CARE QUALITY COMMISSION SYSTEM REVIEW OF DELAYED TRANSFERS OF CARE 2017

TRAFFORD SYSTEM ACTION PLAN

OCTOBER 2017- OCTOBER 2018

Background

Following the publication of the Care Quality Commission (CQC) Local Review of Health & Social Care Services in Trafford report on 18th December, 2017 (link:), this Action Plan has been developed in response to the issues highlighted in order to enable all partners to play their part in driving forward improvement in outcomes for the Trafford population of older people.

The joint action plan will be the mechanism by which partners are held to account, through the new governance structure, by the Health and Wellbeing Board for improving performance and ensuring effective monitoring and evaluation.

This joint action plan takes account of and cross-references the following plans that have been developed by partners:

Transfers of care plan 2017
Winter Plan 2017
Better Care Fund Plan 2017-18
Trafford Locality Plan 2016
Trafford Transformation bid 2017
All Age Health and Social Care Business Plan 2017-18

Partners are committed to system wide reform as expressed in the Trafford Locality Plan and work is well underway to implement the big ideas detailed in the Trafford Transformation Funding Bid. These include the Urgent Care project, the integration of the Council and the CCG into one new organisation, and the Trafford Local Care Organisation, the delivery model that we see as the future way of working in Trafford.

Trafford's plan for reform is ambitious as is its desire to improve performance around transfers of care. This plan tries to describe all relevant work required to improve that performance and as such cross-references areas of work that are already underway and subject to close monitoring.

Post-CQC the Trafford system has continued to make significant improvement in reducing delayed transfers of care.
The system delivered significant improvement in November and December, and the 'Home for Christmas' campaign engaged the workforce and partners in achieving great performance in the run up to Christmas.

Our performance to ……..is represented here…….below:

Trafford is required to achieve the 3.3% target by the end of March 2018.

*add latest graph

The issues highlighted within the report have been reviewed and themed under the following headings:-

- Maintaining well-being in usual place of residence
- Crisis management: Preparation for winter & urgent care
- Step down, return to usual place of residence and/or admission to a new place of residence
- Challenge and scrutiny
- Market management/commissioning
- Intelligence and evaluation

This Action Plan has been developed by the system as follows:

Trafford Council
Trafford Clinical Commissioning Group
Manchester University NHS Foundation Trust
Pennine Care Community NHS FT
Salford Royal NHS Foundation Trust
Healthwatch Trafford
Trafford Health and Wellbeing Board

1. Maintaining the wellbeing of a person in usual place of residence

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
1.1	Implement transfers of care plan and develop evaluation and performance metrics (this includes compliance with the High Impact Changes model) See APPENDIX 1	JC CW	October 2017	October 2018	Noted in full in the plan in Appendix 1 – to be updated monthly
1.2	Implement Primary Care/Care Home MDT project	CW	January 2018		Project goes live from 19.1.18 with 6 care homes and will continue to be rolled out cross Trafford over the next 3 months as new staff come on stream. Model has been developed as an integrated service offer between existing providers including Pennine Care, NMOPC and Mastercall with opportunities for further support through the voluntary sector.
1.3	Clarify investment via GM H&SC Partnership Transformation Programme into primary care	JC CW	January 2018	January 2018	
1.4	Engage VCS/Third Sector in discharge and planning processes at an earlier stage	KA & KP	November 2017	ongoing	
1.5	Refresh Seven Day Services Plan	DE RS MB	February 2018	April 2018	
1.6	Develop a transformation model for support at home underpinned by a new contractual framework	KA	April 2018		- GM care at home work concluded and reported to GM H&SC partnership - Pilots underway in Partington and Sale to be evaluated at agreed point
1.7	Review impact of support at home prototypes	KA/UM	August 2018		- In keeping with timescales above
1.8	Develop improvement	KA/MM	February		- Adult Safeguarding Board briefed and supportive

	programme for nursing and residential care		2018		- Providers engaged and registered managers network agreed with support from Skills for Care
1.9	Develop comprehensive stakeholder & public engagement programme and strategy	CW TG	December 2017		- Engagement workshops underway - Existing work with Thrive to agree future model
2.0	Ensure new model of primary care addresses improvement required	Dr NG			- Implementation of the MDT commences 19.1.18 and the Primary Care Organisation has a formalised Advisory Board in place though a MoU. Clinical pharmacist recruitment has been successful with commencement on 1.2.18.

2. Crisis management & urgent care

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
2.1	Implement Winter Plan – see APPENDIX 2	CW JC RS MB	October 2017	March 2018	Winter plan implemented, Cold Debrief to be undertaken early February 2018
2.2	Prepare and agree Easter plan	As above	March 2018	April 2018	In development
2.3	Primary Care prevention schemes for UTI and respiratory conditions (preventable admissions) to be considered	ER Dr NG	February 2018		Respiratory T&F group established looking at 'quick wins' to support admission avoidance, in partnership with PCO and community services provider. MDT incorporates an acute visiting element to manage exacerbations of LTC symptoms, acute infections and falls. Clinical review of respiratory pathway with MFT scheduled for Jan 18 to inform admission avoidance pathway in primary care.
2.4	Primary Care access and availability to be reviewed	Dr MJ	February 2018		Additional primary care access supported through winter resilience monies has been secured with go live date of 1.2.18. Full extended access model has been developed through the GP Fed with go live date 3.4.18 with provision through 4 neighbourhood hubs including Sat and Sun opening.
2.5	Engage VCS/Third Sector in Winter Plan	KA	October 2017		As per actions in section 1.
2.6	Ensure all acute providers have accurate and timely information relating to local services – TCC to be considered as the delivery vehicle	DE SR SM	February 2018		• Issued through the winter plan and regularly updated

2.7	Reablement/Care at Home capacity to be reviewed and developed	KA SB	May 2018	July 2018	
2.8	Rapid implementation of single hospital discharge team at MFT Wythenshawe site with MCC	DE	Jan 2018	January 2019	In place
2.9	Early discharge planning to be improved	MB	February 2018		Underway through Integrated Discharge Team
3.0	Escalation channels and reporting to be made clear to all staff	MI	February 2018		This will be part of all escalation plans for clarity on roles and responsibilities. It will remain all system leaders role to ensure that each aspect of the system is contributing. This will be escalated to GM if there remain outstanding issues.

3. Step Down and return to normal place of residence

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
3.1	Discharge summaries and information sharing with community providers to be improved	MB DE	March 2018	April 2018	- Control hub established and up and running since November 2017 - Information sharing flowing more easily across providers via the control hub
3.2	Learning from critical incidents to be routinely shared with clear feedback to all professionals	TBC	January 2018		Discussed with Trafford Safeguarding Adults Board, processes and protocols to be considered by the Board and the relevant sub-group
3.3	Personalisation and personal health budgets to be more routinely considered	MM	January 2018	Ongoing	
3.4	1.1 Roll out of positive outcome for preventing admissions and reducing LOS for frail older people from Wythenshawe Hospital into Trafford General Hospital	Sally Briggs, Divisional Medical Director, Unscheduled Care	December 2017	November 2018	Over the last 3 years the Complex Care team based at Wythenshawe hospital have developed a well-recognised frailty service. This now operates seven days a week on AMU, as well as five days a week in the Emergency Department. There is also a robust orthogeriatric and surgical liaison service five days a week and discharge to assess beds. The service benefits from a continuous improvement approach and there is currently a plan to develop a separate frailty unit so that both the current AMU and ED services would merge to provide robust 7 day cover. Following the merger and creation of MFT there is now a desire to improve all sites to this standard, providing identification of frailty and access to timely comprehensive geriatric assessment. The Wythenshawe, Trafford and MRI teams have already met to discuss the setting of standards for their services and a further workshop is planned for

					February 2018. A key aim of the workshop is to identify which areas of frailty to prioritise as each site will have different cohorts of patients e.g. orthogeriatrics may be key for Trafford, whilst frailty support for surgical patients at MRI might be the more urgent need. Further aims of the workshop will include identification and sharing of resources and expertise and methodology for continuous development over the longer term.
3.5	Operational policies in place at Opal House should be reviewed to ensure they are not placing additional burdens on the wider system	Lauren Wentworth, Clinical Director	December 2017	April 2018	An audit is taking place to review appropriateness of patients transferred from OPAL House to the Emergency Department. The SOP will be reviewed to consider options for management of acutely unwell patients at OPAL House. The areas for consideration will be: 1. The admission criteria – depending on the outcome of the audit, it might be that patients with any outstanding medical should no longer be transferred to OPAL House. However this will be assessed against the risk of the benefits of early transfer for patients. 2. Medical staffing model – This is currently a therapy/nursing led unit with Clinical Fellow input 9-5 Monday to Friday. Out of hours medical cover is via GoToDoc and not by the hospital on call teams.
3.6	Review of Ascot House Intermediate Care facility	RS	February 2018		Routine review of capacity and flow is in place on a daily basis through the control hub and the daily monitoring report

4. Challenge and scrutiny

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
4.1	Aging well strategy, Dementia strategy, frailty strategy and falls strategy to be concluded and implemented	ER Cllr John Lamb	February 2018	July 2018	All strategies have been in development for some time and are progressing well. GM dementia work underway in Trafford
4.2	H&WB Aging Well group to be established	ER	February 2018		In hand
4.3	BCF reporting to include detailed analysis of urgent care performance system wide	JG TC	March 2018		The H&WB actions will also take account of this
4.4	Health Scrutiny Committee challenge function to be strengthened	JC Cllr Joanne Harding	January 2018	February 2018	Meeting planned in the diary accordingly.
4.5	Ensure Trafford has a clear role in the GM partnership and can draw on appropriate support where required	TG/CW			• Part of the Urgent Care network and support received via the GM urgent care approach. • Trafford input into the GM Transformation Board to share learning from others across GM • CCG CO part of the GM wide CCG CO group and CCG Association to ensure shared learning is received
4.6	Review role of the VCS/Third Sector in the H&WB Board sub-groups with a view to strengthening engagement	ER Cllr JL	Ongoing		• Progress underway to confirm vision/statement of intent of working with VCSE as an equal partner in the engagement of commissioning plans across Trafford. CCG (Rebecca Demaine), TC (Adrian Bates) and Thrive Trafford (Chris Hart on behalf of all VCSE in Trafford) to put in place additional infrastructure so that there is an effective two-way engagement between the public sector and VCSE on commissioning and delivery.
4.7	Ensure LCO development takes account of all relevant contracting and business continuity issues	CW JC			• Broad outcomes and design principles agreed for the LCO. Originating partners established a working group to determine operating model, service content and support to put in place shadow form Trafford LCO from

					1 April 2018. Likely to commence with MDT services and build in phases over the next three years. • All services (bar specialised) included, all age and all providers including VCSE, community, social care, primary care, mental health and acute.

5. Market management/commissioning

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
5.1	System wide response to social care market and domiciliary care capacity to be developed and agreed	KA RD AB	March 2018	June 2018	- GM Care at Home workstream which Jill Colbert has led on in 2017 - Early discussions with Manchester CC regarding joint procurement of homecare
5.2	Construct a procurement model that engages service users in the process of selecting service providers/new service design	KA AB	June 2018		- Strong dynamic procurement framework in place
5.3	Agree routine reporting to Joint Commissioning Board on provider performance	RD KA	February 2018		- JCB sub group to be established to agree joint commissioning plan for 18/19 and workpplan for reporting provider performance.
5.4	Ensure all providers are making accessible information available to carers and residents to enable easy navigation through services	TBC			- The optimisation of the TCC to be considered as the vehicle to do this

6. Intelligence and evaluation (including Quality Assurance)

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
6.1	Develop a clear performance dashboard to report to H&WB the Joint Commissioning Board and Scrutiny Committee	IT PF MI			This will be a key role for the new CCG and Council integrated organisation. The new Joint Committee will need to ensure there is oversight on progress to adequately support the HWB.
6.2	CEC referral and activity data to be improved	RS	March 2018		
6.3	Accelerated work on single case records/case summaries for all providers to view on an individual basis	Integrated IT lead (to be announced)			- Optimisation of the TCC to be considered here
6.4	Develop improvement programme for nursing and residential care	KA/MM	February 2018		- Presentation to the Adult Safeguarding Board - Engagement with providers and agreement to support a registered managers network. Chair identified and funding agreed.

APPENDIX 1

Trafford Transfers of Care Plan

Version 8.0

1. Introduction

As part of the refresh of the urgent care responses in Trafford, referenced in the Trafford 2020 plan, Trafford recognises that although significant work has been achieved over the last 2 years where we have seen a 50% reduction of delayed transfers of care, substantial challenges still exist to achieve the 3.3% target. This Transfer of Care Plan is a live plan which will be reviewed and updated by the Trafford Urgent Care Board on a regular basis. We will also engage with all our main Acute providers and with the Greater Manchester Mental Health NHS Foundation Trust regarding the implementation of the plan.

Over the next five years, the urgent and emergency care system, which supports residents of Trafford, needs to make radical changes to drive up efficiencies and reduce the numbers of people who are admitted to hospital, when they could be better cared for in the community.

In order to achieve this, both Trafford CCG and Trafford Council believe that it is essential to engage with patients and families to transform the urgent and emergency care pathway from end to end in line with Greater Manchester standards. By adopting this system wide approach together with the creation of this joint plan, our organisations believe that we can create a sustainable solution, not only to support people to stay at home but also to ensure that they spend the minimum amount of time in a hospital setting.

In keeping with Better Care Fund (BCF) requirements, Trafford Council, Trafford CCG and providers are working together to meet National Condition 4 (NC4) of the Better Care Fund. NC4 states that all areas should implement the High Impact Change Model for managing transfers of care to support system-wide improvements. As such, this plan uses the eight system changes which will have the greatest impact on reduced delayed discharge. Trafford CCG and Trafford Council have worked together to create this single plan, built on a foundation of close working, undertaking development workshops , understanding issues and barriers and recognising that all parts of the system have a part to play to keep delayed transfers of care to a minimum. By working together, and by developing this plan for Trafford, our organisations recognise that there is no single solution; rather there are several key projects which will need to be developed in order to effect change.

This document seeks to describe our joint plan for Trafford and the *'High Impact Change Model'* framework has been adopted as a framework to this end. Additionally, this plan has been drawn together with reference to the following national documents:

- Monthly Delayed Transfers of Care Situation Reports: Definitions and Guidance (NHS England, Oct 2015)

- NICE Guidelines [NG27]: Transition between inpatient hospital settings and community or care home settings for adults with social care needs (*NICE, December 2015*);

- High Impact Change Model – Managing Transfers of Care *(LGA, ADASS, TDA, NHS England, Monitor, December 2015*)

- Integration and Better Care Fund Policy Framework 2017 to 2019 (Department for Communities and Local Government and Department of Health, March 2017)

- Integration and Better Care Fund planning requirements for 2017-19 (*NHS England, July 2017*)

- NHS England: Urgent and Emergency Care Delivery Plan, April 2017

- Greater Manchester Health and Social Care Partnership, ratified the following policies at the Strategic Partnership Board on the 28th of July 2017;

    - Trusted Assessment
    - Patient Choice
    - Discharge to Assess

2. Our vision for older people in Trafford

"A sustainable health and social care system which aims to help older people be healthy, independent and enjoy living in Trafford."

Strategic aims:

- Older People should be able to stay at home, to support people to remain healthy and independent as long as possible, close to family until the day they die.

- Older people and their families should have access to good quality information and have increased skills and confidence to better manage any health conditions they have at home
- Older people should have access to high quality and personalised health care when needed
- **Older people should only be admitted to hospital when hospital is the only setting able to meet their health needs and at these times should expect that their stay is the shortest time needed for their treatment**
- **Older people using health and social care services are safe from harm**
- Older people should have access to high quality services. Dignity and respect remain key both for the older person and their carer. Investing in, protecting and supporting the ageing population and those who care for them are essential prerequisites for the wellbeing of our ageing society.

The voluntary sector and community groups should be key in supporting older people at the interface of health and social care

The two strategic aims highlighted (in bold) are the focus of this plan.

In order to deliver the vision of ***'Older people should only be admitted to hospital when hospital is the only setting able to meet their health needs and at these times should expect that their stay is the shortest time needed for their*** **treatment'** and **'Older people using health and social care services are safe from harm '** we will enact the strategic aims of**:**

- Further develop admission avoidance solutions linking GP activity to community responses
- Use risk stratification tools and the Trafford Coordination Centre (TCC)to further identify residents at risk of admission
- Develop early discharge planning in the acute sector
- Develop systems to monitor patient flow

- Further develop multi-disciplinary/multi-agency discharge teams including the voluntary and community sector
- Embed Home first/discharge to assess practice
- Develop seven day services
- Embed Trusted Assessors
- Develop focus on patient choice and ensure implementation
- Further enhance health in Care home

3. Accountability and governance

The Trafford Urgent Care Board is co-chaired by the Associate Director of Commissioning Trafford CCG and the Director of All Age Commissioning at TMBC. As such, the Board provides the practical arrangements to deliver the vision and strategic objectives and the assurance, capacity and resilience. Trafford Urgent Care Board monitors and reviews the Urgent Care project plan within agree project tolerances of budget, time and quality. If additional capacity and resilience are needed this will be escalated to the BCF steering group which ensures that BCF meets the national condition of reducing DTOCs.

The Trafford Urgent Care Board will report into the Manchester Urgent Care Transformation and Delivery Board, whose chair represents Manchester and Trafford at the Greater Manchester UEC Board.

4. Patient Engagement and Participation

Our organisations work collaboratively with local people to hold conversations which enable us to adjust and develop services according to local need. A plethora of actions take place to engage with local people and whilst these are not always transfers of care specific, the components which make up the plan, such as home care and care home placements, are a fundamental part of the discussions. Below are some examples of where we have engaged with local people.

4.1 The Council has developed engagement techniques through the Trafford Partnership structures to work with providers, partners and communities. Working in partnership with its commissioned VCSE infrastructure support provider, Thrive Trafford, we have established a VCSE Strategic Forum, that brings together larger VCSE providers (such as Age UK and Citizens Advice) with commissioners and other public service representatives, to explore key issues together, building positive relationships which will foster more effective contract delivery and create a space for coproduction and collaboration. There have been sessions on health and social care integration, isolation of older people and community cohesion. Its work in involving the VCSE sector at the earliest stage of development of our place-based working model proved particularly successful, engaging the sector in shaping plans and defining their role in these new ways of working.

Our Locality working programme bridges the gap between public services and communities, through a programme of work that empowers resident action through funding and support, and brings people that live and work in a place together as equals to build relationships, share ideas and create change. Our Locality partnership events have been on a range of topics, covering environment, safety, health and wellbeing. We have seen positive action emerge from them, such as health walks from GP surgeries and a new social isolation project delivered by the fire service. As part of the Trafford Vision 2031 we are undertaking a large community engagement programme in Carrington and Partington, empowering local residents to lead the engagement with people who live and work in the area, to develop a long-term vision which reflects their opportunities and challenges and shapes the health and social care offer of the future.

Trafford Council has used the Working Together for Change (WTfC) process to review the home care service. WTfC identified what is working well for people, what is not working so well and what might need to change for the future. The process helped us to shape the new Care at Home vision to provide the things people want and need in ways that make sense to them.

Additionally, the Joint Quality Team use engagement with residents and families to gain views to enable improved service delivery.

4.2 Trafford Talks Health events

NHS Trafford CCG commenced a series of interactive public events to kick-start conversation with the Trafford population around health priorities for Trafford. The events were co-designed with Healthwatch Trafford and were arranged for each of the neighbourhoods of Trafford (North, South, Central and West)

Public events were held as follows:

3 July 2017: 1pm-3pm at Broomwood Centre, Timperley (South)

4 July 2017: 6pm-8pm at Trafford CCG HQ, Sale (Central)

1 Aug 2017: 10-12.15 at St Matthews Hall, Stretford (North)

2 Aug 201: 6pm-8.15pm at Urmston Library, Urmston (West)

Trafford CCG also had a stall at a 'One Health' community marketplace hosted by Partington Family Practice in Partington on 13 September.

4.3 PEACH – Patient Experience and Continuing Healthcare

There isn't currently a standard measure to collect people's experience of Continuing Healthcare (CHC) and hence the impact on DToCs in England. Anyone over the age of 18 who has a complex medical condition and substantial/ongoing care needs may be eligible for NHS Continuing Healthcare.

A project to develop patient experience measures for adult Continuing Healthcare was awarded by NHS England to Tameside and Glossop CCG. The project is called PEACH which stands for Patient Experience and Continuing Healthcare.

Trafford CCG has worked with Tameside and Glossop CCG to extend the pilot to include Trafford, to hear about experiences of our CHC process and care provision and how we can improve ways of asking for feedback.

Trafford CCG and Patient Experience Matters have made a significant contribution to the compilation of these surveys to enhance usability. It has been confirmed that the changes that have been made will be taken forward as part of the PEACH Toolkit.

4.4 Public Reference and Advisory Panel (PRAP)

Trafford CCG's PRAP is a committee of local people established to represent the views of the Trafford population. Membership is sought from each of the different localities in Trafford (North, South, Central and West) and from various third sector/voluntary groups in Trafford, including Healthwatch.

The panel of volunteers meet monthly to discuss feedback and inform CCG programmes of work. This assurance group reports directly to the CCG Governing Body.

The panel is now in its third year and continues to grow in confidence to question, challenge and ultimately influence CCG commissioning plans and decisions.

PRAP representation is truly valued and we have extended PRAP involvement to other CCG meetings, including: Cancer Local Implementation Group; Locally Commissioned Services Group; Quality Walkaround Visits and Trafford Co-ordination Centre Implementation Board

4.5 Provider Quality Walkrounds

A quality walk around is a snapshot of how a service is performing on that day. It also captures how a service presents regarding: kindness, compassion, dignity and respect.

A walk around plan is shared with those who would undertake the walkaround several days prior to the visit to provide some background to the venue they were due to visit and will outline any current issues that would useful to check whilst on the

walkaround. Those undertaking the walkaround will often liaise with complaints and patient experience colleagues to check if any issues are raised with them around the service to be visited.

Dependent on the service, those involved in quality walkarounds could include: clinical audit nurse, chief nurse, pharmacists, commissioning managers, GPs and also members of Trafford CCG's PRAP.

Walkaround	Timeframe
➢ Ascot House	➢ Q3 16/17
➢ Trafford General UC Centre and MI Units	➢ Q1 17/18
➢ Community Enhanced Care Service	➢ Q1 17/18
➢ Wythenshawe F7 frail elderly/A7 Respiratory	➢ Q1 17/18
➢ Wythenshawe A1 vascular/A3 orthopaedics	➢ Q2 17/18
➢ Opal House	➢ Q2 17/18
➢ Patch 1 District Nursing	➢ Q2 17/18

Following on from the walkaround, a draft report will be produced with key suggestions for improvement. This will be shared with the provider for their comments and an action plan developed jointly.

4.6 Partners

We recognise the valuable contribution our partners make to inform the development and delivery of our local plans, eg, Healthwatch and the Carers Centre. The CCG and Local Authority hold regular contract development meetings with providers e.g. Pennine Care Foundation Trust and homecare providers. We also hold a series of engagement events with providers e.g. annual engagement event with Homecare providers as part of winter resilience planning.

5. Situational Analysis

For the purposes of this Transfer of Care Plan, the table below provides a snapshot of activity at Manchester University NHS Foundation Trust (UHSM – Wythenshawe) for August+ 2017 and outlines the reasons for delayed transfers for both social care and NHS services in Trafford. We recognise that there will be seasonal variations and the data will be regularly monitored by the Trafford Urgent Care Board.

August 2017 – Manchester University NHS Foundation Trust (UHSM – Wythenshawe) Source; UHSM daily DTOC invalidated data

Reason For Delay		Number of bed days lost	% of total delays
A	Awaiting Completion of Assessment	8	1%
B	Awaiting Public Funding	64	8.4%
C	Awaiting Further Non-Acute NHS Care	12	1.6%
Di	Awaiting Residential Home Placement	66	8.6%
Dii	Awaiting Nursing Home Placement	131	17.1%
E	Awaiting Care Package in Own Home	331	43.3%
F	Awaiting Community Equipment and Adaptations	23	3%
G	Patient or Family choice	130	17%
H	Disputes	0	0
I	Awaiting Resolution of Housing Issues	0	0

Those delays classed as 'further Non acute NHS care' are delays in the main attributed to Intermediate Care at Ascot House. These will have been experienced when beds were full or delay in assessment/ transfer. The current criteria for intermediate care at Ascot House should keep these to a minimum.

The current criteria for the council funded step down-step out beds is intended to minimise the number of bed days lost due to 'Awaiting care package in own home'. It is also intended to utilise these beds to support a model of 'residential discharge to assess' by December 2017.

If the discharge to assess criteria and model were achieved it would target those who would contribute to the following delay reasons, however whether 9 beds is sufficient to meet the homecare **and** discharge to assess demand is yet to be quantified;

- Awaiting residential home placement
- Patient/ family choice
- public funding

The Patient/ family choice delays are attributed to both residential and nursing home (a rough estimate 50/50). Ascot House would only be able to influence the residential home delays due to its current CQC registration. In addition, the support of the Acute providers will be needed to implement the Greater Manchester Choice Policy.

In regards to community equipment and adaptations these delays are resolved quicker whilst the patient is on the hospital site and before they become a delay.

The largest number of delays for Trafford residents at Wythenshawe Hospital (UHSM) is due to the availability of homecare packages. The next largest cause of delays are reported as waits for nursing home placements and patients/family choice. This is reflected across both acute trusts – Manchester University NHS Foundation Trust and Salford Royal NHS Foundation Trust.
The tables below show the DTOC position for Manchester University NHS Foundation Trust for all their patients (irrespective of residents). This indicates the level of improvement required to deliver the DTOC target of 3.3%

DTOC Trajectory Analysis - 2017-18
16 October 2017

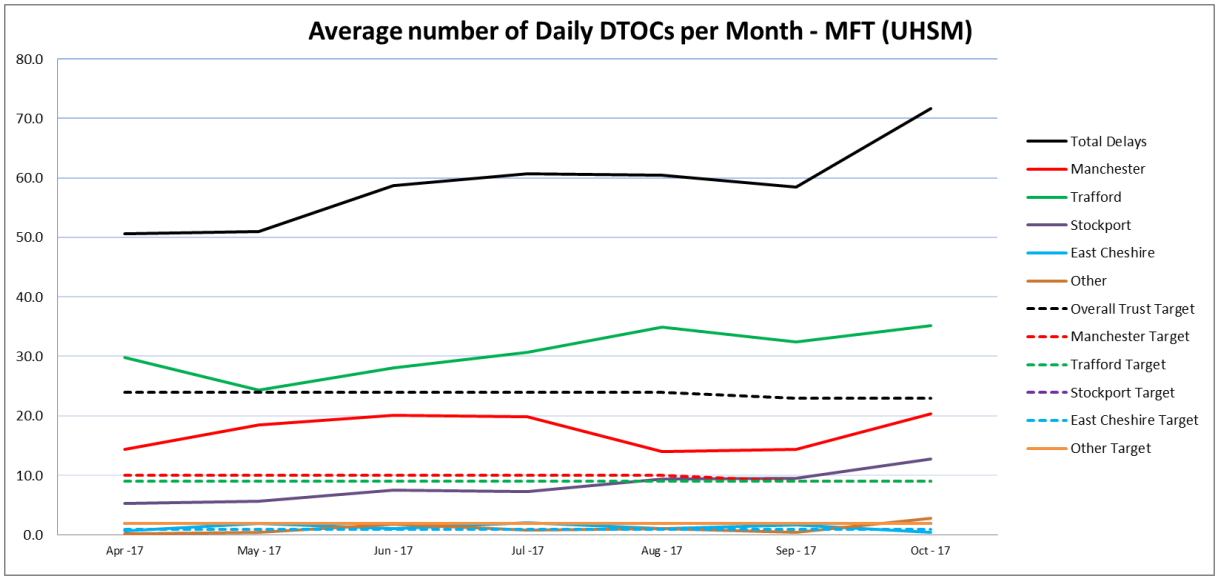
MFT (UHSM)	Description	April -17 Actual	May-17 Actual	Jun-17 Actual	Jul-17 Actual	Aug-17 Actual	Sep-17 Actual	Oct-17 Actual	Revised Monthly Target
	Average DTOCs Per Day	50.6	51.0	58.7	60.8	60.5	58.5	71.7	23.7
	Average Occupied Beds per Day	733	733	745	745	745	718	718	718
	% DTOC Rate	6.9%	7.0%	7.9%	8.2%	8.1%	8.1%	10.0%	3.3%

MFT (CMFT)	Description	April -17 Actual	May-17 Actual	Jun-17 Actual	Jul-17 Actual	Aug-17 Actual	Sep-17 Actual	Oct-17 Actual	Revised Monthly Target
	Average DTOCs Per Day	33.8	31.1	34.7	29.3	34.9	30.4	32.2	35.0
	Average Occupied Beds per Day	1,105	1,105	1,118	1,118	1,118	1,062	1,062	1,062
	% DTOC Rate	3.1%	2.8%	3.1%	2.6%	3.1%	2.9%	3.0%	3.3%

(Note: The 718 figure for UHSM and 1062 CMFT is based on the KH03 return which calculates quarterly the number of occupied beds and therefore this figure is used as the denominator for calculating the 3.3% target.)

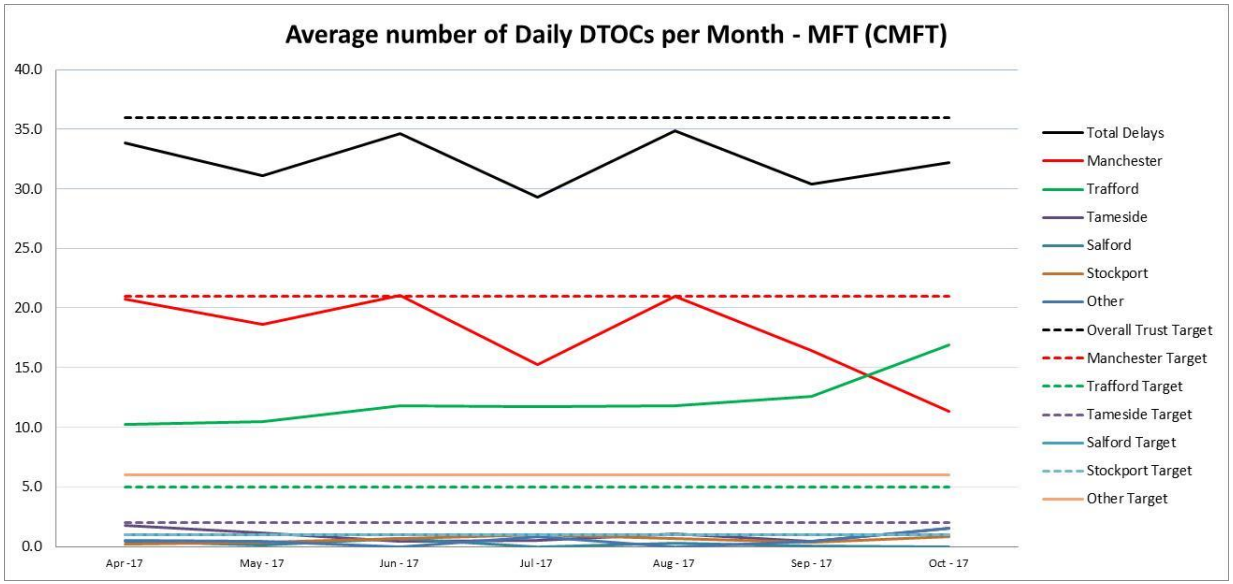
The Graph below shows the number of daily DTOCs for Trafford residents at Manchester University NHS Foundation Trust (UHSM – Wythenshawe) against the target.

Source; NHS England published Stats to end of August 2017, unvalidated local data (to 16/10/2017)



The Graph below shows the number of daily DTOCs for Trafford residents at Manchester University NHS Foundation Trust (CMFT – MRI & Trafford General Hospital) against the target.

Source; NHS England published Stats to end of August 2017, unvalidated local data (to 16/10/2017)


Average number of Daily DTOCs per Month - MFT (CMFT)
40.0
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
Apr -17
May - 17
Jun - 17
Jul -17
Aug - 17
Sep - 17
Oct - 17
Total Delays
Manchester
Trafford
Tameside
Salford
Stockport
Other
Overall Trust Target
Manchester Target
Trafford Target
Tameside Target
Salford Target
Stockport Target
Other Target

6. Trafford Transfers of Care Plan

The table below cross references each of the Programme Objectives against each of the reportable reasons for DTOC.

DTOC Key										
	A	A) Completion of assessment	**C**	C) Further non acute NHS care (including intermediate care, rehabilitation etc)	**Dii**	D) Care Home placement - ii) Nursing Home	**F**	F) Community Equipment/adaptions	**H**	H) Disputes
	B	B) Public Funding	**Di**	D) Care Home placement - i) Residential Home	**E**	E) Care package in own home	**G**	G) Patient or family choice	**I**	I) Housing - patients not covered by NHS and Community Care Act

Programme Objectives	**Projects and Progress**	**Time scale**	**Exec Lead**	**Mgmt Lead**	**Impact of DTOC** **(See Key pg 13)**	**RAG** **(As of Sept,17)**
1. Early Discharge Planning						
An integrated community health and social care team plan early discharges for all elective patient admissions.	1a. Elective discharge planning for hip and knees at UHSM **14.11.2017**-Discussions underway, J Kelly to map requirements as to what is needed on wards. Social Worker to be involved in Pre-Ops	Sept'18	D Eaton	D Walsh/D McNicoll/IDT Manager	B, F	
Robust systems support the development of plans for the management and discharge of all emergency and unscheduled patient admissions, with EDD set within 48 hours.	1b. Integrated discharge team at UHSM, Salford and TGH – **14.11.2017**- Teams in place, live tracker to be installed in control room. M Jarvis to contact C Watts to audit if patient passport is in use.	Jan'18	D Eaton	D Walsh/L Lyons	A	

TRAFFORD COUNCIL

Pennine Care NHS
NHS Foundation Trust

NHS
Trafford
Clinical Commissioning Group

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key pg 13)	RAG (As of Sept,17)
2. Systems To Monitor Patient Flow						
Robust patient flow systems and models are in place to support integrated teams and clinical decision makers to identify and manage problems and prevent bottlenecks 24/7	2a. Community flow manager recruitment **14.11.2017** – Recruited start date 21.11.2017 Line manager to be identified - D Walsh	Oct'17	D Eaton	D Walsh/M Albiston	Maximise capacity throughout the system	
Transfers of care are planned around the individual and patient flow systems allow capacity to be automatically increased where demand (admissions) increases.	2b. GM Discharge pathway mapping project (complete mapping against process and identify gaps) **14.11.2017** – Mapping workshop arranged 16.11.2017 2c. Identify resources to meet increased demand (GM-Transformation Fund Bid) 14.11.2017 – Resources to be identified at workshop 16.11.2017	Nov'17	T Cartmell	D Walsh D Peace S Morton	Maximise capacity throughout the system	

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key pg 13)	RAG (As of Sept,17)
3. Multidisciplinary/agency Discharge Teams						
All discharge planning promotes a coordinated discharge to assess approach, through integrated MDTs, that is based upon joint assessment and discharge pathways, processes and protocols.	a. Discharge to assess project (To develop an agreed model and identify additional necessary capacity) **14.11.2017** – Timescale to be brought forward to end November 2017 b. Procure discharge to assess nursing/ EMI bed(s) **14.11.2017** – Possible beds Manchester or Salford K Ahmed to follow up with J Hughes or escalate to C Elliott c. To identify agreed SW/DNL capacity required (GM – Transformation Fund Bid) d. Training and development requirement for GPs in MDT **14.11.2017** No timescale at present	Nov 17	K Ahmed	S Morton D Pease S Morton D Pease M Albiston M Jarvis	Di, Dii, G	

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key pg 13)	RAG (As of Sept,17)
Integrated discharge MDTs have shared and agreed responsibilities, they include the third sector in discharge planning and they provide special arrangements for complex discharges.	e. Integrated discharge team at UHSM, SRFT, TGH (as per table section 1) **14.11.2017** – In place	Jan 18	D Eaton	D Walsh/IDT Lead	A,G	
	f. Role of Trusted Assessors agreed and implemented for specific tasks eg funding decisions social care/CHC (As per table section 7)	Jan 18	D Eaton	D Walsh/D McNicol	A,G	
	g. Co-design of new model for Voluntary Sector home from hospital (As per table section 7)	March 18	K Ahmed	A Brown	E,I,G	
4. Home First Discharge to assess						
Patients always return home for assessment and reablement, where possible, after being deemed medically ready for discharge and are supported fully by integrated care and support teams.	a. Discharge to Assess Project (As per table section 3)	Jan'17	K Ahmed	S Morton	Di, Dii, G	
	b. Increase in SAMS capacity procured – ongoing **14.11.2017** – 6 people recruited, Sale area. Meeting on Monday with new provider.	Jan 17 Ongoing	K Ahmed K Ahmed	D Gent D Gent	E E	
	c. Develop capacity in Homecare market. **14.11.2017** – On-going-	Jan 17	D Eaton	D Walsh	E	

	possible 2 new providers. d. Develop single-handed care to provide more market capacity **14.11.2017** – Potential models being worked up. Business Case will be needed					
Where discharge home is not possible, step down beds will be utilised for assessment and additional care and support, where this is required.	e. Ascot House Step down beds **14.11.2017** – Being Utilised although a couple of blockages.	Nov'17	K Ahmed	D Gent Sue Burrell	E	
Care homes accept previous residents trusting Trust /ASC staff assessment and always carry out new assessments within 24 hours	f. New framework for nursing and residential homes **14.11.2017** Contract currently with solicitor. Meeting to be arranged with K Ahmed and Merry-Fair Price for Care	April'18	K Ahmed	D Gent J O'Donoghue	Di, Dii	

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key pg 13)	RAG (As of Sept,17)
5. Seven Day Services						
Patients receive seamless care provision that includes assessment and restart of care (within 24 hours) regardless of the time of day or week.	a. 7 day social worker and DN liaison provision for assessments at UHSM	In Place	D Eaton	D Walsh	A, E	
Sustainable staffing rotas and new contracts are in place to deliver person centred seven day discharge to assess services.	b. 7 day social worker and DN liaison provision for assessments at UHSM (As above)	In Place	D Eaton	D Walsh	A, E	
6. Trusted assessors						
Single integrated assessments, carried out across the system, can directly access jointly pooled resources and funding (without separate organisational sign off) and are 'trusted' and accepted by all care providers within the system. In Trafford we expect this to include acceptance by core agencies eg CCG and TMBC	a. Implementation of Trusted Assessor policy within Trusts 24/7 b. Trusted Assessor trial project with Salford for CHC cases **14.11.2017** Monthly meetings in place. Monitor impact. D Pease to pick up with Jacquie Coulton and Dinah	Sept'17 Nov'17	D Eaton M Moore	M Albiston D Pease	A, E A, Dii	

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key pg 13)	RAG (As of Sept,17)
7. Focus on Choice						
Staff understand choice and can discuss discharge proactively, including the active involvement of patients and relatives at the point of admission.	a. Full Implementation of the choice policy including senior ownership of eviction process at each Trust	Sept'17	K Ahmed D Eaton S Morton C Watts CMFT lead	Acute Trust leads	G	
8. Enhancing Health in Care Homes						
Care homes integrated into the whole health and social care community and primary care support	a. MDT for Care Homes; NMOC work, reliant on GM Transformation Fund bid	Jan 18	R Demaine	T Cartmell	Admission Avoidance	
	b. Scope Red Bag transfer System	Nov 17	M Leslee	New Commissioning Manager	Admission Avoidance	
There is no variation in the flow of people from care homes into hospital during the week	c. ATT Plus project **14.11.2017** Decommissioning	Oct'17	T Cartmell	S Morton	Admission Avoidance	
Care home CQC ratings reflect high quality care	d. Implement Enhanced Health in Care Homes quality framework. **14.11.2017** – NHSE Vanguard work to build into MDT standards	Jan 18	M Moore	M Leslee	Di, Dii, G	
	e. Project to increase registered management capacity	April 18	K Ahmed/M Moore	J O'Donoghue	Di, Dii, G	

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key pg 13)	RAG (As of Sept,17)
9 Development of home care market						
There is a high quality home care market in place with sufficient, flexible capacity to meet local need.	a. GM transformational work stream for Support at Home Project	Sept18	J Colbert	K Ahmed	E	
	b. Partington Pilot active	Nov 17	K Ahmed	D Gent	E	
10. Development of the TCC						
The TCC reviews and supports those at greatest need and prevents unnecessary hospital admissions by supporting primary care and linking to appropriate services	a. TCC development project (including increase of service users based on risk and facilitating discharge/preventing readmission) b. Link to Community Enhance Care (CEC) c. Creation of a Urgent Care hub which will provide a central point for the utilisation of commissioned services.	Dec'17	T Cartmell M Jarvis	T Weedall	Admission Avoidance	

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key pg 13)	RAG (As of Sept,17)
11. Development of Intermediate Care Services						
Increasing the utilisation of Intermediate Care (Ascot House) services in Trafford and reducing delays within the unit to ensure effective and timely response and efficient flow	a. Clinical model and pathway developed reviewed and confirmed b. The business model arrangements to reflect service model	Dec 17	R Demaine	S Morton	C	
12. Public Funding decision making						
To ensure decisions for public funding are made appropriately and timely to avoid DTOC	a. CHC funding decisions b. Social Care funding decisions	Nov 17 Nov 17	M Moore D Eaton	Sally Kass/ Debra Peace TBC	B B	
13. CQC action plan						
To identify any actions from the CQC review of the health and social care system which are relevant to the Urgent Care Board.	a. Action Plan to be developed	TBC	J Colbert	K Ahmed T Cartmell	A, Di, Dii, E, G	

7. Trafford Trajectory for DToCs

The table below summarises the projects detailed in Section 6, their mobilisation dates and the delayed transfer of care (DTOC) reason which they have an impact on;

	Reason for delay	% of delays in Q1&Q2 2017	Mobilisation dates of deliverables						
			Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
A	Awaiting Completion of Assessment	1%	6a	2a	2b - 2d, 6b		1b, 2c, 2d, 3e - f		3g
B	Awaiting Public Funding	5%			12a & b				
C	Awaiting Further Non-Acute NHS Care	2%				11a & b			
Di	Awaiting Residential Home Placement	11%	8d				4a - d		
Dii	Awaiting Nursing Home Placement	16%	8d		6b		4a - d		
E	Awaiting Care Package in Own Home	43%			4e, 9b	7b	4a - d		
F	Awaiting Community Equipment and Adaptations	2%	1a						
G	Patient or Family choice	20%	7a, 8d		6b		3a - f, 4a - d		3g
H	Disputes								
I	Awaiting Resolution of Housing Issues	0%							
		Note: admission avoidance and/or deliverables to be mobilised after 31st Mar 18 are omitted from the above							

Based the delivery of these projects Trafford have estimated the following trajectory to achieving the 3.3% DTOC target (based on the number of individuals reported as delayed on a given day). The table below details the current DTOC performance by site (MUFT & SRFT) against the Trafford trajectory.

	Trafford DTOC trajectory to achieve 3.3% in year Current month performance to 30/10/2017												
	Baseline*	Oct-17		Nov-17		Dec-17		Jan-18		Feb-18		Mar-18	
		Trajectory	Actual	Trajectory	Actual	Trajectory	Actual	Trajectory	Actual	Trajectory	Actual	Trajectory	Actual
Average month end number of reportable DTOCs at MFT: UHSM	30*	*30*	37	*30*		*30*		*30*		*15*		*9*	
Average month end number of reportable DTOCs at MFT: CMFT	13*	*13*	18	*13*		*13*		*13*		*7*		*5*	
Average month end number of reportable DTOCs at SRFT	2**	*2*	5 (27/10)	*2*		*2*		*2*		*2*		*2*	
* baseline average of Trafford DTOCs in Q1 and Q2 2017 ** Actual no. of delays end Sept 17													

At the end of March 2018, the target of nine delays at Manchester University NHS Foundation Trust (UHSM – Wythenshawe) are anticipated to be divided amongst the following reasons;

Reason For Delay		No. of individuals reported as DTOC
A	Awaiting Completion of Assessment	0
B	Awaiting Public Funding	0
C	Awaiting Further Non-Acute NHS Care	0
Di	Awaiting Residential Home Placement	0
Dii	Awaiting Nursing Home Placement	1
E	Awaiting Care Package in Own Home	8
F	Awaiting Community Equipment and Adaptations	0
G	Patient or Family choice	0
H	Disputes	0
I	Awaiting Resolution of Housing Issues	0

8. Enablers

Delivery of the above plan will support the achievement of 3.3% DTOC level for Trafford. However, there are additional enablers outside of the eight high impact change areas which will support delivery and these are identified below:

Programme Objectives	Project Dossier	Timescale	Exec Lead	Mgmt Lead
1. Escalation process				
There is a clear escalation policy and process in place in line with national OPEL reporting. Need to identify additional capacity i.e. additional community beds.	➢ Refresh escalation process and apply desk top testing pre winter'18	Nov'17	K Ahmed T Cartmell	S Morton
2. Performance dashboard				
There is clear data reporting in place in a single dashboard format which demonstrates the Trafford DTOC position on a daily basis	➢ Development of joint health and social care dashboard	Nov'17	K Ahmed T Cartmell	S Morton
3. Organisational development				
There is a clear plan, process and funding in place for organisations to develop capacity and capability to deliver the DTOC agenda	➢ TCC ➢ Health and social care integration ➢ Integrated commissioning function ➢ Care complex ➢ New models of care	April'18	C Ward T Grant	I Anderson K Ahmed R Demaine
4. Communication and engagement				
Excellent communication exists in our organisations to ensure that service users and providers understand the portfolio of services available to them	➢ Patient experience and engagement project ➢ Voluntary organisations ➢ TCC	Ongoing	M Moore A Schorah	L Collins K Ahmed D Eaton

9. Conclusion

Both Trafford CCG and Trafford Council recognise the significant challenges involved in reducing delayed transfers of care for Trafford residents. Joint working has enabled our organisations to develop a single joint credible plan to be managed via the joint Trafford Urgent Care Board. However, we do recognise the substantial challenges ahead, both national and local, seasonal variation coupled with the singular issues that impact on Trafford performance; such as high employment levels, the high numbers of self-funders, limited care home placements and the difficulties and challenges affecting the home care market. Nevertheless, our organisations are committed to developing sustainable solutions to topical issues and will work in partnership to offer high quality services to Trafford residents.

1. Appendix 2 Winter Plan 2017

DRAFT WORK IN PROGRESS: Trafford CCG & Trafford Council Provisional Winter Plan 2017/18 Across GM Acute Trust Sites v0.4

Performance

Performance Indicators (National & Local Indicators)

- % of all patients who spend 4hrs or less in A&E per acute site
- Reportable delayed transfers of care (acute & non acute beds) per acute site
- 12hr trolley waits in A&E per acute site
- Bed Occupancy Rates per acute site
- Community Bed capacity utilisation and LOS
- Community Admission avoidance

Key messages

- **UHSM:** Growth in attends and admissions from Trafford over 65s and growth in LoS for over 65s
- **CMFT:** Growth in attends and admissions
- **SRFT:** Growth in admissions and LoS
- Trafford homecare market capacity challenging
- Increase in Adult social care spend in Trafford
- 11 care homes in Trafford are rated as requires improvement or inadequate by CQC

Key Risks

- Workforce across health and social care ,
- Out of Hospital capacity; homecare, community services, intermediate care, care homes
- Increased activity across health and social care
- Bed capacity within the Acute Hospitals
- System fragility - Financial Sustainability

Trafford Initiatives to support Urgent Care

Primary Care;

- Primary Care focus on older patients via risk stratification, identification and intervention
- National directed enhanced service to avoid unplanned admissions for older people
- Locally commissioned service in place for care home residents
- Locally commissioned service to support residents in Ascot House
- Integrated care plans
- MDT meetings in practice for older people
- Development of a Trafford wide MDT model as a part of New Models of Primary Care
- Co-located general practice within Limelight Health and Well-being Centre

Trafford Coordination Centre;

- Through the use of a risk stratification tool the Trafford population with whom we can have the most positive influence is being identified. The TCC are working with the GPs to ensure a coordinated approach to their care management.
- Aims to reduce healthcare costs to the Trafford health and care system and provide more effective care to patients through a Care Co-ordination service.
- Staffed with nurse care co-ordinators representing a variety of medical specialties, including mental health, and seeks to develop strong supportive relationships with patients to signpost service users to new services.
- Supports older people with multiple or complex healthcare needs, those recovering from a stroke or fall, or people showing signs of frailty. Through regular telephone support the service helps patients stay safe and well at home and avoid unplanned hospital admissions and readmissions.
- Pilot to collocate a paramedic in TCC

TRAFFORD ADULT SOCIAL CARE GRANT 17/18

- Step down beds to be developed into D2A model; 9 beds Ascot House
- Home based Discharge to assess; Additional SAMs capacity
- Create new capacity in the home care market
- Price increases to providers – Market stabilisation
- Better care at Home new model; new in house reablement service
- Additional social worker and social care assessor capacity in Hospitals
- Quality assurance and improvement programme for care homes
- Asset based community capacity
- Additional residential/nursing packages

Acute Trusts;

- Better and more timely hand offs (A&E / Acute Physicians)
- Front Door clinical streaming
- Extension of WIC hours at MRI
- Bed Occupancy Level; utilisation of bed modelling tool
- GM policies; Trusted assessor, patient choice, discharge to assess
- Streamlined CHC process
- 7 day discharge

Community Services;

- Neighbourhood Community Enhanced Care teams; provide ongoing management for patients with a long-term condition, conditions associated with ageing or patients with complex needs requiring holistic assessment
- Urgent CEC service; for patients at risk of hospital admission without intervention.
- Single Point of Access for community services
- Ascot House; Intermediate Care and Bed based discharge to assess

North West Ambulance Service

- Alternative to Transfer scheme across Trafford delivered jointly with Mastercall
- ATT+ for Trafford Care homes
- Care home pilot ; NaRT tool
- Clinical Assessment (APAS) for NHS111 calls

Trafford TOC plan

Trafford Transfer of Care Plan

- Community Flow Manager post (December 2017)
- Discharge to Assess pathways; home, residential and nursing inc. EMI (Q3)
- Increasing capacity in the homecare market (ongoing)
- Primary Care and wider MDT support to Care Homes (Q4)
- New Model for Voluntary sector home from hospital service (April 17)
- Increase Registered Care Home Management capacity (April 2018)
- Enhanced Health in Care Homes Quality Framework

Trafford Additional Winter 2017/18 Schemes;

- Review of all current homecare packages <7 hours not reviewed in the last 12 months (October 2017); aim to reinvest homecare hours for new packages
- Flu Campaign launched (September 2017); covering community (staff), Nursing and Residential Homes (staff and residents)
- Infection Control (October 2017); Infection control lead working with each care home to increase IC awareness, tracking of infections and aim to plan a coordinated response to minimise closures where necessary.
- Establish a Trafford Urgent Care Control office (Mid December 2017 to end of March 2018); located in community and managed by Community flow manager, a central point of contact for Acute Trusts to coordinate community capacity
- Specific response to OPEL escalation level 2 and level 3 (in place now)
- Voluntary sector home from hospital service to support winter resilience (Nov 2017)

17/18 UC trajectories

A&E 4hr Performance (Actual Monthly colour coded & Trajectories) Source; NHS England NHS stats to end Sept. Local unvalidated data October)

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
UHSM - Monthly	94.6%	92.6%	90.1%	91.0%	89.4%	86.7%	88.2%	90.0%	90.0%	90.0%	90.0%	95.0%
UHSM - Cumulative	94.6%	93.6%	92.4%	92.1%	91.6%	90.8%	90.5%	90.3%	90.3%	90.2%	90.2%	90.6%
CMFT - Monthly	93.7%	93.6%	93.5%	94.7%	92.9%	92.3%	89.4%	91.1%	91.1%	90.0%	90.0%	95.0%
CMFT - Cumulative	93.7%	93.7%	93.6%	93.9%	93.7%	93.5%	93.1%	91.5%	91.4%	91.3%	91.2%	91.5%
SRFT - Monthly	89.9%	82.1%	83.7%	91.6%	93.0%	89.5%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
SRFT - Cumulative	89.9%	85.9%	85.2%	86.8%	88.0%	88.2%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

DTOC Performance Trajectories For All Delays

Source; NHS England NHS stats to end Aug. Local unvalidated data up to Sept)

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
UHSM - DTOC Rate	6.9%	7.0%	7.9%	8.2%	8.1%	8.1%
CMFT - DTOC Rate	3.1%	2.8%	3.1%	2.6%	3.1%	2.9%
SRFT - DTOC Rate	3.3%	4.6%	4.2%			