TRAFFORD COUNCIL

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

Report Title

NHS Trafford Clinical Commissioning Group Update

Summary

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

Recommendation(s)

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

Contact person for access to background papers and further information:

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COMMISSIONING UPDATE

1.0 PURPOSE OF THE PAPER

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

2.0 COMMISSIONING UPDATE

INTEGRATED CARE PROGRAMME UPDATE

2.1 Reporting and Monitoring

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

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

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

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

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

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

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

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

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

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

2.2 Enabler Projects

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

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

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

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

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

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

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

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

Paediatric Asthma

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

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

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

2.3 Integration (Commissioning) Workshops

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

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

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

2.4 Wider Integration

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

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

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

PROCUREMENT

2.5 Procurement of the Patient Care Coordination Centre (PCCC)

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

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

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

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

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

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

SCHEDULED CARE

2.6 Clinical Referral Management Programme

Recruitment for the vacant specialties has been complete.

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

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

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

2.7 Community Dietetic Service

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

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

2.8 Stroke Action Plan

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

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

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

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

2.9 MSK Community Physiotherapy – Business Case

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

UNSCHEDULED CARE

2.10 Unscheduled Care Business Case

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

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

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

2.11 Respiratory

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

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

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

2.12 Personalisation

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

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

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

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

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

MENTAL HEALTH

2.13 Rapid Assessment Interface Discharge (RAID)

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

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

The Raid team to consist of:

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

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

The core KPIs for the project have been agreed as:

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

PRIMARY CARE

2.14 Primary Care Strategy

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

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

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

The priorities are;

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

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

Challenges to delivery include;

- Single IT solution;
- Estates investment;

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

MEDICINES MANAGEMENT

2.15 New Oral Anticoagulants (NOACs)

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

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

2.16 Practice Prescribing Budget

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

2.17 Patient Group Directions (PGDs)

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

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

2.18 Adult Service Model

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

2.19 Integrated Care Plan

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

2.20 New Health Deal

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

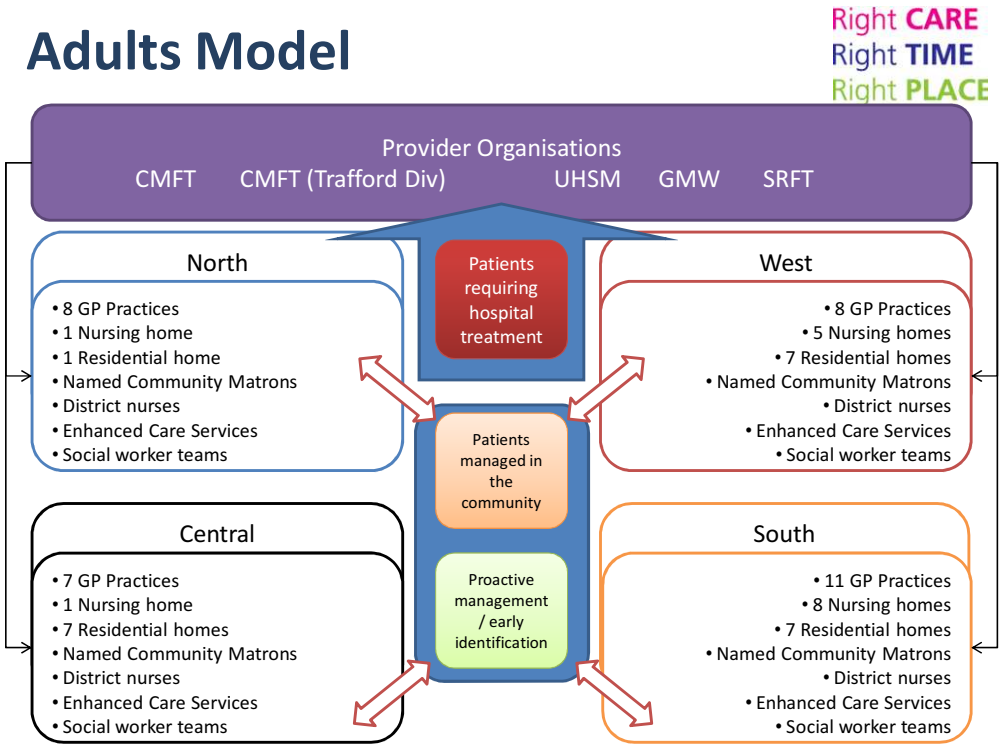
These include:

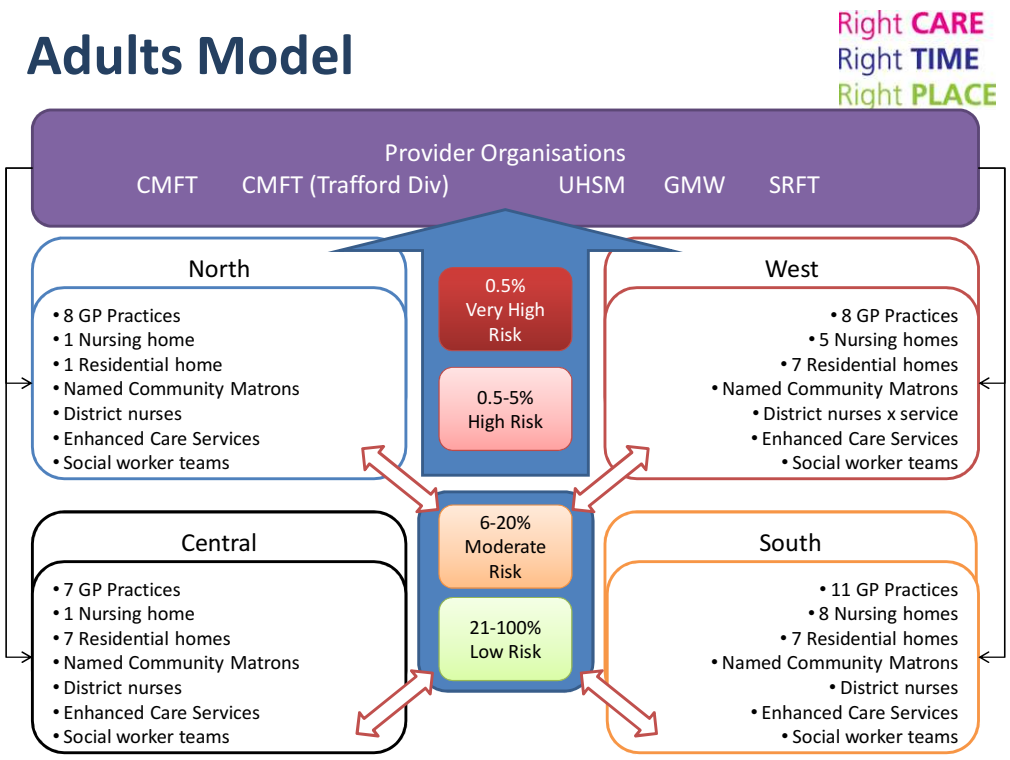
- **A comprehensive communications strategy** which includes communications internally, across organisation and to the public.
- An operations group has been established which includes representatives from all Health organisations including; UHSM, SRFT, CMFT, GMW, NWAS, Pennine Care and Mastercall. Together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

3.0 RECOMENDATIONS

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

APPENDIX A: ADULT NEIGHBOURHOOD MODEL





APPENDIX B: AGMA INTEGRATED PLAN

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

1) Overall Aim

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

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

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

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

Our overarching aims are:

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

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

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

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

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

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

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

2) Partners Involved and Governance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4) The New Service Model

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

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

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

- Central
- West
- North
- South

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

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

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

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

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

- **Avoid unplanned hospital admission**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5) The Investment Proposition/Money Flow

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

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

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

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

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

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

6) Evaluation/Review-

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

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

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

All this work will include as review as central objectives:

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

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

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

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

Examples of the measures to be utilised are:

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

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

7) Next key milestones

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

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

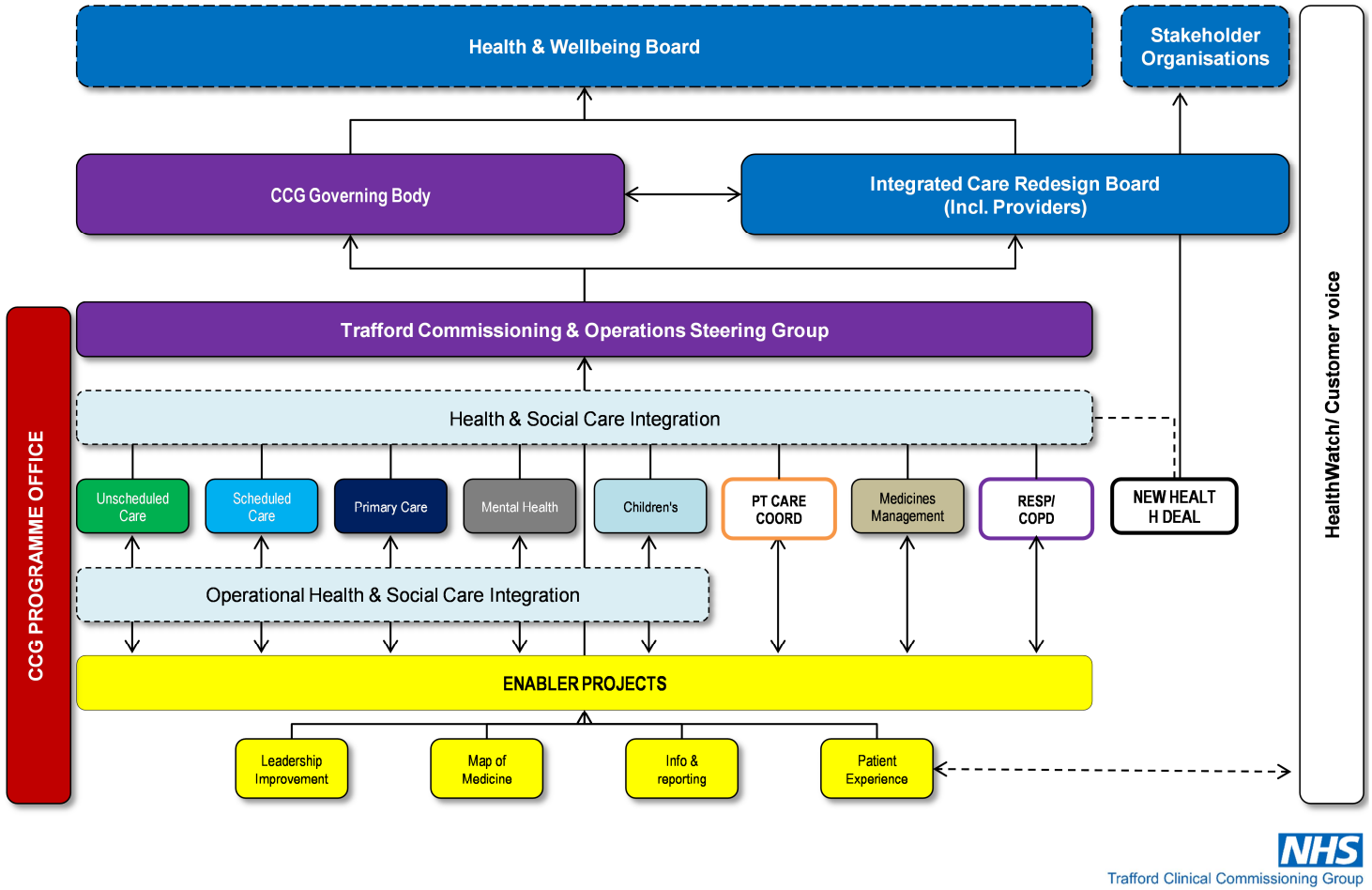
Please send to Will Blandamer w.blandamer@manchester.gov.uk, with the locality integrated care plan attached, by Monday 10th June

Appendix A: Principles of Integrated Care

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

Appendix B: Governance Arrangements

Enablers and Joint Working - Governance



NHS
Trafford Clinical Commissioning Group

Appendix C: Care Coordination Centre