NHS Trafford Clinical Commissioning Group

OUR VISION FOR YOUR HEALTH

5 year strategic plan 2014 - 2019
### INDEX

<table>
<thead>
<tr>
<th>SECTION</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXECUTIVE INTRODUCTION</td>
<td>2</td>
</tr>
<tr>
<td>OUR STRATEGY FOR DELIVERING “Our vision for your health”</td>
<td>4</td>
</tr>
<tr>
<td>FINANCIAL STRATEGIC PLAN</td>
<td>32</td>
</tr>
<tr>
<td>THE TRAFFORD HEALTH SYSTEM</td>
<td>49</td>
</tr>
<tr>
<td>FROM WHERE WE ARE TO WHERE WE WILL BE</td>
<td>58</td>
</tr>
<tr>
<td>SYSTEM CHALLENGES</td>
<td>114</td>
</tr>
</tbody>
</table>
OUR VISION FOR YOUR HEALTH

EXECUTIVE INTRODUCTION

NHS Trafford Clinical Commissioning Group (CCG) is responsible for commissioning the health care provision for the population of Trafford.

In “Our vision for your health” we set out the challenges we face over the next 5 years and our strategy for addressing these to ensure the best possible health outcomes for our population. Trafford CCG has a strong vision for itself and for its role in the wider health economy.

The vision for NHS Trafford CCG is;

*to ensure that the health services we manage for the people of Trafford are provided at the right place and at the right time, and that services are safe, of a high quality and are value for money.*

*The group will promote good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties.*

The CCG has four strategic objectives, which, if we achieve, will ensure we deliver our vision. Our strategic objectives are to;

1. **Consistently achieve local and national quality standards.**

2. **Deliver an increasing proportion of services from primary care and community services in an integrated way.**

3. **Reduce the gap in health outcomes between the most and least deprived communities in Trafford**

4. **Ensure a financially sustainable health economy**
Our vision for the health economy, developed in partnership with key stakeholders is:

To create a health care system in the Borough that is proactive, high quality with excellent clinical outcomes and ease of access.

This will be done through designing services that have integrated teams close to the patient’s home. The people of Trafford who require health care should be able to expect this delivery through a single assessment process by an integrated team working from high quality estates. They can expect health and social care to work together to offer the best possible holistic advice and support for their needs.

There will be particular focus on identifying people 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 services and easier access to primary care delivered through a neighbourhood approach which mirrors that of the Borough Council and Greater Manchester Police. This increase in out of hospital care will naturally lead to a reduction in people having to attend hospital for their care. The reconfiguration of the Acute Trusts we use to offer these services is being done at a Greater Manchester wide level through the Healthier Together programme. This programme is focused on enhancing quality while ensuring a financially stable health economy.

We will continue to focus commissioning activity on conditions that are known to have the most impact in Trafford in terms of premature death, with additional services being put in place for this group of patients.

If you live in Trafford you can expect to have the best possible health care with appropriate treatment and lifestyle support in order for you to stay fit and well for as long as possible.”

Dr Kath Sutton
Chair
Trafford CCG

Dr Nigel Guest
Chief Clinical Officer
Trafford CCG

Gina Lawrence
Chief Operating Officer
Trafford CCG
OUR STRATEGY FOR DELIVERING “Our vision for your health”

This document has been produced to show how we intend to deliver our vision. It is intended to outline our strategy and to give insight into the changes we believe are going to happen which will impact on our ability to commission health services over the next 5 years.

Priorities are identified and explained, objectives from planned initiatives are given and provide the basis upon which we intend to measure our performance and our progress.

Our Emerging Health Economy

As a health economy we have had challenges within Trafford for a number of years. We have areas of high deprivation, pockets of affluence and areas where access is an issue such as Partington and areas with a rich choice of high quality providers and easy access.

In 2009, together with our public, partners and providers, we developed a vision of integrated care which placed patients and not providers at the centre of our health care:

“people requiring treatment and care will have it delivered by multi-agency, multi-provider teams who together have the expertise to give the best holistic care for individuals. More care will be accessible within local GP Health Centres with multiple providers inputting expert advise, support and treatment where required.”
As we move through our story you will see how our thinking on this has developed and matured as we have tested and tried some of these models. Early developments have included a comprehensive unplanned care strategy, commissioned from Pennine Care. A £3.2 million investment has been put in place that includes a number of services to support long term conditions such as community matrons and dementia nurses. It also includes a number of fast response teams who can do rapid interventions and treatment in the patient’s own home. This includes an IV therapy team, 2 hour therapy response and intermediate care facilities.

The planning outlined in this document details the expansion and enhancement of these programmes of work for 2014/15 and beyond.

Co-ordination and collaboration between commissioners and providers is also a critical aspect of making a success of our health care system. As a health economy we commission health care across a number of providers and in association with other commissioners, including the Borough Council.

We recognise that integrated provision of services requires significant investment in ensuring that referrers into care and patients within the system are able to access treatment as seamlessly as possible.
A key element of our programme of work is therefore the commissioning and development of a Patient Care Co-ordination Centre, the detail of which is given as one of our key initiatives (A number of key initiatives are highlighted within the main body of this document).

The Governance and reporting structure through which we manage our Integrated Care programme is illustrated below;

![Governance and Reporting: Integrated Care System](image)

Our strategy includes assessment of the opportunities and risks that arise from this situation and illustrate the attention we are giving to ensuring that relationships are strong and supportive of our aims.

The principle role of the Integrated Care Redesign Board is to engage our stakeholders in the overall direction and project management required to implement the proposals identified following the New Health Deal implementation.
The Board also provides advice and guidance to ensure the successful delivery of any multi stakeholder/integrated care projects being undertaken within the Trafford locality.

The programme office within NHS Trafford CCG project manages the integrated care projects, across health and social care with all commissioning leads progress reporting into the Trafford Transformation Group which will capture improvements in quality, service and outcomes.

Success will be measured in terms of the delivery of commissioning interventions feeding into the overall Trafford outcome ambitions.

We have stayed true to our vision with all stakeholders coming together on a regular basis through an integrated governance structure. The clinical communities have led and driven this change and continue to be at the forefront of the public consultation which we undertake to ensure that there is a strong voice of the public in our commissioning activity.

The CCG has developed good relationships with the general public, patients and carers and has begun to develop a strong working relationship with health watch. All programmes of work are tested with the Trafford population to understand their requirements and priorities.

We have changed our Governance structure to incorporate a patient representative body with a remit to directly influence commissioning decisions, quality and the strategic direction of the CCG (see Patient Engagement Focus).

This forum will be supported by a developing network of patient representative groups which will ensure patients and the public of Trafford are represented in all areas of clinical development.

In the future scenario we envisage, patients will have far more personalised healthcare choices, support to navigate the system, access to 24/7 care at the appropriate level and location, pro-active management of their conditions, with greater support and guidance to self care.
There will be ‘no decision about me, without me’ where GPs and their practices will be the main patient advocate supporting and coordinating individualised care.

We will ensure that the views of patients and the public (all ages) are considered in every decision we make, with public and patient engagement embedded in our ways of working through. E.g. all service redesign work involving patients, all CCG decisions explicitly considering how patients and the public have been involved in proposals, and an expectation on our providers to equally ensure engagement of service users in their plans (We highlight opportunities for people to get involved and have a voice).

The 5 year vision

We have had a vision of integration that we have been working on since 2009. This story of integration and the models of care are grounded in everything that we do.

A plan has been developed in line with the priorities defined in the 2013 refreshed Joint Strategic Needs Assessment (JSNA). This plan has also fed into, and informed, the Joint Health and Wellbeing Strategy (JHWS). We are confident of the alignment between our plan and the JHWS and the resulting priorities that the JSNA has guided us to.

The local JSNA represents a summary of much more detailed work that has been undertaken in Trafford and is available at www.infotrafford.org.uk/hwbstrategy

It is underpinned by a core data set defined in statutory guidance, and by needs assessments which have been undertaken in relation to various client groups and localities. This will evolve and our use of the JSNA and other key intelligence sources will continually inform our planning, our priority setting and our commissioning.

The logical argument of this strategic document is correspondingly simple, and lays out how we are going to respond to the health and well being challenges in the four areas of cardio-vascular disease (CVD), cancer, respiratory disease and mental health during the next three years.
A Modern Model of Integration

This covers all pathways of care and includes the following areas:

- Acute (hospital) unplanned care
- Acute (hospital) planned care
- Community based care
- Primary Care

For NHS Trafford CCG, this requires a transformation of the local health system to one that focuses on integrated care with much greater emphasis on knowledge systems, local clinical leadership and empowerment, and new service delivery and enhanced patient and clinical engagement. This is illustrated in the model below:

Clinical commissioning will enable doctors, nurses and other health and social care professionals in primary and secondary care to be become even more involved in achieving these aims.
This seamless care will be made possible by having a system in which data sharing is in place across the multiple providers and sites. Data sharing and quality programmes will ensure accurate disease registers facilitating comprehensive patient participation. This is made possible by a number of initiatives including the development of a system wide Patient Care Co-ordination Centre.

This model of care has been designed to be the vehicle to deliver the majority of outcomes for the four work streams of the Commissioning Strategic Programme. The detailed outcomes of the work streams have been embedded into the treatment models that are being commissioned within the Integrated Care System and which are evidenced by the priorities within the 5 year strategy.

We understand that there is more to do on improving key lifestyle factors such as diet, physical activity, and positive wellbeing; and the reduction of risk-taking behaviours relating to drugs, alcohol, tobacco, violence and sexual health. People who follow healthy lifestyle advice on four key areas (physical activity, smoking, alcohol and diet) live 14 years longer, on average, than those who follow none.

This is why we will look to “make every contact count”, encouraging people to adopt healthier lifestyles and optimising healthy living through its commissioning responsibilities, its influence and its participation in key partnerships including the Health and Wellbeing board, Safer Trafford Board, Children’s Trust Board and related delivery groups.

We will work with other commissioners to support the commissioning of targeted interventions to reduce the harm caused by smoking, alcohol and drug misuse, a poor diet and lack of physical activity.

We will prioritise improved performance against the National Performance Measure for NHS Health Checks and also ensure immunisation and screening targets are met and continually developed in partnership with the NHS Commissioning Board and Public Health.
We see integration as the key mechanism to deliver high quality, compassionate care leading to improved health and well-being for Trafford residents:

- Improving health and wellbeing being across the course of life rather than reacting to problems
- Investment in keeping people well and able to live independently
- Focusing on preventing and reducing illnesses such as cancers, cardiovascular disease and respiratory disease
- Reducing inequalities in health and wellbeing between the most and least deprived neighbourhoods
- A strategic shift towards early intervention and prevention
- Improving End of Life treatment and experience
- Development of elderly pathways and local services

Within this there is a wider integration strategy across Greater Manchester called Healthier Together. This is described below.

**Healthier Together**

Trafford CCG is a member of the Association of Greater Manchester CCGs who will take this forward. The programme will focus upon primary care services, the shape of hospital services across Greater Manchester, underpinned by models of Integrated Care in each CCG/local authority area. The proposals will undergo a public consultation during the summer.

The Healthier Together programme is part of the Greater Manchester (GM) Programme for Health and Social Care (H&SC) Reform, which aims to provide the best health and care for Greater Manchester. It is the largest and most ambitious health and care reconfiguration programme in the country.

The programme is responsible to the 12 Clinical Commissioning Groups across Greater Manchester, with the CCGs exercising our statutory responsibility for commissioning through a shared decision-making body, the Healthier Together Committees in Common (formally a sub-committee of each CCG).
It is widely recognised that the different parts of the health and social care system are inter-dependent, and that major changes to services in the community are required before significant hospital changes can take place.

The wider Healthier Together programme brings together the locality programmes developing Community-based Care (Integrated Care and Primary care) with the reform of “In Hospital” care across Greater Manchester for the “in-scope” services (these are: Urgent, Acute and Emergency Medicine; General Surgery; and Women and Children’s services).
The way hospital services in Greater Manchester have evolved and are currently organised, with a hospital in each borough providing a similar broad range of services, was designed to meet the needs of the last century. It is clear that this is not suited to the way in which a broad range of individuals require care. Many of the excellent developments we have seen have arisen from local interest rather than from strategic planning.

This has led to variations in the range and quality of services available in different areas, resulting in inequality of access to services in different areas. For example, the mortality of patients who undergo Emergency General Surgery varies from 23.1 to 51.7 per 1,000 spells across Greater Manchester, depending on where people are treated. This needs to change, with everyone entitled to the best outcome wherever they live, and yet we have a limited number of specialist clinicians, rising demand and serious financial pressures.

An analysis by Mott McDonald has forecast the financial gap between expected activity in acute trusts and available funding across Greater Manchester over the next 5 years at £742 million, with a further £333 million gap in social care funding – a total system-wide pressure of over £1 billion. Doing nothing is not an option. Work on determining the figures for each locality will be completed in February 2014.

As more people receive appropriate treatment at home or in the community, those patients that do need to be admitted into hospital, especially in an emergency, are likely to have more complex needs.

They are most in need of very specialist care and being assessed by a senior doctor will improve their chances of recovery. Senior doctors are not available in all specialities on site 24 hours a day, 7 days a week due to the large spread of services across Greater Manchester. This means that Greater Manchester has an inequity of provision out of hours and at weekends often leading to poorer outcomes for patients.
Over the last 24 months, over twenty clinical congresses involving hundreds of clinicians have considered the issues facing our health system. They have explored the potential solutions to ensure services remain high quality, safe and cost effective for future generations. This work, which has been based on evidence and best practice from around the world has developed and contributed to this case for change.

The proposals arising from these congresses are for services to be shared across a number of defined hospital sites, with clinicians working across those sites to provide seamless care, with the teams delivering the “once-in-a-lifetime” specialist care on a designated site. These “single services” are shared across the geographical footprint, and the clinical teams benefit from being part of a wider, sustainable and better supervised team, raising standards in the “routine” work in the District General Hospital as well as meeting the clinical standards at the specialist site, a “win-win” for patients.

This should also significantly improve efficiency at all the sites (as routine activity would no longer be interrupted by emergencies), and it is expected that that the Trusts would share the financial risk to avoid the perception of “winners and losers”.

The proposals to change hospital services will be subject to statutory public consultation, and must pass the requirements of the NHS Assurance process. Clinical assurance has already been secured for the model via the National Clinical Advisory Team (NCAT) – “We unanimously support the Programme to proceed to Consultation. This is the most ambitious and well thought out work we have come across. We are highly impressed”.

The determination of the viable options for consultation are subject to a rigorous 9 stage process.

Following extensive pre-consultation engagement, including with key partners such as the Association of Greater Manchester Authorities (AGMA) the Committees in Common of the CCGs have decided to proceed to consultation in July 2014. Subject to NHS Assurance, it is planned that formal consultation will take place in the summer of 2014, with a final decision at the end of 2014.
There are considerable risks in a programme of this size and complexity, and given the proximity of a general election there is a possibility that the formal consultation and decision will need to be postponed until 2015 – this would clearly delay the programme and the delivery of the benefits expected to be realised.

<table>
<thead>
<tr>
<th>Pre-consultation engagement</th>
<th>CIC decision to proceed</th>
<th>NHS Assurance</th>
<th>Formal public consultation</th>
<th>CIC Decision on hospital reconfiguration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete modelling and Options Appraisal</td>
<td>May 2014</td>
<td>June 2014</td>
<td>July-Sept 14</td>
<td>Dec 2014</td>
</tr>
</tbody>
</table>

Our Primary Care

Primary care is also required to change the way it works within this integrated system and our strategy is very much about working with our GP Practices to develop ways of working which utilise neighbourhood and federation models to optimise the availability of primary care to patients. A number of primary care initiatives are detailed within this strategy.

In order for our integrated community services to be successful Trafford has to improve the primary care offer to complement the new models of care. There are 35 practices in Trafford varying from single handed practices to large group practices. The range of services offered, access times and estates vary across the borough. Trafford CCG has been part of the Greater Manchester work looking at how we can improve quality and access to primary care through a set of agreed standards and is developing a primary care strategy that aligns to our business planning that sets out the direction of travel for primary care over the next five years.
The Greater Manchester standards for primary care are:

- By the end of next year, (2015), all children across GM under the age of 5, when clinically appropriate will be able to access same day appointments within general practice
- By the end of 2016, (sooner in many parts of Greater Manchester), all patients will be able to:
  - get advice from a doctor or nurse 24 hours a day
  - be seen on the same day if clinically appropriate
  - Have seven day access to GP and associated services
- By 2015, every patient with a long term condition or multiple conditions requiring a care plan, will have a care plan accessible by the patient and all those treating and caring for him/her to develop greater personal resilience and enable greater collaborative working of care professionals
- By 2016, all residents will be able to see how their general practice performs against key local and national quality indicators and use this information to ensure they are receiving optimum care
- By 2016, all patients who wish to access their own electronic record will be able to do so
- By 2017 Patients will be able to access a greater range of health services within their communities easily and those services will work together to ensure care remains within primary and community care wherever appropriate

Integral to this work for Trafford has been the development of a neighbourhood model approach with four localities. This foot print matches the Borough council and also the polices delivery models .The four localities has integrated services that support and wrap around the practises offering early intervention and extended support .
Our local GPs will be at the centre of this system and will lead the changes necessary to deliver the future aspirations of the public. We believe that this new design will come from a shift of commissioning philosophy and practice from one which is geared around aggregated population-based services to one which is more individual, with personalised healthcare services as the norm.

Federation and co-ordination of care in these areas will form part of the new models of primary care. The timelines for this have been agreed to fit into the wider strategy which includes estates and changes in existing provider contracts.

The practices have been working together to agree a model for primary care which involves a collaborative approach that is underpinned by a new and aligned infrastructure and support from existing community provision such as out of hours services. The model focuses on intra and inter support and advice as well as innovative new ways of working.

As outlined in the “Call to Action - improving general practice (May 2014) a key action is defining, measuring and publishing information on quality. Trafford CCG has a well embedded system of quality reviews with local GPs. This includes a state of the art electronic score card system that allows GP to measure and benchmark their performance and data against other practices and peers within their own practice. This is supported by practice visits. The CCG has an experienced primary care education team that develop programmes of work to match the needs of the local clinicians.
Whilst the CCG does not commission primary care services we have an increasingly pivotal role in promoting continuous improvement and the evolution of a primary care sector which is motivated to provide high quality care and extended services. We have strategic objectives which will require developments in primary care to be achieved. We are also led by our member practices and seek to support them where we can (See Section on CCG structure and role).

In furthering the ability to deliver this, we have expressed an interest in moving towards co-commissioning primary care services with the NHS England local area team. We see this as a way of strengthening and legitimising an already strong, collaborative working relationship and allowing us to pursue new models of care that are align to our 5 year strategy giving the following benefits:

- 15% reduction in unplanned admissions to hospital, attendances to A&E departments and unplanned admission excess bed days.
- Greater integration of general practice and multi-disciplinary teams will deliver improved quality of care. Patients will experience a more cohesive experience of the health system and see greater amounts of care delivered within or closer to home.
- Integrated patient information under a single system will reduce duplication of record taking, and asking the patient for the same information by different providers within the same episode of care.
- A single care plan accessible by all care providers who need access, along with patient access to the record, will deliver improved continuity of care with out of hour’s providers or community service providers being able to see the full record to support a quality intervention.
- Greater improved access into the evenings mid week and at weekends will give a vastly improved service to the population.
- Locality collaborative working will see an increase in the range of services offered to patients. Historical inequality of service provision due to variation in local enhanced service provision will be reduced as greater access to services is offered by services at locality population level.
Planned Care – achieving a step change

Trafford CCG has had a heavy focus around unscheduled care pathways over the last five years. We are now starting to focus more heavily on planned care. The peer to peer review systems that we have had in place for the last two years have given a rich picture of the types of procedures and treatments that are requested from primary care.

We have also piloted a number of community outreach clinics to understand which models could work at scale in Trafford. Trafford has a higher than average follow up ratio in a number of specialties and in areas such as diabetes this is a particular issue. When looking at better care better value indicators the areas that can produce the best outcomes in terms of quality and value for money in being redesigned are cardiology and diabetes. For 2014/15 there will be a focus on developing improved pathways for diabetes and cardiology.

Trafford has a very high use of map of medicine for decision making to support GP’s to ensure the referral thresholds are set at an appropriate level for elective interventions; further pathways will be developed over the next five years. Trafford also a high use of direct access diagnostics which is being further developed to aid quality decision making in planned care. As part of the integrated work that we are doing we are keen to develop these further, this will be supported by the Patient Care Co-ordination Centre which will help to ensure patients are signposted to the right services.

A key element to the planned care changes required is to work with the acute trust to start to reduce the consultant to consultant activity. The Patient Care Co-ordination Centre will have the ability to offer virtual Consultant appointments which will help to support reduced demand by referrals being directed accurately across all providers.

Trafford has a strategic aim to reduce planned care activity by 10% over the next five years. This has been established following consideration of planned care currently undertaken in an acute setting which could be provided safely and effectively within the community or an enhanced primary care setting.
Unplanned Care – Transformational Change

We have had a focus on unplanned care for the last five years due to the low volume of activity that went through Trafford General Accident and Emergency Department (A&E). We through consultation with the public made the decision to down grade the A&E on the Park hospital site into an urgent care centre. In order to do this it was imperative that the services were developed to be able to deflect patients into more appropriate care in the community.

Trafford CCG has invested a considerable amount of money into these community services and they offer a range of provision. There are services that can be deployed very quickly to stop people going into hospital such as the rapid response teams. For physical and mental health issues, these teams are multidisciplinary and are able to respond within hours to support a patient in A&E or their own home. There is a large team of people who also support early discharge from hospital and prevention to try and keep people well and at home. This includes community matrons, geriatricians, intermediate care facilities, and intravenous therapy services.

These community services are offered by a range of providers with Trafford out of hours services offering a valuable resource around a number of schemes. They work alongside the ambulance service to support people that feel they require an ambulance to hospital.

Services have all been developed over the last two years ready for the change in Trafford General’s A&E to an urgent care centre. This took place in November 2014 and the services are working well. In order to develop this further we need to ensure they are used to their maximum capacity and for this reason we are developing the Patient Care Co-ordination Centre.

Trafford CCG has an objective to reduce the proportion of its unplanned care away from the 15% delivered in hospital. This target has been estimated after considering which people could be cared for safely and effectively in an alternative location to an acute hospital.
This is being done for a number of reasons; acute hospitals are struggling with the volumes of patients, some people have better outcomes if treated away from the hospital, some people prefer the community setting and the ease of access this brings.

In order to ensure we achieve this further service will need to be developed in the community. As the plan outlines there will be further work on respiratory, diabetes and falls services to offer an even wider choice of community services. These will compliment the existing services and the care co-ordination centre will ensure clinicians and patients are able to navigate to the most appropriate treatment. The money saved from deflecting people away from the hospital will be further invested in community care services pathways.

One of the key issues of unplanned care is not supporting people who are at risk of their condition deteriorating early enough. In order to address this Trafford CCG is putting in place a comprehensive risk stratification programme. This will mean that the teams described above are able to know who is likely to be at risk of becoming ill and therefore a proactive service can be offered to them to improve their health, respond rapidly to avoid unnecessary deterioration and admission to hospital. This proactive management which links directly to the developments in our primary care strategy with GPs, who with their community teams, will be developing care planning for this group of vulnerable people.

Ambulance services commissioning and implications for our 5 year strategy

Paramedic Emergency Service (PES)

Commissioning Intentions for the Paramedic Emergency Service (PES) have been produced by the lead commissioner (NHS Blackpool CCG) on behalf of the 33 CCGs in the North West (NW). The Blackpool Ambulance Commissioning Team (BACT) utilised the agreed governance framework within the Memorandum of Understanding between them and the NW CCGs, to produce commissioning intentions for 2014/15, and high level strategic intentions for 2014 to 2019.
Consultation and engagement was carried out with each group within this governance framework, and Trafford CCG attended a planning workshop held in December 2013 and contributed to this process, as well as working with the Blackpool Clinical Commissioning Group working with the BACT and contributing to the final document.

The PES commissioning intentions document recognises the need for whole system transformation in order to move towards the healthcare system described by both the House of Commons Health Committee ‘Urgent and Emergency Services’ report (July 2013), and the Keogh ‘Urgent and Emergency Care Review’ (November 2013).

Both reports describe PES as having a changed role within an enhanced system of urgent care; a role where conveyance to hospital will be one of a range of clinical options open to ambulance services and allow PES to become “mobile urgent treatment centres” (Keogh, 2013). One of these key required changes is to achieve a reduction in conveyance to hospital and the PES contract for 2014/15 has been designed to encourage this by incentivising this through CQUIN. This will allow the provider, North West Ambulance Service (NWAS), to build on the progress they have already made with commissioners over recent years; developing and implementing initiatives such as the Urgent Care Desk, Paramedic Pathfinder, Referral Schemes into Primary Care, Targeting Frequent Callers, and increasing the percentages of patients that are treated by ‘See and Treat’ and ‘Hear and Treat’. All of these schemes support the achievement of ‘Safe Care Closer to Home’, which is a strategic goal of NWAS, as well as supporting Trafford CCG’s plans for integration.

Trafford CCG has a close working relationship with NWAS due to the re-design of services under the New Health Deal. Considerable work on pathfinder has taken place to support the move of Trafford General from an Accident & Emergency to an Urgent Care Centre. NWAS continues to develop and fine tune the pathways of care. The governance of this is through the integrated care redesign board. NWAS are also working on the wider integrated schemes and the impacts and opportunities for their services. As described in the unplanned care section, NWAS are part of the alternative to transport scheme.
The governance framework includes an ‘Ambulance Strategic Partnership Board’ (SPB), and each county area has a representative. Our ambulance commissioning lead feeds back from the SPB to our Greater Manchester Ambulance Commissioning Group, where Trafford has representation. The SPB maintains the strategic oversight of all county area reconfigurations, both at county and CCG level; acting as ‘Change Management Board’ and seeking assurance that county and local changes, translate into a North West level. A workshop has been arranged for June 2014, to begin this work. Trafford will continue to ensure local plans align with the SPB via our Area Commissioning Group.

**Patient Transport Services (PTS)**

Five PTS contracts are in place across the NW, which were awarded following a procurement exercise. Each are three year contracts, which began on 1 April 2013. There is one provider for each of the county areas; the provider for Greater Manchester is Arriva Transport Solutions (ATSL).

The current service specification contains increased operating hours, and higher quality standards than the previous one. The service is provided for eligible patients. Planning for the next tender will begin during 2014/15, which will include reviewing the current service specification against new and emerging policy and guidance, such as 24/7 working. Trafford CCG will engage in this process with our area’s Ambulance Commissioning Group, and the wider governance as described above.
KEY INITIATIVE

Better Care Funds

The Better Care Fund will be used in Trafford to transform local services and deliver improved integrated care which will support individual’s when they most need it. This programme will focus on preventing ill health through early intervention whilst simultaneously preventing deterioration in health of older people with greater support through improved community care. The Better Care Fund will be used to support 3 programmes which promote our priorities. Each programme represents maximising investments that will begin to change the way existing services are provided and how pathways are designed. This will mean increased efficiencies in relation to service delivery and better outcomes for the citizens of Trafford.

Trafford’s programme will therefore consist of a menu of 3 separate (but aligned) programmes:-

- The development of a Trafford Early Intervention and Wellbeing Hub
- The review and redesign of services for Frail and Older people
- The review and redesign of End of Life Care in Trafford.

These programmes will be contributing towards reducing the activity on acute Trusts. The outcome will measure to deliver against;

- A reduction in admissions to residential and nursing care homes
- The effectiveness of reablement and a reduction in long term Homecare Support
- A reduction in delayed transfers of care
- A reduction in avoidable emergency admissions
- Patient/service user experience – people and patients will feel empowered to manage their own condition in the way they choose

Work has all ready commenced to understand the data requirements to underpin and support evidence for monitoring and demonstrating improvement.

The 3 programmes are set out as follow:

- **The development of a Trafford Early Intervention and Wellbeing Hub** - this at initial stage of scoping stage, this service will be benchmarked against other models where the learning can be incorporated into the Trafford approach. A Programme Board is established and is supported by a range of stakeholders
- **Review and redesign of services for Frail and Older people** – the scope of this project has been completed through a multi agency workshop. This is being progressed by the Clinical Director and programme lead through a newly formed mutli agency steering group more detail is set out within the document.
- **Review and redesign of Trafford Palliative Care and end of Life pathway** - this work has already commenced, this will be to review the service provision, an education programme and the third sector.
Better Care Funds continued

The Better Care Funds programme will continue to create a health care system in the Borough that is proactive, high quality with excellent clinical outcomes and ease of access. This will be achieved by indentifying people 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 services and easier access to primary care delivered through a neighbourhood approach which mirrors that of the Borough Council and Greater Manchester Police.

This programme will support the increased focus on prevention and early interval which will reduce the demands on health and social care in the future. The increase in out- of hospital care will naturally lead to a reduction in people having to attend hospital both for scheduled and unscheduled care. The reconfiguration of the acute trust to accommodate this is being done at a Greater Manchester wide level through the Healthier Together programme.

The Better Care Funds programme in Trafford will assist with the delivery of this vision. Trafford is to continue to transform integrated care to support vulnerable, frail and older people to live the life that they choose enabling increased choice and control, as a result of innovative and joined up care and support.

The Better Care Funds will provide the opportunity for both the Trafford CCG and Trafford Council to use the resources to further embed Trafford’s Integration Programme. Joined up services which are flexible and seamless and put the patient at the centre are vital to delivering our model of Integrated Care in Trafford. This will ensure that patients in Trafford have: the right care, at the right time, in the right place. Integrated care in Trafford means care which is delivered in a coordinated way, supported by improved links and communications between services and clinicians. An integrated service will be reliant on support from technology and IT, to enable sharing of health records up to date information which is relevant at all times. Patients and their carers will join health and social care professionals to decide on the right care for the population. Individuals and their carers will be able to make an informed choice about their own care. If this work will result in a reduced need for hospital provision as patients will be supported by enhanced care in the community.

These pooled financial resources will support the 3 programmes outlined to assist to change services and create a greater integrated care system which will support the people of Trafford.

This programme is support by Trafford CCG and Trafford Council and aligns to the strategic objectives of both organisations. These programmes have the support from the whole of the system via the community including acute, specialist and the third sector as appropriate.
Better Care Funds continued

The programme will:

- Re-balance the local Health and Social Care Economy – We 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 – We 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 – We will continue to work closely with individuals, communities and other partner organisations, monitoring and enhancing effective partnerships that improve outcomes for patients and communities which is a key component of our planning process.

- Effective Commissioning – We will commission services that demonstrate value for money for our population and improve the quality of healthcare and wellbeing outcomes and reduce inequalities. We will continue to maintain a robust system of financial control.

- Integration – We 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.

The people of Trafford will continue to be empowered to direct their care and support based on our nationally recognised approach to personalisation.

We will use the BCF to:-

- Invest in the future development of personalised health and care budgets to improve and promote independence, self-resilience and care and quality of life.

- Invest in Telecare and Telehealth to support frail older people to have increased choice and control.

- Invest in enhanced reablement with therapeutic support at the right time and in the right place.

- Invest in an early intervention and wellbeing hub supported by timely and effective information and advice.

- Establish a Joint Programme office to support the further implementation of the integrated work streams identified as priorities in our Health and Wellbeing Strategy, such as mental health, dementia, frail older people and end of life care.

- Enhance the current Nursing and Care Home Market Relationship Team to continue to improve quality, consistency and coordination of care across the nursing and residential care market in Trafford, with a particular focus on end of life care.

- Develop integrated personal budgets for carers.

- Increase our investment in Homecare services and continue to improve quality based on the development and recent launch of the Dementia Kitemark.
Specialist Commissioning

In some cases, it is better for health care commissioning to take place on a regional basis to ensure the best quality health care can be provided. Trafford CCG has a close working relationship with the North West specialist commissioners.

The move to reduce the numbers of centres that deliver specialised care must ensure that our local pathways and systems link, and Trafford see this as part of the overall planning of services for the Trafford residents of Greater Manchester.

Trafford Lead CCG for Cancer for Greater Manchester

As lead commissioner for cancer services across Greater Manchester the CCG chairs a system wide commissioning board which links closely with the Greater Manchester Cancer Provider Board, Specialist Commissioning, the Cancer Strategic Network and Locality Commissioners.

Non Compliant Cancer Pathways (Greater Manchester)

Trafford CCG along with specialist commissioners is re-commissioning the following cancer pathways:

- Upper GI
- Urology
- HPB
- Gynecology

This is in order to ensure both compliance against national specifications and that services offer high quality and with a single service offer across Greater Manchester. The CCG will work with specialist commissioners to ensure this outcome is achieved and that local pathways across Greater Manchester are adapted accordingly.
Breast Services (Greater Manchester)

Work is underway to develop the Greater Manchester wide specification for Breast Cancer services to ensure a high quality service provision across the whole of Greater Manchester.

Improved Screening for Cancer (Greater Manchester)

NHS England Public Health and the Cancer Commissioning Board are working together to develop schemes to improve the uptake of screening. This will also include the increased use of diagnostics to support this.

CWW Specialised Services Commissioning Plan on a page

Implementation of the 2 & 5 year plan we will ..

1. Improve access and quality, reduced variation in clinical outcomes and improved patient experience
2. Consolidate and develop sustainable services based in fewer centres to create networks of excellence, aligned to research and innovation
3. Commission affordable, value for money services which meet national service specifications, thresholds and quality standards ensuring appropriate cost effective care

The priority reviews identified in this plan will seek to achieve these three goals in all areas

<table>
<thead>
<tr>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Develop NW CAMHS tier 4 system</td>
</tr>
<tr>
<td>• Review Secure Mental Health svs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cancer and Blood</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cancer IOG compliance</td>
</tr>
<tr>
<td>• HIV commissioning arrangements</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trauma and Head</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Adult neuro-rehabilitation services</td>
</tr>
<tr>
<td>• Major trauma</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Internal Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cystic fibrosis capacity</td>
</tr>
<tr>
<td>• Cardiac services</td>
</tr>
<tr>
<td>• Vascular services</td>
</tr>
<tr>
<td>• Respiratory services</td>
</tr>
<tr>
<td>• Acute kidney injury</td>
</tr>
<tr>
<td>• Inherited metabolic disorders</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Women and Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Neonatal services</td>
</tr>
<tr>
<td>• Paediatric neurorehabilitation</td>
</tr>
</tbody>
</table>

Patients and the public will be involved in planning, commissioning and service development

Commissioning of Specialised Services will be set within the context of a whole system transformation which builds on the 6 attributes for high performing systems. We will work with partners including Health & Wellbeing Boards and Academic Health Sciences Networks & Centre to ensure transparency and openness of evidence-based commissioning decisions and best practice and innovations are adopted and implemented at scale.
Governance Arrangements

The governance structure of the CCG has been shaped for design, delivery, evaluation and its robust oversight in delivery of the 5 year strategic plan:

The Senior Management Team, consisting of key clinical and non clinical officers have overall responsibility for the design of the 5 year strategic plan, the statutory duties required to be delivered and the development of the organisation to be a successful, high performing CCG.

Through delegated authority from the Governing Body, the Commissioning & Finance Committee is responsible for existing service review and delivery of the 5 year plan through a robust process of approval of commissioning schemes, highlighted to and ratified by the Governing Body as part of the 5 year plan at the outset of 2014/15.

The Commissioning & Finance Committee ensures commissioning schemes are only approved for delivery should they have appropriate consideration of for example quality care, communication and engagement, patient experience and risk management and most crucially agreed improved outcomes for patients. These commissioning schemes are agreed to a financial mandate, as approved by the Governing Body.
The Patient Reference & Advisory Panel (PRAP) in reporting to the Governing Body ensure that appropriate patient communications and engagement have taken place with proposed commissioning schemes, and that such schemes clearly evidence improvements in patient outcomes including experience.

Once implemented commissioning schemes are monitored by the Quality & Performance Committee, where schemes are formally monitored and evaluated against the forecast patient outcomes and lessons learnt feeding back into the commissioning cycle.

A performance management framework monitors the ongoing progress of the improved outcomes for patients in the form of target deliverables, to ensure that the CCG has an ongoing understanding of its performance. Where commissioning schemes are not progressing as intended, the Quality and Performance Committee can recommend performance interventions that can intervene in ensuring delivery of improved patient outcomes as intended. These contingencies ensure effective delivery of the strategic plan, informed by the Performance Management framework, being proactive in achieving improved outcomes for patients.

The Governing Body receive regular oversight of the performance of the 5 year plan, for challenge and scrutiny in delivering the 5 year vision of the CCG, in regards particularly the delivery of integrated care.

The Council of Members as key stakeholders in delivery of the Primary Care Strategy have fed into the design of the plan during its development over the planning cycle and are updated frequently as to its performance and their key impact, in contributing to integrated care across the borough.

Subsequently, the Health & Wellbeing Board ensures that a combined health and social care approach is delivered with oversight of the whole health economy performance against Trafford’s strategic plan. In particular the CCG is focused on delivering the Better Care Fund with the Local Authority.
The Integrated Care Redesign Board (ICRB) is a forum for the CCG to engage with its providers in delivery of commissioning intentions in a measured and sustainable health economy approach.

**KEY ENABLER**

**CLINICAL LEADERSHIP**

As a GP Member led organisation Trafford CCG has strong clinical leadership across all commissioning areas. Each Improvement Area within the plan has an identified clinical lead chosen due to their particular clinical and leadership capabilities. All Clinical leads within the CCG have been involved in the finalisation of the draft Improvement areas, using their clinical expertise, knowledge of the Trafford population and health care system to validate proposed and ongoing initiatives.

The Improvement areas have also been shared with the wider clinical community within Trafford through Clinical Education events.
FINANCIAL STRATEGIC PLAN

Financial Challenge going forward

Following earlier years of significant financial growth the NHS entered a period of limited growth with the new Commissioners; CCG’s and NHS England receiving much lower levels of financial growth than the previous Primary Care Trusts that ceased to exist on 31st March 2013.

Trafford CCG like all other CCGs received growth funding of 2.0% in 2013/14 and has had confirmation that it will receive growth funding of 2.14% in 2014/15 and 1.7% in 2015/16. Some CCGs have had confirmation that they will greater levels of growth funding but the figures above are the minimum level of funding increase that has been allocated to CCGs during these years.

For future year’s, CCG’s have been requested to assume that growth will be in line with the GDP deflator and this amounts to 1.8%, 1.7% and 1.7% for 2016/17, 2017/18 and 2018/19 respectively.

Trafford CCG is considered to be under-funded in terms of the capitation funding allocation it receives, with a 1.91% variance from target at the 31st March 2015 and 2.18% variance from target at the 31st March 2016.

The gap above is known as ‘distance from target’ funding gap and whilst some CCG’s are considered to be ‘over-funded’, other CCGs, like Trafford are considered to be ‘under-funded’.

NHS England are considering a move towards target but the time period for this is unknown and Trafford CCG has assumed growth funding in line with the national assumptions.

Looking forward, there will be significant financial challenges in order to balance the need to deliver high quality services ensuring at the same time that these are sustainable.
Over the same time period, it is known that there is to be a significant reduction in funding for local authorities.

In line with our vision the ‘system’ has to change within the Trafford economy to meet the aims of our CCG.

The CCG like other CCGs will also experience significant increased levels of demand and these will impact upon both NHS Acute sector and Social Care services as well community, mental health, primary care and the voluntary sector.

Trafford CCG has experienced activity growth attributable to people living longer, with multiple long term conditions. This rate of spending increases substantially with age with over 75s having an average cost of acute spending of £2,500 per hospital admission compared to an average of up to £500 for people under the age of 55.

The services and changes to services that the CCG plans to introduce are explained elsewhere within this document but it is clear that there needs to be significant changes to the way services are delivered across NHS and Social Care and the finances to support this are explained in further detail within the SFP.

From a locality perspective, estimates for the wider Trafford health economy suggest the gap, should we do nothing, at the end of 5 years would be £80m.

Social care pressures add a further £29m, given a total-system wide pressure of £109m.

Breaking this down further, Trafford CCG has plans to deliver savings of £22m, providing a balance of £58m of savings that will need to be delivered by NHS Acute Trusts, mental health providers, community and other providers.

We will work, in collaboration with other Commissioners, across its own footprint and catchment areas and across other wider geographical areas to deliver the savings and changes to the services to meet this financial challenge.
Specific reference is made to the joint work being undertaken on areas like the ‘Healthier Together’ programme and the South Sector programme. The detail and scope of this work can be found elsewhere within the document.

From a clinical and financial perspective, Trafford CCG is actively engaged with the Healthier Together plans and the South Sector work and the CCG financial plans have been accounted for within those separate work-streams.

Further work has now commenced, in regard to the co-commissioning of primary care agenda and although this is its infancy it is recognised that the need to work together may mean some sharing of the finances across the system on a ‘place’ basis.

At this stage, no financial assumptions have been included within the CCG financial plans for this programme.
Trafford CCG Financial Plan

Overview

Trafford CCG has set itself clear ambitious plans and in order to do this needs to generate money to invest and commission new services.

Much of the growth monies that the CCG is expecting to receive will be consumed by activity growth in secondary care and the increasing complexity of patients requiring treatment for multiple conditions at the higher end of the cost spectrum.

The aim is to commission services and create a health care system in the borough that is proactive, of high quality and delivers the excellent clinical outcomes that we are aiming for however these must be financially ‘sustainable’ and represent ‘value for money’.

At the same time, our aim is to have services that have integrated teams close to the patient’s home and our plan is for the people of Trafford who require health care to have this delivery through a single assessment process by an integrated team working from high quality estates.

To do this will cost money.

The CCG has initially estimated that it needs to generate funds of £10m in order to deliver this ambition and to make this happen there will needs to be a clear shift in activity from the NHS acute healthcare providers to community, primary, voluntary and social care providers at a lower combined cost.

Our plan aims to deliver a gross reduction of 10% to elective activity and 15% to non-elective activity over the next 5 years. This will generate the £10m that can be invested in new services

The £10m new investment will complement the 2013/14 investment in community enhanced services (£3.4m), RAID (£0.5m) and other services (£0.5m).
The CCG plans to focus new investment on key areas of need but specifically across the CCG prioritised areas of CVD, CHD, Cancer and Mental Health.

All significant investments will go through a robust process of evaluation, challenge and prioritisation, with the CCG Finance and Commissioning Committee, reviewing business cases prior to any decision to invest in a scheme.

Subsequent re-evaluation and review will take place at timely periodic intervals to ensure that the quality and performance outcomes of service investments are being delivered. The CCG will need to take timely calculated decisions based upon good evidence of system delivery and manage the performance of the services being delivered.

5 Year Financial Plan – 2014/15 to 2018/19

Appendix SFP1 provides a summary of the ‘planned’ spending by the CCG across the NHS and non-NHS services for the next 5 years and compares this with the allocation for each year.

As indicated above, allocations have been agreed for the 2014/15 and 2015/16 but are indicative for 2016/17, 2017/18 and 2018/19.

The Strategic Financial Plan (Appendix SFP1) has been compiled using local and national assumptions and in order to comply with the minimum ‘business rules’ outlined within the ‘Everyone Counts’ planning guidance and subsequent planning guidance from NHS England for CCGs.
In summary, it can be seen that we are planning:

- To deliver an in-year surplus of c£2.8m in each and every year, complying with the minimum requirement to deliver a 1% surplus.
- To reduce the spending across the NHS Acute sector over the 5 years. Unplanned costs and pressures, deemed to be outside of growth will occur and these are not within the NHS Acute forecast spend but will be considered in the year in which they arise.
- To maintain as a minimum or increase the level of spending against mental health services at the 2013/14 spending level, in line with the ‘parity of esteem’ requirement although this does not require the spending to remain the same within healthcare sectors.
- To deliver services within defined levels of ‘running costs’ for the CCG. The levels are agreed nationally and allocations are based upon an original £25 per head of population allocation per CCG in 2013/14 but this will decrease year-on-year from a figure of £5.628m in 2014/15 to £5.043m in 2018/19. This represents a real cash reduction in CCG management costs of 10.4% over the 5 years.
- To deliver sufficient cash releasing efficiency savings each year to enable the CCG to deliver its intentions within its Strategic 5 year plan and to generate £10m for investment in new services over the same 5 years. Broadly speaking the CCG savings are forecast to be c£22m at the time of producing this 5 year strategic financial plan.

The Strategic Financial Plan has been based upon national and local assumptions and known activity trends.

The CCG has shared its growth assumptions and its planned integrated care deflections and savings with its main acute providers and Trafford Council to ensure there is a level of triangulation between the CCG, NHS Acute provider plans and Social Care plans.

The assumptions have also been shared with the teams that are leading the work across Greater Manchester on the Healthier Together and the Southern Sector Challenged economy programmes of work.
Further work is required and will be undertaken in the months ahead to further refine and triangulate the CCG assumptions with the provider assumptions, noting that this is particularly critical for the later years of the financial plan.

It is worth highlighting that Trafford CCG agreed all of its contracts with its provider organisations by deadline of 31st March 2014 and therefore there is no discrepancy between the agreed starting points of the CCG plan and the NHS Acute provider plans. However, as indicated above, there are some differences in growth assumptions and planned savings, going forward.

Appendix 2 analyses the plan for CCG by NHS Acute providers over the 5 year period 2014/15 to 2018/19 highlighting planned activity and costs in each year by points of delivery e.g. inpatients, outpatients, day-cases etc.

The plan has been further broken down by the main NHS Acute providers, University Hospital of South Manchester, Central Manchester FT, Salford FT and other trusts although these have not been submitted with this plan. These are indicative plans for each Trust and require further discussions to align CCG assumptions and plans with the acute plans that will be submitted to NHS Monitor by 30th June 2014.

Appendix SFP2 also highlights the net change in activity across NHS Acute providers after accounting for growth and deflections arising from the CCG planned deflection programmes.

The CCG has included growth of 1.6% for non-elective and A&E activity and 1.0% for elective activity and outpatient activity on a year-on-year basis. These were based upon best estimates made by the CCG and aligned with the discussions of Mott Mcdonald as part of the Healthier Together work.

The growth is offset by deflections and activity avoidance arising from new services that the CCG has and is planning is commissioning.

As indicated above, the CCG is aiming to deliver a gross reduction of 10% to elective activity and 15% to non-elective activity over the next 5 years.
It should be noted that the following assumptions have been made:

- Estimated activity shifts between CMFT, UHSM and SFT arising as a result of the reconfiguration of services at the Trafford Hospital have been included within the 2014/15 plan and are now deemed to be fixed. This is an assumption and further activity shifts between hospitals are possible.
- Reductions in non-elective activity from are estimated and are consistent with the assumptions within the Community Enhanced Service business case. Further work is required to align the assumptions within the Better Care plan and these assumptions and this work is on-going.
- Estimated shifts in activity from elective care including outpatients are indicative of the direction of the investments that the CCG is planning to make. In the main these are in regards to the PCCC. Further work is on-going in regard to possible service and clinical reconfiguration across elective care services. This has been highlighted following a review of the performance data for CMFT and UHSM. The clinical review work is being led by Clinicians across CMFT, UHSM and TCCG, CMCCG and SMCCG and a detailed plan for this work is to be finalised by September 2014. The PCCC will be subject to a full Benefits Realisation review prior to consideration and subsequent approval of a business case.

**QIPP/CRES Plans**

NHS organisations are expected to meet savings challenges through firm control of finances and delivery of the Quality, Innovation, Productivity and Prevention (QIPP) programme whilst continuing to improve outcomes for patients.

Nationally, it is suggested that the QIPP savings challenge for the NHS over the next 5 years is in the region of £40 billion. As indicated above, the Trafford health economy is required to deliver savings of savings of £80 million over the 5 year period of 2014/15 to 2018/19.

The national QIPP savings are broken down between cash releasing efficiency
savings (CRES), provider productivity opportunities and cost avoidance schemes.

For the purpose of clarity the Strategic Financial Plan for the CCG aims to deliver CRES savings.

Provider productivity savings will be assumed to be delivered by the relevant NHS Providers.

CCG cost avoidance schemes will only be included with CRES plan where the savings are clearly measurable and attributable to the CCG actions.

It is the CCGs aim to ensure that services are sustainable across the health economy and as indicate the do nothing is not an option with a possible gap across healthcare of £80m in the ‘do nothing scenario (See sustainability below)

CRES 2014/15 to 2018/19

2013/14 was an extremely challenging year and it is pleasing to report within this SFP that the CCG delivered £6.5m of CRES, exceeding the plan by £0.5m.

The CCG recognises that most of the savings were largely delivered from ‘transactional’ savings schemes, considered to be the ‘low hanging fruit’ and not as planned ‘transformational’ savings schemes, with a ratio of 80%:20%.

It is recognised that the real challenge going forward is to deliver significant transformational savings over the next 5 years. In order to do this there will be a need for significant ‘buy-in’ to the programmes being planned and this may require a systemic change to the way that the CCG contracts for these services.

At this stage, plans are being explored to develop different mechanisms for contracting but these have not been included in detail within the SFP.

The CCG embarked on a programme approach to delivering CRES last year following on from the PCT adopting the principles of seeking improvement opportunities at population level, focussing in on the service areas with the
most scope for reform and efficiencies.

In line with this, the principle of triangulating indicative data has been adopted to support the first phase of determining which service areas to review for the highest impact and most effective reforms that are appropriate for the health economy. The programmes of delivery once signed off are managed through the CCG Programme Office, as detailed elsewhere in the 5 year strategic plan.

Major CRES schemes identify a sponsor Clinical Director and Executive lead to take the scheme forward and progress is reported via the CCG Committees and CCG Governing Body.

In the case of the Community Enhanced Services delivery model, a detailed business case was required and economy wide sign up was required to ensure the identified savings were deliverable and the scheme was robust and clinically sound. Further details of the significant areas of clinical re-design and reform are given elsewhere within the CCG Strategic Plan.

Appendix SFP3 shows that the CCG is planning to deliver CRES savings of £22m over the next 5 years although some schemes are still in the process of being finalised as indicated above in the comments around elective care.

The financial impact of the CCG plans to deliver savings over the next 5 years, £22m has been factored into CCG plans. The impact of this element is shown more clearly within Appendix SFP4 to reflect the impact upon the NHS Acute Services. As indicated elsewhere these are indicative of the CCG plans going forward but reflective of contractual agreements in the 2014/15.
Value for Money and Sustainability

The NHS is driven by a system whereby many of the services are paid for on ‘Payments by Results’ contracts.

The very nature of national tariffs, with quality incentives, is assumed to deliver a system that provides value for money.

However, as indicated above, more specialist contracts and more re-procurements may be required going forward to ensure that Trafford CCG can continue to commission and deliver services to its population within the CCG allocation.

There is likely to be a few areas for development over the coming months and early years of this plan that require further work to provide assurance of both the value for money aspects of services being commissioned and the sustainability. In summary at the time of finalising this version of the Strategic Plan the key areas to support sustainability and value for money are considered as:

- New mechanisms for contracting – National models are moving away from the PBR framework and using COBICS and Alliance contract (or other similar models) to facilitate greater buy-in to the delivery of outcomes. At this stage, Trafford CCG has not explored these in any considerable detail but is acutely aware of the ‘levers’ and ‘enabling’ elements of these contracts to service change and will be exploring them soon.

- Re-procurement - Trafford CCG unlike many other CCGs went through a very recent exercise to re-procure its Community Services and although this has driven out some efficiencies, there are other areas of services that could be considered for full scale review and if necessary, re-procurement. The CCG has established through its Programme Management Office the early areas that are currently under review and as described elsewhere key initial areas will be Frail and Elderly services and End of Life service. This programme approach will be supported via the new Committees that have been recently established to drive forward system change.
• CQUIN/KPIs - The CCG intends to drive forward the use of quality payments (CQUIN) and Key Performance Indicator penalties (KPIs) with clinicians at the heart of the decision making process. This will be key to incentivising and where appropriate penalising organisations ensuring wider system engagement in the delivery of the right outcome for the services that the CCG commissions.

• Better Care Fund and Other Joint Ventures with Social Care – The CCG is working collectively with the local authority and key providers to ensure that the Better Care Fund will deliver its intended outcomes when it becomes operational in 2015/16. This is not built into the SFP in detail as the outcomes, metrics and finances associated with the BCF are subject to a separate and more detailed submission to NHS England. The CCG does however recognise that closer working with Social Care services is paramount to deliver services that are sustainable.

• Healthier Together and South Sector Challenged Economy – This work has been referred to elsewhere and will be critical to delivery of services that represent value for money and are sustainable.

• Financial Risk Sharing – As CCGs, Acute Trusts and Social services develop models of new service delivery, it will be essential that CCGs enter into wider risk sharing agreements on a greater scale than that at the present time. These financial risk sharing agreements will need to be balanced to ensure that the right level of risk is there for all services providers and commissioners going forward.
Summary

The CCG Strategic Financial Plan continues to develop and it is recognised that it is iterative and further work will be required to refine this as the CCG 5 year Strategic Plan develops.

The CCG Strategic Financial Plan shows that the CCG will deliver the minimum 1% surplus in each of the next 5 years and has clear aims to set aside £10m for investment in new service delivery as outlined elsewhere within the CCG Strategic Plan.
KEY ENABLER

Patient experience

*Patients care about their experience of care as much as clinical effectiveness and safety. This relates to 'relational' aspects of care (dignity, empathy, emotional support, relationships with NHS staff) alongside 'functional' ('transactional aspects') like access, waiting, food, noise. The emotions evoked, senses stimulated and actual events are all measured against the original expectation of the experience.

Understanding patient experience can be achieved through a range of activities that capture direct feedback from patients, service users, carers and wider communities. Using feedback alongside information on clinical outcomes and other intelligence will help to inform quality improvements, reshape local services and contractual arrangements with providers.

Commissioners are in a position to act as role models - by understanding what is important to patients in their local area and how the process of better understanding patient experience can be a tool for service improvement and a lever for performance. Commissioners should try to set realistic goals, in partnership with providers, which enable organisations to implement programmes and sustain improvement.

*courtesy of (adapted) NHS Institute Patient Experience Network website

At Trafford CCG we need to ensure we achieve our aims around putting patients at the heart of everything we do.

To contribute towards and support that, we want to understand how people feel about the services they receive and what matters to them so that we can embed that intelligence into our service design and commissioning cycle. We also want to know when providers do exceptional work that can be shared as good practice and celebrated along with those occasions where things could be done better or have gone wrong and need to be resolved.

Steps need to be taken to continually improve patient experience by working together across health and social care to ensure a seamless, accessible, safe, high quality, efficient and effective patient journey which inspires confidence from those who use it, delivers best outcomes, improves how people feel about the services that they receive, health outcomes and quality of life.

Trafford CCG has a focus around integration of care and much of the work being progressed in Trafford is concentrated around that strategy, this includes work to understand how patient experience mechanisms can be designed to measure, understand and analyse pathways and co-ordination of care, with intelligence being utilised to feed into the commissioning cycle.

The CCG is working towards ensuring that people are supported to make informed decisions about, and successfully manage, their own health and care, including choosing when to let others act on their behalf.

The CCG’s aim is to ensure that care and treatment is accessible to all based on wants and needs and is responsive to individual needs and preferences - a bespoke approach where people feel that they really matter with a focus on complexity and vulnerability.

We need to make sure we understand that integrated services and coordination of care might mean different things to different people but essentially for many it will be holding a person’s hand through the care journey, an identifiable person who has time and acts with humility; treating the person as an individual. Ensuring needs are met and the person is at the centre of their care, understanding what that means for them and having any person such as a family member, carer or other person involved as much as they want them to be. Ensuring personalisation of seamless care.
Patient experience and our 5 year strategy

The NHS England Business Plan Everyone Counts 14/15 to 18/19 states that we need to make sure that public, patient and carer voices are at the centre of our healthcare services from planning to delivery. NHS England wants commissioners to be informed by insightful methods of listening to those who use and care about services. There is a focus on:

- The importance of service user satisfaction, understanding experiences of those who use services, correlating this with staff experience and making quantifiable changes based on feedback received.
- Being able to demonstrate measurable improvement in patient experience as well as continued investment in generating feedback
- Collaborative sharing of learning and good practice
- Learning from complaints and improving the experience of making a complaint.
- Ensuring that real time patient and citizen voice is at the heart of decision making
- Measureable ambitions to reduce poor experience of inpatient care and poor experience in general practice (outcomes framework)
- Being able to assess the quality of care experienced by vulnerable groups of patients and how and where experiences will be improved for those patients (outcomes framework)
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community (outcomes framework).

There are a number of aims and outcomes measures detailed in Everyone Counts. These are referred to briefly below:

How you will set measureable ambitions to reduce poor experience of inpatient care and poor experience in general practice (Reference is made in the quality overview section of the plan to this and talks about the Friends and family test):
The development of the Friends and Family Test has helped the CCG gain a tangible feel for how patients experience care in the acute sector. The benefit of this has been the questions providers have included in this test allowing them to identify areas of the patient experience that were not optimal and more importantly put plans in place to address these. Information from the Friends and Family Test this year, gives an indication of patient experience in acute providers. The CCG will use this as a baseline to measure, monitor and improve patient experience but will not be looked at in isolation. Providers are required to address concerns and complaints and improve patient experience. Data will be analysed via the CCG early warning system and Quality Surveillance Group, actions identified will be scrutinised through the CCG Quality Committee and progressed accordingly.

Alongside this, there is a wealth of data available via the NHS National Patient Survey Programme the results of which feed into Everyone Counts such as Experience of Adult Inpatient Care.

For Primary Care and other areas in the CCG where services are being developed, designed and redesigned; along with engagement to gain insight to what people want from local services, bespoke measures will be compiled to understand patient experience that will feed into the requirements of the outcomes framework and allow for a local perspective.

The introduction of the NHS Friends and Family Test in General Practice is imminent and will allow for consistent intelligence gathering across General Practice and give a feel, along with the General Practice Patient Survey Programme of areas that need to be focussed on to ensure ambitions to improve patient experience are relevant and achievable.

To directly support the achievement of improved experience in general practice, the CCG’s customer care and patient experience team provides specialised customer care and complaints training to GP member practices to support them in improving complaints handling and patient experience. To raise awareness of this the team attended a GP and practice manager education event.
Patient experience and our 5 year strategy

How you will assess the quality of care experienced by vulnerable groups of patients and how and where experiences will be improved for those patients

Providers are contractually required to gather and report on service users in relation to protected characteristics. As a CCG we request equality monitoring data as part of any patient experience gathering exercises being undertaken. When patient experience feedback is analysed for example, relating to specific focussed projects such as around respiratory service, equality monitoring feedback forms part of the analysis. The CCG’s lead for Equality and Diversity provides an expert view in relation to any issues this might highlight and advises on how these might best be addressed.

Intelligence is fed into relevant CCG committees and groups with full accountability from service leads to process, act on, learn from and report on issues including identification of themes and trends and action taken to address those. This supports the continuous cycle of improvement.

Healthwatch and Patient Experience

Regular CCG/Healthwatch (Trafford) liaison meetings are arranged and hosted by the CCG. These provide an ideal forum to build a strong cohesive relationship with Healthwatch. The meetings provide the opportunity for the CCG’s patient experience and engagement teams and Healthwatch to talk about current issues, raise any areas of concerns and act upon those. Commissioning operational leads are invited to talk about developments in relation to design, re-design and commissioning of services. Invites are extended to the whole of the Healthwatch team including the Chief Officer, Chair and governing body. Uptake is extremely positive.

Speakers are invited to attend to allow for learning and sharing of intelligence. The North West AQuA (Advancing Quality Alliance) have presented at the meeting on initiatives they are progressing to seek insight from those representing Trafford people. AQuA’s lived experience patient has also attended two of the meetings and is positive about some of the developments we are making in Trafford around coordinated care.

Healthwatch Trafford works in partnership with the CCG to understand how people feel about local services in terms of specific projects being undertaken, these align with the CCG’s priorities. Healthwatch carried out a patient experience survey and other work such as focus groups and in depth interviews to understand how adults (aged 17 and over) with a diagnosis of COPD and children (0-16) with paediatric asthma feel about their experience of Trafford services relating to these conditions. The aim being to identify and understand any disparity around offer and uptake of services across Trafford and feed into the CCG’s work around design of respiratory pathways of care which includes an outcomes strategy for respiratory services with domain 4 being ‘improving experience of care’.

Work is underway with Healthwatch Trafford (and the Stroke Association’s support) to measure the experience of and gain insight to how stroke survivors and their carer(s) feels about stroke services in Trafford. This relates to the recent commissioning of an early supported discharge service and life after stroke service by the CCG. The focus of the questions tie into the outcomes framework and integration and provide the opportunity to obtain reflection of those having gone through or advanced along the stroke pathway and so having received care and treatment across the board (as necessary) e.g. hyperacute, acute, community, the stroke association etc.

The CCG’s commitment to always include the experience of service users and their representatives when measuring the impact of a service that is new or has been re-designed goes from strength to strength, allowing the expertise in the patient experience team to grow and give the opportunity to innovate.
THE TRAFFORD HEALTH SYSTEM

Trafford CCG has continued to build on the strength of the integrated health and social care system that has been constructed in Trafford.

The implementation of the New Health Deal for Trafford has given a strong impetus to ensuring that the integration of systems and processes across the multiple organisations impacting on the health and wellbeing of the population of Trafford has moved quickly into reality.

It is key that the initiatives, systems and structures to support the delivery of this vision continue to evolve to reflect changing circumstances and our relationships with key stakeholders will be critical in this respect.

The delivery of this will continue to be through the principles of our integrated model. Shared data and risk stratification will allow us to continue to identify people at risk of certain conditions early. This group will be supported to reduce their risk factors through appropriate treatments and lifestyle changes. We will also proactively manage those people who have pre-existing conditions to ensure that where possible they don’t experience crisis in their conditions and remain fit and well.

This section of our 5 year strategy highlights the key interventions we are aiming to develop to enable the delivery of our vision. In addition to the numerous areas identified we have highlighted the following;

- What we are seeking to deliver in respect of measurable improvements in the health and well being of the Trafford population
- Key initiatives we are planning to deliver
- Some of the processes through which we will manage their delivery
MEASURABLE IMPROVEMENT

Both our progress to date and our plans as outlined in the document, evidence an approach which is increasingly aligned to the seven characteristics identified in “Everyone Counts: Planning for Patients 2014/15 to 2018/19”.

NHS STRATEGIC AMBITIONS

Trafford CCG as part of the overall planning of the NHS is required to evidence how its 5 year strategy will make a contribution to the strategic ambitions of NHS England. The table below shows the 7 Strategic Ambitions together with how these are measured and the targeted ambition for Trafford.

<table>
<thead>
<tr>
<th>Ambition area</th>
<th>Metric</th>
<th>Baseline Data at 2014</th>
<th>Proposed attainment in 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Securing additional years of life for your local population with treatable conditions.</td>
<td>PYLL (rate per 100,00 population)</td>
<td>2152</td>
</tr>
<tr>
<td>2</td>
<td>Improving the health related quality of life of people with one or more long-term conditions</td>
<td>Average EQ-5D score for people having one or more long term condition</td>
<td>75</td>
</tr>
<tr>
<td>3</td>
<td>Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital</td>
<td>Emergency admissions composite indicator</td>
<td>2188</td>
</tr>
<tr>
<td>4</td>
<td>Increasing the proportion of older people living independently at home following discharge from hospital</td>
<td>To be reflected in BCF - Proportion of older people (65 or older) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Increasing the number of people having a positive experience of hospital care</td>
<td>Proportion of people reporting poor experience of inpatient care</td>
<td>154.3</td>
</tr>
<tr>
<td>6</td>
<td>Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community</td>
<td>Proportion of people reporting poor experience of General Practice and Out-of-Hours Services</td>
<td>4.4</td>
</tr>
<tr>
<td>7</td>
<td>Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care</td>
<td>N/a – at this stage</td>
<td>N/a – at this stage</td>
</tr>
</tbody>
</table>

Each of the initiatives detailed in the 5 year strategy has been analysed to determine which of the 7 Strategic Outcome Ambitions they align to and what measurable contribution they will make to the achievement of these. This will give us the basis by which we can assure ourselves and our population that the investments we are making are achieving a return in respect of improved health outcomes.
Key relationships

Trafford CCG is taking a strong and proactive role in collaborative commissioning across the geography of the NHS in Greater Manchester. The principles of the Healthier Together system redesign were embodied in the Trafford New Health Deal and continue through into the plans outlined in this document. The collaborative way in which this key initiative has been implemented has reinforced the importance of maintaining groups which have been developed to oversee and deliver an integrated health care system.

As a CCG we have developed strong relationships with our neighbouring CCGs. We work closely with Central and South Manchester CCGs as they are the lead commissioners of our main acute providers. Through the use of a shared performance and quality team we are able to manage our providers in a single uniform way, and this team will be further expanded in 2014/15.

As part of the healthier together work we have formed a south sector board (this includes Stockport, Tameside, Macclesfield, South Manchester and Trafford). This has been in operation for a year and is looking at ways to develop integration and acute collaboration. The work has been supported by Mckinsey and is testing how we can ensure a viable south sector. This has allowed us to share best practice and develop models of integration that fit across the whole south sector area.

As a CCG we are now starting to spread our wings further and are looking to develop relationships on a wider footprint. To this end Trafford CCG is now leading the cancer work on behalf of the greater Manchester CCGs. We are also the lead commissioner for the North West oxygen contract which offers us the opportunity to also work outside the Greater Manchester footprint directly with NHS England.

As a CCG we believe this is important, and as a developing organisation we are keen to keep learning and expanding our abilities to ensure we are a high performing team with a network of strong relationships.
KEY ENabler

IN PARTNERSHIP WITH – TRAFFORD BOROUGH COUNCIL

Our relationship with the Borough Council has always been strong and includes a number of jointly commissioned services. Children’s services are commissioned through an integrated team lead by the Borough Council with clinical leadership from a senior CCG GP.

The Health and Wellbeing Board (HWB) offers strong leadership and shaping of strategy with a diverse membership including the police, third sector and providers. The Health and Wellbeing strategy has offered us the opportunity to align our work and co-produce our health and social care strategy to ensure the best use of resources for the residents of Trafford.

Its focus is on the need to improve people’s health and wellbeing across the course of life rather than reacting to problems and it represents the overarching plan to improve the health and wellbeing of the population of Trafford and to reduce health inequalities between the north and south of the borough.

The increasingly collaborative relationship with Trafford Council has allowed the planning process for the “Better Care Fund” to build seamlessly on the work outlined in this document, the Health and Wellbeing Strategy and the Integrated Care Strategy.

The HWB has been established as a small, focused decision-making partnership board. Membership includes representation from elected Councillors, Trafford Council (including Children, Families and Wellbeing/public health), Voluntary and third sector organisations and the Clinical Commissioning Group. Wider stakeholders are being engaged as appropriate.

The HWB has a set of four core themes that make up its purpose:

- To reduce health inequalities and improve the health and wellbeing of all Trafford residents
- To lead and champion the delivery of Trafford’s health and wellbeing strategy
- To drive change, innovation and systems reform
- To embed partnership working

The Health and Wellbeing Strategy and improving outcomes based in the context of the strategy, to ensure a coherent plan of action is delivered in achieving the four core themes.
Our relationships with our patients and public are developing to ensure that the services we commission meet the needs of our population and do so in a way which improves their health and wellbeing. There has been an overall improvement in the health of the population as measured by mortality and life expectancy but persistent health inequalities remain between different parts of the borough. Overall male life expectancy in Trafford is 78.8 years which ranks 189 of 404 council areas in the UK and is the highest in Greater Manchester. However, men in the least deprived areas of Trafford, in Hale Barns, live on average 11 years longer than those in the most deprived areas, parts of Partington.

Female life expectancy for Trafford is 83.1 years with the difference for women being 5.9 years between the least deprived and most deprived communities.

**PATIENT AND PUBLIC PARTICIPATION**

Trafford CCG has set up a Public Reference and Advisory Panel to represent the views of the Trafford population in respect of clinical and commissioning decisions, policy and performance. The panel reports to the Governing Body of Trafford CCG. Their roles and responsibilities are listed overleaf.

The membership will is as follows:
- Lay Board Member for Engagement (Chair)
- Four representatives nominated from GP patient participation groups
- Four representatives nominated from Trafford third sector organisations
- Four members of the public recruited from the Trafford population

We have recruited all 12 representatives to sit on the panel which are unpaid positions. Panel members are able to reclaim reasonable expenses as per the policies of the CCG and will be appointed initially for 12 months following which a formal review of the Panel and its role will be undertaken.

Heathwatch are represented on the CCG’s Governing Body and have ongoing engagement with the CCG through their liaison with the Engagement agenda of CCG.

In addition, the CCG has focused on the following targeted improvements for engagement:
- Increasing the proportion of GP practices with some form of patient participation group
- Increasing the membership of groups with which and through which we consult
- Updating and validating stakeholder lists
KEY ENabler

SAFEGUARDING

The vision the Trafford Strategic Adult Safeguarding Board and the Trafford Operational Adult Safeguarding Board is for Trafford Borough to be a place where:

- all citizens, irrespective of age, race, gender, culture, religion, disability or sexual orientation live with their rights protected, in safety, free from harm, neglect or exploitation and the fear of harm, neglect or exploitation, which includes cases of abuse.
- no-one should have to tolerate or be exposed to harm, neglect or exploitation.

This means that as a Strategic and Operational Board, we need to work together, and with local communities to:

- Prevent harm, neglect and exploitation from happening
- Identify and report harm, neglect and exploitation
- End any harm, neglect and exploitation that is occurring

The CCG’s Chief Operating Officer is the Chair of the Trafford Strategic Adult Safeguarding Board with the CCG’s Safeguarding Nurse a key stakeholder on the Trafford Operational Adult Safeguarding Board. Safeguarding will be involved throughout the delivery of commissioning schemes in the 5 year plan, at the outset of individual service design.

Our vision is informed by the knowledge that some people lack the mental capacity to make particular decisions about their own safety, health or wellbeing. We will be single-minded in our efforts to ensure that people are afforded the protection to which they are entitled. We must work together to promote knowledge, understanding and use of the Mental Capacity Act, Independent Mental Capacity Advocates (IMCAs) and Deprivation of Liberty Safeguards (DoLS) that protect the rights and interests of all the people the Boards serve.

Trafford CCG are committed to ensuring vulnerable individuals are safeguarded from supporting terrorism or becoming terrorists themselves as part of the Home Office counter-terrorism strategy Prevent. Staff have a responsibility to help the CCG fulfil its obligation to minimise risks by identifying and supporting adults and children who may be prone to exploitation or influence from violent extremism.
KEY INITIATIVE

Patient Care Coordination Centre

The patient care coordination centre will provide the catalyst for coordinated care across the health and care system, in achieving efficiencies, improving quality of care and improving the overall patient experience.

This programme of work is the main area that underpins integration of services. Over the last three years the CCG in partnership with TMBC has been developing a number of community based services, it has become apparent that in order to use services to gain the maximum benefit out of them a care co-ordination approach is required.

We have already completed early phases of this programme, developing proxy booking and referral management centre, followed by the creation of the health transport bureau. The next phases create the potential for Trafford Clinical Commissioning Group (CCG) to commission an innovative and dynamic solution to deliver seamless coordination for all patients and services users, working with our key partner Trafford Metropolitan Borough Council, our solution is to develop a new Patient Care Coordination Centre (PCCC), working in collaboration with provider organisations which will be tried and tested to meet the needs of Trafford’s local population.

The aim of the current procurement process is to develop optimum solutions to the creation of as service to track patients, signpost, create early warning systems, risk stratify, onward referral and interface with peer review and providers of services. This will potentially followed by developments to include clinical triage, telehealth and the optimisation of the well-being hub concept.

The centre will have innovative IT solutions that allow tracking of all health and social care activity within Trafford. This will allow for early identification of patients in order to plan services in the most appropriate way. The CCG vision for the centre is attached along with the Addendum Document.

We aim for the PCCC to deliver;

- Proactive and coordinated care seamlessly wrapped around the patient/client
- Equitable access to health and social care mitigating any variation which exists within Primary Care
- Greater efficiency within Primary Care by creating a single point of access for practices
- Delivery of the right care and the right time in the right place
- Improved patient choice through having extensive intelligence of services available within the health economy
- A positive patient and care experience, from accessing the service, the way they are treated by staff in the centre and the measurable impact on their experience and patient journey.
- The centre will have a single access point where patients and carers can enquire about their appointments and transport options to care site.
- Speedier up patient pathways

Across the health care system the PCCC will contribute to;

- Report on the performance of care across the system
- A reduction in repetitive complaints themes and trends (measure not outcome)
- Reduction in inappropriate admissions in secondary care
- Reduction in length of stay
- Reduction in unplanned admissions
- Reduction in outpatients – new and follow up (and first to follow up ratios)
- Reduction in DNA and Cancellations (/unable to attend)
- Reduction in consultant to consultant referrals
- Increase in Community care service utilisation (/service development)
- Increase in CATS utilisation
- The ability to monitor audits of service
- The ability to monitor waiting times
- To reduce variations in service/care
- Coordinated trips and appointments
- Proactive Care Planning to meet the health and social care needs
- Reduction in waste through greater coordination of care
- Greater business intelligence for the CCG to identify gaps in service provision and improve patient experience
PUBLIC HEALTH

Public Health provision is lead by Trafford Borough Council and through proactive engagement, campaigning and awareness raising aims to change public understanding and behaviours to positively impact on health outcomes in Trafford.

In a number of areas initiatives have been developed and are planned to align to Trafford CCG objectives.

Moving towards early intervention and prevention and reducing premature mortality in Trafford

The Joint Strategic Needs Assessment (JSNA) describes the impact of unhealthy behaviours on longer term outcomes such as premature mortality. The Trafford Joint Health and Wellbeing Strategy, (JHWBS) identifies a number of actions linked to reducing premature mortality and includes reducing the number of early deaths from cardiovascular disease (CVD) and cancer as one of the eight priorities.

Strategy to reduce premature mortality in Trafford

In order to reduce premature mortality in Trafford particularly from CVD, cancer, respiratory disease and liver disease the following public health strategic actions will be implemented;

1. Improving the quality of primary care and reducing health inequalities overview
2. Reducing alcohol consumption
3. Reducing smoking
4. Reducing obesity
5. Picking up cardiovascular disease risk factors earlier
6. Screening for cancer
7. Reducing premature mortality in people with a learning disability
8. Maternal and neonatal interventions
These strategic actions are funded from the Local Authority Public Health grant, CCG commissioning plans, Strategic Clinical Network (SCN), NHS England and PHE budgets where appropriate.

### KEY ENABLER

**Health & Wellbeing Strategy Action Plan**

The Action Plan is the implementation mechanism for Trafford’s Health & Wellbeing Strategy 2013 – 2016. It has 8 priorities:

- Reduce Childhood Obesity
- Improve the emotional health and wellbeing of children and young people
- Reduce alcohol and substance misuse and alcohol related harm
- Support people with long term health and disability needs to live healthier lives
- Increase Physical Activity
- Reduce the number of early deaths from cardiovascular disease and cancer
- Support people with enduring mental health needs including dementia to live healthier lives
- Reduce the occurrence of common mental health problems amongst adults.

Trafford CCG’s involvement sits at various levels including the Health & Wellbeing Board but in terms for implementation Trafford CCG is a key member of the Health & Wellbeing Strategy Delivery Board.

Implementation timeline:

2013 - 2016

Barriers to success:

1. Strategically – none as health & Wellbeing Board constituted and Strategy approved
2. Delivery – ability of Delivery Board to facilitate range of co-produced initiatives / resources / buy in of all partners
FROM WHERE WE ARE TO WHERE WE WILL BE

Trafford CCG has undertaken a full review to inform its priorities and work programme to be included in its 5 year strategy. The work programme is designed to deliver the CCG’s strategic objectives.

This has been clinically led by the Clinical Directors who have reviewed the Joint Strategic Needs Assessment and the Commissioning Strategic Plan.

KEY ENABLER

TRAFFORD CCG PROGRAMME OFFICE

It is important that the work programme will deliver the main priority of the CCG which is to deliver an integrated care model for the population of Trafford.

Within Trafford there is already a comprehensive integration programme established. This is worked through a programme office who works with the Clinical Directors and the Senior Commissioning Team. The work programmes addresses:

1. gaps in provision
2. to meet and deliver against new targets, standards and clinical guidelines
3. to drive through new efficiencies to reduce the demand on the acute services to switch activity and resources to community and primary care
4. to deliver against patients expectation

Each commissioning scheme is identified by either the clinical leads or the commissioning teams. These are assessed and challenged and once approved each project is worked up which is delivered against the four stages of the projects.

Stages:

1. to review and scope
2. to develop new service model
3. to implement test and review
4. to evaluate and monitor

The programme office is responsible for monitoring progress and to identify any risks or barriers to delivering improvements.

This is further challenged and agreed by Trafford's Clinical Redesign Board and the Health and Wellbeing Board which has membership from health providers, Trafford council and council representatives. Commissioning for Value has been used to inform these priorities and benchmarking against other localities.

The health needs of Trafford have been addressed initially for 2014/15-2018/19 through the JSNA by focusing our improving outcomes and ambitions on those measurable national health indicators (as below). Health services have then been commissioned in the context of addressing these high level health indicators.
PLANNED CARE

Community and home based nursing care

Trafford residents will enjoy high standards of home and community based nursing care which will be easy to access and offer a high quality alternative to hospital treatment. This will enable us to make significant reductions follow up appointments in secondary care, reduce length of stay and improve the patient experience of care in the community.

Work will commence on reviewing this service in 2014 with the implementation of improvements in 2016.

Community Cardiology

We will be investing in services which deliver community based rehabilitation and assessment services for heart related problems. Ideas for consideration include community outreach clinics, access to ECG assessment for Primary Care. We will be focusing on the design and development of these services in 2014 with implementation in 2015-2016.

Our commitment

Our investments in community and primary care provision will deliver:

- Reduced first appointments in secondary care
- Reduced emergency admissions for heart failure
- Increased ability to self manage conditions such as angina

Community Cardiology Programme will deliver:

- 2.5% reduction in elective care from 2015-2019
- 1.6% reduction in outpatients from 2015-2019

PATIENT VOICE

Do you want to be involved in reviewing this service? Contact us on trccg.feedback@nhs.net or 0161 873 6008
Diagnostics

Between 2014 and 2016 we will develop a service which will allow for accurate diagnosis of IHD in a community setting, reducing referrals to secondary care.

Trafford has an existing open access diagnostic service to GPs for investigation of suspected arrhythmias. A review of referrals in 2013/14 with primary care has identified patients who have been referred to secondary care that could have been managed by this service. Work is being carried out with primary care to localise the map of medicine for tachyarrhythmias.

The benefits of developing this service:
- Reduced referrals into secondary care
- Improved access to diagnostics and reporting to GPs

Respiratory

Trafford CCG as part of the respiratory work programme has established a steering group who will have oversight of the work programme that seeks to improve and/or redesign respiratory pathways for COPD and Asthma in line with clinical evidence based practice and the principles of integrated care. The group will ensure delivery of projects and ensure a reduction in unscheduled care admissions and the achievement of National Quality Premiums, CCG QPs and GP QP indicators.

The benefits and goals of the Respiratory Programme are:
- A reduction in unplanned activity into secondary care by 1.8 from 2015-2019
- To relieve symptoms
- Ensure alleviation
- Improve exercise tolerance
- Prevent and treat complications including exacerbations
- To reduce mortality

There are a number of schemes which will deliver change, deliver service improvements with measurable benefits across Trafford.

There is no single diagnostic test for COPD, diagnosis relies on a combination of
history, physical examination and confirmation of airflow obstruction using spirometry. Currently the CCG are seeking to invest in spirometry educational programmes within primary care establishing an expert workforce responsible for both the performance and interpretation of spirometry, ensuring that the primary diagnosis is both accurate and appropriately treated.

The CCG has already commissioned an oxygen assessment and review service who will clinically manage all long-term oxygen patients within a community setting. Additionally, in order to meet the goals of the programme the steering group will redesign the current pulmonary rehabilitation service specification in-line with clinical best practice and national guidance ensuring appropriate outcomes and increased independence and quality of life for Trafford residents.
PATIENT VOICE

Do you want to be involved in reviewing this service? Contact us on trccg.feedback@nhs.net or 0161 873 6008

Minor Eye Conditions Service

We will be assessing the appropriateness of a service to use the skills of optometrists in primary care to manage, assess and prioritise patients and to deliver increased levels of treatment in primary care.

We will be undertaking the initial design and development of this service during 2014 and a cost provision of circa £50,000 has been advised by our Local Ophthalmic Committee.

Integrated Diabetes Care

Trafford CCG is establishing a Diabetes Network to develop a Diabetes Strategy for Trafford covering the period 2014-2017. The Network will be chaired by Diabetes UK and involve key stakeholders from across the diabetes care pathway to include general practitioners, acute sector providers, medicines management, public health and patient representatives.

Procurement to ensure Value for Money

Macular services – Intra-ocular injections

Due to increasing demand, new conditions requiring this treatment and current costs of this service, a decision has been made to review the current service and pathway provided by the Royal Manchester Eye Hospital.

We believe we can both improve accessibility to this service, ensure its quality and achieve financial savings, all of which are critical for us over the next 5 years.

This will be a value for money review with accessibility for Trafford patients a key aspect.

Diabetes Strategy outcomes:

To increase the percentage of people receiving all 8 care process by 15% by 2018/19

To increase the percentage of people achieving all diabetes treatment targets by 2.5% by 2018/19

To reduce the average diabetes outpatient follow up per first attends from 11.48 (2013/14) to 6 by 2018/19

Increase the provision and uptake of a patient/carer satisfaction survey

A reduction in outpatients by 1% from 2015-2019

The Ophthalmology Programme will:

- Improved clinical outcomes for patients
- Increased patient satisfaction
- Improved efficiency and reduced costs
- Reduce elective care by 1% from 2015-2019
- Reduction in outpatient appointments by 3% from 2015-2019

Macular services – Intra-ocular injections

Due to increasing demand, new conditions requiring this treatment and current costs of this service, a decision has been made to review the current service and pathway provided by the Royal Manchester Eye Hospital.

We believe we can both improve accessibility to this service, ensure its quality and achieve financial savings, all of which are critical for us over the next 5 years.

This will be a value for money review with accessibility for Trafford patients a key aspect.
The Network will work towards enhancing the quality of care and improve service provision relating to the prevention and early diagnosis of Type 2 diabetes, and the appropriate management of Type 1 and Type 2. Implementation of the strategy will ensure that future service provision is provided in a timely and universal manner throughout the health economy.

Community Dermatology

Trafford CCG will be working closely with its neighbouring CCG’s in Central & South Manchester to procure a community based dermatology service in 2015.

This service will enable increased, timely and appropriate interventions (assessment, diagnosis and treatment) in the community to ensure only those patients who really need secondary care treatment are referred to hospital.

Community based dermatology will deliver;
- Additional years of life as a result of better management of skin cancers
- Reduced referrals for hospital treatment and savings on the current expenditure of £1.1M
- Improved patient experience
- A reduction in outpatient appointments by 0.5% from 2015-2019

Community based physiotherapy services will deliver;
- Treatment for urgent cases within 2 weeks, and routine treatment within 4.
- Increase in the number of patients completing treatment
- Improved patient experience and satisfaction
- A reduction in elective care by 0.8% from 2014-2019
- A reduction in outpatient appointments by 0.9% from 2015-2019

MSK Integrated Care

Musculoskeletal (MSK) - Community Physiotherapy

We will invest £230,000 in Community based physiotherapy. This will contribute to reducing patient waiting times for treatment.
MSK – Review of hospital based Physiotherapy

To ensure we deliver the desired benefits from our Community based Physiotherapy services we will review the services being delivered by both CMFT & UHSM.

We will be commencing with this review in 2014 with a sustainable revised level of referrals expected to be delivered by 2017.

Community Pain Management & Education

For clinically eligible patients who have been in pain for up to 3 years we will be developing a community pain management and education service. We are targeting an investment of £12,500 per annum based on 140 referrals and aiming to test, assess & implement this initiative during 2014.

Benefits of a community based pain management and education service include:
- Improved patient clinical outcomes
- Increased positive patient experience
- Reduced costs of Secondary Care
KEY ENABLER

JOINT STRATEGIC NEEDS ANALYSIS (JSNA)

All Improvement Areas have been cross referenced against the JSNA in respect of the potential contribution will make to the health and wellbeing of Trafford communities. Further feedback on these is being developed to include third sector input and key stakeholder validation of these areas as the business planning process is further developed.

The JSNA in working with Trafford council has been the source of improving outcome and quantifiable ambitions through focused commissioning. We have also used the first phase of the Commissioning for Value as a sense check in focusing commissioning across Trafford in the right areas, in comparison to other CCGs.

Performance data on previous interventions has been used alongside baseline data through the levels of ambition atlas, to enable ambitions to be quantified in the context of planned commissioning schemes.

Trafford’s JSNA considers all current and future health and social care needs which are capable of being met or influenced to a significant extent by the Local Authority and the Clinical Commissioning Group (CCG). It aims to provide a comprehensive ‘picture of place’ including inequalities and gaps in provision. It has been used as evidence to inform decisions about commissioning services and action to be taken by the local authority and CCG. It has also formed the evidence base for Trafford’s Joint Health and Wellbeing Strategy.

Trafford’s JSNA has taken a life cycle approach - looking at the needs of local people from pregnancy and birth to old age and end of life, and it has also considered the needs of vulnerable groups such as the disabled. It has considered not only health related issues such as lifestyle and long term conditions but wider issues which may impact on health, including housing and employment.

The health needs of Trafford have been addressed initially for 2014/15-2018/19 through the JSNA by focusing our improving outcomes and ambitions on those measurable national health indicators (as below). Health services have then been commissioned in the context of addressing these high level health indicators.

Also agreement from primary care to all move to a single IT system is being developed as part of the primary care strategy.

Trafford is also looking to move to a single patient record. This has been made possible by the integration of health and social care teams.

The patient record is a fundamental part of this system and the Council, Community provider and CCG are working on this development by creating a single patient record that will use the NHS number as the unique identifier.

The latest telemedicine systems will support highly trained clinicians to monitor and offer appropriate interventions particularly for people with long-term conditions such as COPD and Diabetes. Clinical experts will
Cancer – Primary Care, Community Care and Palliative/EOL Strategies

Survivorship/Stepping Out Program (Trafford)

The ‘Stepping Out’ pilot program supports cancer patients making the transition from being a dependant patient within a medical model, to being a healthy active member of the community.

It is anticipated the pilot will result in a business case to develop an effective pro-active model to promote health and well-being to patients with cancer but which can also be adapted for patients with other long term conditions.

This pilot will be reviewed in 2015 and will be conducted with Pennine Care Community Trust and Macmillan Well-being Centre.

Cancer - Acute Oncology (Trafford)

The National Chemotherapy group recommended that acute oncology services should be developed in every trust with an A&E department to improve the management of acute cancer related complications, acutely presenting new cancers and management of metastatic spinal cord compression (MSCC). Also linked is the development of a Cancer of Unknown Primary (CUP) service.

This service is business as usual during 2014 – with a work programme led by the Acute Trusts. This project will involve Community Services, GPs, Macmillan services and require consideration of a cross site cover model - Trafford General Hospital UCC – does not support f/t resource.

Cancer - Acute oncology will deliver:
- Improved patient outcomes and experience

Cancer- Early Detection and Primary Care
- Achieve 80% cervical screening target by 18/19
- Achieve a 60% bowel screening target by 18/19
- Achieve a 70.1% breast screening target by 18/19
- Improve the health–related quality of life for patients with LTC - to contribute to EQ-5D score of 75.46 by 18/19
- Improve the health-related quality of life for carers – to contribute to EQ-5D score of 0.85 by 18/19
Primary Care (Trafford)

Trafford CCG has a particular focus around primary screening for cancer services. The CCG has a locality quality initiative to improve cervical screening uptake to 80%.

Community Stroke Services

PATIENT VOICE

Do you want to be involved in reviewing this service? Contact us on trccg.feedback@nhs.net or 0161 873 6008

Stroke - Early Supported Discharge

Building on a successful pilot, patients of Trafford in Trafford General, Wythenshawe and Central Manchester hospitals who are recovering from a stroke will be able to benefit from an Early Supported Discharge (ESD) service. The ESD will be implemented during 2014 and will allow clinically eligible patients to be discharged from hospital and to receive intensive therapy in their own home.

Stroke - Community Neuro Rehab Team

Focusing on Stroke patients who will be ineligible for the ESD scheme this initiative will create a separate pathway for stroke patients who are cared for by the Community Neuro Rehabilitation Team. The service will also be linked with a Needs-led Life After Stroke Service (commissioned from the Stroke Association) which will include for 12 months reviews of patients.

Anti Coagulation – pathway redesign

<table>
<thead>
<tr>
<th>Stroke ESD will deliver;</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Investment of £300,000</td>
</tr>
<tr>
<td>• Significant inter-Organisation co-operation</td>
</tr>
<tr>
<td>• Improved clinical outcomes for patients</td>
</tr>
<tr>
<td>• Reduced length of stay for a stroke ESD eligible patient by 10 days over 5 years</td>
</tr>
<tr>
<td>• Reduction in readmissions within 30 days</td>
</tr>
<tr>
<td>• Achieve 95% of patients discharged from hospital with a joint health and social care plan in 14/15. 100% target over 5 years</td>
</tr>
</tbody>
</table>

Stroke Community Neuro Rehab team pathway review will deliver;

• 6 months review of patients
• Improved clinical outcomes leading to increased independence
Anti-coagulation is a critical pathway in our integration program and a full redesign and review will be taking place commencing 2016. This will link to work the Medicines Management Team.

**Community ME/CFS/Fibromyalgia Service Intervention**

This initiative will commence in 2015 and will review and then pilot a community ME/CFS and Fibromyalgia service for the population in Trafford to prevent referrals into secondary care for a range of specialties. It is expected that an initial investment of c. £60,000 p.a. will be allowed for.

**Anti Coagulation pathway redesign will:**

- Impact on under 75 mortality rates from cardiovascular disease
- Improve QOL for people with LTC and their carers

**Community ME/CFS/Fibromyalgia Service Intervention:**

- Reduced costs of hospital care
- Improved patient experience
- Improved clinical outcomes
- Improved GP clinical knowledge
- Improve the health–related quality of life for patients with LTC - to contribute to EQ-5D score of 75.46 by 18/19
- Improve the health-related quality of life for carers – to contribute to EQ-5D score of 0.85 by 18/19
- A reduction in outpatients by 0.05% from 2016-2019
Tissue Viability/Lymphoedema review

This project will commence in 2015 and will review the current provision of care provided by tissue viability clinics in Trafford to ensure access to an equitable (non-cancer) fully integrated assessment and treatment service for chronic odema is available to meet the needs of the Trafford population.

Tissue Viability/Lymphoedema review will deliver;

- Early diagnosis and management of chronic odema to prevent longer term problems
- Reduce the number of admissions in ambulatory care (cellulitis)
- To improve the quality of care for patients in the community with lymphoedema and how to best control the symptoms caused by this long term condition
- To reduce the number of first to follow up appointments for vascular services in secondary care.
- Improve the health-related quality of life for patients with LTC - to contribute to EQ-5D score of 75.46 by 18/19
- Improve the health-related quality of life for carers – to contribute to EQ-5D score of 0.85 by 18/19
### MEASURABLE IMPROVEMENT - HOW DO WE COMPARE?

#### Health summary for Trafford

The chart below shows how the health of people in this area compares with the rest of England. This area’s result for each indicator is shown as a circle. The average result for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- **Significantly worse than England average**
- **Not significantly different from England average**
- **Significantly better than England average**

#### Table: Measurable Improvement - How Do We Compare?

<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicator</th>
<th>Local No Per Year</th>
<th>Local Value</th>
<th>英格兰平均值</th>
<th>England Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall measures</td>
<td>Deprivation</td>
<td>22305</td>
<td>10.9</td>
<td>9.6</td>
<td>10.3</td>
</tr>
<tr>
<td></td>
<td>Proportion of children in poverty</td>
<td>7600</td>
<td>15.2</td>
<td>20.2</td>
<td>17.0</td>
</tr>
<tr>
<td></td>
<td>Statutory homelessness</td>
<td>135</td>
<td>1.4</td>
<td>1.6</td>
<td>2.0</td>
</tr>
<tr>
<td></td>
<td>GCSE achieved (%A*-C incl. Eng &amp; Maths)</td>
<td>1697</td>
<td>66.5</td>
<td>55.5</td>
<td>78.3</td>
</tr>
<tr>
<td></td>
<td>Violent crime</td>
<td>2305</td>
<td>11.1</td>
<td>16.8</td>
<td>15.0</td>
</tr>
<tr>
<td></td>
<td>Long term unemployment</td>
<td>821</td>
<td>4.5</td>
<td>9.2</td>
<td>19.6</td>
</tr>
<tr>
<td></td>
<td>Smoking in pregnancy</td>
<td>322</td>
<td>11.3</td>
<td>14.0</td>
<td>31.4</td>
</tr>
<tr>
<td></td>
<td>Breast feeding initiation</td>
<td>2697</td>
<td>73.1</td>
<td>73.6</td>
<td>79.9</td>
</tr>
<tr>
<td></td>
<td>Physically active children</td>
<td>16823</td>
<td>55.2</td>
<td>65.1</td>
<td>25.7</td>
</tr>
<tr>
<td></td>
<td>Obese children (Year 6)</td>
<td>453</td>
<td>18.9</td>
<td>20.7</td>
<td>28.8</td>
</tr>
<tr>
<td></td>
<td>Children’s tooth decay (at age 12)</td>
<td>n/a</td>
<td>0.7</td>
<td>0.7</td>
<td>1.6</td>
</tr>
<tr>
<td></td>
<td>Teenage pregnancy (under 18)</td>
<td>142</td>
<td>54.4</td>
<td>40.2</td>
<td>69.4</td>
</tr>
<tr>
<td></td>
<td>Adults smoking</td>
<td>n/a</td>
<td>19.2</td>
<td>21.2</td>
<td>34.7</td>
</tr>
<tr>
<td></td>
<td>Increasing and higher risk drinking</td>
<td>n/a</td>
<td>27.5</td>
<td>23.6</td>
<td>39.4</td>
</tr>
<tr>
<td></td>
<td>Healthy eating adults</td>
<td>n/a</td>
<td>30.1</td>
<td>28.7</td>
<td>19.3</td>
</tr>
<tr>
<td></td>
<td>Physically active adults</td>
<td>n/a</td>
<td>11.5</td>
<td>11.6</td>
<td>5.8</td>
</tr>
<tr>
<td></td>
<td>Obese adults</td>
<td>n/a</td>
<td>21.4</td>
<td>24.2</td>
<td>30.7</td>
</tr>
<tr>
<td></td>
<td>Incidence of malignant melanoma</td>
<td>39</td>
<td>15.5</td>
<td>10.4</td>
<td>27.2</td>
</tr>
<tr>
<td></td>
<td>Hospital stays for self-harm</td>
<td>402</td>
<td>186.9</td>
<td>186.3</td>
<td>497.6</td>
</tr>
<tr>
<td></td>
<td>Hospital stays for alcohol related harm</td>
<td>473</td>
<td>1892</td>
<td>1745</td>
<td>3114</td>
</tr>
<tr>
<td></td>
<td>Drug misuse</td>
<td>995</td>
<td>7.1</td>
<td>9.4</td>
<td>23.8</td>
</tr>
<tr>
<td></td>
<td>People diagnosed with diabetes</td>
<td>9952</td>
<td>5.49</td>
<td>5.40</td>
<td>7.67</td>
</tr>
<tr>
<td></td>
<td>New cases of tuberculosis</td>
<td>27</td>
<td>13</td>
<td>16</td>
<td>12.0</td>
</tr>
<tr>
<td></td>
<td>Hip fracture in 65s and over</td>
<td>230</td>
<td>404.9</td>
<td>457.8</td>
<td>631.3</td>
</tr>
<tr>
<td></td>
<td>Excess winter deaths</td>
<td>103</td>
<td>17.9</td>
<td>19.1</td>
<td>32.1</td>
</tr>
<tr>
<td></td>
<td>Life expectancy - male</td>
<td>n/a</td>
<td>79.6</td>
<td>78.9</td>
<td>72.7</td>
</tr>
<tr>
<td></td>
<td>Life expectancy - female</td>
<td>n/a</td>
<td>79.1</td>
<td>82.3</td>
<td>79.1</td>
</tr>
<tr>
<td></td>
<td>Infant deaths</td>
<td>10</td>
<td>3.66</td>
<td>4.71</td>
<td>15.63</td>
</tr>
<tr>
<td></td>
<td>Smoking related deaths</td>
<td>343</td>
<td>213.5</td>
<td>216.0</td>
<td>351.5</td>
</tr>
<tr>
<td></td>
<td>Early deaths: heart disease &amp; stroke</td>
<td>171</td>
<td>74.0</td>
<td>70.6</td>
<td>122.1</td>
</tr>
<tr>
<td></td>
<td>Early deaths: cancer</td>
<td>256</td>
<td>112.4</td>
<td>112.1</td>
<td>156.3</td>
</tr>
<tr>
<td></td>
<td>Road injuries and deaths</td>
<td>54</td>
<td>25.4</td>
<td>49.1</td>
<td>155.2</td>
</tr>
</tbody>
</table>

In the South East Region this represents the Strategic Health Authority average.
CLINICAL REFERRAL MANAGEMENT PROGRAMMES

The way in which patients are referred for treatment is potentially a significant cost in respect of making the right referrals, but is also a significant concern for patients both in terms of ensuring they are correctly referred, and that this is to the right clinician, first time.

In a number of areas Trafford CCG is reviewing the process of referral to ensure these are appropriate, cost effective and create a positive patient experience.

Provider Efficiencies

Consultants making referrals to other consultants is a significant cost pressure and a failure in the system to ensure that patients are seen by the right clinician first time.

This review which will be undertaken during 2014 will take into account referral protocols, the level of inappropriate appointments, and national benchmarks.

It will highlight that the importance of effective co-operation across our wider health economy and will involve effective utilisation of our Performance & Quality Team, collaboration with our neighbouring CCGs in Central & South Manchester and optimising the role of Clinical triage, in this instance, Manchester Integrated Care.

Peer Review Scheme

The Peer Review Scheme measures the quality of referrals made by our General Practices to assess their appropriateness against what we have defined as “the map of medicine”. The map of medicine shows the treatment pathways for selected specialties which is followed should ensure that patients receive the right care, in the right place at the right time.

Benefits of Clinical Referral Management Programmes include:

- Improved quality in GP referrals
- Increased positive patient experience in primary care
- Identification of pathways which require local map of medicine
- Shared GP learning
- Identification of services which can be delivered in primary care
- Improved clinical outcomes leading to increased independence
- For reviewed specialties – 5% GP referred FA saved and 0.75 FUP attendance saved for 66.6% of GP referred FA
- A reduction in elective care by 5.7% from 2014-2019
- A reduction in outpatients by 2.3%
GP’s act as peer reviewers and the scheme, which has an annual investment of £160,000, is continually reviewed to ensure its effectiveness in delivering the benefits identified. A full review of the appropriateness of the Scheme will be undertaken upon commencement of the Patient Care Co-ordination Centre (PCCC).

**District Nursing Service Review**

The District Nursing Service review forms part of Trafford CCG’s Frail and Older People’s programme, which is a priority of the CCG for 2014/15 and seeks to transform local services and deliver integrated care. A review of the current service is underway working with Pennine Care NHS Trust which will result in an enhanced service specification and an integrated health and social care offer.

**District Nursing Service Review will:**

- 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.
- Reduce length of stay
- Ensure patients have a positive experience of care and are supported to manage their conditions.
- Enhance quality of life for patients with one or more long term conditions
- Be an enabler to reduce emergency admissions
UNPLANNED CARE

There have been significant changes of the urgent care services within Trafford. In November 2013, following agreement by the Secretary of State, Trafford General Hospital A&E services was changed to an Urgent Care Centre. This service now operates between 08.00 -24.00hrs. Trafford patients requiring A&E services during the hours of 24.00 -08.00 are now sent to Central Manchester Foundation Trust, Salford Royal Foundation Trust or the University Hospital of South Manchester. The CCG manages the flow and impact of these changes through its Urgent Care Group. The implementation of the Urgent Care Centre was the first phase of changes for Trafford General Hospital; the second phase is described below.

Nurse Led Unit

Following the creation of the Urgent Care Centre at Trafford General Hospital, the next stage in the phased development of services will be to create a Nurse led unit. Trafford CCG are planned to lead a full engagement process with partner organisations to agree a clinical model. The timescales for this are not yet known as this will be aligned to the Healthier Together (Greater Manchester) and South Sector changes.

PATIENT VOICE

Do you want to be involved in reviewing this service? Contact us on trccg.feedback@nhs.net or 0161 873 6008

Benefits of the Unplanned Care Review will be:

- To improve the patient experience
- Reduce readmissions
- Improve independence
- Increase effective care planning and reduce admissions in to 24hr health and social care facilities
Deflection schemes

In preparation of these changes a number of services were implemented to effectively manage and deflect potential attendances at our Acute Trusts and therefore deliver the reductions in admissions and re-admissions essential to the delivery of integrated care.

These services are at an early stage and we will be concentrating on reviewing their performance, increasing their utilisation and raising awareness of their availability both with referrers and with our residents. Examples of services are provided below:

Alternative to Transfer (ATT)

The Alternative to Transfer scheme enables paramedics to assess patients who have requested an ambulance to be assessed against agreed protocols to identify patients who could be treated outside of an acute setting by a GP or by enhanced community services. This programme was introduced in winter 2013 and has a high success rate to date.

The Alternative to Transfer projects will deliver:
- A contribution of 11.5% of the total targeted reduction in unplanned activity from 2014-2019
- Increase patient experience

Alternative to Transfer – Pathfinder Nursing Home

The CCG has chosen to expand and enhance the current Pathfinder provision to include Nursing Homes. The Pathfinder scheme enables paramedics to assess patients who have called an ambulance and by following their Pathfinder protocols to identify patients who could be treated within the nursing home by a GP. Mastercall and NWAS have been operating this scheme for a number of months with a high success rate. This expansion has been evidenced from identified capacity within the current scheme therefore this development allows medically trained staff in nursing homes to identify patients who would benefit from being seen by a doctor urgently, but who do not necessarily need an ambulance. In these instances the nursing
home would refer these patients to Mastercall. The aim of this enhancement is not to replace the patient’s GP but merely provide a more suitable safe and effective alternative to using NWAS complementing our admission avoidance schemes.

This service enhancement forms part of the overarching Frail and Older People’s programme.

**Primary Care unplanned admission avoidance DES**

The scheme will integrate a general practice service into accident and emergency department. Patients who are deemed to not need acute care will be assessed and treated by a GP. This is detailed in the Primary care section of the document.

**Community Enhanced Services:**

Trafford CCG in support of the new Health Deal made a proactive decision to develop plans for services that reduce admissions to hospital and improve discharge arrangements for Trafford residents. As a result an integrated service model was designed delivered by the health and social care community infrastructure.

---

**PATIENT VOICE**

Do you want to be involved in reviewing this service? Contact us on trccg.feedback@nhs.net or 0161 873 6008
This service model forms one phase of the move to achieving integrated care across Trafford. The service model seeks to provide:

- Alternatives to attending A&E and any subsequent admission
- Targeted anticipatory preventative care
- Facilitate speedy discharge when clinically appropriate
- On-going care within specified care pathways within a community setting

The model offers transitional care delivered at a residence of choice in the broadest sense supporting, where appropriate admission avoidance, resulting in resumed independence or provision of appropriate long-term care. Additionally, the model will include, but not be limited to:

- Admission avoidance
- Appropriate early supported discharge from an acute setting
- Urgent response
- Intermediate rehabilitation/reablement care

These components will address local challenges relating to unscheduled care and the shift of care from hospital to community settings in-line with Trafford CCGs outcome ambitions.

Community Geriatrician model

Through the frail and older peoples programme a new geriatrician model will be developed to operate across Trafford. The service will ensure a proactive approach to older people care as well as supporting patients to leave hospital as soon as is practicable with ongoing management in their own homes.

The Community Geriatrician Model will deliver:
- A reduction in unplanned care.
- Reduction in length of stay
- Increase in patient experience and independence
Intermediate Care Review

Trafford CCG commissioned the Trafford Intermediate Care (IC) Unit in November 2013 in support of the new Health Deal to reduce the pressure on the three Acute Trusts by creating additional capacity of 18 intermediate care beds across the Trafford health system for an initial period of four months. This decision formed part of the reconfiguration of the clinical model at Trafford General Hospital (TGH) that forms part of the New Health Deal (NHD) for Trafford. A proactive decision was made to extend the current provision, guaranteeing additional capacity and supporting patient flow by maintaining the discharge facility within Trafford. This re-provision which extends beyond phase 1 of the Intermediate Care review, will establish a maximum capacity of 12 intermediate care beds.

The CCG as part of its five year strategic plan has scheduled a full review of intermediate care in Trafford which is seen as Phase 2, with a view to determining whether there is a requirement for further expansion and investment in provision across Trafford, working co-productively with South Manchester CCG adopting a multi-disciplinary approach; within a realistic timeframe for delivery.

Benefits of the Intermediate Care Review will be:
- To improve the patient experience
- Reduction in unplanned care admissions by 5.2% from 2015-2019
- Improve independence
- Increase effective care planning and reduce admissions in to 24hr health and social care facilities

PATIENT VOICE
Do you want to be involved in reviewing this service? Contact us on trccg.feedback@nhs.net or 0161 873 6008
Falls Review

Trafford CCG, working in partnership and parallel to the Public Health Team who are currently developing a Falls Strategy, will establish a multi-disciplinary working group that will scope current service provision and analyse clinical evidence based best practice culminating in the production of a service specification along-with a fully costed business case that will seek to establish a robust evidence based and clinically appropriate Integrated Falls Service, that will include:

- ATT Pathfinder provision providing robust admission avoidance protocols
- Rapid Response provision working in partnership with the ATT Pathfinder protocols, along-with in-reach into Emergency Departments ensuring appropriate timely management of early supported discharge and admission avoidance
- Screening requirements and processes for “at risk” individuals that have contact with the health and/or social care systems
- Multifactorial assessment of individuals identified as being “at risk” including but not limited to; physiological, mental, environmental and social assessment of the individual current condition and needs – following NICE guidelines
- Falls Services delivered in the community, close to / in older people’s own homes
- Community based targeted strength and balance exercise programme following evidence based protocol
- Training packages for various services and/or teams including but not limited to: care and nursing homes, general practice, hospital discharge teams
- Fostering excellent links with both health and social care services to encourage referral to falls services

The Falls Review will deliver:
- A reduction in unplanned care by 5.6% from 2014-2019
- Improved in Patient Experience
End of Life Care

Trafford CCG’s End of Life Programme is part of the Better Care Funds Programme. It has been developed to address areas for improvement to ensure a proactive, person-centred and integrated end of life pathway which is based on national best practice and delivers improved patient family and carer experience. The programme will also establish efficient and effective monitoring of commissioned services, through contract performance to ensure good clinical outcomes and value for money.

We expect the projects on End of Life to:

- Improve the experience for all by planning effectively for EoL care by improving integrated working, communications
- Increase the amount of deaths in patients usual place of residence by 2% each year from 2014 -2019
- Reduce unplanned care by 4.7% from 2014-2019
- Reduce length of stay

The programme will deliver improvements around three key themes:

Redesigning Services – we will seek to understand the journey of a patient who is deemed to be ‘end of life’, review service provision and implement changes to improve patient experience.

Education and Technology - we will develop a comprehensive education programme for nursing home staff, primary care practitioners and hospital staff which seeks to improve clinical care and raise awareness of best practice in delivering end of life care to patients, families and carers. We will introduce new technology to enable all services to access advanced care planning documents to ensure that patient’s wishes are acted upon in the final stages of life.

Developing the Third Sector – We will develop the third sector in Trafford to deliver high quality care and support to patients and their families. We will introduce community awareness campaigns which are targets at varying demographics. We will work with the third
sector to ‘sense check’ all service redesign to ensure we are meeting the needs of our population.

We expect the End of Life Programme to;

- Improve the experience of patients by planning effectively for end of life care allowing patients to avoid spells in hospital and to die in a place of their choosing.
- We will improve the quality and accessibility of services and ensure they are delivered in an integrated way.
- We will ensure that patients and their families have a positive experience of

An investment of £79,000 MPET funding will be spent in 2014/15 in addition to recurrent end of life spend on provider contracts.

The following projects will be implemented by March 2015;

- Multi Professional Education and Training (MPET0 for Care Homes, professionals and clinicians
- Electronic Palliative Care Co-ordination System
- Trafford Advanced Planning Portal
- The introduction of a new care plan for the dying patients
- Review of end of life services

Frail and Older People

Trafford CCG’s Frail and Older People’s Programme is part of the Better Care Funds Programme. The programme will be clinically driven and will focus specifically on the pathway for frail and older patients. The project will seek to understand how services currently operate both at a borough and locality level making recommendations on how we can deliver services better and in a more integrated way. The project will be developed in future years to ensure that patients aged 60+ are engaged in preventative health care.
The programme will consist of a number of projects;

- A review and redesign of a falls service in Trafford
- A review of District Nursing provision with regard to the wider Greater Manchester review
- Develop services which enable patients to live well independently for through improved access to primary care and community therapies
- Roll out of the Alternative to Transfer project to nursing homes
- The redesign of intermediate care provision
- The implementation of a Patient Care Co-ordination Centre

The Frail and Older people's project will provide;

- A reduction in admissions and readmissions of frail elderly complex patients to secondary care.
- Identification of where new relationships are required between acute Care of the Elderly Consultants and Primary Care in order to deliver a whole system approach to the management of this complex cohort of patients.
- Improved knowledge and skills of carers through improved education thus empowering care staff to be able to use knowledge and skills to maintain patients’ independence and their care needs without requiring admission to secondary care.
- Reducing the delay in discharge

KEY ENABLER

WORKFORCE DEVELOPMENT

A key challenge for the CCG in this model is the development of a skilled workforce to service the integrated care provision. The CCG is working closely with Pennine Care Foundation Trust and the Borough council to ensure training and working environment are of the highest standards to attract a skilled workforce. As part of this we are developing two large new community hubs where integrated teams will work together. These will have state of the art facilities and allow teams to skill mix and learn best practice from each other.

We have requested support from the local area team to work with us and with the deanery to think about training and the way it can be done to offer skilled clinicians who can support integrated care.
PERSONALISATION

Personalisation describes the commissioned care delivered through a personal budget option. Patients who are “Continuing Health Care” (CHC) eligible are provided with the funds and support to purchase their own care. Patients will be responsible for their own health outcomes, closely monitored by the Clinical Case Management (CCM) team.

Funds made available to patients will be can be used in an innovative and more cost effective manner. Investment costs. There is a phased roll out of personal budgets with the initial focus on CHC eligible patients, extending to anyone who requests one by January 2015.

Personalisation will have the following outcomes;
- Reduced hospital admissions
- Ability to monitor wellbeing outcomes
- Patient choice and satisfaction
- Market stimulation

Monitoring of CHC providers is targeted to deliver;
- Patients are supported to remain at home longer
- The quality of providers is fully monitored and areas of poor practice addressed
- Integrated working with Borough Council.
- Cost of services is managed and based on quality

Review of Personalisation Team

A full review of the Personalised Care Team’s functions, role, capacity, procedures, patient data management system and ability to deliver a cost effective, quality service for FNC and CHC funded patients has been undertaken. The success of these changes will be reviewed in September and December 2014.
Joint monitoring of CHC providers to ensure quality and reduce risk of safeguarding issues and complaints.

This incorporates the clinical expectations of the Personalised Care Team, Trafford Adult Social Care, Medication Management, infection Control and CQC.

<table>
<thead>
<tr>
<th>The Personalisation Team is targeted to deliver;</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Improved service</td>
</tr>
<tr>
<td>• Reduced appeals</td>
</tr>
<tr>
<td>• Reduced complaints</td>
</tr>
<tr>
<td>• Increased assessment</td>
</tr>
<tr>
<td>• Increase in people living at home longer</td>
</tr>
<tr>
<td>• Increased number of people dying at home (by choice) with appropriate support</td>
</tr>
</tbody>
</table>

Development of a GM CCG homecare framework

Development of a local joint homecare framework with Trafford Social Care with implementation targeted for September 2014.

<table>
<thead>
<tr>
<th>The joint homecare framework will deliver;</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Timely discharge from hospital</td>
</tr>
<tr>
<td>• Decreased re-admission to hospital</td>
</tr>
<tr>
<td>• Increased access and use of cost effective and high quality homecare providers who understand the complex needs of CHC Patients.</td>
</tr>
<tr>
<td>• Increased number of Patients remain at home longer</td>
</tr>
<tr>
<td>• Decreased unit cost of homecare.</td>
</tr>
</tbody>
</table>
KEY ENABLER

Trafford Early Intervention and Wellbeing Hub

This Early Intervention and Wellbeing Hub is to assist clients and potential clients at an early stage. The hub will be available to all; where there has been a need identified. This Hub will provide support to individuals who themselves may need support and to carers who need support as they are caring and supporting others.

The wider determinants of health and wellbeing for example; housing and employment need to be addressed at an early stage to prevent individuals from developing associated health needs. All teams and services within this wellbeing hub will develop a single approach, a single culture with shared ambition and outcomes.

The hub will support individuals from birth to death across all the key areas of life. Services will be delivered by individuals in a co-ordinated way to meet the needs of the individual and to avoid through prevention, acute interventions. Being well reduces stress and stress can create associated health issues. Interventions can be targeted at those who most need them such as the elderly living alone, often in isolation from their families, and jointly we can offer relationships and networks to prevent loneliness and associated mental health issues.

This is one of the Better Care Fund projects and although it will be led from the Borough Council, the project will involve collaborative working with the CCG. The project will be progressed through a project board which the CCG has representation.

The initial stage of scoping out the programme, will set out the services to be included and benchmarking with other models where the learning can be incorporated into the Trafford approach.

The Hub will provide:-

- A Strategic Partnership approach to the management of increasing demand on services based on early intervention and prevention.
- A range of services which will ensure people have the support they need from pre-birth to death.
- Outreach support to communities to link into integrated health and social care teams and build up community capacity and resilience.
- Early support to enable individuals and communities to provide and access the support they need through wider integration – voluntary and community sector, private sector, social enterprise, Acute Trusts, Greater Manchester Police, Housing.
- A holistic approach to assessment and prevention.
- Reduce demand for statutory social care services
- Increased capacity for Specialist services
- Improve the patient and customer experience.
- Deliver improvements in health and wellbeing for individuals.
- Deliver reductions in hospital admissions.
- To reduce delay in discharge

This hub is to be an integral part of the patient co-ordination centre. Although the hub will initially be provided by the Borough Council there will be connectivity to functions of the Patient co-ordination. The co location of both should deliver benefits to its users, and to the health economy as a whole.
MENTAL HEALTH

IAPT

(Improving Access to Services)

IAPT services deliver psychological therapy services. We will be developing a business case which delivers increased access of eligible patients to talking therapies. The investment is targeted to be in the region of £375-500,000 with implementation to be agreed but towards the end of 2014 / 2105.

Achievement will necessitate significant joint working between NHS Trafford CCG, Trafford Metropolitan Borough Council, Greater Manchester West Mental Health NHS Foundation Trust and Self Help Services

RAID

(Reducing the physical health inequalities experienced by people with mental ill health)

The Trafford RAID Service provides mental health care to Trafford Clinical Commissioning Group (CCG) registered patients aged 16 and over attending A&E or admitted to in patient wards at Central Manchester Foundation Trust (CMFT), Trafford Site, Davyhulme and University Hospital of South Manchester NHS Foundation Trust (UHSM), Wythenshawe.

The co-occurrence of mental and physical

RAID Metrix include:

- A reduction of £430K in excess bed day payments
- A reduction in frequent flyers by 25%
- 25% deflection away from Acute Medical Unit
- A 15% reduction in readmissions
- Overall reduction in length of stay of 1 day for RAID patients
- An increase in people returning home from hospital of 25%
health problems is very common among these patients, often leading to poorer health outcomes and increased health care costs. An effective liaison psychiatry service offers the prospect of saving money as well as improving health, with the investment in RAID targeted at £500,000.

**Redesign of Greater Manchester West services**

*(Ensuring the availability of effective specialist mental health services)*

Greater Manchester West (GMW) provide Trafford with hospital and home based mental health services. We will be working closely with GMW in the redesign of these services to ensure they deliver required standards in a way which best meets the needs of Trafford residents. The investment in these services will be in the region of £300,000-£571,000.

The redesign will deliver multidisciplinary care around the clock in patients’ own homes, with services skilled in crisis resolution and offering genuine alternatives to inpatient care.

**Dementia Strategy**

Our dementia strategy will deliver;

- Our diagnosis rate ambition of 67% by 2016

We will develop a Dementia Strategy which builds on existing work to improve diagnostic rates. This will require the development and promotion of brief interview and screening techniques which can be easily utilized in primary care to detect the presence of dementia with an acceptable level of precision and accuracy and support this approach by developing an ‘at risk of dementia’ register so as to efficiently target primary care assessments.
Improved diagnosis will be complemented by the provision of earlier interventions including providing good information, support and care – to help people deal with the challenges of their dementia diagnosis and aspire to a meaningful and positive life.

A shared care step down / step up pathway and protocol between GMW and Primary care will be developed to ensure Trafford’s Memory Assessment and Treatment Service fit for purpose and able to offer timely and early diagnosis.

**RADAR metrix include:**

- A reduction in excess bed day payments paid as a result of admissions to acute hospitals due to alcohol misuse
- A reduction in frequent flyers
- A reduction in A&E breaches
- Deflection away from Acute Medical Unit
- A reduction in readmissions
- Overall reduction in length of stay for RADAR patients
- A reduction in admissions via A&E
- An increase in people returning home from hospital

**RADAR**

RADAR is a UK-first service at the Chapman-Barker Unit in Prestwich. The new RADAR (Rapid Alcohol Detox Acute hospital Referral) Ward accepts referrals from a number of A&E departments across Greater Manchester and beyond.

If A&E hospital staff regularly see the same people presenting with alcohol-related injury or illness and the individual wants to change and improve their health, they can refer the patient directly to the RADAR Ward, so long as they are otherwise fit to leave hospital. The patient then stays in the ward for five to seven days and undergoes a full detox from alcohol. This will help the patient be in the best position possible to start their recovery journey and break the cycle of frequently attending hospital due to their addiction. Ultimately it is envisaged that the RADAR service will align or amalgamate with the Trafford RAID service.
Learning Disabilities

(Reducing the physical health inequalities experienced by people with mental ill health / improving access to services / Ensuring the availability of effective specialist mental health services / Delivering mental health promotion, recovery and social inclusion for people with mental ill health by co-working with our local authority partners / Providing better support for carers and older people.)

The contract for Trafford’s Community Learning Disability Team will be retendered to ensure a continued improvement in performance. Patient and public engagement will be critical to informing the final specification for the services.

The revised specification for the Learning Disability service will include:

- Improved health, wellbeing and access to health care for people with a learning disability
- A reduction in health inequalities
- Continued management of high cost placements
- Support to achieve the Winterbourne View Concordat
- A reduction in inappropriate referrals and placements
- An overall reduction in lengths of stay for people with learning disabilities
MEDICINES MANAGEMENT

Trafford CCG has a team of pharmacists and technicians who are focused on ensuring that our prescribers make the best use of available treatments to enable the delivery of the best clinical outcomes within available funding.

We have a number of initiatives planned which will contribute to the achievement of this goal and our wider strategic aims.

The team works across a number organisations including pharmacies, GP’s. The borough council and community services to encourage and support the desired improvements.

**Anticoagulant/New Oral Anticoagulant (NOAC) pathway to review “out of range” patients taking Warfarin**

The aim is to introduce a pathway to ensure all patients who are not within a specified INR target for a specified time period are reviewed and if appropriate switched to a NOAC.

**Effective use of resources by care homes**

The Medicines Management team via their work in GP practices will provide a clinical medication review of all patients residing in a care home setting as well as visiting each care home to communicate any changes and assessing how medicines are managed within the setting.

Both of the above reviews are underway but will continue to be developed as a recurring work programme.
This supports GP practices to:

- Have a robust repeat prescribing system, reduce waste and ensure clinical targets for medicines management are met.
- Reduce practice prescribing budget overspend; measure reduction/increase in relation to a particular target.
- Set a practice prescribing budget that allows sufficient funding to treat primary care population.

Development of domiciliary medication reviews

We will be developing a domiciliary review service for those patients who are identified as being “at risk” but are not already identified or known via the Urgent Care business case.

This service will be implemented in 2014 and will be reviewed against numbers of patients seen and cost efficiencies achieved.

Support to GP practices - Prescribing and budget setting

The Medicines Management team will develop and ongoing program to support GP practices with repeat prescribing reviews and clinical medication reviews in line with CCG & national objectives and national QiPP targets. The team will work with individual GP practices to establish prescribing budgets for practices.

Medicines optimisation will ensure that medications prescribed are effective and producing desired outcomes.

These reviews will improve patient’s understanding of their medication regimes, adverse effects and side effects of medicines to improve their adherence to the regime.

Medicines Optimisation

In defined clinical areas e.g. CVD, Respiratory, AF, Dementia & Diabetes and Anti Psychotics we need to optimise patients’ medicines in line with national/local guidance and patient’s response to these medicines. During 2014 we will scope a clinical area and pilot a scheme.
Home Oxygen Assessment and Review (HOS-AR) Service

We have commissioned a Home Oxygen Assessment and Review (HOS-AR) Service that will ensure appropriate and effective management of all oxygen patients prescribed oxygen within the Trafford footprint. The HOS-AR service will ensure that every patient is formally assessed by appropriately qualified, trained and competent healthcare professionals using appropriate diagnostic methodology. The service will also provide paediatric and neo-natal services with subject matter expert advice.

The service will be reviewed in October 2014 and is contracted until November 2016.

HOS-AR will deliver;

- Regulatory and clinical assurance
- Reduced administrative burden for GP practices
- Effective financial management
- Improved patient focus with monthly patient support groups to be developed
KEY INITIATIVE

Trafford CCG as Lead Commissioner - Regional contract for Home Oxygen

Trafford CCG is the lead commissioner for the regional contract for home oxygen services, a contract with a value of £7.3M. The contract requires a lead CCG and nominated ‘authorised officer’ to act on behalf of the NHS in contractual matters. From May 2013 NHS Trafford was awarded the role of lead CCG and as such has established a team led by the Authorised Officer optimising the knowledge, skills and abilities of the two regional leads creating an effective and rigorous contract management framework that promotes and ensures patient safety.

The regional contract allows the NHS to work within clinical guidelines prescribing oxygen therapy following specialist assessment through a National Framework Agreement that acts as the regional specification directing a delivery model that places the necessary equipment within a patients’ residence. The non-clinical private provider is contract managed both strategically and operationally by the lead CCG (NHS Trafford) on behalf of the remaining 32 CCGs of the North West. The mechanism for contract management is by delivered by two regional leads with defined remits that offers a robust and comprehensive approach.

The current contract which commenced on the 2nd July 2012 runs until June 2017 with an option to extend for a further two years. As a result the Lead CCG will develop and deliver a North West strategy for the contractual and performance management of the national framework agreement/regional contract. The strategy will provide an efficient, effective and high-quality contract management service capable of meeting all statutory, regulatory and NHS requirements ensuring alignment of the activity of the North West ensuring the current 11,922 oxygen patients receive oxygen therapy appropriate to their clinical condition.

Through the specialist team the lead CCG will drive the development and implementation of consistent, evidence based, best practice clinical service specifications that are aligned and reflective of current clinical guidance.

Through the specialist team the lead CCG will be a fundamental part of the regional procurement call-off process for the next round of reprocurement working in partnership with procurement team, producing and evaluating the entire specification of the National Framework Agreement and local variations culminating in contract award across the North West. The specialist team will also take a lead role in the development and revision of the National Framework Agreement for home oxygen working with NHS England and other regional colleagues.

The remit of the steering group is to oversee the performance of the supplier, currently Air Liquide (Homecare) Ltd for the term of the contract functioning as the approving authority for all issues pertinent to developments, decisions and amendments relating to the regional contract. Additionally the steering group benefits from the establishment of two sub-group undertaking specialist components of the contract; performance and activity and clinical quality. Both groups have differing work programmes that are agreed within the sub-group but ratified and disseminated by the steering group. The steering group and sub-groups have a term that mirrors that of the regional contract.

Members of all groups have been nominated by Heads of Commissioning across the North West with their attendance ensuring comprehensive geographical coverage for the region. The members are all familiar with the oxygen contract and are highly respected within their own organisations and within the oxygen network within the North West.
PUBLIC HEALTH

Improving the quality of primary care and reducing health inequalities overview

Public Health and reducing health inequalities is a significant theme of Trafford CCG’s Integrated Primary Care Development and Improvement Strategy 2014-2018. The Public Health team will support a reduction in health inequalities by maintaining and improving primary care quality through an integrated approach with Trafford CCG, Trafford Council, Locality Partnerships, Public Health England and Trafford’s primary care practices.

This integrated approach will support primary care to:

- promote individual lifestyle changes by offering opportunistic brief advice where appropriate referral to a choice of wellbeing services (e.g. NHS Health Checks, sexual health services, drugs and alcohol advice);
- engage with and encourage communities which are less likely to access services;
- ensure patients are engaged and make an informed decision about participation in national screening programmes, and ensure inequalities are addressed;
- promote wellbeing by treating patients holistically in terms of mental and physical illness;
- promote effective self-management for people with long-term conditions; and
- improve the management of co morbidities by tackling the causes of premature mortality.

Public Health will support primary care to place their patients at the centre of a holistic care approach through the implementation of the Health and Wellbeing Hub. Public Health is working collaboratively with partners on the development and implementation of the Hub, which focuses on reducing the impact of the wider determinants of health such as housing, environment, emotional resilience and lifestyle on the health and wellbeing of patients.
Public Health will provide evidence based solutions to identified inequality issues. Primary care practices need to be responsive to the needs of their registered population. Practices in our more deprived and ethnically diverse communities need to recognise the impact that social and cultural factors have on health status and uptake of public health initiatives.

Working with the CCG Public Health will aim to improve the mental health resilience of Trafford’s population. Public Health is investing £6,000 in 2014/15 on promoting good mental health in the workplace. Primary care will be encouraged to recognise the early symptoms of mental ill-health and signpost patients appropriately. The mental health of children and young people is an important determinant for future health and wellbeing. Public Health will work in partnership with the CCG to support the implementation of Trafford’s Children and Young Peoples Plan, (CYPP). Outcomes from the CYPP include improved mental health and wellbeing.

Strong relationships have been established between Public Health and the Primary Care Interface Team to support practices to improve the quality of their disease registers and reduce the gap between modelled expected numbers and actual numbers. Ensuring patients with conditions such as diabetes and high blood pressure are identified and appropriately managed will prevent early disability and death and will reduce health inequalities.

Public Health will work with the CCG to improve uptake of screening initiatives. Cancer screening programmes identify changes early, early diagnosis often means treatment is more successful compared to those patients who present with symptomatic disease. The NHS Health Check screens patients aged 40-74 years for risk factors of cardio-vascular disease (CVD). Identifying people with risk factors and managing their care, reduces the risk of disability and death. Improving screening uptake across all our practices and reducing the gap in uptake between the poorest performing ones and the national uptake figures will have significant impact on the health of Trafford.
Public Health and the Primary Care Interface Team will work collaboratively to support the implementation of the Health and Wellbeing Strategy where relevant to primary care.

**Reducing liver disease through reducing alcohol consumption**

The Trafford Alcohol Strategy will be implemented – actions include:

- Conduct multi-agency Stay Safe operations in order to conduct outreach work to combat street drinking among young people.
- Conduct awareness sessions in local schools and colleges.
- Trading Standards to conduct test purchases at Off License premises to combat underage sales.
- Partners to use a new screening tool (short questionnaire) in order to identify persons at risk from alcohol consumption and refer to providers.
- Use of social media to promote awareness of risky behaviour and dangers of alcohol.
- Public Health is investing £100,000 to continue the new RAID service to help deal more effectively with persons presenting at Hospital with mental health and alcohol issues.
- Target Women with alcohol related illness. Educational events held with GPs, Practice Nurses and Health Care Workers.
- Trafford to develop and implement a Tier Four framework for individuals with more chronic or entrenched issues.
- Ensure stronger links are developed with the primary care setting to improve the usage of local alcohol services and increase the number of brief interventions. A locally enhanced service has been put in place to reward practices for brief interventions, extended interventions and community detoxification.
- Referrals to be made to Stronger Families where irresponsible drinking or the supply of alcohol to minors is suspected of parents or guardians.
Reducing smoking prevalence

The following will be actioned to reduce smoking prevalence locally:

- Commissioning a cost effective stop smoking service, with links to primary care and community. Expand the links with Secondary Care. Review to be in Place for April 2015
- On-going Maintenance and update of the Tobacco Control Network monitor the progress of our action plans. Partners include: for example Stop Smoking Services, Trading Standards, Health & Wellbeing, Health Visitors, School nurses, Children’s Centres, Youth Services
- Advocacy work supporting Tobacco free futures, national and local initiatives, e.g. Stoptober, Standardised Packaging, LG declaration on tobacco control, school work,
- Results from the Greater Manchester Sector-Led Improvement exercise on Smoking – deliver the Trafford Local Action Plan
- To aim to establish clear high level ownership of reducing smoking prevalence across agencies.
- Public Health invest £288,000 annually to reduce uptake of smoking and help people quit.

Reducing obesity

Obese children become obese adults so the focus on reducing obesity to date has been on childhood obesity.

The following actions are planned:

- Refresh and implement the Trafford healthy weight strategy with a particular focus on:-
- Breastfeeding and early years, primary school aged children, promotion of healthier food choices, workplace initiatives, reducing the obesogenic environment through close working with local authority planners and building physical activity into people’s lives.
- Implement healthy weight care pathway.
• Increase physical activity, a key priority of the H&WBS.
• Public Health is investing £125,000 this year promoting and providing opportunities for people of all ages and abilities to take part in a range of physical activities.
• Public Health is investing £450,000 this year on promoting healthy nutrition, including breastfeeding support, and treating obesity.

The cost of overweight and obesity to the NHS in Trafford is around £25 million a year. Obesity contributes to premature deaths from CVD and cancer and is a major risk factor for diabetes, high blood pressure, liver disease, fatty liver as well as cardiovascular disease

**Picking up cardiovascular disease risk factors earlier**

The NHS Health Checks programme has been in place for several years. Public Health provides £272,000 annually to support the implementation of NHS Health Check programme. The model uses general practice as a method of delivery. All but two general practices participate in the NHS Health Checks programme. Actions for the future improvement of the NHS Health Checks programme are as follows:

• Continue to support practices on data quality and clinical support through the NHS Health Checks support nurse.
• Deliver a pharmacy led pilot for NHS health checks in a large practice in the north west of Trafford. If successful this approach will be implemented in other areas of the borough where the GP model has been less successful in gaining sufficient uptake.
• Continue to monitor closely data by practice and implement best practice and quality standards outlined in the national NHS Health Checks programme.
• Continue to ensure practices link the outcomes of patient’s health checks with appropriate public health and clinical interventions.
• Continue with other areas in Greater Manchester through sector led improvement to improve performance in NHS Health Checks.
Screening for cancer and early detection of cancer

Ensuring that cancer is detected early is essential for improving survival rates. Public Health England co-ordinate a population approach to promoting symptom awareness and early diagnosis of cancer. Lifestyle interventions supported by Public Health in Trafford will reduce population risk factors including strategies focussed on tobacco control, alcohol and substance misuse, and physical activity. Improving the quality of primary care across Trafford through the implementation of the Primary Care Development and Improvement Strategy 2014-2018 will support early diagnosis of cancer.

The equity and quality of screening programmes across our practices is significant for reducing inequalities and improving survival. In Trafford, Public Health is working across the CCG, Council and wider partnership to improve screening uptake across the population and between practices.

- **Cervical Screening**
  Improving Cervical screening uptake is a priority for the CCG in 2014/2015. An integrated improvement plan has been developed to support this and acknowledges the role of primary care and community engagement in increasing the numbers of women being screened. Public Health England and the NHS Local Area Team are involved in the implementation of this plan. Public Health will work with the CCG and primary care to ensure all initiatives linked to this plan are sustainable and become business as usual over the next five years.

- **Breast Screening**
  The public health team will work alongside Public Health England to improve uptake of breast screening

- **Bowel Screening**
  Although Trafford CCG has a high uptake of bowel screening compared to National uptake, the inequalities between practices are a concern.
A pilot reviewing the impact of personalised GP letters on completion rates of bowel screening uptake was tested across 6 practices during early 2014. Learning from the pilot will be implemented across primary care. Public Health is committed to working with the CCG and practices to support the implementation of evidence based interventions to increase the uptake of bowel screening.

Reducing premature mortality in people with a learning disability

People with learning disabilities will continue to be offered an annual check in Trafford.

Maternal and neonatal interventions

Trafford experiences excellence rates of screening for pregnant women and new-born babies. Public Health England will continue to be responsible for implementing this programme locally.

Public Health England will monitor the uptake of immunisations in line with the national schedule for immunisations.


JOINT COMMISSIONING – CHILDRENS HEALTH

Complex and Additional Health Needs

Personal health budgets

Implementation of the single Education, Health Social Care plan and personal health budgets for Children and Young Persons (CYP) with CHC, aged 0 – 25, which includes implementing the CCG statutory duty to jointly commission interventions for children with a single plan.

Implementation is scheduled to take place in Autumn 2014 with a likely increase in costs of 5% per annum.

Personal health budgets for CYP will deliver;

- Personalised care plans co-ordinated across range of specialisms
- Co-design, with Children and Young People with special educational needs, the personal health budgets core offer
- Self-directed support with an agreed personal health budget
- Care that follows the child into any setting to facilitate their engagement in daily life
- Reduced admissions for children with complex disabilities
- Reduced bed nights
- Expedited discharge through a supported CHC plan

Extension of current telecare provision will deliver;

- Safer care in the home environment
- Reduced necessity to commission high cost home support or residential provision
- Reduced likelihood of attendances at urgent care sites
- Reduced likelihood of Disabled Facilities Grant adaptations being required
- Increased quality of life for CYP and their carers
- 100% of eligible CYP are assessed for Telecare solutions

Children’s Long Term conditions

CYP with long term conditions or disabilities currently have access to telecare services provided at a cost of £15,000 per annum. This service will be reviewed with a view to extending its

The Complex and Additional Needs programme will also deliver:

- All CYP with moderate to chronic health needs to have a named GP and community nurse
- All CYP with moderate to chronic health needs (including learning disabilities) have a multi-disciplinary plan in place
KEY ENABLER

Healthwatch

The role of Healthwatch Trafford (HWT) is clear and comprises of the following elements:

- Provide information about health and care services in Trafford.
- Enable people to share their views about Trafford’s health and social care services to help build a picture of where services are doing well and where they can be improved.
- Alert Healthwatch England to concerns about specific care providers.
- Participate in decision-making via local authority health and wellbeing boards.
- Play an integral role in the preparation of the statutory Joint Strategic Needs Assessments and joint health and wellbeing strategies.
- Provide evidence-based feedback to organisations responsible for commissioning or delivering Trafford’s health and social care services.
- Help the Trafford Clinical Commissioning Group (Trafford CCG) to make sure that services really are designed to meet citizens’ needs.

HWT have achieved this in part by working closely with Trafford CCG in a variety of ways. This includes attending ongoing boards and meetings as well as being part of strategic groups to look at particular projects. This includes (but is not limited to):

- Group (CCG)
- Health Overview & Scrutiny Committee
- Integrated Care Redesign Board
- Patient Care Coordination Centre design and tendering process
- Public Reference and Advisory Panel Trafford Health & Well Being Board
- Trafford Clinical Commissioning Group Board
- Locally Commissioned Services review

In addition HWT has undertaken commissioned work from the CCG on clearly identified areas of work:

- HWT was commissioned to undertake a survey of Chronic Obstructive Pulmonary Disease (COPD) patients within Trafford. 440 surveys were issued to patients and 140 returned. In addition 5 focus groups were held with patients to gather data. This report has been compiled and submitted to the CCG. As a direct result of this survey 8 patients were referred to smoking cessation.

Healthwatch Trafford view maintaining this relationship with Trafford CCG as essential to fulfilling their obligation to make sure that services really are designed to meet citizens’ needs.
End of Life (EoL) - CYP

We will be undertaking a timely review of the current end of life experience and place of CYP who are dying, to ensure that services are able to provide an effective and efficient quality service to meet the changing palliative care needs of the Trafford GP registered and/or resident population of CYP, and to maximise its contribution to improving outcomes.

A focus on EoL will deliver;
- Recommendations about more effective ways of working, service redesign opportunities, gaps in provision, opportunities to make best use of expertise and highly developed skills, and potential future investment (with a clear supporting rationale);
- Updating of the latest relevant service specifications and pathways, that clarifies the service offer; and
- Reduction in length of stay in hospital and readmissions during end of life period, increased number of deaths at home, along with improved patient and care experience.
- 100% of CYP who are End of Life will be offered a choice of place of death

Community Paediatrics
Redesign (Greater Manchester - Healthier Together)

As part of the GM Healthier Together Programme (3 to 5 years transformational timescale), to develop, design and implement plans to provide more local integrated care services for children and young people (CYP) in the community and at home rather than in hospital settings.

With regard to Childrens Services Healthier Together should achieve the following outcomes;
- Improve the health and wellbeing of CYP in Trafford - safe services based on best practice;
- Improve equality of access to high quality care - improved, timely access to appropriate staff, facilities and equipment;
- Improve CYP’s experience of healthcare services - integrated care provided in the most appropriate setting to provide better outcomes and experience;
- Make better use of healthcare resources - care provided by sustainable organisations that allow best possible use of the total resource available to the health and social care system in Trafford; and
- Shift, where appropriate, activity undertaken in hospital, to community settings.
Trafford Community Paediatric Model Review

There will be a review of the Trafford community paediatric medical service to ensure that it is able to provide an effective and efficient quality service to meet the changing community medical needs of the Trafford GP registered and/or resident population of children and young people, and to maximise its contribution to improving outcomes.

This service review will cover the breadth of provision including those referred with developmental paediatrics and disability, social paediatrics (including child protection), and educational paediatrics. It will also include analysis of hospital based paediatric activity to ascertain opportunities to redirect provision to the community paediatric medical service. This review will take place during 2014 and 2015.

The Trafford Community Paediatric Model review will achieve;

- Recommendations about more effective ways of working, service redesign opportunities, gaps in provision, opportunities to make best use of expertise and highly developed skills, and potential future investment (with a clear supporting rationale);
- Updating of the latest service specification, that clarifies the service offer; and
- Recommendations to update and/or amend other relevant service specifications and/or pathways, etc.
- Shift, where appropriate, activity undertaken in hospital, to community settings
- Reduction in bed nights and average length of stay for CYP with Long Term Conditions by 10%
- Reduce Urgent care attendances for CYP under 16 by 15%
- Reduce outpatient referrals for general paediatrics, ENT, dermatology and neurology by 15%
- Reduce Out
Trafford Children’s Community Nursing Team Review

We will review the Trafford Children’s Community Nursing Team (CCNT) to ensure that it is able to provide an effective and efficient quality service to meet the changing community nursing needs of the Trafford resident population (as per GM agreement) of children and young people, and to maximise its contribution to improving outcomes.

Full service review to cover the breadth of provision for those with mild / short term acute illness; long term chronic health needs or complex / palliative care requirements.

SPECIALIST MENTAL HEALTH INTERVENTIONS

Implementation of the specification will achieve the following outcomes;

- Seamless transition of care to adulthood
- Access to early identification and support for families
- Reduced incidents of behaviour that challenges
- Implementation of NICE quality standards
- Full implementation of national specification

Learning Difficulties

Implementation of all age learning disability specification across CYPS complex and additional needs service for Trafford registered children and young people aged 0 – 25.
Implementation will take place from 2014 and 2015. The expenditure in this area equates to £65,000 per annum.

Children’s and Young People IAPT Service

Implementation of children’s IAPT model for Trafford registered CYP up to age 18 is targeted to take place in 2015/16
Children’s and Young People urgent mental health assessment review

The review of CYP urgent mental health will enable;
- Reduced episodes of unnecessary admission for delayed assessments
- Timely and appropriate onward referral to specialist accommodation or community follow-up negotiated with social care
- Case co-ordination processes agreed with partners to reduce hand-offs
- Implementation of complex cases protocol with TMBC
- Reduction in T4 in-patient admissions for CYP currently open to CAMHS by 5%
- Fewer bed nights in T4 provision
- Fewer admissions for CYP currently open to CAMHS in the community
- Availability to children’s social care to commission flexible residential provision jointly with CCG

A full review of access to urgent mental health assessments for all Trafford registered CYP, particularly those deliberately self-harming, in Police custody and in an urgent care setting with an acute presentation will take place between 2015 and 2017.

Mental Health - Trafford Council
Review of T3 specialist CAMHS 2014-16

Review of T3 CAMHS will deliver;
- Increased capacity for specialist CAMHS to work more efficiently with CYP waiting for treatment
- Improved identification and treatment of neurodevelopmental disorders
- Improved post-diagnosis support and review
- Integrated eating disorder assessment and treatment provision
- Improved patient experience
- Increased self-care and self-management confidence
- Flexible access for CYP through weekend and evening provision
- 24/7 access to urgent psychiatry assessments for mentally unwell CYP
- CYP with an Autistic Spectrum Condition are assessed and diagnosed within 16 weeks
Step Up/Step Down CAMHS Model

Development of preventable admission (T4) models and commissioning of Step Up/Step Down child and adolescent mental health services model for Trafford registered patients 10 – 18. This development is targeted for 2014 – 2016

MIDWIFERY

Review of provision

To undertake a timely review of local ante-natal and post-natal midwifery provision to ensure that it is able to provide an effective and efficient quality service to meet the changing midwifery needs of the Trafford GP registered population, and to maximise its contribution to improving outcomes. To

The review of Midwifery will enable;
- Recommendations about more effective ways of working, service redesign opportunities, gaps in provision, opportunities to make best use of expertise and highly developed skills, re-commissioning and potential future investment (with a clear supporting rationale);
- Updating of the latest service specification and pathways of care, that clarifies the consistent core and additional service offer; and
- Recommendations to update and/or amend other relevant service specifications and / or pathways, etc.
- Reduction in late notification, identified single access point for ante and post natal care, and improved patient experience.
- Reduction in average length of stay and readmissions for neo-nates and infants with continuing health needs by 5%
- All midwifery bookings for vulnerable women are shared with health visiting by 20 weeks

The review of Perinatal pathways will enable;
- Increased identification of post-natal depression and enduring mental illness for women with children aged 0-2
- Increased parent child attachment through using evidence based tools early in an infant’s development
- Increased clinical expertise in child development
- Decreased referrals for specialist services at an older chronological age
- Decreased likelihood of an inpatient admission

consider opportunities to re-commission this provision.

Perinatal Pathway Implementation

2014/15 will see the implementation of a £40,000 annual investment in perinatal maternal and infant mental health clinical pathway across both acute maternity provider sites and between adult mental health services, Health Visiting and CAMHS for Trafford registered patients (women on an ante-natal or post-natal pathway and their infants and partner)
Children and Young People at Risk Safeguarding (CYP)

A review of the Trafford safeguarding (health) service will be undertaken to ensure that it is able to provide an effective and efficient quality service to meet the changing safeguarding needs of children and young people who normally reside in Trafford.

Vulnerable Children Posts

We will review of the Pennine Care (Trafford) specialist health posts that support vulnerable CYP to ensure that we are able to provide an effective and efficient quality service to meet the changing health and wellbeing (physical and mental) needs of this group.

Young Carers

Integrated physical and mental health checks for children and young people registered in Trafford, with identified caring responsibilities aged 6 - 18 will be carried out in collaboration with primary care.

The Safeguarding review will deliver;

- Recommendations about more effective ways of working, service redesign opportunities, gaps in provision, opportunities to make best use of expertise and highly developed skills, and potential future investment (with a clear supporting rationale);
- Updating of the latest service specification, that clarifies the service offer; an
- Recommendations to update and/or amend other relevant service specifications and / or pathways, etc.; and
- Make more efficient use of the wider safeguarding Reduction in out of borough placements and specialist CAMHS costs.

Young Carer health checks will provide;

- Investment of £15,000 per annum
- Improved access to community health provision for vulnerable CYP
- Reduced likelihood of urgent hospital attendance or admission due to improved self-care and early notification to health care professionals of health needs
- Early identification of poor physical health and poor mental health
- Integrated pathways of care developed to coordinate health interventions in a timely and effective way, in line with NICE guidance
PRIMARY CARE

This section illustrates some of the specific activity aligned to the delivery of Trafford’s Primary Care Strategy outlined earlier in this document.

KEY INITIATIVE

PRIMARY CARE CO-COMMISSIONING

In May 2014 NHS England wrote to CCGs inviting expressions of interest to develop new arrangements for co-commissioning of primary care.

Trafford CCG has been developing its integrated services for several years, and sees this opportunity to advance the implementation of its primary care strategy by securing new arrangements to advance the model of locality integrated care for the population, bringing together Primary Care and Community Health & Social Care.

Greater Manchester CCGs alongside the area team, for consistency, have defined four levels of co-commissioning as planning of primary care services, jointly designing and reviewing and managing contracts, delegated budgets for aspects for primary care contracts associated with contract management, and managing a devolved budget for local APMS/GMS/PMS contracts.

Trafford CCG has expressed an interest to co-commission at level four. The CCG sees advantages for patients and the local health economy in having greater decision making around how primary care services are delivered, the contractual arrangements, estates, the configuration of primary care providers, improved co-ordination with local authority services and enhanced services. Having new responsibility and arrangements to make local determination of these key enabler areas will be key in the implementation of the primary care strategy.

Primary Care Enhanced Out of Hours Access and Continuity

The development will build upon the current provision of general practice in Trafford and deliver enhanced access to primary care better suited to the needs to patients. This could mean enhanced access in early mornings, late evenings or on Saturday or Sunday. Linked to the development of locality federations of practices in Trafford, this could mean a locality provided resource for patients.

Through the CQC compliance programme patients in Trafford will be assured that their GP Practices will be delivering quality care.
Primary Care CQC Compliance Support Programme

The programme supports practices to improve the quality of service to patients by achieving compliance across the CQC care quality domains. The programme provides general practice with learning, intelligence, best practice examples, peer support and a portfolio of resources designed to improve quality, governance and safety of care for patients.

Primary Care community based care standards implementation

NHS England Greater Manchester local area team have developed a set of community based care standards designed to improve quality and safety, wellness and prevention, self care, independence and choice, care planning and multidisciplinary care, and access and responsiveness. This programme forms part of the strategy for primary care, and defines the metrics from which progress of the strategy will be measured.

Primary Care Performance

The CCG is responsible for ensuring that Practices offer high quality services for patients. In order to monitor progress and performance GP Practices are assessed in a number of ways each year and the results from these assessments will be brought together in one place through the development of the Primary Care Dashboard.

The dashboard will present information on the accessibility and availability of services, how well practices are identifying and helping patients manage their long term conditions and how patients rate the care they receive. Data will be collected from a number of sources and the scorecard will be updated and published on a regular basis.

The Primary Care dashboard will:
• Reduce inequalities and raise quality standards in primary care
• Highlight key areas for improvement
• Inform primary care initiatives and developments and share across the locality
• Reductions in the variance of performance between GP practices through benchmarking and sharing best practice
• Increased patient satisfaction which will be monitored through annual GP surveys
The CCG is responsible for ensuring that Practices offer high quality services for patients. Using intelligence sourced from the National GP scorecard, local GP Dashboard, Practice report, Medicines Mgt Prescribing data, peer review scheme and Enhanced service data the Primary Care Interface team will coordinate a Practice visit support Programme identifying and addressing issues specific to each practice in order to reduce variation and drive up quality across Trafford.

The Primary Care Interface Team will coordinate the visit schedule, while the Clinical Directors will lead discussions at the Practice meetings supported by the appropriate CCG department representative as appropriate. Representative from Contracts, Information, Finance, Primary care Interface, scheduled care and Meds Mgt will meet to interrogate the data prior to the visit so to identify the key areas requiring improvement. GPs and the Practice manager will be expected to attend to represent the practice.

Primary Care Disease Prevalence and Data Quality

QOF provides a framework for general practice which aims to promote clinically and cost effective care so to reduce the level of variation amongst practices and promote the delivery of high quality care across a range of areas.
Through monitoring disease prevalence across Practices it is apparent that Disease registers are not fully optimising the QOF clinical domains and not all patients are included within the QOF register and are therefore not benefiting from the evidence based interventions and review process.

Enhanced Services (Locally Commissioned Services from 1 April 2014)

Enhanced services are locally defined primary care services which incentivise GP practices to develop services and programmes of work which make a measurable contribution to NHS Outcomes, local needs assessment/evidence base and Trafford CCG commissioning priorities,

We will be reviewing current enhanced services for their effectiveness.

The enhanced services review will:
- Ensure the value for money and effectiveness of current enhanced services
- Allow for the development of locally commissioned enhanced services which address quality, capacity and demand pressures on primary and secondary care
- Unplanned Admissions Avoidance DES to deliver 2% increase in care plans in 2014/15
- Contribute to the 15% reduction in unplanned care through reducing unplanned admissions by 3.8% over 5 years

The Data Quality prevalence project will:
- Identify indicative patients without a diagnosis recorded
- Cleanse registers and improve data quality
- Improved chronic disease management
- Understanding of the variation on primary care service and quality across Trafford
- Highlight key areas for improvement
- Inform primary care initiatives and developments
- Reductions in the variance of performance between GP practices
- Increased patient satisfaction
- COPD – increase of 0.4% points (from 12/13 baseline) by 18/19
- CHD – increase of 0.37% points by 18/19 (from 12/13 baseline)
- Diabetes – increase of 0.47% points by 18/19 (from 12/13 baseline)
QUALITY

Trafford CCG recognises that strong clinical leadership and engagement is critical in improving quality and improving outcomes for patients.

With a challenging financial climate we will be increasingly more innovative utilising evidence based models to ensure sustained quality improvements for our population.

Through the Performance and Quality team we share with Manchester CCG’s we are strongly positioned to deliver effective scrutiny of the quality of care for our patients.

We will continue to incorporate the findings and recommendations of reports into the NHS and its failings in care working with our providers to ensure there is shared learning from these reviews.

During 2014 we will be refreshing our Quality Strategy and the implementation plan behind this incorporating strong metrics to enable us to monitor and measure success.

Patient Safety

The CCG has an ambition in the current quality strategy in relation to the development of an early warning system.

Trafford CCG has formed a Quality Surveillance Group with the three Manchester CCGs. The role of this group is to review this information and identify any actions needed to improve quality.

The refreshed quality strategy will be jointly developed with the Borough Council to:

- Develop shared values and aims
- Use contract levers with providers to encourage the use of evidence based improvement tools
- Identify how we can measure the culture of a provider and the effectiveness of their Leadership
- Develop quality dashboards to include data on complaints, staffing and safety and to extend their use to smaller providers
- Extend the use of walkrounds as visible, immediate assessments of services
- Build on our relationships with CQC, Monitor and TDA to identify and act on quality concerns as early as possible
- Allow for the development of locally commissioned enhanced services which address quality, capacity and demand pressures on primary and secondary care
The CCG has quality standards in all contracts. These cover areas such as safe staffing, culture, leadership, mortality etc. These are monitored on a quarterly basis with the providers and evidence on compliance against these is gathered in various ways such as the CCGs attendance at internal governance meetings, commissioner led walk rounds and formal reports. With the release of every new national review on quality or national strategy relating to quality the CCG requests providers to share their plan/strategy to address these.

**Patient experience**

Trafford CCG have well developed systems and processes for measuring patient experience. Patient experience is subjective and involves multiple factors. The development of the Friends and Family Test has helped the CCG gain a tangible feel for how patients experience care in the acute sector.

We will use the information from the Friends and Family Test gathered this year to give us an indication of patient experience in the acute providers. The CCG will use this as a baseline to measure, monitor and improve patient experience in this setting. This measure gives the CCG the ability to measure improvement in patient experience but will not be looked at in isolation.

All providers are required to work to address patient concerns and complaints and improve patient experience. To fully understand and improve patient experience all of this data needs to be looked at and analysed. This will be done as outlined in the CCG early warning system and Quality Surveillance Group and actions identified within this forum, these actions will then be scrutinised and agreed through the CCG Quality and Performance Committee and taken forward with our providers from there.
SYSTEM CHALLENGES

The CCG operates in a complex health economy and as a result, has identified a risk profile that it is required to manage through 2014/15 in the context of its strategic objectives as detailed under ‘risk management’. It will assess its risk into delivering the objectives of the CCG aligned to the achievement of its new 5 year Strategic Plan.

Significant challenges have been identified under the following categories:

**Strategic** - Whole system engagement is required to deliver the transformational health care economy changes, including social and health care across all aspects such as Primary, Community and Acute, as well as independent providers. The CCG believes it is well placed to move this forward as significant work has already been undertaken to address the buy in needed for integrated care delivery.

Strong Clinical and Non-Clinical leadership and buy-in from Primary Care via the CCG’s Council of Members ensure the CCG is able to contribute to deliver this whole system change.

**Commercial** - The CCG will be required to work within a constrained level of growth. As an economy with significant variation in health needs, this provides a challenge insofar as meeting the demands of people living longer with multiple co-morbidities, as well as addressing the health needs of the population with the health requirements as a result of inequalities in service provision.

Whole system engagement across the economy to agree and understand plans ensures that we can select the right care, at the right time, in the right place. Contracting management including any qualified provider as part of robust procurement processes are overseen by the Governing Body with assurance provided at the delegated Commissioning & Finance Committee.

**Operational** - Internal operational processes through delivery by the CCG, Commissioning Support Unit and the Shared Service of provider performance management, is challenging in delivering to the required outcomes.
Clinical quality consistent delivery is demanded by patients, and commissioning support is required to be effective, robust and yet flexible to respond to changes in the system and in partnership with other organisations including CCGs.

Service Level Agreements (SLAs) are in place with key performance indicators informing and providing assurance of the performance of the Commissioning Support Unit and Shared Services. The CCG through its own internal performance framework aligned to its commissioning strategic plan, aims throughout 2014/15-2018/19 to develop an ongoing formal understanding of its position moving forward.

Financial - Overall the financial requirements that the CCG is required to operate in delivering its commissioning plan are significantly challenging. The CCG will for example be required to deliver a Cash Releasing Efficiency Scheme (CRES) of approximately £20m whilst recognising the health CRES challenge of a further £60m plus across the local health care system. In addition to the health Quality, Innovation, Productivity and Prevention (QIPP) gap, there is approximately a £29m gap for Trafford Borough Council over the next 5 years. It is noted that transactional savings opportunities will be less in the future with an increased level of system understanding required to achieve further success.

There requires a clear understanding of improvements at scale to achieve the financial savings required in the Healthcare system. The CCG is engaged across the local Healthcare system to make this a reality.

Quality - Ensuring that the respective Healthcare reviews, such as Francis are implemented effectively, is crucial in ensuring that quality of services are developed and implemented at an effective level. Contracts with specifications on quality and safety have been implemented, putting into implementation the Quality Strategy of the CCG. Escalation processes have been developed for quality issues, with a dedicated delegated committee in the CCG; Quality and Performance, receiving quality updates on providers of the CCG linked to the service performance and the financial commitment. The Governing Body has overall oversight of quality reporting dashboards, providing assurance that quality is being implemented effectively in commissioned services.
Risk Management

Risk Management of the 5 year plan is key to the delivery of its constituent parts, with operational risk registers for each commissioning workstream; planned care, unplanned care, primary care, mental health, children’s services and across integrated care maintained, with high risks reported throughout the Governance structure for management intervention.

The Governing Body maintains its strategic risk Board Assurance Framework in delivering the overall vision of the plan, which works together with the operational registers to ensure that strategic risks operational gaps in control are mitigated effectively at commissioning scheme level, delivering improved outcomes for patients.

Strategic key risks and their mitigations include at the plan outset:

<table>
<thead>
<tr>
<th>Strategic Risk</th>
<th>Key Mitigations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ineffective and inefficient delivery of the Everyone Counts 5 Year Strategy, 2 Year Operational, Financial Plans and Better Care Fund</td>
<td>Governance Structure; Governing Body oversight and challenge, Senior Management Team design, Commissioning &amp; Finance Committee delivery, and Quality &amp; Performance Committee implementation and evaluation of plans Health &amp; Wellbeing Board Trafford health economy oversight Performance Management Framework</td>
</tr>
<tr>
<td>Services are not commissioned in a way that delivers integrated and innovative models of care</td>
<td>5 Year Strategy &amp; Vision, incorporating Better Care Fund with the Local Authority Health &amp; Wellbeing Board Trafford health economy oversight Integrated Care Redesign Board</td>
</tr>
<tr>
<td>Failure to appropriately communicate and involve the local Trafford population in the decisions of the CCG</td>
<td>5 Year Strategy &amp; Vision, incorporating Better Care Fund with the Local Authority CCG Communications &amp; Engagement Strategy ratified by Governing Body Public Reference &amp; Advisory Panel Patient Reference Group Services in Consultation processes</td>
</tr>
<tr>
<td>Patients are not able to receive care in the most appropriate setting</td>
<td>5 Year Strategy &amp; Vision, incorporating Better Care Fund with the Local Authority Estates Strategy</td>
</tr>
<tr>
<td>Failure to ensure appropriately governed partnerships for collaborative working are in place and delivering against CCG objectives and specified outcomes and therefore reducing health outcomes in the manner intended</td>
<td>5 Year Strategy &amp; Vision, incorporating Better Care Fund with the Local Authority Trafford CCG Constitution Health &amp; Wellbeing Board Trafford health economy oversight Association of Greater Manchester CCGs</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Major failure of a commissioned provider or services commissioned by a provider</td>
<td>Agreed 2014/15 contracts with providers Robust performance management arrangements and relationships with providers well established Integrated Care Redesign Board</td>
</tr>
</tbody>
</table>

Risks will be managed through the life of the strategic 5 year plan, in the context of the CCG’s strategic objectives.