Name of Committee / Board	**Trafford Health and Wellbeing Board**			
Date of Meeting	**7th February 2023**			
Report Title	**Trafford Section 75 Monitoring Report**			
Report Author & Job Title	**Cathy O'Driscoll Commissioning NHSGM (Trafford)** **Karen Ahmed Director Commissioning TMBC** **Julie Flanagan** **Helen Zammit**			
Organisation Exec Lead	**Gareth James/ Diane Eaton**			
OUTCOME REQUIRED *(please highlight)*	Approval	Assurance x	Discussion	Information

EXECUTIVE SUMMARY

The purpose of this paper is to provide Trafford Locality Board with a Section 75 monitoring report, detailing each scheme in the Section 75, including:

- Scope of Scheme
- Objectives
- Progress update
- Measurement Framework
- Next Steps

The formal section 75 between Trafford Council and NHS GM (Trafford locality) incorporates the following:

- Better Care Fund
- Learning Disabilities Pool
- Discharge to Assess Programme

RECOMMENDATIONS

Locality Board are asked to note the content of this paper.

CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board

Risk implications ***(Please provide a high-level description of any risks relating to this paper, including reference to appropriate organisational risk register)***	N/A

Trafford
Integrated Care Partnership

Financial implications and comment/approval *(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)*	Name/Designation:
	Comment / Approval *(Delete appropriately):*
Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or Clinical Lead *(If not required, please briefly detail why)*	Date of TCAPS / Clinical Lead comment (Delete appropriately): N/A
	Name/Designation: (If appropriate)
	Comment:
What is the impact on inequalities? *(Please provide a high-level description of any known impacts)*	N/A
Equality Impact Assessment / Quality Impact Assessment Outcome *(If not appropriate at this stage please state if an EIA or QIA is necessary)*	N/A
People and Communities: Communications & Engagement *(Please detail relevant patient/public engagement completed and/or planned, and if not required please briefly detail why)*	N/A
Trafford's Carbon Footprint *(Please provide a high-level description of any known positive and/or negative impacts – consider the following topics: energy usage; staff or public transport; waste or materials used. Include steps that could be taken to reduce carbon within relevant plans)*	N/A
Links to Measurement / Outcomes *(Please detail if this is included within the report)*	**Outcome Measures are included in the report**
Enabler implications	**Legal implications: N/A**
	Workforce implications: N/A
	Digital implications: N/A
	Estates implications: N/A
Sub-Board Sign-Off / Comments **(i.e. Trafford Provider Collaborative Board, H&SC Delivery Steering Group)**	N/A
Organisation Exec Lead Sign off	

Trafford
Integrated Care Partnership

1. Background

Section 75 of the NHS Act 2006 allows partners (NHS bodies and councils) to contribute to a common fund which can be used to commission health or social care related services. This power allows a local authority to commission health services and NHS commissioners to commission social care. It enables joint commissioning and commissioning of integrated services.

The formal section 75 between Trafford Council and NHS GM (Trafford locality) incorporates the following:

- Better Care Fund including
- Learning Disabilities Pool
- Discharge to Assess Programme

2. The Purpose

The purpose of this paper is to provide the Locality Board with a Section 75 monitoring report.

- Scope of Scheme
- Objectives
- Progress update
- Measurement Framework
- Next Steps

3. Monitoring Update

Scheme:
3.1 Better Care Fund -Overarching
Scope:
The Better Care Fund (BCF) Programme represents a unique collaboration between NHS England, Department for Levelling Up, Housing and Communities (DLUCH), Department of Health and Social Care (DHSC) and the Local Government Association (LGA).

The Better Care Fund Programme sets out to support local system's to successfully deliver the integration of health and social care services in line with the NHS Long Term Plan in a way that supports person-centred care, sustainability and better outcomes for people and carers.

Launched in 2015, the programme established pooled budgets between the NHS and local authorities, aiming to reduce the barriers often created by separate funding streams. The pooled budget is a combination of contributions from the following areas:

- minimum allocation from integrated care systems (ICSs)
- disabled facilities grant – local authority grant
- social care funding (improved BCF) – local authority grant
- winter pressures grant funding £240 million – local authority grant

The Better Care Fund (BCF) in-year monitoring template is used to ensure that Health and Wellbeing Board areas continue to meet the requirements of the BCF over the lifetime of their plan and enable areas to provide insight on health and social integration.

For Trafford the BCF services/schemes are as follows:

- Community Equipment and Adaptations
- Integrated Crisis and Rapid Response
- Early Supported Hospital Discharge Scheme
- Social Care Client Packages
- Supporting Health and Wellbeing of Carers
- Respite to Carers
- Stabilise and Make Safe
- Advocacy
- Better Care at Home
- Asset based community capacity
- Quality Assurance and Improvement
- Disabled Facilities Grant
- Asset based community capacity
- Ageing Well
    - Integrated Crisis and Rapid Response
    - Enhanced Care in Care Homes
    - Anticipatory Care
- Discharge to Assess (Fighting Fund)
- Learning disabilities

Objectives

To support people to Live Well at Home for as long as possible.ie manage their own health and wellbeing and live independently in their communities

With the aim of reducing unplanned hospital admissions and long lengths of stay

Progress Update

- BCF working groups have been set up to achieve the objectives and to put plans in place for next steps to ensure that patients are being provided the right care in the right place at the right time.
- Quarterly BCF reporting continues to be submitted and working groups meet in the lead up to submission dates.
- The BCF services/schemes will be align to the Provider collaborative Priorities and the insight Priorities for Health and Social Care Delivery Board

Measurement Framework

Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence

UPDATE NOV 22

- The target for 22/23 was set at 91.6% to align with the GM average.
- Q1 figure was 91.6%
- Q2 figure was 91.7%
- Latest data – Sept 22 = 91.8%
- This was the 4th best in GM – improvement from 8th at end of 21/22
- Average for GM was 90.8%
- Range was from 83.7% (Wigan) to 95% (Salford)
- National average was 93%
- Trafford ranked 72 / 106 nationally – Interquartile range

Rate of unplanned hospitalisation for chronic ambulatory care sensitive conditions (per 100,000 population)

UPDATE NOV 22

- 21 / 22 final year figure for Trafford was 772.7 / 100,000 standardised population (equates to 1,976 spells)
- Q1 figures for 22/23 showed a slight reduction (1.7%) compared to Q1 21 / 22. As such, the target for 22/23 was set at 758 / 100,000 – equating to 1,942 spells)
- Cumulative outturn at the end of Q2 is 316.5 / 100,000 (810 spells) which is 17% below the target of 381 / 100,000 (975 spells).
- There will be no comparative figures available for this indicator until the end of 22/23.

Next Steps

- Mapping BCF services/schemes formally to Provider collaborative
- Creating an overarching BCF dashboard

Scheme:

Trafford
Integrated Care Partnership

3.1.2 Better Care Fund- Focus on Age Well

Scope:

The Ageing Well Programme is made up of three key workstreams as outlined below. The proposal will deliver on each of these priorities and requirements as outlined by National guidance:

Urgent Care 2 Hour Response

- Service will be delivered by a multi professional, specialist Crisis Response team within 2 hours of 'referral', offered over 7 days a week covering a minimum of 08:00 – 20:00

Enhanced Health in Care Homes

- new Crisis Response team will provide urgent assessment & interventions for individuals who (temporarily or permanently), live in a care home

Anticipatory Care

- Anticipatory Care is proactive health and care intervention at individual and population level. It is proactive care and support, targeted at people living with frailty, multi-morbidity and/or complex needs to help them stay independent and healthy for as long as possible at home or the place they call home focussing on what is important to the individual.

The programme is supported by £1.1m of new funding, which was transferred to MFT (TLCO) in December 2021.

Objectives:

Urgent Care 2 Hour Response

- A Trafford wide universal coverage of a 2 hour crisis response at home service operating 8am-8pm 7 days a week at a minimum, and using a model in line with national guidance. All services should be accepting referrals directly from all key sources incl. 111, 999, general practice, social care, care homes and SDEC services
- Phase 1 referrals to the service will be taken from Community colleagues (Primary Care / health teams / social care staff / NWAS) as well as A&E and front door areas of the acute trusts.
- Phase 2 will include higher acuity 'Amber Pathway' referrals from NWAS (currently delivered by ATT (Mastercall))
- assessment and short-term interventions within the agreed 2 hours response metric and interventions lasting up to 72 hrs
- A staff consultation was undertaken and closed in December 2022. Where necessary interviews have or will take place for posts across the UCR team.

- In addition to this recruitment to vacant roles is being undertaken but there are some roles that are difficult to recruit to including ACPS and OTs. The provider Comms team are working on a website and social media to generate additional interest.

- An implementation plan for roll out is being developed by the management and team leads there is also an Operational Manager who has been recruited and is awaiting start date.
- Pathways are being developed with other services within the locality to meet the requirements of the UCR in addition to referral routes and direct booking.

Enhanced Health in Care Homes

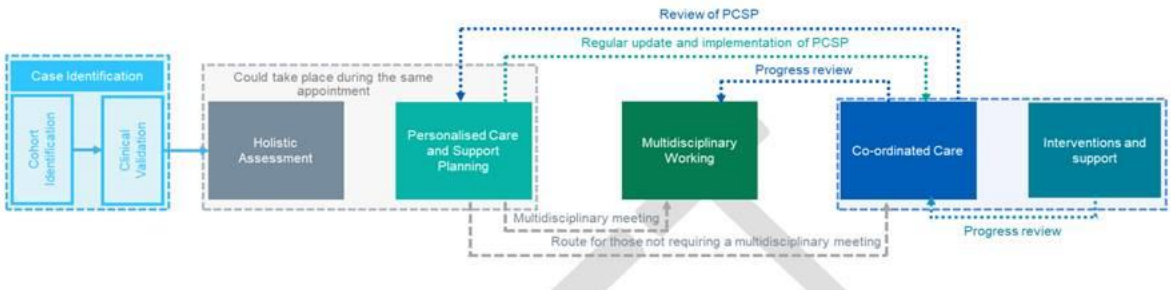
- Prevent unplanned hospital admissions for care home residents and fully utilising Personalised Care and Support Planning to ensure their care is proactive
- Further reduce inequalities for people living in care homes by ensuring all health and care needs are met through delivery of EHCH framework
- Create a single Care Sector Support offer which leads to the development of a single approach between the care sector and the NHS
- Embed good commissioning practices in integrated health and social care
- Improve outcomes and experiences for care home residents and those in receipt of health and social care
- Make data and evidence the basis for policy development, good practice and targeted improvement support
- EHICH programme by delivering a 2-hour community response for those in need.

Anticipatory Care

The draft national anticipatory care framework identifies the 6 core components of AC which localities will need to implement:

1. **Case identification**: using data-driven approaches to identify individuals eligible for Anticipatory Care, and clinical validation of their eligibility
2. **Holistic assessment**: identifying the health, social and self-care needs of an individual
3. **Personalised care and support planning:** empowering and enabling individuals to take an active role in making decisions about their care
4. **Multidisciplinary working:** development of MDTs that review, recommend and deliver care
5. **Co-ordinated care:** working with individuals to support them to understand recommendations and co-ordinate their care through a single point of contact
6. **Interventions and support:** recommended clinical and/or non-clinical interventions that should be tailored to the individual's needs and preferences.

Figure 1: The care model is both a process and a cycle



Progress Update

Urgent Care 2 Hour Response

- Delivery models and high level SOPs agreed and in place

- Partial 2 Hour UCR service currently delivered via TLCO CEC Service and ATT
- ATT/UCR review and clinical audit undertaken considering patient cohorts across two services- with recommendations for implementation
- Outline agreement with LCO of Measurement Framework for UCR deliverables
- Staff consultation and engagement in place to support redesign of services
- New service yet to be implemented with delays due to consultations, recruitment and current staffing levels. Recruitment is now underway, with vacant posts out for advert along with competitive interviews for existing posts. An implementation plan for mobilisation of the service is currently in development.

Enhanced Health in Care Homes

- Introduction of Primary Care and Community Redesign Group and joint Health and Social care Programme Delivery Group
- Co-ordinated COVID response
- Development of health and social care joint action plan – named leads and timescales
- Primary Care Gap Analysis
- Community Services Gap Analysis
- Digital Gap Analysis
- Alignment of GP Practices to Care Home
- Development of draft Home rounds and MDT guidance
- Formalising 'Home Rounds' model including supporting documentation
- Working with Primary Care and TLCO to develop a MDT model; including supporting documentation
- Developing of a model for Structured Medication Reviews
- Pulse Oximeters guidance for use to Care Homes
- Registration of patients to new aligned Care Home
- Development of training and workforce development plan for care workforce
- Agreement of Digital solution and roll out to care homes – 4G, tablets, HiM–Restore2 mini; clinical dashboards

Anticipatory Care

Two Trafford locality workshops have been held with multi-stakeholder representation. This has resulted in the development of a draft process chart outlining how AC could work in Trafford. This model now needs to be refined and operationalised in line with emerging national and GM guidance; the publication of a primary care enhanced service specification, and the development of the Trafford neighbourhood model.

The service will work in synergy with the Anticipatory Care elements of the PCN DES.

Measurement Framework

Urgent Care 2 Hour Response

Draft Proposed measurements for UCR

UC1	csds	% referrals for 2 hour response service met within timescales
UC2	csds	% referrals dealt with in person
UC4		% Interventions completed within 48 hours
UC6	csds	% Clinical handovers from NWAS to CR, patient contacted within 1 hour
UC8		% patients referred to A+E following intervention
UC9	csds	Routes of referral via 111/999/LCAS/TPAS – for Trafford/GMCAS

Currently we are unable to report

Enhanced Health in Care Homes
To be confirmed

Anticipatory Care
The publication of the full AC national framework is anticipated within Quarter 4 of 22/23; which will offer increased clarity on the expectation for local delivery. Further work and input is also expected from GM regarding prioritisation of key outcomes within locality programmes, this is also expected in Q4.

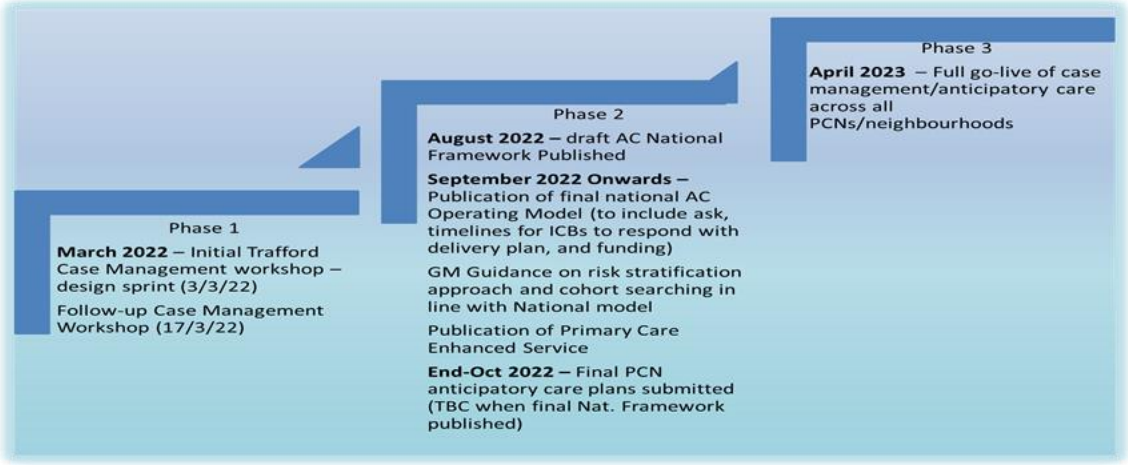
This work continues to be will be progressed with partners. The delivery team and its development part of the wider consultation with LCO Staff and we continue to work with PCN colleagues on the development of plans to roll out Anticipatory Care.

Next Steps

Urgent Care 2 Hour Response

- 6 month implementation with outcome monitoring and audits to review delivery model
- Development of collaborative pathways between Mastercall and LCO utilising both services and resources available to support the most appropriate referral routes for the service
- Following 6 month review, services right sized to support ongoing delivery model in a collaborative approach

Anticipatory Care
Over the coming weeks, Trafford will work to develop a case finding approach through which the relevant cohorts of patients can be identified; this will stimulate discussion and planning as to the required MDT approach required at locality level.



Scheme:

3.2 Learning Disabilities Pool

Scope:

The commissioning scope included in the s75 includes all social care commissioned services for learning disabilities – support with activities of daily living, accommodation costs in excess of the LHA, residential and nursing care beds, day activities and employment services. It also includes specialist homecare and respite services for families who support people with learning disabilities.

Objectives:

Health Checks

Improving Learning Disabilities AHC's remains a key priority in Trafford. The aspiration is to achieve the national target of 70% with trajectories set. A working group is also in place which meets on a quarterly basis with representation from Cheshire Wirral and Partnership (CWP) who are a key partner to help deliver the AHC's.

Progress Update

1. Health Checks

Our current performance for August 22 is currently at 29.5% exceeding the cumulative target by end of Q2 of 25%. The majority of health checks will take place during Q3 and 4 of the year as this is related to the Quality Outcome Framework (QOF), and the associated recall system is in place to invite those patients who are due. A new LD coordinator is in place working in the West PCN to help in completing the LD AHC's, this also includes assisting practices complete the pre-screen health questionnaire. CWP's LD nurse is linked to each PCN in Trafford and is continuing to provide practices with specialist LD support. Trafford Data Quality Team also share the LD data with CWP with an aim to identify any practices which require further support.

2. Employment

We are one of the highest performing authorities in England for this indicator, but our performance has slipped slightly. We have a number of routes into employment and we don't believe that we are accurately capturing all the employment activity in Trafford.

Current performance for employment is 11.4% which represents a continued decline from last year's out-turn of 12%. The decline in figures is partially due to the aftermath of Covid. As stated previously, the main reason for the apparent decline is that we have a number of routes into employment and we don't believe that we are accurately capturing all the employment activity in Trafford. Our ambition is to increase the number of people in employment and work related activities and we are currently working with Impower to review our LD services with a view to improving the outcomes for our residents. Employment forms a key focus of this review

3. Accommodation

The current performance for settled accommodation is 84% which represents a continued drop from last year's outturn of 91%. Commissioners are looking into the reasons for this apparent drop in performance as little has changed since August – sadly we believe that the change in figures has been due to a number of deaths. We are continuing to work closely with providers to de-register a couple of care homes that could provide supported living opportunities, but we have a small number of specialist learning disability nursing care homes that provide care and support to people with complex clinical needs that need a nursing environment. We are also working with

a care provider who is withdrawing from residential provision for people with learning disabilities and closing the home. We have set up a number of small supported living schemes in July and we expect to see more of an upward trend for the remainder of the year, Accommodation forms part of the work we are doing with Impower and following completion of that work, we will review this indicator and set a local target. We also need to consider the level of specialist care that we require to support an increasing population of people with learning disabilities who also have other conditions, many of which are complex, and require complex nursing care.

Measurement Framework

Health checks
Current performance for August 22 is currently at 29.5% exceeding the cumulative target by end of Q2 of 25%. The majority of health checks will take place during Q3 and 4 of the year as this is related to the Quality Outcome Framework (QOF), and the associated recall system is in place to invite those patients who are due. A new LD coordinator is in place working in the West PCN to help in completing the LD AHC's, this also includes assisting practices complete the pre-screen health questionnaire. CWP's LD nurse is linked to each PCN in Trafford and is continuing to provide practices with specialist LD support. Trafford Data Quality Team also share the LD data with CWP with an aim to identify any practices which require further support.

Next Steps

The Council have commissioned Impower to work across the system to improve the life chances of people with learning disabilities and are currently identifying key workstreams which relate to Preparing for Adulthood, respite and day activities including employment and accommodation. Further reports will include updates from relevant workstreams.

Scheme:

3.4 Discharge to Assess

Scope:

1. Non Recurrent Model for 22/23

GP and Medicines Management Model

a. Single Provider model of GP Support
b. Additional g Medicines Management support to manage medicines challenges following discharge to hospital.

Therapy in D2A: Integrated and Co-ordinated Assessment and Intervention

c. New therapy capacity to undertaken therapy assessments in D2A beds and to participate in MDT working with Social Care and nursing expertise to ensure full and timely assessments of resident long term needs. Intervention will be provided by D2A therapy team, where an intervention could support a person to go home from D2A.

d. Introduction of OT/Physio expertise and support to the UCCR to support D2A pathway decisions and liaison with hospital therapy teams.
e. Any longer term community rehabilitation will be referred to and provided by Community Rehabilitation Service.

D2A Beds (Excluding Ascot House)

2. Commissioned D2A block bed residential and nursing capacity within Trafford Care Homes. 39 block beds commissioned from April 2022- November 2022. Following a review of capacity and demand, 39 block commissioned D2A beds has been reduced to 24 D2A beds for Q4 of 2022/23.
3. An agreement of maximum of 18 spot beds (at one time) is in place, commissioned on a individual basis by the Urgent Care Control Room.
4. 37 block beds commissioned with 18 plus spots through approval. The beds were reduced in capacity by 3 in August when one home withdrew and expanded by 4 beds in December to meet increased demand. Beds in one home reduced due to poor quality. In addition, spots have been increased to cover any reduction in capacity due to reduced capacity in the blocks due to Covid.

Home Care - Sufficient capacity to support timely discharges from hospital

5. Sustainability and development of D2A Model for 23/24.
6. The OSRC has been reviewed and whilst there are still some delay in equipment provision, this is improving. Closer working and additional capacity in particular is addressing the majority of the delays related to equipment.

Objectives:

- To ensure that Trafford has a resilient D2A services which support system flow safely, meets statutory responsibilities and fundamentally embeds Home First principles and approaches.
- To support delivery of the Manchester and Trafford Sector wide No Criteria to Reside Target of 240, thereby supporting Elective Recovery and Urgent Care Access
- To reduce the number of people permanently admitted directly to residential and nursing care for the first time following and emergency admission to hospital.
- To increase the number of residents who return to their usual place of residence and remain 90 days following discharge from hospital.
- To establish a recurrent funding approach for D2A, including ensuring sufficient funding and workforce capacity is established for more home-based, strengths-based care and support, and with less reliance and expenditure on bed-based provision.

Progress Update

1. Non Recurrent Model for 22/23

Primary Care Model

- Single Provider model for GP Support D2A block and spot bed, and the Cognitive Behavioural Unit at Allingham Care Home, is now fully implemented. This model is currently in place until 30th September 2023.
- Medical Support to Ascot House (Intermediate Care and D2A) is provided by MFT Acute, so a separate Primary Care Support service has been commissioned from an alternative practice. This is service will provide an administrative service; temporary registration of patients and access to EMIS but it will not provide clinical care which will continue to be the medical responsibility of MFT.

Therapy in D2A: Integrated and Co-ordinated Assessment and Intervention

- It is agreed that a Trafford only model of therapy assessment and intervention will be implemented. In addition to addressing the current gap in therapy assessment within the D2A P3 Assessment process, this will introduce new ways of MDT working with Social Care and nursing to ensure the timely and appropriate assessment of a person's long term care needs are established and to support the completion of the assessment period within 28 days.
- This model and ways of working will also introduce additional therapy expertise within the UCCR.
- This capacity will be embedded within a branch of Community Rehabilitation service to ensure resilience of provision and to ensure those who return home from D2A and require input form community rehab have a smooth and timely care pathway.
- A design group has been established with social care, therapy staff and UCCR management and nursing has been established, which meets every 2 weeks.
- A Project Initiation Document is in development which will outline this approach and model of provision, and the parameters for success.
- Patients discharged from Hospital on Pathway 1 who require therapy input will be supported by Community Urgent Care Response Service once implemented, for a period of up to 6 weeks.
- Patients discharged from UCR service, Ascot House or following P3 D2A process who require community rehab in their usual place of residence, will be supported by Community Rehabilitation Service in line with existing service criteria.

D2A Beds

- Following a review of capacity and demand, 39 block commissioned D2A beds has been reduced to 24 D2A beds for Q4 of 2022/23. The incoming discharge funding will be added to the BCF and will extend the D2A capacity as required for winter.
- An agreement of maximum of 18 spot beds (at one time) continues to be in place.
- Flexible bed model set be introduced at Ascot House, so that up 9 IMCs beds can be flexed to become D2A beds, should demand require and capacity allow has been paused during Winter pressures period to ensure stability of service provision and patient flow through hospital. This will be reviewed in the New Year.
- Funding is being realigned to facilitate discharge funding additional capacity

Homecare

- Pathway 1 discharges continue to be primarily through externally commissioned reablement known collectively as SAMS.
- Activity is monitored and there is capacity in the market.

Measurement Framework

D2A Performance Dashboards

To ensure optimal delivery against national and local targets in relation to discharges from hospital and to support the resilience of our local system it was agreed that following two performance dashboards would be developed.

1) Trafford D2A Operational Delivery Dashboard

This dashboard is a formalised sit-rep with the specific focus of supporting operational delivery and management of discharge processes. It will provide up to date information that influences discharge decisions including the numbers of people in hospital with no criteria to reside, available capacity in short term community beds, the current waiting list for homecare amongst others.

This will eventually replaces the daily community flow dashboard which is completed manually by the Business support unit of Urgent Care Control room.

2) Trafford D2A System Assurance Dashboard.

This dashboard has been developed to monitor capacity and demand, and delivery against key aspects of D2A provision, over time. This dashboard will provide an overview of the effectiveness of system flow, providing an 'early warning' mechanism by which to alert our local system and enable timely and managed escalations and subsequent commissioning decisions.

The following areas have been included within the specification;

<u>Flow in</u>

- System flow
- Hospital throughput
  - Accident and Emergency (A+E)
  - Elective waits
- Length of Stay in hospital beds
- No Criteria to Reside – numbers discharged by pathway compared to numbers waiting to be discharged
- Length of time on NC2R pathway

<u>Flow Through</u>

-
- D2A utilisation:
  - For block beds – the % usage against D2A capacity available for the period
  - For spot placements – the number of bed days used in the period Cross reference against available block bed capacity
- Length of stay in a D2A facility / Long Stayers (28+days)

- Cost of spot placements
- Homecare – capacity and length of wait to obtain service
- Readmissions to hospital from D2A facility

<u>Flow Out</u>

- Destination on Discharge

The report will be produced on a monthly basis, with the first report of the D2A System Assurance Dashboard is being finalised and will be shared at September Provider Collaborative following joint internal health and social care review.

Next Steps

- <u>Non Recurrent Model for 22/23</u>

Primary Care Model

- GP APMS contract incorporating Medicines Management and future proofed to be established, ahead of the end of the current care taking arrangements on 30th September 2023. Initial SLT paper on recurrent cost including staffing model for APMS was delivered in December 2022.
- Current activity monitoring via the existing GP provider will inform future model for 23/24.

Therapy in D2A: Integrated and Co-ordinated Assessment and Intervention

- Finalise model and approach of therapy assessment and intervention, via Project Initiation Document and Trafford system governance.
- Develop a SOP to underpin new ways of working.
- Establish a start date for P3 D2A therapy assessment provision, as a branch within community rehabilitation and recruit to posts.
- Establish start date for the Community Urgent Care Response Service, who will support those discharged on Pathway 1.
- To ensure sustainable model of therapy input is agreed for 23/24.

D2A Beds

- Agreement of the number of D2A beds to be commissioned for 23/24 ahead of 30th March 2023, to ensure the scale of support provision/ capacity can be modelled appropriately.
- Long term and recurrent funding agreements needed before end of March 23.
- All work is aligned to quality oversight framework

HomeCare

- Activity and capacity will continue to be monitored to support any flexing of the market
- All work is aligned to quality oversight framework
- The OSRC is being reviewed and this should smooth out some of the delays related to equipment.

D2A Performance Dashboards

- Updated reports from both dashboards are available weekly, with assurance via Trafford governance on a monthly basis. Work continues to develop refine these reports, addressing data issues when identified. er.

- First paper to SLT/Joint finance regarding finance and delivery considerations for 23/24 was delivered in December 2022. This will continue to be refined as part of the ongoing developments outlined above. l

System development of recurrent D2A model by December 2022

4. Finance Update

A summary of the Section 75 financial position is included in Table 1 overleaf. The values within the report are a combination of NHS GM incurred expenditure and Trafford Council. It should be noted that the Local Authority does not undertake accrual accounting in year therefore variances year to date reflect the invoiced costs paid.

- Better Care Fund – the position at month 8 is showing an underspend of £643k but forecast to breakeven at the year end.

- Learning Disabilities pooled fund – achieving breakeven at month 8 and forecast to remain the same.

- Discharge to Assess – showing an under spend of £590k at month 8 largely linked to home care costs with a forecast underspend of £566k including a contribution of £250k for Age Well 2 hour community crisis response. The age well contribution may be lower dependent on the recruitment process. Expenditure forecasts are reviewed regularly in the joint finance group attended by ICB and LA colleagues. Additional funding for discharge to assess of £1.85m identified in the ICB month 4 position as a risk has been received. More recently Trafford locality is to receive £2.1m discharge funding for which plans were submitted to NHSE in mid December and will be formally included in the S75 agreement for future reports.

- Allocation and spending plans agreed through health and well being board.

Table1: Financial Summary Year to Date and Forecast

Service Description	Annual Pooled Value £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Variance £'000	Forecast Expenditure £'000	Forecast Variance £'000
Total ~ Better Care Fund	30,151	20,102	19,459	643	30,151	0
Total ~ Learning Disabilities	28,814	19,208	19,208	-	28,814	0
Total ~ Discharge to Assess	4,283	2,856	2,266	590	3,787	496
Total ~ S75	63,248	42,166	40,933	1,233	62,752	496

5. Conclusion

The report will support the double aim of providing assurance to Locality Board on the achievement of the joint ambitions set as part of the Section 75, and more detailed analysis of the three schemes within the Section 75 i.e.

- Better Care Fund including Age Well
- Learning Disabilities
- Discharge to Assess

In terms of performance, finance and delivery, As the BCF and Learning Disability Pool covers a number of areas the proposal is that there will be a rotating focus on all elements, support by an overarching update in all reports. Supported by a measurement framework so that as a Locality we are fully sighted on the elements which are working well to achieve our overall locality plan objectives and where there needs to be further improvement work.