TRAFFORD COUNCIL

Report to: **Health & Wellbeing Board**
Date: **3rd March 2015**
Report for: **Trafford Better Care Fund**
Report of: **Julie Crossley**
Report Title

Trafford Better Care Fund

Purpose

This is to provide the Health and Wellbeing board with an update of the progress of Trafford Better Care Fund and the next phase.

Recommendations

The Health and Wellbeing Board are asked to note the contents of this report

Contact person for access to background papers and further information:

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1. Introduction

1.1 Following the resubmission in December of Trafford's Better Care Fund to NHS England the CCG has received notification that the programme has received full approval. A copy of the resubmitted programme which has now been approved is provided at **Appendix 1** for information**.**

1.2 The attached copy has some sections in red text, this denotes the additional information which was included for the final submission. The programme has been approved with no conditions.

2. Current Position

2.1 Further progress is now being made on all the individual schemes. The current position of all schemes is summarised in the Chief Clinical Offers report. All project groups will resume to progress the schemes now that the programme has been approved.

2.2 The CCG are working with Trafford Council to agree a section 75 for the pooled budget for Better Care Fund. A draft of the work-in –progress is provided at Appendix 2.

2.3 NHS England has provided support to each locality to progress their Better Care Fund programme. Representatives from the Trafford CCG, the Council and Pennine care have attended a leadership workshop and received material which has been made available to support progress. This also provided the opportunity to share ideas and share good practice.

2.4 There have been a number of issues which have been raised at these sessions which are being addressed by NHS England these include:

- Assistance with communications and engagement
- The impact on primary care and community services workforce to address the required increase in capacity , skills and competency
- Support of managing joint budgets
- Creating and delivering new models of care
- Clinical leadership

3. Recommendations

3.1 The Health and Wellbeing Board will continue to receive updates on the progress of the Better Care Fund Programme. The Board are asked to note the contents of this report

Appendix 1

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.

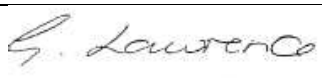
1) PLAN DETAILS

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	19 September 2014

Signed on behalf of the Council	 Trafford Council
By	Theresa Grant
Position	Chief Executive
Date	19 September 2014

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	19 September 2014

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.  280314 HWB strategy action plan a
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.
Trafford CCG 5 Year Strategic Plan	Trafford's 5 year Strategic Commissioning Plan which outlines the CCG intentions for 2014-19 This outlines the new CCG commitment to commissioning high quality services for the Trafford population  Trafford_CCG_Strategic_Plan.doc
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.  PID CCG - Integration and Hub \  End Of Life PID  Frail and Older People PID
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.  ISOS Document 3 - PCCC Visioning Docun
Memorandum of Understanding Patient Care Coordination Centre	 MOU_FINAL_v4.0_091214.docx

Trafford Integrated Care Journey Document	Trafford Journey to Integration

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 Journey towards integration began in 2008, the background to this is provided in the document referenced at the beginning of this submission. This provides the opportunity to the reader to understand the integrated work that has already undertaken and we seek to build on through the Better Care Fund Programme. 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, with close links into community and voluntary sector. 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 and care plans will be easily accessible to these teams and primary care.

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, and 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.

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 incorporating the

development of an Early Help Hub, redesigning frail and older people's 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 within each scheme to ensure input to 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's 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 and 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 project will be clinically driven by the needs of this patient cohort and be supported by the voluntary and community 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 project 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 across health, social care and the community and voluntary sector will be developed to support the changes to services and practice with particular reference to those patients with mental health. 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 and the Council will be able to demonstrate that an increased number of 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. However social care will need to continue to work with the registered population regardless of the GP Practice population.

This model 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. The Early Help Hub will ensure that Trafford citizens, of all ages, improve their health and wellbeing using their own resources, the support of their communities and co-ordinated support and tools

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. Supported by the Early Help Hub people will 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.

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, voluntary sector 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, SRFT, UHSM, and CMFT
- Improved co-ordination of patient care A coordinated and supported network of community organisations providing preventative

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
- Residents and communities will be empowered to be more resilient and proactive about their wellbeing
- Locality services will meet the needs of patients and will better equipped to respond to their needs
- Through a proactive model, patients will be able to access support at an early stage which will reduce the need for more acute services
- 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 and no longer
- Patients will benefit from early care planning by multidisciplinary teams
- Patient and service users will have a positive experience of care
- Reducing duplication for people using services
- Improved support to carers and families

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 (health and social care) 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.

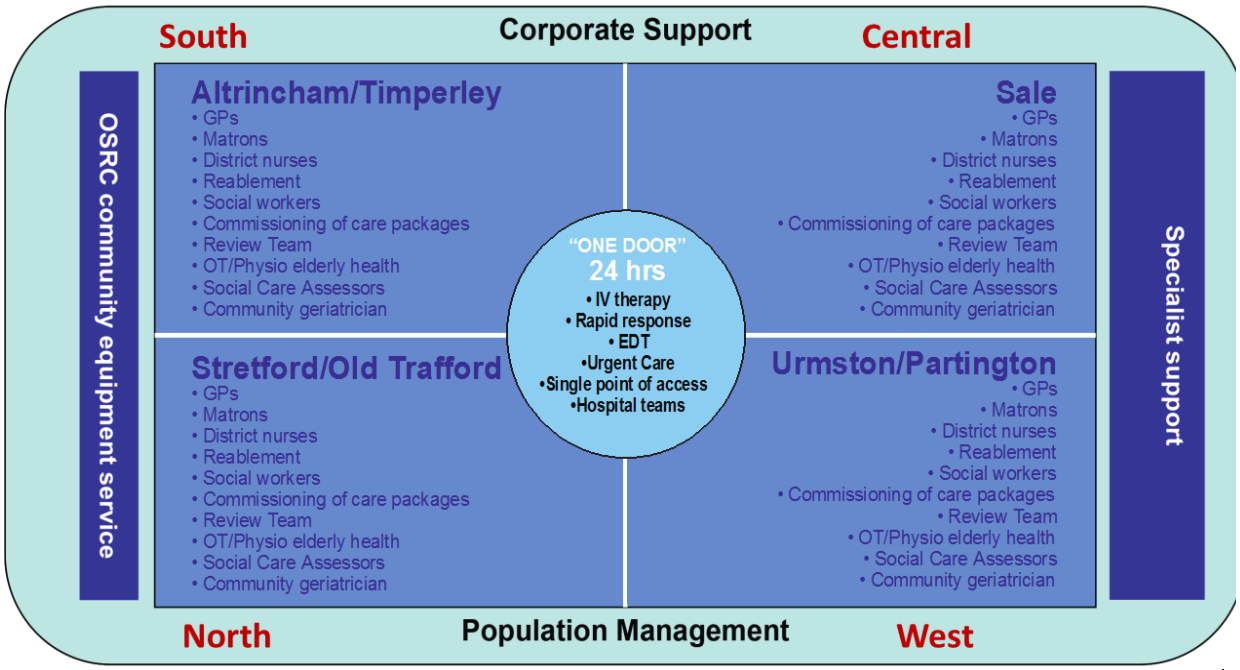
<u>The Integration of Health and Social Care and the development of an Early Help Hub:</u>

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 and community services, 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 multiagency, coordinated 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 November 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, with strong links to the voluntary and community sector, 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 requiring support, or their conditions deteriorating and needing more intense care and support at a later stage.

Integrated care teams will help people remain at home by utilising community and voluntary sector support, 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 timely 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, social care and community and voluntary sector 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 isolation.

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 and "My Way". 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 the voluntary sector and a 'hub' of co-ordinated support and tools. It will work closely with communities and their organisations to coproduce innovative solutions addressing local needs, and where required, support development and sustainability. 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.

The Redesign of Frail and Older People's Services

Falls Service Falls Service

From analysing Trafford's A&E activity, a significant number of older people are admitted into acute services as a result of a fall. The current spend on an annual basis exceeds £2.5m. Although there is a consultant led falls service in Trafford, this service does not have the capacity to meet this increasing demand from an aging population. This increasing demand requires a service which is easily accessible across Trafford and also has the capacity to support this growing demand.

The current service is reactive and only has the current capacity to assess those patients who have had a number of falls. The redesign of this service needs to support vulnerable patients who will receive any assistance/support to prevent them from having on-going falls and consequently hospital admissions. Within Trafford, the Public Health team are finalising a Falls and Bone Health Strategy. This is in line with national guidance and best practice. To reduce the growing pressure on A&E departments, the CCG sees the prevention of falls as a priority for its patients. Also for a comprehensive approach to the prevention of falls be introduced across Trafford delivered within the community. Therefore, there are 2 work streams to address this priority,

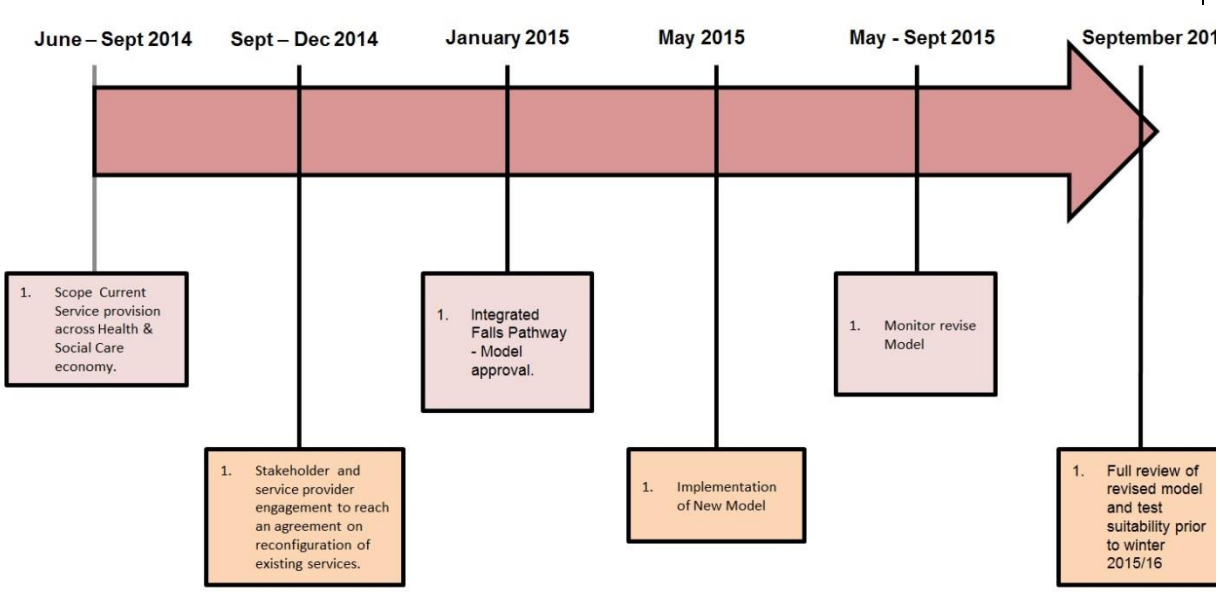
- The development of the falls strategy – to be completed by October 2014
- The development of a Trafford Falls Service by January 2015

A falls service will consist of the following services;

1. A central service based in the community which will receive all referrals from Primary care , Nursing homes and other Community service. This will offers rapid response to those patients who have fallen including triage by Occupational therapist and supported by a multi-disciplinary team including, OT, Physiotherapy, Community Nursing, rehabilitation ,medicines management and mental health
2. The community service will be accessible across Trafford delivered across the 4 localities. This service will assess and provide a service which offers physiotherapy, rehabilitation and clinical advice and adaptions where appropriate to enable patients to remain at home and be safe.
3. This service will have links to specialised services where appropriate through community health and social care or a secondary care setting.

This scheme will require investment as part of the Better Care Fund however significant benefits from the reduction in secondary care admissions will be

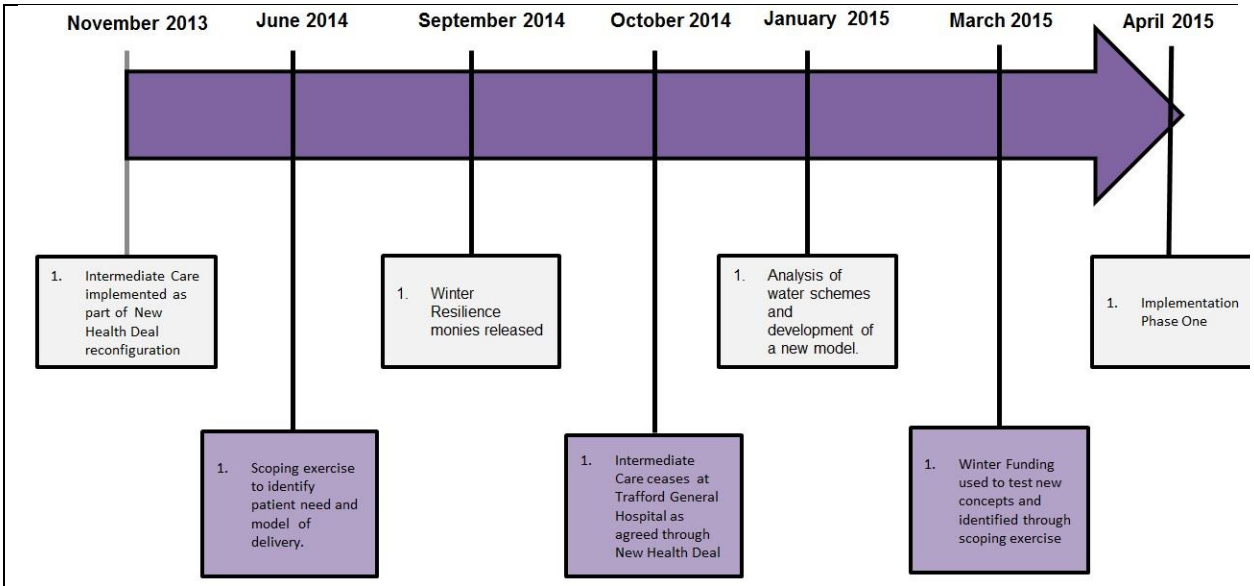
realised. The new community services will link to other community services such as community matrons and community nursing to assess patients on their caseload. This scheme will require investment through the Better Care Fund however significant savings can be realised through the reduction in demand 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 and Trafford Council to evaluate and to redesign the Intermediate Care Services across health and social care and provide an intermediate care offer from April 2015. 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 and deflection of unnecessary admissions for the acute providers.



Transforming Community Nursing

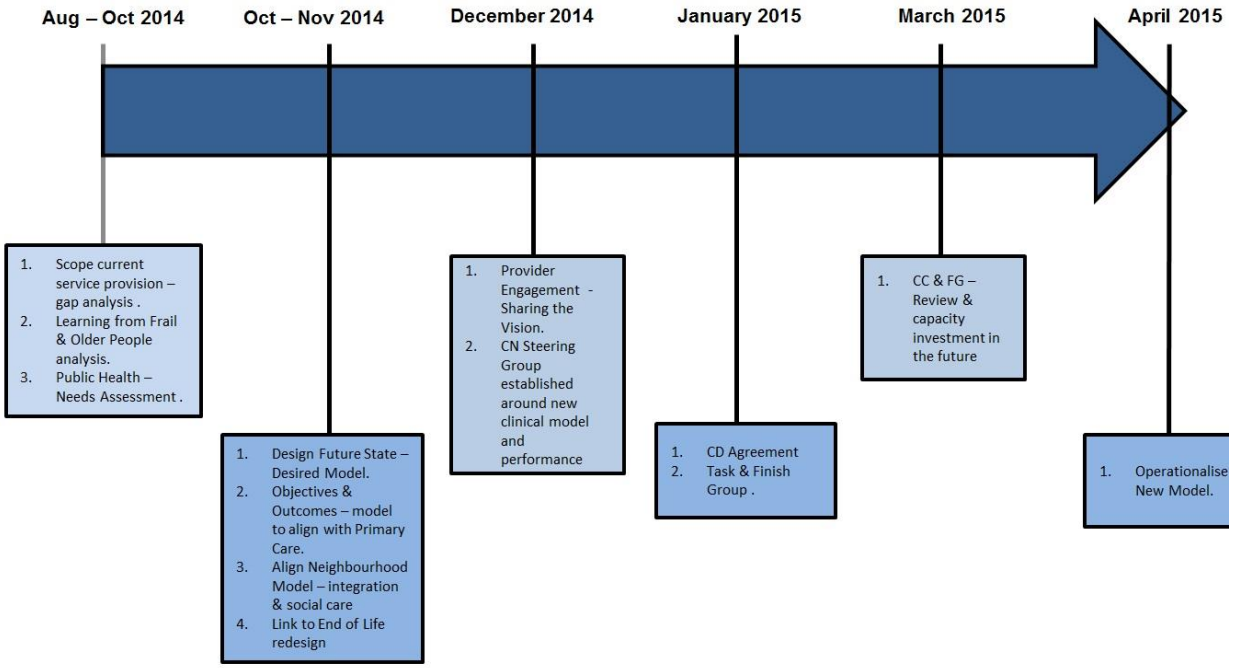
This will review and build on the current provision of community nursing provided by

- 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:

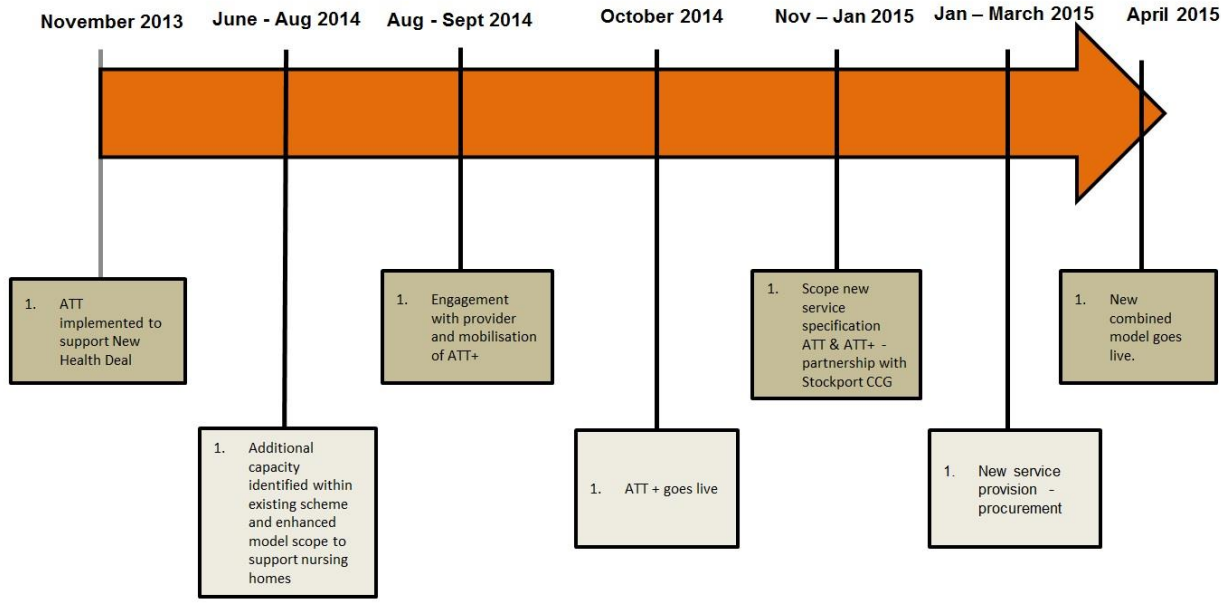
- improve the quality of care received by patients in the community and enable patients to stay at home for longer, living independently, preventing emergency admissions and readmissions;
- Enable patients to be discharged from hospital in a timely manner and transferred safely and appropriately into a fully integrated health and social care provision in the community including from A and E. 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.

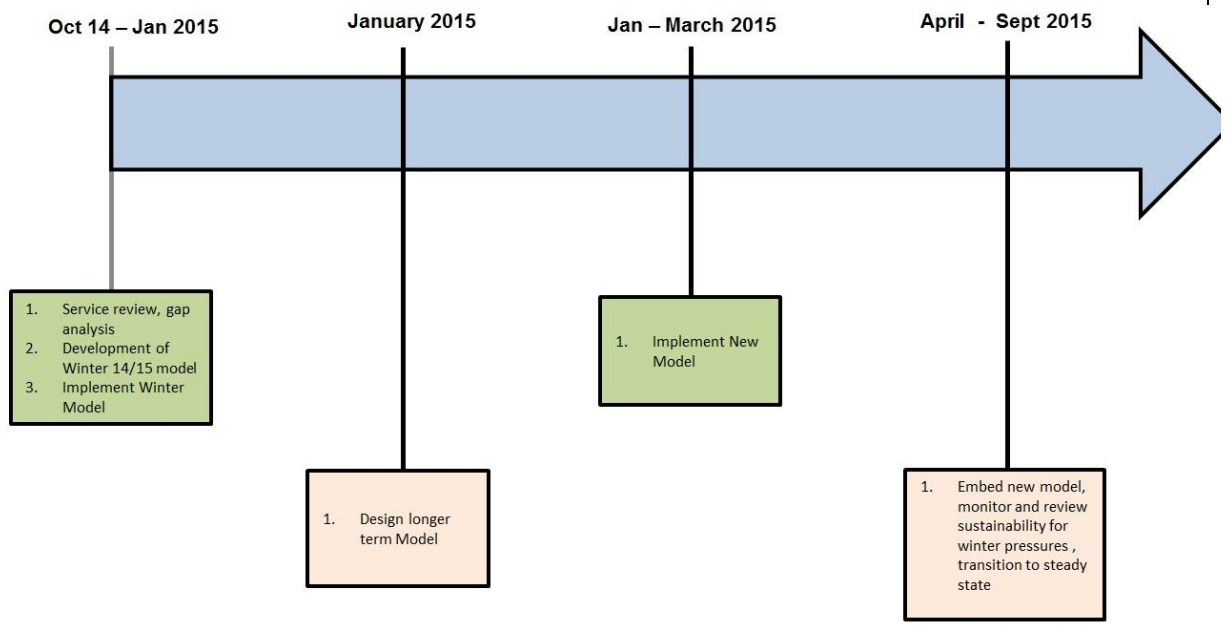


Primary care for nursing and residential care homes

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. It is expected that this review will not implement a new care model within the BCF year; however the reviews of community geriatrics and transforming community nursing will have regard to the progression towards any new service.

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 if required and/or responsive on-going 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 and the community and voluntary sector 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 and voluntary and community organisations have the appropriate skills to meet the needs of the elderly population. The training programme will also assist 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 and a level of certainty about the point at which a person becomes a 'dying person' and when treatment may end and care becomes palliative.
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;

- Delivering end of life advice/support service in collaboration with Trafford Carers Centre, community services and hospices through MPET funding
- 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

The Trafford Better Care Fund does not stand alone and enhances our approach to existing integration. Detail descriptions of the BCF schemes are attached as Annex 1, however the table overleaf summaries the resources already committed to developing integrated services, the resource required to enhance this and the level of impact each scheme will have. The rational for quantifying the impact is attached as Appendix 6

Ref	Scheme Name	Existing Spend £000	New Spend £000	Admissions to Care Homes	Effectiveness of Reablement	Delayed Transfers of Care	Patient and Service user Experience	Hospital Admission Avoidance	Increase % of Deaths in Preferred Place
FOP01	Developing a Falls Service	0	400	**Significant**	**Significant**	**Significant**	**Moderate**	**Significant**	**Low**
FOP02	Reproviding Intermediate Care	322	600	**Significant**	**Significant**	**Significant**	**Moderate**	**Significant**	**Low**
FOP03	Alternative to Transfer Plus	257	100	**Low**	**Low**	**Low**	**Moderate**	**Moderate**	**Low**
FOP04	Transforming Community Nursing	3078	0	**Moderate**	**Moderate**	**Moderate**	**Moderate**	**Low**	**Moderate**
FOP05	Community Geriatrics	400	0	**Moderate**	**Moderate**	**Moderate**	**Moderate**	**Moderate**	**Low**
FOP06	Primary Care for Nursing and Residential Homes	0	300	**Low**	**Moderate**	**Low**	**Moderate**	**Moderate**	**Moderate**
EOL01	Redesigning End of Life Care	2112	200	**Low**	**Low**	**Low**	**Moderate**	**Low**	**Significant**
EOL02	End of Life Enablers	As above	As above	**Low**	**Low**	**Low**	**Moderate**	**Low**	**Significant**
EOL03	Developing the 3rd Sector in End of Life Care	As above	As above	**Low**	**Low**	**Low**	**Moderate**	**Low**	**Significant**
	Enablers								
HSCI 01/-05	Integration of Health and Social Care	0	0	The integration of community health and social care services will enable the successful delivery of the schemes highlighted above. Whilst no direct impact has been quantified against these schemes, it will have a key role in achieving the BFC Metrics. The protection of social care services will support the continuation and enhancement of a number of existing schemes.					
	Protection of Social Care	4987	2000						
	Total	11156	4388						

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 BCF.

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.

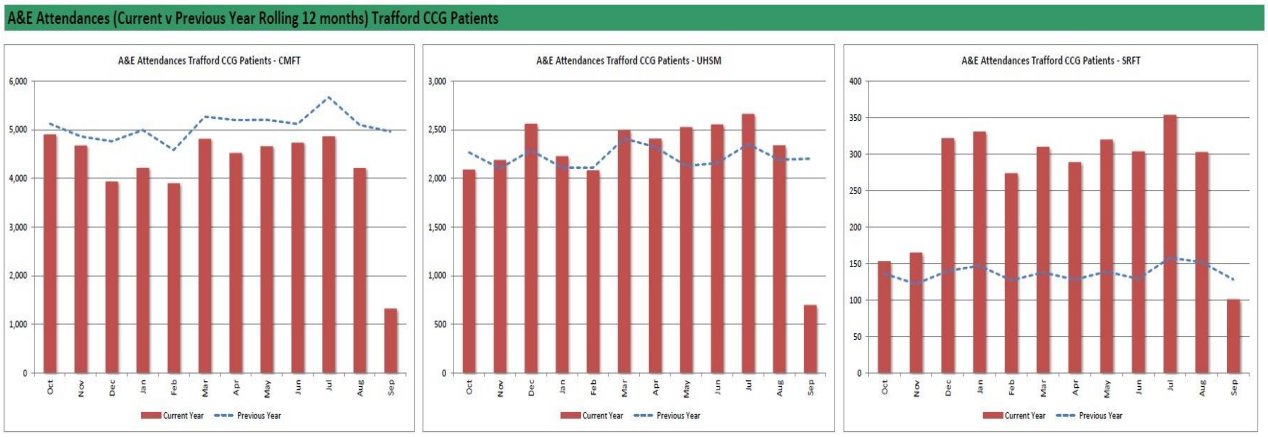
The table below shows the number of Emergency hospital admissions for injuries due to falls in people aged 65 years and over in Trafford and England, 2011-12

Indicator	Trafford	England
Injuries due to falls in people aged 65 and over	1,801	1,665
Injuries due to falls in people aged 65 and over - males	1,412	1,302
Injuries due to falls in people aged 65 and over - females	2,190	2,028
Injuries due to falls in people aged 65 and over - aged 65-79	1,052	941
Injuries due to falls in people aged 65 and over - aged 80+	5,172	4,924

New Health Deal for Trafford

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.

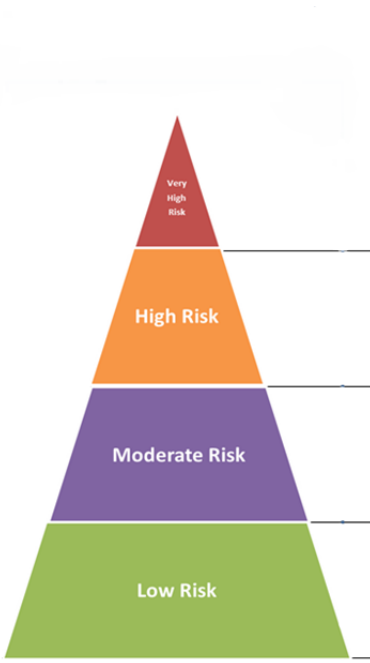
The graph below shows the changes in A & E attendances for Trafford patients since the implementation of the New Health Deal for Trafford.



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

Trafford CCG has undertaken a risk stratification exercise of all registered population. This is summarised in the graph below. Whilst very high and high risk patients make up 6.4% of the population, they account for 26.3% of all emergency attendance at secondary care and 35.8% of all emergency admissions. The majority of these patients are over the age of 65 and have multiple health and social care needs. The most common reasons for presentations have been identified and will be addressed through the Better Care Fund Schemes.



		Population	Elective Admissions	Outpatient Appts	A&E Attendances	Emergency Admissions
Very High Risk	No	1,462	5,080	45,985	9,362	3,265
	% of Total	0.6%	6.2%	5.1%	6.4%	8.1%
High Risk	No	13,773	31,906	257,976	29,079	11,116
	% of Total	5.8%	38.9%	28.4%	19.9%	27.7%
Moderate Risk	No	37,476	34,801	335,247	38,609	17,205
	% of Total	15.7%	42.4%	36.9%	26.4%	42.9%
Low Risk	No	185,503	10,324	269,188	69,181	8,508
	% of Total	77.9%	12.6%	29.6%	47.3%	21.2%
TOTAL		238,214	82,111	908,396	146,231	40,094

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, social care and community and voluntary sector 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.

The chart at Appendix 3 outlines how each of the BCF schemes will be aligned to target each segment of the Trafford population.

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 and the Council to evidence the requirement for intermediate care and allowed the enhanced model to be developed.

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.

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%. 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 the community. 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.

Revised Metrics

Residential admissions metric:

Although Trafford's figure for permanent admissions of Older People per 100,000 populations in 2013/14 was slightly below the National average (698 compared to 638), it was 10% better than the North West and 2% better than the IPF averages.

Trafford was ranked 5th out of 23 authorities in the North West in 2013/14 and has reported a 14% improvement against this indicator since 2011/12.

Furthermore the introduction of new data returns means the methodology for calculating the admissions indicator changed in April 2014 and may significantly affect the potential outturns / targets. As yet, we are unable to accurately predict the effect of these changes.

In light of this, and taking into account the increasing population, Trafford has agreed a 4.1% reduction in the rate of permanent admissions to care homes over the next two years. This is an improvement of 1.97% in year 1 and a further 2.1% in year two.

Therefore the Trafford Target against this measure will remain unchanged against that set out within the 19th September 2014 submission

Reablement metric:

The Trafford figure for this indicator in 2013/14 was 4.4% better than the National and 4% better than the North West average. We have also reported a 25% improvement against this indicator since 2011/12.
After reviewing the targets and trajectories Trafford has agreed to increase the 15/16 target to 88%, which represents a 2.9% improvement from 13/14.

Delayed Transfers Of Care

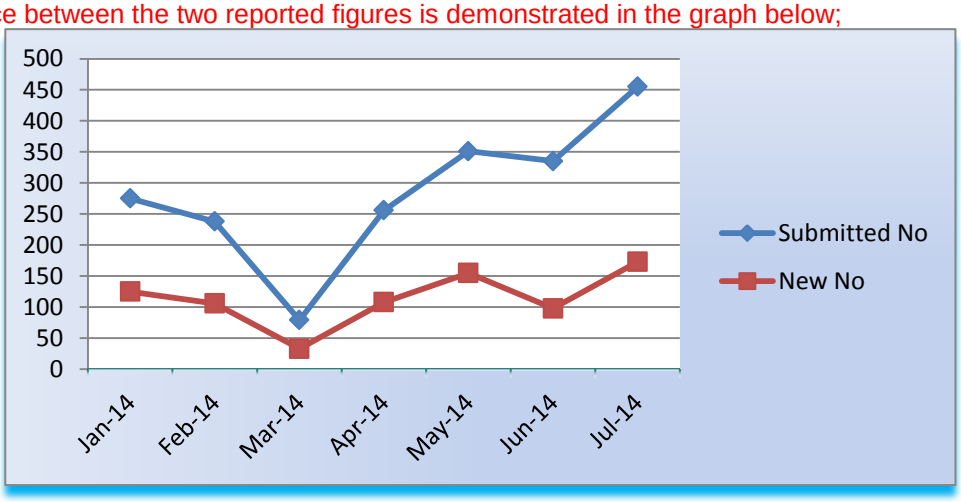
Following a significant rise in reported DTOC's from November 2013 onwards at UHSM, the CCG supported by external experts in this field conducted a review of the process between June and August 2014. The basis of the review was to ensure all patients who were issued a section five complied with the delayed transfers of care act 2003 as outlined below: -

A delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when:

- A clinical decision has been made that patient is ready for transfer
- A multi-disciplinary team decision has been made that patient is ready for transfer
- The patient is safe to discharge/transfer.

A multi-disciplinary team in this context includes nursing and other health and social care professionals, caring for that patient in an acute setting.

It became apparent that UHSM were reporting all delays, including patients who were not "ready to go". The Trust therefore corrected their reporting in line with guidance and statutory reporting from August 2014 and delivered an exercise of reflection to January 2014 resulting in the figures demonstrated on the charts. This change will be fed back into reporting structures to ensure a revised correct record of DTOC's is recorded. The Trust has routinely reported appropriately since September 2014.
The difference between the two reported figures is demonstrated in the graph below;



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;

Falls Service	
November 2014	Development of the service needs
April 2015	Implementation of new service
Intermediate Care	
Complete	Scoping of current provision and need
February 2015	Service Specification and business case (Joint with South Manchester CCG)
April 2015-16	Roll out of integrated intermediate care offer
Alternative to Transfer Plus	
September 2014	Business Case for Alternative to Transfer Plus
October 2014	Implementation of service
Primary Care for Nursing Homes	
January 2015	Borough wide review of existing primary care provision to nursing homes
March 2015	Redesign of model if required
April 2016	Implementation of new model (phased)
Community Geriatrics	

August –October 2014	Review of current provision
November 2014	Considerations of recommendations of new proposed model
December 2014	Implementation of Winter pilot
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 BCF 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 throughout the project for the ICRB to receive changes on redesign and the evidence to invest in service models and the implications of shifting 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.

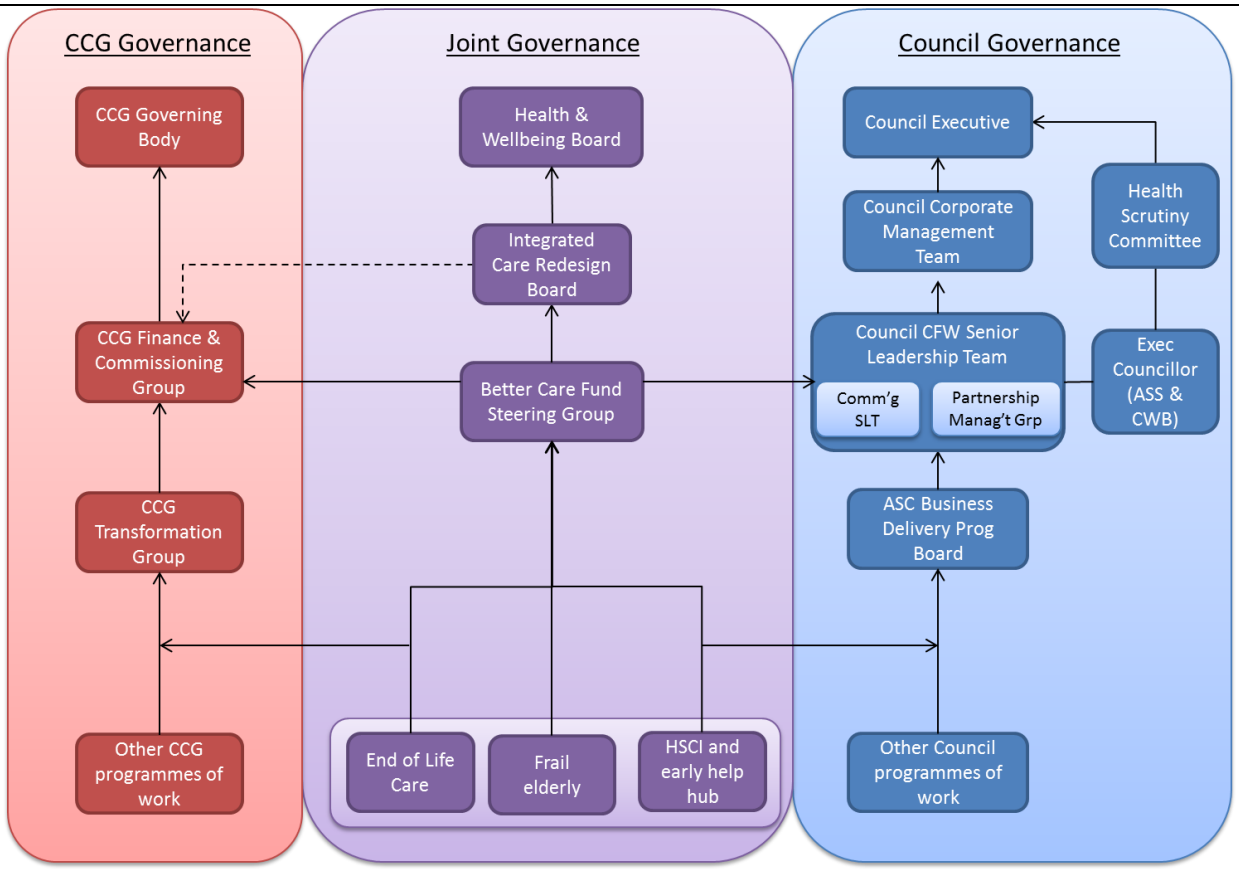
Each project has dedicated commissioning operational and clinical leads which work collaboratively with operational managers from service providers, the third sector and patient representatives. This provides the opportunity for provider organisations to understand the implications on their own organisations.

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 BCF 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 Adults (Social Care) 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.

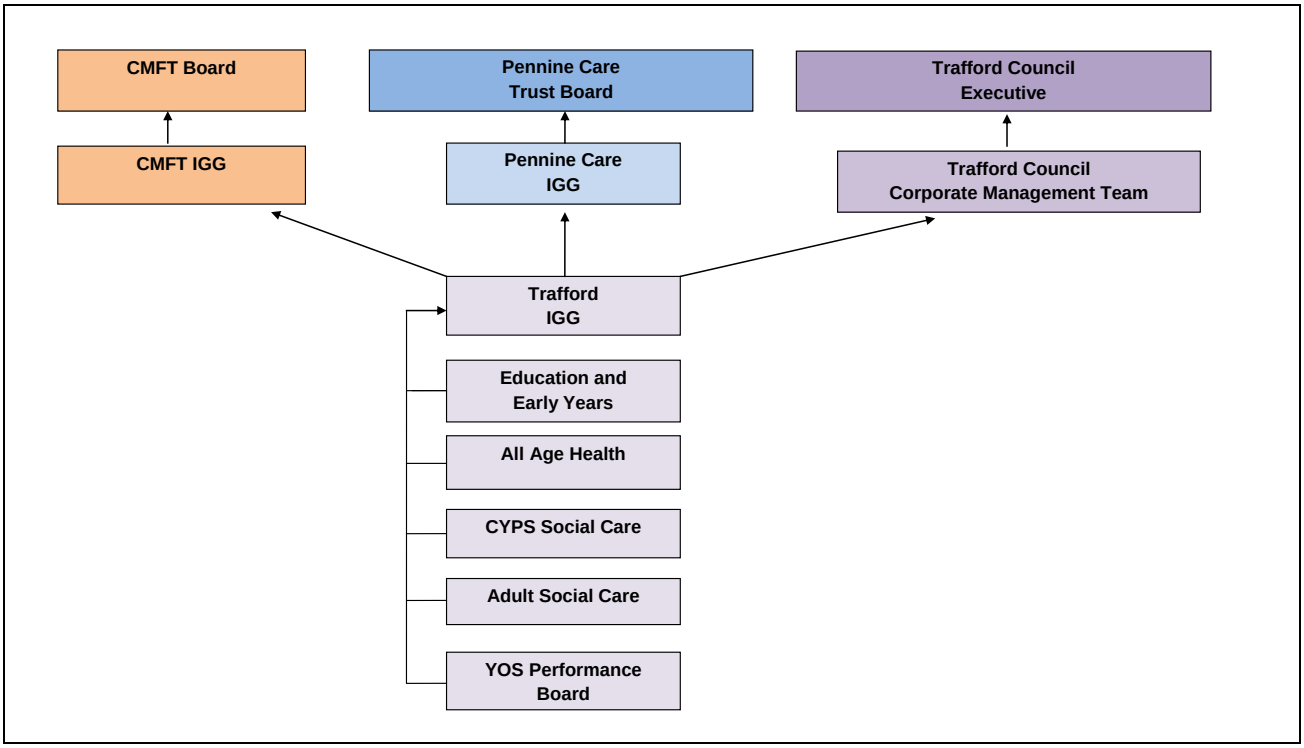


The CCG has a dedicated programme office accountable to the Associate Director of Transformation who supports each work stream and project lead to monitor and report**:**

- 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 CMFT. 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
	Review and Redesign of Frail and Older Peoples Services
FOP 01	Provision of a Falls Service
FOP 02	Reprovision of Intermediate Care
FOP 03	Alternative to Transfer for Nursing Homes (admission avoidance scheme)
FOP 04	Transforming Community Nursing
FOP 05FOP06	Review and Redesign of Community Geriatrician Model/ Primary care model Primary Care for Nursing and Residential Homes Education Programme to support redesign as stated above
	Review and Redesign of End of Life Care in Trafford
EOL 01	Review and Redesign of Service Provision
EOL 02	Education, Enablers and Technology
EOL 03	The role of the third sector in end of life care
	Community Health and Social Care Integration and Early Help Hub
HSCI 01	Redesign and integrated locality teams
HSCI 02	Redesign and integrated pathways (Linked to schemes above)
HSCI 03	Complex care coordination
HSCI 04	All age Early Help front door/hub
HSCI 05	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.

Ref	There is a risk that:	How likely is the risk to materialise?	Potential impact	Overall risk factor	Mitigating Actions	Risk Owner
1	Operational risks which result in milestones not being achieved within the project plan. This has been compounded by the lengthy assurance process, delaying the start of critical projects.	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	Julie Crossley & Diane Eaton
2	The reduction is emergency admissions is not achieved and BCF initiatives dependent on the P4P payment cannot be supported. The financial risk to Trafford is £1,319.	2	4	8	The Steering group will be responsible for monitoring the overall progress of BCF against the trajectories. Each of the work schemes will be providing highlight reports on a monthly basis. This risk is linked to risk 5- see commentary	Gina Lawrence & Deborah Brownlee
3	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	Gina Lawrence & Deborah Brownlee

4	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. There have been a number of dedicated sessions with Providers to ensure full engagement. This includes a dedicated Integrated care redesign workshop with all provider Health organisations. Separate sessions with CMFT, Pennine Care and the Resilience group with representatives including all acute Trusts, Primary care and NWAS.	Julie Crossley & Joe Mcguigan
5	The financial plans and joint risk sharing plans are still being developed	3	3	9	The discussions are being driven and 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 Pooled Fund shall be managed with the intention of producing a balanced budget at the end of each Financial Year. In the event that the CCG or the Council identify at any period during a financial year that there will be insufficient budgetary provision to meet the likely expenditure for the current financial year then expenditure shall be managed in accordance with an agreed joint plan to bring where necessary the	Ian Duncan & Joe Mcguigan

					spending back in line with the funding. There may be circumstances where the above is not possible and there is a financial risk as a result of non-elective savings plans not deliver at the agreed target level. Under these circumstances and line with the guidance, monies will be withheld by the CCG from the pool in line with the under-performance against this performance target. In order to protect the schemes being delivered, it has been agreed that the CCG and Local Authority shall enter into a risk share agreement up to the maximum on the non-elective performance payment for a particular year. For the purpose of the initial agreement and first financial year of the pool the contributions to the risk share will be on a 70% (CCG):30% Council basis. The terms of the pool shall determine the process for revising this risk share arrangement. Final plans and S75 will need signing off by H&WB before 1st April.	
6	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.	Julie Crossley

					Engagement as started with Pennine Care to discuss the workforce issues to look at generic grades and skill mix which will be required.	
7	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.	Julie Crossley & Diane Eaton
8	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.	Gina Lawrence
9	Lack of commitment from the voluntary and community sector to support the shift to early intervention and prevention activity.	2	4	8	BCF Steering Group to oversee and agree the 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	Deboarh Brownlee
10	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, impacting on health and social care provision in Trafford.	4	5	20	Council and CCG finance leads to keep the BCF Steering Group updated on progress with this, including potential projections and any DH allocation decision	Ian Duncan & Joe Mcguigan
11	Local authority	2	5	10	Funds set aside within	Deborah

	cannot maintain social care and the voluntary and community sector to the level needed to support effective out of hospital integrated care.				the BCF to protect social care and integrated community services. Close monitoring and reporting of social care budget and pressures by the council finance lead, reporting into the BCF Steering Group.	Brownlee
12	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.	Deborah Brownlee

Risk holders are identified within Appendix 1.

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

The Pooled Fund shall be managed with the intention of producing a balanced budget at the end of each Financial Year

In the event that the CCG or the Council identify at any period during a financial year that there will be insufficient budgetary provision to meet the likely expenditure for the current financial year then expenditure shall be managed in accordance with an agreed joint plan to bring where necessary the spending back in line with the funding.

There may be circumstances where the above is not possible and there is a financial risk as a result of non-elective savings plans not deliver at the agreed target level. Under these circumstances and line with the guidance, monies will be withheld by the CCG from the pool in line with the under-performance against

this performance target. In order to protect the schemes being delivered, it has been agreed that the CCG and Local Authority shall enter into a risk share agreement up to the maximum on the non-elective performance payment for a particular year.

For the purpose of the initial agreement and first financial year of the pool the contributions to the risk share will be on a 70% (CCG): 30% Council basis.

The terms of the pool shall determine as part of the Section 75 Agreement.

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

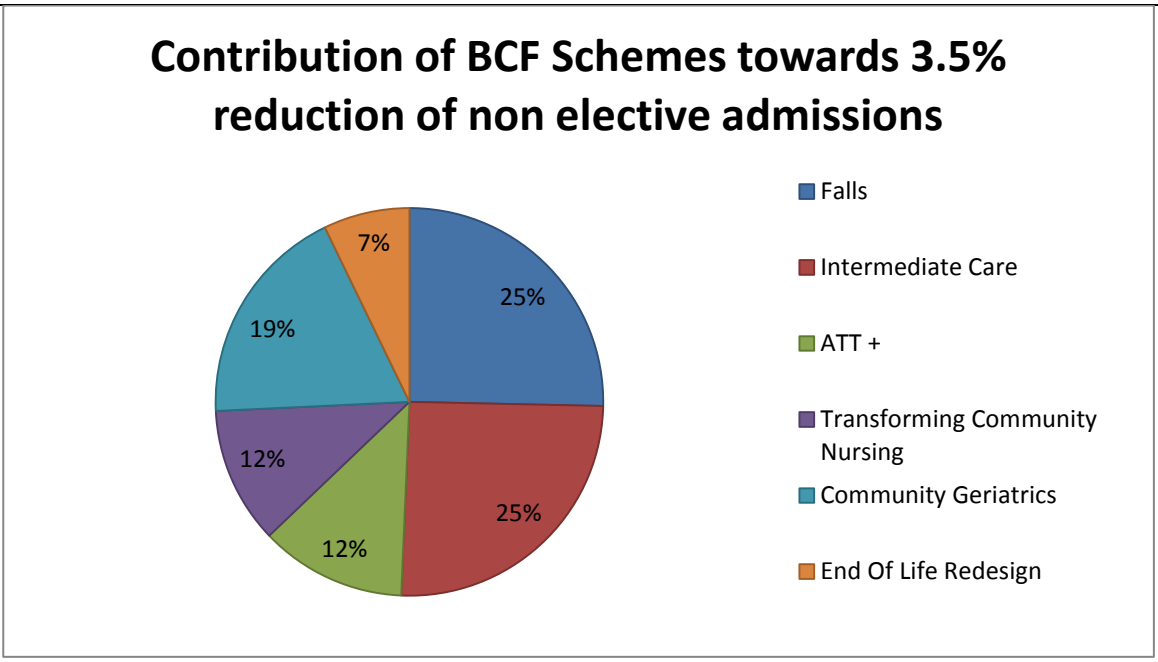
As set out in the Strategic Plan the vision for NHS Trafford is

"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, 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, easier access to primary care and a coordinated and supported network of community organisations providing preventative options. 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. An outline of the contribution each scheme will have towards the reduction in non-elective admissions is detailed in the graph overleaf.



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 BCF 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.

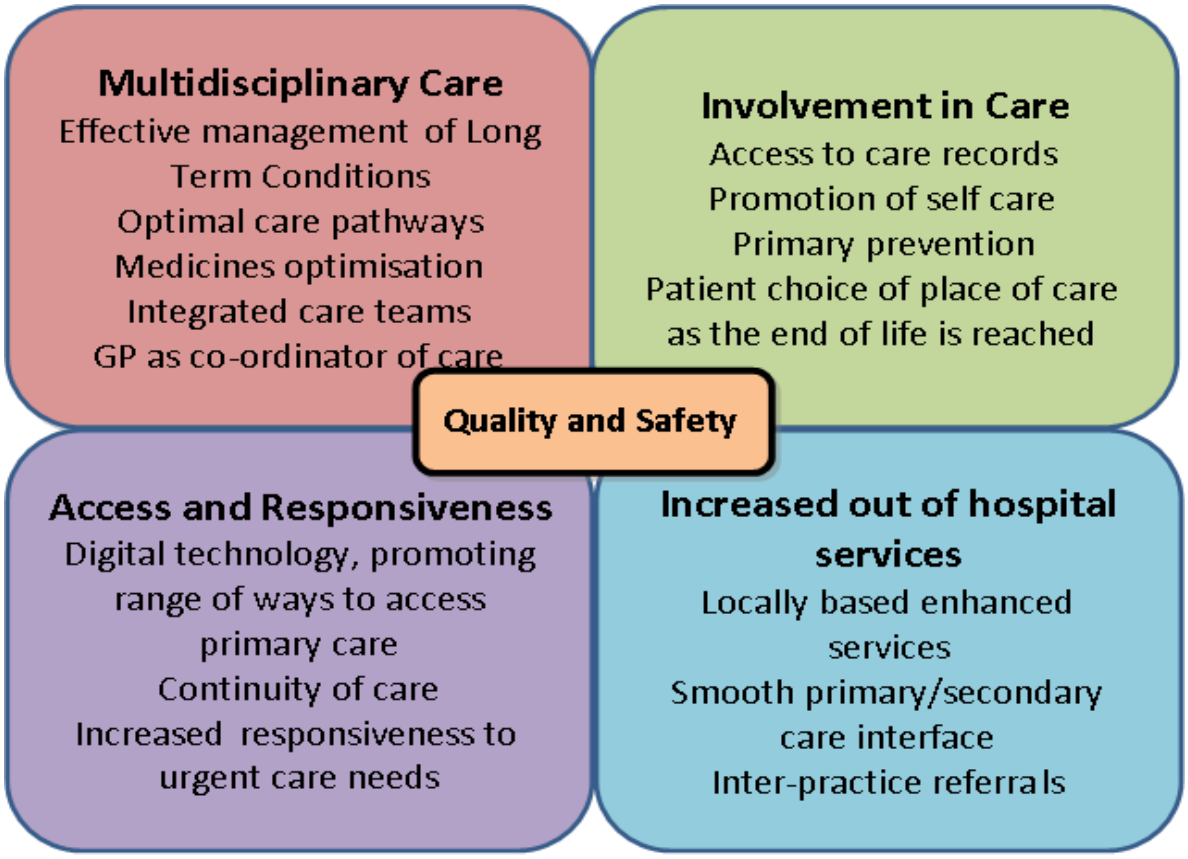
c) Please describe how your BCF plans align with your plans for primary co-commissioning

- 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 BCF.

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, the rest of the health and social care system and the voluntary and community sector. 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 the BCF. Both are equally focussed on delivering the GM primary care strategic requirements illustrated overleaf.



Trafford Locality Integrated Care Model

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

The *BCF* 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 that underpin 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 will be 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, , school nurses, health visitors, connexions, youth workers, and education workers and other voluntary and community sector organisations

It is envisaged that the model for integrated community health and social care, and the adult integrated care model for general practice, will overlay each other and make a real difference to people and improve

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 is 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.

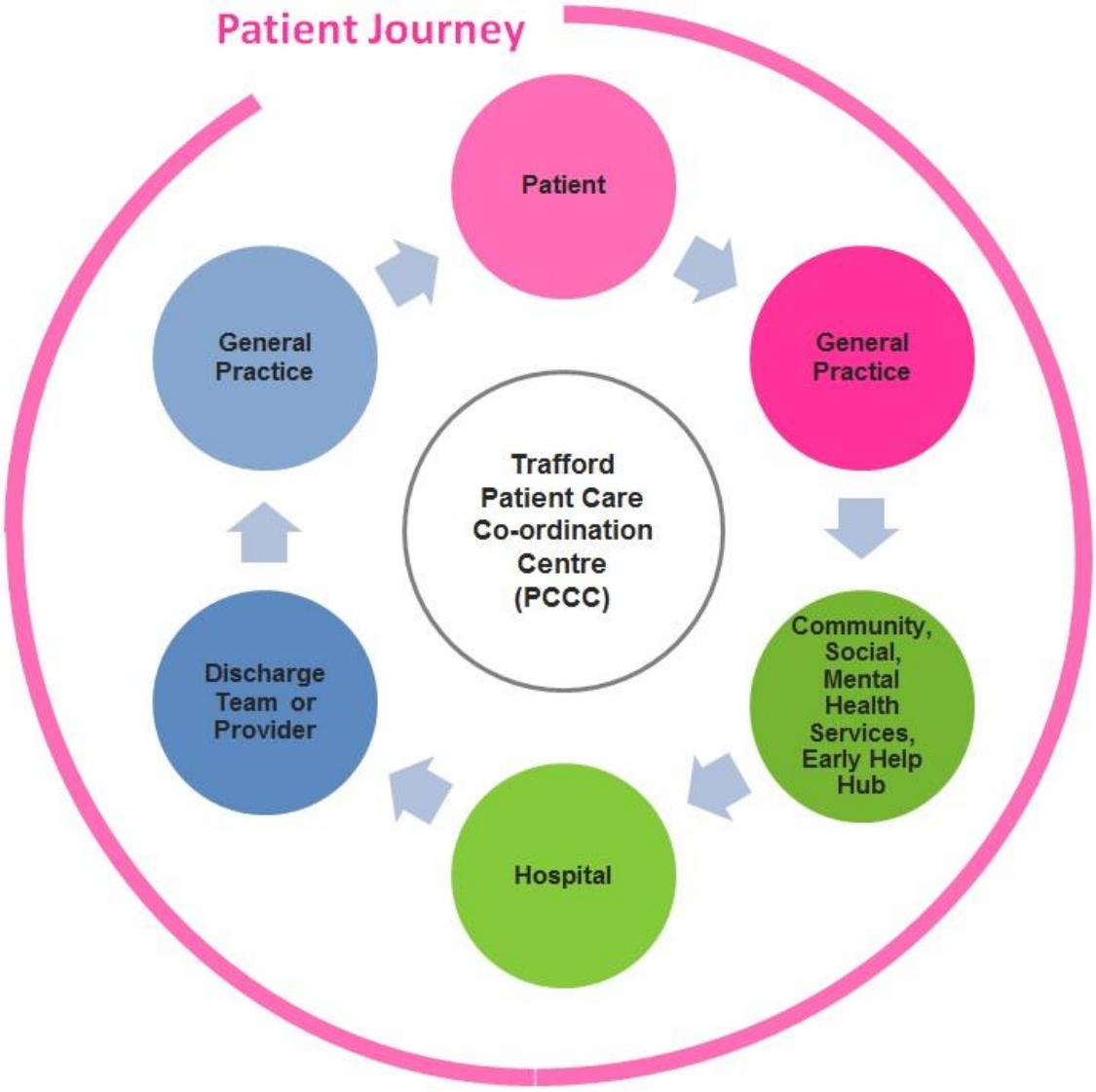
The model for enhanced access and continuity will provide patients with locality access over the weekend and evening period for both routine and urgent care. The service will be integrated with all appropriate care providers to support and provide care for patients, keeping people cared for in the community, 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 health, social care and the voluntary and community sector 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. The model is detailed below.



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 and Trafford Council 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 practical 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)

Through the BCF Trafford is committed to maintaining its current eligibility criteria of meeting substantial and critical needs, as defined by Fair Access to Care Services (FACS) criteria. Following April 2015 Trafford is committed to meeting the new national eligibility framework as articulated in the Care Act.

Protection of social care is also critical to the delivery of the ambition described within the BCF, most notably the transformation of community health and social care to an integrated model. This new delivery model will increase the focus on helping people remain in their own homes and maintain or increase their independence.

However, this is set in the context of financial pressures, rising demand and demographic pressures. In 2015/16 Trafford Council faces further financial challenges and budget reductions. The local authority's latest predictions identified a budget gap of £57m over the period 2015-18.

The population profile in Trafford is also changing with an increase in the number of elderly people living with long term conditions with complex co-morbidities, resulting in escalating demand on health and social care services.

The census data from 2011 identified that 35,300 people in Trafford are aged over 65 years and by 2030 this population is estimated to increase to around 55,500. The greatest rate of increase will be seen in those people aged over 85. In Trafford there is predicted to be a 78% increase by 2030. This is the age group most likely to need health and social care and the impact this will have on local health and social care services is a key consideration for local services. The local population overall is expected to increase by 13.9% by 2030.

The 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. The impact this will have on some social care services is displayed on the table below. This shows that by 2020 people with a learning disability will increase by 4%, people with a physical disability by 5% and people with a common mental health disorder by 2%.

	2013	2014	2015	2016	2018	2020
People with a moderate / Severe	761	763	767	772	782	792

Learning Disability						
% Change from 2013		0.3%	0.8%	1.4%	2.8%	4.1%
People with a moderate / severe Physical Disability	14,121	14,163	14,239	14,355	14,631	14,862
% Change from 2013		0.3%	0.8%	1.7%	3.6%	5.2%
People with a common mental health disorder	22,420	22,465	22,542	22,651	22,850	22,984
% Change from 2013		0.2%	0.5%	1.0%	1.9%	2.5%

Furthermore, demand for social care was significantly impacted by the reconfiguration of acute healthcare provision in Trafford in November 2013. For example the number of people receiving home care increased by 10% from 2011/12 to 2013/14, the number of reablement episodes increased by 9% from 2012/13 to 2013/14 and assessments of new clients in year has increased by 10.5% from 2012/13 to 2013/14. The number of contacts/referrals received from Trafford General and Wythenshawe hospitals has also increased, the exact figure varies at each hospital, but a 19% increase has been seen at Wythenshawe Hospital from April 2012 to March 2013 compared with April 2013 to March 2014.

In the face of rising demand and budget reductions the Council's ability to maintain its current provision and eligibility is an on-going challenge. The positive steps to protect social care under this joint fund do not provide a solution beyond 2015/16 for social care funding.

It is therefore crucial for health, social care and voluntary and community sector partners to work together across the health and social care system. By joining up services in the community and providing extensive step up and step down enablement it will reduce demand and the use of hospital care and residential/nursing home care, and deliver services closer to home in a community setting. Trafford's health and social care economy will focus on ensuring that people stay healthy and well at home by intervening much earlier, promoting self-care and maximising people's independence and resilience.

Health and social care integration at a community level, supported by BCF funding, will lead to new delivery models to which social care services will be central.

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

It is confirmed that the 2014/15 investment previously serviced via NHSE S256 monies will be maintained within the BCF, this totals £3,546,480. A summary of the usage of these monies in 2014/15 is outlined on the table below.

Service Area	**Amount**
Community equipment and adaptations	150,000
Integrated crisis and rapid response services	324,000

Maintaining eligibility criteria	407,000
Reablement services	400,000
Bed-based intermediate care services(Ascot)	783,000
Early supported hospital discharge schemes	440,480
Joint health and care teams/working	342,000
Other social care residential and nursing placements	700,000
Total	**3,546,480**

***an additional £788,000 will be spent on integrated assessments and integrated records**

In addition, a further £2m is to be made available in 2015/16 via the BCF to protect core social care services and to meet the additional duties and responsibilities placed on the local authority by the Care Act.

This will enable the Council to protect and sustain the current level of eligibility criteria and provide robust assessment and care management services based on a model of integrated care and support.

This new delivery model will continue to create new and innovative ways of working which will change how social care services look and provide care in the future, and is critical to sifting activity out of the hospital and reducing demand on the acute sector.

This model will be supported by the other schemes in the BCF, which are pivotal to achieving the overall vision and outcome, for example the provision of a falls service, re-provision of Intermediate Care, review and redesign of a community geriatrician model/ primary care model.

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.)

An additional £2m has been allocated for the protection of adult social care services in 2015/16.

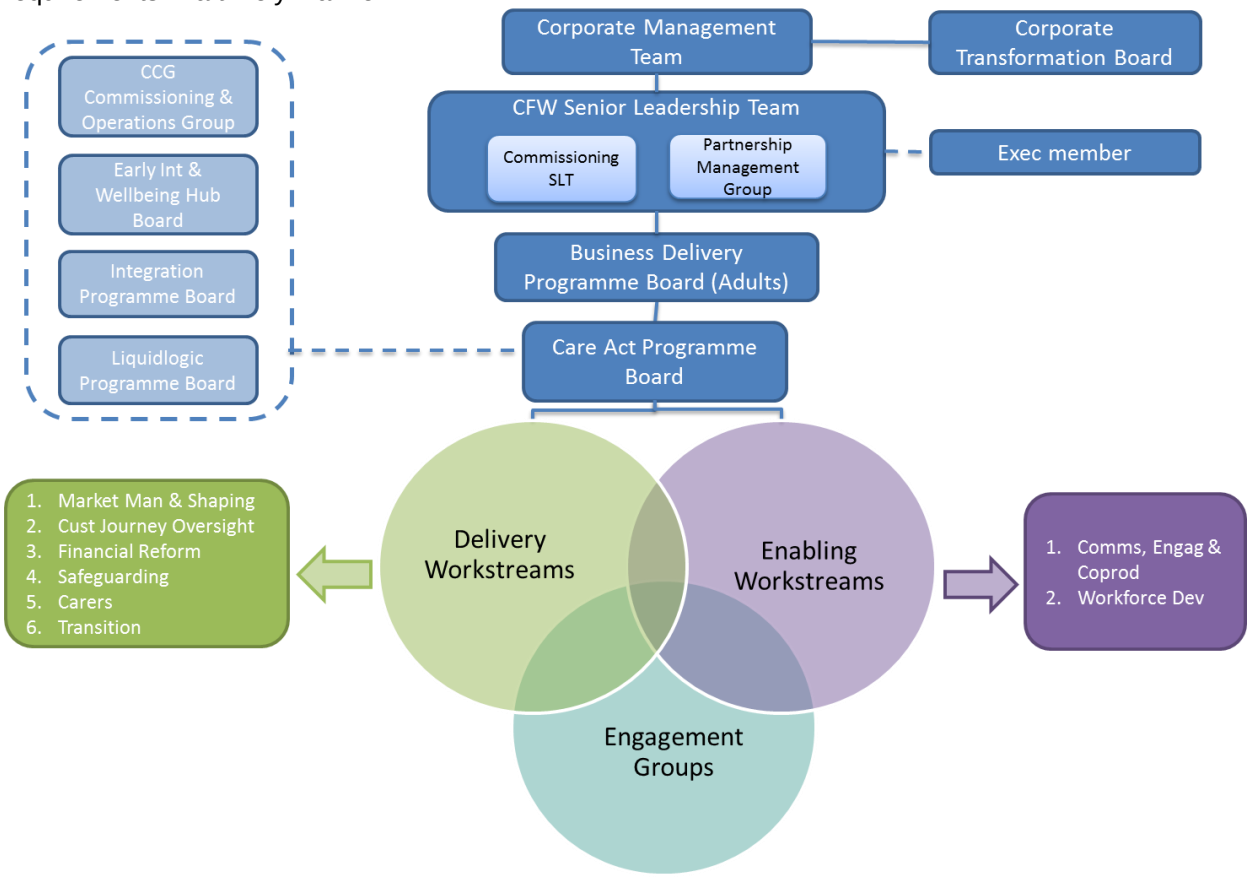
Included in this is £538,000 to support the implementation of the Care Act reforms in 2015/16 and the additional duties and responsibilities this brings for adult social care. This represents Trafford's proportion of the £135m that has been identified nationally for the implementation of the Care Act.

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 workstreams where possible, link into existing arrangements and structures. 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 overleaf.

There are strong interdependences between the implementation of the duties and responsibilities in the Care Act and the deliverables of the BCF projects, most notably the community health and social care integration and early help hub work. The delivery of these are linked to such an extent that many of the workstreams are shared, e.g. workforce development, customer journey and market management and shaping.

The Care Act responsibilities for early intervention and prevention, wellbeing, information and advice and advocacy will be picked up through the early help hub project. The community health and social care integration project will deliver a number of the changes required, including; assessment and eligibility, care and support planning, reviews and integration, cooperation and partnerships. Furthermore the requirement for 7 day working cuts across both programmes.

The Care Act Programme Board plays a critical role in coordinating the activity and work taking place for the Care Act across these and other programmes of work.

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

Trafford CCG and Council will dedicate £411,500 to carer specific support. The breakdown of this funding is highlighted in the table below.

- Trafford Call plus provided practical home based support to carers in the borough who specifically care for those with cancers and long term, life limiting conditions
- AgeUK Trafford provide a range of services including day sitting services, respite and organised trips to support carers looking after the most elderly residents
- Trafford Carers centre provide a range of practical and emotional support services to carers. They also support families to find the most appropriate care settings and offer signposting to alternative services.

The above services are underpinned more widely through the local authorities carers strategy

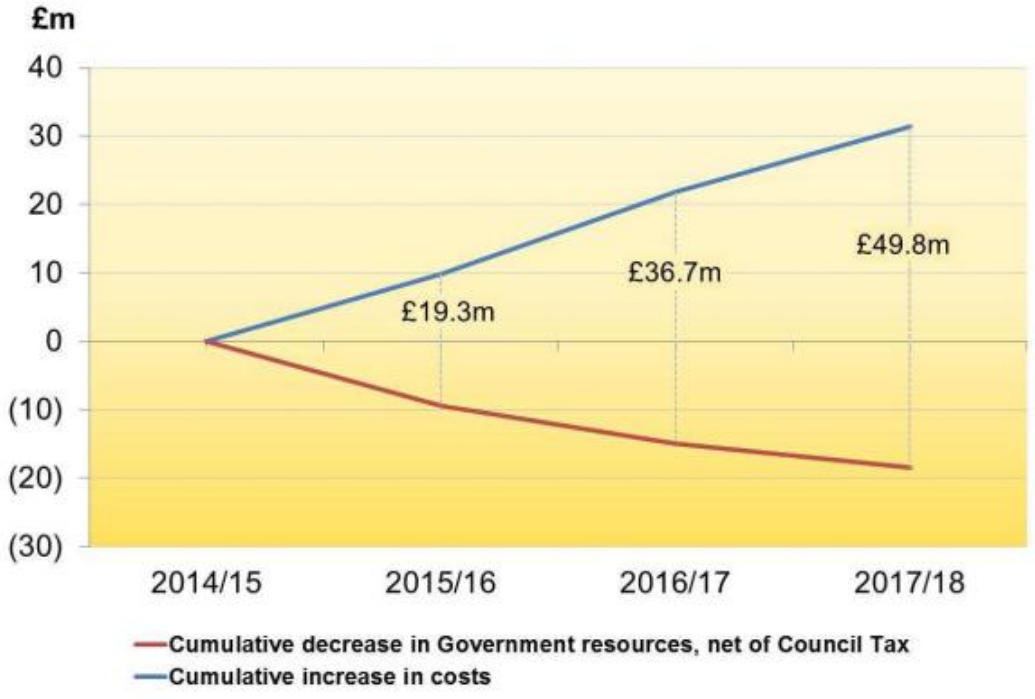
	Total Budget
	£
Trafford Call Carers (Call Plus)	54,500
Trafford Call Carers (Call Plus) 13/14 error	
Trafford Caring for Carers - Age Concern	96,210
Trafford Caring for Carers - TMBC Recharge	-59,210
Trafford Carers Centre - TMBC	170,000

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 £2m 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

Primary Care

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. This will be delivered in two phases. Phase one (January 2015) with is an 8-8 service Monday – Friday across all Trafford GP practices. Phase two (Summer 15) will be to consider 7 day work on a locality basis , which will increase access at weekends. Phase One will provide an additional 31,000 primary care appointments annually. This model is currently being finalised for implementation in January/February 2015.

Community Services

There are a number of community services which currently operate on a seven day basis which are referenced in Appendix 3

This includes Urgent care services provided by Pennine Care already operate on a 7 days basis and the review of community nursing services will be expanded for capacity to match demand over 7 days. This will be implemented in Summer 2015. These services will support patients who are discharged from the acute providers.

DTOCS, Intermediate Care and Acute Services

Trafford patient flow is more complex with patients being admitted to 3 acute Trusts, CMFT, UHSM and Salford Royal Foundation Trust. As part of the implementation of Trafford New Health Deal, Pennine community health services and social care 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. The transition to a seven day discharge model is currently being piloted through Winter Resilience monies at UHSM jointly with Trafford Council with the intention that this is accessible to all Trafford Patients by Summer 2015.

As part of this Trafford CCG and Trafford Council are piloting reablement packages to support flexible intermediate care services which will operate seven days a week supported by social services at the weekend.

Acute partners are committed to moving towards 7 day services. In addition to the development towards a seven day discharge model, winter resilience funding has provided the opportunity to transition a number of hospital based services towards a seven day model. These included diagnostics such as, radiology and

phlebotomy, pharmacy and geriatrician support within emergency departments.

ATT+

The Alternative to Transfer Plus scheme is fully operational over seven days and has been enhanced to provide a 24hr service (previously 22 hours). This has been operational since October 2014 as a pilot and will form part of a new combined ATT service in March 2015.

Equipment Services

In redesigning services for the Frail and Elderly and End of Life patients, it is recognised that equipment services must be available 7 days a week to prevent admission to hospital and support the timely discharge of patients. Work is already underway to move towards a service which can support patients out of hours and provide rapid access to equipment when needed to support admission avoidance

Social Care

Many social care services already operate across 7 days, including:

- Social Care Emergency duty team (covers out of hours for Long term Social Work Teams, Mental Health Team, Hospital teams) –provided in the evenings 7 days a week including bank holidays
- Reablement & Assessment service – provided in the evenings 7 days a week including bank holidays
- Rapid Response – provided in the evenings 7 days a week including bank holidays
- Bed based Reablement (Ascot House) – operates a 24hr service 7 days per week

A gap analysis has begun in social care as part of the Care Act Programme to explore and model the services that are and are not provided across 7 days, to prioritise which services need to further extend their operating hours. This will include an analysis of the areas of intense activity over the weekend and an evaluation of the section 5's generated over the weekend by the hospitals that serve Trafford residents. It is anticipated that access to assessment, linked to the Patient Care Co-ordination Centre, will amongst other areas be delivered on a 7 day basis to prevent unnecessary admissions.

Social care is committed to ensuring the availability of comprehensive 7 day services. This expansion will support patient discharged from all our acute providers.

Resilience funding has provided the opportunity to pilot weekend working in acute settings to support patients to return home. It is recognised that nursing and residential care homes will also need to operate a more flexible model of working to support this and will form part of the health and social care integration programme.

All Trafford's BCF schemes will include elements 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 within secondary care.

Patient Care Co-ordination Centre

The Trafford Patient Care 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 social care services**.**

Trafford Council has invested in upgrading its adult social care system to a supplier (Liquidlogic) which provides a single solution for both children's and adults services and integrates with other health systems. This system will hold the NHS Number and Trafford are in the early stages of working through data sharing policies with Trafford CCG, specifically around the CCGs PCCC.
The first phase of the implementation of Liquidlogic's adult social care solution will go live in December 2014. Phase 2 will address integrations and will examine the needs for supporting changes resulting from the Care Act. Phase 2 is due to commence in January 2015.
The PCCC 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.

The memorandum of understanding between providers is attached at the front of this submission.

A summary of the key milestones is displayed on the table below.

Date	**Milestone**
December 2014	LiquidLogic implementation complete – phase 1 Trafford Council
January 2015	NHS number routinely used on the social care system
January 2015	Start of LiquidLogic implementation – phase 2 (Planning connection to heath systems, PCCC, data sharing agreements, open APIs and Open Standards)
March 2015	Health and other ICT systems mapped and ICT integration plans for LiquidLogic in place
March 2015	Data sharing agreements and policies in place
tbc	PCCC implementation complete
tbc	PCCC ICT integration with all health and social care systems in place
December 2015	NHS number used as unique identifier on the social care system
March 2016	LiquidLogic implementation complete – phase 2

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.

The unified system for social care at Trafford supports open standards. Trafford are supporting the dialogue between suppliers to ensure they adhere to the HL7 standards and the ITK. Suppliers engaged in the CCG's current PCCC procurement process are in dialogue with the Councils social care supplier (Liquidlogic) to ensure these standards are met via any future integration. We are also in commercial discussions with Liquidlogic to understand their approach to adopting open APIs and open standards.

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 (IG) and controls which will reflect all requirements set out in Caldicott 2.

Trafford is currently compliant with the NHS IG Toolkit.

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 PCCC, 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 the 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, social care and community and voluntary sector 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 includes the integration with health ICT systems. Work is currently on-going to look into requirements of each organisation to enable systems to integrate.
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 PCCC – The information and Advice Programme Board which is now aligned to the PCCC and the Early Help Hub
- COPD redesign
- Evaluation of unscheduled care redesign
- The development of the all-age Early Help Front 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 Trafford CCG's 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 BCF 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 BCF, 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.

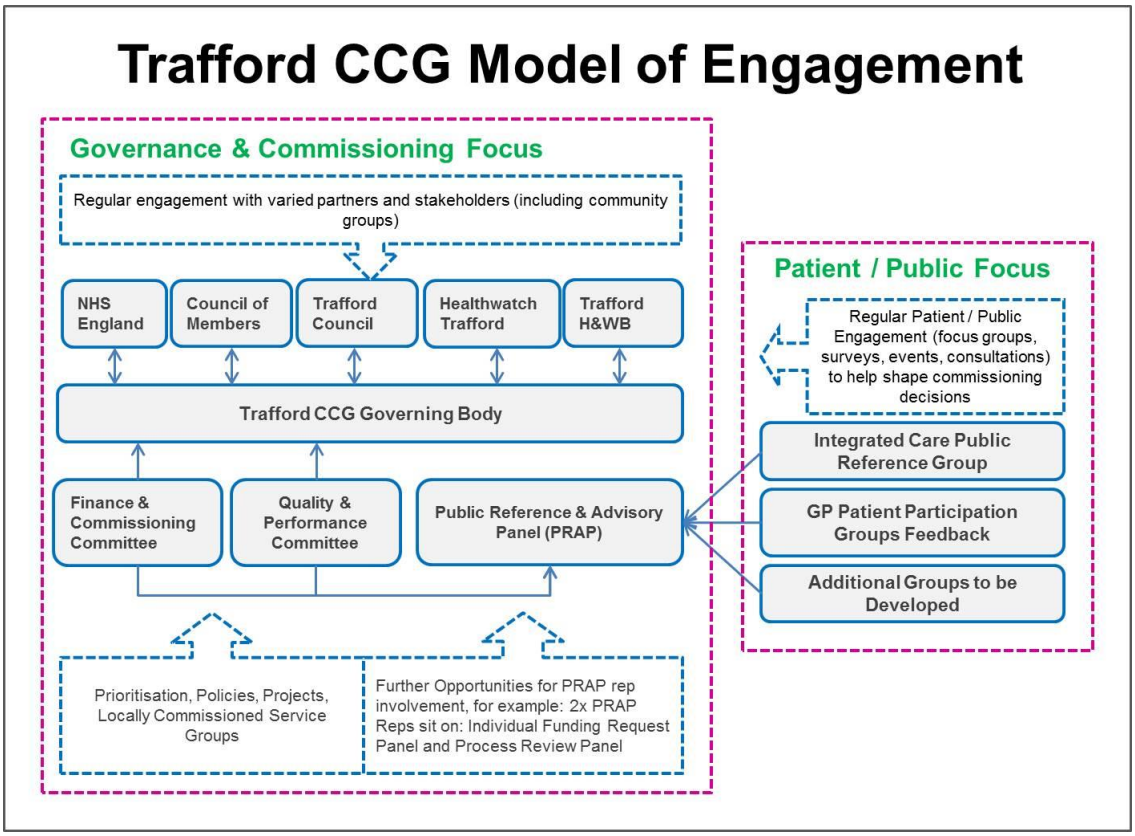
Patient and carer representation is at the heart of service redesign. Membership of steering groups and scheme project groups is made up of the representatives from Trafford's third sector such as Age UK Trafford, Trafford Carers Centre and Macmillan. Not only does this ensure that patients experience 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:-

- BlueSci – 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 FT has undertaken a customer care survey for a number of services that fall 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 ICRB which represents providers and commissioners across the whole economy, including the Acute Sector providers, in addition to the Trafford Health and Wellbeing Board.

The BCF 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 the BCF, forms part of the agenda for Trafford's new Operational 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 4 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 and are key members for the Frail and Older people's project with the Medical Director being on the Steering group. The locality representative for the OOH provider is also 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.

For example, 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 for 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 TGH, Trafford no longer has a local hospital where the majority of acute activity is undertaken. TGH 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 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 ICRB to share in the programmes which are included in the BCF. It is essential that the programme boards which are used for the 2 health programmes have representatives 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 by these two programmes, Elderly Care and Palliative Care are both redirecting activity away from the acute setting to 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 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 shift the clinical resources to enable the community and primary care model to be delivered.

The shift in activity will be delivered by the 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 UHSM, CMFT 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 experience of people.

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 service will initially triage and access the patient by an OT. The service will be delivered from a location in each of the localities. The multidisciplinary service will include medicine management, physiotherapy, community nursing, 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 due to existing capacity and can only offer a service to those individuals who have fallen a number of times. 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

Investment to date	2015/16
£0	£400,000

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 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.

The impact of scheme against the metric set out within the BCF is outlines in Appendix 6.

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 be implemented in early 2015/16 .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 Trafford adults (this includes those registered with primary care and those who are resident). 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 and the Council to evidence the requirement for intermediate care and allowed the enhanced model to be developed.

Investment requirements

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

Investment to date	2015/16
£322,000	£600,000

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 usual 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.

The impact of scheme against the metric set out within the BCF is outlines in Appendix 6.

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) for health and social care 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.

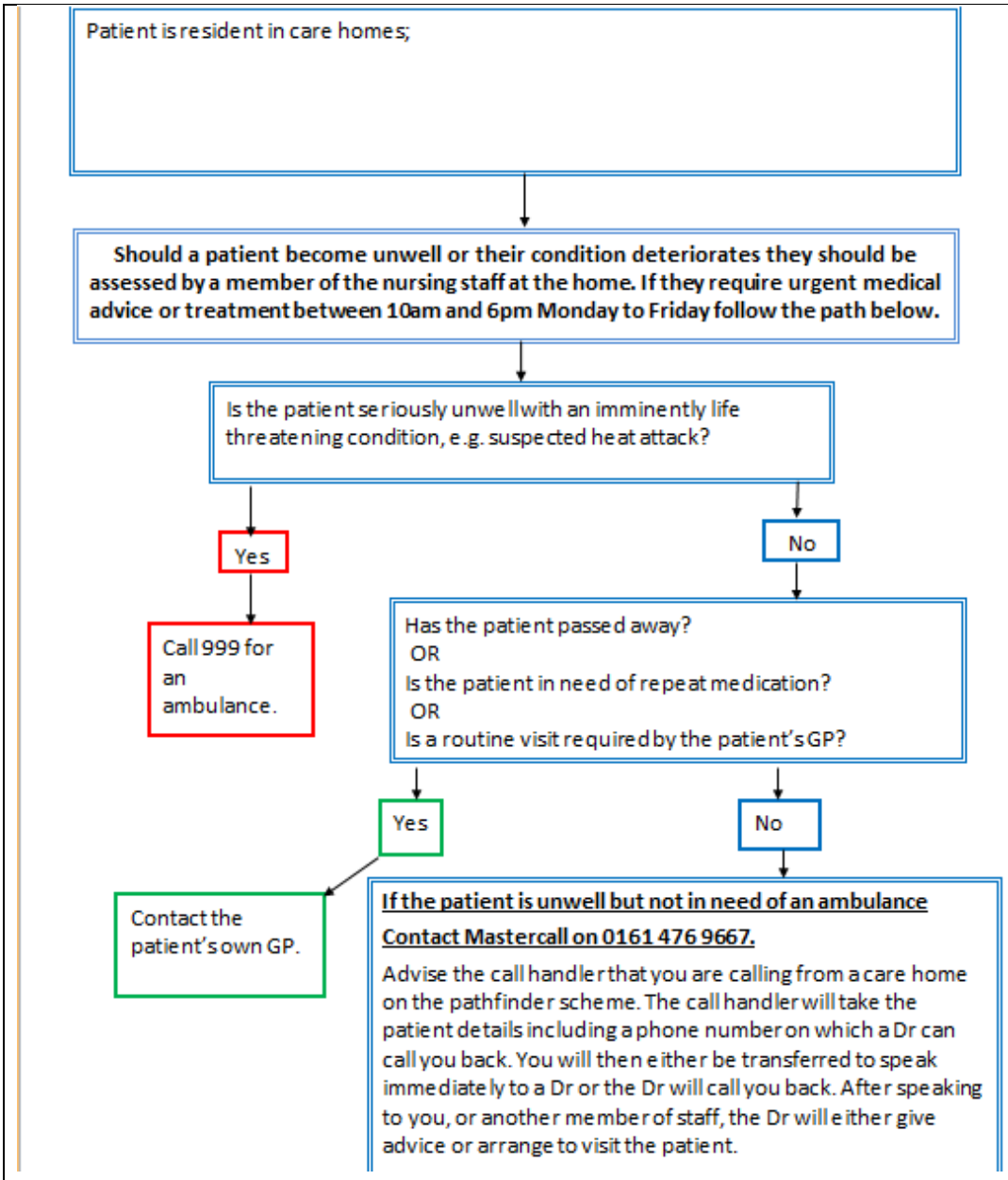
The previous intermediate care model was unique and benefited from a strong partnership approach; this will be mirrored in the new service going forward guaranteeing co-production.

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 including social services 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 – *Alternative to Transfer Plus* Detailed Scheme Description

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

Scheme ref no.
TCCG/FOP/03
Scheme name
Alternative to Transfer Plus (nursing homes)
What is the strategic objective of this scheme?
The Alternative to Transfer Plus model for Trafford has been developed with the philosophy of ensuring a reduction in A&E attendance and subsequent admissions to an acute ward for nursing home residents, with the additional benefit of reducing delayed transfers of care.
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?
The aim of the scheme is to provide an alternative option for nursing home staff other than calling an ambulance when for a patient who has become unwell. The scheme will be available to patients who are in Nursing Home care only as patients can be triaged by a clinician. This will apply across all age groups. The scheme has been operational for the population at large since November 2013 with a high deflection rate of 90%
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Mastercall will provide a general practitioner on call 24hrs a day who is able to offer medical advice. This is outlined in the diagram below.

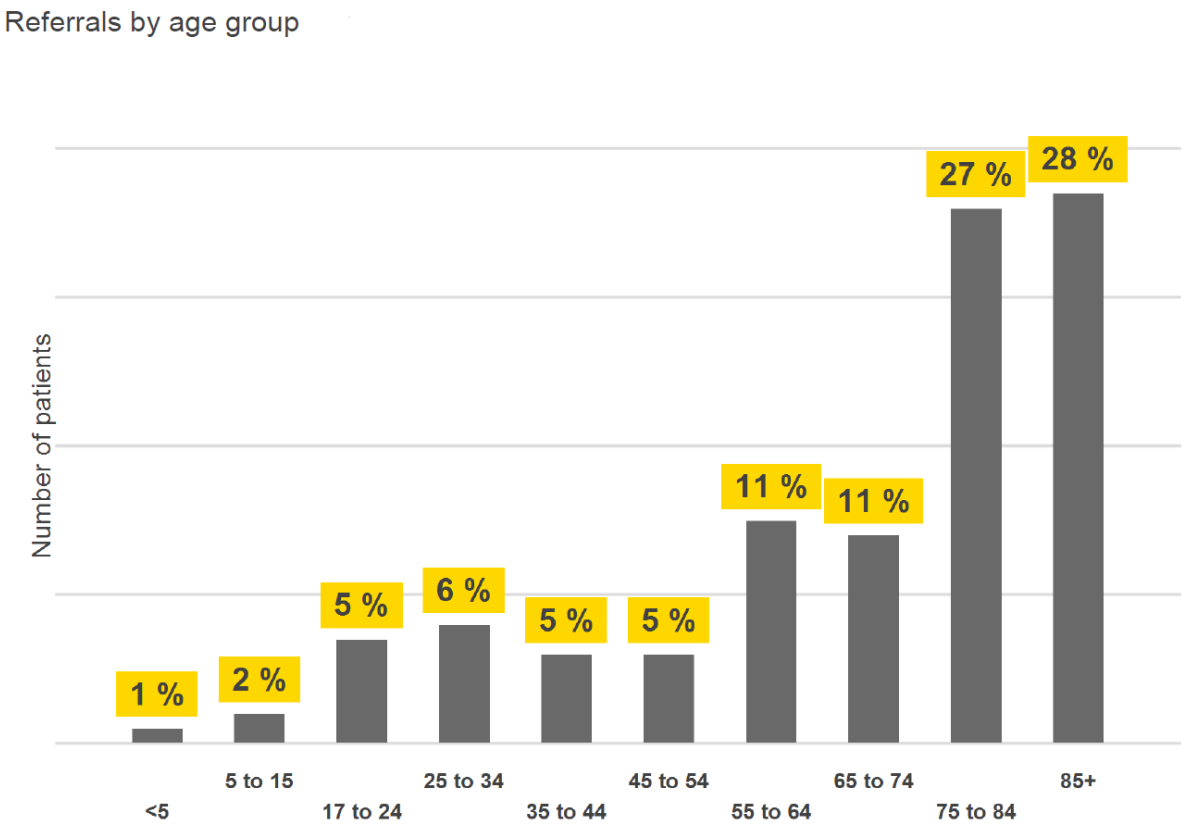


The evidence base

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

Statistics show that a high percentage of patients who are treated in A&E after conveyance are likely to be admitted to a ward. This percentage increases with elderly patients. It is recognised that many of these patients could be treated at home. Not only is this taking only does this create extra pressure on secondary care providers but it is often distressing for patients who are frail and elderly but can result in further deterioration. Through analysis of the ATT scheme it is recognised that the greatest numbers of people using the service are over the age of 65. This is shown in the graph below.



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

Investment to date	2015/16
£257,000	£100,000

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: This service will reduce pressure on both the ambulance service and also the attendances and subsequent admittance to secondary care through providing a clinically safe model of care at patients' homes. Conditions which are deemed appropriate are will be conveyed to hospital as at present.
Reduce inappropriate admissions to residential care: This service will not have an impact on this measure
Proportion of older people who are still at home 91 days after discharge from hospital: This service will impact on this measure in such a way that it supports admission and readmission to an acute trust and in doing so guarantees sustained physical and mental stability that could be reduced should an older person remain in an acute hospital bed for a longer period than their expected episode of treatment.
Delayed transfers of care from hospital: This service ensures that the right person is admitted to an acute trust when their care requires this approach; reducing the level of patients requiring transferring back into the community allows the existing resources in both secondary and community care to target the patients requiring discharge more effectively.
Patient/service user experience: The impact of this service guarantees that only those acutely unwell patients are admitted into an acute setting, avoiding inappropriate admissions and safeguarding a much more appropriate and beneficial experience for all older people.

The impact of scheme against the metric set out within the BCF is outlines in Appendix 6.

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?

This scheme will be monitored on a month basis through the Systems Operational Resilience Group. Any issues will be dealt with and can be escalated if appropriate. The Frail and Older Peoples steering group will review the service after 6 months to ensure effectiveness.

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

ANNEX 1 –*Transforming Community Nursing* Detailed Scheme Description

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

Scheme ref no.
TCCG/FOP/04
Scheme name
Transforming Community Nursing
What is the strategic objective of this scheme?
The Redesign of District Nursing is to be delivered in 3 phases. District Nursing services was part of the "Transforming Community Services" process. Trafford PCT as part of building the Trafford Integrated Care model undertook a full procurement for all community services. District Nursing was part of this. The service has a specification of service which describes the service which is very traditional and is a task driven specification. Trafford CCG has a very robust review process in place with a rolling programme to review all community services which forms part of the contract governance framework for the Community Contract. Trafford CCG held a mapping event as part of its Frail and Older Peoples programme. This identified gaps in service provision with inconsistencies across Trafford. This programme is to provide a consistent service. The service has also received in additional requirements from GP's. Also an objective is to understand the role of a community nurse and practice nurses. The strategic objective is to deliver an integrated model on a neighbourhood basis which will integrate with primary care but will also integrate with other community services including other specialist nursing services. The new service support admission avoidance and will in reach into acute trusts, residential and nursing homes. It will proactively manage patients with a holistic approach and it will integrate health and social care needs of an individual. Although the redesign will be focused on the older cohort of patients, the service will be responsive to all health needs for adults. This service will align with the other schemes which are part of Better Care Fund including : • Intermediate care • Falls service • End of life. Pennine Care as current provider are working with the CCG on the redesign but it is also ensure that other stakeholders are involved in the redesign so to understand this new service , as they understand the complex requirements including, mental health issues, therapy alignment, acute services for in reach and handover to community services and social care. This programme will align directly with the work streams of the integration of health and social care.
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?

The new model will be a holistic approach to deliver a full and comprehensive service for the traditional “scheduled care” support in the community. This will include treating patients at home, in the community on an individual and clinic basis. .

Trafford has set out its strategy, the four neighbourhoods localities will have local teams working together to support the local population. .It has to be accepted that each locality has different considerations to meet the needs which will be reflected in the capacity and sill mix planning.

The redesign will be clinically led by a GPSI who is working with the CCG and has researched and tried and tested similar models of nursing outside of Trafford. The approach will drive efficiency to avoid any duplication with other services.

This service redesign will eventually bring together the 3 elements of the service including scheduled /planned, urgent /enhanced services and specialist nursing.

The resign will have 3 phases.

Phase 1 –traditional district nursing planned care service to review the current service, (this is almost completed). To scope the needs and requirements of the new service. This will take into account public health information.

To develop in parallel the design of the new service and to be present to the clinical directors in December.

This will be presented to the Steering group which has been established. Although this is clinically led by the CCG, this group have representatives from Pennine Care, social care, CMFT clinicians /operational manager and GP’s. The steering group is supported by a clinical model design group and a finance, capacity and contracts group.

The Steering group will have the responsibility to agree the new model (clinically led by the CCG) The clinical design group will then work on the detail, the skill mix and the capacity required to meet the population needs .

The finance and activity group will develop the business case for this to be presented to the CCG finance committee.

Phase 2 will merge the newly designed holistic service with the urgent care services which are new and were implemented in November 2013. These services receive referrals through a single access point where all referrals are triaged.

The urgent care services including rapid response, IV services will merge so the whole community services is shaping and delivered at the 4 localities.

Phase 3 will merge the new service with specialist services including heart failure nurse, dementia, tissue viability etc**.**

The outcome from this will be one service delivered in the 4 localities**.** The principles of this model are outlined in the presentation enclosed.

TCCG Future of Community Nursing C

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

The whole of community services will partner with Trafford Council as the delivery element of integrated services. Delivered by Pennine Care NHS Foundation Trust the full accountability will be

through the community services contract. The community contract is currently for 3 years up to March 2016. In order for the full clinical model to be fully embedded a recommendation for an extension to the Pennine contract is to be proposed to the CCG Governing body.

This will enable Pennine Care working with primary care to deliver this strategic change.

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 due to existing capacity and is a very traditional service which does not include the new medical and social elements.
Also the service is not provided to residential and nursing homes. This has always been difficult to support especially nursing homes but Trafford like many other economies Trafford have a number of admissions into acute A&E service from activity from Nursing and residential homes. By providing this new service and working and supporting a new primary care this should reduce in appropriate admissions to acute hospital.
The integrated model will also combine health and social care which will reduce duplication in time and release additional capacity.

Investment requirements

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

Investment to date	2015/16
£3,078000	£0

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 will link with the other work streams in this programme. This will be an enabler to reduce in appropriate activity. The Target reduction for this scheme is 74 admission in 2015/16
Reduced inappropriate admissions to residential care: the service delivery model will support the discharge to assess model from our Acute partners and community nursing will in reach into hospitals to pull out patients and support in the community. The service will align to the Patient co-ordination centre to the sharing of data across services.
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.
Delayed transfers of care from hospital: the service will benefit from the in reach into acute. Patient's length of stay is reducing and the service needs to have the skills and experience to support and treat these patients.
Patient/service user experience: as with any NHS service the community nursing service 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.

The impact of scheme against the metric set out within the BCF is outlines in Appendix 6.

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 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 contract Board for community services. The Board has a service review committee which will be responsible to over eel the new service implementation. A key element of this is the communication plan to acute services to ensure seamless hand over and in reach but also to Primary care. This service will be integral with the GP and Practices nurses to ensure the service supports patients and avoids duplication in service

As part of the governance framework for community services there is a Finance, Activity and Performance committee which meets on a monthly basis. This new service will contribute to the dashboard for community services and will form part of the on-going reporting and monitoring which Pennine produces for this committee. This will evidence the impact of the service on avoided admissions.
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.

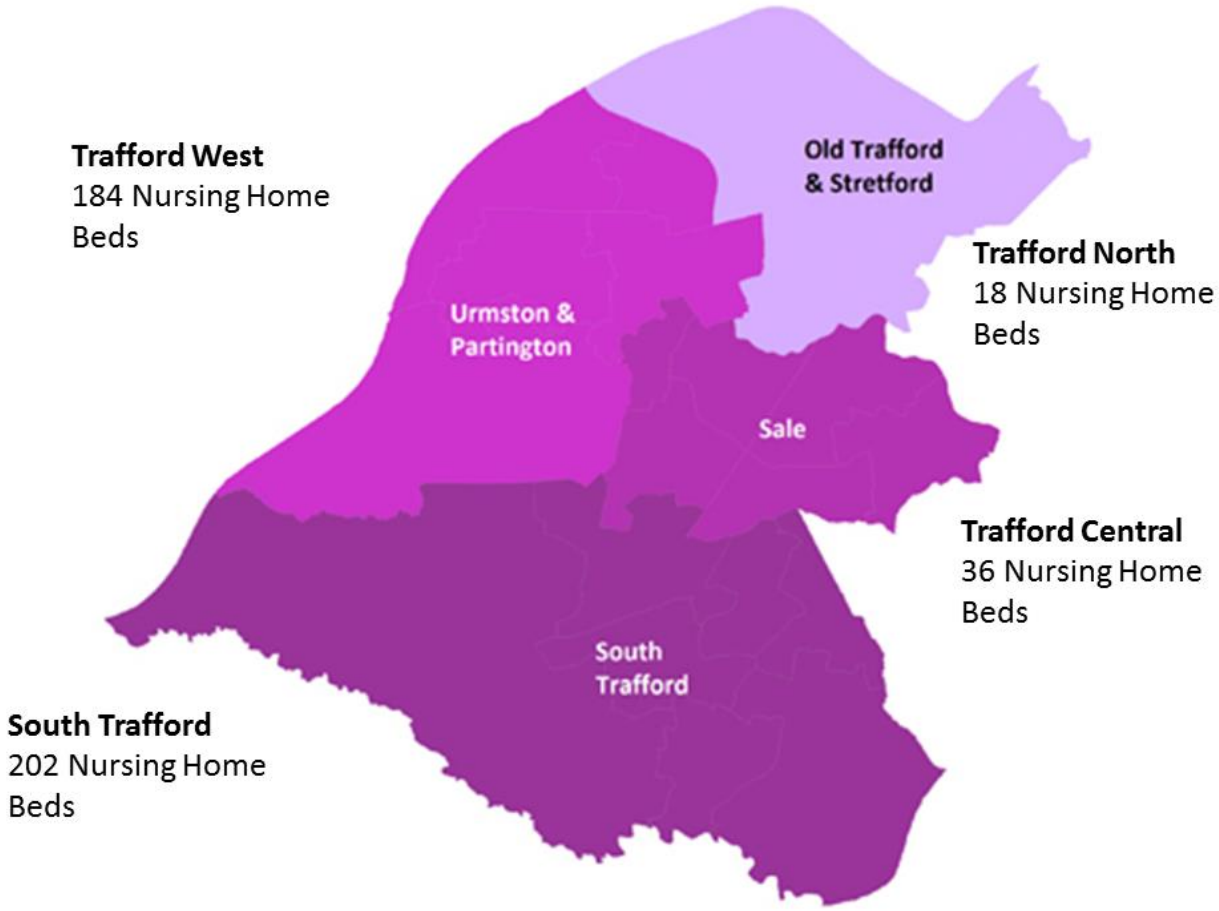
Due to the multi-agency approach, the community nursing delivery model will have been implemented by Q! 2015/16 .The CCG has established a steering group with a membership from all partner organisations will approve the model and the associated principles of delivery. The CCG has evaluated other service with a GPSI leading the redesign. The new service will include elements of good practice into the service specification.

As part of success the service will evidence the support to Frail and older people and should impact on reduced admissions from residential and nursing homes. This will be further evidenced when all elements of the urgent care and scheduled care merge together and with the specialist nursing services. The single access point will triage the demand to ensure the correct service is provided.

ANNEX 1 –*Community Geriatrics* Detailed Scheme Description

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

Scheme ref no.
TCCG/FOP/05
Scheme name
Community Geriatrics
What is the strategic objective of this scheme?
The scheme aims to reduce the number of emergency admissions to hospital from nursing and residential care homes through proactive management of complex and high risk patients. The scheme will also support general practice in the ongoing care planning for this target group.
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 CCG currently commissions a community care of the elderly consultant service. The north of the borough is served with two sessions a week by CMFT. This service was initially designed to cover all homes in the north of the borough but due to staffing changes this service only provides transient support to residents entering intermediate care provision at Ascot House. The south of the borough receives four sessions a week provided by UHSM. This service currently provided to patients who are resident in 4 nursing homes in the south of the borough**.** This is a reactive service and the consultants receive referrals from GPs and community services as well as patients discharged from hospital The current service has capacity to deliver more contacts and increased activity numbers per month. Currently fewer than 100 patients at any one time receive specialist geriatric support through this service. However, Trafford has on average 40 non elective attendances per month into acute trusts from Trafford Nursing homes many of which convert into admissions. There are 440 nursing home beds in Trafford which are spread across the 4 localities, as follows:



Trafford CCG has committed to a short term proposal for the winter months until March 2015 is to achieve greater utilisation of the consultant input within the current contract. This will involve General Practice identifying those residents in nursing and residential care homes who have the most complex health needs and at high risk of admission to hospital. Patients will be offered a comprehensive geriatric assessment and a care plan put in place to manage the patient's needs. The service will also target those residents who have been identified through the alternative to transfer Plus scheme with the same principle applied to these patients.

The results of this pilot will be used to inform a new model of community geriatrics based on an increasingly proactive approach to managing the health care needs of those patients in the top 2% of risk in both nursing homes and in the wider community.

This scheme is currently in development.

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

Trafford CCG is the lead commissioner for this service. It is intended that this service will continue to be delivered by the two main providers within the borough (UHSM and CMFT) and in line with patient flow into secondary care. General practice will be a key partner is ensuring the success of this scheme.

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 reference within the Trafford Better Care Fund, the CCG footprint has an increasingly elderly population with a high rate of growth over the coming decade. This work will work in parallel the options being considered for the new primary care model. The typical resident in a care home in the UK is female, aged 85 years or older, and in the last years of their life. The majority of care home residents have dementia and

take seven or more medications. Many live with depression, mobility problems and pain .A review of the literature of models for providing improved care in nursing homes concludes that medical care for care home residents could be improved by making it more proactive.

Investment requirements

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

Investment to date	**2015/16**
£400,000	**£0**

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: This is an admission avoidance scheme with a target reduction of 130 in 2015/16. This will be achieved through proactive case management and target interventions to ensure only the most appropriate patients attend secondary care.
Reduced inappropriate admissions to residential care: the service delivery model will support the discharge to assess model from our Acute partners and community nursing will in reach into hospitals to pull out patients and support in the community. The service will align to the Patient co-ordination centre to the sharing of data across services.
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 admission and re-admission and therefore are eligible for referral into the service.
Delayed transfers of care from hospital: the service will benefit from the in reach into acute which will enable patients to be discharge home earlier with the assurance that there is specialst support within the community to manage patients at their own home.
Patient/service user experience: as with any NHS service the service 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.

The impact of scheme against the metric set out within the BCF is outlines in Appendix 6.

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 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 Frail and Older Peoples Steering Group. A key element of this is the communication plan to Nursing Homes which will be achieved through the Service improvement. This service will be integrated with the GP and Practices nurses to ensure the service supports patients and avoids duplication in 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 success of this scheme will depend on developing effective and robust relationships between community geriatricians, primary care and nursing home staff. Effective partnership arrangements with the ambulance service and out of hour's primary care will also need to be developed. The confidence to share information between professionals will also be a key driver to the success of this scheme.

ANNEX 1 –*Redesigning End of Life Care* Detailed Scheme Description

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

Scheme ref no.
TCCG/EOL/01,02,03
Scheme name
End of Life Service Redesign, Enabler Project and Third Sector
What is the strategic objective of this scheme?
To enhance the level and quality of care provided for patients with complex life limiting conditions, those in their last 12 months of life and those in the final days of life.
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 CCG has already undertaken work to understand the provision of palliative and end of life care in Trafford. For the purpose of this scheme end of life is defined from the point of terminal diagnosis until the patient dies. Trafford CCG commission a number of services relating to palliation and specialist end of life care. Through dialogues with stakeholders and patients it has become evident that this causes duplication, a high number of interactions with patients and families and is no longer aligned to service in acute trusts. Given the complexity of health care provision within Trafford the scheme proposes the movement towards a single integrated end of life team lead by a sole provider who will provide both long term palliative care and the enhanced care required in the final months of life. The model will be support by social care, medicines management and oxygen services as well as other existing services delivered in the community. Support by a specialist palliative consultant will underpin the clinical element of this model The Transforming community nursing project will be tailored to take regard of this. New investment will be required to deliver this scheme. The model will be delivered in two stages, with the later stage moving towards a 7day model to support dying patients It has also been recognised that advanced care planning is limited across the Trafford health economy. Trafford CCG has already completed work to design and implement an advanced care planning process supported by an individual plan of care for the dying patient. This will be rolled out more comprehensively in 2015/16. The use of technology will be key to the delivery of a new end of life care model. Trafford CCG is committed to rolling out an EPaCCS solution and this will continue in 2015/16 ensuring that all stakeholders have real time information and can be responsive to advanced plans. Trafford CCG also plans to develop a solution for families and carers to ensure that where agreed they can have access to plans ensuring that where a patient cannot articulate plans these can be accessed quickly. Trafford has a thriving third sector and work will be undertaken to ensure that the needs of the sector are identified and developed in order to meet patient and family need.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The service will be led by a sole provider and will require full procurement. This will be conducted by Trafford CCG. Partnership arrangements will be established with voluntary sector groups where appropriate

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 National Bereavement Services survey shows that 81% of patients would prefer to die at home.

NHS Trafford CCG End of life Care Profile shows that a higher than average number of deaths which occur in a hospital setting at 61% compared to an England Average of 50.7%. This equated to 1,139 deaths in hospital in 2013/14.

At 12.9% the number of death occurring in a nursing and residential care home is nearly 7% lower than the average in England suggesting that there are a high number of emergency admissions to hospital for terminal patients.

The length of stay for patients who are admitted to hospital in the last 12 months of life exceeds 8 days in over 75% of cases when much of the care could be provided closer to home

The number of deaths in a hospice is also lower than the England average (5.6%) at 4.3%

Investment requirements

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

Investment to date	**2015/16**
£2,112,000	£200,000

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

Increase the number of patients dying in a place of their choice- The service will ensure that advanced care planning is at the forefront of end of life care. This will enable patients and families to express and have implemented their wishes as the need for care increases. It is the intention the deaths in hospital will reduce by 2% each year for the next 5 years as a result of this service.
Reduced non-elective admissions: This service will reduce the number of emergency admission to hospital by 53 in 2015/16 through enhanced community and hospice based support
Reduce inappropriate admissions to residential care: This service will not have an impact on this measure
Proportion of older people who are still at home 91 days after discharge from hospital: This service will link with the integrated health and social care scheme to ensure that once a person is discharged from hospital they are supported to die at home
Delayed transfers of care from hospital: This service ensures that the right person is admitted to an acute trust when their care requires this approach; reducing the level of patients requiring transferring back into the community allows the existing resources in both secondary and community care to target the patients requiring discharge more effectively.
Patient/service user experience: The impact of this service guarantees that only those acutely unwell patients are admitted into an acute setting, avoiding inappropriate admissions. The service will enhance the offer of care to patients as well as ensuring families and carers are support to recognise death and the options available as the end of life approaches.

The impact of scheme against the metric set out within the BCF is outlines in Appendix 6.

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?

Trafford CCG has established a number of local mechanisms to ensure the outcome of this service are understood across the local health and social care economy. These are based around the following;

- End of Life Steering Group
- Palliative Care Partnership
- Carers Forum
- Patient Reference Group

- Contract Monitoring

Work is also ongoing with neighbouring CCG's to ensure that the model of care aligns around acute trusts rather than CCG footprints. In the future new data will be required to monitor this service and this will be addressed with individual provider(s)

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

Ensuring that all partner organisation are committed to delivering a new model of care for end of life patients in Trafford
Ensuing that technological solutions are easily accessible and deliver the appropriate level of clinical and social detail to allow patients wishes to be executed in a timely manner
Ensuring that the voluntary sector is developed sufficiently to support non clinical care.

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/01,02,03,04,05
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, accessing universal community support 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. • To create an Early Help Hub that will provide step up and step down support for people, reducing both a reliance on services and the likelihood of re-entering the system. 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 and community organisations.
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 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

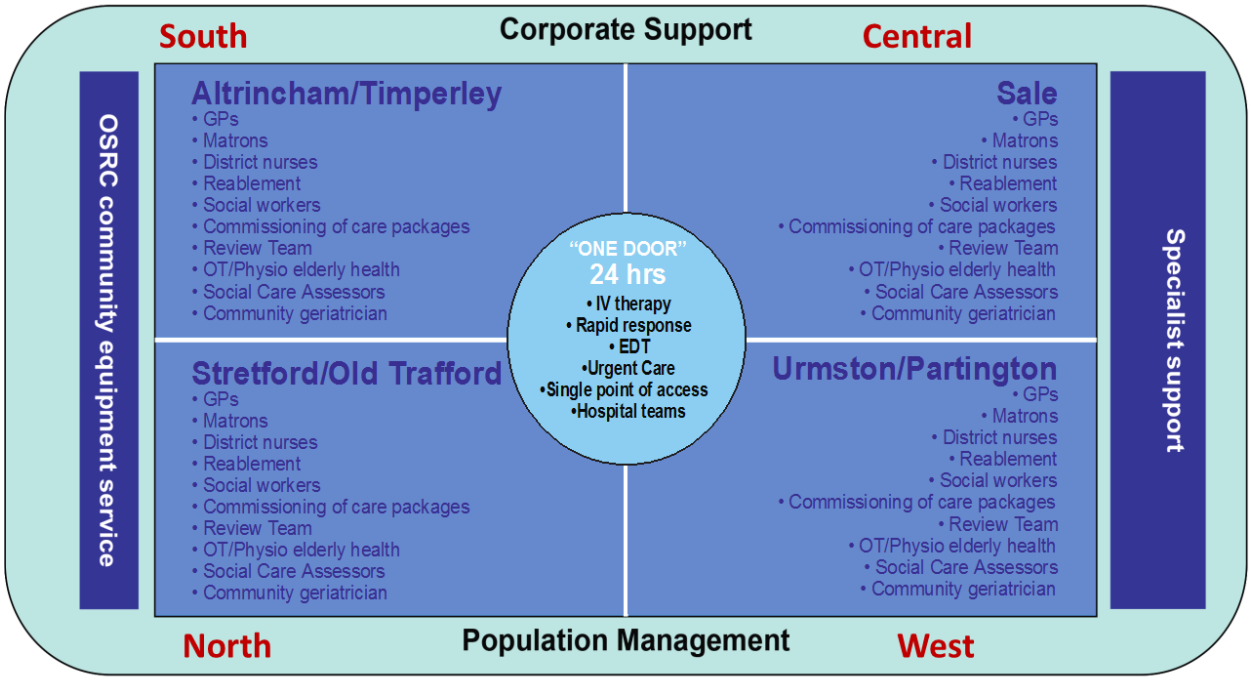
The vision for Trafford is to develop an integrated service delivery model made up of co-located multi-agency teams, who will work closer with local services such as GP's, pharmacists, nursing and residential homes, and other community and voluntary sector providers clustered with defined residential 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 November 2014 will have replicated this for adults through a comprehensive Section 75 agreement between Trafford Council and Pennine 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 and community and voluntary organisations and will operate on a 7 day basis.

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 diagram outlines the core services that will be delivered in each of the four areas. The core services are those that are viewed as pivotal to partnership working within each neighbourhood and which currently or will in future have a presence in the localities. These include:

- Matrons
- District nursing
- Reablement provision
- Social work
- Social work assessors
- Commissioning of care packages
- Review team
- Occupational therapy and physiotherapy provision

The Core Access Services (CAS) will be a central function and provide access to service provision in a more acute phase. It will promote timely discharge and support step up and step down to support people to be managed and cared for closer to home and will draw on 24 hour services to do this e.g. rapid response, IMC. The CAS will work closely with each neighbourhood team where local provision is required.

The CAS will proactively work with the wealth of other community services, including clinic based therapies and specialist nursing provision which will be provided on a borough wide basis across the neighbourhoods.

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 community support, 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 the 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, social care and community and voluntary sector 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 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, by integrating systems across health and social care. 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.

The hub will reflect the locality based approach applied throughout integration, being based centrally, as part of the CAS, with a strong presence in each of the four localities. It will work closely with communities and their organisations to coproduce innovative solutions addressing local needs, and where required, support development and sustainability.

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 the 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/.

Various pieces of work have also taken place across Trafford to indicate the need for a collaborative and holistic approach across health and social care, including evidence from the Joint Strategic Needs Assessment and the extensive consultation that took place to form Trafford's Joint Health and Wellbeing Strategy. Additionally information and advice provision was reviewed across all partners and indicated areas of partnership working and accessibility that could be strengthened.

The background and focus towards achieving integrated health and social care teams in Trafford is well documented, see the following reference, http://www.nuffieldtrust.org.uk/talks/removing-policy-barriers-integrated-care-trafford-experience. Building on the integration of health and social care for children and young people's services much work has already been undertaken within the Trafford health and social care economy to develop a robust case for change. Opportunities have been identified to achieve both horizontal and vertical integration of services and support systems and processes to provide an integrated care offer and support the Healthier Together strategic change across the Greater Manchester conurbation.

As part of the initial scoping for the Early Help Hub, the following research took place:

- Individual scoping meetings with a range of professionals involved in potential interventions that fall in scope.
- Workshop held with key individuals to shape service
- Trafford Compliments and Complaints information
- Benchmarking across other local authorities
- Information gathered on future demand to evidence need for redesigned prevention service
- National studies on prevention
- NICE guidelines
- Health and Wellbeing Strategy and consultation results
- JSNA
- Requirements of Care Act and Children and Families Act researched
- Stronger Families approach
- Evidence of blueSCI model locally- Salford university research
- Performance figures from services in scope
- Research on technological solutions to support health and wellbeing

In June 2014 a full market research phase with the public was carried out. This included direct interviews with 548 individuals to understand the scope of wellbeing and look beyond the presenting health issues to analyse the root cause. Results indicated the importance of addressing issues such as social networks, self-esteem, personal resilience, life guidance and learning. The Early Help Hub will incorporate these aspects into the model and measure the effect that this has on reducing unhealthy lifestyles and behaviours.

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

As shown on the Tab 3. HWB Expenditure Plan, there is no additional investment required for this scheme; the focus is on reshaping the existing resources across health and social care.

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 with appropriate input from the voluntary and community sector. 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, through health and social care professionals and voluntary and community organisations, is committed to focusing 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 community and voluntary sector services, 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, social care and community services 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 and a coordinated and supported network of community organisations. 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.

Increased number of people dying at their usual place of residence. The model will wrap care around people and better coordinate a person's health and social care support, particularly in the last 12 months of their life. The model will also link to the hospice at home provision and bed based hospice provision in Trafford to better support individuals and their families. This will support people to better plan for the end of their life.

As described above this scheme is an enabling programme of work and is integral to the performance improvements planned on the HWB P4P metric and HWB Support Metric tabs. Due to the nature of this programme and the strong interdependencies with the other planned schemes no specific improvement has been directly attached to this scheme.

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
- Residents and communities will be empowered to be more resilient and proactive about their wellbeing
- Locality services will meet the needs of patients and will better equipped to respond to their needs
- Through a proactive 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

Activities that are critical to occur to ensure the success of the project are outlined below.

Date	Milestone
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

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)	Attila Vegh

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?	-119
	How many non-elective admissions is the BCF planned to prevent in 15-16?	-442

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?**	UHSM and Trafford have reflected assumptions in their 5 year commissioning plans that account for demographic growth and the impact of schemes falling under the New Deal for Trafford/BCF umbrella. Through the joint governance structures between UHSM and Trafford CCG and including the wider health economy UHSM will continue its active and committed support to achieving the goals jointly agreed. UHSM notes the figures included within this template and acknowledges the assumptions used to derive the reductions. Both Trafford and UHSM will evaluate the impact of deflection schemes on Non Elective Admissions over the course of 14/15 and will refresh forward activity planning assumptions accordingly. UHSM notes the figures included within this template and acknowledges that high level assumptions have been used to derive the reductions, i.e. the table is based on FFCEs and a key assumption has been made for the 15/16 BCF reductions that there is a 1 for 1 relationship between FFCEs and Admissions which could overstate the BCF reduction.

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?**	UHSM - The evaluation and therefore detailed implications of the success of these schemes has not yet been undertaken, due to the timing of implementation of the BCF schemes. Therefore, it is too early to fully determine success; however the investment is based upon commissioner and provider clinical commitment for success, and experience of other health economies in England.

ANNEX 2b – Provider commentary – *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)	Michael Deegan

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	-293
	How many non-elective admissions is the BCF planned to prevent in 14-15?	-64
	How many non-elective admissions is the BCF planned to prevent in 15-16?	-237

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?**	CMFT and Trafford CCG have previously discussed the 5 year commissioning plans that account for underlying demographic growth and the impact of the BCF schemes and other admission avoidance schemes. CMFT acknowledges these commissioner planning assumptions targeting a net reduction in emergency admissions and will continue our active and committed support to achieving the goals agreed jointly, over the five year planning horizon for this work. CMFT note the figures included within this

		template and acknowledges that high level assumptions have been used to derive the reductions, i.e. the table is based on FFCEs and a key assumption has been made for the 15/16 BCF reductions that there is a 1 for 1 relationship between FFCEs and Admissions which could overstate the BCF reduction. CMFT has not been able to review and comment on the detailed content of the schemes and so there is still some uncertainty as to whether the targeted reductions are achievable from a provider perspective. CMFT will continue to work with the Trafford CCG as further information becomes available to complete this more detailed assessment.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	*NA*
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Evaluation and therefore detailed implications of the success of these schemes has not yet been fully possible, due to the timing of implementation which part way through the year of the plan is too early to fully ascertain.

ANNEX 2c – Provider commentary – *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

Appendix 3- Community Services Operating Hours

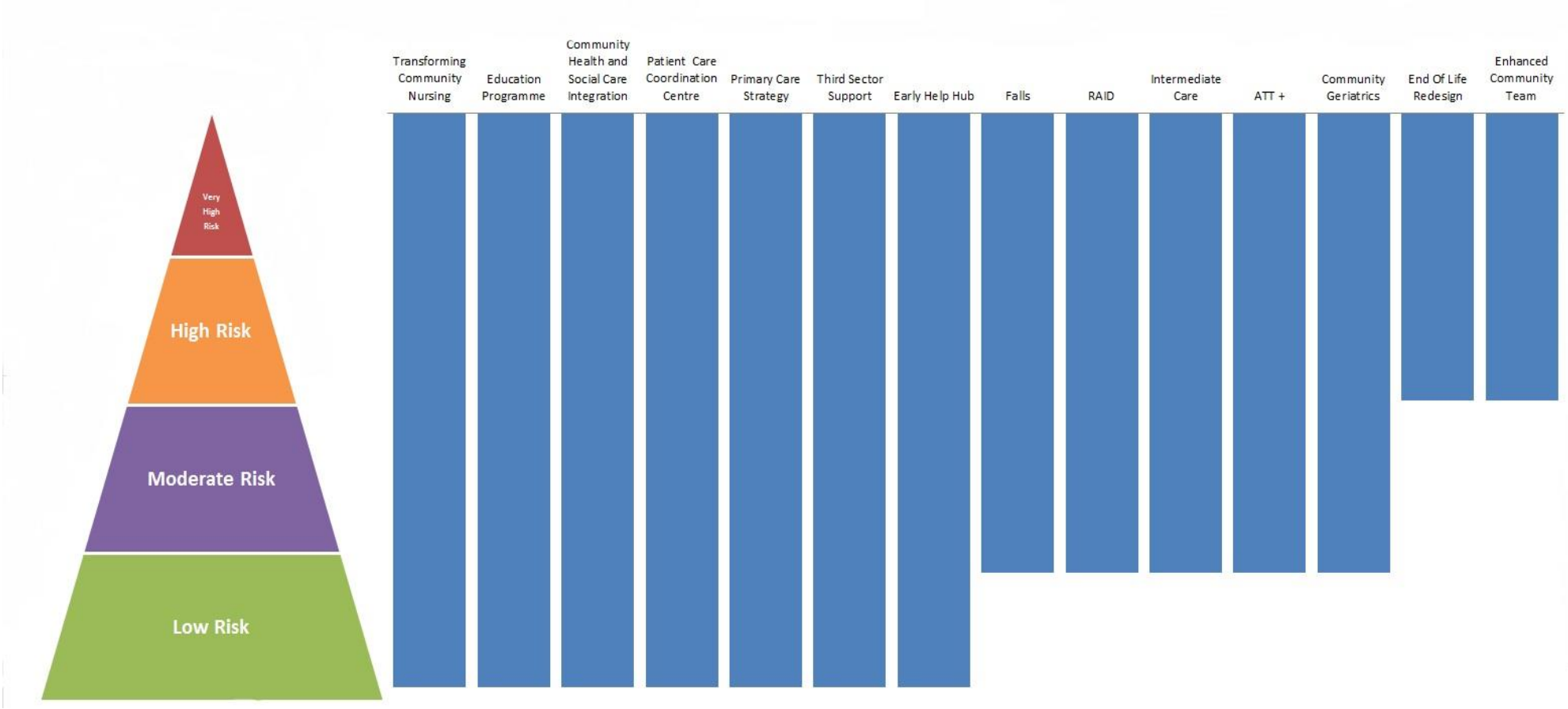
Service Name	Hours and days of operation	Location
DISTRICT NURSE SERVICES	7 days a week, 24 hours a day	□ Each locality in Trafford (North, Central, West, South) □ Dedicated Treatment Room Service in 5 locations across Trafford □ Undertake home visits to housebound patents. □ Residential homes □ Out of hours Nursing Service - Trafford Wide
IV THERAPY	7 days a week, 08:00 to 22:00	□ Home visits throughout Trafford
URGENT CARE TEAM	7 days a week, 24 hours a day	□ All localities in Trafford (North, Central, West, South) □ Home visits
CAMHS CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CYPS)	Mon-Fri 09:00 to 17:00 24/7 emergency on call via A&E only	□ Various health,education, and other settings across Trafford
CHILDRENS COMMUNITY NURSING TEAM (CYPS)	7 days a week 08:30 to 22:00	□ Each locality in Trafford (North, Central, West, South) □ Home and community visits
IMMUNISATION TEAM	Mon-Thurs 08:30 to 16:30 One Sat morning per month 09:30 to 13:00	□ Each locality in Trafford (North, Central, West, South) □ Monthly Saturday clinics alternating between Chapel Road/Mitford St clinic □ Home visits (for hard to reach families)
BLADDER AND BOWEL SERVICE	Mon-Fri 08:00 to 17:00	□ Each locality in Trafford (North, Central, West, South) □ Home visits (to patients identified as housebound)
COMMUNITY HEART FAILURE SPECIALIST NURSE SERVICE	Mon-Fri 09:00 to 17:00	□ Each locality in Trafford (North, Central, West, South) Nurse led clinics □ Home visits
COMMUNITY NEURO REHABILITATION TEAM (CNRT)	Mon-Fri 08:30 to 16:30	□ Home visits □ Within a Gym □ Within a clinic setting
COMMUNITY REHABILITATION TEAM	Mon-Fri 08:30 to 16:30	□ Patient's own home □ Out patient facility

DIETITIANS	Mon-Fri 08:30 to 16:30 Evening (X-Pert programme only)	□ Clinics in each locality in Trafford (North, Central, West, South) □ Special schools □ Home visits □ Health promotion □ X-pert (structured Education Diabetes Course)
EAR CARE	Mon-Fri 08:30 to 16:30	□ Meadway Health Centre (Sale) □ Delamere Health Centre (Stretford) – Fridays only
ENHANCED CARE TEAM	Mon-Fri 09:00 to 17:00	□ Each locality in Trafford (North, Central, West, South) □ Home visits
LEG ULCER SERVICE (WITHIN TISSUE VIABILITY)	Mon-Fri 09:00 to 17:00	□ Chapel Road Clinic, Sale. □ Home visits for patients who are genuinely housebound (shared with District Nurses)
MACMILLAN WELLBEING CENTRE	Mon-Fri 09:00 to 17:00	□ Macmillan Wellbeing Centre – Moorside Rd site, Davyhulme.
MUSCULOSKELETAL (PHYSIOTHERAPY) SERVICES	Mon-Fri 08:00 to 17:00	□ Physiotherapy- Trafford and Altrincham General Hospitals □ Podiatry- Trafford and Altrincham General Hospitals, Woodsend clinic, Chapel Road clinic, Delamere Centre
ONE STOP RESOURCE CENTRE	Mon-Fri 08:30 to 16:30	□ Each locality in Trafford □ Home visits including cross border where patient has a Trafford GP
PARKINSON'S NURSE	Mon-Fri 08:00 to 16:00	□ Meadway Clinic (Sale) – Tues afternoon /Thurs morning clinics □ Home visits for housebound patients registered with Trafford. GP □ Residential /Nursing home residents in the area. □ Hospital follow up/review/MDT as required
PHLEBOTOMY	Mon-Fri hours and locations vary	Drop in clinics held in various locations across Trafford and booked clinic for fasting bloods at Woodsend clinic Urmston Mon And Wed 8am – 9am □ Home visits for people who are housebound or in residential care □ Trafford General - Moorside Unit (weekly

PODIATRY SERVICES	Mon-Fri 08:00 to 16:00 Evening clinics Tues & Thurs 16:30 to 19:00	□ 7 Clinics across Trafford □ Home visits □ Trafford General Hospital □ Care homes (depending on referrals)
PULMONARY REHABILITATION	Mon-Fri sessions run at set times	□ Trafford General Hospital □ George Carnall Leisure centre, Urmston □ St Albans Church Hall, West Timperley
RAPID RESPONSE TEAM	Mon-Fri 09:00 to 17:00	□ Home visits
SPECIALIST PALLIATIVE CARE TEAM	Mon-Fri 09:00 to 17:00	□ Home visits
SPECIALIST WEIGHT MANAGEMENT SERVICE	Mon-Fri 09:00 to 17:00 (Tuesdays until 19:30)	□ Each locality in Trafford (North, Central, West, South) □ Seymour Grove Health Centre, Room 28 □ Home visits □ Trafford General Hospital
SPEECH AND LANGUAGE THERAPY (ADULTS)	Mon-Fri 08:30 to 16:30 Monthly evening session	□ Out patient clinics. □ Timperley Health Centre (Community clinic) □ Home visits and residential and Nursing homes
TISSUE VIABILITY SERVICE	Mon-Fri 08:00 to 17:00	□ Partington Health Centre. □ Others settings including patient's home, care homes, community clinics,GP surgeries, intermediate care facilities
TRAFFORD MACMILLAN INFORMATION AND SUPPORT SERVICE	Mon-Fri 09:00 to 17:00	□ Drop in at the Macmillan Wellbeing Centre in Davyhulme. □ Outreach sessions across Trafford
TREATMENT ROOMS	Mon-Fri 09:00 to 16:00	□ Firsway Clinic – Sale (Manor Ave) □ Woodsend Clinic-Flixton □ Delamere Clinic- Streford □ Seymour Grove Clinic – Old Trafford □ Timperley Health Centre
WELLBEING COUNSELLING SERVICE (Formerly Trafford Supportive, Palliative & Bereavement Service)	Mon-Fri 09:00 to 17:00 2 evenings per week until 19:00	□ Macmillan Wellbeing Centre, Davyhulme □ Chapel Rd Clinic, Sale
WOMENS' HEALTH SERVICES (PHYSIOTHERAPY)	Mon-Fri 08:30 to 16:30	□ Trafford & Altrincham General Hospitals □ Community clinics – Parent Craft sessions □ Trafford Leisure Centres - Aqua-natal

COMMUNITY PAEDIATRICS	Mon-Fri 09:00 to 17:00	□ Each locality in Trafford (North, Central, West, South) □ Home visits
HEALTH VISITING	Mon-Fri 08:30 to 16:30	□ Each locality in Trafford (North, Central, West, South)
ORTHOPTICS (CHILDREN'S)	Mon-Fri 08:30 to 17:00	□ Community clinics at Broomfield Lane, Chapel Road, Conway Road, Delamere Centre, Meadway, Partington, Woodsend, Seymour Grove □ Dyslexia Clinic at Woodsend Clinic □ Vision Screening – All reception Classes in Trafford □ Special School Clinics Delamere, Brentwood, Pictor
PERINATAL HEALTH VISITING	Mon-Fri 09:00 to 16:00	□ Home visits □ Clinic based appointments □ Children's Centre appointments
PHYSIOTHERAPY AND OCCUPATIONAL THERAPY (CYPS)	Mon-Fri 08:30 to 17:00	□ Cherry Manor Centre □ Chapel Road Clinic – specialist clinics □ Pictor school - Orthotic clinic (Mainstream O/P children) □ Special schools – Brentwood /Delamere /Pictor □ Home Visits □ Local schools / nurseries – Weekly Specialist Exercise group at Ashton on □ Mersey School during term time □ Respite settings
SAFEGUARDING CHILDREN	Mon-Fri 09:00 to 17:00	□ Trafford wide
SCHOOL NURSING	Mon-Fri 09:00 to 17:00	□ Each school in Trafford (North, West, South) within area Family Support Teams.
SPEECH & LANGUAGE THERAPY (CYPS)	Mon-Fri 09:00 to 17:00	□ Timperley, Delamere, Partington, Woodsend & Conway Rd clinics □ Home visits □ Schools
UNDER 5's ECZEMA CLINIC:	Thurs 09:00 to 13:00	□ Chapel Rd Clinic, Sale
ORTHOPTICS (ADULT)		□ Stretford Memorial Hospital □ Altrincham General Hospital

Appendix 4- List of schemes against risk stratified population


Very High Risk
High Risk
Moderate Risk
Low Risk
Transforming Community Nursing
Education Programme
Community Health and Social Care Integration
Patient Care Coordination Centre
Primary Care Strategy
Third Sector Support
Early Help Hub
Falls
RAID
Intermediate Care
ATT +
Community Geriatrics
End Of Life Redesign
Enhanced Community Team

Appendix 5 – Mrs Trafford's Journey

Co-ordinated Patient Journey

Mrs Trafford

- Mrs Trafford is 86 years old and lives alone
- Her sons live in Trafford and work full time
- She currently receives input and monitoring from Community Matrons and her GP
- Mrs Trafford also receives carer support 3 times a day to assist with activities of daily living
- Mrs Trafford has a diagnosis of COPD and shows early signs of heart failure which requires investigation

- Clinic information is available on GP system and options discussed with Mrs Trafford. Carer and transport needs identified.
- Information received by the PCCC who contact Mrs Trafford to discuss her needs.
- PCCC will liaise with TGH to arrange an appointment suitable for Mrs Trafford.
- PCCC coordinate the booking of patient transport and carer support to and from appointment.
- PCCC confirm all details of Mrs Trafford's appointment via her preferred mode of communication.

- Live' information is provided by secondary care through shared data reporting to PCCC and GP
- PCCC contacts Mrs Trafford to assist with booking her follow up appointment with GP within advised 2 weeks. This appointment is arranged at a convenient time for Mrs Trafford
- PCCC coordinate the booking of patient transport and carer support to and from her appointment.

- As results of Mrs Trafford's appointment are available her GP is able to discuss outcomes of appointment and advise on treatment plan.
- Due to the flow of 'live' information this treatment plan is electronically shared with community matrons who discuss and reassure Mrs Trafford of any concerns at their next visit.

Evaluation of Mrs Trafford's Current Journey

- Appointment and post outpatient follow up in Primary Care timely arranged and at a time that is convenient for Mrs Trafford
- A seamless journey with personal care wrapped around Mrs Trafford with timely and appropriate communications with the patient and between professionals .
- Efficient use of NHS and Local Authority resources
- Positive patient experience

Appendix Six- Impact of schemes against Better Care Fund Metrics and rationale

Trafford Metrics Mapping

4. Progress to date

a. Progress is now being made to on the various work streams and providers will be invited back onto the various project teams. The following is a position

Appendix 2

Dated 1st April 2015

TRAFFORD COUNCIL

and

NHS TRAFFORD CLINICAL COMMISSIONING GROUP

Version 6 24th Feb

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES RELATING TO THE BETTER CARE FUND

Dated 1st April 2015

TRAFFORD COUNCIL

and

NHS TRAFFORD CLINICAL COMMISSIONING GROUP

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FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES RELATING TO THE BETTER CARE FUND

Contents

THIS AGREEMENT is made on the 1st day of April 2015

PARTIES

(1) **TRAFFORD COUNCIL** (the **"Council"**)

(2) **NHS TRAFFORD CLINICAL COMMISSIONING GROUP** (the "**CCG"**)

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the borough of Trafford.

(B) The CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the borough of Trafford.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose.

(D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also the means through which the Partners will pool funds and align budgets as agreed between the Partners.

(F) The aims and benefits of the Partners in entering in to this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives;

c) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services;

d) 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.

e) Improve Health and Wellbeing –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.

f) Develop Communication/Relationships – Trafford will continue to work closely with individuals, communities, voluntary sector 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.

g) Develop 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.

(G) The Partners have jointly carried out consultations on the proposals for this Agreement with all those persons likely to be affected by the arrangements.

(H) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Affected Partner means, in the context of Clause 24, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agreement means this agreement including its Schedules and Appendices.

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

Better Care Fund means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

Better Care Fund Plan means the plan attached at Schedule 6 setting out the Partners plan for the use of the Better Care Fund.

Better Care Fund Steering Group means the board responsible for review of performance and oversight of this Agreement as set out in Schedule 2.

CCG Statutory Duties means the Duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the date of this Agreement

Commencement Date means 00:01 hrs on 1st April 2015

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

(c) which is a trade secret.

Contract Price means any sum payable to a Provider under a Service Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not include any Default Liability or Performance Payment.

Financial Contributions means the financial contributions made by each Partner to a Pooled Fund in any Financial Year.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(g) any form of contamination or virus outbreak; and

(h) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming relief

Functions means the NHS Functions and the Health Related Functions

Health Related Functions means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.

Host Partner means for each Pooled Fund the Partner that will host the Pooled Fund.

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes which is agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification.

Integrated Commissioning means arrangements by which both Partners commission Services in relation to an individual Scheme on behalf of each other is exercise of both the NHS Functions and Council Functions through integrated structures.

Joint (Aligned) Commissioning means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are

published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and the Council Functions.

Lead Commissioner means the Partner responsible for commissioning an Individual Service under a Scheme Specification.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

National Conditions mean the national conditions as set out in the NHS England Planning Guidance as are amended or replaced from time to time.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of the Services and which may be further described in each Service Schedule

Non Pooled Fund means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 10.

Overspend means any expenditure from a Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.

Partner means each of the CCG and the Council, and references to "**Partners**" shall be construed accordingly.

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

Personal Data means Personal Data as defined by the 1998 Act.

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations

Pooled Fund Manager means such officer of the Host Partner which includes a Section 113 Officer for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause 10.

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement.

Public Health England means the SOSH trading as Public Health England.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Regulations means the means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement.

Sensitive Personal Data means Sensitive Personal Data as defined in the 1998 Act.

Services means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification.

Services Contract means an agreement for the provision of Services entered into with a Provider by one or more of the Partners in accordance with the relevant Individual Scheme.

Service Users means those individual for whom the Partners have a responsibility to commission the Services.

SOSH means the Secretary of State for Health.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date.

2.2 The Government have committed funding for the Better Care Fund for 1 year only. This Agreement shall therefore continue until 31st March 2016 unless it is terminated beforehand in accordance with Clause 22. When the national position on the future of Better Care Fund beyond 31st March 2016 has been determined the agreement will need to be reviewed. The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification.

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.

3.2 The Partners agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme specification.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to establish one or more of the following:

4.1.1 Lead Commissioning Arrangements;

4.1.2 the establishment of a Pooled Fund

in relation to Individual Schemes (the "Flexibilities")

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement shall include such functions as shall be agreed from time to time by the Partners.

5.3 Where the Partners add a new Individual Scheme to this Agreement a Scheme Specification for each Individual Scheme shall be in the form set out in Schedule 1 shall be shall be completed and agreed between the Partners. The initial scheme specification is set out in schedule 1 part 2.

5.4 The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.5 The introduction of any Individual Scheme will be subject to business case approval by the Better Care Fund Steering Group.

6 COMMISSIONING ARRANGEMENTS

Integrated Commissioning

6.1 There are no integrated Commissioning Arrangements.

Appointment of a Lead Commissioner

6.2 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Commissioner shall:

6.2.1 exercise the NHS Functions in conjunction with the Health Related Functions as identified in the relevant Scheme Specification;

6.2.2 endeavour to ensure that the NHS Functions and the Health Related Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year.

6.2.3 commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;

6.2.4 contract with Provider(s) for the provision of the Services on terms agreed with the other Partners;

6.2.5 comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned;

6.2.6 where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the "Commissioner" and "Co-ordinating Commissioner" with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

6.2.7 undertake performance management and contract monitoring of all Service Contracts;

6.2.8 make payment of all sums due to a Provider pursuant to the terms of any Services Contract.

6.2.9 keep the other Partners regularly informed of the effectiveness of the arrangements.

7 ESTABLISHMENT OF A POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such pooled funds for revenue expenditure as set out in the Scheme Specifications.

7.2 Each Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.3 It is agreed that the monies held in a Pooled Fund may only be expended on the following:

7.3.1 the Contract Price;

7.3.2 where the Council is to be the Provider, the Permitted Budget;

7.3.3 Approved Expenditure

7.4 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners.

7.5 Pursuant to this Agreement, the Partners agree to appoint a Host Partner for each of the Pooled Funds set out in the Scheme Specifications. The Host Partner shall be the Partner responsible for:

7.5.1 holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

7.5.2 providing the financial administrative systems for the Pooled Fund; and

7.5.3 appointing the Pooled Fund Manager;

7.5.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

8 POOLED FUND MANAGEMENT

8.1 When introducing a Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

8.1.1 which of the Partners shall act as Host Partner for the purposes of Regulations 7(4) and 7(5) and shall provide the financial administrative systems for the Pooled Fund;

8.1.2 which officer of the Host Partner shall act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations.

8.2 The Pooled Fund Manager in respect of each Individual Service where there is a Pooled Fund shall have the following duties and responsibilities:

8.2.1 the day to day operation and management of the Pooled Fund;

8.2.2 ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification;

8.2.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

8.2.4 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

8.2.5 reporting to the Better Care Fund Steering Group as required by the Better care Fund Steering Group and the relevant Scheme Specification;

8.2.6 ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement;

8.2.7 preparing and submitting to the Better Care Fund Steering Group Quarterly reports (or more frequent reports if required by the Better care Fund Steering Group) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Better Care Fund Steering Group to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

8.2.8 preparing and submitting reports to the Health and Wellbeing Board as required by it.

8.3 In carrying out their responsibilities as provided under Clause 8.2 the Pooled Fund Manager shall have regard to the recommendations of the Better Care Fund Steering Group and shall be accountable to the Partners.

8.4 The Better Care Fund Steering Group may agree to the viring of funds between Pooled Funds.

9 NON POOLED FUNDS

9.1 For the avoidance of doubt, there will be no non pooled funds in relation to this agreement.

10 FINANCIAL CONTRIBUTIONS

10.1 The Financial Contribution of the CCG and the Council to each service is set out in Schedule 6

All financial contributions are made on a block basis.

10.2 With the exception of Clause 13, no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to the Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in the Better care Fund Steering Group minutes and recorded in the budget statement as a separate item.

11 NON FINANCIAL CONTRIBUTIONS

11.1 The Scheme Specification shall set out non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of service contracts and the Pooled Fund).

12 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

12.1 The partners have agreed risk share arrangements as set out in schedule 3, which provide for financial risks arising within the commissioning of services from the pooled funds and the financial risk to the pool arising from the payment for performance element of the Better Care Fund.

Overspends in Pooled Fund

12.2 Subject to Clause 12.1, the Host Partner for the relevant Pooled Fund shall manage expenditure from a Pooled Fund within the Financial Contributions and shall ensure that the expenditure is limited to the Contract Price or Approved Expenditure.

12.3 The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT the only expenditure from a Pooled Fund has been in accordance with the terms of this agrement and it has informed the Better Care Fund Steering Group in accordance with Clause 12.4.

12.4 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Better Care Fund Steering Group is informed as soon as reasonably possible and the provisions of the relevant Scheme Specification and Schedule 3 shall apply.

13 CAPITAL EXPENDITURE

Apart from the amounts set aside in the expenditure plan for Social Care Capital and Disabled Facilities grants, no Pooled Funds shall normally be applied towards any capital expenditure. If a further need for capital expenditure is identified this must be agreed by the Partners.

14 VAT

The Partners shall agree the treatment of the Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise.

15 AUDIT AND RIGHT OF ACCESS

15.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the Audit Commission to make arrangements to certify an annual return of those accounts under Section 28(1) of the Audit Commission Act 1998.

15.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

16 LIABILITIES AND INSURANCE AND INDEMNITY

16.1 Subject to Clause 16.2, and 16.3, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Partner ("Other Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

16.2 Clause 16.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Better Care Fund Steering Group.

16.3 If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 16. the Partner that may claim against the other indemnifying Partner will:

16.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

16.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

16.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and

records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

16.4 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement.

16.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

17 STANDARDS OF CONDUCT AND SERVICE

17.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective Standing Orders and Standing Financial Instructions).

17.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

17.3 The CCG is subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Funds are therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

17.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

18 CONFLICTS OF INTEREST

The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in schedule 7.

19 GOVERNANCE

19.1 Overall strategic oversight of partnership working between the partners is vested in the Health and Well Being Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

19.2 The Partners have established a Better Care Fund Steering Group to:

ensure the overall direction, implementation and successful delivery of the BCF for Trafford.;

be responsible for joint decisions on the BCF spend and subsequent monitoring;

oversee the programmes of work identified

19.3 The Better Care Fund Steering Group is based on a joint working group structure. Each member of the Better Care Fund Steering Group shall be an officer of one of the Partners and will have individual delegated responsibility from the Partner employing them to make decisions which enable the Better care Fund Steering Group to carry out its objects, roles, duties and functions as set out in this Clause 19 and Schedule 2.

19.4 The terms of reference of the Better Care Fund Steering Group shall be as set out in Schedule 2

19.5 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

19.6 The Better Care Fund Steering Group shall be responsible for the overall approval of the Individual Services, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

19.7 Each Services Schedule shall confirm the governance arrangements in respect of the Individual Service and how that Individual Services is reported to the Better Care Fund Steering Group and Health and Wellbeing Board.

20 REVIEW

20.1 Save where the Better Care Fund Steering Group agrees alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement and the provision of the Services within 3 Months of the end of each Financial Year.

20.2 Subject to any variations to this process required by the Better Care Fund Steering Group, Annual Reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 2.

20.3 The Partners shall within 20 Working Days of the annual review prepare a joint annual report documenting the matters referred to in this Clause 20. A copy of this report shall be provided to the Better Care Fund Steering Group

20.4 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan.

21 COMPLAINTS

The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services.

22 TERMINATION & DEFAULT

22.1 This Agreement may be terminated by any Partner giving not less than 6 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes.

22.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that the Partners ensure that the Better Care Fund requirements continue to be met.

22.3 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

22.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach.

22.5 Upon termination of this Agreement for any reason whatsoever the following shall apply:

22.5.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

22.5.2 where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

22.5.3 the Lead Commissioner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Commissioner in breach of the Service Contract) where the other Partner requests the same in writing Provided that the Lead Commissioner shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

22.5.4 where a Service Contract held by a Lead Commissioner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows the other Partner may request that the Lead Commissioner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

22.5.5 the Better Care Fund Steering Group shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

22.5.6 Termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

22.6 In the event of termination in relation to an Individual Scheme the provisions of Clause 22.5 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

23 DISPUTE RESOLUTION

23.1 In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

23.2 The Authorised Officer shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 23.1, at a meeting convened for the purpose of resolving the dispute.

23.3 If the dispute remains after the meeting detailed in Clause 23.2 has taken place, the Partners' respective chief executive/ chief operating officer or nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

23.4 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them

separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

23.5 Nothing in the procedure set out in this Clause 23 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

24 FORCE MAJEURE

24.1 Neither Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

24.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

24.3 As soon as practicable, following notification as detailed in Clause 24.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

24.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Partner shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

25 CONFIDENTIALITY

25.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 25, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

25.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

25.1.2 the provisions of this Clause 25 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

25.3 Each Partner:

25.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

25.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25;

25.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

26.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Act to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

26.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Act. No Partner shall be in breach of Clause 26 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Act.

27 OMBUDSMEN

The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

28 INFORMATION SHARING

The Partners will follow the Information Governance Protocol set out in schedule 8, and in so doing will ensure that the operation this Agreement complies comply with Law, in particular the 1998 Act**.**

29 NOTICES

29.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 29.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

29.1.1 personally delivered, at the time of delivery;

29.1.2 sent by facsimile, at the time of transmission;

29.1.3 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

29.1.4 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

29.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report

was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

29.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Partner in writing:

29.3.1 if to the Council, addressed to Teresa Grant, the Chief Executive, Trafford Metropolitan Borough Council

Tel: [ ]

Fax: [ ]

E.Mail: teresa.grant@trafford.gov.uk

and

29.3.2 if to the CCG, addressed to Gina Lawrence, Chief Operating Officer

Tel: 0161 873 9531

Fax: N/A

E.Mail: gina.lawrence@nhs.net

30 VARIATION

No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

31 CHANGE IN LAW

31.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

31.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

31.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 23 (Dispute Resolution) shall apply.

32 WAIVER

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

33 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

34 ASSIGNMENT AND SUB CONTRACTING

The Partners shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

35 EXCLUSION OF PARTNERSHIP AND AGENCY

35.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

35.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

35.2.1 act as an agent of the other;

35.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

35.2.3 bind the other in any way.

36 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

37 ENTIRE AGREEMENT

37.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

37.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

38 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

39 GOVERNING LAW AND JURISDICTION

39.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

39.2 Subject to Clause 23 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement

THE CORPORATE SEAL of **THE**)
COUNCIL OF [ ])
was hereunto affixed in the presence of:)

Signed for on behalf of **CLINICAL COMMISSIONING GROUP**

_____

Authorised Signatory

SCHEDULE 1 – SCHEME SPECIFICATION

Falls Service in Trafford

Falls service in Trafford
Provider – not yet decided
Contracting arrangements: not yet decided
This service does not require any delegated functions
Host pooled fund partner and service commissioner: Trafford CCG
Funding will be on a block basis, therefore over/under spends will not occur
No data sharing is required between BCF partners
Strategic objective
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
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 service will initially triage and access the patient by an OT. The service will be delivered from a location in each of the localities. The multidisciplinary service will include medicine management, physiotherapy, community nursing, 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

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

The current provision in Trafford is limited due to existing capacity and can only offer a service to those individuals who have fallen a number of times. 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

Investment to date	**2015/16**
£0	£400,000

Impact of scheme

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

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.

Key success factors for implementation

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 be

implemented in early 2015/16 .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.

Reproviding Intermediate Care in Trafford

Reproviding Intermediate Care in Trafford
Provider – not yet decided
Contracting arrangements: not yet decided
This service does not require any delegated functions
Host pooled fund partner and service commissioner: Trafford CCG
Funding will be on a block basis, therefore over/under spends will not occur
No data sharing is required between BCF partners
Strategic objective
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
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 Trafford adults (this includes those registered with primary care and those who are resident). 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
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

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 and the Council to evidence the requirement for intermediate care and allowed the enhanced model to be developed.

Investment requirements

Investment to date	2015/16
£322,000	£600,000

Impact of scheme

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 usual 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

The service specification for the intermediate care facility will benefit from the development of robust Key Performance Indicators (KPIs) for health and social care 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.

Key success factors for implementation

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.

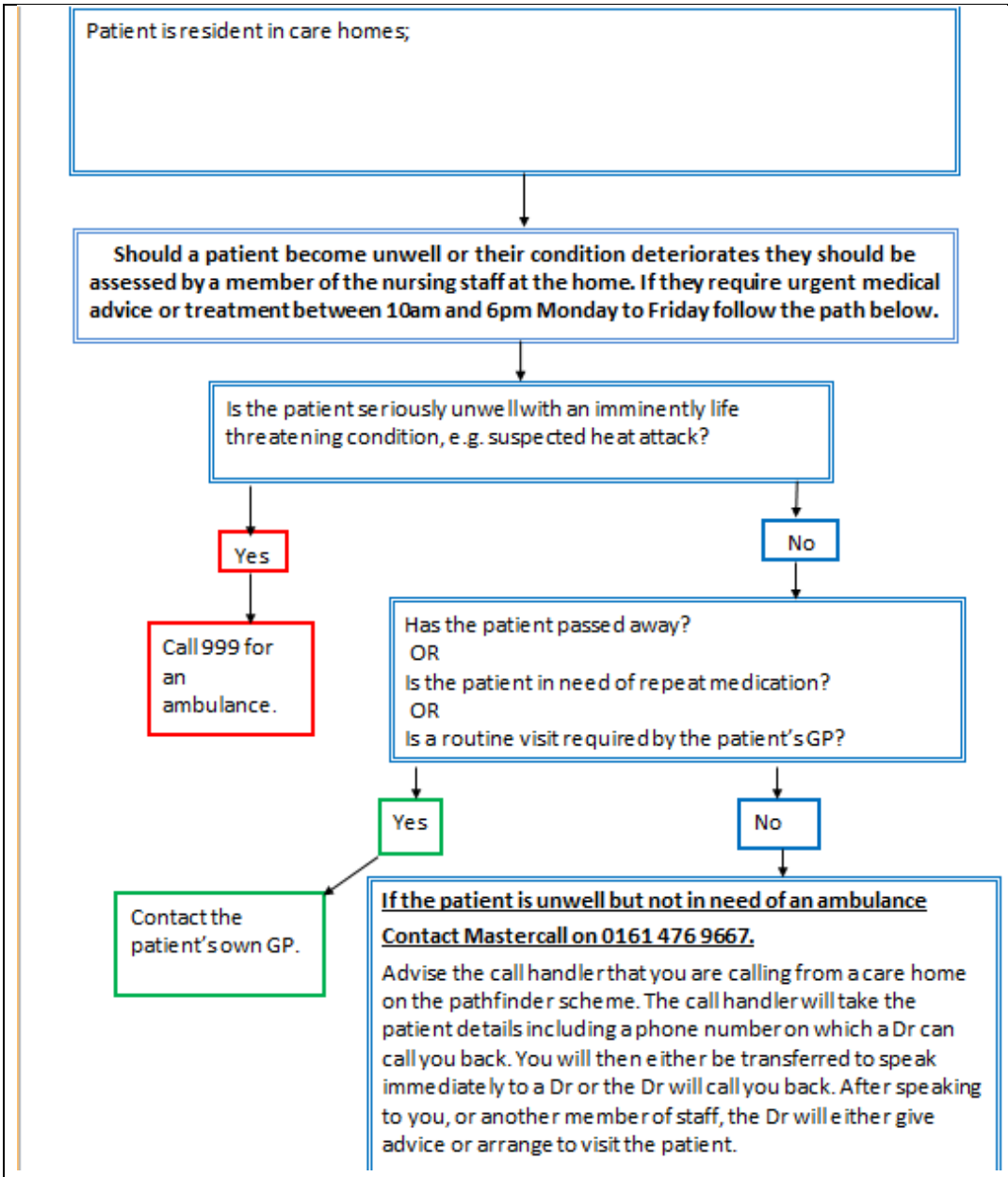
The service will benefit from constant review guaranteeing a timely response to the changing needs and environment of Trafford's population.

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 including social services 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.

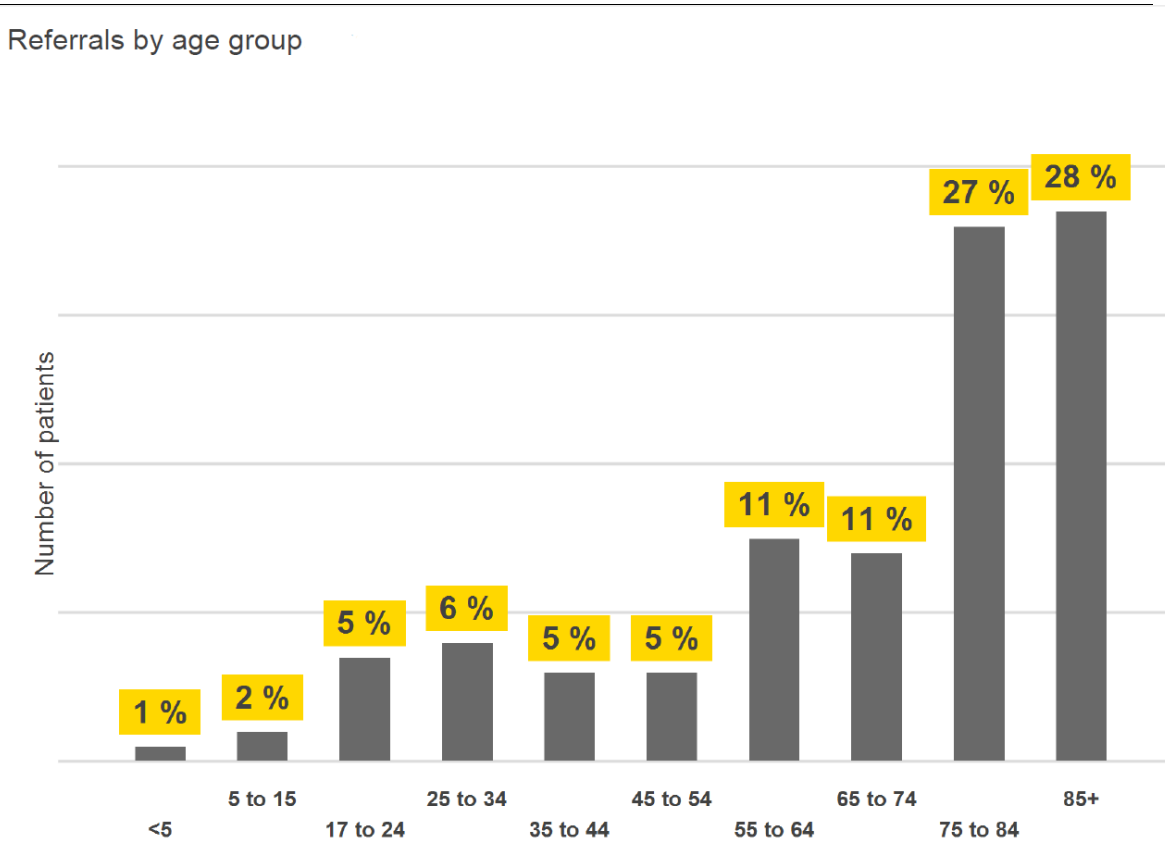
Alternative to Transfer Plus Detailed Scheme Description

Alternative to Transfer Plus (nursing homes)
Provider – not yet decided
Contracting arrangements: not yet decided
This service does not require any delegated functions
Host pooled fund partner and service commissioner: Trafford CCG
Funding will be on a block basis, therefore over/under spends will not occur
No data sharing is required between BCF partners
Strategic objective
The Alternative to Transfer Plus model for Trafford has been developed with the philosophy of ensuring a reduction in A&E attendance and subsequent admissions to an acute ward for nursing home residents, with the additional benefit of reducing delayed transfers of care.
Overview of the scheme
The aim of the scheme is to provide an alternative option for nursing home staff other than calling an ambulance when for a patient who has become unwell. The scheme will be available to patients who are in Nursing Home care only as patients can be triaged by a clinician. This will apply across all age groups. The scheme has been operational for the population at large since November 2013 with a high deflection rate of 90%
The delivery chain
Mastercall will provide a general practitioner on call 24hrs a day who is able to offer medical advice. This is outlined in the diagram below.



The evidence base

Statistics show that a high percentage of patients who are treated in A&E after conveyance are likely to be admitted to a ward. This percentage increases with elderly patients. It is recognised that many of these patients could be treated at home. Not only is this taking only does this create extra pressure on secondary care providers but it is often distressing for patients who are frail and elderly but can result in further deterioration. Through analysis of the ATT scheme it is recognised that the greatest numbers of people using the service are over the age of 65. This is shown in the graph below.



Investment requirements

Investment to date	2015/16
£257,000	£100,000

Impact of scheme

Reduced non-elective admissions: This service will reduce pressure on both the ambulance service and also the attendances and subsequent admittance to secondary care through providing a clinically safe model of care at patients' homes. Conditions which are deemed appropriate are will be conveyed to hospital as at present.

Reduce inappropriate admissions to residential care: This service will not have an impact on this measure

Proportion of older people who are still at home 91 days after discharge from hospital: This service will impact on this measure in such a way that it supports admission and readmission to an acute trust and in doing so guarantees sustained physical and mental stability that could be reduced should an older person remain in an acute hospital bed for a longer period than their expected episode of treatment.

Delayed transfers of care from hospital: This service ensures that the right person is admitted to an acute trust when their care requires this approach; reducing the level of patients requiring transferring back into the community allows the existing resources in both secondary and community care to target the patients requiring discharge more effectively.

Patient/service user experience: The impact of this service guarantees that only those acutely unwell patients are admitted into an acute setting, avoiding inappropriate admissions and safeguarding a much more appropriate and beneficial experience for all older people.

Feedback loop

This scheme will be monitored on a month basis through the Systems Operational Resilience Group. Any issues will be dealt with and can be escalated if appropriate. The Frail and Older Peoples steering group will review the service after 6 months to ensure effectiveness.

Key success factors for implementation

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

Transforming Community Nursing Detailed Scheme Description

Transforming Community Nursing
Provider – not yet decided
Contracting arrangements: not yet decided
This service does not require any delegated functions
Host pooled fund partner and service commissioner: Trafford CCG
Funding will be on a block basis, therefore over/under spends will not occur
No data sharing is required between BCF partners

Strategic objective

The Redesign of District Nursing is to be delivered in 3 phases.

District Nursing services was part of the "Transforming Community Services" process. Trafford PCT as part of building the Trafford Integrated Care model undertook a full procurement for all community services. District Nursing was part of this. The service has a specification of service which describes the service which is very traditional and is a task driven specification.

Trafford CCG has a very robust review process in place with a rolling programme to review all community services which forms part of the contract governance framework for the Community Contract.

Trafford CCG held a mapping event as part of its Frail and Older Peoples programme. This identified gaps in service provision with inconsistencies across Trafford. This programme is to provide a consistent service. The service has also received in additional requirements from GP's. Also an objective is to understand the role of a community nurse and practice nurses.

The strategic objective is to deliver an integrated model on a neighbourhood basis which will integrate with primary care but will also integrate with other community services including other specialist nursing services.

The new service support admission avoidance and will in reach into acute trusts, residential and nursing homes. It will proactively manage patients with a holistic approach and it will integrate health and social care needs of an individual.

Although the redesign will be focused on the older cohort of patients, the service will be responsive to all health needs for adults.

This service will align with the other schemes which are part of Better Care Fund including :

- Intermediate care
- Falls service
- End of life.

Pennine Care as current provider are working with the CCG on the redesign but it is also ensure that other stakeholders are involved in the redesign so to understand this new service , as they understand the complex requirements including, mental health issues, therapy alignment, acute services for in reach and handover to community services and social care.

This programme will align directly with the work streams of the integration of health and social care.

Overview of the scheme

The new model will be a holistic approach to deliver a full and comprehensive service for the traditional "scheduled care" support in the community. This will include treating patients at home, in the community on an individual and clinic basis. .

Trafford has set out its strategy, the four neighbourhoods localities will have local teams working together to support the local population. .It has to be accepted that each locality has different

considerations to meet the needs which will be reflected in the capacity and sill mix planning.

The redesign will be clinically led by a GPSI who is working with the CCG and has researched and tried and tested similar models of nursing outside of Trafford. The approach will drive efficiency to avoid any duplication with other services.

This service redesign will eventually bring together the 3 elements of the service including scheduled /planned, urgent /enhanced services and specialist nursing.

The resign will have 3 phases.

Phase 1 –traditional district nursing planned care service to review the current service, (this is almost completed). To scope the needs and requirements of the new service. This will take into account public health information.

To develop in parallel the design of the new service and to be present to the clinical directors in December.

This will be presented to the Steering group which has been established. Although this is clinically led by the CCG, this group have representatives from Pennine Care, social care, CMFT clinicians /operational manager and GP's. The steering group is supported by a clinical model design group and a finance, capacity and contracts group.

The Steering group will have the responsibility to agree the new model (clinically led by the CCG) The clinical design group will then work on the detail, the skill mix and the capacity required to meet the population needs .

The finance and activity group will develop the business case for this to be presented to the CCG finance committee.

Phase 2 will merge the newly designed holistic service with the urgent care services which are new and were implemented in November 2013. These services receive referrals through a single access point where all referrals are triaged.

The urgent care services including rapid response, IV services will merge so the whole community services is shaping and delivered at the 4 localities.

Phase 3 will merge the new service with specialist services including heart failure nurse, dementia, tissue viability etc**.**

The outcome from this will be one service delivered in the 4 localities**.** The principles of this model are outlined in the presentation enclosed.

TCCG Future of
Community Nursing C

The delivery chain

The whole of community services will partner with Trafford Council as the delivery element of integrated services. Delivered by Pennine Care NHS Foundation Trust the full accountability will be through the community services contract. The community contract is currently for 3 years up to March 2016. In order for the full clinical model to be fully embedded a recommendation for an extension to the Pennine contract is to be proposed to the CCG Governing body.

This will enable Pennine Care working with primary care to deliver this strategic change.

The evidence base

The current provision in Trafford is limited due to existing capacity and is a very traditional service which does not include the new medical and social elements.
Also the service is not provided to residential and nursing homes. This has always been difficult to support especially nursing homes but Trafford like many other economies Trafford have a number of admissions into acute A&E service from activity from Nursing and residential homes. By providing

this new service and working and supporting a new primary care this should reduce in appropriate admissions to acute hospital.
The integrated model will also combine health and social care which will reduce duplication in time and release additional capacity.

Investment requirements

Investment to date	2015/16
£3,078000	£0

Impact of scheme

Reduced non-elective admissions: the will link with the other work streams in this programme. This will be an enabler to reduce in appropriate activity. The Target reduction for this scheme is 74 admission in 2015/16
Reduced inappropriate admissions to residential care: the service delivery model will support the discharge to assess model from our Acute partners and community nursing will in reach into hospitals to pull out patients and support in the community. The service will align to the Patient co-ordination centre to the sharing of data across services.
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.
Delayed transfers of care from hospital: the service will benefit from the in reach into acute. Patient's length of stay is reducing and the service needs to have the skills and experience to support and treat these patients.
Patient/service user experience: as with any NHS service the community nursing service 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.

The impact of scheme against the metric set out within the BCF is outlines in Appendix 6.

Feedback loop

The service specification for the 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 contract Board for community services. The Board has a service review committee which will be responsible to over eel the new service implementation. A key element of this is the communication plan to acute services to ensure seamless hand over and in reach but also to Primary care. This service will be integral with the GP and Practices nurses to ensure the service supports patients and avoids duplication in service

As part of the governance framework for community services there is a Finance, Activity and Performance committee which meets on a monthly basis. This new service will contribute to the dashboard for community services and will form part of the on-going reporting and monitoring which Pennine produces for this committee. This will evidence the impact of the service on avoided admissions.
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.

Key success factors for implementation

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.

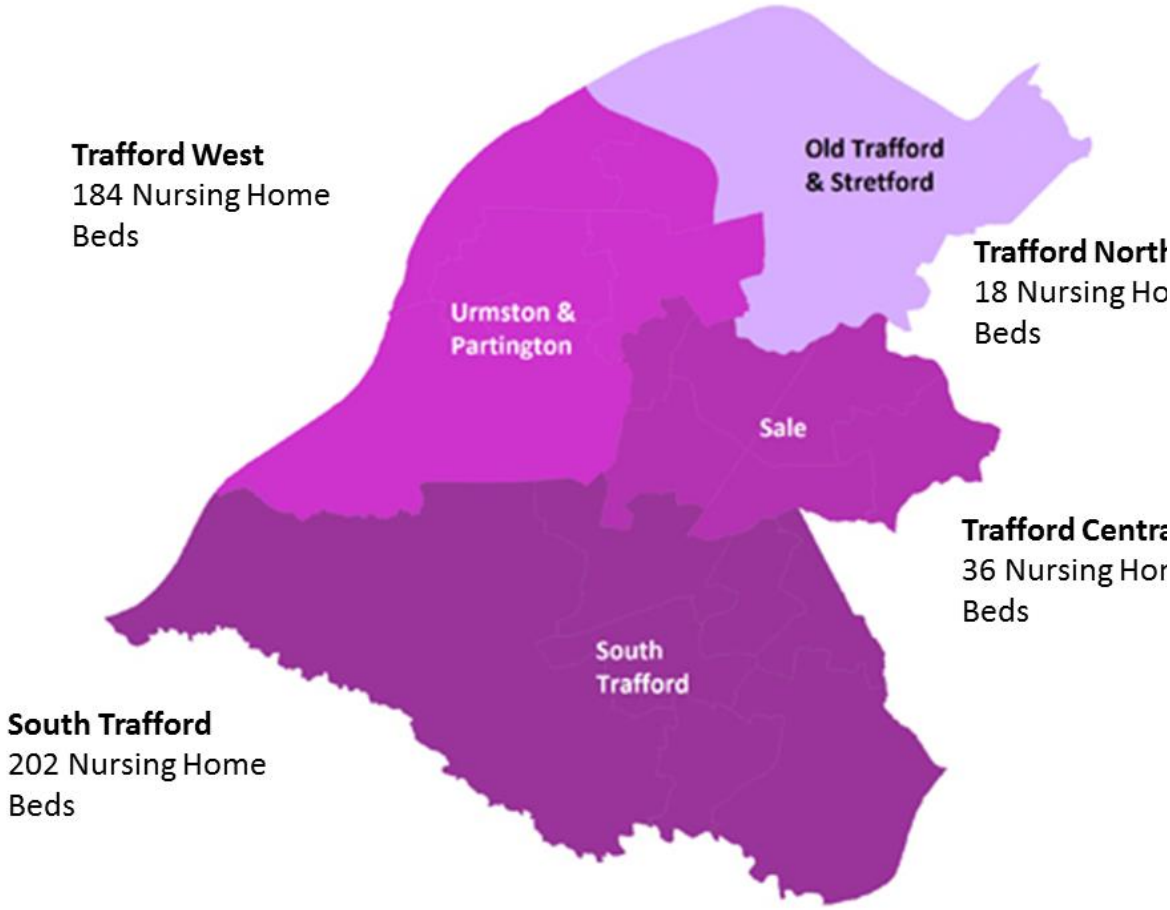
Trafford has an excellent record of developing and maintaining a strong partnership approach; this will be mirrored in the new service going forward guaranteeing co-production.

Due to the multi-agency approach, the community nursing delivery model will have been implemented by Q! 2015/16 .The CCG has established a steering group with a membership from all partner organisations will approve the model and the associated principles of delivery. The CCG has evaluated other service with a GPSI leading the redesign. The new service will include elements of good practice into the service specification.

As part of success the service will evidence the support to Frail and older people and should impact on reduced admissions from residential and nursing homes. This will be further evidenced when all elements of the urgent care and scheduled care merge together and with the specialist nursing services. The single access point will triage the demand to ensure the correct service is provided.

Community Geriatrics Detailed Scheme Description

Community Geriatrics
Provider – not yet decided
Contracting arrangements: not yet decided
This service does not require any delegated functions
Host pooled fund partner and service commissioner: Trafford CCG
Funding will be on a block basis, therefore over/under spends will not occur
No data sharing is required between BCF partners
Strategic objective
The scheme aims to reduce the number of emergency admissions to hospital from nursing and residential care homes through proactive management of complex and high risk patients. The scheme will also support general practice in the ongoing care planning for this target group.
Overview of the scheme
Trafford CCG currently commissions a community care of the elderly consultant service. The north of the borough is served with two sessions a week by CMFT. This service was initially designed to cover all homes in the north of the borough but due to staffing changes this service only provides transient support to residents entering intermediate care provision at Ascot House. The south of the borough receives four sessions a week provided by UHSM. This service currently provided to patients who are resident in 4 nursing homes in the south of the borough**.** This is a reactive service and the consultants receive referrals from GPs and community services as well as patients discharged from hospital The current service has capacity to deliver more contacts and increased activity numbers per month. Currently fewer than 100 patients at any one time receive specialist geriatric support through this service. However, Trafford has on average 40 non elective attendances per month into acute trusts from Trafford Nursing homes many of which convert into admissions. There are 440 nursing home beds in Trafford which are spread across the 4 localities, as follows:



Trafford CCG has committed to a short term proposal for the winter months until March 2015 is to achieve greater utilisation of the consultant input within the current contract. This will involve General Practice identifying those residents in nursing and residential care homes who have the most complex health needs and at high risk of admission to hospital. Patients will be offered a comprehensive geriatric assessment and a care plan put in place to manage the patient's needs. The service will also target those residents who have been identified through the alternative to transfer Plus scheme with the same principle applied to these patients.

The results of this pilot will be used to inform a new model of community geriatrics based on an increasingly proactive approach to managing the health care needs of those patients in the top 2% of risk in both nursing homes and in the wider community.

This scheme is currently in development.

The delivery chain

Trafford CCG is the lead commissioner for this service. It is intended that this service will continue to be delivered by the two main providers within the borough (UHSM and CMFT) and in line with patient flow into secondary care. General practice will be a key partner is ensuring the success of this scheme.

The evidence base

As reference within the Trafford Better Care Fund, the CCG footprint has an increasingly elderly population with a high rate of growth over the coming decade. This work will work in parallel the options being considered for the new primary care model. The typical resident in a care home in the UK is female, aged 85 years or older, and in the last years of their life. The majority of care home residents have dementia and take seven or more medications. Many live with depression, mobility problems and pain .A review of the literature of models for providing improved care in nursing homes concludes that medical care for care home residents could be improved by making it more proactive.

Investment requirements

Investment to date	2015/16
£400,000	**£0**

Impact of scheme

Reduced non-elective admissions: This is an admission avoidance scheme with a target reduction of 130 in 2015/16. This will be achieved through proactive case management and target interventions to ensure only the most appropriate patients attend secondary care.
Reduced inappropriate admissions to residential care: the service delivery model will support the discharge to assess model from our Acute partners and community nursing will in reach into hospitals to pull out patients and support in the community. The service will align to the Patient co-ordination centre to the sharing of data across services.
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 admission and re-admission and therefore are eligible for referral into the service.
Delayed transfers of care from hospital: the service will benefit from the in reach into acute which will enable patients to be discharge home earlier with the assurance that there is specialst support within the community to manage patients at their own home.
Patient/service user experience: as with any NHS service the service 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.

The impact of scheme against the metric set out within the BCF is outlines in Appendix 6.

Feedback loop

The service specification for the 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 Frail and Older Peoples Steering Group. A key element of this is the communication plan to Nursing Homes which will be achieved through the Service improvement. This service will be integrated with the GP and Practices nurses to ensure the service supports patients and avoids duplication in 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.

Key success factors for implementation

The success of this scheme will depend on developing effective and robust relationships between community geriatricians, primary care and nursing home staff. Effective partnership arrangements with the ambulance service and out of hour's primary care will also need to be developed. The confidence to share information between professionals will also be a key driver to the success of this scheme.

Redesigning End of Life Care Detailed Scheme Description

End of Life Service Redesign, Enabler Project and Third Sector
Provider – not yet decided
Contracting arrangements: not yet decided
This service does not require any delegated functions
Host pooled fund partner and service commissioner: Trafford CCG
Funding will be on a block basis, therefore over/under spends will not occur
No data sharing is required between BCF partners
Strategic objective
To enhance the level and quality of care provided for patients with complex life limiting conditions, those in their last 12 months of life and those in the final days of life.
Overview of the scheme
Trafford CCG has already undertaken work to understand the provision of palliative and end of life care in Trafford. For the purpose of this scheme end of life is defined from the point of terminal diagnosis until the patient dies. Trafford CCG commission a number of services relating to palliation and specialist end of life care. Through dialogues with stakeholders and patients it has become evident that this causes duplication, a high number of interactions with patients and families and is no longer aligned to service in acute trusts. Given the complexity of health care provision within Trafford the scheme proposes the movement towards a single integrated end of life team lead by a sole provider who will provide both long term palliative care and the enhanced care required in the final months of life. The model will be support by social care, medicines management and oxygen services as well as other existing services delivered in the community. Support by a specialist palliative consultant will underpin the clinical element of this model The Transforming community nursing project will be tailored to take regard of this. New investment will be required to deliver this scheme. The model will be delivered in two stages, with the later stage moving towards a 7day model to support dying patients It has also been recognised that advanced care planning is limited across the Trafford health economy. Trafford CCG has already completed work to design and implement an advanced care planning process supported by an individual plan of care for the dying patient. This will be rolled out more comprehensively in 2015/16. The use of technology will be key to the delivery of a new end of life care model. Trafford CCG is committed to rolling out an EPaCCS solution and this will continue in 2015/16 ensuring that all stakeholders have real time information and can be responsive to advanced plans. Trafford CCG also plans to develop a solution for families and carers to ensure that where agreed they can have access to plans ensuring that where a patient cannot articulate plans these can be accessed quickly. Trafford has a thriving third sector and work will be undertaken to ensure that the needs of the sector are identified and developed in order to meet patient and family need.
The delivery chain
The service will be led by a sole provider and will require full procurement. This will be conducted by Trafford CCG. Partnership arrangements will be established with voluntary sector groups where appropriate
The evidence base
The National Bereavement Services survey shows that 81% of patients would prefer to die at home. NHS Trafford CCG End of life Care Profile shows that a higher than average number of deaths which occur in a hospital setting at 61% compared to an England Average of 50.7%. This equated to 1,139 deaths in hospital in 2013/14.

At 12.9% the number of death occurring in a nursing and residential care home is nearly 7% lower than the average in England suggesting that there are a high number of emergency admissions to hospital for terminal patients.

The length of stay for patients who are admitted to hospital in the last 12 months of life exceeds 8 days in over 75% of cases when much of the care could be provided closer to home

The number of deaths in a hospice is also lower than the England average (5.6%) at 4.3%

Investment requirements

Investment to date	2015/16
£2,112,000	£200,000

Impact of scheme

Increase the number of patients dying in a place of their choice- The service will ensure that advanced care planning is at the forefront of end of life care. This will enable patients and families to express and have implemented their wishes as the need for care increases. It is the intention the deaths in hospital will reduce by 2% each year for the next 5 years as a result of this service.
Reduced non-elective admissions: This service will reduce the number of emergency admission to hospital by 53 in 2015/16 through enhanced community and hospice based support
Reduce inappropriate admissions to residential care: This service will not have an impact on this measure
Proportion of older people who are still at home 91 days after discharge from hospital: This service will link with the integrated health and social care scheme to ensure that once a person is discharged from hospital they are supported to die at home
Delayed transfers of care from hospital: This service ensures that the right person is admitted to an acute trust when their care requires this approach; reducing the level of patients requiring transferring back into the community allows the existing resources in both secondary and community care to target the patients requiring discharge more effectively.
Patient/service user experience: The impact of this service guarantees that only those acutely unwell patients are admitted into an acute setting, avoiding inappropriate admissions. The service will enhance the offer of care to patients as well as ensuring families and carers are support to recognise death and the options available as the end of life approaches.

The impact of scheme against the metric set out within the BCF is outlines in Appendix 6.

Feedback loop

Trafford CCG has established a number of local mechanisms to ensure the outcome of this service are understood across the local health and social care economy. These are based around the following;

- End of Life Steering Group
- Palliative Care Partnership
- Carers Forum
- Patient Reference Group
- Contract Monitoring

Work is also ongoing with neighbouring CCG's to ensure that the model of care aligns around acute trusts rather than CCG footprints. In the future new data will be required to monitor this service and this will be addressed with individual provider(s)

Key success factors for implementation

Ensuring that all partner organisation are committed to delivering a new model of care for end of life patients in Trafford
Ensuing that technological solutions are easily accessible and deliver the appropriate level of clinical and social detail to allow patients wishes to be executed in a timely manner
Ensuring that the voluntary sector is developed sufficiently to support non clinical care.

Community Health and Social Care Integration and Development of an Early Help Hub

Community Health and Social Care Integration and development of an Early Help Hub
Provider – not yet decided
Contracting arrangements: not yet decided
This service does not require any delegated functions
Host pooled fund partner and service commissioner: Trafford CCG
Funding will be on a block basis, therefore over/under spends will not occur
No data sharing is required between BCF partners

Strategic objective

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, accessing universal community support 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.
- To create an Early Help Hub that will provide step up and step down support for people, reducing both a reliance on services and the likelihood of re-entering the system.

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 and community organisations.

Overview of the scheme

Model of Care

The focus for changes is:

6. All age Early Help Hub
7. Redesigned and integrated adult locality teams

8. Redesigned and integrated adult pathways, including for frail elderly people and end of life pathway
9. Complex care coordination
10. All age integrated locality teams

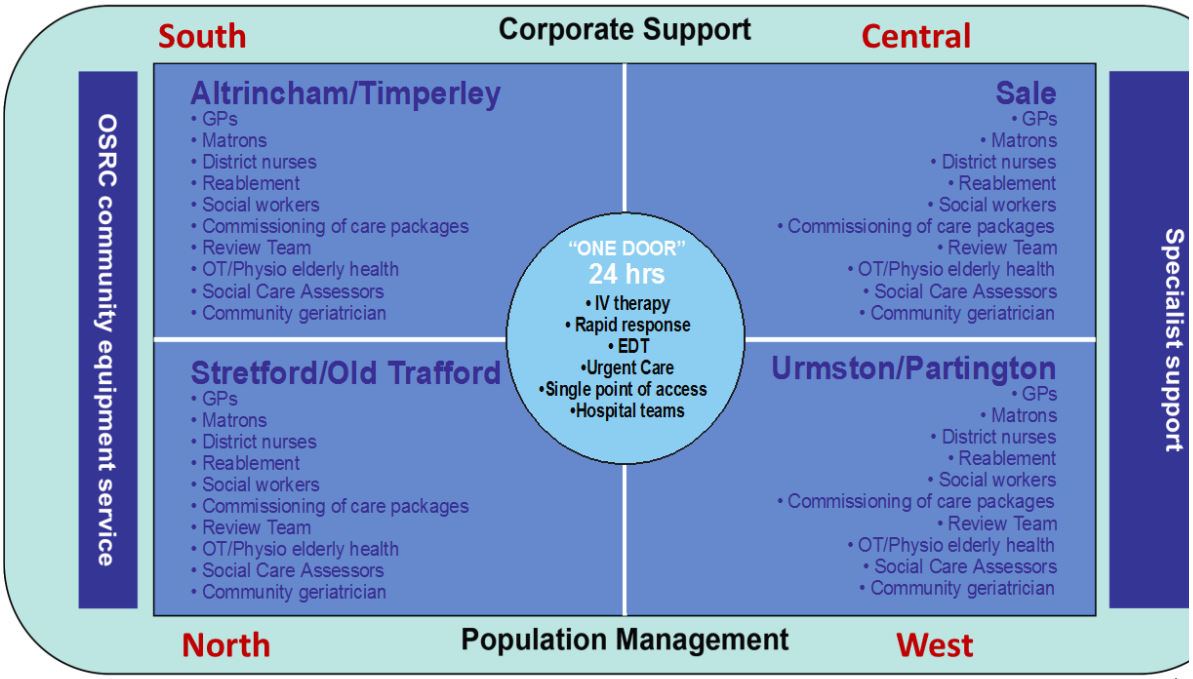
The vision for Trafford is to develop an integrated service delivery model made up of co-located multi-agency teams, who will work closer with local services such as GP's, pharmacists, nursing and residential homes, and other community and voluntary sector providers clustered with defined residential 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 November 2014 will have replicated this for adults through a comprehensive Section 75 agreement between Trafford Council and Pennine 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 and community and voluntary organisations and will operate on a 7 day basis.

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 diagram outlines the core services that will be delivered in each of the four areas. The core services are those that are viewed as pivotal to partnership working within each neighbourhood and which currently or will in future have a presence in the localities. These include:

- Matrons
- District nursing
- Reablement provision
- Social work

- Social work assessors
- Commissioning of care packages
- Review team
- Occupational therapy and physiotherapy provision

The Core Access Services (CAS) will be a central function and provide access to service provision in a more acute phase. It will promote timely discharge and support step up and step down to support people to be managed and cared for closer to home and will draw on 24 hour services to do this e.g. rapid response, IMC. The CAS will work closely with each neighbourhood team where local provision is required.

The CAS will proactively work with the wealth of other community services, including clinic based therapies and specialist nursing provision which will be provided on a borough wide basis across the neighbourhoods.

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 community support, 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 the 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, social care and community and voluntary sector 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 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, by integrating systems across health and social care. 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.

The hub will reflect the locality based approach applied throughout integration, being based centrally, as part of the CAS, with a strong presence in each of the four localities. It will work closely with communities and their organisations to coproduce innovative solutions addressing local needs, and where required, support development and sustainability.

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 the 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

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

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/.

Various pieces of work have also taken place across Trafford to indicate the need for a collaborative and holistic approach across health and social care, including evidence from the Joint Strategic Needs Assessment and the extensive consultation that took place to form Trafford's Joint Health and Wellbeing Strategy. Additionally information and advice provision was reviewed across all partners and indicated areas of partnership working and accessibility that could be strengthened.

The background and focus towards achieving integrated health and social care teams in Trafford is well documented, see the following reference, http://www.nuffieldtrust.org.uk/talks/removing-policy-barriers-integrated-care-trafford-experience. Building on the integration of health and social care for children and young people's services much work has already been undertaken within the Trafford health and social care economy to develop a robust case for change. Opportunities have been identified to achieve both horizontal and vertical integration of services and support systems and processes to provide an integrated care offer and support the Healthier Together strategic change across the Greater Manchester conurbation.

As part of the initial scoping for the Early Help Hub, the following research took place:

- Individual scoping meetings with a range of professionals involved in potential interventions that fall in scope.
- Workshop held with key individuals to shape service
- Trafford Compliments and Complaints information
- Benchmarking across other local authorities
- Information gathered on future demand to evidence need for redesigned prevention service
- National studies on prevention
- NICE guidelines
- Health and Wellbeing Strategy and consultation results
- JSNA
- Requirements of Care Act and Children and Families Act researched

- Stronger Families approach
- Evidence of blueSCI model locally- Salford university research
- Performance figures from services in scope
- Research on technological solutions to support health and wellbeing

In June 2014 a full market research phase with the public was carried out. This included direct interviews with 548 individuals to understand the scope of wellbeing and look beyond the presenting health issues to analyse the root cause. Results indicated the importance of addressing issues such as social networks, self-esteem, personal resilience, life guidance and learning. The Early Help Hub will incorporate these aspects into the model and measure the effect that this has on reducing unhealthy lifestyles and behaviours.

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

As shown on the Tab 3. HWB Expenditure Plan, there is no additional investment required for this scheme; the focus is on reshaping the existing resources across health and social care.

Impact of scheme

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 with appropriate input from the voluntary and community sector. 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, through health and social care professionals and voluntary and community organisations, is committed to focusing 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 community and voluntary sector services, 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, social care and community services 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 and a coordinated and supported network of community organisations. 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.

Increased number of people dying at their usual place of residence. The model will wrap care around people and better coordinate a person's health and social care support, particularly in the last 12 months of their life. The model will also link to the hospice at home provision and bed based hospice provision in

Trafford to better support individuals and their families. This will support people to better plan for the end of their life.

As described above this scheme is an enabling programme of work and is integral to the performance improvements planned on the HWB P4P metric and HWB Support Metric tabs. Due to the nature of this programme and the strong interdependencies with the other planned schemes no specific improvement has been directly attached to this scheme.

Feedback loop

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.

Key success factors for implementation

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
- Residents and communities will be empowered to be more resilient and proactive about their wellbeing
- Locality services will meet the needs of patients and will better equipped to respond to their needs
- Through a proactive 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

Activities that are critical to occur to ensure the success of the project are outlined below.

Date	**Milestone**
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

Primary Care for Nursing and Residential Care Homes

Primary Care Nursing

Provider – not yet decided

Contracting arrangements: not yet decided

This service does not require any delegated functions

Host pooled fund partner and service commissioner: Trafford CCG

Funding will be on a block basis, therefore over/under spends will not occur

No data sharing is required between BCF partners

Overview of the scheme

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. It is expected that this review will not implement a new care model within the BCF year; however the reviews of community geriatrics and transforming community nursing will have regard to the progression towards any new service.

Investment requirements

Investment to date	**2015/16**
£0	£300,000

Pump Priming – content to be agreed

Pump Priming
Provider – not yet decided
Contracting arrangements: not yet decided
This service does not require any delegated functions
Host pooled fund partner and service commissioner: Trafford CCG
Funding will be on a block basis, therefore over/under spends will not occur
No data sharing is required between BCF partners
Overview of the scheme **To be decided by Ian Duncan &Joe McGuigan**
Investment requirements

Investment to date	**2015/16**
£0	£788,000

SCHEDULE 2 – GOVERNANCE

The governance will be as per the Terms of Reference for the Better Care Fund Steering Group:

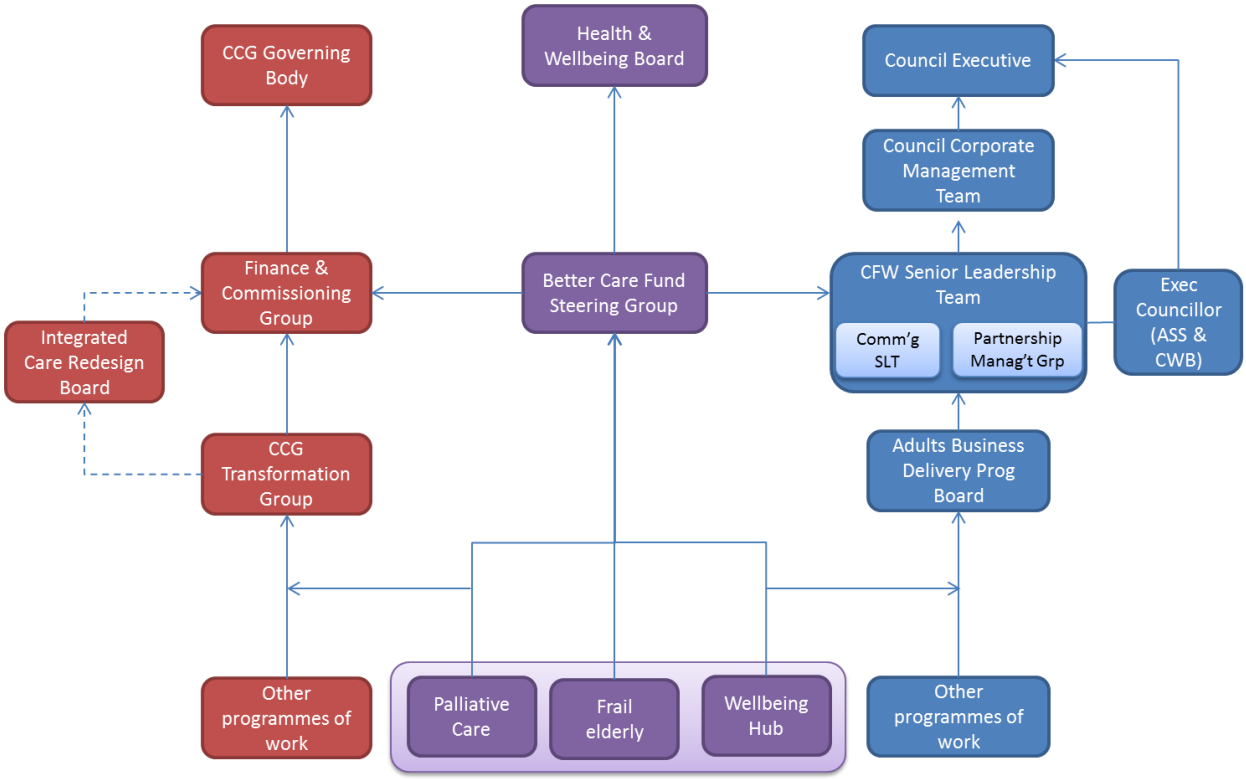
BETTER CARE FUND STEERING GROUP

TERMS OF REFERENCE

Name of group	Better Care Fund Steering Group
Accountable to	Health & Wellbeing Board (see appendix 1)
Overview	The Better Care Fund Steering Group is responsible for ensuring the overall direction, implementation and successfully delivery the Better Care Fund (BCF). This includes decisions on the BCF spend and monitoring of this as well as overseeing the programmes of work identified through the BCF.
Terms of Reference	1. To provide assurance directly to the Health and Wellbeing Board on progress of the Better Care Fund and its programme of work and report on risks and deliverables 2. To agree the assurance provided to the Health and Wellbeing Board 3. To receive regular reports on the BCF and its programme of work, including scope, tolerances, benefits, and outcomes 4. To oversee the BCF programme of work and its delivery against the BCF conditions and performance measures. 5. To develop a dashboard which allows the steering group to maintain a rigorous oversight of the performance metrics associated with the BCF. The steering group will regularly monitor and review the performance against the targets and take corrective action were required 6. To receive regular reports on the progress, risks and issues relating to the BCF and its programme of work 7. To agree and make recommendations on investment to the Council and CCG Boards regarding the BCF shared financial resource and monitor the use of these funds. Any recommendations must be agreed by the Council and CCG governance structures and the Health and Wellbeing Board, who have final approval 8. To ensure that all plans are in-line with the principles of integrated care and the BCF outcomes and ambitions 9. To monitor the risks between the BCF Programmes, the Integrated

	Care Programme and the Commissioning portfolios 10. To provide resource/assistance with removing blockers/issues associated with the BCF and its programme of work 11. To ensure that the communications and engagement plans for the BCF align to the organisational communications and engagement strategies 12. To ensure data sharing and communications within the commissioning teams and integrated care programme is continuous		
Chair	Deborah Brownlee **(Chair)**	Corporate Director CFW	Trafford Council
	Gina Lawrence **(Deputy Chair)**	Chief Operating Officer	Trafford CCG
	1.		
Membership			
	Ian Duncan	Director of Finance	Trafford Council
	Imran Khan	Service Transformation Project Manager	Trafford CCG
	Julie Crossley	Associate Director	Trafford CCG
	Joe McGuigan	Chief Financial Officer	Trafford CCG
	Tamara Zatman	Programme Manager	Trafford Council
	Diane Eaton	Joint Director Adult Social Services	Trafford Council
Duration of membership	To be reviewed in 8 months' time		
Frequency of Meetings	The Better Care Fund Steering Group will meet monthly. Extraordinary meeting can be held as and when required.		
Quorum/ attendance	At least two senior officers from Trafford CCG and at least two senior officers from Trafford Council.		
Deputising arrangements	Members who cannot attend should send a named representative. Diane Eaton and Julie Crossley will deputise for those representing the BCF projects.		
Decisions	Representatives will have the decision making of the person he / she is representing.		

Agenda & papers	An appropriate set of papers for each meeting will be forwarded to the members at least 2 working days before the meeting.
Minutes	The Better Care Fund Steering Group will be supported administratively by Trafford Council who will produce action minutes for the group and arrange meetings as required.



SCHEDULE 3– RISK SHARE AND OVERSPENDS

Pooled Fund Management

The Pooled Fund shall be managed with the intention of producing a balanced budget at the end of each Financial Year

In the event that the CCG or the Council identify at any period during a financial year that there will be insufficient budgetary provision to meet the likely expenditure for the current financial year then expenditure shall be managed in accordance with an agreed joint plan to bring where necessary the spending back in line with the funding.

There may be circumstances where the above is not possible and there is a financial risk as a result of non-elective savings plans not deliver at the agreed target level. Under these circumstances and line with the guidance, monies will be withheld by the CCG from the pool in line with the under-performance against this performance target. In order to protect the schemes being delivered, it has been agreed that the CCG and Local Authority shall enter into a risk share agreement up to the maximum on the non-elective performance payment for a particular year.

For the purpose of the initial agreement and first financial year of the pool the contributions to the risk share will be on a 70% (CCG): 30% Council basis.

SCHEDULE 4– JOINT WORKING OBLIGATIONS

Part 1 – LEAD COMMISSIONER OBLIGATIONS

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1 The Lead Commissioner shall notify the other Partners if it receives or serves:

1.1 a Change in Control Notice;

1.2 a Notice of a Event of Force Majeure;

1.3 a Contract Query;

1.4 Exception Reports

and provide copies of the same.

2 The Lead Commissioner shall provide the other Partners with copies of any and all:

2.1 CQUIN Performance Reports;

2.2 Regular Activity Reports;

2.3 Review Records; and

2.4 Remedial Action Plans;

2.5 JI Reports;

2.6 Service Quality Performance Report;

3 The Lead Commissioner shall consult with the other Partners before attending:

3.1 an Activity Management Meeting;

3.2 Contract Management Meeting;

3.3 Review Meeting;

and, to the extent the Service Contract permits, raise issues reasonably requested by a Partner at those meetings.

4 The Lead Commissioner shall not:

4.1 permanently or temporarily withhold or retain monies pursuant to the Withholding and Retaining of Payment Provisions;

4.2 vary any Provider Plans (excluding Remedial Action Plans);

4.3 agree (or vary) the terms of a Joint Investigation or a Joint Action Plan;

4.4 give any approvals under the Service Contract;

4.5 agree to or propose any variation to the Service Contract (including any Schedule or Appendices);

4.6 suspend all or part of the Services;

4.7 serve any notice to terminate the Service Contract (in whole or in part);

4.8 serve any notice;

4.9 agree (or vary) the terms of a Succession Plan;

without the prior approval of the other Partners (acting through the [JCB]) such approval not to be unreasonably withheld or delayed.

5 The Lead Commissioner shall advise the other Partners of any matter which has been referred for dispute and agree what (if any) matters will require the prior approval of one or more of the other Partners as part of that process.

6 The Lead Commissioner shall notify the other Partners of the outcome of any Dispute that is agreed or determined by Dispute Resolution

7 The Lead Commissioner shall share copies of any reports submitted by the Service Provider to the Lead Commissioner pursuant to the Service Contract (including audit reports)

Part 2 – OBLIGATIONS OF THE OTHER PARTNER

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1 Each Partner shall (at its own cost) provide such cooperation, assistance and support to the Lead Commissioner (including the provision of data and other information) as is reasonably necessary to enable the Lead Commissioner to:

1.1 resolve disputes pursuant to a Service Contract;

1.2 comply with its obligations pursuant to a Service Contract and this Agreement;

1.3 ensure continuity and a smooth transfer of any Services that have been suspended, expired or terminated pursuant to the terms of the relevant Service Contract;

2 No Partner shall unreasonably withhold or delay consent requested by the Lead Commissioner.

3 Each Partner (other than the Lead Commissioner) shall:

3.1 comply with the requirements imposed on the Lead Commissioner pursuant to the relevant Service Contract in relation to any information disclosed to the other Partners;

3.2 notify the Lead Commissioner of any matters that might prevent the Lead Commissioner from giving any of the warranties set out in a Services Contract or which might cause the Lead Commissioner to be in breach of warranty.

SCHEDULE 5 – PERFORMANCE ARRANGMENTS

The main area of performance monitoring is non-elective admissions to acute hospitals for Trafford CCG patients.
This is measured against a baseline of the previous year's activity. A reduction of 3.5% has been agreed as the target.

There are also a number of subsidiary performance measures

The full list of reported measures is as follows:

- Reduction in non-elective admissions
- Reduction in permanent residential admissions
- Increased effectiveness of reablement
- Reduction in delayed transfers of care
- Patient/Service user experience metric
- Deaths at usual place of residence

Reports on performance against each of these measures will be presented to the Better Care Fund Steering Group on a monthly basis

SCHEDULE 6 – BETTER CARE FUND PLAN

Scheme Name	Area of Spend	Commissioner	Source of Funding	2015/16 (£000)
ATT	Primary Care	CCG	CCG Minimum Contribution	357
Pump priming schemes	Other	CCG	CCG Minimum Contribution	788
End of Life	Community Health	CCG	CCG Minimum Contribution	1,067
End of Life	Hospices	CCG	CCG Minimum Contribution	1,245
Falls	Community Health	CCG	CCG Minimum Contribution	400
Intermediate Care (Reablement)	Community Health	CCG	CCG Minimum Contribution	922
Protecting Social Care Capital Grants (Disabled Facilities)	Social Care	Local Authority	CCG Minimum Contribution	914
Protecting Social Care Capital Grants (Social Care)	Social Care	Local Authority	CCG Minimum Contribution	527
Protecting Social Care s256 Services	Social Care	Local Authority	CCG Minimum Contribution	3,546
Protecting Social Care Other	Social Care	Local Authority	CCG Minimum Contribution	2,000
Primary Care Nursing Homes	Primary Care	CCG	CCG Minimum Contribution	300
Community Geriatricians	Community Health	CCG	CCG Minimum Contribution	400
Community Nursing Other	Community Health	CCG	CCG Minimum Contribution	2,564
Community Nursing Other	Other	CCG	CCG Minimum Contribution	514
Total				**15,544**

All payments for the services above are block payments and will not vary with any levels of activity.

SCHEDULE 7 – POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

See current NHS Trafford Policy:

http://www.traffordccg.nhs.uk/wp-content/uploads/2014/05/Conflicts-of-Interest-Policy-v1-270913.pdf

SCHEDULE 8 – INFORMATION GOVERNANCE PROTOCOL

The parties acknowledge their duties with regards to Information Governance and in particular to the requirements of the Data Protection Act 1998 and the Freedom of Information Act 2000. The parties are required to ensure that technical and organisational processes and procedures are in place to protect and secure personal confidential / sensitive data. The parties must only process personal confidential / sensitive data which are necessary. Key aspects of compliance include Information Governance / data protection training for all staff, incident reporting processes, technical / encryption tools to ensure personal confidential data (pcd) is stored and transported securely, assistance with Freedom of Information and Subject Access Requests when required, having an up to date Information Commissioners Office (ICO) notification, having a nominated data protection / Information Governance lead and maintenance of and / or progress to achieving level 2 for the Information Governance Toolkit.

Further detailed information on the Trafford CCG policy can be found in the "Information Governance Clause":

Information Governance Contract Clause

Trafford CCG

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INFORMATION GOVERNANCE CONTRACT CLAUSE

1. Introduction

The aim of this Information Governance Contract Clause is to ensure that a supplier / third party / contractor / provider who has access to personal confidential data (PCD) and / or sensitive information, via a service or support arrangement they provide to the CCG, has effective Information Governance requirements in place. This ensures that the confidentiality and security of personal and sensitive information is protected. This increases public confidence that the NHS and its partners can be trusted with personal confidential data and sensitive data.

The NHS holds the most sensitive and confidential information about individuals and is bound by the Data Protection Act 1998. When sharing data with external parties or is processed by a third party, we must adhere to Principle 7 which states that:

"Appropriate technical and organisational measures shall be taken against unauthorised and or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data."

Therefore all Data Processors acting on behalf of the CCG or under instruction from the CCG must adhere to the Data Protection Act 1998 and afford the appropriate security to the information it may hold/process where the CCG is the Data Controller. Measures include statements regarding information security, controls for physical security and access control, ensuring Business Continuity is implemented, information governance training for staff is in place and incident reporting procedures are followed and monitored. Failure to do so may lead to the CCG seeking damages if a breach/data loss occurs."

<u>On site contractors / third parties</u>

Contractors, suppliers and / or third parties may be located on-site for a period of time as defined within their contract. They include the following types of staff:

- Hardware and software maintenance and support staff
- Cleaning, catering, security guards and any other outsourced support services
- Consultancy and IT contract support staff
- Temporary agency staff

It is important that those who work for contractors, suppliers and / or third parties are aware of Information Governance requirements; what you can and can't do and who you should contact if things go wrong. The CCG also needs to know what security arrangements / controls the third party has in place such as:

- Do you have adequate security controls, policies and training?
- Are your staff screened prior to commencing employment
- Do you have necessary skills to train your staff regarding confidentiality and data protection?

Data protection legislation (Data Protection Act 1998) imposes formal obligations on data controllers (the CCG) that use third party processors to ensure that the processing by the data processor is carried out under a contract, which is made or evidenced in writing, to state that the data processor is to act only on instructions from the data controller.

For the purposes of this document, the term 'contractor' applies to anybody undertaking work for or with the CCG.

All personnel who may come into contact with any Personal Identifiable Data, Personal Confidential Data (PCD), sensitive or business confidential (definitions of each type of data are below) information must follow this agreement. This covers information held manually (for example, on paper) or electronically and also information heard during a visit to any CCG site or access to any systems containing PCD. It applies to any combination of information, which enables the identification of a patient or a member of staff, either directly or indirectly.

All third party contractors working on site must sign the Confidentiality Agreement for Third Parties.

Personal Data (Identifiable Data)

As per the Data Protection Act 1998, and defined by the ICO:

- "Personal data means data which relate to a living individual who can be identified:

(a) from those data, or
(b) from those data and other information which is in the possession of, or is likely to come into the possession of, the data controller, and includes any expression of opinion about the individual and any indication of the intentions of the data controller or any other person in respect of the individual".

The House of Lords decided a case which addressed a number of issues with a direct bearing on what constitutes personal information. It gives comfort to the view that:

". . . pseudonymous information may be disclosed like anonymous information so long as the key to the re-identification is only held by the discloser. This may be of considerable significance to those in the health sector, who often need access to uniquely coded data for research purposes, but where the recipient of the information does not need access to the code."

Where identifiable data is required there should be consent from the patient or it will be clear that there is a secure statutory basis for the requirement such as Section 251 approval. Examples of identifiable data are:

- Name
- Address
- Postcode
- Date of Birth
- NHS Number

Sensitive Data

Sensitive personal data is different from Personal Data. Sensitive personal data means personal data consisting of information as to:

- (a) the racial or ethnic origin of the data subject,
- (b) their political opinions,
- (c) their religious beliefs or other beliefs of a similar nature,
- (d) whether a member of a trade union (within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992),
- (e) their physical or mental health or condition,
- (f) their sexual life,
- (g) the commission or alleged commission of any offence, or

(h) any proceedings for any offence committed or alleged to have been committed, the disposal of such proceedings or the sentence of any court in such proceedings.

Personal Confidential Data (PCD)

This is a term used in the **Caldicott Information Governance Review** and describes personal information about identified or identifiable individuals, which should be kept private or secret and includes dead as well as living people.

The review interpreted 'personal' as including the Data Protection Act definition of personal data, but included data relating to the deceased as well as living people, and 'confidential' includes both information 'given in confidence' and 'that which is owed a duty of confidence' and is adapted to include 'sensitive' as defined in the Data Protection Act.

Business Confidential / Commercial Sensitive Data

This is data which is deemed by the organisation to be confidential and / or commercially sensitive regarding the business activities / reports / documents of the CCG.

The public entrust the NHS with, or allow us to gather, personal and sensitive information relating to the clinical and business activities of the NHS where this is justified. They do so in confidence and they have a legitimate expectation that all persons who may be exposed to, or process information will respect the confidentially of that information and act appropriately. It is essential, if the legal requirements are to be met, that the NHS provides, and is seen to provide, a confidential service in all of their clinical and business activities.

2. Rationale

The CCG is under common law duty to ensure that confidential information is protected from inappropriate disclosure. Furthermore, under Principle 1 of the Data Protection Act 1998, personal information must be processed lawfully. This is also emphasised in the Information Governance Toolkit requirements, the NHS Confidentiality Code of Conduct (2003) and the HSCIC Guide to Confidentiality (2013).

The CCG will only be able to comply with these conditions where it has ensured that third parties with whom they have contracts with are subject to, and comply with, patient confidentiality, information security, freedom of information and data protection legislation and requirements.

3. Legislation and guidance

The following is a list of legislation and guidance for safeguarding personal confidential data and sensitive date:

- Information Governance Toolkit (Department of Health / Health and Social Care Information Centre)
- Data Protection Act 1998
- Freedom of Information Act 2000
- Environmental Information Regulations 2004
- Computer Misuse Act 1990
- Human Rights Act 1998
- Re-use of Public Sector Information Regulations 2005
- Privacy and Electronic Communications Regulations 2003
- A guide to confidentiality in health and social care (HSCIC) 2013
- Confidentiality: NHS Code of Practice 2003
- Caldicott Principles
- Common Law Duty of Confidentiality

- Records Management: NHS Code of Practice 2006
- NHS Care Records Guarantee, Commitment 9
- Information Security: NHS Code of Practice 2006
- NHS Information Risk Management 2009
- Checklist for the Reporting, Managing and Investigating Information Governance Serious Incident Requiring Investigation (IG SIRI's) 2013

4. Contractor / Suppliers responsibilities

Contractors / Suppliers must ensure that they have read and comply with this agreement and other relevant Information Governance policies and procedures. Contractors must comply with the following:

4.1 Information Governance Toolkit

The supplier / contractor shall work towards achieving standards outlined in the Information Governance Toolkit. This is a useful framework to help organisations comply with Information Governance legislation and the law such as the Data Protection Act 1998. It is expected that organisations attain a minimum level 2 performance against all relevant requirements applicable to it, if they:

a) Have access to personal confidential data via N3 connection
b) Have access to personal confidential data via other means of access – on site, paper copies

Where the supplier / contractor has not achieved the minimum requirement, the Data Controller (the CCG) may, in its sole discretion, agree a plan with the supplier / contractor with enables the CCG to obtain assurance that there are adequate data protection and security arrangements in place. This will be dependent upon the size and turnover of the organisation.

The CCG has the right to audit a contractors / suppliers Information Governance Toolkit assessment as and when required in order to provide assurance.

4.2 Data Protection and Information Security

4.2.1 Notification

The Contractor (where access is required to personal confidential data (PCD)) must certify that they are notified with the Information Commissioners Office under the Data Protection Act 1998. To check if you are required to notify, please visit the ICO website (www.ico.gov.uk).

4.2.2 Technical and organisational measures

The Supplier / Contractor must put in place technical and organisational measures against any unauthorised or unlawful processing of personal data, and against any accidental loss or destruction of or damage to such personal data.

The Supplier / Contractor must take reasonable steps to ensure the reliability of staff who will have access to personal confidential data, and ensure that staff are aware of and trained in the policies and procedures relating to Information Governance.

4.2.2 Limitations on disclosure and use of personal confidential data

You must ensure that no personal confidential data (PCD) or sensitive data is transferred, transmitted, disclosed or transported inappropriately to any media, equipment and / or device unless the data is encrypted to the NHS standard and approved.

4.2.3 Security and Data Protection standards

When personal confidential data is in your custody, it must be kept secure and confidential at all times.

Any personal confidential data sent from one location to another by or for the contractor shall be carried out utilising safe haven locations and processes at all times. Areas must be risk assessed to ensure personal confidential data is received in a secure area where no unauthorised access may occur.

The CCG shall arrange for the equipment or software to be maintained, repaired or tested using dummy data that does not include the disclosure of any personal identifiable data.

If data is to be transferred overseas, then the eighth data protection principle must be observed: Personal data shall not be transferred to a country or territory outside the European Economic Area, unless that country ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data. (The EEA consists of the EU member states and Iceland, Norway and Liechtenstein). Before a transfer takes place, the Data Controller must be consulted.

4.2.4 Restrictions

The Contractor should only act on instructions from the CCG (data controller) regarding the use, transfer and / or storage of information it receives or has access to.

Changes regarding the use of information between the CCG and the contractor should only take place following authorisation by the Information Asset Owner for the system / information asset, or other accountable personnel within the CCG.

5. Freedom of Information

The Freedom of Information Act 2000 gives anyone the right to ask any public body for all the information they have on any subject. Unless there's a good reason, the CCG must provide the information within 20 working days.

Most third parties categorise all contracting documentation as confidential and not for disclosure outside of the contracting parties. In light of the Freedom of Information Act this 'confidentiality' may not apply.

As a contractor, you must be aware of the CCG's obligations and its responsibilities under the Freedom of Information Act 2000. This may mean that information which the CCG holds about your organisation may be subject to disclosure in response to a Freedom of Information request. A document may have been categorised as confidential but the CCG may be obliged to disclose the document, or parts of it, to an applicant making a request under the Freedom of Information Act 2000.

If you provide any information to the CCG in the expectation that it will be held in confidence then you must make clear in your documentation as to the information to which you consider a duty of confidentiality applies. The use of blanket protective markings such as "commercial in confidence" will no longer be appropriate and a clear indication as to what material is to be considered confidential and why should be provided.

In certain circumstances and in accordance with the code of practice issued under section 45 of the Freedom of Information Act 2000, the CCG may consider it appropriate to ask you for your views as to the release of any information before the CCG makes a decision as to how to respond to a request. In dealing with Freedom of Information requests, the CCG has to comply with strict

timetable and it would therefore expect a timely response to any such consultation within the time period stated to you at the time.

The CCG cannot accept that trivial information or information which its very nature cannot be regarded as confidential should be subject to any obligation of confidence.

In certain circumstances where information has not been provided in confidence, the CCG may still wish to consult with you as to the application of any other exemption such as that relating to disclosure may prejudice the commercial interests of any party. However, the decision as to what information will be disclosed will be reserved with the CCG.

5.1 Records Management

A record is anything that contains information, in any media, which has been created or gathered as a result of any aspect of the work carried out. All records need to be managed in a way that allows the information contained within them to be available when they are needed, where they are needed, about whom they are needed by the person who needs them. Contractors must abide by the Records Management: NHS Code of Practice regarding the management of records. Further information can be sought in the CCG's Corporate Records Management Policy and Corporate Records Management Procedure.

6. Incident Reporting

If an Information Governance incident occurs whilst you are working for or on behalf of the CCG, you must report this as soon as possible to your management according to your incident reporting procedures. This must also be reported to the CCG as soon as possible. Please report to the Information Governance Team / Senior Information Governance Officer and / or the Caldicott Guardian. The incident must be formally documented using your organisations incident reporting processes. Any information security or confidentiality breaches made by supplier's employees, agents or sub-contractors must be immediately reported.

The CCG expects an escalation process and action plan in order to resolve problems relating to any incidents / breaches of security and / or confidentiality of personal information by the contractor.

It is imperative that incidents are reported in order:

1. To maintain the security of the CCG's information and information processing facilities that are accessed, processed, communicated to, or managed by external parties.
2. To implement and maintain the appropriate level of information security and service delivery in line with third party service delivery agreements.

- All CCGs and those who work for or on behalf of the CCG are under a common law duty to ensure that confidential information is protected from inappropriate disclosure. Furthermore, under Principle 1 of the Data Protection Act 1998 personal information must be processed (disclosed) fairly and lawfully. The CCG will only be able to comply with these duties where it has ensured that third parties with whom it contracts are subject to, and comply with, patient confidentiality, information security and data protection requirements.

- Definition of an Information Governance incident - An Information Governance incident is any incident involving the actual or potential loss of personal information that could lead to identify fraud or have an impact on staff or patients. They relate to any breach of security and / or confidentiality. Examples of such breaches are given below (this list is not intended to be exhaustive):

Breach of security:

- Loss of computer equipment due to crime or an individual's carelessness
- Loss of computer media e.g. memory stick, CD etc due to crime or individual's carelessness
- Trying to access a secure part of the CCG using someone's else's PIN Number, swipe card etc
- Finding the doors and / or windows have been broken and forced entry gained to a secure room / building
- Loss of patient / staff data due to IT software / hardware failure

Breach of confidentiality:

- Finding a computer printout with a header and a person's information on it at a location outside of an CCG premises / buildings
- Looking at confidential patient records on a NHS patient system when you are not directly involved in the care / treatment of that patients in question
- Finding any paper records about a patient / member of staff or business of the CCG in any location outside of the CCG premises / buildings
- Discussing patient or staff personal information with someone else in an open area where the conversation can be heard
- Sending information insecurely using email, post, fax
- A fax being received by an incorrect recipient
- A letter being received by an incorrect recipient

What may at first appear to be of minor importance may on further investigation be found to be

serious and vice versa.

- The Information Commissioner's Office (ICO) can now issue monetary penalties to a data controller of up to £500,000 for serious breaches of the Data Protection Act 1998 and the Privacy and Electronic Communication Regulations 2003.

7. Monitoring and Review

The CCG reserve the right to audit the contractor or to have those audits carried out by a third party. Monitoring and reviews are designed to ensure that the services in question are being delivered securely and confidentially and that controls are adhered to.

On request, the contractor must supply or allow the CCG to view information governance and security policies, procedures, training records and / or controls to ensure they are acceptable, complete and up to date. If these are not in place, the CCG can audit current practices and / or assist with training and development of such policies / procedures.

Where a contractor has assessed itself meeting the Information Governance assurance requirements to an appropriate level and has recorded its assessment within the Information Governance Toolkit, this must be available for inspection by the CCG to obtain assurances that Information Governance standards are being met. Alternatively, an independent certificate could be provided by the contractor (for example, ISO 27001 certification).

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)