Trafford Transfers of Care Plan

Version 11.0

06/02/2018

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

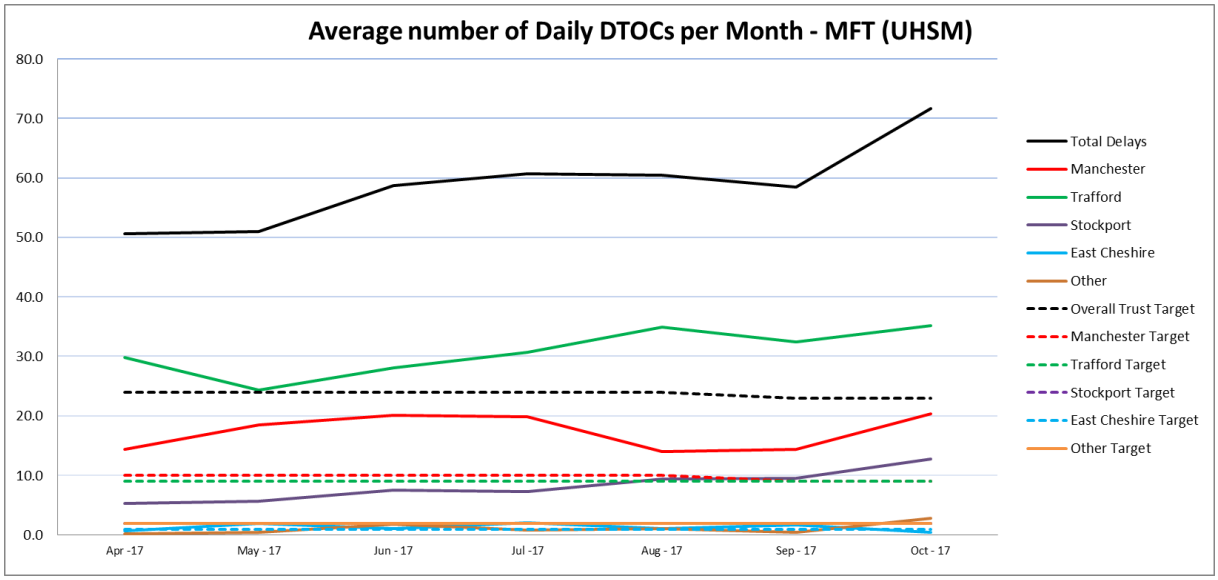
MFT (UHSM)	Description	April -17 Actual	May-17 Actual	Jun-17 Actual	Jul-17 Actual	Aug-17 Actual	Sep-17 Actual	Oct-17 Actual	Revised Monthly Target
	Average DTOCs Per Day	50.6	51.0	58.7	60.8	60.5	58.5	71.7	23.7
	Average Occupied Beds per Day	733	733	745	745	745	718	718	718
	% DTOC Rate	6.9%	7.0%	7.9%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

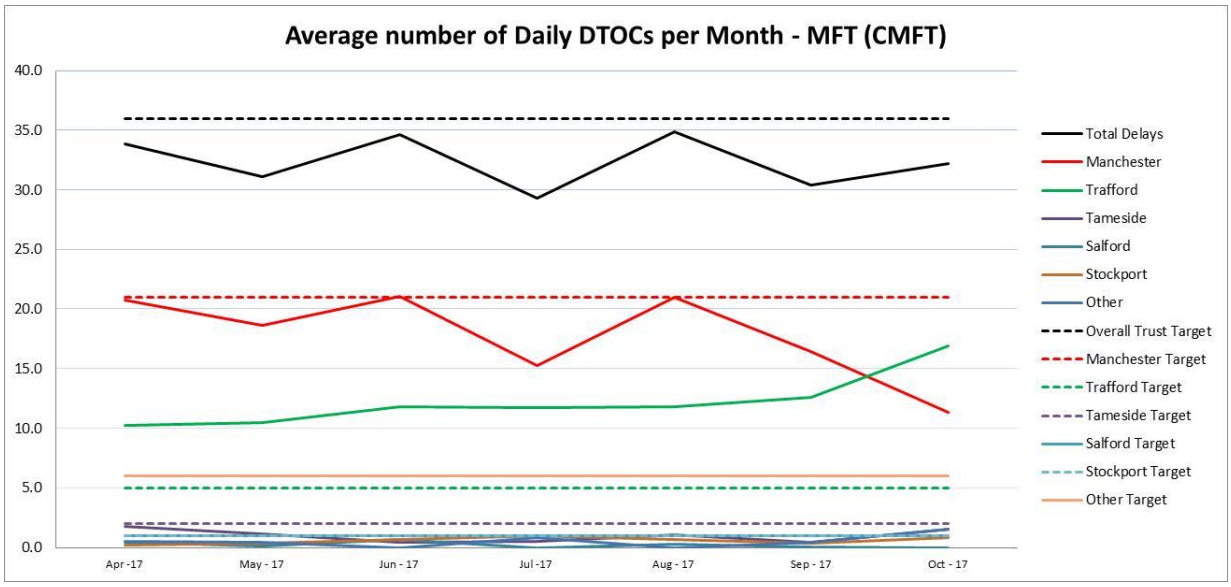
The Graph below shows the number of daily DTOCs for Trafford residents at Manchester University NHS Foundation Trust (UHSM – Wythenshawe) against the target.

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)



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 Jan,18)**
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 New IDT manager commences at UHSM on 8th Jan. 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 – Full plan for patient track being developed for UHSM Length of stay group underway at	Jan'18	D Eaton	D Walsh/L Lyons	A	

	Trafford general (reduced to below 70 days) District nurse liaison approach agreed for Salford and Trafford general **06.02.2018** D2A team base agreed and cabling /Wi-Fi has been reviewed –to be fitted asap Separate D2A team to be established using ;- 1 senior practitioner 2 social workers 2 SCA Deputy Community flow manager 1 admin OT Supervision of Ascot and Hospital Senior practitioners to move to the control room					

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key pg 13)	RAG (As of Jan,18)
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 **09/01/2017**; Started in post 21/11/2017	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) **09/01/2017;** Mapping workshop took place on 16.11.2017. Revised Discharge Pathway documentation circulated and in test throughout the system and all four acute sites. 2c. Identify resources to meet increased demand (GM-Transformation Fund Bid) **09/01/2017;** Additional out of hospital capacity commissioned for D2A beds from 27/11/17.	Nov'17	T Cartmell	D Walsh S Morton	Maximise capacity throughout the system	

	Urgent Care Control Room established in November 2017, is monitoring capacity and demand throughout the system and informing commissioning intentions. **06.02.2018** The numbers of beds is presenting a significant strain on community teams and delays in discharges. Commencing a review of data re Admissions , referrals to social care and package of care requirements The patterns to referrals to support the ability to flex resources.					

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key pg 13)	RAG (As of Jan,18)
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) **09/01/2017;** D2A beds commissioned from 27/11/2017. Admission criteria/spec letters etc.in use –review booked with homes this week Rehab /intermediate care process developed b. Procure discharge to assess nursing/ EMI bed(s) **09/01/2017;** 13 Nursing home beds commissioned including 2 EMI beds	Nov 17	K Ahmed	S Morton M Leslee J O'Donoghue S Morton M Leslee J O'Donoghue	Di, Dii, G	

	c. To identify agreed SW/DNL capacity required (GM – Transformation Fund Bid) **09/01/2017;** Interim community social work allocation process being monitored pending agency recruitment to track use of D2A beds and completion of social work assessments	**Nov 17**	K Ahmed	M Albiston		
	d. Training and development requirement for GPs in MDT **09/01/2017;** MDT due for initial rollout in late January.	**Jan 2018**	M Jarvis	J Telford		

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key pg 13)	RAG (As of Jan,18)
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) **09/01/2017;** Integrated discharge team at - UHSM - SALFORD - TGH Integrated manager started at UHSM on 8th Jan 18. Discussions commenced with Salford and Trafford general re Integrated on site management arrangements	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) **09/01/2017;** Trusted assessors in place at UHSM AMU /IMC However we Review the	Jan 18	D Eaton	D Walsh/D McNicol	A,G	

	Trusted Assessor role –due to D2A process -					
	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 section 3)	Jan'17	K Ahmed	S Morton M Leslee J O'Donoghue	Di, Dii, G	
	b. Increase in SAMS capacity procured – ongoing **09/01/2017;**Streamlined assessment introduced and tracking in place Daily availability included in the daily tracking sheet through the urgent care control room. Clear line of sight on numbers per day and expected availability and those waiting has supported commissioning to prepare for extension of SAMS with anew provider . Discussions re expanding SAMS with one provider with potential start date in January	Jan 17	K Ahmed	D Gent	E	
	c. Develop capacity in Homecare market.	Ongoing	K Ahmed	D Gent	E	

	09/01/2017;On-going- New homecare provider sourced d. Develop single-handed care to provide more market capacity **09/01/2017;**Potential models being worked up. Business Case will be needed	Jan 17	D Eaton	D Walsh	E	
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 **09/01/2017;**All beds know as discharge to assess. Patients requiring an interim 24 hour care placement will be processed through the D2A beds.	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 **09/01/2017;**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 Jan 18)
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 **09/01/2017;** 7 day SW/ DNL in place at UHSM/TGH and Salford	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. See section 3f. b. Trusted Assessor trial project with Salford for CHC cases **14.11.2017** Monthly meetings in place. Monitor impact. Evaluation due January 2018. **06.02.2018** Trusted assessors in place at	Sept'17 Nov'17	D Eaton M Moore	M Albiston S Kass	A, E A, Dii	

	UHSM AMU /IMC However we Review the Trusted Assessor role – due to D2A process – to be looked within the workshop					

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key pg 13)	RAG (As of Jan 18)
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 **09/01/2017***;* Leaflets in redesign MCA processes been reiterated across all sites to ensure D2A options are used	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 **09/01/2017**; Pennine care, OOH Mastercall and CCG preparing implementation plans. First phase roll out planned by end January. Meadway office being prepared to accommodate care homes team initially	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 **09/01/2017;** Service under review within OOH contract	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. Further review Jan 2018	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 Jan 2018)**
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 **09/01/2018**; pilot live in Partington and Sale	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. Deliver a Care Coordination service to 2,000 patients by April 2018, identified through a risk stratification tool. b. Discharge coordination service to prevent readmission 09/01/18; pilot underway with Wythenshawe site c. Agree referral protocols with Community Enhance Care (CEC) service d. Link TCC to Urgent Care control centre(the central point for the utilisation of commissioned services) 06/02/2018 The TCC reviews and supports those at greatest need and prevents	Jul 17 - Apr 18 Dec'17 Jan 18 Mar 18	T Cartmell M Jarvis	T Weedall	Admission Avoidance	

	unnecessary admissions by supporting primary care and linking to appropriate services TCC development Facilitate discharge/prevent admission—increase service users based on risk stratification tool to facilitate advanced planning with CEC- initial discussions held re how we can develop the model Referrals to CEC from risk stratification tool being tested					

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key pg 13)	RAG (As of Jan 2018)
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 **09/01/2018;** Care at home taking dedicated step down from Ascot, CEC and MRI –working well and supporting flow New manager appointed in Care at home Electronic rota system being explored Pathway being reviewed further to develop trusted assessor /and three conversations as new senior prac started at Ascot house Pathway from CEC revised and working well with capacity available on a Monday to take step downs Available resource in community	Dec 17	R Demaine	S Morton D Eaton	C	

	showing successful improvements in community flow					
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 **09/01/2018;** All decisions up to £850 delegated to senior pracs on site in hospital teams being extended to include new IDT manager. New funding operating procedures written System changes completed Fast track decisions making in place for decisions above £850. Out of panel MH cases activated **06/02/2018** Mtg MH RAID service held –need a further session with GMMH to discuss completion of assessment process and out of panel decisions making and distribution to all acute sites	Nov 17 Nov 17	M Moore D Eaton	Sally Kass/ Debra Peace TBC	B B	

	Access to HOST out of hours added to Easter plan Trafford housing trust out of hours process added to Easter plan					
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 **09/01/2018;** plan in development to be integrated on completion.	Jan 2018	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 31/01/2018												
	Baseline	Oct 17		Nov 17		Dec 17		Jan 18		Feb 18		March 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	40	30	15	28	23	25	23	15		9	
Average month end number of reportable DTOCs at MFT (CMFT)	13*	13	19	13	13	10	9	8	5	7		5	
Average month end number of reportable DTOCS at SRFT	2**	12	3	2	1	2	2	2	4	2		2	

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.