Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Trafford Borough Council**
Clinical Commissioning Groups	**Trafford Clinical Commissioning Group**
Boundary Differences	**Both Local Authority and CCG boundaries are co-terminus**
Date agreed at Health and Well-Being Board:	**15/09/2014**
Date submitted:	**19/09/2014**
Minimum required value of BCF pooled budget: 2014/15	**£0.00**
2015/16	**£15.544m**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£15.544m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Trafford CCG
By	Gina Lawrence
Position	Chief Operating officer
Date	

Signed on behalf of the Council	Trafford Council
By	Theresa Grant
Position	Chief Executive
Date	

Signed on behalf of the Health and Wellbeing Board	Trafford Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Dr Nigel Guest
Date	

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	**Synopsis and links**
Joint Health and Wellbeing Strategy	The Joint Health and Wellbeing Strategy sets out the eight priorities and actions which the Health and Wellbeing Board are planning to carry out from 2013 to 2016 for the borough of Trafford. http://www.infotrafford.org.uk/custom/resources/TraffordHWB2014.pdf
Joint Health and Wellbeing Action Plan and Performance Framework	The Joint Health and Wellbeing Action Plan translate the 8 key priorities of the Health and Wellbeing Strategy with clear milestones, lead officers, outcomes and rag status. The Joint Action Plan is overseen by the Health and Wellbeing Programme Delivery Group.
Joint Strategic Needs Assessment	Joint Local Authority and CCG assessments of the health needs of a local population in order to improve the physical and mental wellbeing of individuals and communities across the borough of Trafford. http://www.infotrafford.org.uk/jsna
Children, Families and Wellbeing Strategic Plan	The plan for 2012 – 14 sets out the intentions of the Local Authority to continue the development of services which are high quality, personalised, flexible and integrated, promoting resilience and independence whilst safeguarding vulnerable adults. http://www.trafford.gov.uk/about-your-council/children-families-and-wellbeing/docs/children-and-young-peoples-strategy-2011-2014.pdf

Dementia Strategy	Joint Local Authority, CCG, provider and patient/service user plan for 2012- 16 which outlines the key priorities and commissioning intentions to support adults with dementia and their carers.
Dementia Strategy Implementation Plan.	The Joint Dementia Strategy Implementation Plan translates the key commissioning intentions reflected in the Strategy with clear milestones, lead officers, outcomes and rag status. The Joint Implementation Plan is overseen by the Health and Wellbeing Board and driven forward by the Dementia Strategy Delivery Programme Board.
Early Intervention and Wellbeing Hub Programme	The Early Intervention and Wellbeing Hub Programme is underway which will further facilitate the integration of health and social care, supporting the shift of resources from the acute sector to integrated community based services across 4 localities in Trafford. The hub will be based in the Patient Care Co-ordination Centre and will support people on a family based footprint from cradle to the grave – domestic abuse, drugs and alcohol, information, Telecare.
Commissioning Strategic Plan(CSP	Trafford's Strategic Commissioning Plan which outlines the CCG intentions for 2013-15..This outlines the new CCG commitment to commissioning high quality services for the Trafford population
Trafford's joint Integration plan and support documents	The joint integrated plan from the CCG and Trafford Council which was submitted to AGMA which demonstrates the joint working between both organisations and commitment to deliver integrated care
Project Initiations Documents for Redesigning Frail and Older Peoples Services Redesigning End of Life Care Community Health and Social Care Integration and Early Help Hub	These documents outline the scope of three workstreams covered in our Better Care Fund submission.
Visioning and Addendum for Patient co-ordination centre	The vision for Trafford's Patient Co-ordination centre. This will be delivered through competitive dialogue procurement. The Early Intervention and Wellbeing Hub will be part of this to track and identify individuals most at risk, and to undertake timely interventions which will promote self-management.

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Introduction:
Trafford's model of integration is founded on a whole system transformation which will result in significant changes across the health and social care economy. Trafford's commissioners are committed to working together with health and social care providers across the economy to develop different ways of working. There is strong commitment to do this on a collaborative and co-produced basis, working with all key stakeholders, including GP's, clinicians, health and social care providers, patients, service users, carers and local communities.

Much work has already taken place within the Trafford health and social care economy to develop both horizontal and vertical integration of services and support *Healthier Together's* strategic change across Greater Manchester. Part 1 of Trafford's CCG strategic plan has been delivered with the reconfiguration of the acute sector within the borough, with the implementation of Trafford New Health Deal with significant changes to the urgent care services within Trafford, which is now showing a deflection of activity as predicted. The emphasis is now shifting to reshaping community provision of health and social care, developing Primary Care with a focus on frail older people, end of life care and promotion of self-care. As part of these changes, Trafford will deliver the community standards across both health and social care and this will as a consequence reduce the pressure on acute Trusts.

In developing the community standards, the CCG and Council will utilise the partnership working across Trafford Council and Pennine Care Foundation Trust to deliver reshaped community health and social care services. This will put service users/ patients at its heart and embed joint provision in local communities to improve outcomes for the local populations. This is based on a neighbourhood footprint across Trafford which will align primary care, community health and social care into four neighbourhoods that actively support admission avoidance into the acute health sector, expediting early discharge and delivering care closer to home.

The current state of health and social care services in Trafford

Trafford is unusual in that its patients have access to multiple providers within the economy, rather than the usual 1:1 relationship between commissioners and providers. In health, the population of Trafford have choice in providers but the flow of patients is also influenced by where they live. Patients in South Trafford predominantly go to University Hospital of South Manchester (UHSM). Patients in the North access Central Manchester Foundation Trust (CMFT) both on their main site and the Trafford General Hospital (TGH) site. Community services are delivered by Pennine Care NHS Foundation Trust (PCFT) and mental health services by Greater Manchester West NHS Foundation Trust (GMW). Primary care is delivered across 36 GP practices and 1 walk in centre.

Trafford already has a fully integrated health and social care service for children and young people operating on a four neighbourhood model and this has been in place since 2007. Adult's health and social care in Trafford, like many economies, is currently a traditional model with primary, community and social care all being delivered

independently which can cause duplication. This results in inefficiencies and confusion for service users. Many patients use secondary care instead of primary and community services. Trafford has already begun developing its adult's integrated health and social care community service to address this. By October 2014 the adult's model will replicate that of children's through a comprehensive Section 75 agreement between Trafford Council and Pennine Care and integrated management structures will also be in place.

The intention by 2016 is to have moved this model on still further to create an all age integrated health and social care service, incorporating our new all age Early Help Hub to compliment the Patient Care Coordination Centre being developed by the CCG. The BCF projects will help to accelerate this work further.

The Future of Health and Social Care Services in Trafford

The future model for health and social care will be delivered in Trafford based on a locality model where there is seamless delivery of primary and community services which are proactive in the management of patients. This model will deliver high quality services which are accessible over seven days and will in the majority of cases meet the demands of our patients. A consequence of this is a change in the type of patients requiring and using secondary care. The ambition is that only patients needing surgical and medical interventions in a hospital setting will be admitted. The integrated care model in Trafford will be all-age and will be both proactive and reactive in its delivery, with a greater emphasis on prevention to ensure that individuals retain good health for as long as possible. Social care and community health will be integrated as part of this model where there will be seamless joint working between professionals to meet the needs of individuals. This new model will have a workforce that has the skills and competencies to treat and care for these patients. Within Trafford, clinical information will be available to health and social care professionals working across the economy.

In Trafford changes have already been implemented in secondary care as part of the redesign of Trafford General Hospital, however this may further change as a consequence of *Healthier Together* across Greater Manchester. There may be further changes to some elements of secondary care as a consequence of an ageing population and the associated health needs.

As part of the identification of schemes, both the CCG and Trafford Council have recognised the need to develop further end of life care. This will align to the integrated care model and national best practice with increased support being provided to patients dying in their preferred place of choice.

The four neighbourhood model will be delivered alongside Trafford's Estates Strategy. Early discussions indicate that the locality model may utilise developments for North Trafford, with plans for a health and wellbeing hub planned for Old Trafford currently underway. This will deliver primary care, community care and social services to this target community from a single location. It is anticipated that voluntary and third sector organisations will also have the benefit of this new development.

South Trafford will benefit from a development which is at its early stages will again bring together several services in a single site. This will be in close proximity to the new Altrincham Community Hospital allowing patients easy access to all diagnostic and minor interventions to provide attendance at an acute setting.

The estates strategy will look to agree these proposed plans and address the remaining two localities, where similar models will be developed with either new build or utilising existing provision.

The CCG will work with NHS England as part of the new co-commissioning arrangements for primary care estates.

Aligning the Better Care Fund to existing plans

Trafford CCG has set out in its 5 Year Strategic Plan to reduce unscheduled care activity at acute Trusts by 15% and scheduled care by 10% .There are a number of individual programmes of work which are currently being developed which will deliver these changes in activity. These are based on information within the Trafford JSNA and the priorities identified within the Joint Health and Wellbeing Strategy. These include respiratory, cardiology, diabetes and cancer which will reduce the demand on planned care within a secondary care setting as the redesign of these services will deliver more choice and care closer to home delivered by primary and community services.

The Better Care Fund (BCF) identifies 3 projects which will contribute to changes in activity flows and reduce demand on A&E departments; integration of health and social care and the development of an early help hub, redesigning frail and older peoples services and redesigning end of life care in Trafford.

Patient Experience at the heart of service redesign

As part of the redesign of services, Trafford CCG has a comprehensive patient engagement framework which brings together experiences from users, carers and professionals. Each scheme has patient and service user representation to ensure the voice of the patient is central to changes. As part of the governance structure of the CCG, the Patient Reference Advisory Panel (PRAP) is presented with each scheme to input to the approval of service model changes.

All redesign is driven by the following principles;

- That care is delivered around the needs of the patient and not that of systems and processes that support models of care
- That patients are assessed for health and social care needs early and receive care in a timely manner
- Respect and dignity for the patient, their families and carers is at the heart of delivering health and social care
- Service redesign should support patients to remain as well as possible in their own homes for as long as possible
- Redesign must take place across the whole system rather than specific services to enable patients to have the best possible experience of care.

Public Health and Socio-economic changes

The rationale for our vision is rooted in the evidenced health and care profile for Trafford which demonstrates that we face a number of challenges across the whole health and social care economy. In summary the strategic drivers for this programme and plans are as follow:

- The population profile is changing with an increase in the number of elderly people living with long term conditions with complex co-morbidities
- Escalating demand on health and social care services
- Increasing customer and patient expectations
- Inequalities within our borough, resulting in a difference of life expectancy between people living in the north compared to the south of the borough
- Supporting patients, their families and carers at the end of life to improve patient experience
- A proportion of the population have adverse lifestyles, including high levels of smoking, alcohol consumption and obesity
- Backdrop of challenging financial times for the whole of the public sector, who has seen real term reductions in public spend and funding, impacting significantly on health and social care budgets

Trafford JSNA states that the number of older people over 65 years is expected to increase by 8% from 2010 -2015 and by 37% over the next 20 years and reach at least 48,000 by 2030. Following the release of the census data from 2011, these figures have been updated and in fact 35,300 people in Trafford are aged over 65 years and by 2030 this population is estimated to increase to around 55,500. Many of these will be over the age of 85 years. This is the age group most likely to need health and social care.

The local population overall is expected to increase by 13.9% by 2030; the 0-18 year age group by 14.2%, the 18-64 year age group by 8.1% and the over 65 years by 36.8%. The greatest rate of increase will be seen in those people aged over 85. In Trafford there is predicted to be a 78% increase, from the current 5,000, to 8,900 by 2030. The impact an ageing population will have on local health and social care services is a key consideration for local services.

The 2030 population projections represent a significant increase in demand for community based health and social care services, particularly for older people and those with more complex needs or at the end of their life. Taking this into account, the CCG and Trafford Council need to ensure services are developed to meet the challenges that these changes present, ensuring the best outcomes for patients and delivering within the financial constraints within the public sector. The redesign of services has to have an emphasis on reducing duplication and driving through efficiencies as well as meeting increasing patient expectations.

One of the greatest challenges in Trafford is the impact of health and social inequalities which are often masked by Trafford's positive outcomes. Using lower super output areas (LSOAs) as a measure of geography, 24 Trafford LSOAs are ranked amongst the 10% most affluent in England in contrast 9 are amongst the top 10% most deprived. Life expectancy is 10.6 years lower for men and 5.7 years lower for women in the most deprived areas of Trafford than in the least deprived areas. Deprivation has been shown

to impact on demand for and use of health and social care services. Integrated health and social care working in partnership with primary care and public health will reduce inequality across Trafford with the four neighbourhood model delivering accessible services to patients within each locality. Patients will be supported by local multi-disciplinary teams to remain independent for as long as possible.

In areas of deprivation, demand for health and social care services will be greater due to the evidenced relationship between poor health and social economic factors. In regards to this service it is important to acknowledge that cardiovascular disease, (CVD), cancer, diabetes and obesity are more prevalent in areas of deprivation.

However, it is also important to acknowledge that in the less deprived communities, particularly to the south of the borough, the population of older people who are living independently in their own homes is increasing and when support is required people are often more frail. Independence and isolation will also impact on demand, especially where the local family networks are not available.

It is clear that there is a need to improve health and life outcomes and service user/ patient experiences by addressing issues of access and reducing health inequalities. There is also a need to target resources to the most deprived areas and support those with the greatest health and social care needs. The reform and increasing the role of community health services, social care and primary care will support this and also ensure resources and efficiency across the public sector are maximised.

Overview of each Better Care Fund Project

Redesigning Frail and Older Peoples Services

Age related chronic and complex medical conditions account for the largest and growing share of health and social care budgets. However, people living with multiple health and social care needs often experience a highly fragmented service which leads to sub-optimal care experiences, outcomes and increased costs.

The Frail and Older Peoples programme will be clinically driven by the needs of this patient cohort and will seek to review and where appropriate, redesign health and social care pathways for service users. The project will seek to ensure all schemes are integrated and will support partners to ensure patients receive the best possible care, in the most appropriate setting at the right time.

The programme will be underpinned by the principles outlined in the *Silver Book* 2013. Pathways which do not support frail and older people are not included in the scope of this project although consideration will be given to all adult pathways where required.

It is anticipated that the programme will ensure the following outcomes for Trafford patients;

- All patients over the age of 75 years have the right to a comprehensive, single medical and social care needs assessment in order to respond to current, and anticipate future care needs. Any assessment must include mental health.
- Any urgent care service response to older people will be person focused and driven by individual need

- People will be treated as individuals with dignity and respect; their wishes and those of their carers must be acknowledged, with shared decision making based on clinical need
- Advanced and proactive care planning will be offered to all patients to support appropriate decision making for those with long term conditions and those approaching the end of their lives
- Where there is an urgent or emergency care need, frail and older people, their carers or professionals involved in care should only need to make one phone call to a central telephone number to mobilise a 24/7 integrated health and social care response to address their needs, be they physical, physiological, social or to support carers
- The use of telecare and telehealth will support older people to remain in their own homes, anticipate problems and to support treatment and monitoring and must be utilised prior to delivery of care
- Re-ablement services are not only relevant after discharge from hospital but also as part of the integrated health and social care response in managing older people with acute medical needs in the community when clinically acceptable to do so.

A comprehensive education programme will be developed to support the changes to services and practice. This will assist in the development and delivery of care packages that allow patients to retain their independence, receive appropriate care and place patient choice at the centre of service redesign.

Redesigning End of Life Care in Trafford

Trafford CCG's End of Life care project will be developed to address areas for improvement to ensure a proactive, person-centred and integrated end of life pathway which is based on best practice and delivers improved patient, family and carer experience. The project will also establish efficient and effective monitoring of commissioned services, through contract performance to ensure sound clinical outcomes and value for money.

The project will be responsive to the recommendations of other ongoing projects including the *Redesign of Frail and Older Peoples Services* and *Transforming Community Paediatrics.*

The project will deliver a redesigned end of life pathway for Trafford residents. Existing service provision will be reviewed and where appropriate redesigned to ensure that pathways across primary and secondary care, hospice care and community care are joined up and patients are able to access the most appropriate care when they need it most. In particular, community care and 'hospice at home' care will be developed to ensure that those patients wishing to remain at home in the final stages of life are supported to do so in a clinically safe and environmentally sensitive setting. This will inevitably impact on the demand for community health and social care services and the funding required to effectively support this.

Underpinning service redesign will be the implementation of new technologies to ensure that patient records are up to date and easily accessible across care pathways. Care plans for end of life patients will be available to individuals, their carers and professionals across the health and social care economy when required. This will ensure plans are followed by all partners, especially in the case of an emergency out of hours.

Trafford CCG recognises the crucial role which the third sector plays in delivering specialised support to patients at the end of their lives and will support and enhance community organisations to offer appropriate non clinical support to patients in the community.

Pathways which do not impact on end of life patients are not included in the scope of the project.

The schemes within the project will deliver a reduction in the number of emergency admissions and length of stay for patients at the end stages of life. The programme will also deliver an increase in the number of patients who are in receipt of an advanced plan and the number of deaths in a patient's preferred place of residence.

The development of a comprehensive education programme, involving social care, community services and nursing and residential care homes , will provide specialised knowledge and advice around best practice at the end of life, resulting in improved consistency and quality of care to patients**.**

A multi-disciplinary approach, to pathway review and programme implementation will improve the coordination of palliative care services across multiple organisations, resulting in greater holistic, person centred care delivery that improves patient experience and utilises the best use of Trafford health and social care economy resources.

Through the increase of advanced planning it is envisaged that in the future, the CCG will be able to demonstrate that an increased number end of life patients are dying in their preferred place of death.

Integration of health and social care and the development of an early help hub:

The integrated health and social care service for children and young people operating on a four neighbourhood model has been in place since 2007. Trafford has begun its journey to develop adult's integrated health and social care community services and integrated management structures will be in place by October 2014.

The intention is that by 2016 Trafford will have completed its journey to develop an all age, integrated and locality based health and social care service. This will ensure that Trafford's health and social care system works better for local people, but in particular for the most vulnerable residents.

The vision for Trafford is an integrated service delivery model that will offer effective team working through integrated structures that are multi-agency and geographically based in four localities; North, South, Central and West. These will be co-terminus with the four neighbourhood areas that are supported by the local strategic partners including Primary Care to offer synergy between the different providers.

Health and social care teams will work much more closely with local GPs, pharmacists, nursing and residential homes and other community providers clustered within defined areas. This will ensure that their patients have access to tools and information to support their wellbeing and that the more vulnerable e.g. frail elderly or children with complex health needs, have one care plan. This plan will be one that all the professionals and the

individual understand, own and act upon when necessary, including the emergency services.

The 'whole systems' multi-agency approach to achieving better life, health and emotional well-being outcomes for individuals coupled with care closer to home will be supported by integrated care pathways, personalised care and shared systems and processes.

The integration of health and social care will offer extensive opportunities to deliver services flexibly and collaboratively with an emphasis on a community approach. The working model will provide integrated management structures and multi-agency teams from a range of disciplines notwithstanding the clear lines of accountability in respect to professional leadership.

The integrated management and delivery structures, systems and processes will support a seamless service provision for patients/service users, offering improved access to advice, support, care and treatment achieving innovation and value for money.

This will be supported through an all age, integrated 'front door' to services ensuring that all local residents understand where to go to get support and have their needs quickly responded to.

Through this model there will be a greater focus on early intervention and prevention to manage the increasing pressure on health and social care services. It will also build on the principles of our 'stronger families' approach so professionals will work with all members of a family not just the individuals who need support for their more complex needs.

The flexibility of the community resources working together means that the support available to individuals and families can be stepped up and stepped down as their circumstances require; therefore resources are used more efficiently and a tailored package of support and care is provided.

Achieving our vision

In Trafford our processes for achieving our vision and making our ambition a reality is set out in our integrated plan, which highlights the commitment to:

- Re-balance the local Health and Social Care Economy – Trafford will target our resources on the major causes of ill-health and community breakdown to improve outcomes for Trafford patients and residents, but doing so at an appropriate cost so our resources across the health and social care economy are deployed to deliver best value.
- Health and Wellbeing Improvement –Trafford will utilise our own commissioning responsibilities and work with partners across the public, private and voluntary sector to protect good health and prevent ill health by ensuring evidenced based practice at the appropriate scale.
- Communication/Relationships – Trafford will continue to work closely with individuals, communities and other partner organisations, monitoring and enhancing effective partnerships that improve outcomes for patients and communities which is a key component of our planning process.
- Integration – Trafford will continue to commission and manage effective integrated

care pathways in partnership with our local clinical senate, the local Health and Wellbeing Board and other appropriate partnership structures. We will reduce duplication, improve co-ordination across settings and continue to re-design and transform services so they are people-focused to improve outcomes and the patient experience.

For further detail on these projects, please refer to section 2c.

b) What difference will this make to patient and service user outcomes?

The 3 projects within Trafford's Better Care Fund will all deliver changes to the population of Trafford. Although each project will deliver changes in the service delivery all will deliver;

- Enhanced local health and social care services
- Safe and high quality health and social care services with a skilled workforce
- Alternatives to secondary care through community health and social care services
- Reduction to unscheduled and scheduled activity at the 3 acute Trusts, Salford Royal Foundation Trust (SRFT) University Hospital of South Manchester (UHSM) Central Manchester Foundation Trust (CMFT)
- Improved co-ordination of patient care

The following sets the changes to patients and service user outcomes.

- Trafford residents will receive the right care, by the right person, when they need it, in the right place as patients will benefit from increased resilience and capacity in the community
- Locality services will meet the needs of patients and will better equipped to respond to their needs
- Through a proactive model, patients will be able to access support at an early stage which will reduce the need for more acute services
- Emergency and unplanned admissions will be reduced
- Re-admissions will be reduced
- Delayed transfers of care will be reduced for Trafford residents, regardless of which hospital they are using
- Length of stay at hospital will be appropriate to the clinical need of the patient
- Patients will benefit from early care planning by multidisciplinary teams
- Patient and service users will have a positive experience of care
- Reducing duplication for people using services
- Improved support to carers and families

For example by health and social care professionals working much more closely with local GPs, patients will have access to tools and information that they can use to support their wellbeing through the early help hub. Furthermore the more vulnerable e.g. frail elderly or children with complex health needs, have one care plan. The care plan will be available to all professionals to be used to support the individual patient's needs and requests.

There will be a greater focus on early intervention and prevention to manage the

increasing pressure on health and social care services. For example, we will be able to identify and act upon any child protection or adult safeguarding concerns quickly and either provides support to help the child or adult stay within their family or find another safe, loving home for them as quickly as possible. We will also build on the principles of our 'stronger families' approach so professionals will work with all members of a family not just the individuals who need support for their more complex needs. This will mean linking into the services provided by the early help hub to help resolve any wider issues which may be hindering them from being healthy, active and responsible citizens.

The overall model will reduce the demand from people entering services and also enable people to utilise existing resources to reduce their reliance on services and the likelihood of returning for additional support.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contributes to this?

As described earlier, Trafford Clinical Commissioning Group and Trafford Council have a strong, vision for the health and social care economy in Trafford, developed in partnership with key stakeholders.

The specific changes across the three key areas of activity are described below.

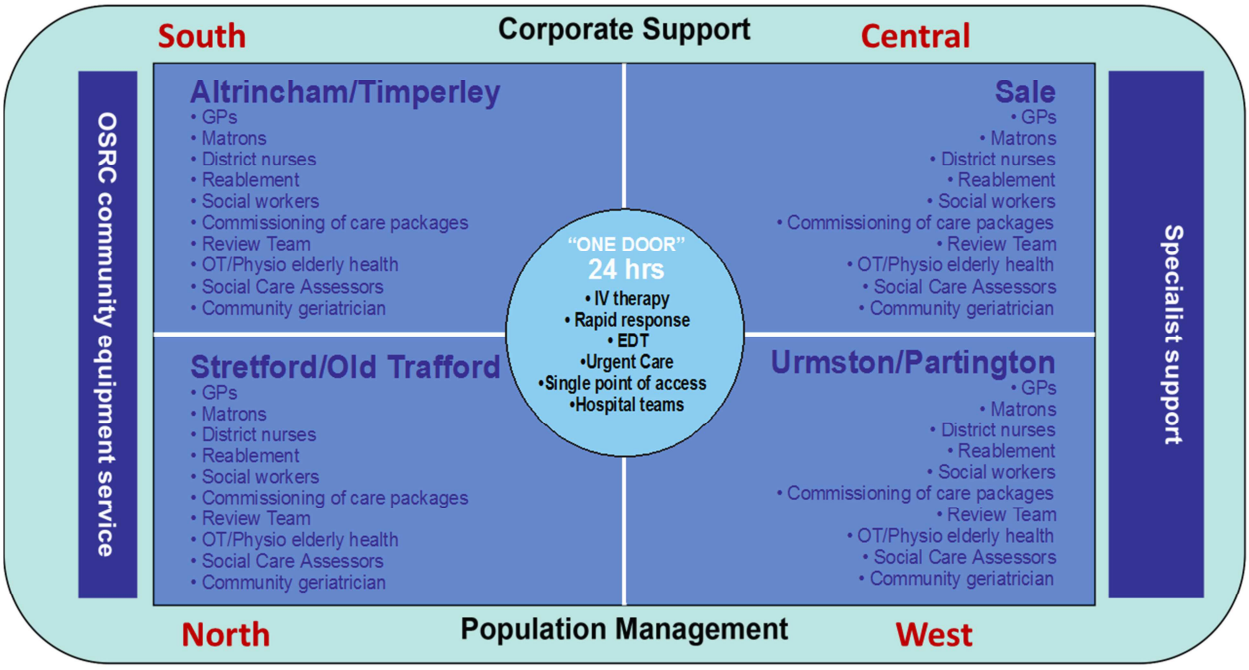
The integration of health and social care and the development of an early help hub:

Redesigned and Integrated Locality Teams and Pathways for adults

Over the next five years the people of Trafford will benefit from an increase in community health and social care services and greater and more seamless access to primary care, delivered through an integrated service delivery model, with multi-agency integrated structures based in four localities. This transformation to integrated care will support vulnerable, frail and older people to live longer, more independently and take greater ownership of their care as well as supporting those at the end of life.

The increase in out of hospital care will naturally lead to a reduction in people having to attend hospital both for scheduled and unscheduled care. The reconfiguration of acute trusts to accommodate this is being conducted across the Greater Manchester region through the *Healthier Together* programme.

By October 2014 Trafford will have multi-disciplinary teams compromising of health and social care professional such as GP's, social workers, practice and district nurses and therapist operating on a neighbourhood basis across the borough. This is displayed on the diagram below and mirrors the existing integrated model currently in place for children services;



The integrated care model will have both reactive and proactive elements, with a stronger emphasis on prevention and early intervention to prevent individuals deteriorating and needing more intense care and support at a later stage.

Integrated care teams will help people remain at home by utilising reablement, intermediate care, a community falls service and the urgent care response. Through this the model will provide step up from primary care to support the reduction of patient flows into secondary care and step down from hospital to support and ease discharge.

This programme of work will require investment through the BCF to assist with the delivery of this vision and ensure a reduction in demand within the acute sector, both for unscheduled and scheduled care.

Complex Care Co-ordination

Individuals at high risk of hospital admission with complex needs will be prioritised in the new integrated multi-disciplinary teams, and identified through a risk stratification tool. Their care will be co-ordinated and delivered through a single lead professional. The lead professional will be allocated based on the primary care needs of each person. Their care will be managed more effectively and the lead professional will improve the quality of the patients and carer experience as well as reducing fragmentation within the system. The lead coordinator will create a proactive care plan in agreement with the individual and their families. The service will work with NWAS and acute sector services, primary care and the Patient Care Coordination Centre as this goes live to contribute to Trafford's ambition of a 15% deflection rate for unscheduled activity over the next five years.

Care plans will be focused on promoting the individuals understanding of their care and support needs, self- care where appropriate and building health and social care community resources around the person, including crisis response plans to changes in someone's health and social care needs e.g. the use of rescue packs. This approach will

also encourage consultants to work in the community, reducing unplanned admission and changing the use of outpatient appointments.

This will contribute to the CCG's plan for care plans to be completed for all residents aged 75 years and over.

All Age Early Help Hub

In parallel with the focus on complex needs there is a commitment to focus on early intervention and general wellbeing, encouraging and fostering self resilience and independence, both for the individual and local communities. This is being built into all the revised models of care and includes the creation of the early help hub. This will provide a 'front door' for services to those that need information or support to maintain their own family's health and wellbeing. It will include a community screening function providing an initial assessment about appropriate next steps. The hub's key aim will be to manage the future demand on services, reducing the need for more reactive support from social care, community health and secondary care, by utilising low level voluntary and community options to maximise people's wellbeing and reduce social isoloation.

The early help hub will offer access to a range of support and advice services to complement the integrated health and social care service. This will include easy to use technology and a website that connects people to self-help tools and sources of support across a wide range of issues, including the Family Information Service. It will help people to reflect on how happy they are with their health and wellbeing, set goals and link to social network support.

The vision of the hub is that Trafford Citizens, of all ages, improve their health and wellbeing using their own resources, the support of their communities and a 'hub' of co-ordinated support and tools. By empowering individuals and communities to take more proactive responsibility for their wellbeing it will lead to healthier, happier and more resilient communities and reduced demand for health and social care.

All Age Integrated Locality Teams

Children's health and social care in Trafford is already an integrated service and operates on a neighbourhood model. By 2016 the intention is for this to join with Trafford's planned adults integrated community model to complete the journey to an all age, integrated and locality based health and social care service. This will incorporate the all age Early Help Hub to compliment the Patient Care Coordination Centre being developed by the CCG and will ensure that Trafford's health and social care system works better for all local people.

<u>The Redesign of Frail and Older Peoples Services</u>

Falls Service

At present Trafford Health and Social Care economy does not have a dedicated falls service; which results in a number of unplanned admissions into acute care. The patients who are most vulnerable do not receive any assistance/support to prevent them from having on-going falls and consequently hospital admissions. Within Trafford, work has commenced via the Public Health team to draft a Falls and Bone Health Strategy. This is

in line with national guidance and best practice. The CCG sees the prevention of falls as a priority for its patients but also to reduce the pressure on the A&E departments within the acute sector. Also a lack of this service provision has to be addressed in the support which the CCG wants to provide to this cohort of the Trafford population. Therefore, there are 2 work streams to address this priority,

- The development of the falls strategy – to be completed by September 2014
- The development of a Trafford Falls Service by April 2015

A falls service will consist of the following services;

1. A central co-ordinating hub which offers rapid response to those patients who have fallen including triage, medicines management and mental health
2. Locality based falls clinics offering physio, rehabilitation and appropriate advice and adaptions to enable patients to remain at home
3. Links to more specialised services where appropriate be they through community health and social care or a secondary care setting.

This scheme will require investment through the Better Care Fund however significant savings can be realised through the reduction in demand and the current flow of patients into the acute sector.

Intermediate Care

Following the implementation of the pathway changes for unscheduled care activity post the implementation of New Health Deal for Trafford, Trafford CCG wishes to review the current Intermediate Care Services across Trafford working with Community Health and Social Care services.

The objective is for the Trafford CCG to evaluate and to redesign the Intermediate Care Services across Health and Social Care. The timescales will be to provide an intermediate care offer from April 2015. From joint working with South Manchester CCG, this will be a joint review considering service provision in Trafford and South Manchester.

The model will provide both step up from primary care and step down from acute trusts. Therapies and rehabilitation will be a core part of the offer as well as linking to respite care and palliation for end of life patients. This will assist with improvements in the discharge planning for the acute providers.

Transforming Community Nursing

This will review and build on the current provision of community nursing provided by

- District nursing
- Community enhanced services
- Treatment rooms
- Community therapies

Each of these services have an existing service specification however these require review and aligning to changes which have taken place over the last 2 years. They also have to take into account a wider provision within the community to accommodate the changes in primary care to ensure delivery of the community standards.

The expected outcomes will be to:

- improve the quality of care received by patients in the community and enable patients to stay at home for longer, living independently, preventing emergency admissions and readmissions;
- Enable patients to be discharged from hospital in a timely manner and transferred safely and appropriately into a fully integrated health and social care provision in the community. This will reduce the length of stay in hospital; and
- Ensure patients have a positive experience of integrated care (health and social care teams) and are supported to manage their conditions. This will enhance the quality of life for patients with one or more long term conditions.

Alternative to Transfer Plus

Trafford CCG has set out in its Strategic Plan an ambition to reduce unscheduled care activity over the next 5 years by 15%. In December 2013, the Alterative to Transfer scheme was introduced. This includes clinically appropriate assessment by NWAS and a GP assessment of the patient in the first instance to consider a safe and clinical alternative to a hospital admission. To date, over 90% of patients accessing the scheme have avoided attendance and admission to hospital saving in the region of £600,000.

As a follow up from this and following the success of ATT, Trafford CCG will implement an enhancement of this scheme for nursing and residential care homes across the borough. By October 2014, nursing homes will be able to access the service 24hrs a day, 7 days a week. Linking the scheme to community health and social care services will ensure that patients are supported through equipment and 'step up services' to remain at home.

Primary care for nursing and residential care homes

A review will take place around the primary care provision for nursing homes in the borough. This work will build on best practice across the Greater Manchester region. The project will seek to ensure that patients are offered rapid access to primary care and a single professional to coordinate care on behalf of the patient. Any changes to primary care will allow capacity to be generated for the population as a whole, preventing unnecessary attendances at emergency departments. This capacity will closely link with the integrated health and social care neighbourhood teams.

Community Geriatrics

Alongside the review of primary care for nursing homes, Trafford CCG will undertake a stocktake of current community geriatrician provision. This will consider the effectiveness of current provision, value for money and the integration between secondary and community health care. As a consequence Trafford CCG will seek to develop a community geriatrician model which supports the most complex cases through the health and social care system, leading to appropriate and rapid care within a secondary care setting and ongoing support in the community whether that be in a patient's own home through a virtual ward or in a nursing/residential care setting. This will link with the integrated adult's model being developed.

Education Programme

In order to support the above scheme it is recognised that additional resource will be required to support a programme of education, training and awareness raising amongst patients, carers and health and social care practitioners to promote self-care. The education programme will seek to not only raise the profile of newly developed services but ensure that Trafford's integrated workforce have the appropriate skills to meet the needs of the elderly population. The training programme will also assist staff in nursing and residential homes to support staff in key skills and competencies to support patients who are currently entering secondary care inappropriately. The new model will increase the clinical support to these homes which will assist in patients remaining at home.

Redesigning End Of Life Care in Trafford :

Service Redesign

Over the coming years Trafford residents will benefit from greater, more seamless access to end of life care and support in a place of their own choosing.

Access to end of life services in Trafford will be reviewed across general practice, community services, secondary care, nursing and residential care and in a patient's own home.

Through the review of intermediate care, more provision will be made available to support respite care for patients who are deemed to be end of life and those who care for them.

Enablers

Education

An education programme will be developed to support professionals and carers in the delivery of end of life care. It is recognised that at present the are many misconceptions about the point at which a person becomes a 'dying person' at which treatment may end and care become palliative and about the level of certainty surrounding such judgements.

The education programme will support professionals to make clear to the dying person and those who are important to them when it is thought that the person is likely to be dying, explaining to them why they think this is and what this is likely to entail. Where a person's condition changes, this should be a trigger for making decisions to change care and treatment.

Open and honest communication between staff and the person who is dying, families and carers is critically important to good care. The education programme will ensure that professionals use clear, understandable and plain language, both verbally and through other forms of communication. Communication must be regular and proactive, two-way and in such a way that it maximises privacy

EPaCCS and advanced care planning

End of life care is provided by many professionals across a wide range of organisations, often working across varying geographical boundaries. Consequently, effective co-ordination of care is crucial for safe care delivery that supports the person to achieve their preferences and choices at the end of their life.

To support this Trafford CCG, will implement an Electronic Palliative Care Co-ordination System (EPaCCS). The national requirement of EPaCCS is that all electronic clinical systems contain the minimum data set for end of life care and that systems are interoperable with other systems making the minimum dataset available to all involved in a patients care. There are a stringent set of guidelines to ensure the EPaCCS system meet the requirements including interoperability, audit trail, and security.

The ethos behind the EPaCCS programme is the development of a single Advance Plan containing the choices of the individual patient for end of life planning. The aim of the system is to reduce repetition for patients and families, improve awareness of the choices made, and reduce the admissions to hospital in the last year of life and ultimately enable patients to die in the place of their choosing.

Across England CCGs have been tasked with leading this programme. It is expected that they will lead the health economy in developing and implementing the EPaCCS solution for their population. The national palliative care programme carry out regular audits to confirm compliance with EPaCCS with performance measured across England.

In order to support this Trafford has developed and will implement across the health and social care economy an advanced care planning document which can help patients prepare for the future. It will give patients the opportunity to think about, talk about and write down their preferences and priorities for future care, including how they want to receive their care toward the end of their life.

Third Sector

Trafford benefits from a diverse and thriving voluntary sector. Many organisations are already involved in the delivery of health care across the borough. As part of the review and redesign of end of life care services, Trafford CCG will work with the voluntary and community sector to identify current provision, map need and develop solutions which support the third sector to deliver non clinical care.

The review and redesign will support;

- Deliver end of life advice/support service in collaboration with Trafford Carers Centre (MPET)
- Map the current Third sector provision and how this can support existing and newly commissioned services through partnership working
- Develop community awareness campaigns regarding end of life

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Ageing population

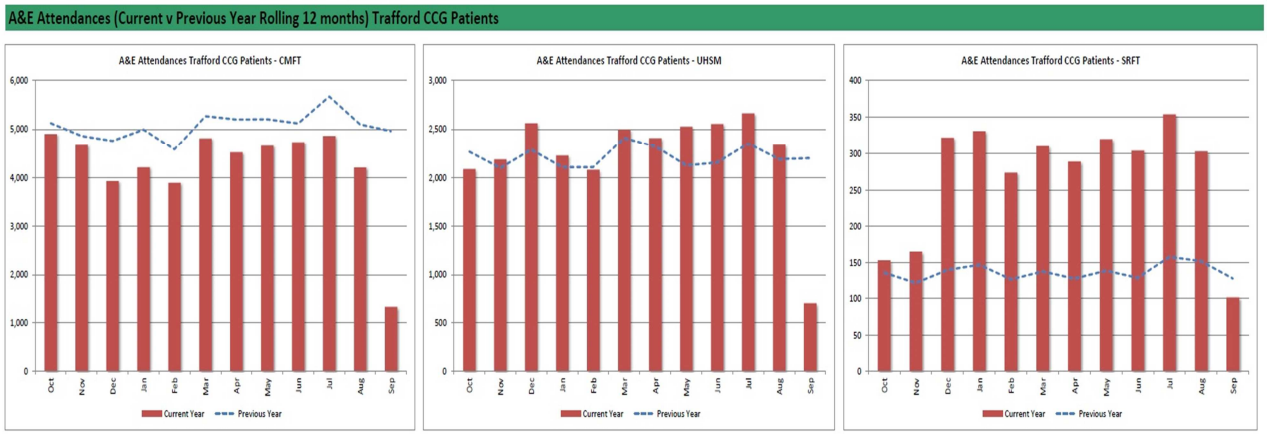
There are currently 35,300 people aged 65 years and over in Trafford, of which 5,000 are aged 85 and over. Projections suggest that by 2030 Trafford will have an additional 13,000 people aged 65 and over. These patients are increasingly presenting with more complex and challenging needs. Trafford has identified a number of key conditions which represent the greatest pressure on our acute trusts. These are; Falls, IV therapies, respiratory and COPD. Significant redesign of these services forms part of the 5 year strategic plan and elements are addressed within the Better Care Fund.

Over the last 5 years over 9000 Trafford Patients have been admitted to an acute trust as a result of a fall. This represents a spend of £22m excluding the costs to community health and social care services. Analysis of the data shows that whilst the average length of stay for these patients is 17 days (aged 65+), 58% receive no significant treatment. At present no specific falls provision exists within Trafford and the BCF will be used to develop and implement a community response to patients across the health and social care economy.

New Health Deal

In Trafford the flow of patients is complex and demand is placing extra pressure on the three acute trusts (UHSM, CMFT, and SRFT). Trafford PCT gave a commitment as part of the new health deal to deliver an integrated model to reduce this pressure and increase the activity across primary and community health and social care services. The model will also focus on prevention and education at an early stage so to support individuals to take responsibility for their own health and reduce the demand on health and social care services.

The graph below shows the changes in A & E attendances for Trafford patients since the implementation of the New Health Deal for Trafford.



As part of this Trafford CCG as set out in its 5 Year strategic plan is developing a number of new models of services which will deliver changes and reduce this demand, either in a preventative way or by reducing the length of stay for patients admitted to secondary care.

Risk Stratification

The Integrated multi-disciplinary neighbourhood teams will work with GP's and utilise a risk stratification tool to identify people at high risk of hospital admission. These individuals will be prioritised and allocated to the most appropriate professional within the team; this may be a social worker, practice or district nurse or therapist. In Trafford fully integrated mental health services already exist and as part of phase 2 of the integration programme this provision will be overlaid with the neighbourhood teams

The identified lead professional will ensure the person's care is coordinated and managed more effectively. The lead professional will improve the quality of the patients and carer experience as well as reducing fragmentation within the system.

The lead professional will meet with the individual to gain consent and to begin proactive care planning with the person and their families. Care plans will be focused on promoting the individual's understanding of their care and support needs, self-care where appropriate and building health and social care community resources around the person including crisis response plans to changes in someone's health and social care needs e.g. the use of rescue packs. This approach will also encourage consultants to work out in the community, reducing unplanned admission and changing the use of outpatient appointments. This earlier proactive care planning with GP's by social workers, nurses and therapists will require investment through the BCF.

Intermediate Care

As part of the new Health Deal for Trafford an intermediate care facility was commissioned in November 2013 with a bed capacity of 18 to support the change in patient flow for Trafford. This facility was unique being operationally managed by the CCG, clinical led by a general practitioner from our Out-of-Hours Provider with nursing and therapy provision by Trafford General Hospital. The monitoring and evaluation of this service over a 10 month period has allowed the CCG to evidence the requirement for intermediate care and allowed the enhanced model to be developed.

Whilst the capacity in the re-provision has reduced to 15 in-patient beds, the overall capacity has been increased with the addition of the virtual component of the delivery model. During periods of pressure, the redesigned model of care will have the ability to flex its in-patient capacity to meet those needs, reducing when the risk is removed

Community Nursing and Therapies

In 2011, 48 500 local residents were aged between 0-17 years, (22.4%), 133 500 were aged between 18-64 years (61.4%) and 35 300 (16.2%) were aged over 65 years old. Currently, the borough has a slightly higher percentage of older people than the profile of Greater Manchester as a whole[i].

The local population is expected to increase by 13.9% by 2030; the 0-18 year age group

by 14.2%, the 18-64 year age group by 8.1% and the over 65 years by 36.8%[ii]. The greatest rate of increase will be seen in those people aged over 85. In Trafford there is predicted to be a 78% increase, from the current 5 000, to 8 900 by 2030. The impact an ageing population will have on local health and social care services is a key consideration for the CCG.

For the community nursing service the increasing older population is a significant risk. Any redesign will need to ensure that the service is integrated, future proof, meets changing needs and is sustainable

Review of Respiratory and COPD

In 13/14 Trafford CCG's clinical programme focused on respiratory medicine. Initiated through a multi-disciplinary and multi-organisational respiratory panel the programme sought to address the following areas:

1. Greater expertise and support in the delivery and interpretation of Spirometry in Primary Care
2. The review and redesign of the existing Pulmonary Rehab Service
3. To 'test the concept' of an COPD Early Support Discharge Service (ESDS) at Trafford General Hospital

Spirometry in Primary Care: is fundamental to making a confident diagnosis of COPD, yet research has shown that it has been under-utilised and forms an essential investigation for diagnosis and severity assessment in people with COPD and other respiratory conditions. Evidence suggests that around a quarter of people on general practice COPD registers do not meet the diagnostic criteria for COPD and therefore may be receiving inappropriate and expensive therapies. This misdiagnosis is due primarily to the diagnostic spirometry failing to meet essential quality standards.

Within Trafford spirometry is most commonly delivered by Practice Nurses within their respective practices, the frequency of which depending upon the needs of their registered patients. There are approximately 4500 patients on the COPD register within Trafford. Trafford has commissioned a programme of education and mentorship that will increase the level of expertise, the accuracy of interpretation and overall quality of spirometry undertaken in General Practice across Trafford, reducing the variation and inequality of provision. This approach will develop a primary care workforce that is trained through an accredited training programme and confident in their ongoing ability to provide a high quality service to Trafford patients. GPs will be confident in the accuracy of their COPD registers and have increased knowledge of their cohort of patients diagnosed with COPD, enabling appropriate care planning and proactive management. In turn; patients will receive an accurate diagnosis, regular reviews and care management plans informed by accurate clinical information.

The benefits to this education and mentorship programme will translate into efficient management of those patients at a higher risk of exacerbation who would have routinely been overlooked and as a consequence admitted to hospital unnecessarily. Once a primary accurate diagnosis is confirmed general practice are then able to optimise medication and offer anticipatory techniques that will support patients at risk of exacerbation guaranteeing appropriate management of their condition at home. This process overall will assist in the reduction of unnecessary attendance and subsequently

admission to hospital.

Community IV – admission avoidance

Trafford has commissioned an IV therapy service which allows patients who are medically stable and whose only reason for admission is the requirement for IV antibiotic therapy, to be treated in an outpatient setting. The key objective of the service is to safely and effectively manage patients with infections, ensuring their treatment is optimised, appropriately delivered and supervised and that risks are minimised.

Patient benefits:

- Improved patient satisfaction
- Decreased Hospital acquired infection including Clostridium difficile
- Admission avoidance/Reduced length of stay
- Prevents social / psychological problems associated with admission
- Allows choice of therapy to suit individual needs
- Delivery of care in greater comfort and privacy
- More rapid return to normality (work, education etc.)

Adult Social Care

Trafford Council's gross projected spend for 2014/15 on adult social care packages of care for those aged 75 years and over is £20.7million. This represents 82% of all spend on for older people (aged 65 year and over) and 59% of the total adult spend on care packages (for people aged 18 years and over). Community health and social care services will be redesigned to improve patient experience and to meet these financial challenges.

End of Life Outcomes

At present there are on average 1700 deaths a year in Trafford with many of these expected, however performance against measures such as the length of stay at hospital (16 days) for end of life patients, the number having an advanced care plan in place and those able to die at a place of their own choice require improvement. Through the BCF, Trafford CCG will review and where appropriate redesign end of life pathways for patients to ensure that their needs are met in a sensitive and clinically safe way.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

The 3 projects which form the basis of Trafford's Better Care Funds have fully developed PIDS which set out the full details and scope of these projects together with the desired outcomes and deliverable.

The key milestones associated with each of these projects are outlined below:

A summary of the integration of health and social care and the development of an early help hub milestones are outlined below:

Date	Event
Mar 2014	Integration project set-up complete
Jun 2014	Complete engagement phase to co-design early help hub model
Jul 2014	Early help hub project implementation plan and work streams in place
Aug 2014	Early help hub project development team in place
Jun 30th 2014	Formal integration information and consultation document issued
Jul 13th 2014	Collation of feedback from staff
Jul 14th 2014	Staff integration consultation meeting (48 days consultation meeting)
Jul 14th onwards	Training offered to staff and locality roadshows held
Jul 16th 2014	Individual meetings with affected staff held
Aug 31st 2014	Close of staff consultation – integration
Sept 5th 2014	Collate staff feedback, review and amend integration proposal
Sept 8th 2014	Final structure and response issued to staff
Sept 12th 2014	Expressions of interest submitted by affected staff
Sept – Oct 2014	Interviews
Nov 5th 2014	Appointments confirmed and integrated management structure in place
Oct 2014	Pathway redesign started
Oct 2014	Public consultation – all age integrated care model started
Dec 2014	Public consultation – all age integrated care model finished
Dec 2014	Co-location of adult staff
Feb 2015	Council decision on all age integrated care model
Mar 2015	Detailed implementation plan agreed for all age integrated care model
Apr 2015	Integrated adults pathways in place
Apr 2015	Integrated adults systems and process in place
Apr 2015	Functional early help hub developed

A summary of timescales relating to the redesign of Frail and Older Peoples services is outlined below;

Date	Event
Falls Service	
November 2014	Development of the service needs
April 2015	Implementation of new service in South and Central Trafford & Review
April 2016	Implementation of service in North and West & Review
April 2017	Relocation of South and Central Falls Clinics & Review
April 2018	Review of new service and consideration of enhancements
Intermediate Care	
Complete	Scoping of current provision and need
November 2014	Service Specification and business case (Joint with South Manchester CCG)
April 2015-16	Roll out of integrated intermediate care offer
April 2016	Service Review
Alternative to Transfer Plus	
September 2014	Business Case for Alternative to Transfer Plus
October 2014	Implementation of service
March 2015	Service review
Primary Care for Nursing Homes	
September 2014	Borough wide review of existing primary care provision to nursing homes
October 2014	Redesign of model if required
April 2015	Implementation of new model (phased)
April 2016	Service review
Community Geriatrics	
August –October 2014	Review of current provision
October	Considerations of recommendations of new proposed model
April 2015	Implementation begins (to be considered alongside review of general practice for nursing homes.
Education Programme	
June – October 2014	Identification of issues requiring professional development
October 2014 – march 2015	Development of specific education projects
April 2015 onwards	Roll of education programmes to support service redesign as each model goes on live

A summary of timescales relating to the redesign of end of life care in Trafford;

Date	Event
Service Review	
June 2014	Review and redesign of EOL care plan for the dying patient
July – Nov 2014	Mapping of current service provision, identification of need – include Acute, Community and Hospice Service
Nov 2014 – Jan 2015	Consideration of recommendation commissioning of new services
Enablers	
March 2014	Implementation of new advanced care planning

August – November 2014	Implementation of EP & CCs
November 2014 – March 2015	Development of Education Programme
March 2015	Implementation of ECL Plan
July 2014	Application for MPET Funding
Third Sector	
July – November	Review of 3rd Sector provision
November 2014 – January 2015	Consideration of recommendations
January- March 2015	Implementation of recommendations

The implementation of locality working across primary care will drive the development of a range of locally commissioned enhanced services, designed around the needs of the locality population. These services will be provided to the locality rather than an individual practice level thus ensuring a broader, equitable and accessible range of services than is currently offered. Delivered from locations based in localities that integrate with other services such as community and social services, will provide improved quality through multidisciplinary care teams designed to keep care delivery outside of hospital settings.

All NHS Trafford CCG general practices operate the nationally directed enhanced service to avoid unplanned admissions to hospital. This service is designed to reduce avoidable unplanned admissions by improving services to vulnerable patients and those with physical or mental health needs who are at high risk of hospital admission or readmission. The services aims to increase practice accessibility via timely telephone access, identify patients who are at high risk, establish a case management register and proactively manage these patients, review the hospital discharge process for patients on the register and coordinate delivery of care, and undertake internal practice reviews of emergency admissions and A&E attendances. This service will dovetail with developments as part of the Better Care Fund to develop whole system commissioning approaches to enable outcomes of reducing avoidable unplanned admissions.

b) Please articulate the overarching governance arrangements for integrated care locally
c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

Trafford's Health and Wellbeing Board is established with representatives from CCG, local authority, health providers, third sector, and police. The Joint Health and Wellbeing Strategy was approved in 2013. The delivery of this strategy is supported by a Health and Wellbeing Delivery Programme Board which has responsibility for delivery based on a collaborative approach with a wide range of stakeholders. The Boards are responsible for the realisation of priorities reflected in the Health and Wellbeing Strategy, all of which are underpinned and aligned to the integrated health and social care commissioning intentions across Trafford CCG and Trafford Council.

In addition Trafford CCG has an established Integrated Care Reference Board (ICRB), which is the forum for all health providers, the Council and the neighbouring CCG's to work together to agree and monitor the progress of Trafford's integration plan. Trafford CCG and Council use this forum to monitor progress of the integration programme and more recently BCF projects. This provides the opportunity of senior representatives from

health providers to influence the co-production of service redesign and the opportunity to challenge. For each scheme a PID is presented which sets out scope, expected changes in activity, service and income flows. It also provides the opportunity through out the project for the ICRB to receive changes on redesign and the evidence to invest in and service models and the implications of the shifting of resources from acute into primary and community health and social care services. ICRB monitor the progress of each scheme in line with the CCG's Strategic Plan.

There is an established governance structure in place which reports into the ICRB.

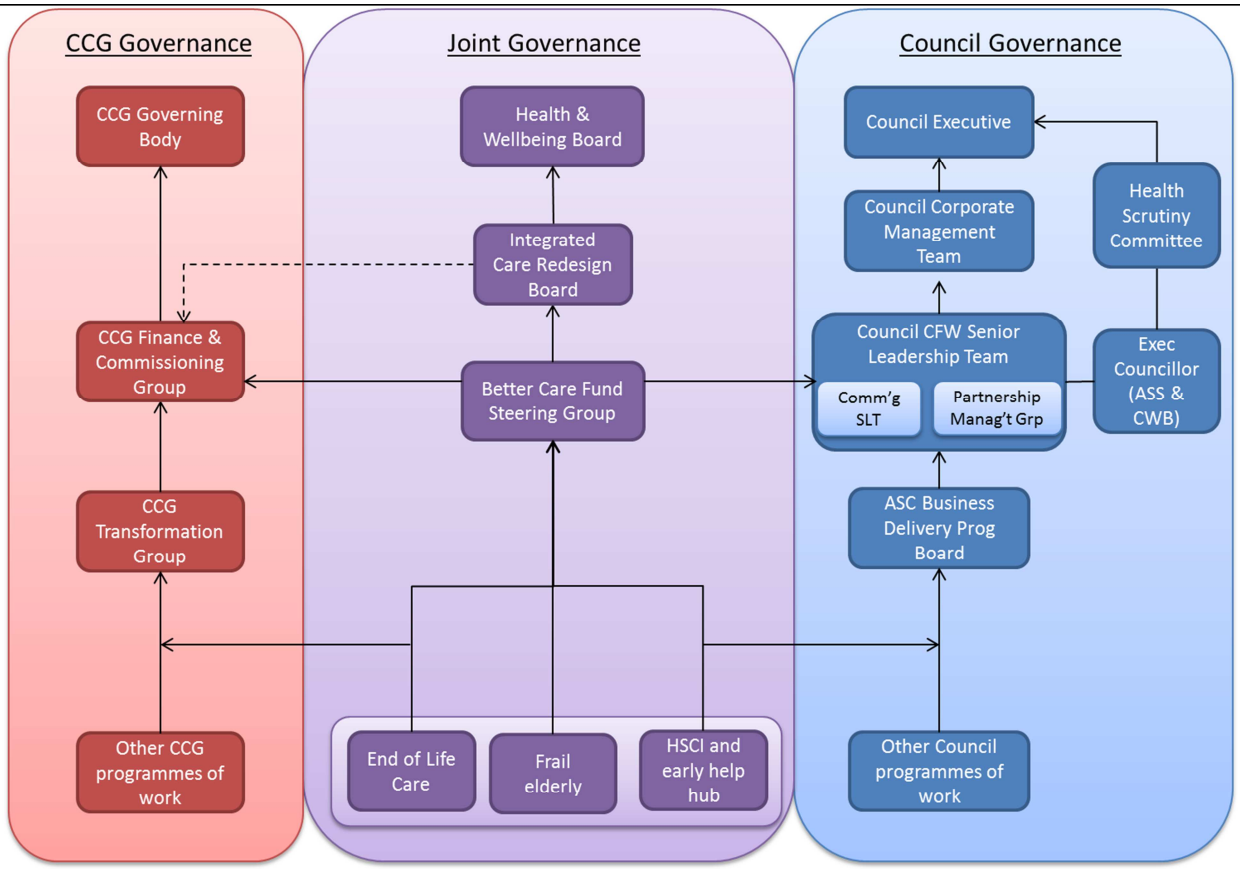
Each project has dedicated commissioning operational and clinical leads which work collaboratively with operational managers from service providers, the third sector and patient representatives. This provides the opportunity for provider organisations to understand the implications on their own organisations for changes to services

A BCF Steering Group has been established and is responsible for ensuring the overall direction, implementation and successful delivery of the BCF for Trafford. This is responsible for joint decisions on the BCF spend and subsequent monitoring in addition to overseeing the programmes of work identified. The Steering Group is accountable to the Health and Wellbeing Board. The BCF Steering Group includes members from Trafford Council and Trafford CCG. This is attached at Appendix 1.

The responsibility of the BCF steering group is to monitor progress and receive monitoring and exception reports from the three projects. The Transformation Group is a forum where any barriers to progress and delivery from the three projects will initially be presented and remedial action agreed and activated. It is the responsibility of the senior accountable officers for BCF to report this to the monthly BCF steering Group. The BCF steering group will also have sight of this as part of the exception reporting.

The delivery of the Better Care Fund is overseen by senior representative from the CCG and Trafford Council namely the Associate Director of Commissioning and Deputy Corporate Director, Children, Families and Wellbeing Directorate ,Director of Service Development, Adult and Community Services. The CCG governing Body receives an update as part of the regular reporting.

The joint governance arrangements are outlined below.

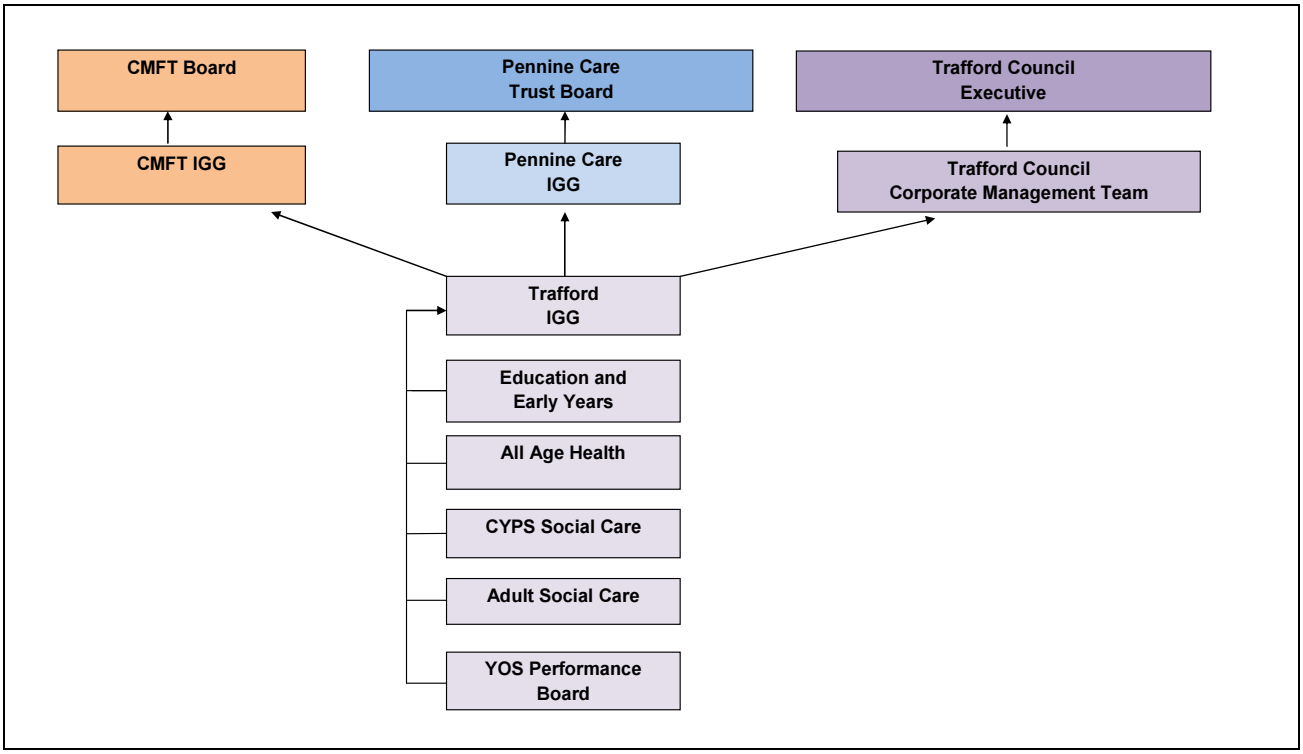


The CCG has a dedicated programme office accountable The Associate Director of Transformation who supports each work stream and project lead to monitor and report**:**

- **progress**
- **measured improvements**
- **risk**
- **barriers to delivery**

This is accountable to the transformation group which is part of the CCG's internal governance framework but has senior representation from the local authority children's and adults commissioning teams and Pennine Care Trafford Divisional lead.

The all age community health and social care integration model in Trafford is underpinned by a Section 75 agreement between the three key statutory agencies; Pennine Care FT, Trafford Council and Central Manchester FT. This arrangement requires strong governance to be in place to provide compliance assurance in respect to delegated authority. The assurance for the service delivery and performance of Trafford Children's and Young People Service and Adult Social Care services is provided from the Service Directors via Trafford Integrated Governance Group (TIGG), which is a joint governance arrangement between the three partner agencies. The TIGG reports directly to Pennine Care FT Executive Board and Trafford Council Management Team and is chaired by the medical Director at Pennine Care FT. The governance arrangements are displayed in the diagram below;



d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	**Review and Redesign of Frail and Older Peoples Services**
A	Provision of a Falls Service
B	Reprovision of Intermediate Care
C	Alternative to Transfer for Nursing Homes (admission avoidance scheme)
D	Review and Redesign of Community Geriatrician Model/ Primary care model
E	Transforming Community Nursing
F	Education Programme to support redesign as stated above
2	**Review and Redesign of End of Life Care in Trafford**
A	Review and Redesign of Service Provision
B	Education, Enablers and Technology
C	The role of the third sector in end of life care
3	**Community Health and Social Care Integration and Early Help Hub**
A	Redesign and integrated locality teams
B	Redesign and integrated pathways (Linked to schemes above)
C	Complex care coordination
D	All age early help front door/hub

E	All age integrated locality teams

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Operational risks which result in milestones not being achieved within the project plan	4	2	8	Identified risk should be dealt with at a project level if not escalated to Transformation Group for remedial action. Schemes which will impact on reduced A & E activity are also reported at Trafford's System Operational Resilience Group
Lack of engagement from stakeholders at an early stage across the health and Social Care economy	3	3	9	Provider organisations and the third sector to be involved and engaged throughout the process. They are also members of the HWB Board, which oversees the programme. Regular reports and issues will also be flagged to the Integrated Care Redesign Board (ICRB), which has representation from all providers operating in Trafford
Provider organisations not understanding the impact of service changes on their own organisation	3	3	9	Provider organisations are involved in the redesign of services from an early stage through to the monitoring and review of service changes.
The financial plans and joint	3	3	9	The discussions are being driven and

risk sharing plans are still being developed				overseen by the BCF Steering Group. This group will monitor the use of these funds and take recommendations regarding the shared financial resource through the Council and CCG governance structures. Ultimately this will be agreed by the HWB Board, who have final approval
The redesign of services resulting in increased demands being placed on community services may result in a delayed reduction in A and E activity	3	3	9	Establish a robust performance management framework, ensuring the BCF Steering Group have rigorous oversight of the performance metrics and can regularly review and monitor performance. Also monitor through the Trafford SROG where all stakeholders are represented. This is also monitored at The Pennine Care Contract Board.
A successful Integrated Care model requires a skilled workforce to respond to new demands and clinical requirements	2	3	6	For Primary care the CCG has a dedicated team to oversee the primary care education development programme. This is also monitored at the Primary Care Strategy Group. Pennine Care are fully engaged with all redesign of services which impact on their staffing and workforce establishment.
Secondary health services not decommissioned to release funds and shift resources into the community.	2	5	10	BCF Steering Group to oversee and agree the direction of travel. Continue conversations with provider organisations about the strategic direction and ensure appropriate contracts and service specifications. ICRB will be the forum for discussions at a senior level.
Lack of commitment	2	4	8	BCF Steering Group to oversee and agree the

from the voluntary and community sector to support the shift to early intervention and prevention activity.				direction of travel. Continue conversations with the voluntary and community sector about the strategic direction, utilising the Thought Chamber. Ensure appropriate contracts and service specifications are in place to facilitate this
Reducing available spend in the face of increasing demand and uncertainty about the scale of additional burdens monies that will be available in 2015/16	4	5	20	Council finance lead to keep the BCF Steering Group updated on progress with this, including potential projections and any DH allocation decision
The baseline for the older people permanent residential admissions measure included as part of the BCF metrics is calculated using the old methodology in the ASCCAR annual return. From 2014/15, this information will be generated from the new SALT return. There is no indication as to what the overall implications of this will be and the impact on the figures reported.	2	2	4	The DH has been made aware of this change; the council's performance lead will keep the BCF Steering Group updated with any progress and monitor the impact once the first calculation has been done using the new methodology.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place

i) between commissioners across health and social care and ii) between providers and commissioners

At the time of issue this section is still being completed

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Care Act

At Trafford a programme of work is underway to prepare for the wide range of reforms and changes that are articulated in the Care Act to ensure Trafford is fully prepared to implement these. The changes will start coming into place from April 2015.

The Care Act is an historic piece of legislation that will make a difference to some of the most vulnerable people in society for many years to come. It places care and support law into a single, clear modern statute for the first time and enshrines the principle of individual wellbeing as the driving force behind it.

The Act represents the most significant reform of adult care and support in over 60 years, putting people and their carers in control of their care and support and introducing a cap on how much people will have to pay for the costs of care in their lifetime. It also delivers key elements of the Government's response to the Francis Inquiry. This will significantly impact on the integrated neighbourhood teams, these have been mapped and the interdependencies identified.

Telecare

Trafford Council in partnership with Trafford Housing Trust developed and implemented a telecare service in 2012. This service supports vulnerable people to remain living independently at home for as long as safely possible. This supports the BCF plans to prevent or reduce the need for hospital admissions, residential and nursing care and the level of domiciliary care required. In Trafford 2400 people have accessed telecare since 2012 with a range of devices including Epilepsy sensors, GPS locators, extreme temperatures sensors and the traditional pendant alarms. This programme supports a range of initiatives including frail and elderly, falls prevention and personalisation. The telecare service is one of many interventions that supports people to remain independent and often is linked with adaptations in the home, community equipment and home care. Future developments with the CCG aim to add telehealth services to complement the existing telecare programme.

Housing Strategy

One of the key objectives of Trafford's housing strategy is to grow opportunities for the residents of Trafford to improve health outcomes and promote independence. These objectives are particularly focussed on tackling; health inequalities between the north and south of the Borough, the future demographic increase in the number of people aged over 65 and 85, and promoting choice and control and the range of support services that are available to people to help them live at home and stay healthier and fitter for longer. Trafford's Strategic Housing Partnership is represented on the Health and Wellbeing Board and are key partners in the delivery of the health and wellbeing strategy. Key activities include healthier and warmer homes, lifetime homes and aids and adaptations, development of new extra care housing and the development of preventative support services provided by social landlords.

Personalisation

The development of personalisation in Trafford resulted in the offer of a personal social care budget to all eligible service users as an alternative to a commissioned service. These personal budgets could be taken as a direct payment by the individual, family or carer or as a virtual budget managed by the local authority. This gives choice and control to the individual over decisions on how their care needs are met and this will continue to underpin the integrated community teams. To support this initiative Trafford Council recognised the need to develop the marketplace to ensure good quality providers were ready to meet the range of needs that personal budget holders presented. This resulted in the development of the My Choice Marketplace a personal budget consortium with an online market that service users or brokers can access to choose the service that meets their needs.

In addition to 3 projects identified within the Better Care Fund , Trafford CCG support by Trafford Council are procuring a patient co-ordination Centre (PCC) This will co-ordinate the care for Trafford Patients and provide a single access for all its users. This will be the overarching catalyst which supports all these projects to deliver change, deliver improvement and to reduce the current inefficiencies with the Health and Social Care System. The PCC is being procured through a competitive dialogue procurement process.

Trafford Patient Care Co-ordination Centre

This will be an innovative and dynamic solution to deliver refined coordination for all patients and service users. The Patient Care Co-ordination Centre (PCCC) will be tried and tested to meet the needs of Trafford's local population. This PCCC is an innovative and ground breaking development and will be responsible for the delivery of seamless, coordinated, quality care, and which ensures that a high quality solution to the coordination of care is developed. A high level vision of the deliverables for the PCCC have been developed, this is detailed below:

Principles

- Health and Social Care Proactive System
- Patients always get the right care at the right time, in the right way through a journey which is seamless and smooth
- A focus on complexity and vulnerability

Infrastructure

- Single point of access
- Single 'live' directory
- Supported by IT infrastructure
- Access to all records i.e. enabling patient/client care plans feeding into proactive planning
- Alignment to 111 and out of hours
- The PCCC will have a robust interface with and awareness of Trafford Council's and Pennine Care's integrated health and social care service.

Benefits

- Proactive and coordinated care seamlessly around the patient
- Delivery of the right care at the right time in the right place
- The level of care will be delivered from the appropriate care setting
- Provide the best possible patient experience.
- Greater focus on local issues e.g. health appointments and transport in Partington
- Report on the performance of care across the system
- Proactive Care Planning to meet health and social care needs
- Improved health outcomes, wellbeing and quality of life

Core Services

- Tracking of patient journey
- Close monitoring of vulnerable patients, following them through the care journey
- Health Transport Bureau
- 'Auto pick up' patients as they go through the system
- Clinical coordination to support monitoring of patient/clients and appropriateness of care to need

Full capability and capacity to gather, analyse, act on and learn from thus demonstrate achievement of measurable improvements in patient experience.

Trafford CCG has co-ordinated estates across Trafford from an early stage as it is imperative that we have the appropriate buildings across Trafford to deliver community and primary care services from. The buildings need to fit for purpose and provide high quality and high technical care. These also accessible to those patients who most require them.

Although Trafford is not a challenged health economy, Trafford CCG is participating in the South Sector reconfiguration and the outcome of this may severely impact on the flow of Trafford patients. Therefore incorporating more services into an out of hospital model provides greater assurances for patients, families and professionals.

Trafford's Primary Care Strategy sets out the ambition for consistency of all practices to use the same IT solutions and for this to be aligned to community health and social services. This is being progressed separately and progress reported through the internal CCG Transformation group

The CCG and Trafford Council both have active communications and engagement teams who engage with all service redesign projects and actively support the necessary communications which need to be shared internally and externally. All progress on BCF projects as outlined in this document are regularly reported to the ICRB, Health and Wellbeing Board and Trafford CCG Governing Body (Public Forum).

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

As set out in the Strategic Plan the vision for NHS Trafford is

"To ensure that the health services we manage for Trafford are provided at the right place at the right time, and that's services are safe of a high quality and are value for money"

This will be delivered through the CCG's strategic objectives and all the three BCF projects are aligned to delivering this vision

As set out in the Strategic plan, particular focus is on identifying particular people who are at risk of developing conditions or exacerbating existing conditions and proactively managing them. Over the next five years the people of Trafford can expect to see a far greater range of community health and social care services and easier access to primary care and the BCF projects for Health and Social Care integration and Frail and Older people very much align to ensuring these individuals receive improved experience.

The redesign of these services will naturally lead to a reduction in people having to attend hospital for their care and this will be aligned to the reconfiguration of acute services through the *Healthier Together Programme*. The BCF will continue the collaborative working between the local authority and CCG in delivering enhanced quality whilst ensuring financial stability across the health economy.

The decision to implement a PCCC has been made to support the whole integration programme within Trafford. This will provide a single access point for patients, families and carers as well as professions which will support patient flow between multiple providers and will drive efficiencies and improve patient experience. The PCCC will bring together a number of interdependencies including the three identified BCF projects. The PCCC will be an overarching IT solution which will have all patient information fed through a single portal which will enable staff within the centre to use and direct information to appropriate clinicians and health professionals to improve patient pathways. All BCF projects are aligned with this vision.

As set out in the CCG operational plan, the schemes set out in the Better Care Fund will align with the reduction in activity within the acute trusts.

The development of an education programme to support these programmes may enhance the reduction in activity further, though this is not included in the figures above. Projected activity across UHSM, CMFT AND SRFT in 2015-16 is 17246 patients. This relates to emergency admissions only and accounts for acute trusts where patient flow greater than 5%

Trafford Health and Wellbeing Strategy

The Strategy was developed by Trafford's Health and Wellbeing Board. It is the overarching plan to improve the health and wellbeing of children and adults in the borough and to reduce health inequalities between the north and south of the borough. It is a working tool which concentrates on highlighting Trafford's challenges and provides

visions for a coherent approach for partners involved in improving health and wellbeing across the borough.

The Trafford Partnership Community Strategy and Vision 2021

In 2014 a refresh of the Community Strategy was carried out, which revisited the vision and outcomes, to ensure the partnership is focused on achieving improved outcomes over the next 7 years. It was also important to reflect changes in the environment, economy and community and the accomplishments since it was initially developed. The Trafford Partnership Community Strategy and Vision 2021 sets out what Trafford wants to be like in 2021, by working together with organisations and communities.

The new vision and priorities have been developed in consultation within the Trafford Partnership, including the Strong Communities Partnership and the Diverse Communities Board, both of which have community representation on them.

Trafford is a place where our residents achieve their aspirations, and our communities are thriving. By working together:

- Trafford's residents will have equal opportunity to be healthy, safe and prosperous, with fair access to housing, education, jobs in a flourishing, clean, green and sustainable local community.
- Trafford's communities will take positive action to improve their local area and support those living amongst them in vulnerable situations, in partnership with services and businesses
- Trafford's businesses will have the skills, investment environment and infrastructure to achieve their ambitions and be successful.

Trafford will be a place people enjoy, with excellent cultural, sporting and heritage attractions and vibrant town, shopping and entertainment centres.

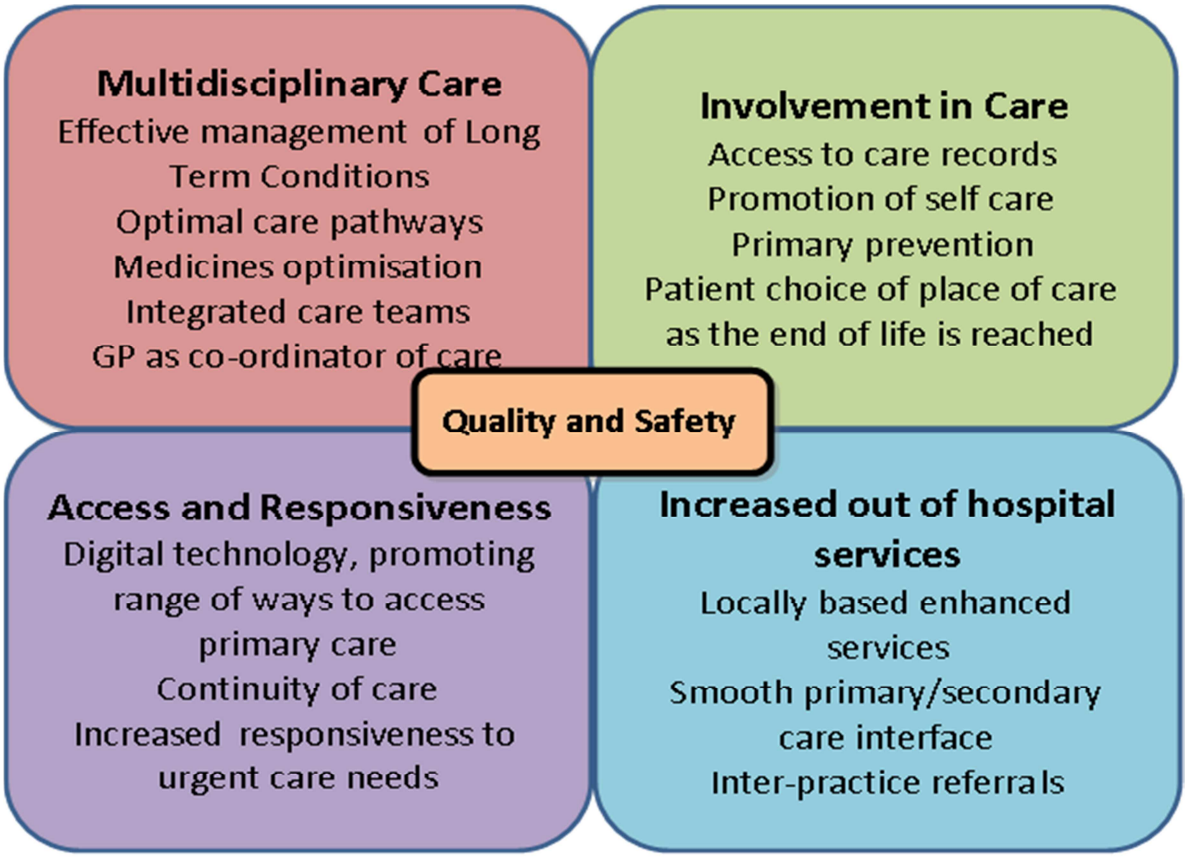
c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Trafford has used the opportunity of co-commissioning to revise its Primary Care Strategy.

The new strategy aligns to the projects which are included within the Better Care Funds.

Trafford Health and Social Care has always strived to deliver integrated care as an alternative to the traditional secondary care model, to provide high quality and accessible services in the community. Integrated care has to deliver improved pathways and working between primary care and the rest of the health and social care system. In delivering this model more patients will receive the right care, by the right person, in the right environment, with more care taking place out of the traditional environment where this is appropriate. These operating principles apply to both portfolios within the co-commissioning of primary care in Trafford and better care fund. Both are equally focussed on delivering the GM Primary Care Strategic requirements illustrated below.



Trafford Locality Integrated Care Model

Co-commissioning within Trafford will better enable the CCG, alongside NHS England, to take responsibility for Primary Care IT systems, estates, APMS contracts and enhanced services to deliver responsively on the outcomes within the commissioning strategic plan.

The Better Care Fund schemes and the Primary Care Strategy both have a collaborative locality model for integrated primary care at their heart. Securing the benefits of federated working, whilst retaining the individual practice ethos will enable the BCF projects to deliver outcomes for patients.

The map below outlines the localities for general practices in Trafford, underpinning the BCF projects and primary care strategy.

Trafford CCG will continue working with its member practices and patients to define and develop the model of locality integrated care for Trafford. This will be a phased development of integrated care over the next 4 years, determined to some extent by the capital build programme for Trafford.

Much work has already been undertaken with community services and local authority partners to facilitate the implementation of an integrated care model under the governance of the integrated care programme board. Any model of integration by Trafford general practices, would seek to maximise the benefits of the locality arrangements of the community service and local authority model. This would provide Trafford patients with a fully integrated primary care system, with wrap around services provided by partner organisations involved in the health and social care provision of patients working from locality hubs where appropriate.

Each locality is supported by named community matrons, district nursing, social worker teams, urgent care teams, community integrated care teams, intermediate care HP team, community geriatricians and IV therapy teams, CAMHS and young offender early help, social workers, school nurses, health visitors, connexions, youth workers, and education workers.

It is envisaged that the model for integrated community and social care, and the adult integrated care model for general practice, will overlay each other to provide a level of integration that patients and health and social care workers feel can make a real difference to improving the quality and continuity of care in Trafford.

Frail and Elderly Patients, Long Term Conditions Patients, and High Intensity Users of Services

BCF developments support the primary care shift to proactive care of frail older people. Co-commissioning will provide the opportunity Trafford CCG as set out in the CCG's 5 year strategic plan to work with member practices to secure a more robust and sustainable model for general practices across Trafford.

The co-commissioning of primary care seeks to build upon the locally commissioned portfolio to increase the access to and range of services offered outside of hospital environments. The BCF projects are developed in synergy with these primary care developments.

This strategy will drive improvement to, and reduce variation of disease registers of patients in Trafford. This will provide increased identification of and proactive care to, increased numbers of patients with long term conditions. The aim of both primary care and BCF developments seek to reduce the health inequalities within Trafford.

Enhanced Primary Care Access and Continuity

A key part of co-commissioning is to improve access to primary care and support the locality model for integration, a model of enhanced access, supported by BCF projects will be secured in Trafford to keep care closer to home, with improved continuity of care.

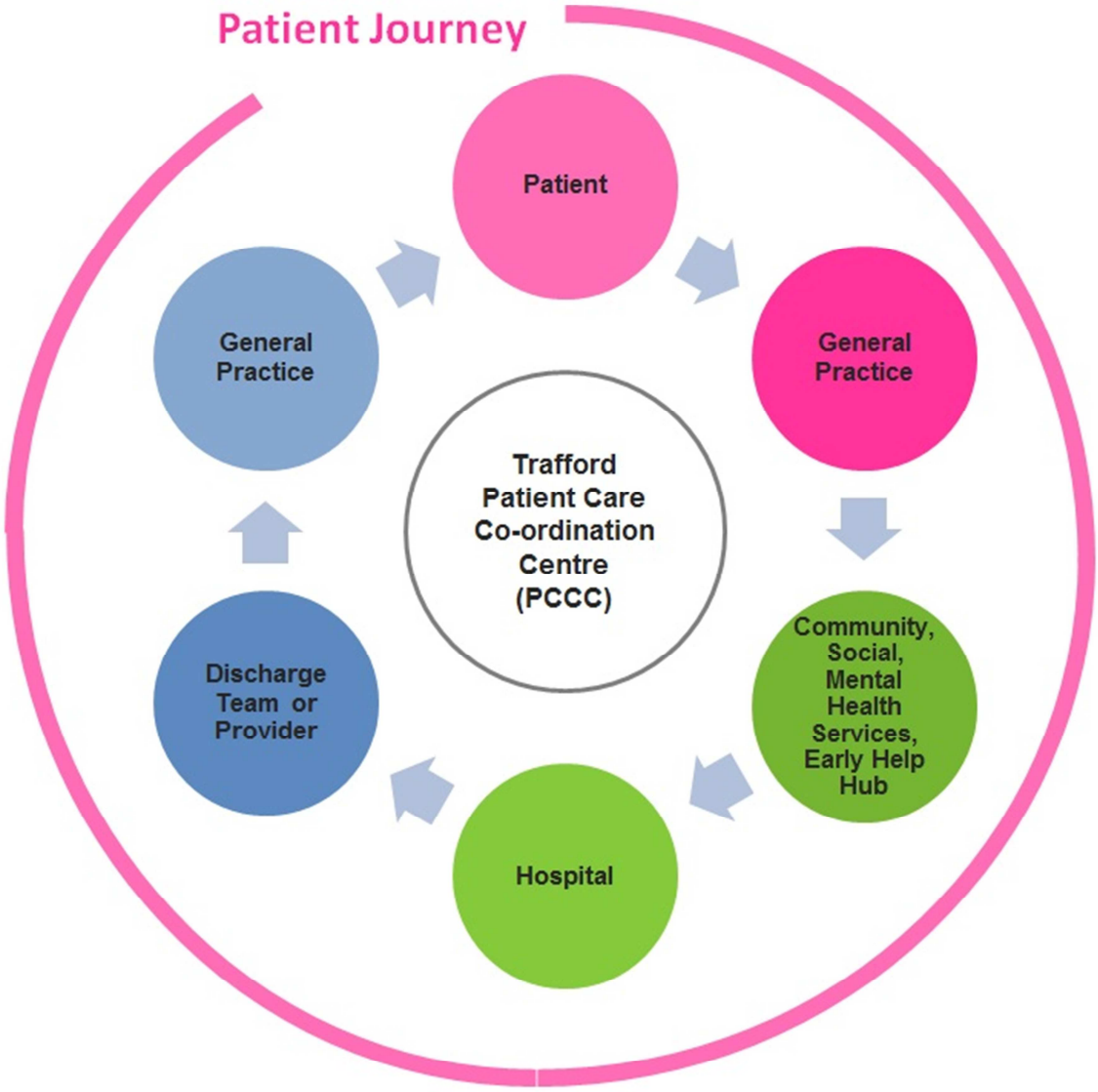
The model for enhanced access and continuity will provide patients with locality access over the weekend and evening period for both routine and urgent care. The service will be integrated with all appropriate care providers to support and provide care for patients, keeping people cared for in the community, if appropriate, and prevent the need for inappropriate admissions to hospital.

Where patients' access enhanced out of hours care routinely at the weekend, the system will integrate with community and social care to ensure the general practitioner has care options to manage patients within the community, where appropriate, without the need to admit to hospital. Robust development with a range of providers undertaken within both BCF work and the primary care strategy has created an environment of change amongst stakeholders.

A principle of both the BCF and primary care strategy work is that any avoidable admission that ends with a patient having an unplanned admission to hospital will see this as a system failure.

Patient Care Co-ordination

The Patient Co-ordination centre will be key to the success of this new system.



In order to ensure our patients who are receiving planned care are seen and treated in a timely manner the following systems are required within the PCCC:

- Clinical Support System which understands referral pathways and has an up to date directory of available referral routes both within the acute, mental health, social care and community care;
- Referrals must pass through a decision support pathway to ensure appropriate tests have been undertaken prior to referral but that also allows override by the clinician if there is clinical justification;
- The functionality to allow both direct bookings of appointments by GP's, Practice Staff or the Patient Care Coordination Centre;
- Referrals must be guided to the appropriate service and activate an alert if referrals are outside their regulatory referral target date;
- All required investigations/tests must be carried out and results available for the referee to view prior or at consultation;
- The functionality to view all results for example; radiography, path lab must be available;
- The quality of referrals must be audited; and

- Risk stratification must be supported to allow anticipatory care of at risk patients.
- Trafford patients will receive their acute services mainly from UHSM or CMFT at Manchester Royal Infirmary or Trafford General Hospital
- The PCCC will ensure follow up appointments which require further investigations / tests are carried out prior to an appointment date and results available to view by relevant clinical staff
- Avoid duplicate appointments and ensure the sequencing of appointments ensure reduction in DNA's and improvement in quality for patients. The PCCC will ensure patient's appointments are co-ordinated.
- Allow for discharges or results to be accessible by the GP/Referrer; and
- Sharing medicine information for all outpatient/hospital admissions.

Information Technology

Information management and technology underpin the BCF developments as part of the primary care strategy and is a key enabler. Strategic developments such as population risk stratification and inter-practice and inter-organisational patient flows require a platform that is fit for purpose. Key engagement activities have secured a basis for achievement of the aim. As far as possible all stakeholders in an episode of care will be able to see full patient records, along with patient access.

As part of the BCF work, Trafford CCG will work to secure an information system that facilitates integrated care and federated working across Trafford through secure data sharing across clinical systems and organisational boundaries, ideally and as far as practicable through a single operating system.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

The Trafford health and social care economy want to ensure that people in Trafford are able to live as independently as possible for as long as possible, in spite of escalating demand from demographic changes, a shift in activity from the acute to community settings, customers rising expectations and challenging financial pressures.

Trafford will utilise the BCF to:

- Maintain current eligibility criteria (substantial and critical)
- Protect social care ability to promote and provide step up and step down enablement and recovery to prevent admissions to hospital, residential and nursing care.
- Prioritise a reduction in delayed transfers of care so that people only remain in hospital for as long as necessary.
- Transform our services in line with Pennine Care, increasing the focus on helping people remain in their own homes and maintain or increase their independence.
- Provide service users and carers with community based solutions that prevent admissions to hospital and offer real choices about the ways in which they are supported. Ensuring access to services for all citizens, including excluded and disadvantaged groups.
- Focus on improving quality, involving service users, carers and providers in the redesign of existing services and the development of new services.
- To maintain and continue to build and support the infrastructure for carers in order to identify and support carers whose needs are not currently met and maintain the support currently provided to carers so they are able to carry out their invaluable role for as long as possible.
- Focus on personalisation with an emphasis on outcomes rather than systems and processes which has increased flexibility of services and facilitated a move away from ‘one size fits all’ approach, working with service users and providers to deliver more innovative, person centred and cost effective solutions that maximise public sector funding.
- Focus on protecting the social care and voluntary and community sector. Market management and quality assurance is pivotal to our efficiency agenda and has been essential in relation to market development. It has gone some way to bridge the gap between fluctuating demand, budget constraints and receptiveness to different models of support.
- Focus on the development of housing strategy including the development of the extra care facilities, offering lower level community based support to prevent admissions to care homes, based on a collaborative transformational approach across partner organisations and a commitment to pooling resources.
- Foster co-production and engagement with service users, carers, voluntary and

community sector and private sector organisations in the development, design and delivery of services.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

The Adult Social Care Grant to date has been invested in assessment and reablement services to manage escalating demand, which was significantly impacted by the reconfiguration of acute healthcare provision in Trafford in November 2013. The shared vision for Trafford CCG and Council promotes and enables people to live at home and remain as independent as possible. This has enabled the Council to protect and sustain the current level of eligibility criteria and to provide robust assessment and care management services based on a model of integrated care and support with Pennine Care.

In 2015/16 Trafford Council faces further financial challenges and budget reductions, this will impact on the Council's ability to maintain its current provision and eligibility. The local authority's 2014/15 Budget Report identified that based on current budget assumptions the Council will need to reduce expenditure and /or increase income by at least £49.8m over the next three years.

Since the budget was approved the Council has identified a shortfall in its Adult Social Care budget of approximately £7m. The Council is therefore currently working to identify proposals to address a budget gap of £57m over the period 2015-18.

It is therefore proposed that the BCF be used to;

- Sustain current levels of adult social care provision in the face of increasing demand. For example the number of people receiving home care increased by 10% from 2011/12 to 2013/14, the number of reablement episodes has increased by 9% from 2012/13 to 2013/14, assessments of new clients in year has increased by 10.5% from 2012/13 to 2013/14 and the number of contacts/referrals received from Trafford General and Wythenshawe hospitals has increased by 5.75% from April 2012- March 2013 compared to April 2013 – March 2014
- Continue to be used to be invested in social care to deliver enhanced rehabilitation and enablement services which will reduce hospital readmissions and admissions to residential and nursing home care
- Directed to equipment, adaptations and telecare to support people to remain at home
- The additional duties and responsibilities placed on the local authority by the Care Act in 2015/16 will need to be funded through BCF monies
- Support the integrated health and social care neighbourhood model and achieve their vision and outcomes to ensure a reduction in demand within the acute sector, both for unscheduled and scheduled care
- Support new models of care that will deliver and embed a culture of early intervention and wellbeing, supported by the development of all age early help hub
- Support the implementation of a new social care ICT system that will include integration with Health ICT systems

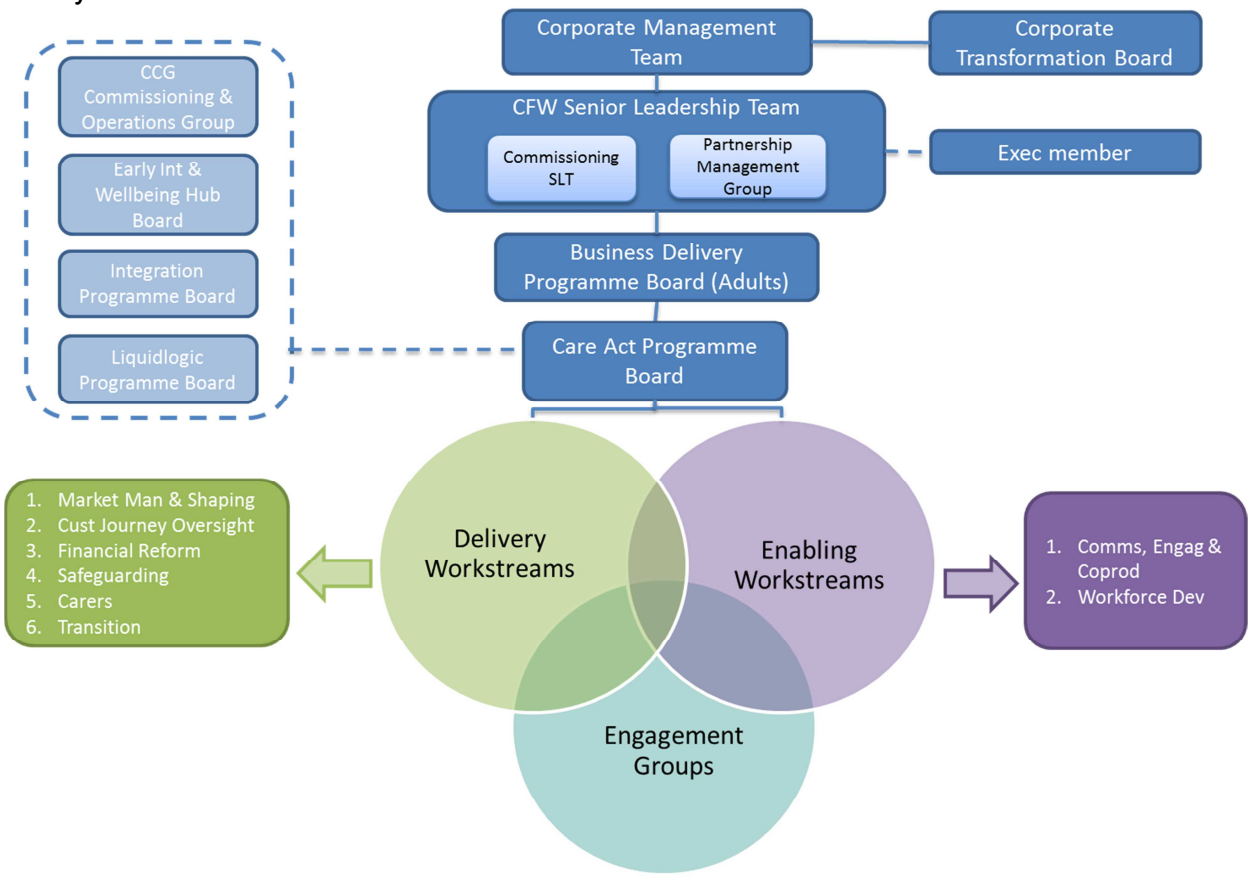
iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

At the time of issue this is still under discussion and will be written up ahead of submission.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

At Trafford a programme of work is underway to prepare for the wide range of reforms and changes that are articulated in the Care Act to ensure Trafford is fully prepared to implement these. The changes will start coming into place from April 2015.

The programme's structure and governance arrangements are in place, the programme is made up of eight workstream and a Programme Board which oversees and steers the programme of work – see diagram below. The deliverables and timescales have been mapped across the programme to ensure Trafford meets the Care Act requirements in a timely manner.



A Programme Initiation Document has been drafted for the programme which outlines the programme's background, objectives, scope, deliverables, success criteria and governance arrangements.

Key changes in the Care Act that will impact on the delivery of local service include:

- Duty to provide comprehensive advice and information to allow people to make the right decisions about their care and support. This will ensure that people will have clearer information and advice to help them navigate the system.
- Role of market shaping to ensure diverse, high quality range of support for people to choose from to meet their needs, giving people more choice and control over care and support
- A new duty to provide preventative services to maintain people's health. The Act places more emphasis than ever before on prevention – shifting from a system which manages crises to one which focuses on people's strengths and capabilities and supports them to live independently for as long as possible.
- Makes the care and support system clearer and fairer for those who need it. The government will set a national minimum eligibility threshold to help people better understand whether they are eligible for local authority support.
- Paves the way to allow older people and those with disabilities to move from one area to another with less fear of having their care and support interrupted.
- For the first time, carers will be put on the same legal footing as the people they care for, with extended rights to assessment, and new entitlements to support to meet their eligible needs.
- Puts personal budgets on a statutory footing for the first time.
- A duty on councils to consider the physical, mental and emotional wellbeing of individuals.
- Streamlined and more effective working across adults and children's services during transition.
- Gives Safeguarding Adult Boards a legal basis for the first time.
- Reform to the way that care is paid for, including:
    - Reforms to how people pay for care so they get more financial support from the state. This includes a cap on care costs of £72,000 and care accounts for those with eligible needs
    - Increases the asset (savings or property) threshold to around £118,000
    - Introduction of the universal deferred payment scheme which will ensure that people are not forced to sell their home during their lifetime to pay for care
- Requirement to integrate services with health and any health related services such as housing
- An up to date and accessible Market Position Statement
- Clearer approach to charging and financial assessments
- Transparent and visible quality management for the whole market
- Powers for chief inspector of social care to hold poor-performing providers to account

Based on the national timescales for the implementation of the Care Act a detailed programme plan has been produced to ensure Trafford is fully prepared to implement the wide range of reforms and changes that are articulated in the Act. An overview of these plans is provided on the table below.

Date	Milestone
Apr 2014	Communications, engagement & coproduction (CEC) strategy and plan finalised

Mar – Apr 2014	Deliver phase 1 of CEC plan – strategic engagement
May – Jun 2014	Deliver phase 2 of CEC plan – engagement and design
Jun 2014	Self-funder modelling complete
Jul – Aug 2014	Deliver phase 3 of CEC plan – coproduction and communication (incl consultation process on guidance)
Aug 2014	Financial modelling complete
May – Aug 2014	Develop proposals – model, processes and protocols (Part 1) • Market management & shaping • Customer journey implications • Financial reform (deferred payments system, care accounts, self-funders) • Safeguarding • Carers • Transition
Aug 2014	Workforce development plan finalised
Sept – Mar 2015	Deliver workforce plan – skills, training and culture (Part 1)
Sept/Oct 2014	Final proposals for local reforms and changes (Part 1)
Oct – Dec 2014	Prepare for implementation (Part 1)
Nov – Mar 2015	Deliver phase 4 of CEC Plan – launch activity
Jan 2015	Go live – Trafford – Part 1
April 2015	Go live – National – Part 1
May – Aug 2015	Develop and finalise proposals – model, processes and protocols (Part 2) • Care accounts • Cap on care costs • Extended means test • Updated financial assessments • Extended access to financial support
Jul 2015	Approach in place for managing self-funder demand
Aug – Mar 2016	Deliver workforce plan – skills, training and culture (Part 2)
Sept/Oct 2015	Final proposals for local reforms and changes (Part 2)
Oct – Dec 2015	Prepare for implementation (Part 2)
Nov 2015	Go Live – Early assessments for self-funders (National & Trafford)
Jan 2016	Go live – Trafford – Part 2

April 2016	Go live – National – Part 2

v) Please specify the level of resource that will be dedicated to carer-specific support

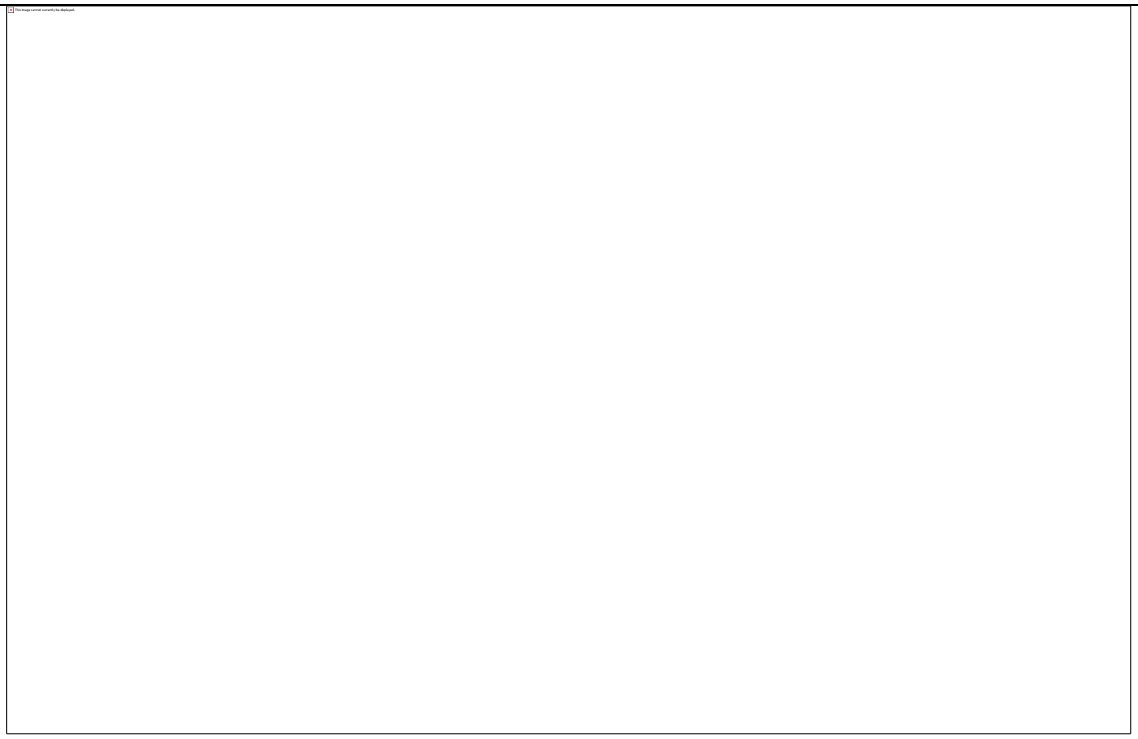
Trafford CCG will dedicate £411,500 to carer specific support. This is broken down as;

	Total Budget £
Trafford Call Carers (Call Plus)	54,500
Trafford Call Carers (Call Plus) 13/14 error	
Trafford Caring for Carers - Age Concern	96,210
Trafford Caring for Carers - TMBC Recharge	-59,210
Trafford Carers Centre - TMBC	170,000
Trafford Carers Strategy - TMBC	150,000
Total	**411,500**

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

Local government continues to face the largest cuts in spending across the entire public sector, at a time of continual increases in demand for social care. Like all upper tier authorities, expenditure on social care in Trafford represents the biggest single budget commitment by some way. Therefore in times of reducing government support it is inevitable that care and related support services cannot be immune from the effects of financial restraints.

In Trafford a total of £75m has been saved since the first austerity budget in 2010. Over the next three years a savings requirement of a further £57m is required:



Care services represent over 60% of the Council's net controllable budget. When the BCF was first announced it was hoped that this would offer a necessary and welcome change in the funding for social care.

When the indicative financial settlement for 2015/16 was announced the Council's *Spending Power* was stated to be a reduction of only 0.74%. Clearly stated within the figures was an increase in NHS and BCF pooled funds worth an additional £7.514m. Not unreasonably the Council assumed the majority of this funding would support social care, especially when considered against the scale of reductions required in 2015/16 (approaching 20% of net controllable budget).

The actual additional funding from the BCF is now expected to be **£xxx** and falls well short of the implied funding boost announced last year.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

The new clinical integrated model will provide services in the community over 7 days In addition this model will be supported by increased access to primary care with an 8-8 service Monday – Friday and increased access at weekends. The primary care increase in capacity is currently being developed as part of the implementation of Trafford's Primary Care Strategy.

Urgent care services provided by Pennine care already operate on a 7 days basis and the review of community nursing and therapy services will be expanded for capacity to match demand over 7 days. These services will support patients who are discharged

from the acute providers. Trafford patient flow is more complex with patients being admitted to 3 acute Trusts, Central Manchester Foundation Trust, University Hospital of South Manchester and Salford Royal Foundation Trust. As part of the implementation of Trafford New Health Deal, Pennine Community Services and Social Care service have been working collaboratively with the discharge teams from these 3 acute Trusts and this relationship will continue. Pennine Care currently in reach into the hospital so that they understand each patient's requirements as they are discharged.

For social care, analysis of the areas of intense activity over the weekend will underpin the focus of future transitional work, including evaluating the section 5's generated over the weekend by the hospitals that serve Trafford residents. Access to assessment, linked to the Patient Care Co-ordination Centre will amongst other areas be delivered on a 7 day basis. There will inevitably be resource and cost implications as a result of this, and the BCF monies will need to be used to support this.

All Trafford's BCF schemes will include services which will operate on a 7 day basis The financial resources to support the increased access and capacity will be delivered by reduced activity and spend to secondary care.

Trafford CCG and Council acknowledge a review of the current End of Life service to be a priority and the service has to be available and flexible to support dying patients preferred place of choice. This service will not only support patients but families and carers'. This support is often required when other services are not available, otherwise, admission of the terminally ill into hospital will continue. Ultimately people need to be supported to die in their preferred place, regardless of time and resources.

The Trafford Patient Co-ordination centre will operate over 7 days. This will be available for patients to contact and receive support out of hours. The co-ordination of services out of hours is a priority to deliver safe alternatives to acute interventions and patients should receive high quality care out of hospital services as part of their pathways. The PCCC will also ensure there are communications with community health and social care and primary care as patients become ready for discharge from each of the hospitals.

If reductions in hospital admissions and readmissions are to be achieved, 7 day community health and social care and primary care have to be available. Patients should only be admitted to hospital when hospital care is needed. Their stay in hospital should match their clinical needs and once medically fit for discharge and where additional clinical treatment/support is required this will be provided by primary care or community nursing and social care. Patients will receive a greater proportion of their health and social care support outside of a hospital environment.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

The NHS number is the primary identifier for correspondence across health and this will be expanded to include care services**.**

The Council is committed to using the NHS number as a primary identifier for correspondence and this requirement has been incorporated as part of the Council's

procurement and transition to a new adult social care ICT system which will be launched in December 2014.

The PCC will require data sharing agreements to be in place across the whole system. In advance of the implementation programme, the CCG are working with all provider organisations to ensure data sharing agreements are in place. All these will reference the NHS Number as the prime identifier for patient tracking, correspondence and all associated activities.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Trafford CCG and Trafford Council are committed to adopting systems which are based upon Open API's.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practice and in particular requirements set out in Caldicott 2.

Trafford CCG complies with the NHS standard contract requirements by;

- Ensuring compliance with the DPA is maintained at all times,
- Only processing PCD where there is a legal basis for doing so and ensuring that there are measures in place to prevent unlawful processing,
- Ensuring all staff and contractors are trained in information governance,
- Not allowing transfers of PCD outside the EEA without the appropriate assurances
- Completing an annual IG toolkit,
- Establishing an IG management framework including assigning IG responsibility to appropriately senior staff,
- Following national IG incident reporting protocols,
- Ensuring proper data encryption standards are in place,
- Having a full suite of IG policies in place,
- Having appropriate data sharing agreements in place where required.
- Trafford CCG has an annual IG work plan for completion of the IG toolkit to at least level 2 for all requirements which is approved and continually reviewed by a designated IG Group. The CCG is committed to Caldicott principles and has implemented IG policies that incorporate these principles to embed them throughout the organisation.

Trafford Council and Trafford CCG confirm that we are committed to ensuring the appropriate Information Governance (I.G) and Controls which will reflect all requirements set out in Caldicott 2.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Risk stratification in Trafford is a key element of proactive integrated care designed to avoid unplanned admissions to hospital and unplanned A&E attendances. Currently all NHS Trafford general practices have their registered populations risk stratified, so that interventions, patient recalls and care plans are put in place to improve care, deliver proactive health management and avoid unplanned hospital admissions. Using Kings Fund evidence based algorithms, Predictive Model, information is taken from both acute hospital activity data sets and the general practice clinical system to produce for each practice a stratified patient list to identify those most at risk of having an unplanned event. Across Trafford each practice has a risk register that takes the top two percent of patients over 18 at high risk. This cohort of patients has an advanced care plan that general practice use to coordinate care along with other stakeholder providers required to deliver care according to the patient's needs. This system facilities general practice, community and social services, and acute providers to better manage the care for this high risk group of patients, linking into the other developments within the better care fund improvements. Across Trafford this amounts to some 4500 patients.

Individuals who are currently at high risk of admission and readmission to hospital have a clinical/professional lead. However, this will be further developed as we further integrate the operational teams of health and social care into localities. This will also take into account any changes as services are expanded to implement 7 day working. The clinical/professional lead will be appropriate to the individual but may be from health or social services.

Following the implementation of the Patient Care Co–ordination Centre, the Risk Stratification tool will identify the next cohort of patients who will require tracking to ensure they have active case management to prevent unnecessary admissions.

In the initial stages of the PCCC the data flows populating the Risk Stratification tool may be weekly or monthly depending on the data sources and the development of data sharing processes and agreements with relevant healthcare providers. The aspiration for the PCCC is to have as near to real-time data flowing into the Risk Stratification tool as possible, providing a continually updated risk score for patients.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

The Integrated multi-disciplinary neighbourhood teams will work with GP's and utilise a risk stratification tool to identify people at high risk of hospital admission. These individuals will be prioritised and allocated to the most appropriate professional within the team; this may be a social worker, practice or district nurse or therapist. In Trafford fully integrated mental health services already exist and as part of phase 2 of the integration programme this provision will be overlaid with the neighbourhood teams

The identified lead professional will ensure the person's care is coordinated and managed more effectively. The lead professional will improve the quality of the patients and carer experience as well as reducing fragmentation within the system.

The lead professional will meet with the individual to gain consent and to begin proactive care planning with the person and their families. Care plans will be focused on promoting the individual's understanding of their care and support needs, self-care where appropriate and building health and social care community resources around the person

including crisis response plans to changes in someone's health and social care needs e.g. the use of rescue packs. This approach will also encourage consultants to work out in the community, reducing unplanned admission and changing the use of outpatient appointments. This earlier proactive care planning with GP's by social workers, nurses and therapists will require investment through the BCF.

This will also contribute to the CCG's plan for care plans to be completed for all people over 75 years and those entering the final stages of life.

Work is on-going to review and update the information sharing arrangements across health and social care. This will support joined up and aligned assessment and care planning and ensure professionals are clear about the patient data and information that can and should be shared. The Council's implementation of a new social care ICT system will also support this. Phase 2 of the programme included the integration with health ICT systems. Work is currently on-going to look into requirements of each organisation to enable systems to integrate.
However a shift in culture across health and social care is also required to create more sustained integration of services. The planned physical co-location of teams from different professionals will support this.

The joined up governance arrangements outlined in section 4b also supports these integrated systems and joint clinical decision making.

iii) Please state what proportion of individuals at high risk already has a joint care plan in place

Currently 4500 Trafford GP registered patients above the age of 18 have a joint care plan in place. This represents 2.42% of the 185,241 patients attending a Trafford practice.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Trafford's vision and overall aim in relation to integration is founded on a joined up commitment to deliver better outcomes for the people of Trafford, including experiences for individuals, families, carers and communities. The integrated care model strives to give local people choice and control and aims to facilitate the shaping of services for future generations.

Healthwatch Trafford is fully involved with the design and implementation of the Trafford model and has representation on the Integrated Care Redesign Board (ICRB) and the Citizen Reference Board. Healthwatch have a comprehensive programme, working with the public through reference groups on the redesign and evaluation of a number of our integration projects. The involvement of Healthwatch is continuous, from the commencement of each project, defining the scope through to evaluation stage. As part

of our current work streams they are taking an active role in the redesign programmes:-

- The development of the Patient Care Co-ordination Centre – The information and Advice Programme Board which is now aligned to the patient care co-ordination centre and the Early Intervention and Wellbeing Hub
- COPD redesign
- Evaluation of unscheduled care redesign
- The development of the all- age Early Help Front Door Hub.
- The project for Frail and Older People

In addition, Trafford CCG conducts quarterly liaison sessions with Healthwatch Trafford and have worked together to identify training and development opportunities across the Trafford health and social care economy.

As a newly formed organisation Trafford CCG engaged with the public to determine the values which underpin our operations.

In developing the TCCG Strategic Plan, stakeholders across the economy were consulted on the identification of priorities over the coming five years, these included patient and service users through Healthwatch Trafford, local authority service user groups and through the Public Reference and Advisory Panel (PRAP). This provided the opportunity to scrutinise plans and revise them to better reflect the needs of Trafford's Communities. Membership of the PRAP is referenced at Appendix 2.

Throughout all service redesign the PRAP are involved in decision making, providing challenge to lead commissioners and clinicians and making recommendations for further engagement with the public and service users. All Better Care Fund projects of work have been signed off by the PRAP and regular updates will be provided as schemes are further developed and implemented.

In articulating schemes for the Better Care Fund, Trafford CCG and Trafford Council have held a number of engagement events with professionals, service users and the public at large. Both organisations recognise the importance of continuous engagement with these groups and will seek to develop a " you said, we did" framework to ensure that stakeholders feel involved in service redesign and the public can easily recognise changes and provide challenge when things go wrong.

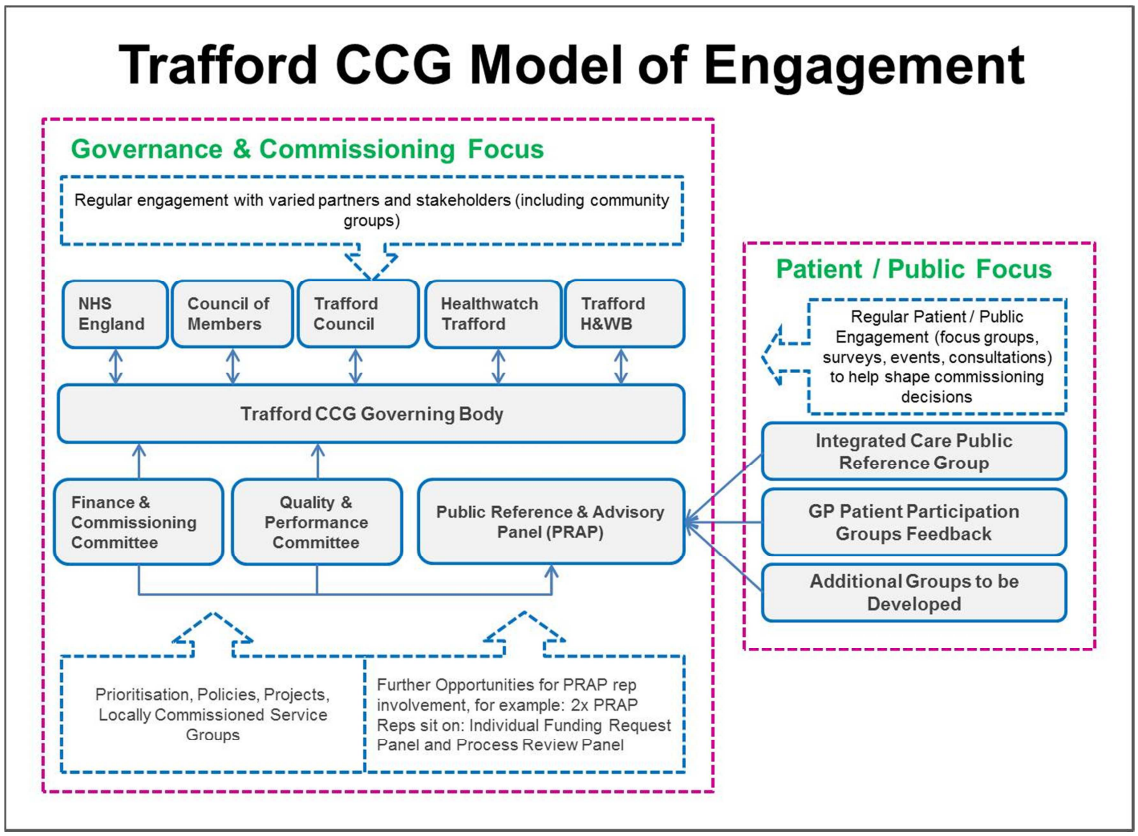
Patient and carer representation is at the heart of service redesign. Membership of steering groups and scheme project groups is made up of the representatives from Trafford's third sector such as Age UK Trafford, Trafford Carers Centre and Macmillan. Not only does this ensure that patients experience of services is central to remodelling services but also supports the development of key performance indicators to ensure that services deliver what matters most to those who use them.

Given the diverse and varying natures of Trafford's Communities, Trafford CCG and Trafford Council recognise the need to engage with those groups who are typically hard to reach. For example we have work with the Lesbian and Gay Foundation to raise the importance of cervical screening within the Lesbian Community and with the British Minority Ethnic Service improvement Partnership to identify health and social care needs within this community. This has resulted in an education programme for general

practitioners, the results of which are currently being analysed. Both organisations are represented on the Diverse Communities partnership and issues are regularly fed into this group to ensure that service redesign is equitable to residents across Trafford.

Trafford CCG Model of Engagement

The model of engagement used by Trafford CCG is articulated in the diagram below;



Trafford CCG and Trafford Council are passionate about the need to co-produce service transformation which is underpinned and evidenced by several other embedded forums and approaches:-

- Trafford Quality Checkers – service users and carers who are trained to assess the quality of community services and inform their future direction in relation to improved quality, increased efficiencies and person centred care and support.
- Expert by design Programme – patients and carers who are involved and influence patient and customer journey experience in a hospital setting.
- Learning Disability Partnership Board.

Health and Social Care Commissioners have worked proactively with local people to ensure a wide and diverse continuum of universal and preventative services based on the fundamental principles of co-production and 'Working Together for Change'. Such an approach to patient, service user and public engagement has evidenced a menu of shared investment in innovation and creative services, which underpins our plan for integration such as:-

- Blue Sci – a not for profit Social Enterprise that supports people that may be experiencing emotional or psychological distress founded on the principle of well-being.

- Age UK Trafford – shared investment in peer support, expert patient, time banking, volunteering.
- Trafford Carers Centre - shared investment in Health Checks, GP awareness, information and support, brokerage volunteering and carer assessments.
- Locality outreach services in our most deprived communities, working with local neighbourhood communities to unleash untapped community capacity and reconnect people with their local communities to develop increased social capital, improve quality of life outcomes and divert people from long term health and social care services.
- Pennine Care NHS Foundation Trust has undertaken a customer care survey for a number of services that full within frail and older people, for example; district nursing, to understand common themes from patients and users of service, to inform improvements. This will be fed into the redesign of services and the development of the new neighbourhood models.
- An integral part of Trafford's Integration Care Programme is 'patient voice' and the Citizen's Reference Board which informs a variety of communication and engagement methodologies ensuring service review and re-design is based on ongoing co-production

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

The plan has been developed from a strong history of collaborative working across the Trafford Health and Social Care economy. This is an approach which has achieved the integration of health and social care services for Children and Young People and Adults.

The plan further builds on Trafford's wider Integration Plan which puts the individual at the centre of our care and support approach ensuring that individuals in Trafford have: 'The right care, at the right time, in the right place'.

The details of our approach can be found in our Integrated Care Model (Executive Summary,) Economy for Trafford Health and Social Care (June 2013). Our Integrated Care Plan Submission (September 2013) and our Joint Health and Wellbeing Strategy Action Plan outlines how strong collaboration across health and social care and the voluntary and community sector is embedded in our approach and reflected in our current governance arrangements.

Trafford has used a number of existing forums to share these plans and for NHS Foundation Trusts to consider the impact of these system changes on their own organisations.

The plan is supported by the Integrated Care Redesign Board which represents providers and commissioners across the whole economy, including the Acute Sector providers, in addition to the Trafford Health and Wellbeing Board.

The Better Care Fund programme is part of the CCG's 5 year Strategy which has been

shared with and discussed with individual provider organisations. Each of the projects within the BCF has steering groups which include senior operational management. The BCF projects are also part of the CCG's Operational and Resilience plan. The collaborative working with acute Trusts and neighbouring CCG's has provided another opportunity for these plans to be understood and supported .The delivery of Trafford's strategic plan, including BCF forms part of the agenda for Trafford's new Operation and Resilience group where progress and impact of change for each projects will be monitored and reported,

There has been ongoing engagement with providers (including residential and nursing care homes, third sector providers and primary care practitioners).

Together, Trafford Council and Trafford CCG have committed to build on the extensive and embedded provider engagement approach that has been recognised through:

- Excellent ratings on a National, Regional and Local level
- IDEA Innovation Fund
- Partnership Award for Excellence
- Right to Control Trailblazer
- National recognition from the Equality and Human Rights Commission
- Trailblazer site in relation to Health watch
- Think Local Act Personal pioneer

Appendix 1 has an example referred to as 'Mrs Trafford' which demonstrates integration is already being delivered in Trafford.

ii) Primary Care Providers

Trafford CCG as part of its constitution holds quarterly meetings with the Council of Members. These forums provide the opportunity for the CCG to share with its member's plans, services changes and an opportunity for them to be part of the process for delivering change.

Practices have been involved with the development of the 5 year strategic plan, the projects which are part of the BCF and many representatives are members on the various project groups.

The provider for the Out of Hours Service is included in all these discussions, are a key members for the Frail and Older peoples project with the Medical Director being on the Steering group.

The locality representative for the OOH provider is a member of the Trafford Operations and Resilience group.

Locality working groups have been formed with reporting lines into the CCG and are overseen by governance arrangements in synergy with BCF monitoring. These groups secure the input of local clinicians and non-clinicians and link into the BCF to deliver integrated health and social care at a locality level.

iii) Social care and providers from the voluntary and community sector

A network of joint commissioner and provider forums aligned to our key priorities and

linked to integration are well embedded and they continue to drive our ambition for excellence in relation to integrated care across the borough of Trafford. Such forums embrace the key priorities outlined in our plan:

- Dementia Strategy Group
- Residential and Nursing Service Improvement Partnership
- Mental Health Service Improvement Partnership
- Homecare Service Improvement Partnership
- Carer Services Board
- Health and Wellbeing Delivery Programme Board
- BME Service Improvement Partnership
- Information and Advice Review Programme Board

Trafford's transformational approach to integration has been underpinned by strong partnerships with the voluntary and community sector where Trafford communities have supported and developed the partnership between Pulse Regeneration and Trafford Housing Trust to extend the delivery of support to third sector organisations and communities in Trafford. The fundamental driver of this partnership approach with providers has been to deliver the vision of a 'thriving third sector' which is enterprising, responsive to change, sustainable, and one which can flex to the requirements of integration. The support has included capacity building, funding, community engagement, private sector, engagement and active citizenship.

Four locality workshops were held in June 2014 to begin the co-production and the joint working with the voluntary and community sector and service providers in relation to the all – age Early Help Hub.

A voluntary and community sector Thought Chamber, supported by Thrive, Trafford's third sector development support organisation, was held in July. This encourages open dialogue between commissioners and the voluntary and community sector in Trafford, on the future challenges facing health and social care and how these might need to be addressed.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending of plan is a whole system change pror local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Trafford's is a whole system change programme which will impact on acute services and due to complexities of Trafford patient's flows these will impact on a number of acute hospitals. Following the changes which have been implemented at Trafford General Hospital, Trafford no longer has a local hospital where the majority of acute activity is undertaken. Trafford General Hospital is now part of CMFT and Trafford patients tend to flow to the different trusts dependent upon their location. The majority of patients living in south of Trafford tend to flow to UHSM, others in small quantities flow to Salford and to SRFT. Another difference in Trafford is that community services are provided by a Mental health Trust and not part of an acute Trust which results in greater transparency

of the community care patients' pathways.

Trafford CCG has used the forum of the Integrated Care Redesign Board (ICRB) to share in the programmes which will be included in the Better Care Funds Programme. It is essential that the programme boards which are used for the 2 health programmes have representatives on from both CMFT and UHSM. By expanding community health and social care and primary care, this will create a proactive model as opposed to a reactive model. It can be seen from our Integrated plan that Trafford CCG has already made a commitment to a 15% reduction in unscheduled care at acute Trusts. This follows the investment already made but these two programmes, Elderly Care and Palliative Care are both redirecting activity away from the acute setting to be used in primary and community services.

The ICRB and Health and Wellbeing Board will provide the opportunity for acute providers to be kept updated on progress. The ICRB also has representatives from the two neighbouring CCG's who are the main commissioners for CMFT and UHSM, Trafford are associate commissioners to both these 2 contracts.

These plans require further development and refinement over the forthcoming months. Acute Trusts have a clear understanding of Trafford's vision; they appreciate and understand the changes which have to be delivered in the 'community model' to reduce activity in the acute setting. This transformation will be the delivered outcome which will shift the clinical resources to enable the community, and primary care model to be delivered.

The shift in activity will be delivered by a comprehensive Integration Programme, set out in the CCG's 5 year Strategy and the Council's Strategic Plan for the Re-Shaping of Trafford. There are workshops planned with both University Hospital South Manchester and Central Manchester Foundation Trust and Pennine Care so that all parties can understand the potential impact on activity and capacity. As part of the preparation for the workshop an assessment of the impact on acute services is being undertaken. The further integration of Adult Social Care Teams with Health will support a more localised model in relation to the support of individuals in the community.

Trafford CCG and Trafford Council will deliver this vision jointly to improve the health and the patients' experience.

As set out in the new guidance for BCF, the CCG jointly with the Local Authority are confident that for 2015/16 a 3.5% reductions in A&E activity and subsequent unscheduled admissions will reduce. As part of the programme office within the Commissioning Directorate of the CCG, systems are in place to monitor the reduction and pressure on secondary care. In Trafford, as community services are provided by a non-acute provider, the embedding and successful delivery of the community Urgent Enhanced Service is reported and monitored independently. It is anticipated that the reductions in A&E activity will result in an increase in the demand for community services.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description- Providing a Falls Service in Trafford

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
TCCG/FOP/01
Scheme name
Providing a Falls Service in Trafford
What is the strategic objective of this scheme?
The Falls Prevention model for Trafford has been scoped and developed with the philosophy of ensuring a reduction in A&E attendance and subsequent admission to an acute ward. Falls affect 30% of people over 65 and 50% over 80 and are a major cause of hospital attendance and admission. Falls and fragility fractures require a common prevention strategy; both are associated with high mortality, morbidity and cost. Nationally evidence has shown that annual costs of fragility fracture care cost over £2 billion. Locally we have gathered considerable evidence that would support these assumptions and in particular high numbers of excess bed days associated with a diagnosis of fractured neck of femur in people aged 65 and over. Evidence has also shown that following a fall and episodes of hospitalisation there is often a long-term deterioration in the individual's health leading to an increased dependency on both health and social services. Whilst most falls do not result in serious injury, the consequence of a fall for the older person can be psychological such as fear of falling again, loss of confidence, self-imposed restriction of activity and social isolation culminating in a loss of independence. Our model will address all of these factors by implementing an integrated delivery model.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Trafford, through the establishment of a multi-disciplinary working group, has scoped current service provision and analysed clinical evidence based best practice. The result is to develop an integrated falls prevention delivery model. The model will reflect and build upon the recent NICE Falls in Older People Overview Pathway Quality Standards. NICE also recommend that a falls service should follow five factors: • Case/risk identification • Multifactorial falls risk assessment • Multifactorial interventions • Encouraging the participation of older people in falls prevention programmes, including education and information giving • Professional education Trafford has drafted an initial delivery model that utilises a neighbourhood approach with a single point of access that will triage and screen all referrals. The "hub" will

have access to and include pharmaceutical, mental health and geriatrician sessions that will assist with assessment and diagnostics allowing for the individual referral to be aligned to an appropriate falls pathway.

An aspect that cannot be underestimated is the risk of falling with dementia, this area is extremely complex and one that needs a targeted reduction as dementia patients are 8 times more likely to fall (Allen et al 2009) and evidence shows that many people with dementia are frequently denied access to falls services. With the Trafford model there will be a specific pathway that addresses this issue.

The service model will allow rapid intervention to support admission avoidance and discharge to assess methodology; it will also link to the Alternative to Transfer (ATT) models already in place to allow NWAS Pathfinder intervention and referral into the falls service. The development of a Trafford falls risk assessment and multifactorial clinic access will allow optimised treatment for people who have already fallen or are identified as at risk of a fall occurring. The service model will be available to all adult Trafford registered residents and will utilise the risk stratification model within Primary Care to identify those patients at risk of falling. Once identified this would result in referral into the single point of access allowing for alignment to an appropriate falls pathway which will reduce the likelihood of an admission.

The financial envelope of this service delivery modal warrants a procurement exercise which will appoint a preferred provider for Trafford. This process will define the geographical delivery model and outline the phased implementation schedule. Phase one of the process will be operational within quarter one of 2015/16.

Trafford has a higher than average older population profile and as such the service specification would need to account for higher acuity of referrals and growth. The proposed service specification and delivery model will provide comprehensive and cross-cutting interventions designed to detect osteoporosis and prevent the first or subsequent falls.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The integrated falls prevention service will partner with Trafford Council and the existing community service model delivered by Pennine Care NHS Foundation Trust. Following the procurement process other partners may be identified.

Falls prevention is within the remit of the Unscheduled Care department of the CCG and will be led by the Urgent Care Lead and the Service Transformation Manager. The CCG procurement team will ensure an appropriate tender process is followed and the continued contract monitoring of the service will be part of the CCGs internal governance as outlined in section 4.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The current provision in Trafford is limited and fragmented and as a consequence not fit for purpose. The provision of an integrated falls service specification will address these issues along-with ensuring a more appropriate evidence based

delivery model for Trafford residents.

Over the last five years over 9,000 patients have presented at an acute setting as a result of a fall (coded within an acute setting as a fall), however, this does not account for those fallers who present without an explanation of the reason for the injury i.e. wound as a result of a slip, trip or fall. Analysis of falls data show that over half of these patients, 4,903 are aged 75 years and over, with the majority living in South and Central Trafford neighbourhoods. On average 58% of those patients who present at A&E as a result of a fall receive no treatment. For those admitted the average length of stay is on average 17 days, the age profile of these patients often determines deterioration in their health leading to an increased dependency on both health and social services along-with a reduction in their independence and ability to return to their usual place of residence.

It is essential to provide educational support to residential and nursing homes to ensure competency when referring patients into the falls service, within the service specification a KPI will be developed to ensure that education practice is delivered effectively not only to social care partners but also within a primary and community care setting.

Financially the cost of falls within secondary care is in excess of £21m (excluding community and social care services). The Trafford service delivery model once operational will realise not only improved patient experience but a reduction on demand within the acute sector, along-with financial savings across the health economy.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

The CCG has anticipated a recurrent financial investment of £XXXX

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Reduced non-elective admissions: the integrated service specification has the ability for general practice, social services, mental health practitioners, NWAS Pathfinder, ATT plus and community services to refer patients who would benefit from a falls rapid response intervention, by doing so this would not require admission to an Acute ward therefore reducing both attendance and admission into hospital. Where appropriate patient's with a fall that requires invasive treatment will be admitted into an acute setting, however, the benefit from an integrated falls service allows a much more appropriate and speedy discharge into an environment supportive of the individuals future needs and treatment.

Reduced inappropriate admissions to residential care: the service delivery model will support the discharge to assess model from our Acute partners which will ensure that appropriate falls risk assessment and treatment can be offered to individuals allowing them to retain as much independence as possible and return where appropriate to their original place of residence. Although separate both the intermediate care service model and the falls service model will have the ability to refer patients between services ensuring the most appropriate and beneficial care is

delivered. This will safeguard unnecessary admission to residential care which would result in an individual's independence being actively limited.
Each patient admitted to the service will be aligned to a treatment pathway appropriate for their condition and rehabilitation needs. This will ensure that if a change in the individual's usual place of residence is required, it will be identified and appropriately sought by the service.

Proportion of older people who are still at home 91 days after discharge from hospital: this cohort of people will be identified by general practice using the risk stratification as a high-risk of re-admission and therefore are eligible for referral into the service for additional rehabilitation goals or specific targeted short-term treatment using the falls multifactorial treatment pathway.

Delayed transfers of care from hospital: the service will benefit from the discharge to assess model that is operational within our secondary care providers and therefore those patients identified as meeting the criteria for falls prevention will be referred, accepted and aligned to a treatment pathway within the service. We will align the existing equipment and adaptation service to the falls delivery model to ensure speed of access and availability of the most suitable equipment for fallers.

Patient/service user experience: as with any NHS service the falls prevention model will be subject to annual patient surveys, it will benefit from review by the CCG that will include the Patient Reference Advisory Panel. By supporting patients in avoiding admission to and subsequent discharge from hospital this approach will reduce the risk of a hospital acquired infection, limit the deterioration in both mobility and mental capacity of the patient and allow the patient to maintain as much independence as appropriate with their condition. This model ultimately supports independence, the choice agenda and facilitates individuals to remain in their preferred place of residence.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The service specification for the falls prevention service will benefit from the development of robust Key Performance Indicators (KPIs) and outcome measures. These will be monitored on a monthly basis through the CCGs System Resilience Operational Group, and the Frail and Older Peoples Steering Group assessing the impact of the service.

The KPIs will be focused on reducing A&E attendances and inappropriate admissions together with reducing the Delayed transfer of care (DTOCs). The DTOCs are monitored weekly through existing arrangements; however, it is a standing agenda item on the SROG that adds more rigor to the measurement of the service impact.

As part of the new arrangements and establishment of Trafford's SROG a performance dashboard is being developed that will record both planned and unplanned care, the KPIs from this service will be shown within this dashboard.

What are the key success factors for implementation of this scheme?

The key successes will form part of the aims and outcomes of the service

specification and will have associated KPIs aligned to them. The service specification will identify the skills, competencies and knowledge base for the staff delivering the model and also those who will have clinical and operational links into service delivery. The staffing establishment will benefit from a multi-disciplinary, multi-experienced, multi-organisational/agency skill mix this will allow the delivery of a fully integrated service.

The service will benefit from constant review guaranteeing a timely response to the changing needs and environment of Trafford's population.

Trafford has an excellent record of developing and maintaining a strong partnership approach; this will be mirrored in the new service going forward guaranteeing co-production.

Due to the multi-agency approach, the integrated falls prevention service delivery model will have a phased implementation methodology. The CCG has established a steering group with a membership from all partner organisations who have approved the model and the associated principles of delivery. The CCG has evaluated other falls prevention models including elements of good practice into our service specification.

ANNEX 1 – Detailed Scheme Description *Reproviding Intermediate Care in Trafford*

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
TCCG/FOP/02
Scheme name
Reproviding Intermediate Care in Trafford
What is the strategic objective of this scheme?
The Intermediate Care model for Trafford has been developed with the philosophy of ensuring a reduction in A&E attendance and subsequent admissions to an acute ward, with the additional benefit of supporting the discharge to assess model.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Trafford has enhanced the scope of Intermediate Care as the model will include the recognised step down and step up offer, with the additional components of respite, social worker, rehabilitation officers, CHC assessment, palliation, therapy goals, appropriate environmental assessment including equipment and adaptation provision, virtual wrap-around care, short-term crisis support and in cases where the cared for patients' carer becomes acutely unwell and requires hospitalisation, the Intermediate Care facility will accommodate that individual ensuring appropriate support is enhanced until such time as other support mechanisms can be found. In addition, the intermediate care facility will have access to and include pharmaceutical, mental health and geriatrician sessions; these will seek to optimise treatment for patients both within the IC facility and within the community setting once returned to their usual place of residence, supporting their independence. However, it may be more appropriate to commission a more suitable place of residence following reassessment of care needs. The financial envelope of this re-provided service warrants a procurement exercise which will appoint a preferred provider for Trafford. This will establish where the in-patient bed facility will be delivered from and will outline the phased implementation schedule. Phase one of the process will be operational within quarter one of 2015/16. The enhanced integrated intermediate care facility will be available to all adult Trafford registered residents. Utilising the risk stratification model within Primary Care, those patients who are identified as a high-risk of admission to hospital would be screened into the facility which will reduce the likelihood of an admission. Trafford has an older population profile and therefore it is expected that a minimum capacity of 15 in-patient beds would be available to support this enhanced model. This figure has been evaluated and evidenced following the analysis of the previous intermediate care provision in Trafford. We have yet to establish the number of virtual beds that would be included within the enhanced model. We are looking at innovated ways to provide additional facilities exploring options with our Local Authority possibly

utilising existing sheltered housing and extra care schemes.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The integrated intermediate care service will co-commission with South Manchester CCG, additionally the service will partner with Trafford Council and the existing community service model delivered by Pennine Care NHS Foundation Trust. Following the procurement process it is likely that other partners may be identified. Intermediate care falls within the Unscheduled Care department of the CCG and will be led by the Urgent Care Lead and the Service Transformation Manager. The CCG procurement team will ensure an appropriate tender process is followed and the continued contract monitoring of the service will be part of the CCGs internal governance as outlined in section 4.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
As part of the new Health Deal for Trafford an intermediate care facility was commissioned in November 2013 with a bed capacity of 18 to support the change in patient flow for Trafford. This facility was unique being operationally managed by the CCG, clinical led by a general practitioner from our Out-of-Hours Provider with nursing and therapy provision by Trafford General Hospital. The monitoring and evaluation of this service over a 10 month period has allowed the CCG to evidence the requirement for intermediate care and allowed the enhanced model to be developed. Whilst the capacity in the re-provision has reduced to 15 in-patient beds, the overall capacity has been increased with the addition of the virtual component of the delivery model. During periods of pressure, the new facility will have the ability to flex its in-patient capacity to meet those needs, reducing when the risk is removed.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
The CCG has anticipated a recurrent financial investment of £1,000,000
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Reduced non-elective admissions: the enhanced service has the ability for general practice to refer patients who would benefit from additional short-term care, by doing so this would not require admission to an Acute ward therefore reducing both attendance and admission into hospital. **Reduce inappropriate admissions to residential care**: the enhanced service model will support the discharge to assess model from our Acute partners which will ensure that appropriate evaluation and treatment can be offered to individuals allowing them to retain as much independence as possible prior to their acute episode. Each patient admitted to the service will be aligned to a treatment pathway appropriate for their condition and rehabilitation needs. This will ensure that if a change in the individual's usujulieal place of residence is required, it will be identified and appropriately sought by the service.

Although separate both the intermediate care service model and the falls service model will have the ability to refer patients between services ensuring the most appropriate and beneficial care is delivered. This will safeguard unnecessary admission to residential care which would result in an individual's independence being actively limited.

Proportion of older people who are still at home 91 days after discharge from hospital: this cohort of people will be identified by general practice using the risk stratification as a high-risk of re-admission and therefore are eligible for referral into the service for additional rehabilitation goals or specific targeted short-term nursing treatment i.e. IV therapy etc.

Delayed transfers of care from hospital: the service will benefit from the discharge to assess model that is operational within our secondary care providers and therefore those patients identified as meeting the criteria for intermediate care will be referred, accepted and aligned to a treatment pathway within the service.

Patient/service user experience: as with any NHS service the intermediate care facility will be subject to annual patient surveys, it will benefit from review by the CCG that will include the Patient Reference Advisory Panel. By supporting patients in avoiding admission to and subsequent By supporting patients in the discharge from hospital this approach will reduce the risk of a hospital acquired infection, limit the deterioration in both mobility and mental capacity of the patient and allow the patient to maintain as much independence as appropriate with their condition.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The service specification for the intermediate care facility will benefit from the development of robust Key Performance Indicators (KPIs) and outcome measures. These will be monitored on a monthly basis through the CCGs System Resilience Operational Group (which replaces the Urgent Care Boards) assessing the impact of the service, highlighting and removing any blocks that would deter an admission avoidance or supported discharge and reviewing the provision of social packages of care and residential and/or nursing home provision.

The KPIs will be focused on reducing A&E attendances and inappropriate admissions together with reducing the Delayed transfer of care (DTOCs). The DTOCs are monitored weekly through existing arrangements; however, it is a standing agenda item on the SROG that adds more rigor to the measurement of the service impact.

As part of the new arrangements and establishment of Trafford's SROG a performance dashboard is being developed that will record both planned and unplanned care, the KPIs from this service will be shown within this dashboard.

What are the key success factors for implementation of this scheme?

The key successes will form part of the aims and outcomes of the service specification and will have associated KPIs aligned to them. The service specification will identify the skills, competencies and knowledge base for the staff delivering the model and also those who will have clinical and operational links into service delivery. The staffing establishment will benefit from a multi-disciplinary, multi-experienced, multi-organisational/agency skill mix this will allow the enhanced model to deliver a fully

integrated service.

The service will benefit from constant review guaranteeing a timely response to the changing needs and environment of Trafford's population.

The previous intermediate care model was unique and benefited from a strong partnership approach; this will be mirrored in the new service going forward guaranteeing co-production.

Due to the multi-agency approach, the integrated intermediate care model will have a phased implementation methodology. The CCG has established a steering group with a membership from all partner organisations who have approved the model and the associated principles of delivery. The CCG has evaluated other intermediate care models including elements of good practice into our service specification.

ANNEX 1 – Detailed Scheme Description- *Community Health and Social Care Integration and Development of an Early Help Hub*

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
TC/CHSCI/01
Scheme name
Community Health and Social Care Integration and development of an early help hub
What is the strategic objective of this scheme?
The strategic objectives of the project include: • To provide an all age, integrated and locality based health and social care delivery service for the population of Trafford by the end of 2016, based in Trafford's four localities • To ensure access to a choice of high quality, person centred, and coordinated services, supported by an integrated model of service delivery. • To manage demand on health and social care services, through new delivery models and pathways and a new all age front door, the Early Help Hub, for all community health and social care. This will have a strong focus on promoting self-care as well as a coordinated route into service provision. This will provide a more coordinated approach to prevention and early intervention, whilst empowering people to increase their wellbeing and building resilient communities. • To create multi-agency integrated structures, with health and social care practitioners and to integrate approaches to assessing, planning and managing care. • To deliver the new models of care for frail older people and those facing end of life through coordinated integrated health and social care delivery teams wrapped around general practice and primary care. The overall intentions of the project include: • Deliver high quality integrated community services through the integration of health and social care for children and adults into a single function. • Create a culture which integrates and values existing membership and principles through the work already completed to create an overarching vision to improve the form and function of the service provision • Develop a robust framework for the transfer and changes of organisational provision which maintains the agreed level of service • Integrate the governance, performance, human resource, finance, estates and communication functions for the organisation. • Develop a robust and sustainable delivery model • Develop new integrated structures to drive innovation into the organisation in the move to a central function in Trafford • Create active and meaningful engagement internally and with partners, developing innovative partnership arrangements with other agencies

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

Model of Care

The focus for changes is:

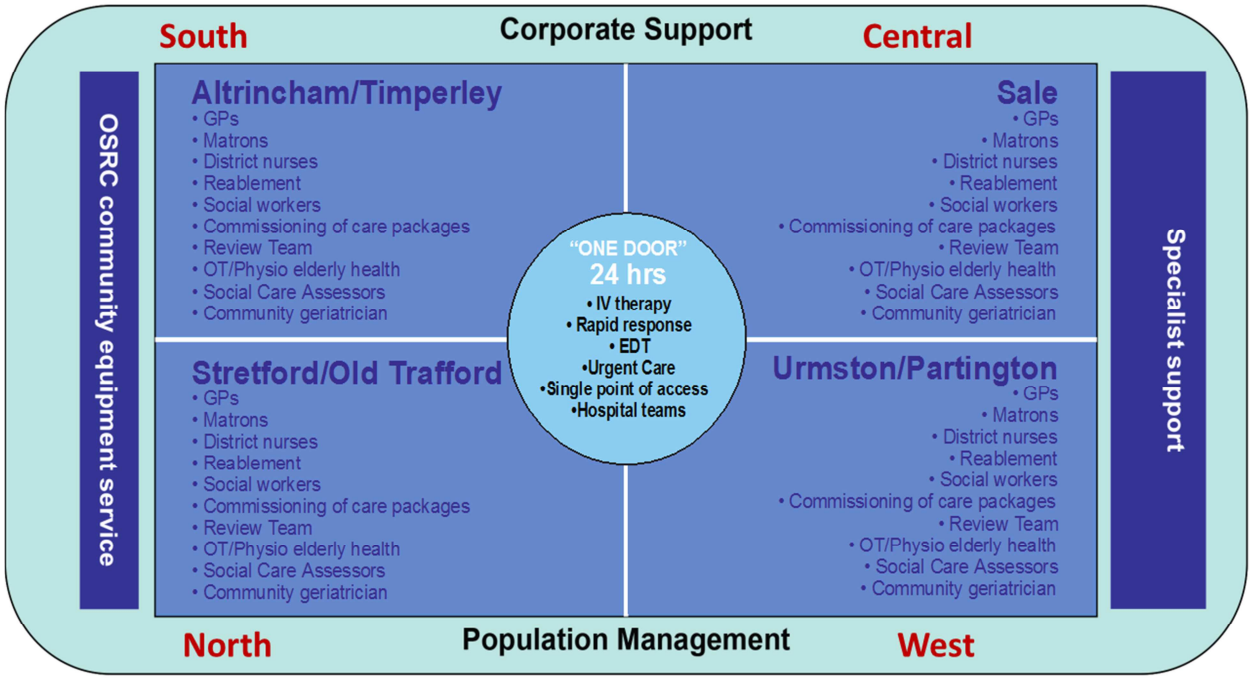
1. All age early help front door/ hub
2. Redesigned and integrated adult locality teams
3. Redesigned and integrated adult pathways, including for frail elderly people and end of life pathway
4. Complex care coordination
5. All age integrated locality teams

The vision for Trafford is to develop an integrated service delivery model made up of co-located multi-agency teams, who will work closer with local services such as GP's, pharmacists, nursing and residential homes, and other community providers clustered with defined residential areas. Trafford already has a fully integrated health and social care service for children and young people operating on a four neighbourhood model and by October 2014 will have replicated this for adults through a comprehensive Section 75 agreement between Trafford Council and Penine Care. The intention by 2016 is to have moved this model on still further to create an all age integrated and social care service, incorporating our new all age Early Help Hub to compliment the Patient Care Coordination Centre being developed by the CCG.

The teams will be co-terminus with the four neighbourhood areas that are supported by the local strategic partners to offer synergy between the different providers.

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

The new model will bring existing services and staffing structures together to offer effective team working through integrated structures that are multi-agency and geographically based in the four neighbourhoods, see diagram below.



The all age integrated care model will have both reactive and proactive elements, with a stronger emphasis on prevention and early intervention to prevent individuals deteriorating and needing more intense care and support at a later stage.

Integrated care teams will help people remain at home by utilising reablement, intermediate care, community fall service, the urgent care response and by facilitating coordinated care plans which detail the support needed for the person to maintain their heath and care at home and the response required in an emergency. Through this the model will provide step up from primary care to support the reduction of patient flows into the hospital and step down from hospital to support and ease discharge and reduce the length of stay in hospital. The service will also link to community provision to ensure proactive planning occurs within the community to prevent the likelihood of readmission.

Individuals at high risk of hospital admission with complex needs will be prioritised in the new integrated multi-disciplinary teams. The teams will work with general practice to proactively identify appropriate people through a risk stratification tool. Their care will be coordinated and delivered through a lead professional. The lead professional will be allocated based on the primary needs of each person, this could be a social worker, practice or district nurse or therapist. Their care will be managed more effectively and the lead professional will improve the quality of the patients and carer experience as well as reducing fragmentation within the system. The care coordinator will create a proactive care plan in agreement with the individual and their families and will be shared across the health and social care system. The service will work with NWAS and acute sector services, primary care and the Patient Care Coordination Centre as this goes live to contribute to Trafford's vision of a 15% deflection over 5 years, as well as reducing admissions, reducing length of stay in hospital and reducing admission to care homes.

The lead professional will meet with the individual to gain consent and begin care planning. Care plans will be focused on promoting the individual's understanding of their care and support needs, self-care where appropriate and building health and social care

community resources around the person, including crisis response plans to manage deterioration or fluctuations in someone's health and social care needs at home e.g. the use of rescue packs. This approach will also encourage consultants to work out in the community, reducing unplanned admission and changing the use of outpatient appointments.

This will contribute to the CCG's plan for care plans to be completed for all people over 75 years.

In parallel with the focus on complex needs there is a commitment to focus on early intervention and general wellbeing, encouraging and fostering self resilience and independence, both for the individual and local communities. This is being built into all the revised models of care and includes the creation of an all age early help hub, which will be Trafford resident's first port of call if they need information or support to maintain their own or their family's health and wellbeing. This will align Trafford council and Pennine Care FT with the resources in local communities that can be focused to support people to self-care where appropriate, understand their long term condition and how to effectively manage this at home.

The hub will provide an all age 'front door' for services for those that need them, including a community screening function providing an initial assessment about appropriate next steps. The hub's key aim will be to manage the future demand on services, reducing the need for statutory support from social care, community health, or acute hospitals.

The vision of the hub is that Trafford citizens, of all ages, improve their health and wellbeing using their own resources, the support of their communities and a 'hub' of co-ordinated support and tools. By empowering individuals and communities to take more proactive responsibility for their wellbeing it will lead to healthier, happier and more resilient communities and reduced demand for health and social care.

The early help hub will offer access to a range of support and advice services and is a whole system change to the way in which services approach prevention and early intervention. Its key principles are focused on developing interventions to be holistic, collaborative, ageless and promote self-care.

The primary element is through the use technology that connects people to self-care tools and portals to support individuals to take control of their own health and wellbeing. The principle is that a large number of people will never need to come into direct contact with services as the self-care element will provide them with the tools and support needed to make changes to their lives. The tools will enable people to focus on any area of their lives, even if the initial direct impact is not on health, as this will contribute to wider wellbeing.

Work is also on-going to review and update the information sharing arrangements across health and social care. This will support joined up and aligned assessment and care planning and ensure professionals are clear about the patient data and information that can and should be shared. The Council's implementation of a new adult social care ICT system will also support this. However a shift in culture across health and social care is also required to create more sustained integration of services. The planned physical co-location of teams and different professionals will support this.

Target Audience

The integrated services will be available for all people with health or social care and support needs. Whilst the hub element will be open to everyone, the health and social care services will continue to follow the existing eligibility criteria;

- Social care: for any residents of Trafford, (including those considered to be ordinarily resident) assessed as eligible for social care services
- Health: any person registered with a Trafford GP, requiring health support

Individuals at high risk of hospital admission with complex needs will be prioritised in the new integrated multi-disciplinary teams, and identified through a risk stratification tool. Their care will be coordinated and delivered through a lead professional and a proactive care plan will be developed for them. This will link with the cohort of people aged 75 years and over to align with the GP requirements to complete proactive care plans for 2% of this population.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Trafford CCG commission Pennine Care FT to deliver their community health services and social care is provided by Trafford Council. The specific list of services provided is detailed below.

Community Health Services:

- Matrons
- District Nursing
- Occupational therapist / Physio
- Ear Care
- Palliative
- Treatment Room Provision
- Heart Failure Nurse
- Phlebotomy
- Tissue Viability and Leg Ulcer Clinic
- Bladder and Bowel
- IV Therapy
- Occupational Therapist and Rapid Response
- Dementia
- Infection Control
- One Stop Resource Centre
- Equipment Nurse
- MSK
- Podiatry
- SALT
- SWMS & Dietetics
- Pulmonary rehab
- CNRT /Parkinsons Disease / Stroke

Social Care Services:

- Assessment for people over the age of 18 where social care is felt to be

appropriate
- Reablement
- Equipment provision
- Carers services
- Ascot house
- Direct payments
- Safeguarding
- Deprivation of liberty
- Review team
- Screening service
- welfare rights

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

With an ageing population and increasing numbers of people living longer with multiple long term conditions the demand for social care and support is growing. By 2030 almost 20% of the Trafford population will be over 65, with a 78% increase in the number of people aged over 85. This is set against a backdrop of challenging financial times for the whole of the public sector, who has seen real term reductions in public spend. It is clear that the current health and social care systems are not sustainable. This was compounded by the recent concerns with the quality of care which were highlighted in the Winterbourne and Francis Inquiries. These challenges highlight the need for a new and innovative solution that delivers the right support to individuals at an early stage.

The government's commitment and corresponding evidence for the integration of community health and social care has been clear and explicit and is in part a response to these challenges. This evidence is highlighted by the work done by the Kings Fund on integration, which can be found at; http://www.kingsfund.org.uk/topics/integrated-care.

The government have also embedded their commitment into legislation through the Care Act 2014 which received royal assent in May 2014, http://careandsupportregs.dh.gov.uk/category/integration/.

There is a clear need to explore new ways of working, which can lead to greater efficiency and a reduction in demand. In Trafford this is being done through the community health and social care integration and the development of an early help hub to manage demand into and out of the system and enable self-help.

The development of the hub has been coproduced with members of the public, through a borough wide engagement exercise, and service provides through locality workshops.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Confirm/ insert funding figure from template (part 2) – expenditure plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Reduce non-elective admissions. The community health and social care integration model will have stronger emphasis on prevention and early intervention to prevent individuals deteriorating and needing more intense support at a later stage. The model will also provide step up from primary care to support the reduction of patient flows into the hospital. The service will also ensure proactive planning occurs within the community to prevent the likelihood of admission and readmission. Individuals at high risk of hospital admission with complex needs will be prioritised in the new integrated multi-disciplinary teams and will have proactive care plans, which are agreed with the individual and their families and will be shared across the health and social care system. This will incorporate crisis response plans to manage deterioration or fluctuations in someone's health and social care needs at home.

Reduce permanent admissions to residential and nursing care. This model is committed to focus on early intervention and general wellbeing, encouraging and fostering self resilience and independence, both for the individual and local communities. This will focus on supporting people to self-care where appropriate, understand their long term condition and how to effectively manage this at home.

Increase the proportion of older people who are still at home 91 days after discharge from hospital. The model will closely link to intermediate care support and maximise the reablement and telecare offer to provide comprehensive step down provision that will rehabilitate peoples' skills and ensure they are able to remain at home.

Reduce delayed transfers of care from hospital. This model will improve the step down offer from hospital to support and ease the discharge of people and reduce the length of stay in hospital. The locality team will quickly work with people on discharge to provide holistic care that prevents readmission. By wrapping health and social care around the person a more joined up, coordinated and timely response will be provided.

Improved patient/ service user experience. The model will ensure access to a choice of high quality, person centred and coordinated services. Social care and community health will be integrated as part of this model where there will be seamless joint working between professionals to meet the needs of individuals. This new model will have a workforce that has the skills and competencies to treat and care for these patients. Within Trafford, clinical information will be available to health and social care professionals working across the economy. This will all see a significant improvement in the experience of individuals.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Quality outcomes will be agreed for the programme with targets in place to measure success at each of the milestones. National NHS, social care, public health and user experience metrics will be used alongside locally developed indicators to evidence and report outcomes.

Work is on-going to analyse present indicators in the existing outcome frameworks for social care, public health, and health, to benchmark and evidence the impact of these

changes.

Performance indicators and outcomes will be monitored by the project steering group and reported through the agreed governance structure to the Partnership Management Group and the Health and Wellbeing Board.

Data will be gathered both automatically, to evidence activity for health and social care services, and the use of other methods, such as surveys and customer feedback, to provide qualitative evidence.

A communications plan has been developed to ensure key messages and updates are shared with stakeholders throughout the project, feedback gathered and used to inform the on-going development.

What are the key success factors for implementation of this scheme?

The community health and social care integration and development of an early help hub will see the following changes for patients and service users:

- Trafford residents will receive the right care, by the right person, when they need it, in the right place as patients will benefit from increased resilience and capacity in the community
- Locality services will meet the needs of patients and will better equipped to respond to their needs
- Through a proactive clinical model, patients will be able to access support at an early stage which will reduce the need for more acute services
- Emergency and unplanned admissions will be reduced.
- Re-admissions will be reduced
- Delayed transfers of care will be reduced for Trafford residents, regardless of which hospital they are using
- Length of stay at hospital will be appropriate to need
- Patients will benefit from early care planning by multidisciplinary teams
- Improved patient and service user experience
- Reducing duplication for people using services
- Improved support to carers and families

ANNEX 2a – Provider commentary – *University Hospital of South Manchester NHS Foundation Trust*

Name of Health & Wellbeing Board	Trafford
Name of Provider organisation	University Hospital of South Manchester NHS Foundation Trust
Name of Provider CEO	Dr Attila Vegh
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	10768
	2014/15 Plan	10694
	2015/16 Plan	10241
	14/15 Change compared to 13/14 outturn	-74
	15/16 Change compared to planned 14/15 outturn	-453
	How many non-elective admissions is the BCF planned to prevent in 14-15?	-108
	How many non-elective admissions is the BCF planned to prevent in 15-16?	-1175

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	

ANNEX 2b – *Central Manchester University Hospitals NHS Foundation Trust*

Name of Health & Wellbeing Board	Trafford
Name of Provider organisation	Central Manchester University Hospitals NHS Foundation Trust
Name of Provider CEO	Sir Michael Deegan
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	9562
	2014/15 Plan	5790
	2015/16 Plan	5497
	14/15 Change compared to 13/14 outturn	-3772
	15/16 Change compared to planned 14/15 outturn	-294
	How many non-elective admissions is the BCF planned to prevent in 14-15?	-72
	How many non-elective admissions is the BCF planned to prevent in 15-16?	-769

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	

ANNEX 2c –*Salford Royal NHS Foundation Trust*

Name of Health & Wellbeing Board	Trafford
Name of Provider organisation	Salford Royal NHS Foundation Trust
`	Sir David Dalton
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	808
	2014/15 Plan	1503
	2015/16 Plan	1441
	14/15 Change compared to 13/14 outturn	695
	15/16 Change compared to planned 14/15 outturn	-62
	How many non-elective admissions is the BCF planned to prevent in 14-15?	-10
	How many non-elective admissions is the BCF planned to prevent in 15-16?	-195

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	

Appendix 1 – *Membership of the Trafford Better Care Fund Steering Group*

Name	Organisation	Role
Deborah Brownlee (Chair)	Trafford Council	Corporate Director, Children Families and Wellbeing.
Gina Lawrence	Trafford CCG	Chief Operating Officer
Julie Crossley	Trafford CCG	Associate Director of Commissioning
Linda Harper	Trafford Council	Deputy Corporate Director / Children Families and Wellbeing Directorate and Director of Service Development, Adult and Community Services
Ian Duncan	Trafford Council	Director of Finance
Joe McGuigan	Trafford CCG	Chief Finance Officer
Imran Khan	Trafford CCG	Service Transformation Project Manager (Frail & Older People and End of Life)
Tamara Zatman	Trafford Council	Programme Manager (Care Act)
Diane Eaton	Trafford Council	Joint Director for Adult Services (Social Care) Children, Families and Wellbeing Directorate (Health and Social Care Integration)

Appendix 2 – *Membership of the Patient Reference Advisory Group*

Name	Organisation	Job Title
Shabir Abul	North Trafford	Patient Representative
Gill Long	Central Trafford	Patient Representative
George Devlin	West Trafford	Patient Representative
Pat Lees	South Trafford	Patient Representative
Ann Marie Jones	Age UK	Third Sector/Voluntary Organisation
Chris Jacob	42nd Street	Third Sector/Voluntary Organisation
Khan Mogul	Voice of BME Trafford	Third Sector/Voluntary Organisation
Lesley Thornton	Counselling & Family Care	Third Sector/Voluntary Organisation
TBC	North Trafford	GP Patient Participation Group Reps
TBC	Central Trafford	GP Patient Participation Group Reps
Priscilla Nkwenti	CCG Vice Chair	Member lead for engagement
Brian Wilkins	Healthwatch Trafford	Trafford Health Watch Rep

[i] Trafford Council, (2012) *Trafford Overview*, www.infotrafford.org.uk/custom/resources/JSNA.
[ii] Trafford Council, (2012) Trafford Overview, www.infotrafford.org.uk/custom/resources/JSNA.