3485.3	3797.8	3562.5	3517.6	3472.1	3402.6	3360.2	3317.8	3274.9	3211.3
	Numerator (total)	5,647	5,874	6,322	6,938	6,508	6,426	6,343	6,261	6,183	6,105	6,026	5,948
	Denominator	181,393	181,393	181,393	182,682	182,682	182,682	182,682	184,007	184,007	184,007	184,007	185,222

2016/17 Performance:

Performance against the DTOC target for 2016 / 17 has proved extremely challenging – outturn of 24,781 bed days was 55% above the required target of 16,000. During March 2017 Greater Manchester Health & Social Care Partnership tasked all acute Trusts to achieve a DTOC position of no more than 3.3% of their average daily bed occupancy to be reportable delays. To support this work MHCC has worked with partners to:

- Clarify the reporting requirements, including submission times (daily snapshots) and data definitions.
- Developed a method for capturing and monitoring improvement trajectories and assessment of performance against these trajectories – at LA / CCG level to enable focussed escalation.
- Actual Performance against target for Manchester's acute Trusts was:
    - UHSM - 4.9%% (3.3% Target)
    - CMFT - 3.2% (3.3% Target)
    - NMGH - 3.7% (3.3% Target)

Despite only one Manchester Trust achieving the required trajectory it would be key to note that considerable improvement has been made across Manchester and efforts continue into 2017 / 2018 to achieve maintain this improvement.

Risks:

- The risk remains non-achievement of the A&E 4 hr performance STF cumulative trajectory.

Timescales for Delivery:

- For 2017 / 2018 the immediate priority of MHCC / TCCG will be to ensure that the Manchester Urgent Care Transformation & Delivery Board is mobilised to lead the urgent care agenda for the year in order to support our systems to perform against constitutional standard to ensure all patients attending A&E departments are seen within 4 hours.

Appendix 5 - Trafford Transfers of Care Plan

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.

This is an extract from a live working document, and this is a final draft.

Programme Objectives	Projects	Time scale	Exec Lead	Mgmt Lead	% Target	RAG (As of Sept, 17)
1. Early Discharge Planning						
An integrated community health and social care team plan early discharges for all elective patient admissions.	➢ Elective discharge planning for hip and knees at UHSM	Sept'18	D Eaton	D Walsh	0.1%	
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.	➢ Integrated discharge team at UHSM, Salford and TGH	Jan'18	D Eaton	D Walsh	0.3%	
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	➢ Community flow manager recruitment ➢ Review current monitoring and realign to new model	Oct'18	D Eaton	D Walsh	0.3%	
Transfers of care are planned around the individual and patient flow systems allow capacity to be automatically increased where demand (admissions) increases.	➢ Discharge pathway mapping project (complete mapping against process and identify gaps) ➢ Identify resources to meet increased demand (GM-Transformation Fund Bid)	Sept'17	T Cartmell I Anderson	D Walsh D Peace S Morton	0.1%	
3. Multidisciplinary/agency Discharge Teams		**Time scale**	**Exec Lead**	**Mgmt Lead**	**% Target**	**RAG**
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.	➢ Discharge to assess project (To identify additional necessary capacity) ➢ Procure discharge to assess nursing/ EMI bed(s) ➢ To identify agreed SW/DNL capacity required (GM – Transformation Fund Bid)	Nov'17	K Ahmed	S Morton	0.4%	
Integrated discharge MDTs have shared and agreed responsibilities, they include the third sector in discharge planning and they provide special arrangements for complex discharges.	➢ Integrated discharge team at UHSM, Salford, TGH (as per table section 1) ➢ Role of Trusted assessors agreed and implemented for specific tasks eg funding decisions social care/CHC (As per table section 6)	Jan'18	D Eaton	D Walsh	As above	

	➢ Co-design of new model for Voluntary Sector home from hospital (As per table section 7)					
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.	➢ Discharge to Assess Project (As per table section 3) ➢ Increase in SAMS capacity procured – ongoing	Nov'17	K Ahmed	S Morton D Gent	As above	
Where discharge home is not possible, step down beds will be utilised for assessment and additional care and support, where this is required.	➢ Ascot House Step down beds	Nov'17	K Ahmed	D Gent Sue Burrell	0.05%	
Care homes accept previous residents trusting Trust /ASC staff assessment and always carry out new assessments within 24 hours	➢ New framework for nursing and residential homes	April'18	K Ahmed	D Gent J O'Donoghue	0.05%	
5. Seven Day Services		**Time scale**	**Exec Lead**	**Mgmt Lead**	**% Target**	**RAG**
Patients receive seamless care provision that includes assessment and restart of care (within 24 hours) regardless of the time of day or week.	➢ 7 day social worker and DN liaison provision for assessments at UHSM	Sept'17	D Eaton	D Walsh	0.1%	
Sustainable staffing rotas and new contracts are in place to deliver person centred seven day discharge to assess services.	➢ 7 day social worker and DN liaison provision for assessments at UHSM (As above)	Sept'17	D Eaton	D Walsh	As above	
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	➢ Implementation of Trusted Assessor policy within Trusts 24/7 ➢ Trusted Assessor trial project with Salford for CHC cases	Sept'17 Nov'17	D Eaton M Moore	M Albiston D Pease	0.2%	
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.	➢ Full Implementation of the choice policy including senior ownership of eviction process at each Trust	Sept'17	K Ahmed D Eaton S Morton C Watts CMFT lead	M Albiston (supported by Acute Trust leads)	0.2%	
The voluntary sector are fully integrated into the health and social care team, within both the trust and the community.	➢ Co-design of new model for Voluntary sector home from hospital service	Dec'17	K Ahmed D Eaton	A Brown	0.1%	
8. Enhancing Health in Care Homes		**Time scale**	**Exec Lead**	**Mgmt Lead**	**% Target**	**RAG**
Care homes integrated into the whole health and social care community and primary care support	➢ MDT for Care Homes (NMOC work) (reliant on GM-Transformation Fund Bid) ➢ Scope Red Bag Transfer System	Jan'17 Nov 17	R DeMaine M Leslee	T Cartmell J O'Donoghue	0.05%	

There is no variation in the flow of people from care homes into hospital during the week	➢ ATT Plus project	Oct'17	T Cartmell	S Morton	0.05%	
Care home CQC ratings reflect high quality care	➢ Implement Enhanced Health in Care Homes quality framework ➢ Project to increase registered management capacity	Sept'18 April'18	M Moore D Eaton	M Leslee J O'Donoghue	0.05% 0.05%	
9 Development of home care market						
There is a high quality home care market in place with sufficient, flexible capacity to meet local need.	➢ GM transformational workstream for Support at Home Project ➢ Partington Pilot active	April'18	J Colbert	K Ahmed	2%	
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	➢ TCC development project (including increase of service users based on risk and facilitating discharge/preventing readmission) ➢ Link to Community Enhance Care (CEC)	Dec'17	C Ward	Prog Dir TBC	0.4%	

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