Public Document Pack

AGENDA PAPERS MARKED 'TO FOLLOW' FOR

HEALTH SCRUTINY COMMITTEE

Date: Tuesday, 23 January 2018

Time: 6.30 p.m.

Place: Committee Rooms 2 & 3, Trafford Town Hall, Talbot Road Stretford, M32 0TH.

	A G E N D A	**PART I**	**Pages**
4.	**CQC LOCAL SYSTEM REVIEW**		1 - 64
	To receive a report from the Corporate Director of Children, Families and Wellbeing.		
6.	**CCG CHANGES IN SERVICE DELIVERY AND TRANSFORMATION**		To Follow
	To receive a presentation from the Interim Accountable Officer, Trafford CCG.		
7.	**TRAFFORD COORDINATION CENTRE**		To Follow
	To receive a presentation from the Interim Accountable Officer, Trafford CCG.		
8.	**SINGLE HOSPITAL SERVICE**		To Follow
	To receive an update from the Director of Strategic Projects, MFT.		
9.	**FRAIL AND ELDERLY PEOPLE AT TRAFFORD GENERAL**		65 - 68
	To receive an update from Dr Helen Hurst.		
10.	**HEALTHWATCH TRAFFORD UPDATE**		69 - 114
	To receive an update from the Chairman of HealthWatch Trafford.		

THERESA GRANT
Chief Executive
Membership of the Committee

Councillors J. Harding (Chairman), Mrs. P. Young (Vice-Chairman), Miss L. Blackburn, Mrs. J.E. Brophy, Mrs. A. Bruer-Morris, R. Chilton, Mrs. D.L. Haddad, J. Lloyd, K. Procter, S. Taylor, Mrs. V. Ward and M. Young (ex-Officio).

Further Information
For help, advice and information about this meeting please contact:

Alexander Murray,
Tel: 0161 912 4250
Email: alexander.murray@trafford.gov.uk

This agenda was issued on **Monday, 15 January 2018** by the Legal and Democratic Services Section, Trafford Council, Trafford Town Hall; Talbot Road, Stretford, Manchester, M32 0TH.

Any person wishing to photograph, film or audio-record a public meeting is requested to inform Democratic Services in order that necessary arrangements can be made for the meeting.

Please contact the Democratic Services Officer 48 hours in advance of the meeting if you intend to do this or have any queries.

Trafford CQC review

October 2017

TRAFFORD COUNCIL

NHS Trafford Clinical Commissioning Group

What is it?

- The additional Adult Social Care monies announced in 2016, to be allocated from 2017/18 onwards for 3 total years, were associated with an expected improvement nationally in Delayed Transfers of Care, especially the implementation of the High Impact Change Model for delayed transfers of care and the Trusted Assessor model
- The target for DTOC was set nationally as a result at 3.5%
- Trafford's allocation of funding was:

17/18 £4,073,044

18/19 £2,687,568

19/20 £1,335,021

- The funding announcement was accompanied with early warning that the 12 worst performing areas would be subject to a CQC review/inspection . Given Trafford's historic performance it was always likely we would be one of those areas
- It was confirmed in a Ministerial announcement in July that Trafford was going to be subject to an area review which has been set for October 16th 2017
- The review is exercised under the Secretary of State's Section 48 powers (Health and Social Care Act 2008, amended by the Care Act 2014) which means that the CQC can take enforcement activity to protect and safeguard if they feel the need to
- The aim of the reviews is described as to support improvement and identify focussed help. The areas expected to see improvement in:

How many people are waiting for discharge from hospital

How long are they waiting for discharge from hospital

Total level of Delayed Transfers of Care - target 3.5% of occupied hospital beds

Specifically they will focus on:

How people over the age of 65 move around the health and social care system, including delayed transfers of care

The experiences of people living with dementia as they move through the system but not residents with mental ill-health or learning disability

The 'pain points' across the health and social care system, in other words those areas where people experience hand-offs, delays and multiple processes

An assessment of commissioning across the interface of health and social care and governance and processes that accompany that

Their findings will be reported in a report/letter to the Health and Wellbeing Board and there will be an expectation that an action plan is developed to address recommendations

A national report will be published summarising all of the reviews in the New Year

Pressure or ‘Pain’ points:

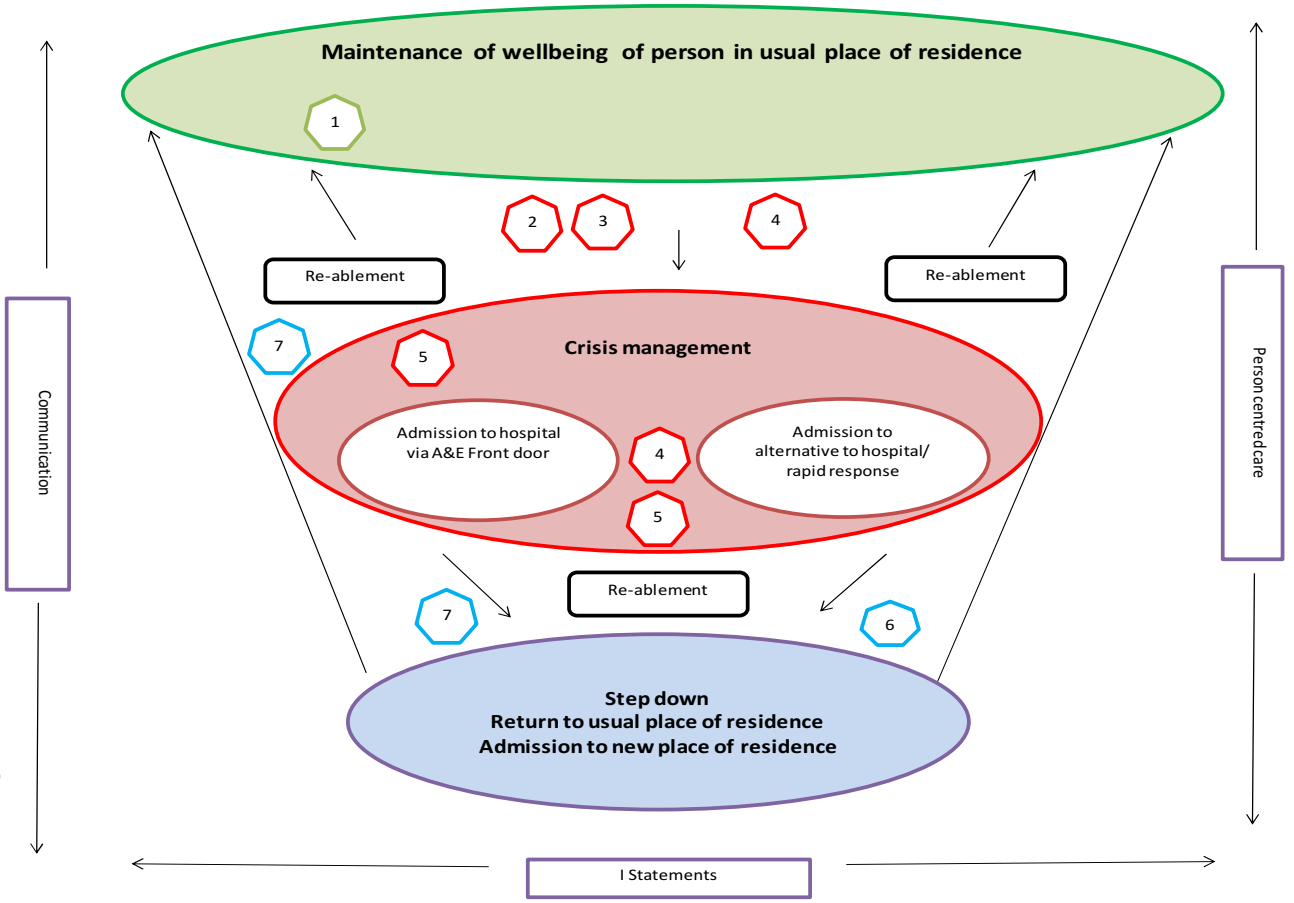
These are the areas the CQC feel are most challenged in the system:

1. Maintenance of peoples health and well being in their usual place of residence (in other words keeping people well at home)
2. Multiple confusing points to navigate in the system
3. Varied access to GP/ Urgent Care centres/ community care/ & social care
4. Varied access to an alternative to hospital admission
5. Ambulance transfers
6. Discharge planning delays and varied access to ongoing health & social care
7. Varied access to re-ablement

Areas of Focus to underpin KLOEs : Key system pressure points

Pressure Points:

1. Maintenance of peoples health and well being in their usual place of residence
2. Multiple confusing points to navigate in the system
3. Varied access to GP/ Urgent Care centres/ Community care/ social care
4. Varied access to alternative hospital admission
5. Ambulance transfers
6. Discharge planning delays and varied access to ongoing health & social care
7. Varied access to re-ablement



The 12 systems in the review nationally are:

ID	Authority	Council Type
1	Oxfordshire	County
2	Birmingham	City
3	Bracknell Forest	Borough
4	Coventry	City
5	East Sussex	County
6	Halton	Borough
7	Hartlepool	Borough
8	Manchester	City
9	Plymouth	City
10	Stoke-on-Trent	City
11	Trafford	Metropolitan Borough
12	York	City

The performance dashboard

ID	Indicators	What this indicates about the system	Full definition
1	Emergency Admissions (65+) per 100,000 65+ population	Can indicate how good collaboration across the health and care system is to support good management of long term conditions	(Emergency admissions for those with identified age (65+) resident in a local authority) divided by; (Local authority population 65+/100,000)
2	90th percentile of length of stay for emergency admissions (65+)	Longer lengths of stay can indicate poor patient flow out of hospital and hence downstream blockages	The 90th percentile length of stay following emergency admission. e.g. 10% of patients within a local area have a length of stay longer than X days.
3	TOTAL Delayed Days per day per 100,000 18+ population	This indicates how effective the interface is between health and social care and joint working of local partners	Average number of monthly delayed days (ALL) per day Divided by; (Local authority population 18+/100,000)
4	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	This captures the joint work of social services, health staff and services commissioned by joint teams, as well as adult social care reablement. Reablement services lead to improved outcomes and value for money across the health and social care sectors.	The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital.
5	Proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation services		The proportion of older people aged 65 and over offered reablement services following discharge from hospital.
6	Proportion of discharges (following emergency admissions) which occur at the weekend	This can indicate successful, joint 24/7 working leading to good flow of people through the system and across the interface between health and social care	Percentage of discharges (following emergency admission) at the weekend

The table below shows the rank of the systems under review compared to their 15 statistically similar nearest neighbours for each of the indicators.

Local Authority	Emergency Admissions (65+) per 100,000 of 65+ population	90th percentile of length of stay for emergency admissions (65+)	Total Delayed Days per 100,000 18+ population	Proportion of older people (65+) who were still at home 91 days after discharge	Proportion of older people (65+) who are discharged from hospital who receive reablement/ rehabilitation services	Proportion of discharges (following emergency admissions) which occur at the weekend
Birmingham	16	5	14	13	5	9
Bracknell Forest	8	13	13	16	9	8
Coventry	16	14	15	10	15	3
East Sussex	4	16	14	1	14	14
Halton	9	16	15	15	6	10
Hartlepool	10	13	14	7	9	13
Manchester	16	10	11	16	6	8
Oxfordshire	9	1	16	9	8	4
Plymouth	3	7	16	8	5	14
Stoke-on-Trent	15	7	16	12	16	9
Trafford	14	15	16	1	10	6
York	12	8	11	15	12	15

Timeline for the review

- Formal notification 31st July 2017 to Theresa Grant
- 6 week in advance we receive confirmation of the date and a formal request to complete the *Local System Overview Information Request (LSOIR*)– expect on the **4th September**
- We will also get a *System Contact form* request to tell CQC who are key partners are so that they can contact them in advance. This will need to be submitted earlier than the LSOIR
- Deadline to submit data and the LSOIR - **25th Sept**
- There may be a set up meeting with them the week commencing the 25th September - TBC
- Review week on site **16th October**
- Feedback on 5th day (20th October)
- Full report to Health and well being board –**17th November**

Key lines of enquiry

Whilst on site the CQC will use their 5 domains to assess our performance and effectiveness:

- Safe – how are people using services supported to move safely across health and social care to prevent avoidable harm?
- Effective – how effective are health and social care services in maintaining and improving health and wellbeing and independence?
- Caring – do people experience a compassionate, high quality and seamless service across the system which leaves them feeling supported and involved in maximising their wellbeing?
- Responsive – to what extent are services across the interface between health and social care responsive to people's individual needs?
- Well led – is there a shared clear vision and credible strategy which is understood across health and social care interface to deliver high quality care and support?

Evidence needs to be gathered against those 5 domains

CQC outline on-site timetable to develop

- **Day 1: Focus groups**
- Commissioning staff
- Provider staff (across broad groups)
- Social workers and OTs
- People using services, carers and families
- Third sector
- **Day 2-3: Interface pathway interviews**
- Focus on individuals' journey through the interface through services (with scenarios) and case tracking/ Dip sampling
- **Day 4: Well-led interviews**
- Senior leaders
- Sense check with nominated people from key partners
- **Day 5: Final interviews, mop up and feedback**

Provisional outline for the on-site activity

Day 1	AM	Lunch	PM	PM+
Monday 16th October 2017	9am – 9.30am Arrive 10-11.00am **Focus Group 1** 11-11.15am Break 11.15am – 12.15pm **Focus Group 2**	Venue Time 12.30pm – 1pm	1pm – 2pm **Focus Group 3** 2pm – 2.15pm **Focus Group 4** 2.15pm – 2.30pm Break 2.30pm – 3.30pm **Focus Group 5**	

Focus Group composition

- 1: Commissioning from LA & CCG
- 2: Operations -
- 3:
- 4:
- 5:

Day 2	AM	Lunch	PM	PM+
Tuesday October 2017		Venue Time 12.30pm – 1pm		Out of hours?

- Ascot?
- UHSM
- TGH

Day 3	AM	Lunch	PM	PM+
Wednesday 18th October 2017		Venue Time 12.30pm – 1pm		Out of hours?

Sale Waterside – case file audit
3 conversations?

Day 4	AM	Lunch	PM	PM+
Thursday 19th October 2017	Well led interviews	Venue Time 12.30pm – 1pm	Well led interviews	

System leaders:
Theresa Grant
Sean Anstee
Stephen Anstee
John Lamb – chair of H&WB
Jill Colbert
Cameron Ward
Richard Spearing
PCFT?
Ian Williamson/Carolyn Kus
Salford - ?
Eleanor Roaf
Karen Ahmed
Healthwatch
Age UK?
Housing?

GMFRS
Darren Banks/Silas Nichols

Day 5	AM	Lunch	PM	PM+
Friday 20th October 2017	Further final interviews – all to be available	Venue Time 12.30pm – 1pm	N/A	

This page is intentionally left blank

Trafford

Local system review report

Health and wellbeing board

Date of review:
16-20 October 2017

Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and for Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives the Care Quality Commission (CQC) the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

The review team

Our review team was led by:

- Delivery Lead: Ann Ford, CQC
- Lead reviewer: Rebecca Gale, CQC

The team included:

- Three CQC reviewers
- One CQC analysts

- One Pharmacy Inspector
- Two CQC Inspectors
- One CQC Expert by Experience
- Four specialist advisors (two current Directors of Adult Social Services, one Clinical Commissioning Board member and a former National Director).

How we carried out the review

The local system review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on **older people aged over 65**.

We also focussed on the interface between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across three key areas:

1. Maintaining the wellbeing of a person in usual place of residence
2. Crisis management
3. Step down, return to usual place of residence and/ or admission to a new place of residence

Across these three areas, detailed in the report, we have asked the questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?

We have then looked across the system to ask:

- Is it well led?

Prior to visiting the local area we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We requested the local area to provide an overview of their health and social care system in a bespoke System Overview Information Request (SOIR) and asked a range of other local stakeholder organisations for information.

We also developed two online feedback tools: a relational audit to gather views on how relationships across the system were working, and an information flow tool to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care.

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as people who use services, their families and carers. The people we spoke with included:

- Senior leaders and managers from Trafford Council (the local authority), NHS Trafford Clinical Commissioning Group (the CCG), Manchester Health and Care Commissioning (MHCC), Manchester University NHS Foundation Trust (MFT – previously Central Manchester NHS Foundation Trust and University Hospital South Manchester NHS Foundation Trust), Salford Royal NHS Foundation Trust (SRFT) and Pennine Care NHS Foundation Trust (PCFT)
- Health and social care professionals including social workers, GPs, discharge teams, therapists, nurses and commissioners
- Healthwatch Trafford and voluntary and community sector (VCS) representatives
- Representatives of health and social care providers
- People using services, their families and carers at the Carers Centre, Fiona Gardens and a dementia day centre run by Age UK. We also spoke with people in A&E, the discharge lounge and visits to intermediate care facilities

We reviewed 20 care and treatment records and visited 11 services in the local area including acute hospitals, intermediate care facilities, care homes, domiciliary care providers, GP practices, extra care housing, the Urgent Care Centre, out-of-hours GP and the Trafford Co-ordination Centre.

The Trafford context

Demographics

- 16% of the population is aged 65 and over.
- 86% of the population is categorised as White.
- Trafford is in the 20-40% least deprived local authorities in England.

Adult Social Care

- 42 active residential care homes:
  - 23 rated Good
  - 13 rated Requires improvement
  - 2 rated Inadequate
  - 4 currently unrated
- 21 active nursing care homes:
  - 9 rated Good
  - 10 rated Requires improvement
  - 2 currently unrated
- 36 active domiciliary care agencies:
  - 16 rated Good
  - 13 rated Requires improvement
  - 7 currently unrated

GP Practices

- 32 active locations
- 2 rated Outstanding
- 28 rated Good
- 1 rated Requires improvement
- 1 currently unrated

Acute and community Healthcare

Hospital admissions (elective and non-elective) of people of all ages living in Trafford LA were almost entirely at the following NHS acute hospital trusts:

Central Manchester University Hospitals NHS Foundation Trust (RW3)

- Received 46% of admissions of people living in Trafford LA
- Admissions from Trafford made up 18% of the trust's total admission activity
- Rated Good overall.

The second main trust is University Hospital of South Manchester NHS Foundation Trust (RM2)

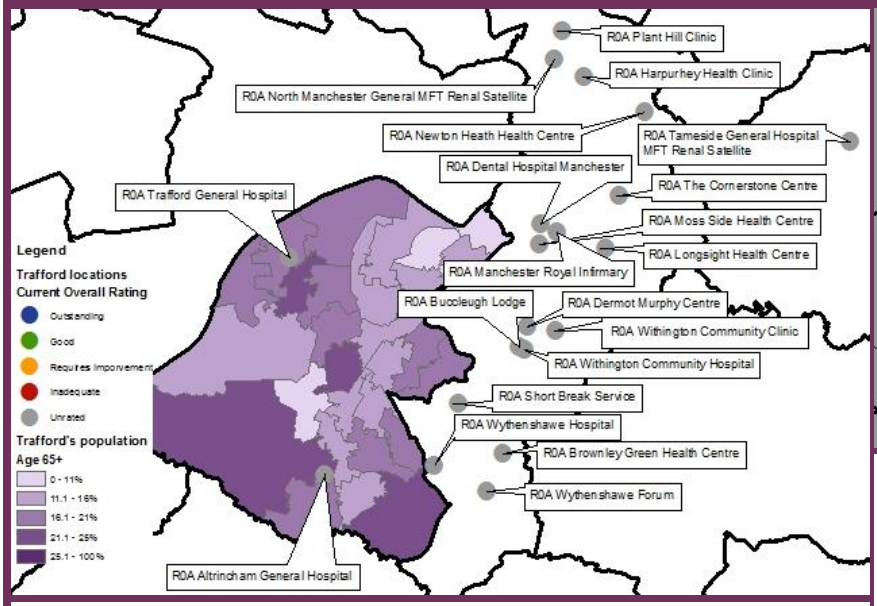
- Received 45% of admissions of people living in Trafford LA
- Admissions from Trafford made up 29% of the trust's total admission activity
- Rated Requirement improvement overall.

These two trusts have recently merged to create Manchester University NHS Foundation Trust (R0A).

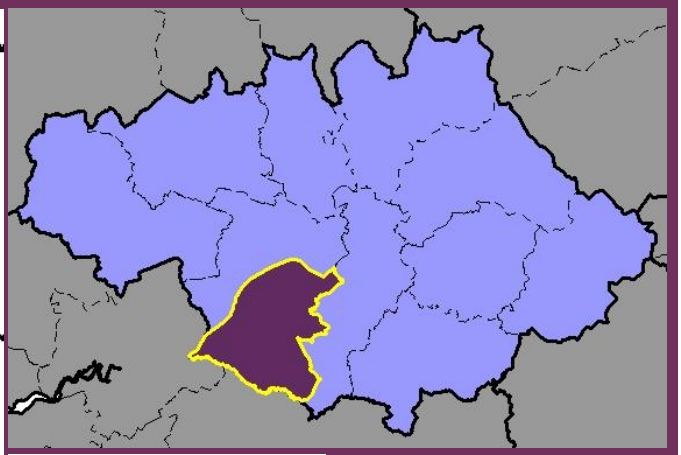
Community services are provided by:

- Pennine Care NHS Foundation Trust (RT2) - currently rated Requires improvement overall

All location ratings as at 29/09/2017. Admissions percentages from 2015/16 Hospital Episode Statistics.



Map 1: Population of Trafford shaded by proportion aged 65+ and location of services provided by the main acute trust for Trafford (R0A). Due to the recent merger, locations under this new trust are listed as Unrated. Community locations provided by RT2 aren't mapped as they cover a larger geographic area.



Map 2: Location of Trafford LA within Greater Manchester STP. Trafford CCG is also highlighted.

Summary of findings

Is there a clear shared and agreed purpose, vision and strategy for health and social care?

- There was system-wide commitment to serve the people of Trafford well. Trafford was on a journey of transformation and integration to achieve the strategic vision. The CCG and local authority were due to become fully integrated as commissioners by 1 April 2018 and there were governance structures in place to facilitate this transformation.

- The New Health Deal (NHD) for Trafford in 2012 was a programme of transformation of out- of-hospital services to ensure future viability. This incorporated the redesign of Trafford General Hospital (TGH) from an A&E site to a nurse-led urgent care centre and minor injuries unit, as well a site for day case surgery, some specialist elective procedures and an older person medical assessment unit.

- The context of Greater Manchester (GM) and the devolution of power provides a unique opportunity to transform the health and social care landscape. The Greater Manchester Health and Social Care Partnership is the vehicle for transformation across the GM-wide health and care system. The GM *'Taking Charge Implementation and Delivery Plan*,' set out a compelling and powerful vision for the future of health and social care services. This vision clearly set out what it would deliver for the people of Greater Manchester, and its localities including Trafford. Secondary care was also in transformation with recent hospital mergers and the vision for a single hospital service provided the opportunity for change.

- There was a clear line of communication and accountability from the Greater Manchester Health and Social Care Plan to Trafford. The Trafford Locality Plan and associated Transformation Bid (the Trafford case for transformation and associated transformation funding) were aligned to the priorities and strategic objectives of the wider conurbation, but were specific to the Trafford area, informed by the Trafford Joint Strategic Needs Assessment (JSNA).

- The Transformation Bid from Trafford set out the vision for a new model of integrated community care, mental health services, primary care and social care services to underpin the establishment of a Local Care Organisation (LCO), which would come into shadow form in April 2018. Trafford was earlier on in its journey compared to some other areas in Greater Manchester and system leaders should take the opportunity to see how contractual arrangements are being developed with other LCOs in GM.

Is there a clear framework for interagency collaboration?

- Historical relationships had been challenging across the system and there had been a significant amount of change among system leaders. Relationships were now improving and system leaders described the transformation agenda as the opportunity and accelerator for addressing systemic challenges and cultural issues. There was a shared understanding of the challenges, and a willingness to work together to achieve solutions.

- Manchester Health and Care Commissioning (MHCC) was the agreed GM lead commissioner for acute care, but Trafford system leaders felt their voice was heard in the wider system, despite their relatively smaller 'purchasing power'. To maintain influence, Trafford should continue to ensure that their relationships with secondary care providers remain collaborative and effective. This is critical for improvements to be realised across the system.

- A section 75 agreement had been in place between the local authority and Pennine Care NHS Foundation Trust since 1 April 2016 to provide all-age health and social care community services. Joint commissioning arrangements existed between the CCG and local authority with regards to the voluntary sector, Ascot House (intermediate care facility) and children's community services and they had developed joint working principles ahead of the planned merger when they would form a single commissioning function.

- There was evidence of some risk sharing between partners. For example, the CCG and the local authority had proceeded at risk to implement some of the proposals outlined in the Transformation Bid. However, commissioning was collaborative rather than joint and the system needs to push forward with the transformation agenda through joint commissioning.

How are interagency processes delivered?

- The challenge for this system was to transform services while also delivering improvements to ensure people were cared for in the right place, at the right time, by the right person. While there had been some significant improvements in performance over the past year, it was from a low base and the system's ability to cope with periods of surge in demand was uncertain.

- Governance structures were aligned to the Greater Manchester model and supported partnership working. A high level of scrutiny and challenge was provided by the Greater Manchester assurance process, but the role of Trafford's Health and Wellbeing Board and Scrutiny Board (the health overview scrutiny committee) needs to be strengthened.

- There was interagency collaboration at a high level, but frontline delivery of services was

still siloed. There was a complex service landscape and much of the High Impact Change agenda needed to be implemented, including seven day services and the use of trusted assessors. Strict admission criteria meant Ascot House was not working at capacity and some work was required to engage staff, provide clarity about the purpose of the service and encourage appropriate referrals.

- There were mechanisms in place to consult with wider system partners, including providers and voluntary sector organisations. However, the extent to which they felt like partners varied and there were missed opportunities to include and maximise providers' contributions.

What are the experiences of front line staff?

- System leaders and senior managerial staff were visible, engaged and had an overview of system performance. However, staff were not always clear who held the overall responsibility performance at a system level. Escalation channels were organisation-based and although issues were being escalated, there was mixed feedback from staff on whether this led to change.

- The degree to which frontline staff could articulate the system's vision varied and was often in the context of their own role rather than the wider system. There was a perception that staff were working to competing priorities, often dictated by sector-specific budgets and targets. There was a lack of trust across the health and social care interfaces, which was a legacy of historical cultural issues within the system.

- Front-line staff were committed to providing high quality, person-centred care. We saw some good examples of multi-disciplinary working. However, the system was multi-faceted and not yet working operationally in an integrated way across the health and social care interface. The capacity of individual teams was not always sufficient to keep up with demand.

- Staff reported there were multiple and confusing points to navigate the system and they did not always know who they could contact or which services they could refer into. There was limited evidence to date to demonstrate the effectiveness of the Trafford Co-ordination Centre (TCC). The TCC aimed to provide a single patient register of those identified most 'at risk' to remotely co-ordinate their care and keep them well in the community by anticipating any interventions required.

What are the experiences of people receiving services?

- The experience of people receiving health and social care in Trafford was varied.

- If a person received a reablement service they achieved positive outcomes and were more likely to remain independent and at home. There were effective arrangements in place to provide equipment to people swiftly and community-based therapy services were responsive to referrals.

- However, there were also missed opportunities to support people to stay in their usual place of residence and prevent admissions to hospital. Primary care provision and GP access varied across the borough and information and support was not always easily accessible. In the first quarter of 2016, A&E attendances and emergency admissions from care homes were higher than average. A recent data refresh showed that emergency admissions from care homes had moved to being lower than comparator areas and the England average. However, the actual numbers of admissions from care homes were as high as they were the previous year and an increase in national averages overall had reduced the gap. People were being admitted with conditions that potentially could be cared for in the community, such as urinary tract infections.

- If a person went into crisis, data showed they were likely to be admitted to hospital and experience longer lengths of stay due to a shortage of homecare packages and affordable, high-quality residential and domiciliary care.

- The implementation of the personalisation agenda was underdeveloped. Very few people were in receipt of direct payments or personal health budgets and while there were innovation sites using the 'three conversations' model, commissioning and contractual arrangements were traditional with a time and task focus.

- Providers and people who used services were extremely negative about the continuing healthcare (CHC) process in Trafford in terms of the assessment process and timely provision. There had been an injection of resource into the CHC team and data showed there had been some significant improvements to performance in recent months. Work was required to improve relationships and the negative perceptions.

Are services in Trafford well led?

Is there a shared clear vision and credible strategy which is understood across health and social care interface to deliver high quality care and support?

As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, multi-

agency and multidisciplinary working and the involvement of people who use services, their families and carers.

There was a shared clear vision and credible strategy for Trafford, which was aligned to the overarching vision for Greater Manchester. This was well articulated by leaders and there was a real commitment across system partners to deliver together; integration was the vehicle to achieve this. Historically there had been some challenging relationships, but these were improving. Staff at all levels were committed to achieving better outcomes, centred around the person and although there was a will to work more collaboratively they were frustrated by the number of barriers in the way. There were some missed opportunities to involve wider system partners in joint delivery plans, specifically around winter pressures which could have been addressed with a more cohesive, system-wide approach.

There were pockets of integrated working arrangements already in in place. The strategic vision for Trafford included establishing a Local Care Organisation to provide the foundations of integrated provision, consistent with the GM-wide vision. These needed to be built upon and expanded at pace with a shift of focus to delivery.

Strategy, vision and partnership working

- System leaders acknowledged that historically some relationships had been challenging, which had resulted in silo working, a culture of blame and a lack of shared responsibility in relation to performance. There had been some recent changes to senior personnel and organisational structures in the system. Relationships within Trafford and between statutory bodies were improving and integration was the vehicle to making the strategic vision a reality. However, we found varying progress in implementation of effective partnership working across different levels of the system. Leaders that we spoke to recognised there was work to be done to integrate delivery, through system transformation.

- The Greater Manchester Sustainability and Transformation Plan, *'Taking Charge Implementation and Delivery Plan'* set out a compelling and powerful vision for the future of health and social care provision and new models of care. Developed in partnership with 37 NHS organisations and local authorities, it clearly outlined what it hoped to deliver for the people of Greater Manchester. The GM STP was rated category 2 – advanced in the July STP progress dashboard.

- A key deliverable of the Greater Manchester Plan was the development of a single hospital service which saw the merger of Central Manchester NHS Foundation Trust and University Hospital South Manchester NHS Foundation Trust to form Manchester University NHS Foundation Trust on 1 October 2017. There was universal support for this change from the

senior staff, voluntary sector organisations and providers we spoke with in the hope it would improve performance and consistency in people's experiences.

- There was a clear line of sight between the Greater Manchester STP, set out in the *'Taking Charge Implementation and Delivery Plan',* and Trafford's vision and strategy, set out in the Trafford Locality Plan and Transformation Bid, which was well understood and articulated by system leaders. These outlined the approach to providing integrated, co-commissioned services with a place-based and community-asset focus to deliver on the vision of *"A sustainable health and social care system which aims to help older people be healthy, independent and enjoy living in Trafford".* The strategic vision for Trafford focused on prevention and early intervention, outlining proposals for new models of community care, underpinned by the Local Care Organisation which would be coming into shadow form in April 2018.

- A section 75 Partnership Agreement had been in place between the local authority and PCFT since 1 April 2016 to provide community services via integrated health and social care teams within each of Trafford's four localities. Feedback from front line staff and senior leaders about this service delivery model was positive. Leaders described how the partnership agreement had led to effective working relationships with high levels of trust and thought it was something to be replicated across the system.

- Partners had agreed and signed of a joint plan for the Better Care Fund (BCF) within the deadline and the Improved Better Care Fund (iBCF) submission for Trafford was aligned with the Transformation Bid. System partners were working together to begin to implement the changes in the High Impact Change Model, one of the national conditions for the BCF. The rate of delayed transfers of care had started to improve, but much more needed to be done. Commissioners told us they were modelling future commissioning arrangements around the High Impact Change Model, but the extent to which this had been achieved was limited. For example, trusted assessors were being piloted in pockets, but not used widely. Some discharge to assess beds had been established, but seven day services were not operating across the system.

- There was awareness among system leaders of the shared challenge to reduce the causes of delayed transfer of care (DTOC). Data showed the whole system had made improvements to the length of stay and number of DTOC, but the latter remained considerably higher than average. At the time of our review there were 11 empty beds at Ascot House (an intermediate care facility), but on 16 October 2017 there were 39 people at Trafford General Hospital waiting to be discharged. Ascot House had dedicated GP input for approximately five hours a day, yet the service was supposed to be for medically

optimised people. We were advised that a review of the admission criteria was underway, but this should be concluded as a matter of urgency to ensure that services across the system are being used effectively and that people are being cared for in the most appropriate facility for their needs.

- A review was carried out by the Emergency Care Improvement Programme in 2017. This is a clinically led programme provided by NHS Improvement to provide practical advice and support to improve patient care and flow. As a result, a Head of Patient Flow had recently been appointed at Wythenshawe Hospital. A Community Flow Manager was due to begin work in November 2017. Although there was a clear ambition, there lacked a robust, system-wide response to the contributing factors to DTOC, such as managing capacity issues in the Homecare market. People from across the system told us issues were not being tackled with sufficient urgency to prevent a potential crisis.

- Trafford's plan for winter was presented and signed off at the Greater Manchester Urgent Care Board during the week of our review. The Trafford plan was aligned to Manchester's and had been developed jointly due to shared resilience plans around acute care. However, there was some confusion evident at strategic and operational level relating to the status of the plan. Some groups reported they had only recently been asked for their input, some had been asked to submit their organisation-level plans and others reported they had not been involved at all. Some system partners felt the plan was late, had not been adequately stress tested and was not a systematic approach.

- The system reported that they worked collaboratively with providers, housing partners and voluntary sector organisations. They had commissioned Healthwatch Trafford to undertake a system-wide review of intermediate care and were in discussions with extra care housing providers regarding winter capacity. While there were structures in place to facilitate engagement, there was not a single, coherent approach to working with other partners. Providers and VCS organisations felt the system was well-meaning, but some felt their input was a 'tick-box exercise' and there was a top-down approach to issues such as winter planning and managing delayed transfers of care. Commissioners told us they recognised the potential of VCS organisations in preventative work and the need to learn from previous years and engage with them earlier on, in a more flexible way. However, the plan for winter had already been signed off by the Urgent Care Board, while a meeting with the voluntary sector to discuss winter resilience was planned, but had not yet taken place.

Involvement of people who use services, their families and carers in the development of strategy and services

- The Trafford Partnership, chaired by the leader of Trafford Council, brought together organisations across the public, private, voluntary, faith and community sector and local residents and was the system's Local Strategic Partnership to deliver on the 'One Trafford' vision which aims to make Trafford a place where residents achieve their aspirations and communities thrive. There was a clear line of communication and accountability to Greater Manchester through Trafford's governance structures and Health and Wellbeing Board.

- The response to the System Overview Information Request (SOIR) described the approach to public engagement to ensure commissioning and service planning was based on the needs of Trafford residents. The local authority's approach was underpinned by a strategy, *'Building Strong Communities'* and the Trafford Partnership. Engagement approaches varied from targeted events to help shape the Care at Home vision and commissioning priorities, Locality Partnership Events to empower communities through funding and support; to engagement of the VCS via an umbrella organisation. Thrive Trafford had been commissioned by the local authority to establish a voluntary/ community/social enterprise (VCSE) strategic forum to bring together VCS providers, commissioners and other public service representatives to discuss issues including health and social care integration and isolation of older people. Positive outputs from these events have included a social isolation project delivered by the fire service and health walks from GP practices.

- System leaders were committed to involving service users, carers and their families in the strategic approach and a series of public and partner engagement events had been held in relation to the Transformation Bid. However, it was acknowledged that more targeted engagement was needed going forward to ensure service design proposals were co-produced. While there were mechanisms in place to obtain feedback from people, these were often focused at service or provider level rather than capturing their experience of the entire pathway.

- We received mixed feedback from some VCSE providers on how valued they felt as system partners in the planning and delivery of services, including planning for winter pressures. They felt underutilised by the system and that they had a lot to offer in relation to keeping people well at home. The VCSE organisations reported there used to be regular meetings with the local authority, but these had become fragmented. Concerns were also raised about the tender process and a lack of transparency around funding decisions following several short-notice contract terminations two years ago. Following our review, the system told us these contracts had not been part of the delayed transfer of care agenda and were a historic procurement issue. The local authority led joint commissioning arrangements with the CCG, including the Carer's Centre and children's community services.

- It was recognised by the partnerships team at the local authority that there was a need to bring together health and social care contracts. We were told some 2017/18 VCSE winter resilience scheme monies were being used to work with VCSE organisations to develop innovative ideas.

Promoting a culture of inter-agency and multi-disciplinary working

- The Trafford Locality Plan, Transformation Bid and existing section 75 agreement between the local authority and community care provider PCFT, provided the foundations for inter-agency and multi-disciplinary working. The local authority and the CCG will be fully integrated commissioners by April 2018 and there were joint working principles already in place. We found some positive examples of staff working in an integrated way to commission and deliver services.

- All staff we spoke with during the week of our review expressed a will to work more collaboratively and although we saw some examples of staff working in an integrated way, these were often dependent on individual relationships and not always facilitated by the system. Frontline staff were frustrated by the barriers to inter-agency working. These included technological barriers, a lack of clarity about services available, duplication of efforts and a lack of trust or competing priorities between organisations. Frontline staff were highly focused on delivering high-quality care, focused on the needs of the person.

- Our analysis of 2015/16 Hospital Episodes Statistics (HES) data showed prior to the creation of Manchester University NHS Foundation Trust, 45.7% of admissions of people of all ages from Trafford went to Central Manchester NHS Foundation Trust (CMFT), 45.1% went to University Hospital of South Manchester (UHSM) and 6.9% went to Salford Royal NHS Foundation Trust. Additional information supplied by the system indicated that UHSM received a greater proportion of admissions of Trafford's older population. Admissions from Trafford made up 18% of CMFT's admission activity and 29% of UHSM's, so the system's purchasing power was less than others particularly as they did not commission services directly.

Learning and improvement across the system

- There were a variety of forums where quality and performance were monitored and discussed, but more evaluation and sharing of lessons learned across the system was needed. At the time of our review there were multiple pilots and concept testing programmes underway prior to system-wide roll-outs. Learning from these pilots was

shared with system leaders to demonstrate the impact they were having, but it was not systematically being cascaded to reach wider system partners or frontline staff at this stage. The system needs to work at pace to collate and implement the learning to drive improvement.

- Across the system, newsletters were used to share learning and feedback with staff. However these were for organisational news and there was not a system-wide mechanism for cascading messages to incorporate all partners. For example, staff reported they did not always receive feedback on incidents raised or whether there were common themes identified through safeguarding investigations.

- Social care providers reported there had historically been forums where they could feedback to the local authority, but all that existed currently were contract monitoring meetings. Following our review, the local authority told us there were fora available to providers, namely service improvements partnerships. Work was required to ensure these were well-known among commissioned services. There were plans in place to develop a Greater Manchester provider forum, but this had not been established at the time of our review.

- There were missed opportunities to ensure there was system-wide learning and improvement. The system could benefit from making sure there are opportunities to come together and discuss challenges, evaluate the effectiveness of initiatives and generate shared solutions.

What impact is governance of the health and social care interface having on quality of care across the system?

We looked at the governance arrangements within the system, focusing on collaborative governance, information governance and effective risk sharing.

Providers and commissioners across the health and social care interface had governance systems and processes in place to assess, monitor and mitigate risks. There were three levels of governance to support the planning and delivery of integrated care, reporting upwards from the local system to Greater Manchester Health and Social Care Partnership Governance structures within the Trafford system and with Manchester Health Care Commissioning were aligned with those of Greater Manchester and provided a mechanism to ensure consistency in performance monitoring.

System leaders felt the level of assurance required at both Greater Manchester and national levels was burdensome at times, but this was outweighed by the benefits of a shared

endeavour. Data and intelligence monitoring was shared across the system and reviewed daily at a senior level, but there needed to be more evaluation to drive improvements at pace. The Chairs of the Health and Wellbeing Board and of the Scrutiny Board acknowledged that the challenge functions of these bodies were not being used effectively. While risks were being escalated at every level, it was not always clear who held overall accountability for them.

Overarching governance arrangements

- There were three levels of governance to support the planning and delivery of integrated care:
    - the local level – locally commissioned services and BCF governed through local commissioning accountabilities, HWBB and CCG, and through local providers;
    - the wider system level (e.g. urgent care delivery board joint with Manchester, and Manchester Health and Social Care Commissioning as lead commissioner for acute care; and
    - the Greater Manchester level through the Health and Social Care Partnership Board (HSCPB) and Joint Commissioning Board.

- Governance structures within Trafford mirrored those across Greater Manchester with local representation on the GM Health and Social Care Partnership Boards and there was a clear line of communication and accountability between the two, with vertical and horizontal reporting structures. Trafford's Integration Board, Joint Commissioning Board and Urgent Care Board worked alongside each other and reported to the local authority's executive boards as well as through to GM assurance structures. Although the level of assurance submitted to the GM HSCPB felt burdensome at times, this was outweighed by the benefits. System leaders felt the collaboration and supportive network facilitated by GM provided a unique, innovative accelerator for change. Trafford system partners need to continue to ensure their voice in the partnership; that the priorities set by GM remain relevant to the Trafford local area and that support is drawn from other areas where local challenges are identified.

- The Trafford Urgent Care Board provided the practical arrangements to deliver the vision for integrated health and social care pathways relevant to urgent care across Manchester and Trafford and set out strategic aims via a jointly developed and agreed project plan, providing oversight for implementation progress. This was attended by key system partners.

- There was a transparent approach to sharing of management information across the health and social care interface. There were some agreed performance metrics set by GM in relation to flow and performance dashboards were in place. However, there were no integrated metrics between health and social care and monitoring was based on traditional performance indicators. We were told that work was underway to develop system-wide universal outcome measures. SRFT had developed a set of agreed, integrated metrics and Trafford could look to wider partners to see if these could be replicated within their system.

- Local authority leaders were visible and engaged. They were aware of the challenges faced by the system and were sighted on performance, but some were relatively new in post. Leaders reported positive working relationships despite political tensions in the past and there was a shared vision for the future.

- Although there was a significant amount of monitoring and measuring, there needs to be more evaluation. The Scrutiny Board's challenge function was underutilised; the Chair told us they were given verbal assurances by system leaders that performance was improving and pilots were producing positive outcomes, but there was a lack of data to evidence it. The Health and Wellbeing Board Chair had taken up the post two months prior to our review. There was an acknowledgement the Health and Wellbeing Board would benefit from a strengthening of its oversight and challenge function in relation to the transformation agenda. Work was already underway at the time of our review to facilitate this.

Risk sharing across partners

- There was a shared view of risks across the system. These were managed in different forums depending on commissioning arrangements. For example, primary care performance was monitored by the CCG Governing Body and social care risks and quality performance were overseen by Joint Quality Monitoring meetings. There was little evidence of shared risk management outside of these arrangements.

- The Trafford system was early on in its journey to integration of health and social care. At all levels it was acknowledged there was some isolated working, but there was a will by system leaders to respond to risks collaboratively. Prior to the Transformation Bid being approved, the CCG and local authority had proceeded 'at risk' to implement some elements of the proposed schemes to prevent delay. For example, increasing capacity of reablement services in the community.

- Staff at all levels had clarity about their roles and responsibilities, but this varied in relation

to inter-agency working. Staff were able to describe the governance structures in place to identify, record and escalate risks appropriately within their organisations. While system leaders were clear about their accountabilities, staff at other levels were not always aware of who was ultimately responsible for performance and risks at a system level. For example, in relation to DTOC or winter pressures.

Information governance arrangements across the system

- The Trafford Locality Plan outlined the importance of adopting a universal approach to sharing information across health and social care to meet its strategic objectives and there were a number of information sharing agreements in place across the health and social care interface.

- The Trafford Co-ordination Centre (TCC), described by the system as “air traffic control”, aimed to provide a single patient register of those identified most ‘at risk’ to remotely co-ordinate their care. The TCC had signed up all Trafford partners to an information sharing protocol to enable personal information to be moved through different agencies. However, at the time of our review not all partners could access the TCC clinical portal containing the shared patient data. This, coupled with the confusion around the role of the TCC and mixed feedback around its effectiveness, meant the benefits of a reciprocal information sharing arrangement were not being fully realised.

- Staff throughout the system reported that information sharing across the health and social care interface needed to improve and this was described as a key barrier to integrated working and improving outcomes for people. GPs and PCFT used the same electronic records system and the University Hospital of South Manchester site had permission to access GP records on a view-only basis, but this was not being put into practice by staff. We heard from GPs that a lack of access to primary care records by people working in the acute sector lead to people undergoing unnecessary diagnostic investigations, assessments and admissions. Eight of the of 15 Registered Managers of social care providers who responded to our survey in relation to information flows reported they received discharge summaries at least 75% of the time, but these were mostly in paper format and rarely electronic. Three respondents reported they rarely received discharge summaries.

To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?

We looked at how the system is working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource.

There was a system-wide understanding of workforce capacity and future needs. Workforce strategies were aligned to that of Greater Manchester, however there was not one whole-system workforce strategy for Trafford; there were separate arrangements at commissioner level. While these were aligned in terms of strategic vision, the system needs to ensure that operational priorities are addressed through a fully integrated workforce strategy. There had been some efforts to address domiciliary care capacity issues, but with limited success to date.

System level workforce planning

- There was not a system-level strategy for Trafford; Manchester, as lead commissioners, had developed a strategy for acute sector staff and Trafford CCG fed into the Greater Manchester workstream for acute workforce. The local authority and PCFT had developed a strategy for community health and social care, aligned to Greater Manchester, and had identified local workforce priorities:
    - Growing our own
    - Developing and promoting our brand
    - Developing our talent and a system wide approach to leadership

- The individual workforce plans were aligned with the strategic vision to move to multi-professional, place-based and asset-focused models of care. However, as the Trafford Local Care Organisation comes into shadow form, system leaders should ensure priorities are complimentary to each other and succession planning is considered.

- There was a Greater Manchester workforce strategy overseen by the Health and Social Care Partnership Board, which outlined the workforce challenges and proposed GM wide solutions in the context of new models of care.

Developing a skilled and sustainable workforce

- System leaders were working to develop and future-proof the workforce through partnerships at local and regional levels as well as with local further and higher education institutions. Workforce development was focused on “growing our own”, using apprenticeship levies, developing career paths and re-skilling and re-purposing existing teams. Some teams were already working in an integrated way in the four locality areas and pilots were being rolled out to empower staff at the frontline to make decisions.

- We heard from all system partners that competition with the retail sector and high educational attainment were key factors in recruiting domiciliary care staff. Analysis of Skills for Care workforce estimates for 2016/17 showed that the staff turnover rate in

Trafford was 35%, which was higher than the England average. However, 61% of new appointments were made to people who were already working in the social care sector in Trafford, which supported the view of providers who told us they were recruiting staff from the same pool as each other. Therefore, while employers were having to recruit to posts, the sector was retaining skills and experience. The local authority had tried several methods to increase workforce capacity, including recruitment days and a 'grow our own' salaried, homecare workforce in the Partington area. The outputs from these initiatives had been minimal to date, so whilst the social care vacancy rate in Trafford was in line with the England average, it had increased since 2013. While all system leaders recognised domiciliary care capacity was a significant issue, there was not a system-wide response to addressing this issue.

Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?

We looked at the strategic approach to commissioning and how commissioners are providing a diverse and sustainable market in commissioning of health and social care services.

Future commissioning strategies were aligned to the wider Greater Manchester STP 'Taking Charge Implementation and Delivery Plan' and Trafford's locality plan, based on a needs assessment which took account of variation within the borough. Funding for transformation had just been approved and although some initiatives had been set up using iBCF monies and some partners taking shared risks, these had had limited success. Commissioners did not take a proactive approach and remained traditional and reactive to pressure points in the system, notably delayed transfers of care. Trafford faced significant market challenges which were widely accepted by system partners. However, responsibility for resolving them was not collective. There was scope for longer-term gains to the wider system if investment was made now to get a grip on the market.

Strategic approach to commissioning

- The Trafford Locality Plan and Transformation Bid, involving the local authority, the CCG and acute care providers, set out the strategic approach to providing care within the four localities. This model was already being used by integrated community health and social care teams and some of the iBCF monies had been used to begin to implement some of the proposals. A needs assessment had been carried out for each of the localities to inform future commissioning plans and ensure local variation was considered.

- There were joint commissioning arrangements between the CCG and local authority with

regards to the voluntary sector, Ascot House (intermediate care facility) and children's community services. The two organisations were in the process of integrating to form a single commissioning function and a Joint Commissioning Board was already in place. Commissioning arrangements were collaborative rather than integrated at the time of the review, but a commissioning outcomes framework was being developed as part of the wider Greater Manchester devolution and staff were positive about future working arrangements. A strategic commissioning decision had led to putting a section 75 agreement in place between the local authority and Pennine Care NHS Foundation Trust (PCFT) since April 2016 in relation to community health and social care services.

Commissioning support services to improve the interface between health and social care

- Future commissioning plans were focused on prevention, and on pathways and the person rather than services, which was positive. At the time of our review these were still to be implemented; commissioning was still separate and based on meeting national objectives and targets rather than taking a coherent system-wide approach.

- Data from March 2017 on provision of extended access to GPs outside of core contractual hours showed that only 3.2% of the 31 GP practices in Trafford surveyed offered full provision of extended access over the weekends and on weekday mornings or evenings compared to the England average of 22.5% and the average across Trafford's comparators of 23.8%. Weekend appointments were provided by the GP Federation on Saturdays and the out-of-hours provider on Sundays. However, if a person needed a face-to-face appointment out-of-hours when the walk-in centre and Urgent Care Centre were closed, they had to go to a site in Salford. Data available at the time of our review showed hospital admissions from care homes were higher than average. A recent data refresh showed that although there had been a reduction in the number of admissions, improvements were not sustained and care home providers reported that GP provision was variable. CCG staff advised plans were in place to enhance the level of support to care homes with a multi-disciplinary team model and up-skilling of nursing staff, but these had not been implemented at the time of our review.

- Although there were 'front door' services commissioned to avoid hospital admissions, including the Older Persons Assessment and Liaison (OPAL) team, Community Enhanced Care (CEC) team, out-of-hours GP services and local pharmacies treating minor ailments; emergency admissions for over 65s in the first quarter of 2017 were higher at 75 per 1,000, compared to similar areas and the national average which were 69 and 64 per 1,000 respectively.

- The number of intermediate care beds had increased from five to 36 at Ascot House and the local authority had also commissioned nine discharge to assess beds at the same

facility. The response to the System Overview Information Request (SOIR) stated this increase in capacity had enabled the system to respond to seasonal fluctuations in activity and led to 30 delays in the summer of 2017 compared to 70 the year before. Published data showed there had been a reduction in DTOC across Trafford in recent months. While Ascot House could be used for 'step-up' care, 90% of referrals were for 'step down' care. In September 2017, the occupancy rate was 75% compared to a target of 85-90%. There was potential for this service to increase system-wide capacity and be utilised more effectively. An evaluation of the admission criteria had begun, but this needed to happen at pace and in collaboration with acute partners.

- Published data in relation to continuing healthcare (CHC) showed that Trafford CCG's performance in quarter one of 2017/18 was poor. High numbers of people were waiting longer than 28 days for their assessment and low numbers of people had been deemed eligible for Fast Track CHC (an indicator of end of life care performance). The response to the SOIR stated that the CCG had increased spending across CHC and Funded Nursing Care between 2013/14 and 2017/18 by approximately £5 million. There had been some changes to the CHC team and data provided by the system showed some positive improvements in performance; more people were receiving CHC funding, were being assessed quicker and not in an acute setting.

- Uptake of personal budgets was low at 5% and of 339 recipients of CHC, only 26 had a personal health budget or direct payment for all or part of their care. There were pilots ongoing with a focus around the 'three conversations' model, which aims to replace traditional assessments for services with three conversations or questions, identifying what financial and social assets a person has and how they can be best supported to use them. While there were pilots ongoing around 'three conversations' and building on assets in the community, there was no coherent plan to increase uptake of more personalised options for purchasing care and supporting the informal workforce. Current contracting arrangements were traditional and time and task focused.

- Voluntary sector organisations felt they were underutilised and there were concerns about the lack of provision for people with dementia. There were limited intermediate care facilities for people with dementia due to the admission criteria and while the local authority told us they commissioned dementia day care from Age UK on a spot-purchase basis, the provider told us they had not received any referrals since block funding was stopped by the local authority in July 2016. The cost of this service was prohibitive to many, often the most vulnerable groups. People we spoke with described some voluntary sector organisations as their "life line", but finding out about the services available to support them was difficult.

Market shaping

- Trafford faced significant challenges in relation to the social care market, both in terms of quality and affordable capacity. Forty-nine percent of care home beds and 35% of domiciliary care packages were purchased by people funding their own care, which created a buoyant market where providers were not reliant on local authority income to exist. In addition, as of September 2017, 53% of nursing homes in Trafford were rated as requires improvement, a figure much higher than the comparator (30%) and national averages (27%). The percentage of domiciliary care providers rated requires improvement was 45% compared to 13% in comparator areas and 16% nationally. This meant that people were at risk of receiving unsafe care and it limited the capacity of the market as the local authority would suspend placing people in homes rated inadequate.

- The system had explored the use of innovative options to exert greater control over the domiciliary care market through the Partington pilot and purchasing packages of care off framework at a higher cost, although the number was small. The iBCF was used to finance some of these initiatives, but as this was one-off funding the system hoped the recently approved transformation fund would help to stabilise the market. New models of care were included in Trafford's Transformation Bid, but were not established at the time of our review.

- The local authority felt supported by wider Greater Manchester workstreams which recognised workforce was an issue for the wider conurbation. While system partners in Trafford all recognised the challenge the market posed, there was not a shared response. Homecare providers were not paid a retainer by the local authority to keep packages of care open if a person was admitted to hospital; there was an informal expectation they would do so for 72 hours. Frontline staff reported that this lead to unnecessary delays while new packages of care were arranged and assessments carried out. It also impacted on continuity of care. In one case file reviewed a person experienced a 15-day delay because their previous long term agency had stopped their package of care and another provider had to be sourced. System partners should take a long term view and make short term investments for longer term gains. Traditional contractual arrangements with homecare providers with a time and task focus rather than flexible commissioning around the person, should be reviewed to create additional capacity and provide continuity of care for people.

Contract oversight

- Contract arrangements for health and social care provision were not joint, but were collaborative. As lead commissioner, Manchester Health and Care Commissioning had overall contract oversight for acute contracts. However, as an associate contract holder, Trafford system leaders told us they felt there was parity in the partnership and they had influencing power.

- Commissioners across health and social care had systems in place to monitor and respond to performance issues and there was evidence of partnership working to drive improvements. The CCG and the local authority worked together and had developed a virtual joint quality team to support providers which fed into joint quality meetings attended by key partners, including Healthwatch and CQC. Data showed this was having a positive effect as 46% of adult social care services were found to have improved following a CQC re-inspection compared to 33% in similar areas. However, 17% of all adult social care services had also declined on re-inspection, which was higher compared to 11% in similar areas. Commissioners had prioritised support to those services most in crisis and so this figure is perhaps not unexpected.

How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting people's independence?

We looked at resource governance and how systems assure themselves that resources are being used to achieve sustainable high quality care and promote people's independence.

There were governance structures in place which facilitated transparent and collaborative lines of reporting. There was a shared understanding of where resource gaps were, but the focus was on the transformation agenda and future projections. While there was high scrutiny of those financial pinch points within the system, current investments were not supporting people to remain at home and the personalisation agenda was underdeveloped.

- There was a shared understanding of where resource gaps were in the system, informed by activity data, quality monitoring reports and the Joint Strategic Needs Assessment for each the four localities. These gaps were articulated within Trafford's Transformation Bid which reflected the resource gaps in the context of the Greater Manchester Delivery and Implementation Plan and the move to a Local Care Organisation model.

- The planning and delivery of the BCF, including the delivery of the Section 75 agreement, was overseen by the Better Care Steering Group, which consisted of senior and middle commissioning managers from the local authority and the CCG. There were transparent reporting lines and evidence of positive working relationships between finance departments at the CCG and the local authority. However, system leaders told us it was difficult to pool budgets at the health and social care interface because of national conditions imposed on monies. System leaders felt that, as Trafford was not high on the deprivation index, they were not prioritised for funding in Greater Manchester despite having some of the most significant challenges in terms of performance.

- Governance structures were designed to provide assurance; commissioners monitored the outcomes for people through ongoing contract monitoring while finance teams assessed the value for money. Transformation Project leads attended the Transformation Board to present real-life case studies to demonstrate the impact pilots and interventions were having on individual people. However, many of the pilots and concept tests underway during our review had not yet been fully evaluated and any cost benefits were projected.

- There had been investment into the adult social care system, but system leaders acknowledged it was not as much as it should be while they were trying to transform it. There had been significant spend on tackling delayed transfers of care (SAMS and Ascot House), but no system-wide cost benefit analysis of the resource being spent on monitoring flow versus investment in managing the homecare market. The local authority had carried out a cost modelling exercise, which had assessed the current hourly framework rate for home care (£14.06) as value for money. Information provided after our review showed this rate was the third lowest out of the 10 local authority areas in Greater Manchester, which ranged from £13.50/ hour to £14.58/ hour. The local authority had paid a provider off the framework at a higher cost and they had subsequently been able to provide 24 packages of care. However, this had not addressed the wider issues and a feasibility study by the local authority estimated it would cost an additional £5.2 million per year to develop a local authority-owned homecare service. At the time of our review, there was no plan to proceed with this option.

- Our analysis showed that there were slightly fewer residential and nursing home beds per population aged 65+ in Trafford compared to comparator areas and the England average. However, data collected by the system and a recently published consumer report contradicted CQC's data and predicted an over-supply of 20% by 2020. Rates of admission to residential and nursing care homes to provide long term support for older people had declined in 2015/16 to 69 per 100,000 from 72 per 100,000 the previous year and were below the England average and that of similar areas. Avoiding permanent admissions is a good measure of delaying dependencies. However, with low uptakes of personal budgets, limited homecare capacity and high numbers of people waiting to be discharged from hospital, the system needs to assure itself that resources are being used most effectively to ensure good outcomes for people. Examples were provided of where high costs of care were agreed to meet the needs of the person, but it was reported that these were not sustainable in the longer term.

Do services work together to keep people well and maintain them in their usual place of residence?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in usual place of residence

Are services in Trafford Safe?

There was a system-wide commitment to keeping people safe in their usual place of residence and proactive prevention and intervention were key priorities in Trafford's strategic vision. However, the reality for people at the time of our review was that support was variable and disjointed at times; some people fell through the gaps and ended up in crisis. Although there was a shared view of who was most at risk, the Trafford Co-ordination Centre was not being used at full capacity and there was limited evidence it had reduced hospital attendances or admissions. There were shortfalls in support to care homes and we found evidence of people being admitted to hospital with conditions that could have been managed in the community.

- The system did not ensure people were consistently supported to stay safe and well at home and people's experiences varied significantly. Age UK held the overall responsibility for delivering the prevention and wellbeing contract for people aged 65 and over with the aim of reducing hospital admissions. They had jointly developed a falls pathway with system partners. Greater Manchester Fire Service conducted 'safe and well' visits and made minor adaptations following referrals from the community.

- However, when we spoke to a group of voluntary sector stakeholders and a group of carers, they felt the system was disjointed and there were gaps, particularly around support for people with dementia. There were no intermediate care facilities for people if they lacked capacity and there was a perception that people with dementia were unlikely to return home if they had a hospital admission. We were given examples of where people had been admitted to hospital with urinary tract infections (UTI) or pressure sores because of variable GP access and difficulties in obtaining specialised equipment. During our review of case files, we found an example where opportunities had been missed to respond to a person's social needs and they were later admitted to hospital following a fall in the community.

- Our analysis of HES data showed that in the first quarter of 2016/17, admissions from care homes in Trafford as a result of UTI were higher than similar areas at 189 per 100,000 aged 65+, compared to 171 per 100,000 aged 65+ across comparators, but in line with the England average of 190. During our review of case files we found an example of a person being admitted with a UTI and approximately two thirds of patients on the acute medical

unit (AMU) at Trafford General Hospital were referred by their GP. Staff felt that some of these people could have avoided admission to hospital if IV antibiotics could have been administered in the community, an opinion shared widely within the system. Care and nursing home providers were frustrated at the lack of response from commissioners to their suggestions. We were advised by system leaders that there was a programme of work in place to roll this out.

- System leaders told us partnership work was well established to safeguard adults at risk of harm. Safeguarding was monitored by system partners monthly, but with the merging of the CCG and the local authority commissioning functions there was an opportunity for these to become more integrated. The lead for safeguarding at the CCG had been in post for six months at the time of our review. They had begun to implement a series of safeguarding assurance and monitoring groups but these had not yet been fully embedded.

- Front line staff across health and social care providers and the voluntary sector were able to describe the process for reporting safeguarding concerns and other incidents. We were given examples of where action had been taken by commissioners to ensure areas of quality and safety concern were mitigated and monitored. While staff reported the system was responsive, they felt that there was limited feedback on any themes or lessons learned which could be cascaded widely across health and social care for future improvement.

- People who were frail, had complex needs or were at high risk of deterioration and/or hospital admission were identified at a system level using a risk stratification tool developed by the Trafford Co-ordination Centre, using primary and secondary care data. The information was shared with GPs and the Community Enhanced Care team (CEC) to provide a coordinated approach to managing their care. These people could be enrolled in the TCC, which aimed to reduce hospital admissions by providing telephone support and remote pathway tracking by managing referrals and preventing missed ‘contacts’ or appointments. It also provided a point of contact for carers or relatives if they felt the person’s condition was beginning to deteriorate.

- Feedback from care home providers indicated there was a variable response from community healthcare services which was putting people at risk of avoidable harm. Some providers had their own contractual arrangement in place with GPs and were complimentary about the Alternative to Transfer initiative, a view which was supported by the Ambulance Service. However, others described a lack of support from some GPs and the out-of-hours provider, which led to some unnecessary admissions. HES data available at the time of our review showed in the first quarter of 2016 the percentage of older people that attended A&E from care homes in Trafford was higher at 11 per 1,000 people than in

similar areas and the national average at 9 per 1,000. A data refresh showed there had been some improvement in recent months. In the first quarter of 2017 the percentage of older people that attended A&E from care homes was lower than the national average at 955 per 100,000 people compared to 979, although it was still higher than the 866 per 100,000 in comparator areas. It was too soon to determine if these improvements were sustained. The numbers referred to A&E by a GP had fluctuated between 9% and 13% over a two year period up to the first quarter of 2017, but was consistently higher than the national average of 6%.

Are services in Trafford Effective?

The strategic vision for the future provided a compelling narrative and outlined how it could improve outcomes for the people of Trafford. Although pilots were showing promising outcomes and some proposals were entering the implementation phase, at the time of our review the landscape was fragmented and performance remained a challenge for the system. The system was not easy to navigate and hospital avoidance schemes were patchy.

- People's experiences were varied and they reported that the system was difficult to navigate and information about support was not easily accessible. There was not a single point of contact for people to access health and social care services. Those who thought they might need some social care support were triaged and either referred for an assessment or signposted to alternative services via the social services screening team. People, providers and voluntary sector organisations told us that information was not easily accessible or understood, particularly for people who funded their own care. Adult Social Care Outcomes Framework (ASCOF) data for 2015/16 showed only 69% people over 65 in Trafford found it easy to find information about support, the lowest of its comparator group.

- We received positive feedback from people who use services and staff about the One Stop Shop when low-level equipment (for example, raised toilet seats and grab rails) was needed and the 'safe and well' checks conducted by the fire service. However, we also heard about delays when waiting for more complex pieces of equipment, and individuals buying equipment themselves because of a lack of clarity about how the system worked. System leaders acknowledged there had historically been long waits for aids and adaptations. However, following a review and increase of resource, waits for major aids or adaptations had reduced from 18 months to nine months.

- While plans were in place for system-wide transformation, in the interim there was an inconsistent approach to assessments which was leading to duplication of work, referrals to services being refused and difficulties in planning care around the person. Care home and homecare providers reported the level of detail they received from commissioners to plan a package of care was poor. Case files we viewed supported this view; some assessments

contained repetitive standardised statements and very little about the person's needs or preferences.

- The Trafford Locality Plan and Transformation Bid outlined the shared vision for supporting people to stay in their usual place of residence, to remain healthy, safe and independent for as long as possible. Health and wellbeing priorities had been reviewed to reflect Trafford's local context and there had been a surge of activity around the public health agenda. Future service delivery was being planned around a locality model, where teams would use the Joint Strategic Needs Assessment (JSNA) to determine the care needs of the people in their local neighbourhood. However, some plans were not fully operational at the time of our review and the *Ageing Well* strategy, frailty strategy, dementia strategy and falls strategy were all in draft.

- The system had considered the wider determinants of health in future plans and had worked with partners in housing and leisure. For example, the falls rehabilitation programme had been expanded from an eight week to a 16-week course, through collaborative working between commissioners, PCFT and Trafford Leisure to incorporate prescribed exercise classes. There were four extra care housing facilities, some with primary care facilities co-located and commissioners were in discussion with Trafford Housing Trust about winter resilience.

- The strategic vision placed an emphasis on keeping people healthy and at home, but this was not being achieved in reality and the personalisation agenda was underdeveloped. Data showed the proportion of people who received personal budgets was low with only 5% of the local authority's total adult social care expenditure going on direct payments. There had been a downward trend in the number of people aged 65 and over whose long-term support needs had been met by admission to residential care, which was positive. However, a higher proportion of the local authority's adult social care expenditure was on nursing and residential care (60%), compared to services designed to maintain people in their usual place of residence (26% of expenditure was on homecare and 11% on reablement). Ascot House was designed to be used as a 'step-up' as well as a 'step-down' facility, but at the time of our review, 10-15% of referrals were from the community. Local authority commissioners had hoped to expand the Stabilise and Make Safe (SAMS) service to include 'step-up' provision but it was currently operating at capacity.

- Although frontline staff in acute and social care services had the skills to support the transition of people between health and social care services, their knowledge of the services available varied and there was a risk that people could fall through the gap. Information about the services available was not always consistent and staff reported they

did not know where and when they could refer people. For example, the CEC team was a 24/7 service, but the information available to staff at Wythenshawe Hospital stated it was available from 08:00 to midnight. Staff reported they felt confused by the different pathways, especially when different local authority areas had different systems or services in place. As a result, some people ended up being seen in the wrong place by the wrong person and at the wrong time.

- Voluntary sector organisations felt there were missed opportunities and that they could be better utilised by commissioners to support people to stay at home. One voluntary organisation told us they had been approached last winter about doing shopping and wellbeing visits in an effort to reduce admissions to hospital, but it had been too late to arrange. They have not been approached since and this was felt to be a short-sighted response by the system.

- There were some good examples of integrated working between health and social care staff delivering community services. However, staff across the system reported that the lack of digital interoperability impacted on their ability to share information effectively. Health and social care services used different IT systems and the lack of trusted assessors meant duplication of effort by services.

- There was an initiative being piloted in the northern locality, 'One Trafford Response'. Coordinated by Trafford Partnership, staff from different agencies including health, social care, police and housing were co-located in a central hub to see how working together to manage referrals and community issues in real-time could reduce the burden on other parts of the system. Initial findings were positive and there were plans to roll this out further.

Are services in Trafford Caring?

There was a commitment and desire from staff at all levels in the system to provide person-centred care and to empower people to make decisions and to remain in their usual place of residence. While we found examples of where people had been well supported and their preferences documented, they may have had to tell their story multiple times to multiple professionals. There was not a coordinated approach to assessments and information and support was not always easily accessible.

- The voluntary sector was extremely active in Trafford and provided a range of services designed to maintain and improve people's health, wellbeing and independence. These were targeted at specific groups, such as the BME community, people with Alzheimer's Disease and carers. Services offered included, support groups, yoga classes and advice lines. Voluntary sector organisations felt they could be better utilised by health and social

care partners to provide information and support to people and carers to prevent crisis episodes.

- During our review we visited an extra care housing facility where people were universally positive about their involvement in making decisions about their care and the information and support available to remain well.

- Some people felt there was a reliance on carers and relatives to navigate the system, particularly if a person was funding their own care. We were told that if a person had an advocate they could have a good experience and while there was an advocacy service in Trafford, this was not well known. Another person described how they had needed to reduce their working hours to care for their relative, and pay for equipment to keep them at home.

- Several carers reported that they had not been given information on how to access financial support until they had discovered the Carers Centre or had searched the internet themselves. According to a 2017 survey carried out by the Carers Centre, only 27% of 333 respondents had been signposted or offered information. ASCOF outcome data for 2015/16 showed the proportion of people over 65 in Trafford who find it easy to find information about support was the worst compared to comparator areas.

- ASCOF outcome data for 2016/17 showed the overall satisfaction score of adults in Trafford who use services with their social care and support (58) had improved from the previous year (52), but still remained below most of the comparator local authority areas where scores ranged from 55 to 68.

- Front-line staff were, without exception, committed to providing more personalised care. Assessments of need were not always coordinated effectively to ensure the person was at the centre of their care and support planning. We heard from people who use services and from staff that often multiple assessments would be carried out meaning the person would have to tell their story more than once. Our review of case files found examples of duplicated assessments where different conclusions were reached about the person's needs by different professionals. This was recognised by the system; for example, the local authority was piloting a neighbourhood-based scheme where referrals, assessments and interventions were managed by one local team to provide consistency and reduce duplication.

Are services in Trafford Responsive?

There were some good initiatives in place to respond to people's needs and prevent admission

to hospital, but the system was fragmented, over-complicated and not easy for people or staff to navigate. Therefore, people were not always seen in the right place, at the right time by the right person.

- People were not always seen in the right place, at the right time by the right person. People we spoke with described varied experiences. GP patient survey data showed there had been a decline in the number of people who felt supported to manage their long-term condition from 70.5% in 2011/12 to 65.1% in 2016/17, but this was in line with the national average of 64%. Case files showed some positive examples of where staff had carried out assessments and arranged packages of care to either support a person to remain at home or be referred to Ascot House for intermediate care. However, in two cases there had been missed opportunities to provide preventative interventions, which may have contributed to their hospital admission.

- The care coordination aspect of the TCC had been in operation for 12 months. At the time of our review, it was providing support to approximately 1,000 people, but had capacity for 3,000. We received mixed feedback from staff across the health and social care system about the purpose, efficacy and impact of the service. As it was a telephone-based service only, the perception from health professionals was that it did not reduce the burden on other professionals as they would be expected to carry out home visits if one was required. The Transformation Bid outlined plans to optimise performance but these had not been realised at the time of our review.

- The rate of emergency admissions in the first quarter of 2017 for over 65s was higher at 75 per 1,000, compared to similar areas and the national average which were 69 and 64 per 1,000 respectively. Performance against this indicator had worsened over a twelve-month period.

- Feedback on GP provision from people who use services, families and carers, staff and system partners was mixed. National survey data showed that satisfaction with GP opening hours was in line with national averages, but data from March 2017 showed that a low proportion of practices provided full extended hours provision. Analysis of HES data showed that in the first quarter of 2017 the percentage of older people that attended A&E as a result of being referred by their GP was 8% which was in line with similar areas and the national average of 8%. The percentage of those people who were then discharged from A&E without being admitted to hospital was lower in Trafford (12%) than similar areas (17%) and the England average (17%). Staff throughout the system felt a lack of support available in the community meant more people were being admitted to hospital.

- The response to the SOIR stated there was a Local Enhanced Service to encourage GPs to proactively manage their patients in residential care by producing individualised care plans to help reduce unnecessary admissions. Although A&E attendances from care homes had declined and were in line with England averages as were emergency admissions, care home providers reported a variable response from GPs and the out-of-hours provider, which meant that people were being sent to A&E unnecessarily. System leaders told us the aim was to provide an enhanced, multi-disciplinary level of support to care homes in two of Trafford's localities by Christmas 2017, but this timescale was ambitious with no contracts in place at the time of our review.

Do services work together to manage people effectively at a time of crisis?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management

Are services in Trafford Safe?

Systems, processes and practices did not always keep people safe when they were in crisis. There had been some improvements in performance in recent months, but data showed that more older people in Trafford were attending A&E, being admitted to hospital and staying longer compared to similar areas. While there was a positive risk reporting culture, risk-averse decision making may have contributed to more people going into crisis than necessary.

- Systems, processes and practices across the health and social care interface did not always safeguard people from avoidable harm. More older people in Trafford were going into crisis, being admitted as an emergency and staying longer than necessary. Our analysis of HES data in the first quarter of 2017 showed the rate of A&E attendances for people aged 65+ was 13,601 per 100,000 compared to similar areas with a rate of 9,724 per 100,000 and the England average of 10,534 per 100,000. The emergency admission rate for people aged 65+ in Trafford was 7,470 per 100,000 compared to a rate in similar areas of 6,922 per 100,000 and the England average of 6,391 per 100,000. While there had been a slight upward trend over the past year, performance had consistently remained worse than average and indicated a gap in community service provision.

- Risks to people were not always assessed, mitigated and monitored to support them to stay safe. Our analysis of HES data showed that in the first quarter of 2017, 33% of people aged over 65 had a hospital stay lasting longer than seven days, which was in line with similar areas with an average 32%, but a slight increase from 32.7% the previous year. Significant capacity issues in the homecare market were contributing to this, however there

were no systems in place to risk stratify people according to need once they became medically fit for discharge; the priority was around their length of stay. Longer hospital stays put people at risk. We were given an example where a patient who had waited a significant time to be discharged and had suffered a fall in hospital, resulting in a sub arachnoid haemorrhage.

- There was a positive risk reporting culture and frontline staff were able to provide examples of where they had reported incidents and safeguarding concerns. However, some staff shared their frustration about when they had escalated incidents or operational issues which presented risks and there was no evidence of any action being taken in response.

- There was a system-level escalation procedure to manage risks to service delivery; the Operational Pressure Escalation Levels (OPEL) framework. There had been some inconsistencies about when to trigger a Level 3 response, but system partners were agreeing the criteria at the time of our review.

- System leaders had a shared view around the reasons for high levels of A&E attendances and hospital admissions and were hopeful this would be addressed as part of the system-wide transformation. There was a shared view among front-line staff that social care market capacity and primary care support was a key factor. However, both acute and community staff described each other as “risk averse” when it came to decision-making. This was supported by the findings of our relational audit where one of the lowest scores was on the statement: people take organisational risks where it had the potential to serve wider system goals without fear of criticism or failure.

- There was a shared view of risks to delivery of services to people in crisis across the Greater Manchester landscape. Safeguarding dashboards were shared monthly and there were daily status update reports to system leaders on flow and system capacity. Working groups had been set up to respond to particular pinch-points, such as delayed transfers of care.

Are services in Trafford Effective?

During a crisis front-line staff demonstrated an awareness of assessing a person holistically in order to meet their needs. Where multi-disciplinary teams were co-located this was working well and they were supported to move through the system more effectively. However, the multiple and confusing pathways meant staff did not always know who to refer to, particularly out of hours. Communication and sharing of information varied and trusted assessors had only been piloted in parts of the system.

- In two case files we viewed there was evidence of holistic assessments of peoples' needs and effective multi-disciplinary working. There was a Choice Policy available to help support people in making decisions, but this was not being universally implemented.

- Services designed to improve flow through the health and social care system were evidence based, but there were multiple, disjointed pathways which meant they were not always being used effectively. The CEC team was designed to provide short term emergency care and where it was providing care to people we were advised it was having good outcomes. According to the CEC's key performance indicator dashboard, 49 people were referred to the urgent arm of the service in September 2017, but there was no measure of whether this was in line with the number of referrals they would expect and there was no break-down of where referrals had come from so targeted engagement could be done with system partners.

- Acute hospital staff showed us the different algorithms they were meant to use depending on where a person lived, but these were not used consistently. They found the system confusing and difficult to navigate and described how strict admission criteria and complex referral processes to services such as Ascot House, made them disinclined to refer.

- Where and when a person was treated had the potential to impact on how well they moved through the system. Multi-disciplinary teams were based at Trafford General Hospital and Wythenshawe Hospital five days a week. At Wythenshawe Hospital there was a geriatrician-led, multi-disciplinary team (OPAL) which worked in A&E Monday to Friday and the Medical Assessment Unit seven days a week. The team identified those people who could avoid admission who may be put on the frailty pathway and supported at home with a package of support. This model of care was producing positive outcomes for people and the system should review any outcome data available to determine whether rolling out the same model to Trafford General Hospital or in to the community would have wider benefits, building on the Community Enhanced Care team to avoid duplication.

- Trusted assessors had been piloted in parts of the system, but there was not widespread implementation at the time of our review. Each service would carry out their own assessments, which could cause a delay to care being delivered. There was little evidence of system-wide learning from pilots or incidents being disseminated across the workforce. Where staff could describe where they had achieved positive outcomes for people this was very much at team or location level.

- One of the strategic objectives of the Trafford Locality Plan was to have a universal approach to sharing information across health and social care. At the time of our review

there was limited interoperability of record systems to allow staff to share accurate, real time information and staff told us often the only piece of information available at the point of crisis was a person's DNACPR record. The senior executive team of the newly formed, Manchester University NHS Foundation Trust outlined the plans to have one IT system and one assessment process, but acknowledged this was in the early stages of development.

Are services in Trafford Caring?

Frontline staff understood the importance of involving people who needed support and their families in decisions in about their care and there was an innovative approach to supporting people in their discharges from Trafford General Hospital. However, we received mixed feedback from people and their families during our review. Some did not always know who was coordinating their support or feel they had been given sufficient information to make decisions.

- Our review of case files showed assessments of care were centred around the needs of the person and people we spoke with at the hospital knew the plan for their care and felt involved in making decisions. However, when we spoke to a group of carers and relatives they were less positive. They felt decisions had been made without their input even where they had Lasting Power of Attorney. Staff reported more advanced care planning in the community would prevent the person from having to tell their story multiple times.

- We found some innovative practices to involve carers, families and advocates in future plans. At Trafford General Hospital there was a purpose-built flat based on Ward Two where discharges could be simulated to determine what support was required and how the family or carers felt they might cope.

- Providers, voluntary sector organisations and carers raised concerns about the support for people with dementia when they went into crisis and felt that the right people were not always involved. They reported that staff were not able to provide the support they needed and the hospital environment often heightened a person's anxiety. Hospital staff told us that relatives and carers were encouraged to visit at all hours, especially meal times, and to stay overnight. Some specialist support was also available and dementia was observed to be a high priority for staff at all levels.

Are services in Trafford responsive?

People living in Trafford did not always receive the services they needed at the right time and in the right place. People were more likely to be admitted to hospital and were also more likely to stay in hospital for too long because of a shortage of care packages and affordable beds in the community.

- In July 2017 North West Ambulance Service (NWAS) treated 32% of 999 calls without transferring them to hospital, which was slightly below the England average. We were told there were few incidents where ambulances were diverted elsewhere, which may indicate that the transfers were appropriate or it may be there were shortfalls in community provision.

- During our review we identified an operational policy which directed staff caring for people within the OPAL unit at Wythenshawe Hospital to call 999 if a person became acutely unwell. System leaders should review the policies and procedures relating to the OPAL unit to ensure additional burden is not placed on the wider system and that people who are still under the care of the acute trust are seen by the right person at the right time.

- Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM) merged and as of 1 October 2017 formed Greater Manchester University NHS Foundation Trust. Published data was still at the disaggregated level. Between 2014/15 and 2016/17 both CMFT and UHSM failed to meet the national four hour A&E target of 95%. Unverified data, collated by the system as part of their on-going monitoring of performance showed performance had declined across both hospital sites in the last quarter.

- Older people in Trafford were more likely to end up being admitted to hospital and staying longer. Between 2016 and 2017, bed occupancy at CMFT was consistently above the optimal target of 85%. Bed occupancy at UHSM was slightly lower, but only dipped below 85% in one quarter.

Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: step down, return to usual place of residence and/ or admission to a new place of residence

Are services in Trafford Safe?

There was not a coordinated response to discharges, which meant some people experienced unnecessary delays and, in some cases their risk factors increased as a result. Once people were ready for discharge, there were some systems in place to ensure their safety was not compromised, including provision of equipment and reviews of their needs. However, these need to be strengthened to ensure information is provided to all partners in their care and is sufficiently detailed and accurate. Emergency readmission rates for older people in Trafford had

increased over time.

- The number of older people in Trafford requiring emergency readmission once discharged was in line with the England average at the time of our review, but had been higher for five of the last six quarters. Our analysis showed that over all of the financial year 2016/17, Trafford's emergency readmission rates occurring within 30 days of discharge for people aged 65+ was 19.5% compared to the England average of 18.7%.

- The systems in place to return people to their usual place of residence or a new facility did not always protect them from avoidable harm. In two case files we found examples where people had experienced hospital stays of over a year and their health condition had deteriorated as a result. Groups of voluntary sector organisations and carers we spoke with also described hospital acquired delirium as a barrier to people returning home and we saw an example of this in one case file we reviewed.

- At Trafford General Hospital, Ward Two was a 25-bedded 'complex discharges' ward and staff gave examples of where people had experienced falls or detriment whilst waiting for packages of care to be arranged. Although these were reported as incidents, there was no evidence of these incident reports effecting changes. There was a sense of learned helplessness among staff and that these incidents were a symptom of the wider flow issue within the system.

- Eight of the of 15 Registered Managers of social care providers who responded to our survey reported they received discharge summaries at least 75% of the time, but these were mostly in paper format and rarely electronic. Three respondents reported they rarely received them. Eleven said they usually received summaries within 24 hours, but there was mixed feedback on the quality of the information and whether it was sufficient to plan a package of care. Six respondents said there was sometimes enough information, five said there was not; eight said there was rarely information in relation to any mobility issues. This was supported by a group of care home and homecare providers we spoke with who also reported referrals often failed to include whether a person had a cognitive impairment.

- Once a person was discharged there were some systems in place to ensure they were reviewed to prevent a readmission. There was a Directed Enhanced Service in place to encourage GPs to review and amend care plans for those identified at risk of admission and if a person was in receipt of reablement, they received weekly reviews following discharge to ensure the package of care was sufficient to keep them safe. The One Stop Shop prioritised discharge referrals and aimed to provide equipment the same day (93% of urgent referrals were completed within 48 hours). Community pharmacies were informed by

Trafford General Hospital if a vulnerable person was discharged with a monitored dosage system, but there was no formal scheme in place to facilitate discharge information being sent from secondary care to community pharmacies. There was a pilot ongoing in Salford, but no concrete plans were in place to roll this out in Trafford.

- Our analysis of HES data showed that in the first quarter of 2017 emergency readmission rates occurring within 30 days of discharge for people aged 65+ from care homes in Trafford was lower, at 14%, than similar areas and the England average (21% and 20% respectively). This was an improvement from 21% the previous year (compared to an England average of 20%), but the system needs to ensure this is sustained.

Are services in Trafford Effective?

Whilst there had been some improvement in performance, the number of delayed transfers of care remained high and people were not always enabled to return to their preferred place of residence with a timely integrated approach. Those that did receive reablement had good outcomes, but the number in receipt of these services was below the England average and market forces were having an impact on the system's capacity to keep up with demand. The recent appointment of a Community Flow Lead was intended to provide a system-wide view of capacity and co-ordination, but they were not in post at the time of our review.

- Readmission rates had declined over recent months, but so too had the number of people receiving a reablement service from 3% in 2013/14. Analysis of ASCOF data for 2015/16 showed that the percentage of older people who received a reablement service was slightly lower compared to similar areas at 2.6% for Trafford and 3.0% for comparator areas. Where people did receive reablement, it had good outcomes; 93% of people over 65 were at home 91 days after discharge from hospital to a reablement service. This had improved significantly from 69% in 2011/12. The Stabilise and Make Safe (SAMS) service, commissioned from two homecare providers, was the preferred route out of hospital. For bed-based reablement, people could be referred to Ascot House and Wythenshawe Hospital. Patients could also be sent to Opal House, based on site.

- There had been a sharp decline in DTOC between February 2017 and July 2017 from 46.3 days to 25.5 days per 100,000 population (aged 18 and over). While this shows a significant improvement, it was still high compared to the average of 13.6 days for both comparator areas and England averages. A Community Flow Lead had been appointed to have a system-level view of capacity and was due to start in November 2017. Daily meetings were held at each hospital site to discuss delayed transfers of care and next steps. However, the sense of urgency varied and there was an attitude that delayed transfers of care were an accepted symptom of the system.

- There were multidisciplinary teams co-located at the four hospitals serving Trafford residents to facilitate timely, holistic assessments to promote a person's independence on discharge. While we saw some good examples of where teams worked together, the system was disjointed and not easy to navigate. A lack of in reach by community staff, shared records, trusted assessors and competing priorities were cited as barriers by staff to providing an integrated response to a person in crisis. We were told about a person who presented to A&E on a Friday evening and due to a lack of seven day services could not be discharged back out into the community. Their package of care was stopped over the weekend and they ended up staying in hospital for a month while a new one was arranged.

- The acute medical unit (AMU) at Trafford General Hospital no longer had any formal occupational therapy input following the retirement of member of staff, funded by PCFT. System leaders told us this change was made in 2013 as part of the transformation of community services. Hospital staff felt it had negatively impacted on delayed discharges with the AMU. This example was illustrative of the feedback from some staff who felt changes were made in isolation without wider consultation. Where referrals had been refused to Ascot House, referring staff were not always clear why and felt the criteria was too strict. Staff at Ascot House recognised a need to work more closely with their secondary care colleagues to ensure there was a shared understanding of the purpose of this service.

- Some private providers told us they had to ring hospital wards to find out when an existing client may be ready for discharge; often they were only contacted when the person was medically fit. For new packages of care, they were alerted via an email from commissioning teams. They were required to submit an 'Expression of Interest' based on the information provided, which was often limited. If their tender was accepted, they would be expected to assess and start delivering a package of care within 24 hours. Providers were concerned about the level of information supplied by commissioners and relied on their own assessments, so there was a reluctance to consider the use of trusted assessors. Furthermore, the practicality of this system did not encourage person-centred care.

Are services in Trafford Caring?

The extent to which people, their families, carers or advocates were treated as active partners varied. Where efforts were made to put the person at the centre, the extent to which they could make choices was limited to what care was available in the community, particularly if they were not funding their own care. There was limited use of voluntary sector organisations by the system to support people to return to their usual place of residence.

- The SOIR stated people and their families were engaged at each assessment in each

setting and choices offered between solutions to meet needs, providers to deliver care and commissioned care or direct payments. Our review of case files showed a person-centred approach was applied inconsistently and to varying degree. In one example, there was consistent support of the community social worker upon hospital discharge and a package of care was increased rapidly to prevent a carer breakdown. However, we also saw some assessments where there was little evidence to demonstrate the person's input. People we spoke with awaiting discharge or assessment felt they had been kept up to date and knew what the next steps were. However, a group of carers were less positive and did not feel like they had been treated as partners in care.

- There was a choice policy in place, but this was not understood by all staff or universally applied. We heard from various sources that due to demand outweighing supply in affordable, high-quality community care, it was less about choice and more about what was available. This was contributing to delays as people and their families refused placements. There was a common perception among different groups we spoke with that if a person funded their own care, they would get a better experience.

- Voluntary sector organisations told us they were rarely directly involved in supporting people to return home. The response to the SOIR stated that a volunteer-led support to hospital discharge service had been commissioned to work in partnership with hospital discharge teams, but this had delivered limited outcomes and a new service was being co-designed. Voluntary sector organisations we spoke with told us they were not involved in any discharge planning or support and felt this was a missed opportunity. A Carer Liaison Worker was based at Trafford General Hospital twice a week with the aim of providing information, advocacy and advice around admissions and discharges.

- We received negative feedback in relation to the CHC process. Unverified data from the system's latest submission showed there had been some significant improvements in the last quarter. However, work was required to alter this negative perception through positive engagement with staff, providers and people who use services. As of September 2017 only 42% of local resolution meetings were happening within three months of notification of an appeal compared to a target of 100%.

Are services in Trafford Responsive?

Systems processes and services were in place to support the transition of people to their usual place of residence or alternative setting, but there was insufficient capacity to meet demand. The system had made significant improvements in relation to delayed transfers of care, but the significant shortage of homecare packages meant people were still waiting too long in inappropriate settings and not always receiving continuity of care or choice.

- Services were commissioned to help improve the flow through the health and social care system, but there was insufficient capacity to meet demand. A reliance on the homecare market with its workforce capacity issues, a lack of Elderly and Mentally Infirm (EMI) beds and affordable residential care, meant people were not always being seeing in the right place, at the right time, by the right person.

- The SAMS service had seen a 68% increase in referrals between November 2015 and October 2017. Following a change in criteria in August 2017 to include more complex cases, the service quickly became full. System leaders told us they had hoped to use the SAMS for 'step-up' as well as 'step-down' provision, but the providers could not recruit to keep up with the demand. The service had recently been supplemented by the in-house Care at Home service to increase capacity. Between April 2016 and March 2017 out of 287 completed cases, 33% of people who had received the service were living independently and 12% were able to have their packages of care reduced. It was not clear how this compared with expectations and the system should review how performance is measured.

- Where there was a reliance on homecare staff to provide a service, there were bottle-necks in the system. This was demonstrated by data in relation to reasons for DTOC; between February and April 2017 'awaiting care package in the home' was reported as one of the main reasons for delay in Trafford, accounting for an average daily rate of 12.7 delayed days per 100,000 population, compared to an average of 2.6 days in similar areas and 3.1 days nationally. The system should consider its reliance on the homecare sector to provide its community rehabilitation service, considering the workforce challenges and inability to reduce capacity with winter approaching.

- Nine discharge to assess beds had been commissioned at Ascot House and Opal House and Ward Two were also using the same model. The response to the SOIR stated that there was flexibility to enable the SAMS service to provide additional capacity. However, as this service was already at capacity this seemed to be an unrealistic assertion.

- There had been significant improvements in performance of continuing healthcare (CHC) over the past quarter. NHS CHC data showed the conversion rate for people being referred and then assessed as eligible for CHC had stayed below the system's target of 23% (19.65% in September 2017), but the total number of people referred had increased from 63 in May 2017 to 173 in September 2017. More people were being identified by frontline staff. People were receiving timely assessments once in the most appropriate setting for their care; 83.3% of assessments were completed within 28 days compared to 10.8% in May 2017 and only 6% took place in an acute setting. One hundred percent of people referred for Fast Track CHC received it, meaning people at the end of their life were

supported to be moved to their preferred place of care.

- The High Impact Change model for managing transfers of care identifies seven day services as one of the changes that can support health and social care systems reduce delays. The Department of Health's analysis of activity between October 2015 and September 2016 showed that the proportion of older people discharged over the weekend in Trafford was slightly higher than similar areas at 20%. There was the potential for this number to increase through improved partnership working and further development of seven day working across the system.

Maturity of the system

What is the maturity of the system to secure improvement for the people of Trafford?

- Although the system had a clearly and consistently articulated vision across health and care agencies, which was aligned to the Greater Manchester STP *'Taking Charge Implementation and Delivery Plan'*, delivery and implementation was at an early stage. The CCG and the local authority commissioning functions were on track to become fully integrated and the Local Care Organisation would be coming into shadow form in April 2018. These foundations need to be built upon and expanded at pace to ensure the benefits are felt more widely across the system. Trafford's strategic vision for a Local Care Organisation is the vehicle to achieve this, and now that the Transformation Bid has been approved by the Greater Manchester Health and Social Care Partnership Board, the focus needs to shift to delivery

- Governance arrangements in Trafford facilitated transparent conversations, information sharing and some shared decision-making between statutory organisations. However, the challenge function of Trafford's Scrutiny Board and the Health and Wellbeing Board were underdeveloped and a lack of integrated outcome measures meant monitoring of performance was siloed and in accordance with traditional key performance indicators.

- Historically relationships within the system had been challenging, but these were improving. System leaders were united in a shared endeavour and there was a commitment to work together in a collaborative way. There were still some legacy cultural issues which were apparent among frontline staff, but these were recognised by system leaders and actions were planned to address them.

- Some funds from the iBCF had been used to stabilise and shape the adult social care market. However, market pressures remained a significant challenge for Trafford and the extent to which system leaders worked collaboratively to address them was limited and system partners recognised they had scope to improve.

- There was a shared understanding of where resource gaps were in the system. While the BCF had facilitated integrated working between health and social care, budgets remained separate. The use of personal budgets was low and commissioning was collaborative rather than integrated. The CCG and the local authority will form a joint commissioning function in April 2018.

- Trafford did not have a single workforce strategy, but were aligning to the strategy at GM level at GM level

- Information governance arrangements were at the early stages of integration. Health and social care used different records systems, but there was a shared use of NHS numbers.

- There was some evidence of multi-disciplinary team working for effective outcomes, but they were not system-wide. There were multiple pathways and a reliance on homecare to provide services meant people became stuck in the system and suffered poor experiences and outcomes as a result.

Areas for improvement

We suggest the following areas of focus for the system to secure improvement

- With winter approaching; the system should remain focused on the here and now to ensure improvements in performance are sustained while delivering transformational change. There should be a shift from monitoring and piloting to evaluating and implementing.

- The system should fully implement the High Impact Change Model.

- The challenge functions of the Health and Wellbeing Board and Scrutiny Board should be strengthened. Where there are shared risks these should be made explicit and managed through joint governance structures.

- There should be a proactive system-wide response to effectively managing the social care market and domiciliary care capacity.

- The OPAL multi-disciplinary team were producing positive outcomes in preventing admissions by providing an in-reach service. The system should endeavour to review outcome data and consider whether the model can be rolled out in other areas.

- Operational policies in place at Opal House should be reviewed to ensure they are not placing additional burdens on the wider system.

- Admission criteria to intermediate care services should reviewed to ensure consistency and efficacy of service provision. Acute hospital staff should be engaged in the evaluation process.

- The system should ensure there is a Trafford-wide workforce approach, which identifies current needs as well as predicting future requirements in alignment the GM workforce strategy.

- The system should continue to ensure that its voice is heard in partnerships with the wider conurbation to make sure priorities remain relevant to the Trafford area and that support is drawn from other areas where local challenges are identified.

- With the Local Care Organisation coming into shadow form, the system should learn from wider system partners to ensure that new contractual arrangements do not destabilise the system.

- There should be a joined-up, coordinated response to engaging with the voluntary sector and provider organisations as system partners.

- Work is required to share learning and experience between staff at the interface so there is shared trust and understanding and historical cultural barriers are broken down.

This page is intentionally left blank

Manchester University
NHS Foundation Trust

Frailty in Trafford General Hospital: Briefing Paper for Scrutiny Committee

Prepared by Helen Hurst Consultant Nurse Jan 2018

Background

It is now widely acknowledged that recognising frail older people admitted to hospital is an area of practice that needs to be addressed. Not only recognising this cohort of patients but providing a comprehensive assessment that will affect outcomes by improving care, reducing length of stay and working more closely with community services. It has prompted many published articles including systematic reviews and standards from the Royal College of Physicians and British Geriatric Society. Many Trusts and organisations have developed different ways of working and introduced teams that specifically focus on frail older people admitted through the emergency departments and the acute medical units.

Project to Date

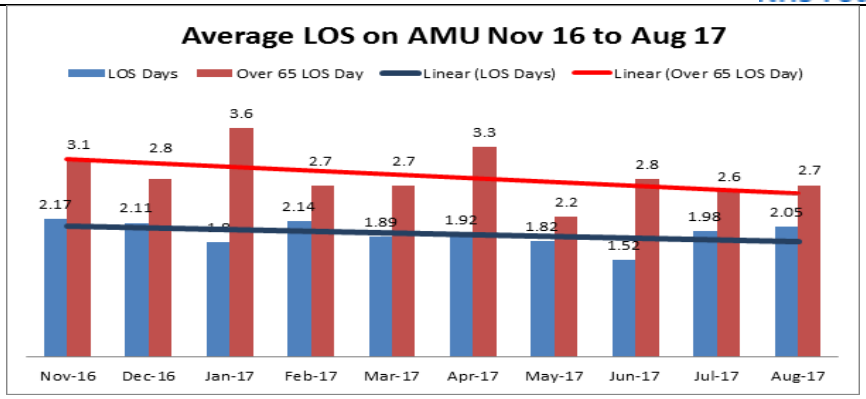
At Trafford General Hospital (TGH) a pilot week in June 2016 led by a Consultant Geriatrician prompted a review of how best to implement a frailty pathway into the acute medical assessment unit (AMU). It became clear that to continually improve required leadership and organisational changes. The Consultant Nurse was employed in November 2016 to enable this transition and introduce a frailty pathway within the AMU. Visits to other hospitals was also undertaken to understand how teams and services are being provided. It is clear that often this can take 2-3 years to achieve successes and have a stable and sustainable service. KPI's identified early on related to workforce planning, IT to support frailty screening and comprehensive geriatric assessments (CGA) and building links to community services. Over the last few months many achievements have been realised but there is still a need to plan for the next 12 months and beyond. Part of the early work involved a partnership event with Pennine Care and other providers. This event was held at TGH and was an opportunity for community and hospital teams to discuss and plan services. Understanding what's available within the community is always challenging for secondary care and building those relationships is crucial.

Below is a summary of the work so far.

- There were identified gaps in the workforce for therapy services, with no therapy service based. Historically therapy input had been commissioned via Pennine Care and in place until the practitioner resigned in 2016. Working closely with the therapy lead and Pennine Care it became clear the

money for these posts had been redirected into the community enhanced therapy services. The provision of therapy from Pennine Care and service criteria was too limiting and did not enable therapy assessments on in-patients. The criteria set was patients had to be in hospital for < 5 days and medically optimised for discharge. An agreement was made to introduce a physiotherapist and occupational therapist into AMU funded by TGH for a three-month pilot period. This was successful and although the posts are now vacant, funding has been agreed and posts are about to be advertised. Provision of therapy services from Pennine Care continues within their criteria.

- Education has been provided to both medical and nursing staff through presentations and a successful animation of an ideal service, funded by the transformation team at MFT.
- The screening for frailty was agreed to be done by nurses at the point of admission and since March 2017 a frailty screening tool was added to the nursing assessment tool. Compliance has gradually increased.
- The CGA was first tested in the nursing/observation tool but was not successful and is now included in the electronic patient record system. The electronic CGA was introduced in July 2017 and is still undergoing some changes to enable the assessment process to be multidisciplinary. IT system development is currently limited due to the merger of three hospitals and the need for an integrated system across all sites. The GCA assessment should really follow the patient into community for the GP and other providers.
- The functioning of the board round on the AMU and the safer standards document has also been the focus and through PDSA cycles has now an agreed format. This still requires leadership and direction.
- Stronger links with community and different trials of in- reach with community teams have happened over the months. There was no benefit demonstrated with the community enhanced therapy team coming in daily to board rounds. No additional patients were identified for discharge as per the criteria described above. The next steps now are to secure a therapy service within AMU and to then review the referral criteria that has been set by Pennine Care and examine different ways of working to enhance discharge processes. This will include trusted assessments to allow easier discharge and follow up.
- Evaluation and data collection has also been part of the project and results to date are encouraging with a reduced length of stay (see graph below). Further in-depth data is currently on going.



Next Steps Vision

Many models of frailty within secondary care have been published to share and demonstrate good practice. The most common processes and models are the development of teams to provide a minimum 5-day service at the front door in secondary care for frail older people. With the merger of three/four hospitals, standards of care need to be agreed so that every patient is expected to receive the same care and service wherever they are admitted. Current strategic plans and meetings are taking place across Manchester to examine this in detail.

TGH Next Steps

- To enhance and consolidate the frailty team requires a business plan and funding which has been put forward to the appropriate management team. This includes a frailty assessment model so patients are referred direct from GP's, UCC and community teams.
- Continue to build links with community teams and look at ways of cross over working bringing expertise out into community and community expertise into the hospital.
- To have another partnership event to examine success and challenges for the next 1-2 years. This includes working with NWAS to assess patient flow and try to ensure patients are transferred to the most appropriate urgent/emergency care facility; the aim being to reduce patient movement between hospitals within the first 48 hours.
- A strategic alliance between Manchester Foundation Trust and Manchester Metropolitan University has been formed to bring together experts including clinicians and academics to address three key areas relating to frailty: education, clinical practice and research. The alliance includes all hospitals and representatives in the new configuration to align frailty pathways and standards.

This page is intentionally left blank

healthwatch Trafford

Healthwatch Trafford Chair's Report to Trafford Health Scrutiny Committee 1st December – 16th January 2017/18

Work with other local Healthwatch in Greater Manchester

Since the creation of a liaison function based at Piccadilly Place, there is much improved communication and cooperation between the 10 HWs on issues of joint interest. This has been based on work which each HW has been doing as independent organisations. The number 1 priority has been mental health where every HW has been undertaking work.

Four representatives from Stockport, Wigan, Rochdale and Salford are leading respectively on Adult mental health, CAMHS, Dementia and population health. An induction programme has been planned. The liaison manager will set out clearly for these groups the expectations of HW representatives. I will meet with these individuals on a regular basis as the representative on the mental health policy development group to ensure effective communication.

We held a bi-lateral meeting with Salford Healthwatch to kick start an initiative looking at referrals from care homes to the Police and Ambulance Services. Trafford has taken the lead on the former.

We also held a bi-lateral meeting with Manchester Healthwatch on two main topics. The first is the CQC report on delayed transfers of care and the new mental health network established by GMMH covering both Trafford and Manchester mental health services.

CQC local system review of delayed transfers of care mandated by the Department of Health and Social Care. I attended the findings as a member of the Health and Wellbeing Board. We anticipate that the report findings and the resulting action plan will provide a steer for improved system-wide collaboration and thereby improve the health and wellbeing of Trafford residents.

Healthwatch Trafford's review of bed based intermediate care – our review was published on the 22 December. This was purposefully delayed to incorporate the evidence provided by the National Audit of Intermediate Care and the NICE guidance both published in November 2017. There are 12 recommendations in our report, split by short term measures for consideration at Ascot House and longer-term measures concerning the planned new care complex. In the early part of 2018 we will be selecting a second area of intermediate care to review. We will consult with partners on the most important area to cover. We have stated quite clearly that we believe that intermediate care is a fundamental adjunct to improving the flow of patients around the health and social care system and hope and anticipate that this will be a key component of policy in Trafford.

Strategy development – we have been concerned for some time about the lack of progress in developing longer term plans in some areas of policy. We are pleased, therefore, that

progress is being made in relation to dementia, frailty and palliative care – all necessary components of the proposed care complex.

Dementia United visit to Trafford

The Chief Executive of Salford CCG, on behalf of Dementia United and the Health and Social Care partnership hosted a visit to Trafford in early December. This was the penultimate visit around the 10 boroughs and only one of two visits which had invited a person with dementia. Whilst there were many good examples of practice there were, nevertheless, areas of improvement that were highlighted. Delayed transfers from mental health providers was one, as was improvements to care homes and increasing the numbers of people diagnosed with dementia which, although exceeding the original government targets, was below other areas of Greater Manchester.

Enter and View Visits

We have continued our programme of enter and view visits to care homes and these are provided to the Joint Quality meeting. We also visited Trafford General Hospital orthopaedic ward. Unfortunately, our report has been somewhat delayed because we received a substantial amount of staff comments two months following the visit and we felt that it was important that these should be incorporated. We anticipate that the final report will be published in February. Overall it was a positive visit particularly in respect of inpatients. There were a few recommendations in relation to outpatient attendances.

Partnership working – we have met with Chairs of PRAP and Health Scrutiny to improve collaboration and communication. We jointly agree that a master plan for communication as well as other means of engaging the public and providing the necessary scrutiny and challenge is required.

We have seen headline news during the period relating to people with mental health needs (across GM) having to travel long distances to have their needs met and, of course, the local CQC review.

We continue to be concerned about how the necessary CCG savings will impact on the public's health and wellbeing and will do whatever we can to facilitate engagement. We also agreed with the CQC findings in terms of strengthening both Health Scrutiny and the Health and Wellbeing Board but this does not absolve the need to improve effectiveness of all partners, including Healthwatch and PRAP.

We have met with the Chief Executive of Wythenshawe Hospital and also Diane Eaton and Paula Lee from Pennine Care. At both meetings we discussed the intermediate care report and our 2018 work plan so that we can provide engagement and feedback on the key issues facing Trafford's health and social care services.

Healthwatch Trafford Report on Bed Based Intermediate Care

Please find embedded below a copy of our recent report on Bed Based Intermediate Care.

HWT Report on Bed Based Intermediate

Quarter 3 2017/18 Highlights Report

Below is a copy of our most recent Highlights Report for information. This report is distributed to the public (primarily electronically) and gives brief updates of our activities within the specified quarter.

HWT Highlights Report Q3 2017/18

HW100

We continue to run our monthly Healthwatch 100 (HW100) surveys, which provide valuable insights into health and social care issues affecting Trafford residents. We have already published the results of our GP survey and will publish the results of surveys on allergies, NHS Choices, Dentistry, Women's Health and Pharmacies in the next couple of months.

Report on Dentistry

Following receipt of several complaints from Trafford residents about difficulties in registering with an NHS dentist, we conducted a survey and a mystery shopper exercise to try and establish the extent of the problem. The findings of this work are due to be published in a report in the next few weeks along with our recommendations. The report found that there are clear issues to address, the details of which will be released on publication.

Chair
Healthwatch Trafford

This page is intentionally left blank

Highlights report

Winter edition

Covering October – December 2017

Healthwatch Trafford is the independent local watchdog for local health and social care services. We provide information and signposting for local services and gather views and experiences from people that can be used to help providers improve.

Healthwatch Trafford helps local people get the best out of local health and social care services by:-

- providing information and advice about care choices and how to navigate health and social care systems
- listening to and taking people's experiences of health and social care to services to hold them to account
- making recommendations about how services can be improved
- involving people in monitoring local health and social care services

We listen to what people tell us through a variety of means such as drop-ins, surveys, enter and view visits and feedback to our website info@healthwatchtrafford.co.uk.

The last few months of 2017 were a busy time for Healthwatch Trafford. We spoke to lots of you at our drop-ins, Enter & View visits and stalls at events and have been gathering lots of your opinions and experiences online. It was a great way to end 2017, but we are hoping we will hear a whole lot more in 2018!

Men's Health

In November we published our much anticipated report on Men's Health in Trafford.

Jenny Capel, an intern working with us for 8 weeks over the summer from the University of Manchester, used a number of methods to gather experiences from a wide variety of men in the borough.

We created the report to find out more about how men use health services. The finished report includes conclusions and recommendations for how services can be improved to work better for the men of Trafford.

Advisory Group

Our second bi-monthly Advisory group meeting took place in late November and was well attended. The main topic for the evening was a discussion with Dr Mark Jarvis, Medical Officer/Clinical Director for Quality from Trafford Clinical Commissioning Group about new models of primary care, including plans to ensure quality, safe services and spending NHS money wisely.

Our next advisory group meeting is due to take place on 25th January 2018, with another on 29th March. If you would like to attend, please contact us and we can give you more information.

Enter & View

We have visited two care homes in this quarter.

Shawe Lodge nursing home in Urmston, which can provide care for up to 41 residents with dementia, was visited in October. You can see the published report here.

Serendipity care home, also in Urmston, which can provide care for up to 45 residents with dementia, which we visited in December. The report for that visit will be available in the reports section of our website soon.

In addition to the care homes, we also carried out an enter & view visit on the Manchester Orthopaedic Centre at Trafford General Hospital. The centre provides planned day-case and in-patient surgery for patients from Trafford, Salford and Manchester in a purpose-built facility, and the ward consists of a 20-bedded in-patient area and a 25-bedded day-case area. The report for that visit will be available in the reports section of our website soon.

Intermediate care

We published a report on intermediate care at Ascot house as part of our aim to look at intermediate care provision in Trafford and to contribute to the Care Quality Commission's new style of review.

The report can be found here.

News in brief :

- We were at the amazing opening of Limelight Old Trafford.
- We presented at the inaugural Greater Manchester Healthwatch conference.
- We held drop-ins at Trafford General & Altrincham hospitals as well as the Trafford Age UK dementia hub and Trafford Youth Cabinet conference.
- Our young volunteers presented to classes, schools and to Trafford Youth Cabinet.

The Trafford Healthwatch 100

Last year we launched our initiative to hear more about the experiences, views and opinions of those people that live, work or use health and social care services in Trafford.

The project, called the Trafford Healthwatch 100, aims to get as many local people as possible to sign up and give their views on various topics to do with health and social care on a regular basis.

We trying to capture as much information from people that use (or could use) services in the area as possible, so that we can use it to direct our work to the issues that matter.

The surveys are always quick and simple to complete, so you will never have to spend a long time filling them in. So far, we have covered GP Access, Men's Health, Women's health, Allergies, NHS dentists and more. But there is so much we need your help with.

To take part you can sign up via our website or get in touch with us and we can send you a paper version. Join today at healthwatchtrafford.co.uk/the100

You can find Healthwatch 100 news at healthwatchtrafford.co.uk/blog/

healthwatch Trafford

Call us on : 0300 999 0303

Text or WhatsApp: 07480 615 478

Email: info@healthwatchtrafford.co.uk

Tweet to: @healthwatchtraf

Companies House Reg No. 08466421. Registered in England and Wales

healthwatch Trafford

2017

HEALTHWATCH TRAFFORD'S REVIEW OF BED BASED INTERMEDIATE CARE

Contents

SUMMARY

This review of bed based care at Ascot House was our starting point on this topic; the other elements of intermediate care being crisis care, rehabilitation and home based care which we plan to review in 2018.

We need to point out that HWT has no access to any data sources and, therefore, this report is aimed at providing a rich source of opinion and qualitative feedback from the groups surveyed to inform current and future developments of intermediate care.

The average age of service users nationally in bed based intermediate care is 83 years of age. We know that Trafford's elderly population is set to rise both in terms of numbers (an estimated additional 10,000 by 2030) in complexity and in longevity.

We have, therefore, also looked at the National Audit of Intermediate Care to see if we can provide some indications of the future model of care for Trafford's care complex currently under review by Trafford Clinical Commissioning Group.

Our starting point for the current service was to develop a series of 3 questionnaires for GPs, referring hospital therapists and relatives of people using Ascot House, the current bed based intermediate care facility in Trafford. All responses were anonymised. The only exception to this was that we asked GPs to identify which locality they were part of so that we could see if there was any geographical bias in the responses received.

The GP survey was answered by 20 GPs. In total there were 10 question choices. Excluding yes/no answers we received 94 specific comments. 9 questions were skipped, of which 5 related to the question asking about the benefits of Ascot House.

The hospital Occupational Therapist survey was answered by 5 individuals. There were 35 question choices. Again, excluding yes/no answers we received 98 specific comments. There were 6 skipped comments.

The relatives' questionnaire survey comprised 17 questions. This was only completed by 2 relatives and 1 answer was skipped. This disappointing result is discussed within the main body of this report.

KEY CONSIDERATIONS FOR TRAFFORD'S REVIEW OF INTERMEDIATE CARE

Trafford is one of the 85 out of 154 organisations who took part in the NAIC audit and so will be well placed, on receipt of their individual entries (due in December 2017) to benchmark itself against the current provision and future model under the proposed care complex.

1. 85% of patients' dependence was maintained or improved
2. Mental health workers and social workers need to be well represented
3. There has been no step change in investment and capacity needed to meet demand over the past 4 years nationally
4. Total investment in intermediate care is around £2.8million per 100,000 weighted population (Trafford's current population 233,300 (estimated in 2015) of which there were 38,000 people over the age of 65 which is estimated to rise to 48,300 in 2030.
5. 69% of people in bed based care return home, 12% were returned to acute care reflecting the age and frailty of the service user cohort and increasing dependency.
6. Discharge to assess models have been recognised as effective where service users deemed to be 'clinically optimised' and no longer require an acute bed but may require some short term care and support.
7. A new NICE guideline (NG74) has been published recently. This recommends that intermediate care teams contain a broad range of disciplines including nursing, social work and therapy professions. The guideline also introduces an important aim for bed based services to start within two days of receiving an appropriate referral.
8. There should be a single point of access, a single management structure and a single assessment process as recommended by NICE.
9. It is estimated that 59% of capacity is being used for step up (last local figure is 17.5%) with 41% for step down.
10. The direct cost per service user of intermediate care services (excluding indirect costs and overheads) is £982 with an average length of stay of 26.8 days.
11. Therapy-led intermediate care services are very much in the minority – estimated at 10%.

The NAIC, having looked at the evidence, suggests that intermediate care is an effective component of the modern health and social care system and Healthwatch Trafford strongly supports that belief. We also believe that commissioning an effective intermediate care service will ameliorate delayed transfers of care.

RECOMMENDATIONS FOR CONSIDERATION

Planning for the proposed Care Complex

1. Trafford CCG should benchmark its intermediate care return (submitted to the National Audit of Intermediate Care in early 2017) against the overall NAIC results published in November 2017 and use this information as the basis for planning the proposed care complex. This should include the overall financial benefit to the soon to be established integrated health and social care organisation (see Appendix 1).

2. Health and Social Care should determine the preferred model encompassing capacity required for the period up to 2030, having regard to the standards required in the recently published NICE guideline (see Appendix 2).

3. The main consideration should be whether intermediate care services can provide an integrated nurse-led model (as opposed to the current therapy-led model) supported by the full range of practitioners advocated in the NAIC audit within the available resource set against savings in acute sector activity as a consequence of shorter lengths of stay or hospital avoidance.

4. The health and wellbeing benefits for patients should be uppermost and routinely evaluated.

Short term measures

5. In the short term, the admission criteria to Ascot House should be reviewed to include people with cognitive impairment, physical and learning disabilities.

6. There should be efforts to encourage and enable people from ethnic minorities to use Ascot House.

7. There should be organised activities for residents of Ascot House.

8. A list of conditions that would be suitable for step-up to avoid hospital admission should be agreed between GPs and the acute sector and performance managed to ensure change in behaviour to effect hospital avoidance.

9. The use of the Trafford Coordination Centre as the single point of access and information and advice to referrers in terms of bed availability, access criteria etc. should be explored.

10. The 'trusted assessor' pilot to ensure that patients are only assessed for intermediate care once, should be implemented as quickly as possible.

11. The role and function of Ascot House should be widely communicated and, where possible, acute and community staff exchange visits should be encouraged.

12. Efforts should be made to improve connectivity between IT systems.

PURPOSE AND RATIONALE FOR THE REVIEW

In October 2016, Healthwatch Trafford (HWT) decided to prioritise intermediate care within its work plan. This work plan was shared with TMBC and the CCG.

There are four components to intermediate care – as set out by the National Audit of Intermediate Care (NAIC). These comprise crisis care, home based care, re-ablement and bed based care. We selected Ascot House as the first of these four areas to review.

Our rationale for focussing on intermediate care beds was

- The need to provide patient experience qualitative information to enrich the range of quantitative data currently available to commissioners and providers but not available to HWT.
- To hear at first hand what patients/residents and relatives' views are in relation to the care they receive and whether they feel it enables them to regain their independence
- To seek the views of professionals as to how services could be improved
- To contribute to the understanding of how patients flow through the health and social care system and identify barriers
- To contribute to the understanding of how well services are being integrated.

Since HWT's review began, the CCG has initiated its own review of Ascot House and the CQC, on behalf of the Department of Health, is undertaking a local system review on Delayed Transfers of Care in Trafford (DTOCS) which will be reported back to the Health and Wellbeing Board in January 2018. HWT was invited to provide both verbal and written evidence to the CQC.

We were also asked to provide written evidence to the CQC's 'new style' review of Ascot House and we were able to provide feedback from the questionnaires we sent out but not this report.

ASCOT HOUSE

Ascot House is managed by Pennine Care under a Section 75 agreement with Trafford Metropolitan Borough Council and commissioned by Trafford Clinical Commissioning Group.

Ascot House was formerly a residential care home and is currently registered with the CQC as a residential facility providing 36 beds for the assessment of older adults. It provides rehabilitation for both step up and step down patients from hospital and is a therapy-led model with nursing input as required by district nurses. A local GP practice provides medical input. Ascot House is located in Sale and serves all Trafford GPs.

The current website states that 'Ascot House is an assessment centre for older adults. It also provides rehabilitation and has two beds available for regular respite users. Ascot House provides short term care and accommodation for up to 36 adults. The building is divided into four units, three of which provide assessment while the fourth unit provides intermediate care and rehabilitation to people recovering from illness'.

Recently, the top floor at Ascot House has been turned into a 9 bed 'home to assess' unit, giving a total capacity of 45 beds. A multi-disciplinary team provides physiotherapy, occupational therapy and social work support as required. Community services such as nursing, podiatry, dietetics and speech and language therapy support the unit when necessary.

Ascot House is described as 'supporting people of old age, with mental health conditions, dementia, physical impairment'. We can find no evidence that people with these conditions are admitted; rather that it is a service for the frail elderly who are assessed as being able to benefit from intermediate care therapy to enable them to return to their usual place of residence. The majority of patients are those that are stepped down from a hospital setting with only 17.5% stepped up to avoid hospital care.

HEALTHWATCH TRAFFORD METHODOLOGY FOR THE REVIEW

We set up task and finish groups to develop questionnaires for referrers in the main acute hospitals we use. Our volunteers developed three questionnaires with the help and support of the CCG (our particular thanks to Paul Fleming, Tracy Cartmell and Sarah Morton for their support). We also held meetings with Pennine Care and TMBC around the scope of the work.

Two questionnaires were one-off surveys where we sought the views of GPs, and referring practitioners (principally hospital therapists involved in discharge). In relation to relatives our intention was to have this given out on an 8 weekly basis by Ascot House staff to get an acceptable response level. Relatives were able to use a paper return or an on-line response. Regrettably, we only received two returns. Healthwatch has now decided to visit Ascot House periodically, with the agreement of management, to collect relatives' feedback.

We approached the respective Chief Executives of our acute trusts for their help and support in encouraging their staff to complete these surveys. We approached them on two separate occasions. We also sent out the GP questionnaire twice (with the support of the LMC Chief Executive).

We also visited Ascot House on the 9 August 2017. This was not a formal enter and view by HWT, rather it was a walk round for the HWT Chair and Chief Officer.

We were guided to various parts of Ascot House. Whilst this is a dated building it was, nevertheless, well maintained and meticulously clean. The staff we met appeared caring and friendly.

On the day of the visit the top floor (home to assess) was empty. The only patient who was appropriate for this service had been transferred to the ground floor.

We spoke to several patients, all of whom were elderly. They said that they had therapy in the mornings and then in the afternoons they conversed, had tea, watched TV or read. They were very complimentary about the food with three cooked meals each day.

We noted that in order to get residents ambulant and climbing stairs, they had to use the main staircase from the first to the second floor. These stairs are steep and are wholly inappropriate and, even with staff present, could be dangerous. A chair was sited on the landing but, even so, there were numerous stairs to climb to reach it.

HWT – as mentioned previously – has no access to occupancy rates, lengths of stay, nor have we seen admission or discharge criteria. Our observations on the day were that all the residents were frail elderly. We saw nobody with dementia, mental illness or physical disabilities.

Our impression on the day was that Ascot House was 50% occupied.

We noted that the community nursing team is called in overnight in case of need to support unqualified care staff. On the day of the visit the community rehabilitation team was being re-located to Ascot House.

On discharge from Ascot House, referral was made to each of the four localities in Trafford. Staff wondered if this might lead to differential responses depending on home care, therapist and voluntary sector availability.

A major barrier to more effective functioning was cited by staff as the need to use two different computer systems.

FINDINGS FROM HEALTHWATCH TRAFFORD SURVEYS

The GP Questionnaire

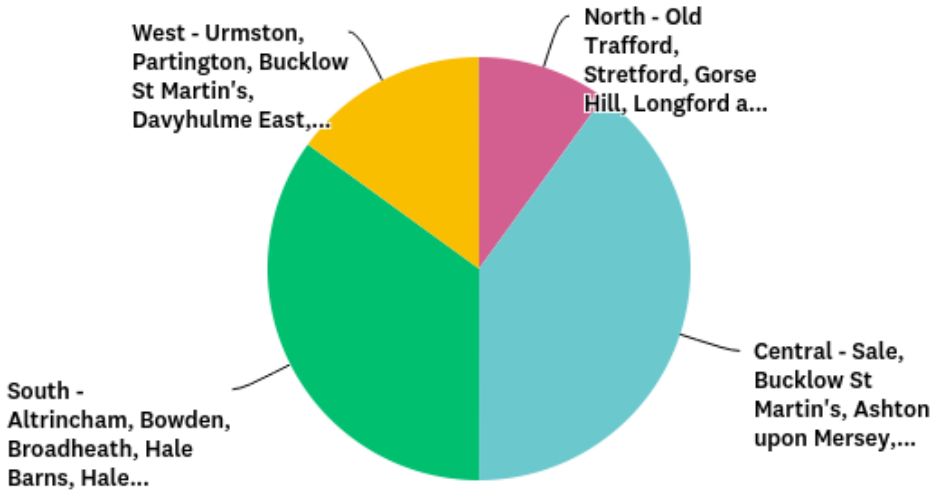


Figure 1. Location of GP surgeries we received responses from

80% of GPs said they were aware of what intermediate care services (step up or step down) can be provided at Ascot House, yet 80% had not used the service.

The reason for not using Ascot House were: 20 out of 20 responded and 16 commented as follows:

- No need to
- Not had appropriate patient
- Too much hassle to get in, in the end – an old lady with UTI almost 'off her legs'
- Both referrals declined, very narrow referral criteria, receiving staff not very helpful or available
- Not had appropriate patient
- I am a practice manager and would expect the GPs to do the referral
- Not required – usually step down from hospital
- Not had the opportunity, not had appropriate patients
- Not easy to access
- Don't know what they do or how to refer or what sort of patients they will see
- Unaware
- Not fully aware of what they do
- Did satisfy admission criteria
- No suitable patients

- Difficult to find patients which fit the criteria most a bit too sick or else don't really need it – is a very narrow window since it opened for step up. I have not come across a suitable patient.
- Too far from south locality

37% of GPs felt that Ascot House was simple to access but 63% found it difficult. 19 out of 20 responses were received. 12 GPs commented as follows:

- Would be easier if one number to someone who knew what they were talking about to talk through and help direct to the different options for step up care available.
- Hard to track down the right form, very hard to speak to someone directly, referrals declined
- Very complicated – reluctance to take patients – not helpful administration at all
- Not easily available
- Know nothing about it really
- My patient did not meet the criteria. However, she fell in her own home a few weeks later and was admitted to hospital. She was then discharged to Ascot House from hospital
- Not accessed
- Not used
- Don't use
- Don't know
- Don't know
- Don't know

85% of GPs felt that the geographical location of Ascot Housed was NOT a factor in referring patients to Ascot House. 20 out of 20 responded and 3 commented as follows:

- Geographical distance
- It is outside practice boundary
- Trafford

When asked whether Ascot House could be considered as an alternative to hospital admission 60% said YES and 40% said NO. 20 out of 20 responded.

When questioned as to whether there were any groups of patients reluctant to use Ascot House, the majority of GPs did not think so. One exception was potentially younger patients. 19 out of 20 responded and commented as follows:

- No
- Not applicable
- Younger patients
- Not sure they know about it – up to us to offer
- No
- Not to my knowledge
- Not known to me
- Nil particular

- Not known
- Not really. I use the enhanced care team to help the process for me
- No
- No
- Not applicable – never tried to refer anybody there
- Unsure
- None that I am aware of
- ?
- no
- no

'Any patient requiring hospital admission will not meet the criteria for Ascot House. It is, therefore, not an alternative to hospital admission. Ascot House is a therapy led service for well patients – step up is for this cohort e.g., fall but not unwell. The care package offered by Ascot House does not offer the diagnostic resource or treatment package needed for an unwell patient requiring hospital admission e.g. 24 hour nursing care, chest x-ray, intravenous antibiotics, diuretics or fluids. As a Sale GP my patients find Ascot House convenient.'

There was an even split of GPs who would refer to the Trafford Coordination Centre (TCC) for those patients that need any type of intermediate care (in crisis, in the community or in the patient's own home, including Ascot House.

Feedback on TCC was as follows: 20 out of 20 responded and 11 commented as follows:

- Too slow to respond, don't do anything
- Have rarely found the TCC of any help or value
- Not overly impressed by response
- With varying degrees of success
- Have not found it helpful
- I refer directly to the service I need using the single point of access
- Not convinced that TCC performs any useful function – not seen any evidence of this
- I didn't know TCC would act in a crisis
- Did not know they provide the role
- Hopeless service – completely ineffectual
- Intermediate care referral do not go via TCC they go to the single point of access for Pennine Care – this should be amalgamated into one gateway.

GPs were asked whether they had any suggestions that would lead to more efficient and effective use of Ascot House or any other form of intermediate care. 18 out of 20 responded as follows:

Responses were:

- Need additional facility within south locality

- Avoiding inappropriate admissions from hospital. It is a therapy led service e.g., ideal for rehabilitation of post op fracture. Patients have been sent to Ascot House very ill – e.g. with rigors and have had to be sent back to hospital
- Yes – can there be a service provision for patients who are frail, elderly and waiting for a nursing home to have a 'holding' service to prevent hospital admissions for social reasons? A criterion for Ascot House is 'patients will return to their home address' – prevents referring this group of patients.
- Ascot House is a therapy led service for the provision of rehabilitation. It is NOT an alternative to hospital admission for medically unwell patients and should not be seen as such. The majority of GPs have a good understanding of this fact. Unfortunately, pressure from Wythenshawe to 'step down' patients to free up beds frequently results in patients who are ill and need hospital treatment being discharged to Ascot House inappropriately. Admission of these inappropriate patients prevents admission of step up patients from the community.
- Single phone number to call, with knowledgeable person answering who is also aware of availability and can help direct as we as GPs not always aware of what options may be available/best for our patients.
- I found their refusal to accept patients with a dementia diagnosis ridiculous – we have an ageing population and increasing number of patients are being diagnosed with dementia but live independently with care at home – they need rehab too at times!
- Make it simpler – they must trust the GP's judgement for their patient care needs and the needs of the families – expansion of intermediate care will be a lot more cost efficient and better to be expanded.
- Needs relocating. Needs full review of function. Needs integrating
- More information and publicity on how to refer and what services are provided e.g., IVs.
- Continue to use the enhanced care team to organise through TCC as we struggle to keep up to date with beds, etc.
- Easier access and ALL beds to have in-house GP cover
- No
- Yes, clarity re what they do, easy referral process and not some long form. Let allied health professionals, district nurses and McMillan refer easily.
- To change the model from a therapy led service to a nurse led model as was originally proposed together with specifically commissioned allied health professional access i.e., speech and language therapists, dieticians and phlebotomy services
- No
- I think a facility such as Ascot House has limited ability to impact on stopping hospital admissions. It is an intensive physiotherapy resource in essence. If the aim is to prevent medical admissions by step up to intermediate care, Ascot House would have to offer a different service – 24- hour nursing – if, in addition to this, it was co-located on a hospital site, patients at Ascot House could be easily access diagnostics across the car park and then more patients could be managed in this facility. Also if they deteriorated, transfer would be easier – similarly step down would also be easier – then it would look something like Opal House at Wythenshawe (the problem is if this facility is run by secondary care it attracts a different tariff than if run by community services. The second problem is if different organisations run adjacent

services, the transfer criteria between the two becomes very bureaucratic and introduces time delays.

From your experience of using Ascot House, what do you consider to be the benefits? 15 of 20 responded as follows:

- Effective rehabilitation for post operative patients which can be done intensively before they return home.
- Therapy-led multidisciplinary approach in a local facility with experienced and dedicated staff
- No experience
- Very little, waste of time referring from primary care, unwieldy referral criteria
- Saving, good care of the patients and help to the families
- I don't
- Rehabilitative post hospital discharge
- Alternative to a busy expensive hospital. More holistic care
- Minimal
- Good way of getting frail elderly back on their feet
- Not applicable
- Not applicable
- Helpful for physical rehabilitation which currently is its commissioned purpose
- Patients like the rehabilitation closer to home that Ascot House provides
- Very good for step down and good for step up if the correct patient is referred in for rehabilitation.

The Hospital Questionnaire

We canvassed Chief Executive support from Wythenshawe, Salford Royal and Manchester Royal Infirmary and had five Occupational Therapist replies as the main referrers to Ascot House

3 OTs aware of Ascot House, whilst 2 were not. Similarly, 3 had referred, 2 of which were in the last 3 months and 1 in the last 6 months.

2 OT' said it was simple to access, whilst 1 did not. 4 said that Ascot House was their preferred option. 4 OTs said that as far as possible they fell in with patients, relatives and carers' influence in the decision to use Ascot House and 1 said 'where appropriate'.

In answer to the question 'do you collect or receive feedback from Ascot House, 1 agreed and 4 disagreed and made the following comments

- They don't send us feedback and the patient is already discharged from us in the hospital
- Never referred anybody there
- Wasn't aware of the service

- Feedback may come to our organisation, but does not necessarily get fed back to individual therapists who had referred.

Of the 5 referring Occupational Therapists, none had ever visited Ascot House in the past 6 months.

In terms of suggestions that would lead to more efficient and effective intermediate care, the following responses were received from 4 of the 5 therapists.

- Accepting the referrals from physiotherapists who have completed assessments and treatments of the patients in hospital, would be more efficient than spending therapists' time from intermediate care therapists coming into the hospital when already assessed and agreement between hospital multi disciplinary team, patients and their family agree to referral and then difficulty if not accepted to intermediate care therapy. Also intermediate care therapy assessors are coming in to see a patient for the first time and basing their acceptance/declining of referrals if they don't know them so can be difficult to build rapport or trust with a patient that is nervous or hard of hearing on first meeting someone new in their care.
- Being aware of this service that our patients are able to access
- Review the ever-changing criteria. For example, patients with cognitive impairment. The acute therapists have already begun rehabilitation and have to continue to rehabilitate this criteria of patient. If they were not able to progress they would not be referred. All deserve a chance.
- It is helpful to be able to discuss directly with Ascot House therapists' individual patients and their suitability. Feedback on how patients do and how we can improve referrals and their appropriateness would be helpful.

In response to the question 'do health and social care assessments take place on admission' 3 said 'yes' and 2 said 'no'.

Who undertakes assessments?

- Patients are assessed depending on their needs, may be a combination of nursing, physiotherapy and OT assessment
- The multi-disciplinary team (social worker, nurses, doctors and occupational therapist)
- Various staff and only when they are nearing the end of their stay in preparation for discharge planning. Minimum stay on the unit is 3 months (unit not identified).
- Therapists
- Uncertain how and if this happens

What do these assessments comprise?

- Depends on the patient's needs, will discuss home circumstances and how they are managing at home. Discuss mobility, transfers, aids, activities of daily living.

- Full nursing assessment. Family meetings, multi-disciplinary meetings and social work input
- Nursing needs assessment, capacity around discharge. Best interest meetings if required around discharge destination, continuing health care screen and meeting.
- Intermediate care therapists review referrals sent, contact therapists or visit the patient on the ward
- Not sure

In response to the question as to whether there was a specified time in the hospital's policy as to when initial assessment is undertaken, 3 responded 'yes' and 2 'no'. The next question asked whether this timescale was met and 1 person responded 'often' and 4 'routinely'.

OTs were then asked what the assessments comprised.

- Dependent on patient need and who they need treatment from e.g., physiotherapist, occupational therapist, social worker etc.
- Nursing needs assessment – continuing health care
- Social worker or district nurse visit to patient and family
- Uncertain

This was followed up by a question on whether there is a set time that assessments happen prior to discharge, and 4 OTs responded 'no' and 1 'yes'. 1 OT said that this timescale was met often and 4 routinely. These all took place on the ward.

Who is involved in the care of the patient during their stay in hospital was cited as health professionals but 4 of the 5 OTs said that social care was involved, 2 that voluntary organisations were involved and that district nurses, Macmillan, orthotics, RAID, psychiatry, and community services could also be called upon.

We then moved on to how quickly GPs were informed of discharge and 2 said same day, 1 next day, 2 next week. The next question was when was the patient's summary sent to the GP. 4 of the 5 said that this was sent on the same day as discharge take place, with 1 saying more than 1 week.

Occupational therapists were then asked if they used the Trafford Coordination Centre. 2 replied that they did and 3 that they did not.

In answer to 'what benefits do you see from TCC', the answers were as follows:

- Unknown service. I am not aware of this. GPs are informed of discharge by the medical team on discharge.
- Advice and liaison of services
- Not applicable
- Referrals are emailed to the single point of access

How are patients, relatives and carers informed of processes within the organisation?

- Open communication
- We arrange an early family meeting and have ongoing meetings as required. The last few around discharge
- Verbally
- Usually met by the professionals caring for the patient. Patient flow, discharged teams etc.
- Patients will be included in the process and informed of referrals and will have given consent.

We asked how often patients' discharges were delayed because their medication was not ready to go with them and the response from all respondents was 'sometimes'. The choices here were very often, often, sometimes or never.

We asked how patients, relatives and carers were enabled to make comments, compliments and complaints.

- Comments cards available, PALS service, friends and family test
- Friend and family test, questionnaire
- Yes
- Wards and departments are aware of PALS. There are notices around departments highlighting how to make complaints or compliments. Some have suggestion boxes to give opportunity for anonymity.
- Encouragement is given to provide feedback.

What out-of-hospital obstacles do you encounter in discharging patients to their chosen destination?

- Availability of onward referral places e.g. nowhere available to send them for rehabilitation, waiting social care at home or placement in nursing home not available. Big delays in getting carers at home. Lack of patients accepted by intermediate care..
- Availability of care packages. Continuing health care screening. Lack of nursing home placements. Complexity of discharges i.e., peg feeding, medication. Family dynamics and expectations.
- Placement availability specialist equipment. Specific placement wheelchair needs if the choice is not appropriate.
- Lack of places at nursing homes and residential homes. Awaiting social worker assessment. Family decision making. Intermediate care criteria. Lack of hospice placements. Not enough community or carer support for patients to return home.
  Unsuitable properties.
- Awaiting rehabilitation beds, packages of care, crisis cleans, provision of essential equipment.

In response to the question of how often patients are admitted/readmitted to hospital from intermediate care (past 6 months), 1 answered 'often' 3 'sometimes' and 1 'never'.

We then asked how services are adapted to account for patients' cultural needs.

- Treatments are completed with sensitivity to cultural or religious requirements e.g. treatment by same sex staff, single sex wards.
- Preferences noted on admission. If requiring a nursing home of their own culture for example. Interpreter services. Help with dietary choices. Give patient and family time to discuss the individual needs whilst in hospital
- Needs are asked and met as much as possible within available resources
- Acute hospital staff are very adaptable and always attempt to meet the needs of patients with cultural needs.
- Often try to look at getting patients directly home rather than to intermediate care beds if language is likely to be difficult to engage them in rehabilitation.
- Uncertainty about what intermediate care beds will have on offer for those with cultural needs.

How are care and services adapted to those patients with complex communication needs?

- Use of communication tools, e.g., written tools, interpreters, encouraging joint working with family and patients and the multi-disciplinary team
- We have a high number of patients with complex communication needs, mainly due to Aphasia due to stroke, cognitive impairment and hearing and visually impaired patients. We have speech and language therapists, rehabilitation assistants and activity coordinator to offer support.
- All our patients have complex needs
- Be aware of the communication difficulties and liaise with the appropriate services. Speech and language therapists, communication cards, translation services, adapting communication to the patient or carers form of communication.
- Use of interpreters and family.

From your experience of using Ascot House, what do you consider to be the benefits?

- A place to go for rehabilitation which is required for patients to aid return of function, but can be difficult to get patients accepted there and would benefit from coordination with ward therapists when they attend to assess the patient's need on the ward.
- I have little knowledge of Ascot House recently as stroke patients were deemed too complex to go there from the stroke pathway, the patient should remain in a stroke specialty environment for the whole of their journey. I feel it would, however, be beneficial if the care the individual receives at Ascot House could be tailored to meet the needs of stroke patients.
- When Ascot House accepted patients we were able to give the patient the opportunity to improve their function to enable them to have a better quality of life.
- More recently, with the extra beds, transfer to Ascot House has been quicker and communication better.

The Relatives' Questionnaire

It was extremely disappointing to have only received two responses from relatives of people in Ascot House. One person admitted from home, whilst the other person was referred by Salford Royal. In one instance the response was made in 3 days, whilst the other was approximately 4 weeks. In both cases the care plan had been explained and both carers had been involved in the development of the care plan. When asked if the staff at Ascot House regularly update on their relative's progress, both said that this did not happen. However, both felt that their relative was receiving appropriate care and that they were listened to. 1 person said they were kept fully aware of the support their relative was receiving, whilst one said they were not. When asked whether their relative had plenty to occupy them, one said they thought that they did but the other felt that although the staff were kind and engaged, more activities could be provided other than TV. Neither respondent felt that their relative was lonely at Ascot House.

WHAT DOES THE FUTURE HOLD FOR INTERMEDIATE CARE IN TRAFFORD?

HWT is absolutely committed to the idea of having a fully integrated intermediate care service. All the evidence points to the fact that, if well organised and properly resourced, this can have a dramatic impact on DTOCs. Furthermore, and as important if not more so, Trafford patients will benefit hugely by not having to stay in hospital one more day than necessary. This will help with re-ablement and reduce the chances of acquiring hospital infections as well as building resilience in the community and enabling people to return to their choice of destination.

However, what does concern HWT are future plans for this service in terms of its size and make-up. As plans proceed to develop Trafford's care complex, we must use the evidence to right-size the intermediate care element.

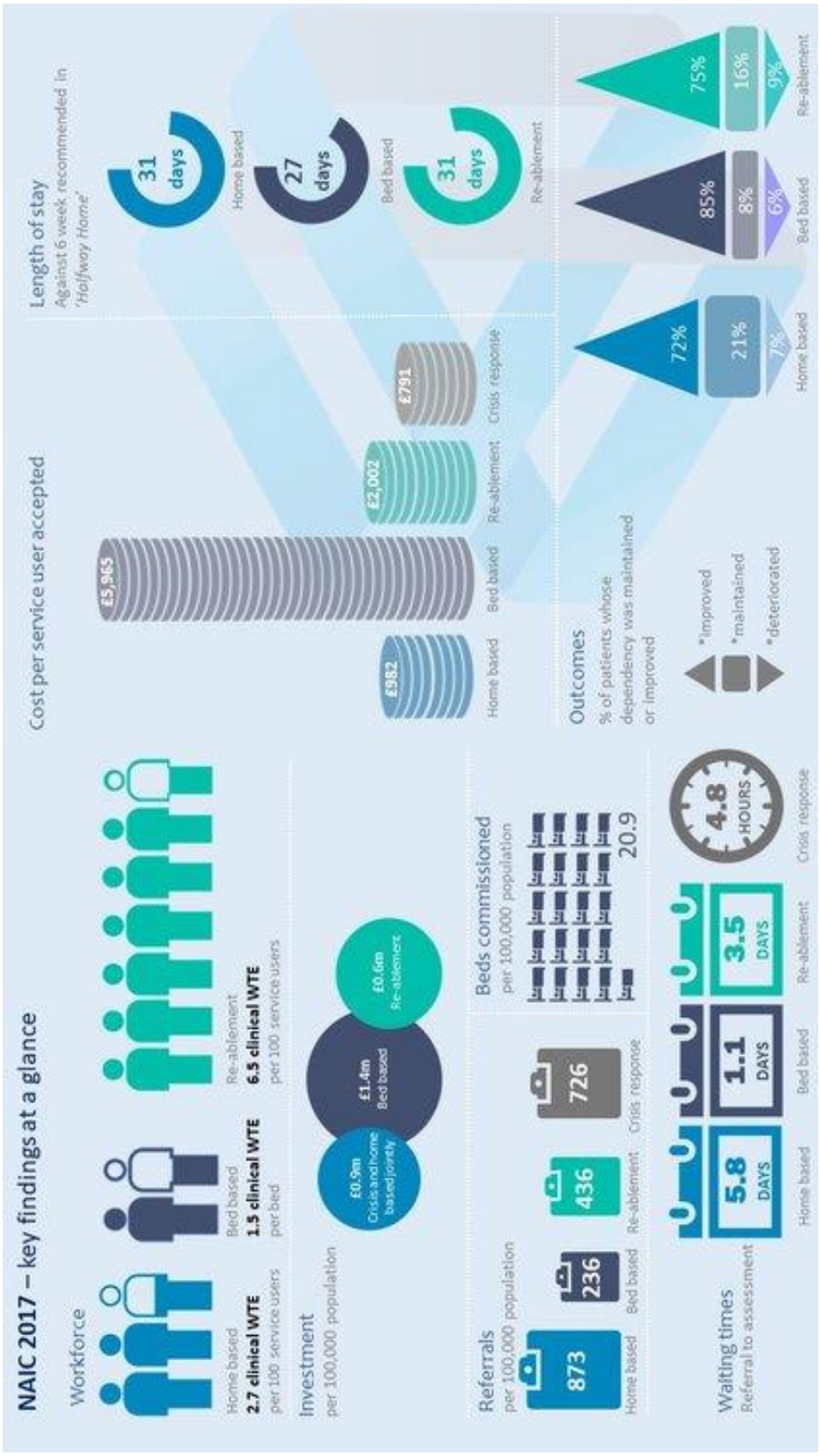
In order to do this, data NAIC has collected is the average – with a clear acknowledgement that current services across England only account for 50% of potential demand.

We make no apology for including key findings from the NAIC (published in mid-November 2017) in support of our belief that intermediate care will significantly improve the health and wellbeing of Trafford's residents.

END
27 November 2017.

Appendix 1: NAIC Key Findings At A Glance

National Audit of Intermediate Care 2017 (published November 2017)



Summary report available at https://www.nhsbenchmarking.nhs.uk/projects/naic

Appendix 2: NICE Guidelines on Intermediate Care

Full details and download of National Institute for Health and Care Excellence guidelines (September 2017) can be found here:
https://www.nice.org.uk/guidance/ng74

Intermediate care including reablement NICE guideline

Published: 22 September 2017

nice.org.uk/guidance/ng74

NICE guideline

Intermediate care including reablement

NICE guideline

Published: 22 September 2017

nice.org.uk/guidance/ng74

Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should **assess and reduce the environmental impact of implementing NICE recommendations** wherever possible.

Overview

This guideline covers referral and assessment for intermediate care and how to deliver the service. Intermediate care is a multidisciplinary service that helps people to be as independent as possible. It provides support and rehabilitation to people at risk of hospital admission or who have been in hospital. It aims to ensure people transfer from hospital to the community in a timely way and to prevent unnecessary admissions to hospitals and residential care.

Who is it for?

- Health and social care practitioners who deliver intermediate care and reablement in the community and in bed-based settings
- Other practitioners who work in voluntary and community services, including home care, general practice and housing
- Health and social care practitioners in acute inpatient settings
- Commissioners and providers
- Adults using intermediate care and reablement services, and their families and carers

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in **your care**.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

The term 'intermediate care' in this guideline refers to all 4 service models of intermediate care described in **terms used in this guideline**.

1.1 Core principles of intermediate care, including reablement

1.1.1 Ensure that **intermediate care** practitioners:

- develop goals in a collaborative way that optimises independence and wellbeing
- adopt a **person-centred** approach, taking into account cultural differences and preferences.

1.1.2 At all stages of assessment and delivery, ensure good communication between intermediate care practitioners and:

- other agencies
- people using the service and their families and carers.

1.1.3 Intermediate care practitioners should:

- work in partnership with the person to find out what they want to achieve and understand what motivates them
- focus on the person's own strengths and help them realise their potential to regain independence
- build the person's knowledge, skills, resilience and confidence
- learn to observe and guide and not automatically intervene, even when the person is struggling to perform an activity, such as dressing themselves or preparing a snack
- support **positive risk taking**.

1.1.4 Ensure that the person using intermediate care and their family and carers know who to speak to if they have any questions or concerns about the service, and how to contact them.

1.1.5 Offer the person the information they need to make decisions about their care and support, and to get the most out of the intermediate care service. Offer this information in a range of accessible formats, for example:

- verbally
- in written format (in plain English)
- in other accessible formats, such as braille or Easy Read
- translated into other languages
- provided by a trained, qualified interpreter.

1.2 Supporting infrastructure

1.2.1 Consider making **home-based intermediate care**, **reablement**, **bed-based intermediate care** and **crisis response** all available locally. Deliver these services in an integrated way so that people can move easily between them, depending on their changing support needs.

1.2.2 Ensure that intermediate care is provided in an integrated way by working towards the following:

- a single point of access for those referring to the service
- a management structure across all services that includes a single accountable person, such as a team leader
- a single assessment process
- a shared understanding of what intermediate care aims to do
- an agreed approach to outcome measurement for reporting and benchmarking.

1.2.3 Contract and monitor intermediate care in a way that allows services to be flexible and person centred. For recommendations on delivering flexible services, see NICE's guideline on **home care**.

1.2.4 Ensure that intermediate care teams work proactively with practitioners referring into the service so they understand:

- the service and what it involves

- how it differs from other services
- the ethos of intermediate care, specifically that it aims to support people to build independence and improve their quality of life
- that intermediate care is free for the period of delivery.

1.2.5 Ensure that mechanisms are in place to promote good communication within intermediate care teams. These might include:

- regular team meetings to share feedback and review progress
- shared notes
- opportunities for team members to express their views and concerns.

1.2.6 Ensure that the intermediate care team has a clear route of referral to and engagement with commonly used services, for example:

- general practice
- podiatry
- pharmacy
- mental health and dementia services
- specialist and longer-term rehabilitation services
- housing services
- voluntary, community and faith services
- specialist advice, for example around cultural or language issues.

1.2.7 Consider deploying staff flexibly across intermediate care, where possible following the person from hospital to a community bed-based service or directly to their home.

1.2.8 Ensure that the composition of intermediate care teams reflects the different needs and circumstances of people using the service.

1.2.9 Ensure that intermediate care teams include a broad range of disciplines. The core team should include practitioners with skills and competences in the following:

- delivering intermediate care packages
- nursing
- social work
- therapies, for example occupational therapy, physiotherapy and speech and language therapy
- comprehensive geriatric assessment.

1.3 Assessment of need for intermediate care

This section relates to the assessment of a person's support needs. It could be undertaken by a range of professionals, for example therapists, nursing staff or social workers, working in various locations. It aims to ensure that the type of intermediate care support is appropriate for the person's needs and circumstances.

1.3.1 Assess people for intermediate care if it is likely that specific support and rehabilitation would improve their ability to live independently and they:

- are at risk of hospital admission or have been in hospital and need help to regain independence **or**
- are living at home and having increasing difficulty with daily life through illness or disability.

1.3.2 Do not exclude people from intermediate care based on whether they have a particular condition, such as dementia, or live in particular circumstances, such as prison, residential care or temporary accommodation.

1.3.3 During assessment identify the person's abilities, needs and wishes so that they can be referred for the most appropriate support.

1.3.4 Actively involve people using services (and their families and carers, as appropriate) in assessments for intermediate care and in decisions such as the setting in which it is provided.

1.3.5 When assessing people for intermediate care, explain to them (and their families and carers, as appropriate) about advocacy services and how to contact them if they wish.

1.4 Referral into intermediate care

People may be referred into the services described in this section by either health or social care practitioners. The location of intermediate care will vary depending on how different areas configure the service to meet local circumstances and needs. Intermediate care could be commissioned by either health or social care commissioners, or jointly as part of an integrated working approach.

1.4.1 Consider providing intermediate care to people in their own homes wherever practical, making any adjustments, for example equipment or adaptations, needed to enable this to happen.

1.4.2 Offer **reablement** as a first option to people being considered for **home care**, if it has been assessed that reablement could improve their independence.

1.4.3 For people already using home care, consider reablement as part of the review or reassessment process. Be aware that this may mean providing reablement alongside home care. Take into account the person's needs and preferences when considering reablement and work closely with the home care provider.

1.4.4 Consider reablement for people living with dementia, to support them to maintain and improve their independence and wellbeing.

1.4.5 Consider **bed-based intermediate care** for people who are in an acute but stable condition but not fit for safe transfer home. Be aware that if the move to bed-based intermediate care takes longer than 2 days it is likely to be less successful.

1.4.6 Refer people to **crisis response** if they have experienced an urgent increase in health or social care needs and:

- the cause of the deterioration has been identified
- their support can be safely managed in their own home or care home
- the need for more detailed medical assessments has been addressed.

1.4.7 The crisis response service should raise awareness of its purpose and function among other local services such as housing and the voluntary sector. This means making sure they understand:

- the service and what it involves
- how it differs from other types of intermediate care
- how to refer to the service.

1.5 Entering intermediate care

1.5.1 Discuss with the person the aims and objectives of intermediate care and record these discussions. In particular, explain clearly:

- that intermediate care is designed to support them to live more independently, achieve their own goals and have a better quality of life
- that intermediate care works with existing support networks, including friends, family and carers
- how working closely together and taking an active part in their support can produce the best outcomes.

1.5.2 When a person starts using intermediate care, give their family and carers:

- information about the service's aims, how it works and the support it will and will not provide
- information about resources in the local community that can support them
- opportunities to express their wishes and preferences, alongside those of the person using the service
- opportunities to ask questions about the service and what it involves.

1.5.3 For bed-based intermediate care, start the service within 2 days of receiving an appropriate referral. Be aware that delays in starting intermediate care increase the risk of further deterioration and reduced independence.

Crisis response

1.5.4 Ensure that the crisis response can be started within 2 hours from receipt of a referral when necessary.

1.5.5 As part of the assessment process, ensure that crisis response services identify the person's ongoing support needs and make arrangements for the person's ongoing support.

1.5.6 Establish close links between crisis response and diagnostics (for example, GP, X-ray or blood tests) so that people can be diagnosed quickly if needed.

Person-centred planning

1.5.7 When planning the person's intermediate care:

- assess and promote the person's ability to self-manage
- tell the person what will be involved

- be aware that the person needs to give consent for their information to be shared
- tell the person that intermediate care is a short-term service and explain what is likely to happen afterwards.

1.5.8 Carry out a risk assessment as part of planning for intermediate care and then regularly afterwards, as well as when something significant changes. This should include:

- assessing the risks associated with the person carrying out particular activities, including taking and looking after their own medicines
- assessing the risks associated with their environment
- balancing the risk of a particular activity with the person's wishes, wellbeing, independence and quality of life.

  For recommendations on supporting people in residential care to take and look after their medicines themselves, see NICE's guidelines on **managing medicines in care homes** and **medicines optimisation**.

  [This recommendation is adapted from NICE's guideline on **home care**]

1.5.9 Complete and document a risk plan with the person (and their family and carers, as appropriate) as part of the intermediate care planning process. Ensure that the risk plan includes:

- strategies to manage risk; for example, specialist equipment, use of verbal prompts and use of support from others
- the implications of taking the risk for the person and the member of staff.

  [This recommendation is adapted from NICE's guideline on **home care**]

Agreeing goals

1.5.10 Discuss and agree intermediate care goals with the person. Make sure these goals:

- are based on specific and measurable outcomes
- take into account the person's health and wellbeing
- reflect what the intermediate care service is designed to achieve
- reflect what the person wants to achieve both during the period in intermediate care, and in the longer term
- take into account how the person is affected by their conditions or experiences
- take into account the best interests and expressed wishes of the person.

1.5.11 Recognise that participation in social and leisure activities are legitimate goals of intermediate care.

1.5.12 Document the intermediate care goals in an accessible format and give a copy to the person, and to their family and carers if the person agrees to this.

1.6 Delivering intermediate care

1.6.1 Take a flexible, outcomes-focused approach to delivering intermediate care that is tailored to the person's social, emotional and cognitive and communication needs and abilities.

1.6.2 Review people's goals with them regularly. Adjust the period of intermediate care depending on the progress people are making towards their goals.

1.6.3 Ensure that staff across organisations work together to coordinate review and reassessment, building on current assessment and information. Develop integrated ways of working, for example, joint meetings and training and multidisciplinary team working.

1.6.4 Ensure that specialist support is available to people who need it (for example, in response to complex health conditions), either by training intermediate care staff or by working with specialist organisations. [This recommendation is adapted from NICE's guideline on **home care**]

1.6.5 Ensure that an intermediate care diary (or record) is completed and kept with the person. This should:

- provide a detailed day-to-day log of all the support given, documenting the person's progress towards goals and highlighting their needs, preferences and experiences
- be updated by intermediate care staff at every visit
- be accessible to the person themselves, who should be encouraged to read and contribute to it
- keep the person (and their family and carers, as appropriate) and other staff fully informed about what has been provided and about any incidents or changes.

1.6.6 Ensure that intermediate care staff avoid missing visits to people's homes. Be aware that missing visits can have serious implications for the person's health or wellbeing, particularly if they live alone or lack mental capacity. [This recommendation is adapted from NICE's guideline on **home care**]

1.6.7 Contact the person (or their family or carer) if intermediate care staff are going to be late or unable to visit. [This recommendation is adapted from NICE's guideline on **home care**]

1.7 Transition from intermediate care

1.7.1 Before the person finishes intermediate care, providers of intermediate care should give them information about how they can refer themselves back into the service, should their needs or circumstances change.

1.7.2 Ensure good communication between intermediate care staff and other agencies. There should be a clear plan for when people transfer between services, or when the intermediate care service ends. This should:

- be documented and agreed with the person and their family or carers
- include contact details for the service
- include a contingency plan should anything go wrong.

For recommendations on communication during transition between services, see NICE's guideline on **transition between inpatient hospital settings and community or care home settings for adults with social care needs**.

1.7.3 Give people information about other sources of support available at the end of intermediate care, including support for carers.

1.8 Training and development

1.8.1 Ensure that all staff delivering intermediate care understand:

- the service and what it involves
- the roles and responsibilities of all team members
- how it differs from other services
- the ethos of intermediate care, specifically that it aims to support people to build independence
- how to work collaboratively with people to agree person-centred goals
- positive risk taking.

1.8.2 Ensure that intermediate care staff are able to recognise and respond to:

- common conditions, such as diabetes; mental health and neurological conditions, including dementia; frailty; stroke; physical and learning disabilities; sensory loss; and multi-morbidity
- common support needs, such as nutrition, hydration, continence, and issues related to overall skin integrity
- common support needs, such as dealing with bereavement and end of life
- deterioration in the person's health or circumstances.

[This recommendation is adapted from NICE's guideline on **home care**]

1.8.3 Provide intermediate care staff with opportunities for:

- observing the work of another member of staff
- enhancing their knowledge and skills in relation to delivering intermediate care
- reflecting on their practice together.

Document these development activities and record that people have achieved the required level of competence.

1.8.4 Ensure that intermediate care staff have the skills to support people to:

- optimise recovery
- take control of their lives
- regain as much independence as possible.

Terms used in this guideline

Bed-based intermediate care

Assessment and interventions provided in a bed-based setting, such as an acute hospital, community hospital, residential care home, nursing home, stand-alone intermediate care

facility, independent sector facility, local authority facility or other bed-based setting. Bed-based intermediate care aims to prevent unnecessary admissions to acute hospitals and premature admissions to long-term care, and to support timely discharge from hospital. For most people, interventions last up to 6 weeks. Services are usually delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

Crisis response

Community-based services provided to people in their own home or a care home. These services aim to avoid hospital admissions. Crisis response usually involves an assessment, and may provide short-term interventions (usually up to 48 hours). Crisis response is delivered by a multidisciplinary team but most commonly by healthcare professionals.

Home-based intermediate care

Community-based services that provide assessment and interventions to people in their own home or a care home. These services aim to prevent hospital admissions, support faster recovery from illness, support timely discharge from hospital, and maximise independent living. For most people interventions last up to 6 weeks. Services are delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

Home care

Care provided in a person's own home by paid care workers which helps them with their daily life. It is also known as domiciliary care. Home care workers are usually employed by an independent agency, and the service may be arranged by the local council or by the person receiving home care (or someone acting on their behalf).

Intermediate care

A range of integrated services that: promote faster recovery from illness; prevent unnecessary acute hospital admissions and premature admissions to long-term care; support timely discharge from hospital; and maximise independent living. Intermediate care services are usually delivered for no longer than 6 weeks and often for as little as 1 to 2 weeks. Four service models of intermediate care are available: bed-based intermediate care, crisis response, home-based intermediate care, and reablement.

Person-centred approach

An approach that puts the person at the centre of their support and goal planning. It is based around the person's strengths, needs, preferences and priorities. It involves treating them as an equal partner and considering whether they may benefit from intermediate care, regardless of their living arrangements, socioeconomic status or health conditions.

Positive risk taking

This involves balancing the positive benefits gained from taking risks against the negative effects of attempting to avoid risk altogether.

Reablement

Assessment and interventions provided to people in their home (or care home) aiming to help them recover skills and confidence and maximise their independence. For most people interventions last up to 6 weeks. Reablement is delivered by a multidisciplinary team but most commonly by social care practitioners.

For other social care terms see the Think Local, Act Personal **Care and Support Jargon Buster**.

Putting this guideline into practice

NICE has produced **tools and resources** to help you put this guideline into practice.

Some issues were highlighted that might need specific thought when implementing the recommendations. These were raised during the development of this guideline. They are:

- Ensuring an integrated approach to intermediate care. Currently, the 4 service models of intermediate care tend to operate separately, delivered by different staff and funded from different budgets. Moving to a more integrated approach for planning, funding and delivery of all 4 models, including transferable assessments that are accepted across all services, would improve the experience for people using the services. However, such changes may be difficult to achieve.
- Starting bed-based intermediate care services within 2 days (and crisis response within 2 hours) of receiving an appropriate referral. Rapid provision of the right intermediate care service will benefit people using the services, and may help reduce pressure on hospital beds. However, this approach will prove challenging in light of the current financial pressures and demands on the services.
- Making sure the aims, objectives and purpose of intermediate care are understood by people using the services, their families, and professionals from the wider health and social care system. There is currently a lack of understanding that the term 'intermediate care' includes intermediate care services funded by the healthcare system and reablement services funded by social care. In addition, there is low awareness that active rehabilitation or reablement is quite different from ongoing care and support.
- Developing leadership that promotes clarity of purpose and good communication within each service, and provides guidance and support to staff. This leadership will help staff working in intermediate care services to deliver a service focused on enabling and supporting independence, and optimising wellbeing.

Putting recommendations into practice can take time. How long may vary from guideline to guideline, and depends on how much change in practice or services is needed. Implementing change is most effective when aligned with local priorities.

Changes should be implemented as soon as possible, unless there is a good reason for not doing so (for example, if it would be better value for money if a package of recommendations were all implemented at once).

Different organisations may need different approaches to implementation, depending on their size and function. Sometimes individual practitioners may be able to respond to recommendations to improve their practice more quickly than large organisations.

Here are some pointers to help organisations put NICE guidelines into practice:

1. **Raise awareness** through routine communication channels, such as email or newsletters, regular meetings, internal staff briefings and other communications with all relevant partner organisations. Identify things staff can include in their own practice straight away.

2. **Identify a lead** with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.

3. **Carry out a baseline assessment** against the recommendations to find out whether there are gaps in current service provision.

4. **Think about what data you need to measure improvement** and plan how you will collect it. You may want to work with other health and social care organisations and specialist groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.

5. **Develop an action plan**, with the steps needed to put the guideline into practice, and make sure it is ready as soon as possible. Big, complex changes may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.

6. **For very big changes** include milestones and a business case, which will set out additional costs, savings and possible areas for disinvestment. A small project group could develop the action plan. The group might include the guideline champion, a senior organisational sponsor, staff involved in the associated services, finance and information professionals.

7. **Implement the action plan** with oversight from the lead and the project group. Big projects may also need project management support.

8. **Review and monitor** how well the guideline is being implemented through the project group. Share progress with those involved in making improvements, as well as relevant boards and local partners. Taking part in the National Audit of Intermediate Care (NAIC) will help to provide a benchmark for measuring progress and will add to the national data on intermediate care.

NICE provides a comprehensive programme of support and resources to maximise uptake and use of evidence and guidance. See our **into practice** pages for more information.

Also see Leng G, Moore V, Abraham S, editors (2014) Achieving high quality care – practical experience from NICE. Chichester: Wiley.

Context

The NHS and social care sectors are experiencing unprecedented pressure due to increasing demand from people living longer, often with complex needs or impairments and 1 or more long-term conditions. Admission to hospital and delays in hospital discharge can create significant anxiety, physical and psychological deterioration, and increased dependence. Multidisciplinary services that focus on rehabilitation and enablement can support people and their families to recover, regain independence, and return or remain at home.

Intermediate care uses a range of service models to help people be as independent as possible. It can prevent hospital admissions, facilitate an earlier, smoother discharge, or be an alternative to residential care. It can also offer people living at home who experience difficulties with daily activities a means to maintain their independence.

This guideline focuses on the 4 service models included in the **National Audit of Intermediate Care summary report 2014** (NHS Benchmarking Network):

- bed-based intermediate care
- home-based intermediate care
- crisis response
- reablement.

These services are for adults aged 18 years or over and are delivered in a range of settings, such as:

- community settings, including:
    - people's own homes
    - temporary accommodation
    - specialist housing, such as sheltered, warden-supported or extra care housing
    - supported living housing (including shared lives schemes)
    - day centres
- residential and nursing care homes
- dedicated intermediate care and reablement facilities
- acute, community and day hospitals
- prisons.

The concept of intermediate care was developed by the Department of Health in 2000 in their **NHS Plan** and implemented in England through their **National Service Framework for Older People**. Reablement specifically received policy support in 2010 when it was recognised as a means of prolonging or regaining independence.

The Care and Support White Paper subsequently announced the transfer of funds from the NHS Commissioning Board to local councils in 2013–14. Most recently, NHS commissioners and local authorities have been required, via the **Better Care Fund** and the **NHS Five Year Forward View**, to take a more integrated approach to planning by pooling budgets to support models of integrated care and support, including reablement and intermediate care. The **Care Act 2014** requires that services, including intermediate care, should consider how person-centred support is planned to promote individual wellbeing.

This guideline covers intermediate care services provided by the NHS and social care, and how these are best planned and delivered alongside services provided by the voluntary and independent sector. It identifies the key components of the intermediate care pathway (see below), and how services can work together with the person and their support networks to deliver effective intermediate care. The guideline draws on the evidence base to highlight best practice, making recommendations that aim to provide equity of access and a more integrated approach to provision. It also aims to bring greater coherence, parity and

responsiveness to service delivery, reducing duplication of effort and clarifying responsibilities for service providers.

The intermediate care pathway

Local areas may take different approaches to configuring their intermediate care service depending on existing resources and team structures, but the pathway should always include the following functions (described in more detail in the recommendations):

- **Assessing the need for intermediate care** – this includes gathering information about the person and deciding which intermediate care setting is most appropriate. If the person is in hospital, their assessment may include developing goals to include in the referral to the intermediate care team. If the person is at home the assessment may be completed by a social worker, community nurse, crisis response team, or community social care occupational therapist.
- **Acceptance by the intermediate care service** – an individual plan is then developed by the intermediate care team, based on the person's assessment. Goals are agreed with the person and then reviewed regularly. The plan should contain enough information so that staff visiting the person and providing their rehabilitation know what needs to be done.
- **Delivery of the service** – this should always be based on the agreed plan, and if problems arise then support staff should be able to contact the assessing practitioner in the intermediate care team.
- **A formal review** – this should be undertaken as the person approaches achieving their goals with a clear plan for transition from the intermediate care service. If the person has ongoing support needs there may be a handover to a new home care provider or day service. If the person has achieved their desired level of independence the plan may include information about how to refer themselves back into the service if they need to, and links to community services that can support them.

More information

To find out what NICE has said on topics related to this guideline, see our web page on **adult social care**.

Recommendations for research

The guideline committee has made the following recommendations for research.

1 Optimal time between referral and starting intermediate care

What is the optimal time between referral to and starting intermediate care in terms of effectiveness and cost effectiveness and in terms of people's experiences?

Why this is important

Recommendation 1.4.3 states that for bed-based intermediate care, the service should start within 2 days of a referral being received. There is moderate-quality evidence to suggest that if the referral is made from acute care then the person's condition will begin to deteriorate if intermediate care does not start within 2 days. There is no clear evidence about the most effective timescale for people whose referral is being made in different circumstances, for example if they are at home and being referred for home-based intermediate care or reablement to prevent hospital admission or improve independence.

A comparative evaluation is needed to assess outcomes associated with different lengths of time between referral and starting the 4 intermediate care service models. Also, to assess the resource impact and overall cost effectiveness of different waiting times. Effectiveness and cost-effectiveness research should be complemented by qualitative data from people receiving and delivering the service to investigate their views and experiences and the perceived impact on the person's level of independence and quality of life.

2 Team composition for home-based intermediate care

How effective and cost effective are different approaches, in terms of team structure and composition, to providing home-based intermediate care for adults?

Why this is important

The skill mix and competency of a home-based intermediate care team can influence the quality of care and outcomes. The evidence on views and experiences of home-based intermediate care is exclusively from health and social care practitioners, with no evidence from other care and support practitioners from the community.

Comparative studies are needed to determine the effectiveness and cost effectiveness of different approaches to delivering home-based care and support, in terms of team skills, structure and composition. A better understanding of how these factors influence quality of care could improve outcomes for people who use home-based intermediate care.

Qualitative studies are also needed to explore the views and experiences of a wider range of care and support practitioners. This will help practitioners learn about and understand each other's roles, which will improve their delivery and quality of care.

3 Crisis response

What are the barriers and facilitators to providing an effective and cost effective crisis response service, with particular reference to different models for structuring delivery of this service?

Why this is important

There is no evidence on the effectiveness and cost effectiveness of crisis response services. The evidence that is available shows that practitioners and people using this service found the short-term support provided (up to 48 hours) too limited to address the needs of older people. It is also unclear if health and social care practitioners fully understand the purpose of the crisis response service when making referrals.

Comparative studies are needed to evaluate the different approaches to structuring the delivery of crisis response services to improve outcomes.

Cost information is also needed. This needs to be supplemented by qualitative data to explore how well the crisis response service is understood among practitioners.

4 Dementia care

How effective and cost effective is intermediate care including reablement for supporting people living with dementia?

Why this is important

Some intermediate care and reablement services support people living with dementia. However, others specifically exclude people with a dementia diagnosis, because they are perceived as being unlikely to benefit. There is limited evidence on the effectiveness and cost effectiveness of using intermediate care and reablement to support people with dementia.

There is no evidence on the views and experiences of people living with dementia, their family and carers, or health, social care and housing practitioners, in relation to the support they receive from intermediate care and reablement services.

Comparative effectiveness and cost-effectiveness studies are needed to evaluate the different approaches to delivering support to people with dementia. This will help to ensure that both a person's specialist dementia needs and their intermediate care and reablement needs are accommodated in the most effective way. The studies should include a comparison of care provided by a specialist dementia team with that provided by a generalist team; and access versus no access to memory services. These need to be supplemented with qualitative studies that report the views and experiences of people living with dementia, their family and carers, and practitioners.

5 Reablement

How effective and cost effective are repeated periods of reablement, and reablement that lasts longer than 6 weeks?

Why this is important

The evidence that reablement is more effective than home care at improving people's outcomes is based on data from 1 period of reablement. In current practice, people can use reablement repeatedly. There is no evidence on the outcomes and costs for people who use reablement more than once.

In addition, there is no peer-reviewed study that measures the impact of different durations of reablement for different population groups. This is important because in practice, reablement is funded for up to 6 weeks only. However, some people are offered reablement for a period of more than 6 weeks based on their identified needs. At present there is very limited knowledge about the costs and outcomes of reablement as provided to different population groups, and the optimal duration for these groups.

Longitudinal studies of a naturalistic design with a control group are needed to follow up people who have received reablement several times or over a longer period than 6 weeks, or both.

Comparative studies are also needed to understand the long-term impact of duration on costs and patient outcomes, by comparing 6-week reablement services with services that last longer than 6 weeks.

6 A single point of access for intermediate care

How effective and cost effective is introducing a single point of access to intermediate care?

Why this is important

There is evidence that poor integration between health and social care is a barrier to successfully implementing intermediate care. A management structure that has a single point of access can help to improve communication between teams and speed up referral and access to services.

Comparative studies are needed to evaluate the effectiveness and cost effectiveness of introducing a management structure that has a single point of access versus a structure with no single point of access. This will help to reduce the length of time from referral to receipt of intermediate care.

7 Duration and intensity of home-based intermediate care

How effective and cost effective are different approaches, in terms of duration and intensity, to providing home-based intermediate care for adults?

Why this is important

There is some evidence that people who used home-based intermediate care found their care ended too suddenly at 6 weeks, and poor communication compounded this negative perception. The optimal time limit can differ depending on people's health and care and support needs.

Studies of comparative designs are needed to assess the effectiveness and cost effectiveness of different intensities and durations of home-based intermediate care for people with a range of care needs.

8 Support for black and minority ethnic groups

How effective and cost effective are different approaches to supporting people from black and minority ethnic groups using intermediate care?

Why this is important

Addressing the cultural, language and religious needs of black and minority ethnic groups can remove some of the barriers to accessing support services. There is no evidence on the effectiveness and cost effectiveness of intermediate care in supporting people from black or minority ethnic groups to access intermediate care and reablement.

Comparative effectiveness and cost-effectiveness studies are needed to evaluate 'what works' in terms of planning and delivering intermediate care for minority groups. This includes all 4 service models of intermediate care. Qualitative data are needed on the views and experiences of people from black and minority ethnic groups, their family, carers, practitioners and voluntary support groups to inform the development of a service that meets the needs of this population.

ISBN: 978-1-4731-2686-2

Accreditation

NICE accredited

www.nice.org.uk/accreditation

November 2017

Text & Whatsapp
07480 615 47

Find out more at
healthwatchtrafford.co.uk

Email us at
info@healthwatchtrafford.co.uk

Tweet and follow us at
@healthwatchtraf

Like and follow us on
Facebook

healthwatch
0300 0303 Trafford

Companies House Reg.No. 08466421.
Registered in England and Wales