HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Health and Wellbeing Board(s) :**Trafford Locality Board**

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils) .

- Trafford Council
- Trafford Locality of Greater Manchester Integrated Care
- Trafford Local Care Organisation (TLCO/Community element of MFT)

How have you gone about involving these stakeholders?

The Trafford BCF plan is a long-term plan which is developed and approved on a rolling annual basis via Trafford's Health and Wellbeing Board. All the relevant partners to the BCF are core members of all our health and social care governance in Trafford and have therefore been fully engaged in the curation and sign off the plan.

The activity within the BCF is a core component of the Trafford Locality Plan (2019-2024) which has been co-designed by system partners and formally adopted through Trafford's Health and Social Care System Governance architecture which is described in more detail under question 5. The Locality Plan was refreshed in 2021 and a further review is anticipated on completion of the GM and Local Operating Model following the transition to ICS arrangements – the BCF will form a fundamental component of the revised plan once actioned.

The BCF outcome measures are monitored and have been evaluated, with key indicators remaining stable or being reduced over the year which evidences positive progress.

Our 23/25 BCF plan will be aligned closely to the planning, design, delivery, and reporting arrangements that span Trafford Locality Board and the Health and Wellbeing Board ensuring a tight system grip on performance, enabling transparent system reporting on all related areas of the wider Section 75, BCF and wider aspirations of the Trafford Locality Plan.

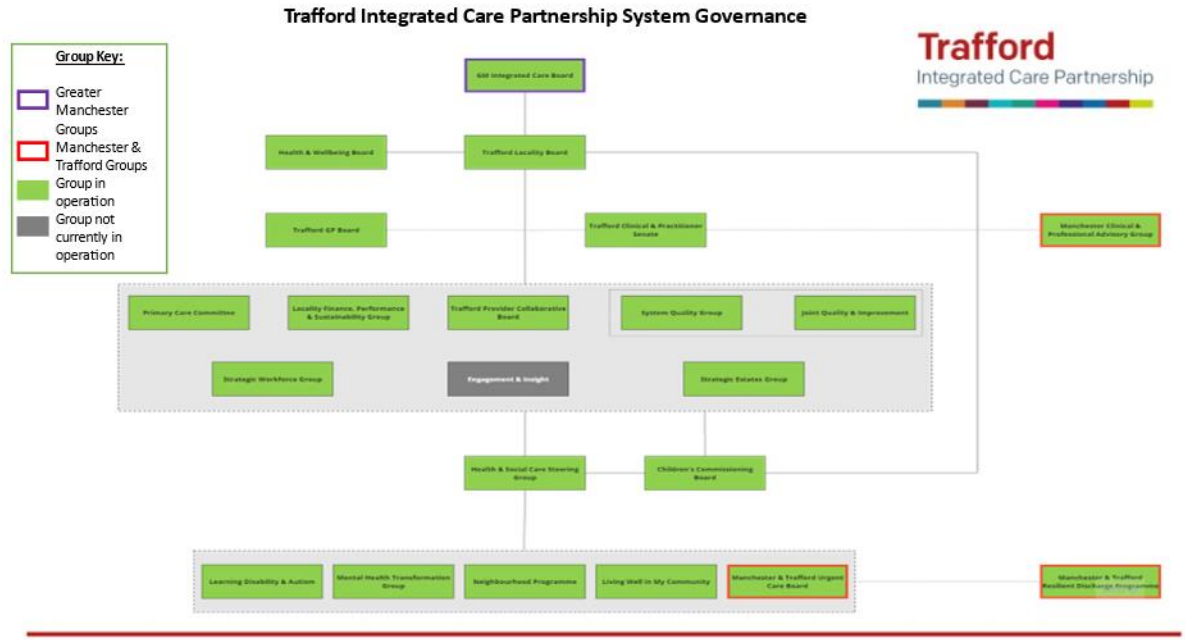
We have ensured that the BCF services/schemes are aligned to the three Trafford Provider Collaborative Board Strategic Priorities (23/24) and the more granular thematic priorities of the various partnership groups that drive forward the work of the BCF schemes are corralled via our regular (monthly) multi-stakeholder Health and Social Care Steering Group.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

The health and care governance structure has evolved significantly since the introduction of the ICS arrangements and disestablishment of Clinical Commissioning Groups. The current Trafford system governance is outlined in Figure 1 below and demonstrates our commitment to an inclusive set of governance arrangements across the Trafford system with full partner engagement/membership.

Figure 1:



The behaviours and ways of working which we aspire to have embedded in all our partnerships forums is encapsulated in our Health and Wellbeing Board (HWB), Trafford Locality Board and Trafford Provider Collaborative Board Terms of Reference, all which have been recently updated and formally signed off by partners (Terms of Reference available on request). The Boards function based on the following operating principles:

- Collaborative working
- Embedding a population health management approach
- Value for money
- Promoting innovation, and encouraging new ideas from patients/service users, carers and the workforce
- Champion both locality and neighbourhood service coordination through our integrated neighbourhood model
- Seek to avoid and identify any conflicts of interest

It is important to note the formalised governance that is operational in Trafford, particularly the arrangements of the Trafford Locality Board. The Locality Board incorporates three elements/'forums' and thus carries out three distinct roles:

1. Consultative forum
2. ICB Committee
3. Section 75 Committee

Of particular importance is the Section 75 Committee:

"A forum through which relevant section 75 arrangements are managed ("Section 75 Committee"). Section 75 arrangements will be managed, and decisions will be taken in accordance with requisite delegated authority given to core members of the Section 75 Committee by their respective organisations. Trafford Locality Board partners who do not have delegated authority in respect of section 75 arrangements will be able to participate in discussions regarding the section 75 arrangements, subject to conflict of interest rules, but will not be able to take de cisions in relation to section 75 arrangements."

The final sign-off of the BCF Plan is the responsibility of the Trafford Health and Wellbeing Board. It is also where assurance is sought that the BCF plan not only aligns to the wider aspirations of the Locality Plan but also contributes towards the Health and Wellbeing Strategy, specifically reducing health inequalities.

We committed in the 2019 Locality Plan to work with our partners on how we create together a culture of co-production that becomes our normal way of working – to plan, design and deliver services together with our partners and the Trafford public, where appropriate. The creation of our Locality Board and the Trafford Provider Collaborative Board as described above are the vehicles by which we will deliver against our system priorities, including the aims of the BCF. The Trafford Provider Collaborative Board has three strategic priorities which are refreshed on an annual basis and the detail of the BCF is operationally overseen through these arrangements with formal escalation to both the Health and Wellbeing Board and the Locality Board.

Below is a list of system partners who are active members of some/all of our locality governance arrangements:

- Trafford Council (Various Directorates)
- Manchester Foundation Trust (MFT)
- Trafford Local Care Organisation (Part of MFT)
- Greater Manchester Mental Health Foundation Trust
- Trafford General Practice Board
- Healthwatch Trafford
- MasterCall (Out of hours provider)
- Trafford Community Collective (VCFSE Representative)
- Thrive (VCFSE Locality Infrastructure Organisation)
- Independent Social Care Providers (Nominated representative)
- Trafford Leisure
- Greater Manchester Police
- Department for Work and Pensions

Executive summary

Trafford's BCF Plans this year are in some respects aligned to previous BCF submissions. However, we have built upon these foundations to create innovative and creative models which ensure our people can remain living well at home for as long as practicably possible.

The priorities for Trafford Locality include the following relevant outcomes to the BCF plan:

- Reduced proportion of admissions to long term care with increased proportion of people living independently at home for longer
- Reduced emergency admissions to hospital
- Increased proportion of people who return to living independently following a hospital admission
- Reduced 'No Criteria to Reside'

The targets agreed by system partners are detailed in the main BCF submission template and the following summarises how they will be achieved within the 4 KPIs are as follows:

- **Avoidable admissions- indirectly standardised rate of admission per 100,000 population**

- **Discharge to usual place of residence:** > % of people, who are discharged from acute care to their usual place of residence

- **Permanent admissions to residential & nursing 24 hour care: long term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes per 100.000 population**-< % of people being admitted to 24 hour care facilities across the Borough

- **Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services:** >% of people remaining at home following an episode of care/treatment.

National Condition 1: Overall BCF plan and approach to integration

Trafford has a long-standing commitment to integration across health and care. Our section 75 incorporates the BCF, Discharge to Assess (D2A) and Learning Disability provision. The section 75 gives lead commissioning responsibility to the Council for the sourcing of D2A beds and provision of homecare. The ICB leads on the clinical elements.

A joint Trafford Council and NHS GM (Trafford) finance group meets on a regular basis to discuss s75 activity, joint ventures and additional areas of work which may have more indirect impact. It is also pertinent to mention the standing up of a formal Finance, Sustainability and Performance Group which will report into the Trafford Locality Board on locally delegated resources. The Locality Board also receives reports on the s75 performance indicators and activity.

We have built our plan around our place and in Trafford this is our four neighbourhoods, our locality and working with other localities in Greater Manchester. We remain committed in Trafford to ways of working that put into practice, our principles and the difference these make to the people we serve. The principles in our 2019-24 Locality Plan remain a key focus as we recover from the pandemic;

- Together as Partners – co-ordinating across our health and social care system, thinking bigger and doing better using our combined resources to improve outcomes for residents.
- In a Place – being positive about our places and spaces, bringing people who live and work in an area together to build stronger communities.
- With People – putting residents at the heart of what we do, listening and working with people.
- Focusing on Prevention – commitment to taking action early and making every contact count.
- Continually improving – making the most of technology and using data and information to make shared decisions. We will continue to learn and develop our workforce and make the best use of our combined assets

The Age Well programme will focus on the delivery of an initial set of Neighbourhood le d services which are a combination of national must do's and gaps identified through our needs assessment , i.e.:-

- Crisis Reponses
- Case Management
- Enhanced Care in Care Homes

This will support the delivery of Core 20PLUS, to provide the right care and support reduces inequalities and address health needs improving outcomes.
New initiatives are described under the relevant headings to prevent duplication.

National Condition 2

Neighbourhood Working (Better Care at Home)

We aim to achieve the objectives set out in the NHS Long Term Plan, through an integrated neighbourhood model with system partners, looking to support individuals with multiple long-term conditions, including frailty to remain well at home.

With the support delivered by a multi-disciplinary team (MDT) , we are confident that our approach will contribute to reduced avoidable episodes of ill health which result in the need for the individual to access unplanned or emergency care. With holistic assessment, personalised care & support planning, coordinated care by the MDT agreeing interventions and support, people will be supported to stay at home, achieve better outcomes for their health & wellbeing while addressing and reducing health inequalities for this group.

Community including community nursing

In recent years, Trafford has placed great importance on the fundamental role of our Neighbourhood model in ensuring we have a social model for health – rather than a predominantly medical one – which focuses on the importance of people and communities as well as health and care services.

The Trafford Neighbourhood model is consistent with the Greater Manchester Model for Health which is based on core principles of co-production, working with people and communities rather than 'doing to'. The Neighbourhood model is the key to making our model for health a reality, ensuring that people are supported to live well with the support they need, whether they're diagnosed with a long-term condition, cancer, dementia, or they're at the end of their life and receiving palliative care.

Our model aims to bring about a shift in the culture of how people approach health and wellbeing, making it more person-centred and community based. It will allow residents and patients to build more personal resilience, increased confidence in self-management as well as addressing their health and social needs. People will be empowered and supported in their independence. Neighbourhoods will strengthen communities and networks to support individuals where required through localised, enhanced and faster access to services.

Trafford system is committed to work together across different partners and services to make the best use of our resources whilst encouraging collaboration. We want to create opportunities to support residents to prevent ill health. We will embed a population health management method and nurture a 'prevention-first' approach that builds on our community assets. It will be co-owned and designed with our residents to support their health and wellbeing needs now and in the future.

We champion locality and neighbourhood service coordination. We work on the principle that organising health and social care service delivery on Neighbourhood footprints creates opportunities for frontline staff to work together in places. This will improve the quality and integration of services and the extent to which they are joined up for residents. The outcomes will be reduced duplication and ensuring people are in control of their care

This will be delivered via:

- Four core Integrated Neighbourhood Teams (INT's) which consist of case management, children's services, adult social care, community nursing, communication and engagement and care navigators.
- Voluntary, Community, Faith and Social Enterprise sector (VCFSE) offer wrapped around the Core Integrated Neighbourhood Teams.
- Primary Care Networks (PCNs) are a key stakeholder within wider Integrated Neighbourhood Teams, with delivery underpinned by the priorities within the Primary Care Direct Enhanced Service (DES).
- Other services such as Palliative Care Nursing, Learning Disability and safeguarding specialists will also be reached out/brought into the integrated neighbourhood teams in a flexible and adaptive manner.
- Realignment of community nursing roles to support new models of Proactive Care (Anticipatory Care).
- Strategic Leadership will be provided by Neighbourhood Leadership Team which includes leads from; Social Care, District Nursing, Mental Health, General Practice and VSCFE.
- Introduction of Trafford Urgent Community Response Service

Technology and Equipment

Our ethos is to ensure that all our people can remain living well at home for as long as possible and to maximise the opportunities, we must use modern solutions. We are investing in our Technology Enhanced Care (TEC) offer and have explored several options include the using of robotics, sensors and connectivity through the Internet of Things to prompt self-care and support independence.

Age UK Passion for life and dementia

The aim of the service for the Dementia Advisors is to ensure that Trafford residents living with dementia and their carers receive high quality information, advice, advocacy and support which promotes independence, increases choice and focuses on social support, peer networks and community cohesion to enable them to live an independent and fulfilling life. Passion for Life is a Day Service that supports those with a Dementia Diagnosis in various sites across the Borough of Trafford.

1:1 Hours

During the Pandemic, the Trafford system witnessed significant changes in the way Health and Social Care operated, one significant change was that our Social Workers were removed from the hospital sites (except for a duty worker for increased complex situations including Safeguarding. This was mainly driven by the National requirement of all Health Social Care partners developing a Discharge to Assess (D2A) offer to meet increasing demand. We simply needed our resources in the

Community to ensure that we could ensure our residents needs were assessed in a timely manner and enabled to return home as soon as reasonably practicable.

As we witnessed the significant restrictions on our people's liberty being infringed with these high levels of intrusive care, it is important to note that the financial costs were also sizeable and reliant on a Social Care professional assessing our people to reduce/remove the 1:1 associated care.

Therefore, in 2021/2022, the Trafford system made the decision to commission our own 1:1 support with a local Care Agency called Cucumber, with a detailed contact which enabled the Local Authority to deploy & cease care when the person no longer needed it, operating this Trusted Assessor model.

- The benefits to our people meant that they only received the right care at the right time
- We were able to deploy our 1:1 workforce where required & not being reliant on the Care Homes sourcing their own 1:1, sometimes at £27-£30 per hour
- We were able to support more of our people who are 'more complex' quicker as the LA supplied the 1:1 care
- We are paying £17.86 per hour, which is currently less that our framework provider rate
- It was the Right thing to do!

Handy Person Service

We have invested in our practical services this year to support the speedy transition from Hospital to Home with a particular focus on making sure that the home is a safe environment to go home to, and meets the person's needs where these have changed as a result of needing care and clinical interventions. This will include filling service gaps such as the removal and moving of furniture, putting curtain rails up and preparing the home to ensure it is a safe environment to go home to from hospital. The Council have commissioned Helping Hands, a not-for-profit social enterprise to provide this service.

Home Care Capacity

Throughout the pandemic we accessed several centrally funded grants, one of which supported one of our providers to purchase a vehicle.

This has enabled the provider to delivery in excess of 500 additional homecare hours in areas of the Borough where transport links are extremely limited, and time restrained and where employees did not have access to their own vehicles.

We have agreed to extend this model through 2023/24.

Stroke Support Service

Stroke Association delivers Stroke Recovery Service for Trafford residents who have experience d a stroke, their families, and carers. The service works with local community stroke teams and other partner organisations to ensure the service is complements the local system and that together they improve people affected by stroke's long-term outcomes

- Coordinated support throughout your stroke journey
- Home visits and/or regular telephone calls

- Emotional support
- Tailored information including communication tools
- Assistance with accessing community-based support
- Support for carers and family members including monthly carers drop in at Trafford General Hospital for newly diagnosed stroke survivors.
- Living well after stroke groups
- Childhood Stroke Support Team has been supporting parents of children who have had a stroke

Ascot House

Ascot House is our 24 hour intermediate care facility within the Borough of Trafford for both community and hospital discharge.

Ascot House is the longstanding provider of Trafford's intermediate care provision, enabling the Trafford system to monitor changes in demand and capacity over a substantial period of time The utilisation of intermediate care beds at Ascot House has maintained relatively consistent levels over the last few years enabling the system to anticipate periods where demand will peak. The number of beds commissioned at Ascot House as been sufficient to manage demand and no additional capacity has been commissioned from alternative providers. Whilst temporary closures of units due to Covid outbreaks impacted on the number of beds open between 2020-2022, 35/36 beds have been consistently open at Ascot House (IMC Unit) between April 2022- March 2023, with the Year to Date (YTD) average occupancy rate of 79%, with a low of 59.3% (April 22) and a high of 92.3% (July 22).

Whilst beds were not up to full establishment of 36 beds in previous years, average YTD occupancy in 20/21 and 21/22 was 73%.

Through the efforts of service and improvements made with regards to patient flow, occupancy rates within Ascot House have improved over time however, utilisation remains under 80% which indicates there is an ability to drive greater utilisation or a review of the number of beds required.

Ascot House currently provides a therapy-led (rather than nursing) model of care. Working in partnership, Trafford system is undertaking a review of this model during 23/24 to identify if there is there is an unmet need for patients with nursing needs who would benefit from bed based intermediate care. Through the introduction of the Rapid MDT in Discharge to Assess beds, the service will identify any patients who should be stepped down from a Pathway 3 bed to intermediate care within the current criteria, and those we could have been supported within intermediate care setting if there was an increase in nursing provision.

This review is also considering the impact of the introduction of Trafford's Community Response service and whether this will enable more patients to be discharged directly home with support, thereby reducing the number of intermediate care beds required within the system.

The impact of introduction of new service offers and their impact on intermediate care bed-based utilisation will be monitored via the Trafford Resilient Discharge Programme and the D2A Assurance Dashboard with reports to Trafford Provider Collaborative on a quarterly basis.

Health Recovery Beds

Throughout 2022-23 it was identified that there was a relatively small number of patients who required a period of recovery prior to receiving rehabilitation or prior to long -term care needs being able to be assessed, taking them outside of D2A pathway 3 assessment period of 8 weeks. Prior to 2022-23 a patient would have experienced a long length of stay in hospital impacting on patient experience and flow through hospital sites.

Subsequently, in January 2023, the Trafford system introduced health recovery beds which are spot purchased in local care homes. This new pathway and provision are managed and commissioned via Trafford's Urgent Care Control Room, which is run and managed by Trafford's Urgent Care Integrated Health & Social Care Team within the Trafford Local Care Organisation (TLCO). To date, 8 health recovery beds have been commissioned and has included:

- Patients who require fractures to heal before rehabilitation can be delivered.
- Stroke patients who have received intensive rehabilitation within specialist stroke units and determined to require long-term residential or nursing care.

Trafford Community Response

Trafford Community Response (TCR) is part of the Trafford Local Care Organisation (TLCO) and provides assessment and short-term interventions including crisis intervention and supported hospital discharge with therapy / nursing input where required.

There are four main aims of TCR:

- Support people to remain at home
- Help people avoid going into hospital unnecessarily.
- Help people return home from hospital as soon as they are medically safe to do so
- Prevent people from having to move into a residential home until they really need to.

Services in the TCR will be integrated with health & social care colleagues forming specialist community teams. The service will provide the 2-hour crisis response, support hospital discharge with nursing and therapy input and will over the coming months work to integrate more community services such as Community IV.

The TCR is designed to be a short-term intervention with possible onward referral to another service if appropriate, including other parts of the Trafford Community Response (TCR) service or wider LCO.

The role of the service is to prevent hospital admission and attendance at urgent care services by assessing, diagnosing, and treating people experiencing a health and social care crisis that requires an inter-disciplinary intervention. The team supports a clinical triage process, supporting the point of entry into the Trafford Community Response service. This includes the Northwest Ambulance Service referral via 999 or 111 as well as via ambulance crews on scene. The team provides an intensive support service for up to 48 hours, before either discharging the person, or making onward appropriate referrals.

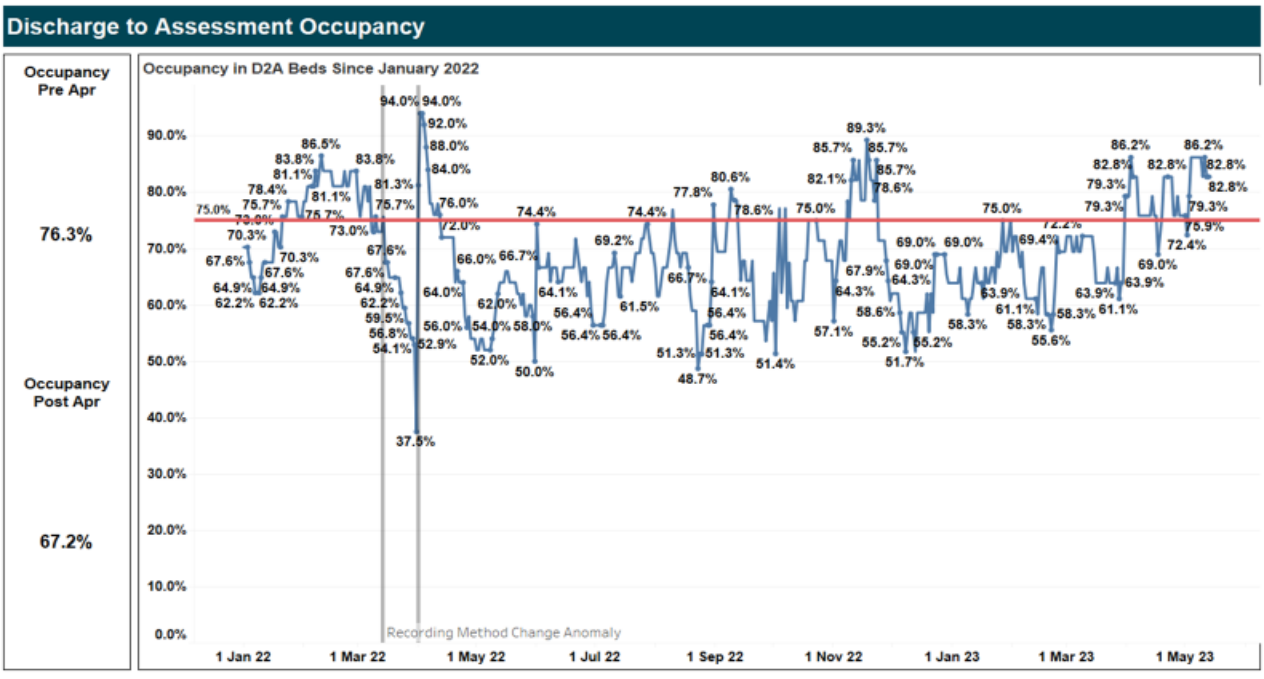
Trafford Resilient Discharge Model

Following the introduction of the hospital discharge guidance and the subsequent increase in residents being discharged for an assessment for long term care into bed-based care, we saw an increase in the complexity of health conditions being managed within a Pathway 3 D2A bed setting, and challenges regarding medications on discharge. This posed significant capacity challenges to General Practice, as these patients required timely review by a clinician. Without timely review and intervention there is an increased risk of patients being readmitted to hospital. Subsequently, the Trafford system commissioned a single GP provider, supported by pharmacists, to provide general practice support for block and spot purchased Discharge to Assess beds. This service provides:

- Temporary Registration of all people
- Provide 3 hours of medical cover per day 5 days per week
- Prescribe both repeat and acute medication as requested/in line with a consultation.
- Action any recommendations from the medicine's optimisation team.
- Service focused on ensuring a safe discharge, proactive care, supporting residents to get the medical care needed by working closely with the wider MDT team and being a single point of contact for primary medical care.
- Leading the MDT approach to care co-ordination.
- Ensuring optimal prescribing support by working in partnership with the dedicated medicines optimisation personnel
- Ad hoc requests from care homes
- Work with the Rapid MDT to D2A Team

Demand and capacity

We monitor capacity and demand across the system together with how we make use of the resources we have commissioned. We look at the number of people under Right to Reside who require support to be discharged, number of people who are discharged across the pathways and available capacity of those services to meet need.



This example shows the activity and use of block purchased D2A beds – we decommission if there is poor response by a provider and/or under use of beds, and spot purchase to increase capacity when there is limited resource.

Our demand predictions are based on the past 3 years level activity and have been in the main fairly accurate – however the key challenges for us is the need to respond to changing activity levels from partners, which is often unprecedented and changes in line with national policy – e.g. increased targets for hospital discharge.

Asset Based Community Capacity

We have employed several Community Link Officers across Adult Social Care to ensure our residents are supported from a preventative perspective. These roles are key to ensuring our people can access universal services and community resources to ensure their needs can be met at neighbourhood level.

Ageing Well Integrated Crisis and Rapid Response - Small team that provides rapid response to crisis in residential and nursing homes for over 65s

Trafford's urgent and emergency care systems have been under significant pressure for a sustained period. Within Trafford an aging population with comorbidities has contributed to increased levels of activity within urgent care across both Manchester and Trafford services.

Similarly, to other localities and areas around the country, Trafford urgent care services have all experienced significant challenges with rising activity levels, increased complexity of need, pressure on beds and in enabling safe and effective discharge. This has meant that the services within the community to support people at home and reduce the need for admission to hospital are becoming even more vital. Urgent Care community services are needing to manage higher levels of demand, acuity, and complexity than traditionally offered. People often have health and social care needs which means that the service offer needs to be provided through a multi-disciplinary approach, with teams working in collaboration with other services. This needs staff with different, developed, and enhanced skills.

Within Trafford our community response service consists of a range of specialists including; Nurses, Social Workers, Therapists and pharmacists.

Trafford Community Response (TCR)

Trafford Community Response (TCR) is part of the TLCO and provides assessment and short-term interventions including crisis intervention and supported hospital discharge with therapy / nursing input where required.

There are four main aims of TCR:

- Support people to remain at home
- Help people avoid going into hospital unnecessarily.
- Help people return home from hospital as soon as they are medically safe to do so

- Prevent people from having to move into a residential home until they really need to.

Services in the TCR will be integrated with health and social care colleagues forming specialist community teams. The service will provide the 2-hour crisis response, support hospital discharge with nursing, social work and therapy input and will over the coming months work to integrate more community services such as Community Intravenous Therapy service (CIV).

The TCR is designed to be a short-term intervention with possible onward referral to another service(s) if appropriate, including other parts of the wider Trafford system service.

The role of the service is to prevent hospital admission and attendance at urgent care services by assessing, diagnosing, and treating people experiencing a health and social care crisis that requires an inter-disciplinary intervention. The team supports a clinical triage process, supporting the point of entry into the Trafford Community Response service. This includes the Northwest Ambulance Service referral via 999 or 111 as well as via ambulance crews on scene. The team provides an intensive support service for up to 48 hours, before either discharging the person, or making onward appropriate referrals.

Integrated Crisis and Rapid Response – Alternative to Transfer (ATT)

The Trafford ATT Service is provided by Mastercall Healthcare. The service is for referrals directly from NWAS or from a Care Home. The service is for those patients where their condition is not life-threatening, but they may be at risk of admission that day due to a medical need. The service provides advice, guidance, and medical intervention where necessary. A senior clinical assessment takes place with a GP who can also arrange to visit the patient in their own home or refer on appropriately.

- Patients can be referred into the service via 999/111/NWAS pathways, GMCAS and Care homes directly
- The service is available 24 hours a day 365 days a year including Bank Holidays
- The ATT service triages all referrals and offer an appropriate response to the presenting issue. This may entail management digitally or through a face-to-face visit, verbal treatment advice, reassurance, or signposting.
- Urgent medical care resolution- potential follow up with Primary Care within the 2-hour response time
- All age all conditions Minimal exclusions
- Short-term assessments and interventions for people in their own homes or place or residence/on scene resolution (to be left in place of safety i.e. in a building)
- All ages in Trafford (no under 2 unless red refusal); any Trafford resident or Out of Area patient within the locality on scene
- GPs supported by wider MDT consisting of ACP/CP/TN/Pharmacist (meds management team)
- ATT/+ is Paramedic and Care Home referral 24/7. Referrals are also accepted from Greater Manchester Clinical Assessment Service (GMCAS) and LCAS directly booked.

The service also supports Red Refusals (unless under 2) within the community via NWAS.

The ATT service is a well-established service within Trafford. The developments taking place around the establishment of a Trafford Community Response also provides further opportunity to integrate and join up the different services available within the locality.

Integrated Crisis and Rapid Response – Trafford Patient Assessment Service (TPAS)

TPAS is the Clinical Assessment Service provided by Mastercall Healthcare who is the Out of Hours (OOH) provider for the Trafford locality. The TPAS supports the Urgent Treatment Centre (UTC) at Trafford General Hospital (TGH) for people who have been referred to the service via 111/999 or another alternative route such as GPs, OOH, ATT, Community Health & Social Care and received an outcome of attend the UTC at TGH.

Most cases that are referred to the TPAS are closed as advice and/or a prescription and do not need to see anyone face to face. Others are referred or booked into an appropriate service if they cannot be closed following initial conversation/consultation. This direct booking will also be undertaken by the TPAS and could be to a range of services across the system that are now interconnected because of the direct booking functionality including UTCs, Emergency Departments and Primary Care.

Clinical Assessment Service models are a key component mandated in the Integrated Urgent Care (IUC) service specification that turned the 111 signposting and referral service, primarily manned by call handlers with junior clinical support, into a full clinical service for Trafford.

Mastercall runs the TPAS service 8am-8pm in line with UTC operating times (note the TPAS operates 8am-8pm and is separate to the GMCAS).

All the service above will reduce the number of unplanned admissions to hospital for chronic ambulatory care sensitive conditions and emergency hospital admissions following a fall for people over the age of 65.

Falls

Within Trafford there are four priority areas in relation to falls:

1) Promote awareness of falls prevention to our residents and increase availability of strength and balance activity for older people.

2) Raise awareness and provide training for health and social care staff of the importance of falls prevention, and support them in delivering evidence based interventions

3) Focus particularly on preventing falls in Care Home and Social Care settings, including Home Care and unpaid carers, including exploring the increase of TEC and 1:1 additional support, additional training for the care home settings has also been provided including the encouragement of the adoption of the Safe Steps and Restore2 tools.

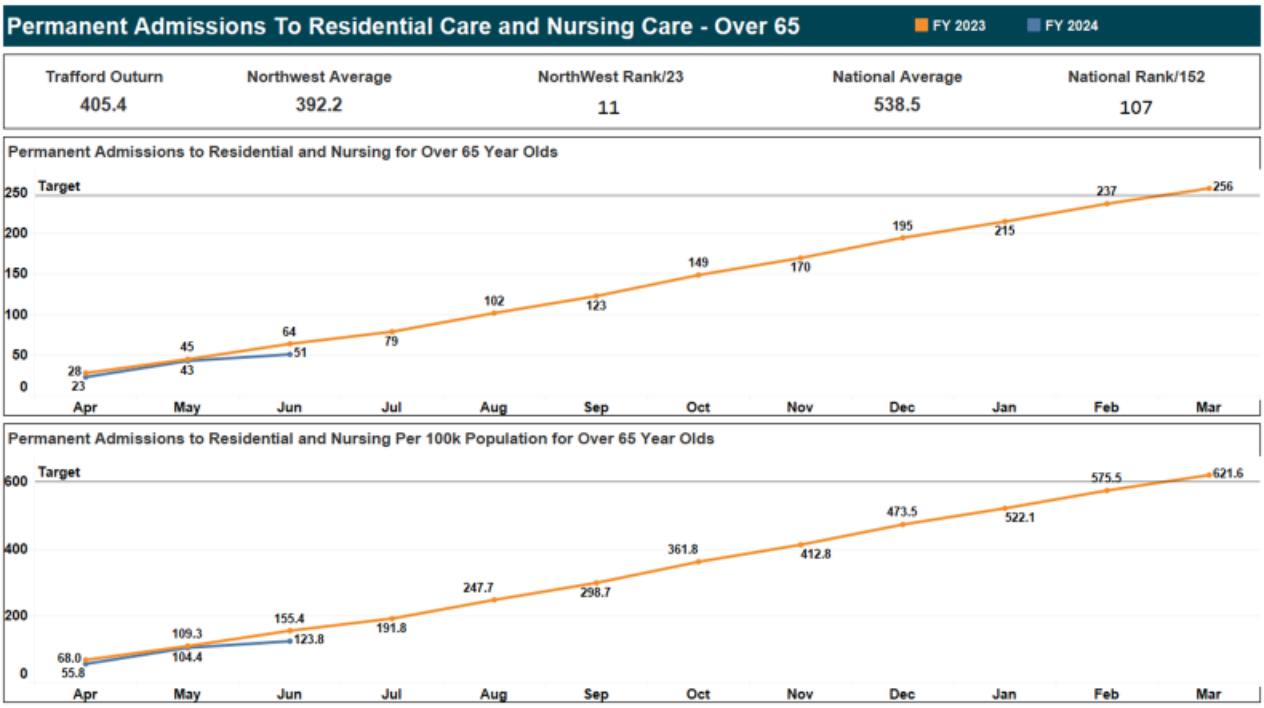
4) Review, revise and embed local falls prevention pathways. Trafford patients who experience a fall and are appropriate for lifting and support rather than conveyance to hospital are referred to the THT falls service via NWAS and will be lifted within their own place of residence.

In addition to this Trafford are also part of a wider GM Falls scheme provide s additional resilience to residents who may have experienced a fall.

Residential and Nursing Care Home admission

Our figures for long term admission continue to decrease year on year as more people choose to stay living at home with care and support . The reablement service we offer together with TEC builds peoples' confidence in making that decision. We only accommodate people in residential and/or nursing care homes where their needs cannot be met safely anywhere else. We have also funded a system Discharge to Assess (D2A) Programme non recurrently, which include GP an integrated assessment service to support discharge pathway choice for people in and out of D2A, therapy support as well as provision of beds and homecare. We continually review and skill up our reablement service to be able to meet the needs of people being discharged from hospital. Outcomes are continually monitored to look at how performance can be improved. Through our Section 75 we have invested in a crisis response service which will support this cohort of patients to stay well at home.

Long-term admission to residential care from D2A beds, is already low, and we are seeking to further reduce this through the expansion of the Rapid MDT which enables people to return home much more quickly. In addition, we have established a new post which will focus on ho using pathways where there is a barrier to someone returning directly home.



National Condition 3

Adults Discharge Fund (ADF)

We have six schemes funded through the ADF as detailed in the BCF Planning template (Excel). To maintain patient flow, the speed, complexity, and numbers of people being discharged has significantly increased along with the unit costs. Trafford has the highest bed cost in Greater Manchester. The cost of D2A beds is in keeping with these rates particularly as the speed with which people enter and leave D2A beds means that the care home staff have an average of 15 times the amount of assessment and discharge work that they have to do for every D2A bed as compared with an ordinary long-term bed. Our targets are 60 people per week which is an increase of 10 on last year. This is putting significant impact on our budget which is not fully offset by the ADF given that bed rates and homecare rates have increased considerably in line with the commitment to pay the Real Living Wage and inflationary increases which have hit the care sector particularly hard. In addition, many of our providers pay more than the Real Living Wage to attract and keep staff and maintain a safe service. We also commission Health D2A beds which are for people who require longer-term placements and support which cannot be provided at home, whilst they await a planned clinical intervention. Our GPs are unable to provide a comprehensive primary care service to our residents and the ADF has funded a contribution to the costs of the contract with a single practice to provide D2A cover. This arrangement enables the provision of complex support to the homes and facilitates the provision of continuity of support together with building close working relationships with the staff in the care homes. In addition, pharmacy support to people in D2A beds is also partially supported through the ADF. This alleviates the pressure on care homes and pharmacies due to the numbers being discharged and prevents the risk of people not having the right medication at the right time.

Trafford Resilient Discharge Programme

The Trafford system has reviewed our High Impact Change Model for transfers of care as part of our Strategic Locality Resilient Discharge Programme (RDP). This programme is aimed at ensuring compliance with; national guidance, clinical safety, providing quality care at the right time and meeting our ambition to ensure that our people can remain Living Well at Home or to a place of residence which meets their assessed needs and outcomes.

Our model of care delivers:

- Acute Trust 'Back to Basics' workstream is to develop a greater understanding of community resources to ensure people are discharged in accordance with our 'Home First principles' are at the point of discharge planning.
- Pathway 3 Discharge to Assess block and spot residential and nursing beds, commissioned within local Care Homes. Our demand modelling has developed since 2017, when we initially embarked on our D2A offer in Trafford.
- To support the timely assessment of residents within Discharge to Assess beds, a Rapid MDT Assessment Team has been established. This multi-disciplinary includes occupational therapy, physiotherapy, nursing, and social care to enable an initial MDT assessment to be undertaken within 48 of admission to a D2A bed. In addition to improving delivery of assessment within the 28-day target for D2A beds, this model ensures that people are on the correct pathway, enabling a change in pathways if clinically. Professionally appropriate

and wherever possible supporting residents to return home. This team subsequently acting as an additional safeguard to support the over prescription of long-term residential care.

- The Rapid MDT model and infrastructure is provided by the Urgent Care Control room as part of its wider system support to provide timely and effective discharge through joint working across the social and health system.
- A small pilot where we adopted the Rapid MDT methodology identified that our people were returning home sooner and between 10-20 days than would have typically been expected with Social Care only interventions.

Community IV Therapies – Delivery of IV in Community to avoid use of hospital capacity

Trafford has a dedicated Community IV service that is provided via the TLCO. This service was commissioned to provide support to 15 patients per month that otherwise would have been in an acute setting/hospital bed.

The IV service supports patients and the local system by:

- Increased patient experience;
- Providing care closer to home;
- Reduction in hospital acquired infection;
- Joined up integrated working between the hospitals and community teams;
- Improvement of patient choice;
- Facilitates early discharge
- Reduces patient admission waiting times by freeing up beds;
- Attendance and admission avoidance (for step up patients)

The Trafford Community IV therapy service aims to ensure the development of:

- An accessible and responsive service that provides patient-centred care either in a patient's home or in an ambulatory clinic setting.
- Provide a service to all Trafford GP registered patients requiring IV therapy in the community. The provision of service delivery for both step-up and step-down patients.
- A focus on outcomes To establish pathways to take patients from A&E, Ambulatory Care, GPs, and the Community Equitable access to the service across the whole of the borough.
- Integration with the local health and social care system.
- Manage patient and public expectations.
- Collaboration and engagement between providers.
- Consistent and proactive use of Shared Care records

Most patients that have been able to access the service have been stepped down from an acute setting; reducing length of stay and reducing the risk of hospital acquired infection/pneumonia whilst providing care closer to home. There is also a cohort of patients within the community who can be stepped up into IV via a community referral usually via a GP or Community service. This then supports both an ED attendance and hospital admission whilst also ensuring the patients can be treated or managed within their own homes where appropriate.

Trafford locality is working with the TLCO to scope the opportunity for enhancement of the service within the locality and the implications for the IV service with the development of the Hospital at

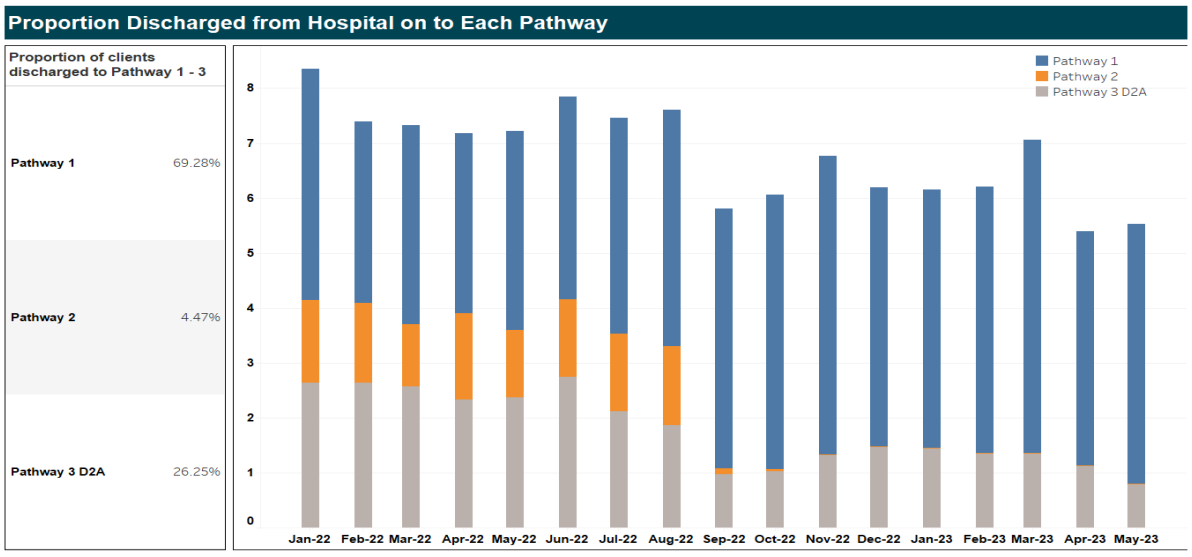
Home programme (incorporating virtual wards) and the enhancement of the Trafford Community Response service

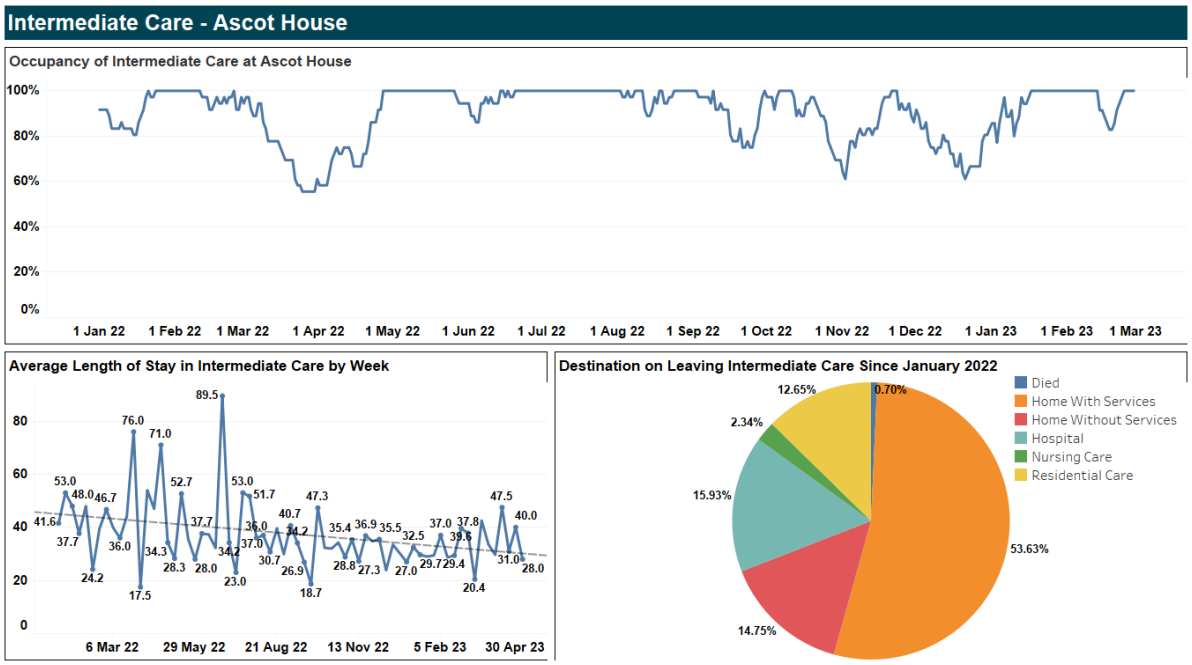
Voluntary Community Faith Social Enterprise (VCFSE) & Statutory Services

Statutory services and our commissioned care and support providers cannot possibly deliver everything for our residents. Consequently, we have decided to invest further in our V CFSE sector to deliver our Living Room projects where our people can attend to not only stay warm but also to engage in meaningful activities including; homework clubs, coffee mornings, afternoon tea, yoga, meaningfulness sessions etc. Further support for our 'Living Rooms' can be found at Trafford Community Hubs (traffordhubs.org)

For example, The Toy House is an inspirational community asset which provides local support to the residents of Urmston (West Trafford locality) and neighbouring areas. They provide a timetable of person-centred activities across an all ages from new mothers, people experiencing mental health associated needs ,older aged adults and adults with a learning disability. The Toy House have asked for additional support to 'grow' their volunteer workforce and we think by promoting our Personal Assistant (PA) offer for those in receipt of Direct Payments (DP's) or Personal Health Budgets (PHB's) is an opportunity to develop a structured approach into paid employment.

As detailed in response to National Condition 2, Ascot House is the long standing provider of intermediate care provision in Trafford. The monitoring of capacity and demand and utilisation of 36 bedded provision is monitored via Trafford's Discharge to Assess Assurance Dashboard which reports to Trafford Provider Collaborative on a quarterly basis. This demonstrates that the current 36 intermediate care beds commissioned are sufficient to meet demand, including periods of increase in demand such as over Winter. Please find current rates of discharges per discharge to Assess pathway and the utilisation of Ascot House below:





As 14.75% of people returning home from Ascot House with no further input from services, this may indicate that there is a over-prescription in the use of bed based rehabilitation and an opportunity for more people to return directly home from hospital with therapy support. This opportunity will be tested through the introduction of the Pathway 1 Discharge to Assess support within the new Trafford Community Response service and the additional community occupational therapy and physiotherapy this provides. The impact of the introduction of this service on the utilisation of Ascot House beds will be closely monitored over the next 12 months, with the outcomes considered within the current review of Trafford's Intermediate Care Model.

Additional Staffing in Care Hub & Control Room

We know that sometimes, people remain in hospital longer than necessary due to reasons which pertain to their accommodation related needs. It may be an environmental issue, health and safety or personal issue. Whilst the needs of the people which fall into the above category may not have 'eligible' care and support needs (under the Care Act, 2014 (Statutory Duty for Local Authority), ensuring people can leave hospital is the right thing to do.

Consequentially, we have secured additional capacity to address the complex housing related issues, our people face by employment of a dedicated Lead (fixed term contract 23/24). Further, we are working more closely with our Housing colleagues to ensure hotel capacity is brokered where required.

Social Work Resource in Emergency Department

We recognise that on occasion our residents are admitted to hospital due to non-medical reasons where they could be cared for at home. We have therefore agreed we will pilot the presence of a Social Worker in the Emergency Department of Wythenshawe Hospital to see if this model would be effective to support our residents more holistically as opposed to a hospital admission.

Early Supported Hospital Discharge-Rapid MDT

We know that once our residents are discharged from hospital and enter our D2A provision, more than 87% of people return home.

This may be because of several reasons, but we believe if we had a Health & Social Care model which met people on their first day this may improve our residents' outcomes even further.

The Council have developed this pilot in partnership with, Greater Manchester Integrated Care, Manchester University Foundation Trust (MFT), who will be providing Occupational Therapy & Physiotherapy assessments & interventions to support individuals during this assessment period.

Provision of Equipment to enable Single Handed Care

The purpose of this project is to ensure our people receive a dignified and less restrictive level of care where their assessed needs have been identified as requiring the support of two registered carers. This project has been delayed due to difficulty in recruiting Occupational Therapy support.

By maximising a modern approach to equipment, this will result in care only being required to be delivered by one carer as opposed to two: maximising our workforce capacity

We learnt prior to the global pandemic, that this approach worked effectively for both our residents and workforce, and we want to build on this through 2023/2024.

The BCF and the iBCF form part of our approach to discharging some of our Care Act (2014) statutory duties and functions.

Provision of Advocacy

Advocacy Focus delivers a range of statutory advocacy: Independent Mental Health Advocacy (IMHA), Independent Mental Capacity Advocacy (IMCA), Care Act Advocacy, NHS Complaints Advocacy, and Child Protection Advocacy (CPA). A recent addition of support delivered by Advocacy Focus is Peer Advocacy. There are 16 individuals that are members of the group. The service is also preparing for the introduction of LPS (Liberty Protection Safeguards), in the future, and is focusing on bringing the waiting lists down. The Trafford Advocacy Hub currently operates a waiting list due to high demand on services. They are fully staffed in line with our original budget and additional funding has been provided to extend capacity in line with demand. When Advocacy Focus took over the contract in 2018, 71 eligible cases were handed over and active within the service, today they work with an average of 211 people which is a 197% increase in demand.

Quality Assurance & Improvement

We have developed a Quality Assurance Lead to ensure that the care people receive of a high standard and is informed by our people's voice. The post holder also ensures that we have effective, safe, and good quality assurance to enable us to discharge our statutory duties and identify any subsequent learning. The Council commissioning team has co-produced an i-Tool with providers and this tool measures the quality of service. The team work closely with the providers to ensure best practice and develop and monitor improvement plans where there are concerns about the quality of a service. We have monthly meetings where the ICB, TLCO and the Council review the quality of commissioned provision across the system.

Urgent Care Control Room

We have temporarily increased our capacity across both Social Care and Health Assessment and Commissioning resources to ensure that we can support as many people as possible to return to their natural place of residence. The demands on data requests and greater assurance, visibility across the system has further increased, resulting in additional positions initially being tested as a 'proof of concept'.

Supporting unpaid carers

The Trafford system BCF plans and BCF funded services consider support for unpaid carers, and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Respite for Carers

The Trafford system is committed to ensuring that our people can receive the right care at the right time. In order to achieve this, we are developing in collaboration with a homecare provider an overnight support service for our residents during times of need (including overnight7 days a week). This usually occurs when their informal carer has become unwell or has been admitted to hospital.

This approach will ensure that the person being 'cared for' will be able to remain in their own home and will avoid any further distress/unrest or hospital admission. Our Social Care and Health workforce would then undertake an assessment of the person's needs the following working day.

Supporting Health & Wellbeing of Carers

The Carers Centre is a substantial resource for our informal carers, and they have requested support to ensure that our carers are aware of the support that is available to them specifically where their loved one is in a hospital setting. Our Carers Ambassadors will be available initially at our Wythenshawe hospital site and will provide additional resources to enable our carers to make informed decisions.

We believe that all carers have the right to be recognised, respected, valued, and supported both in their caring role and as individuals in their own right. Trafford Carers Centre support our carers through the provision of counselling, digital support, direct payments and information and advice. The Council and the ICS work in partnership with the Carers' Centre to ensure that where the independent assessments carried out by the Carers Centre recommend respite, that Carers breaks are available. Advice, information, and signposting is also provided by our Citizens Advice Bureau, in-house welfare services and our local community hubs.

From April to June 2023, the Centre achieved the following:

The Centre also offers Carers Awareness Training and support the roll out of our Employers for Carers initiative. We have funded a hospital discharge project to support carers of people who are being discharged from Trafford General Hospital. The outcomes are extremely positive at Q1 – A worker has been recruited to lead the work. Drop-ins have been established on each ward and awareness raising events held. The Hospital Discharge lead is now in the process of establishing carers' champions on each ward, together with establishing a carers' group. The lead has also raised awareness generally. The events have led to 28 new referrals for information and support.

Disabled Facilities Grant (DFG) and wider services

The Trafford system works collaboratively across health, housing and social care to maximise the availability of accessible housing to enable people to live for longer in their own homes. We consider all aspects of a person's life – not just the accessibility of their home, but also their access to local facilities and the community. We ensure that where possible, people are offered viable housing alternatives to adaptations, which are often extremely disruptive. We also offer grants to support the move. Where these are not available or desirable, we work with the family to develop a cost-effective solution to maintain independence. We consider the lifetime needs of the disabled person in designing an outcome. Our Older People's Housing Strategy outlines several actions to improve our range of housing choices from providing information to encouraging the development of more extra-care housing to support our population. The actions in this plan are regularly updated.

Older-Peoples-Housing-Strategy-2020-25-A-Plan-on-a-Page.pdf (trafford.gov.uk)

At a Greater Manchester level, we have developed a Healthy Homes initiative and we are seeking additional funding in order to implement the same offer of support across all GM boroughs. We meet regularly to share best practice at a strategic level. Managers of the Adaptations team also meet regularly to discuss operational issues.

GM Healthy Homes Final Report Jan 2023

We also have a number of Ageing Well initiatives to support people earlier on in their care journey, preventing hospital admission and maintaining optimum health for as long as possible. In addition, we also support older people to remain happy and healthy through our Age Well Plan which is based on the WHO Age Friendly Community approach. Age Well Plan (traffordpartnership.org) We work closely with the planning department and our Registered Providers to maximise the availability of

extra care provision within the borough which meets HAPPI standards and are in the process of developing our Market Position Statement for older people to provide a framework for this discussion. The number of adaptations requested are now increasing as we receive more OT assessments from an externally commissioned provider. We regularly review and report back on activity.

Adaptations Report May 23.docx

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

Yes - We agreed an RRO in 2018 to enable the provision of

- Moving Assistant Grant – this provides support to people who would live a better life if they moved to an alternative property. The take up of this grant has been very low and we are working with our Registered Providers to promote it again. There is no upper limit for this provision.
- The increase of the DFG upper limit to £50,000 – this particularly supported adaptations for families where there is a disabled child. The table below details those adaptations which are in excess of £50,000 – there is no upper limit in line with our statutory responsibility (and case law) to meet need.

details	gross_grant	certified	landlord (owners left blank)	Age
a ground floor facilities	50,958.03	20-Jun-19	Irwell Valley Homes	47
a ground floor bedroom and shower room facilities	61,769.60	26-Jul-19		55
a ground floor bedroom and bathroom with hoist	56,730.05	30-Aug-19		12
a ground floor facilities	63,549.43	26-Sep-19		35
a ground floor bed/shower room	64,820.84	11-Mar-20		62
a ground floor facilities, wheelchair access to property	58,878.13	02-Jul-20		68
a aquanova scorpio 1800 bath, ramped access rear & fro	55,849.79	09-Mar-21	L&Q	65
a ground floor bedroom/shower room	57,777.55	16-Mar-21	L&Q	6
access to front/back garden & ground floor bed/shower ro	68,933.33	18-Jun-21		6
a ground floor facilities bedroom & wetroom	51,513.36	14-Mar-22	L&Q	83
a ground floor wheelchair accessible bedroom & shower r	81,804.71	14-Dec-22	L&Q	55
a ground floor facilities	117,436.77	10-Mar-23	Irwell Valley Homes	12
a ground floor facilites	84,759.64	14-Apr-23		6
a ground floor facilities	69,853.40	25-May-23	L&Q	7
a ground floor facilities	82,437.26	09-Jun-23	L&Q	44
a ground floor wetroom and clos o mat	60,711.73	13-Jun-23	L&Q	38
a ground floor facilities	78,796.75	16-Jun-23		6
a ground floor facilities	66,915.80	11-Jul-23		5

Equality and health inequalities

Via our established system governance, the Trafford system is working with people, communities and partners, particularly in deprived areas, to improve the physical and mental health of all our residents. The diversity of Trafford's population is one of our greatest strengths and we want all our neighbourhoods to have thriving and healthy communities. However, some groups are currently

disadvantaged – not just in life expectancy but in areas such as housing and poverty that can contribute to poorer health. The recent published Census and our local analysis has helped informed targeted support and activity in our neighbourhood model.

Our ambition to reduce health inequalities is driven by our Health and Wellbeing Board Strategy and Trafford Locality Board and operationalised through our Trafford Provider Collaborative Board which oversees effective delivery of the schemes contained within the BCF. These governance arrangements also ensure that organisational health inequality strategies are connected and that efforts to tackle inequalities across our Trafford Integrate Care Partnership are effectively deployed – including GM system Board efforts to address the priorities laid out in NHS Core 20 Plus 5.

Our Neighbourhood plans, which include priority pathways for change that address inequalities, are planned, designed, and delivered in our four Neighbourhoods. A series of 6 coproduction workshops in each neighbourhood with Trafford citizens and stakeholders have gathered local intelligence to reinforce the PCN, public health and census data which has informed the first iteration of neighbourhood plans – with outcome data being shared back through formal governance via our Locality Performance Framework.

Where applicable, the schemes within our BCF Plan have taken into account the NHS Core 20 Plus 5 clinical areas of focus (Maternity; Severe mental illness (SMI); Chronic respiratory disease; Early cancer diagnosis; Hypertension) and work to ensure these areas are addressed is governed through our Trafford Provider Collaborative Board, with wider support and scrutiny from the Health and Wellbeing Board and specific GM forums.

Conversations have started through Locality Board and Health Scrutiny on planning to support differential neighbourhood spend based on need, to improve outcomes and reduce inequalities. Engagement with the population at Neighbourhood level has commenced in our dedicated Long-Term Conditions and Mental Health programmes, so that services can be shaped to reduce inequalities and prevent the need for urgent care.