Urgent Care and Delayed Transfer Of Care Update

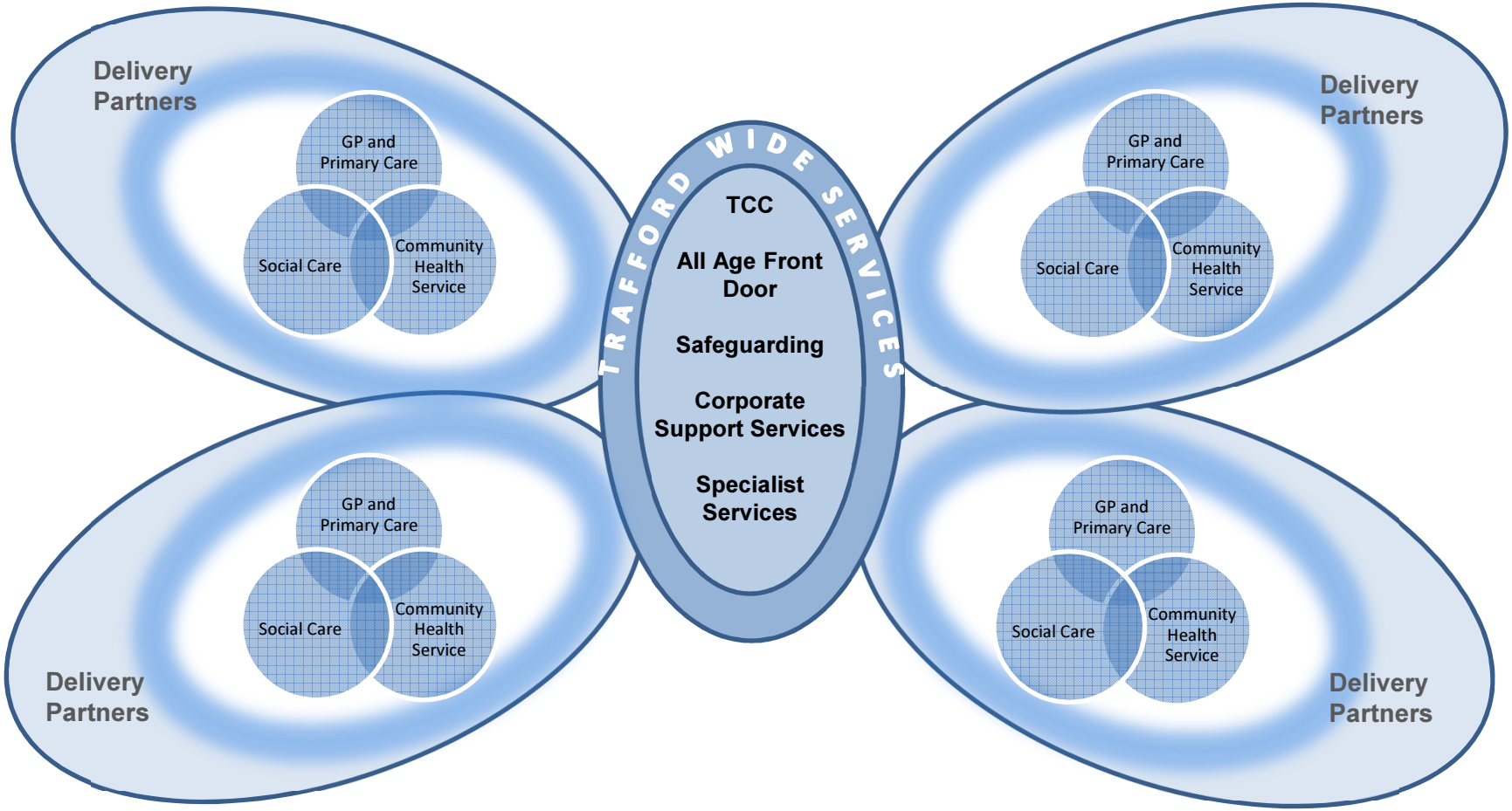
March 2017

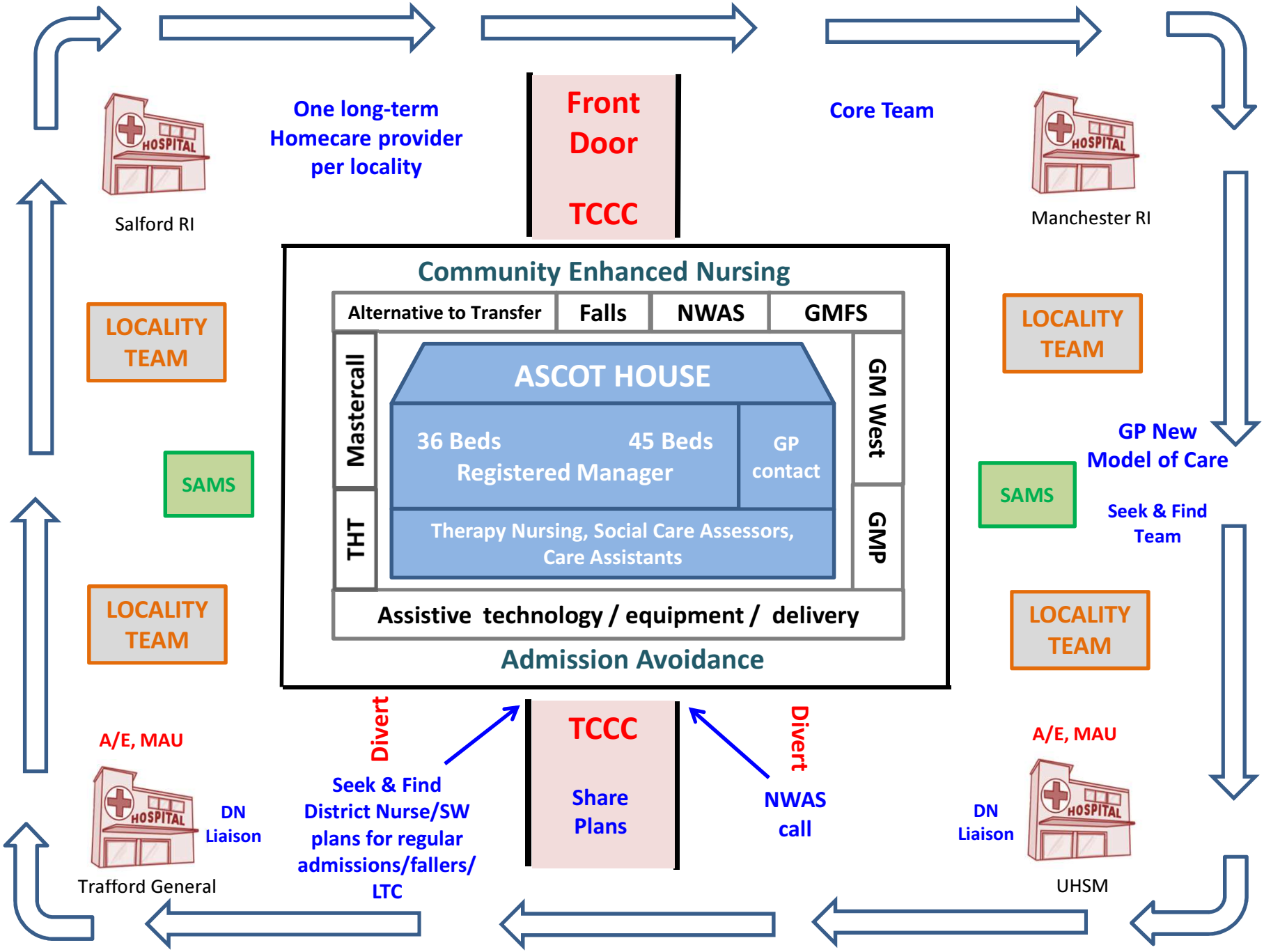
V5 21.02.17

Presentation aims to cover

- Activity levels at Hospital sites
- Home care market
- Residential and nursing care capacity
- Winter pressures and demands

Quick reminder




Front Door
TCCC
One long-term Homecare provider per locality
Core Team
Salford RI
Manchester RI
Community Enhanced Nursing
Alternative to Transfer
Falls
NWAS
GMFS
Mastercall
ASCOT HOUSE
36 Beds
45 Beds
Registered Manager
GP contact
GM West
THT
Therapy Nursing, Social Care Assessors, Care Assistants
GMP
Assistive technology / equipment / delivery
Admission Avoidance
LOCALITY TEAM
LOCALITY TEAM
SAMS
SAMS
GP New Model of Care
Seek & Find Team
LOCALITY TEAM
LOCALITY TEAM
A/E, MAU
A/E, MAU
DN Liaison
DN Liaison
Trafford General
UHSM
Divert
Seek & Find District Nurse/SW plans for regular admissions/fallers/ LTC
TCCC
Share Plans
Divert
NWAS call

Conversion Rate Comparison (2015/16 to 2016/17)

Hospital	Conversion Rate Comparison						
	Q1 Avg	Q2 AVG	Q3 Avg	Q4 Avg	Variance	Trend	15/16 Avg
TGH	43.2%	39.5%	38.5%		-1.0%	Down	N/A
UHSM	47.8%	39.9%	43.2%		3.3%	Up	29%
Manchester Royal Infirmary	44.3%	35.6%	28.6%		-7.0%	Down	N/A
Salford Royal Infirmary	50.3%	43.1%	39.7%		-3.4%	Down	N/A
Other	31.8%	31.1%	23.2%		-7.9%	Down	N/A

*N.B The trend relates to the change from the previous quarter
December data subject to change once all care plans have been updated in Liquid Logic

Trying to increase the appropriate number of referrals/reduce unnecessary assessment activity

Initiatives to support the pressure

- Contact officers completing telephone triage for all wards
- Ward rounds occurring daily with contact officers to support early identification
- Community Enhanced Care pilot completed in ED for 3 months at UHSM
- Dedicated Trafford Manager has been put in place at UHSM to support the work
- CHC presence on all sites at key points to ensure decisions are made quickly and an improved CHC application process.
- Increased District nurse liaison
- Home care commissioning presence at key points to support the process
- Increased commissioning of Stabilise And Make Safe

Home care

- Additional providers brought into Trafford in last 12 months (9). Further Mini block tenders in November 2016 proved unsuccessful. Providers used off Framework during December 2016/January 2017
- New stabilise and make providers piloted for 12 months producing extremely positive outcomes —commissioning looking to expand current offer further
- Developing an innovation site to model a sustainable integrated homecare offer which builds on community assets and individual strengths
- Bidding for well-being teams
- Developing a strengthened voluntary sector offer

Residential and nursing care

- Analysis of market completed by TMBC and CCG to establish capacity required for winter
- 30 Additional rapid discharge beds commissioned and being refreshed as required.
- GM work commenced to redesign the framework and improve access
- Redesigned process at UHSM and TGH to support timely discharges
- Intermediate care beds fully operational at Ascot House (step up/stepdown)

Ascot house Intermediate care unit

Ascot House Intermediate Care Unit

The new Therapy Lead Model commenced in October 2016 delivered jointly by Trafford Council and Pennine Care NHS Foundation Trust.

The bed capacity over a period of time has increased to 36 beds across 4 units each containing 9 beds.

The unit is staffed with Physio therapy, Occupational therapy, In Reach Nursing Staff, Support Workers, Social Care Assessors, Social Care Management team, Domestic staff and cooks.

We have a GP from Washway Road Medical Practise on site each day for several hours. Weekends and evenings are covered by MASTERCALL.

Referral Criteria

Referrals to the unit can be made from both the acute and community sector, for anyone who meets the admission criteria. The patient must be aged over 18 years and with a Trafford GP.

- The patient is medically fit with no outstanding investigations
- For step-up referrals only – a recent GP summary been received prior to referral
- The patient is able to transfer with one or two members of staff with or without a mobility aid (hoist transfers are not accepted)
- The patient's primary need is for short-term therapy input and rehab

- The patient is currently compliant during therapy treatment and interventions (if applicable)
- The patient has consented to this referral and is willing to actively engage with a therapy treatment plan set by the therapy team
- The patient has the ability to actively engage with therapy (including being able to follow and retain verbal instruction and/or information as may be offered to them)
- The patient's current needs are not complex and can be met by health care assistants over a 24 hour period
- Relevant forms - The admission criteria for hospital discharges, admission criteria for community referrals and the referral form are attached to this email, and also available to download at www.penninecare.nhs.uk/traffordcs

From **October 2016** the number of patients who have been admitted to our service and their average length of stay

October 2016 Patients 9 with an average stay of 47 days

November 2016 Patients 21 with an average stay of 56 days

December 2016 Patients 23 with an average stay of 48 days

January 2017 Patients 21 with an average stay of 62 days

Community Enhanced Care (CEC)

- Team completed a 3 month Pilot in A&E at UHSM July to August 2016
- Identify appropriate patients to ‘turn around’ therefore preventing admission.
- Provided overview of reasons why Trafford’s older patient’s were attending A&E especially from Care Homes.
- Increased presence in the hospital and raised profile of the team.
- Identified patients who would on discharge benefit form enhanced care on discharge.
- In total 633 patients who met the referral criteria were reviewed by CEC staff during the project.

- Only 6 patients from a care home presented during the 3 month period. All but one was admitted appropriately.

- The majority were not medically fit for discharge and needed to be cared for in hospital.

- Of those seen 62 were discharged home with no further support.

- There were 13 urgent referrals to CEC during the three month period which was similar to the number normally received from UHSM. This demonstrated that the A & E staff understood the CEC criteria and correctly identified appropriate patients.

- There were 17 patients out of the 633 who were currently on the CEC enhanced caseload and were followed up once home.

- 46 patients were identified as fitting the criteria for enhanced care and were given a leaflet on the service, and the ward staff were asked to refer to CEC on discharge.

Next steps to continue the improvements

- Greater Manchester 7 day policy
- Step down beds being delivered while long term decisions are made
- Exploring options with south Manchester and Salford for support into AMU wards
- Rolling out innovation sites on an incremental basis
- Collaboratively commissioning across authorities and CCGs to support hospital systems

Any Questions