Urgent Care Control Room

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Background of the UCCR

- The Trafford Urgent Care Control Room (UCCR) was established in November 2017 to contribute towards a significant reduction in delayed transfers of care from the acute trusts that serve Trafford residents.

- The team are based in Meadway Health Centre in Sale which a 24/7 health & social care hub.

The team include:-

- 1 Community Flow Manager (social Worker)
- 1 Deputy Flow Manager (Nurse)
- 1 Management information Officer
- 2 Social Workers – D2A
- 2 Social Care Assessor –D2A
- 2 Social Care Assessors (SAM's)

There are plans to further expand the team to allow assessment activity to shift from the hospital to the community.

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Control Room based at Meadway Sale

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Function: What does it do?

- The control room shares data and information with acute discharge teams, providers across the system and commissioners through the daily Community Flow Report.
- The report provides an accurate picture of the capacity required within the community particularly for discharge to assess pathways 1, 2 and 3.
- Provides continual review of the current capacity across Trafford and acts as a single point of escalation to and from key stakeholders re barriers to discharge.
- Manages the flow through the Discharge to Assess (D2A) beds / Intermediate care / community short term home support services and provides a single point of referral for D2A Pathway 2.
- Ensuring assessments and onward journey are appropriate timely and safe.
- The control room is the first point of escalation with regards to system pressures, maximising community services to free up beds in the hospital.
- Supports patients to leave hospital to the right destination.

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Community flow and capacity

- In order to ensure capacity across all of the pathways Trafford Council and Trafford Clinical Commissioning group purchased assessment beds to ensure individuals in hospital who were ready for discharge but were unsafe to return home were provided with a period of assessment and recovery to ensure no long term decision was made in an acute setting.
- In November 2017 we had 7 beds in a small number of Trafford care homes and 9 in Ascot House.
- To date the centre coordinate's discharges from hospital into 36 D2A beds in the community. This is agreed to increase on a flexible basis as required.
- They also support patients who are at home and require some support in a rehabilitation or bed based setting i.e. Ascot House where a full assessment and treatment can be provided, to prevent hospital admission and support recovery.
- Criteria, referral and assessment process have been continually developing to ensure relationships of trust are established with home owners.
- Stabilise and Make Safe Criteria was extended in 2018 to include people who need 2 carers and the assessment process transferred to the Urgent care control room. New contracts have supported the expansion of home based recovery and support.

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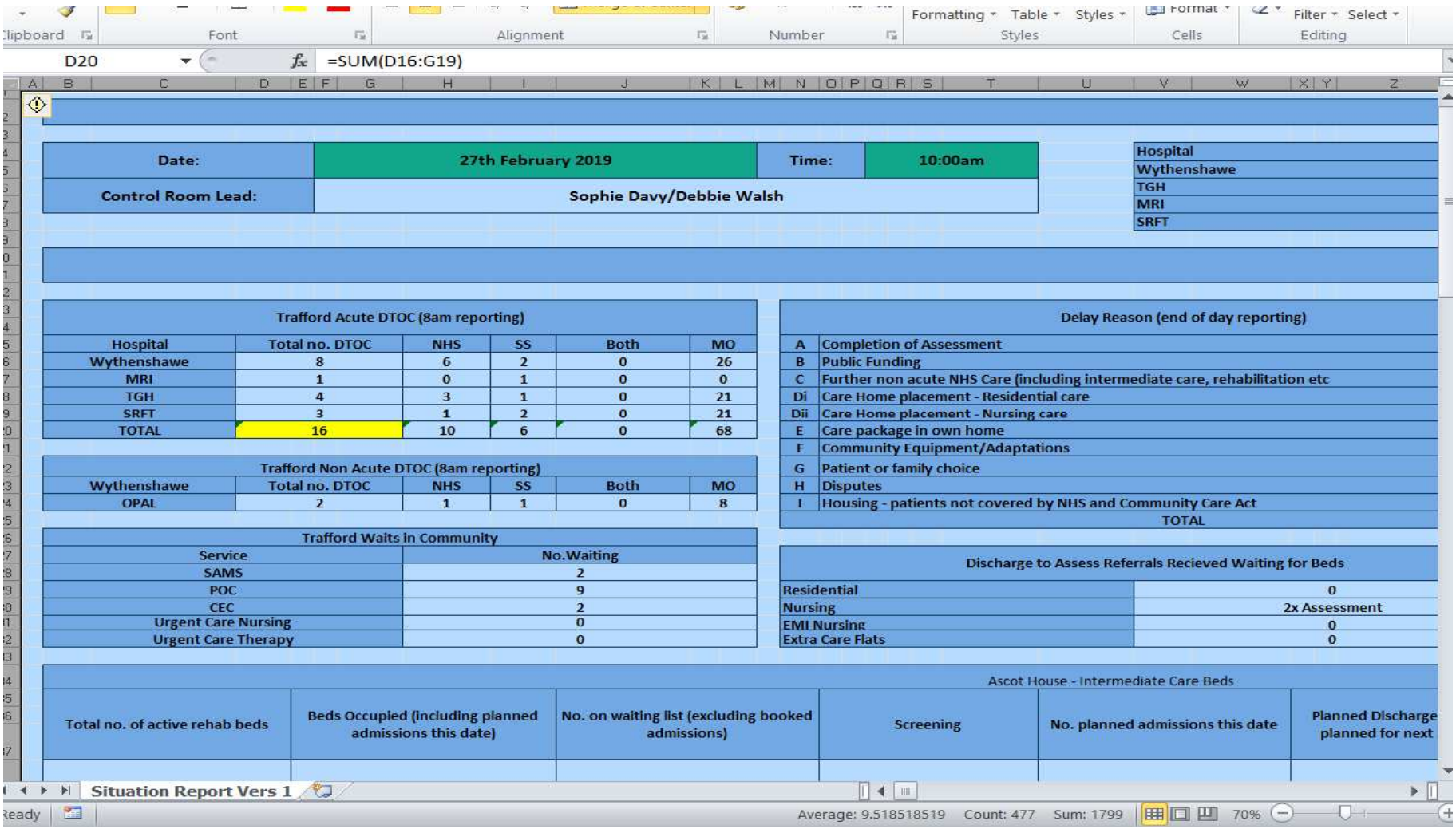
Community Flow Report

The flow report includes key performance targets from the four hospital sites:

Reach and sustain the 3.3% DToC target of no more than 17 Trafford patients delayed in our hospitals per day.

- MFT – South (Wythenshawe) 11
- Trafford General Hospital (TGH) 4
- MFT Central (MRI) 0
- Salford Royal (SRFT) 1

Support and learning across the system is informing the development of the pathways home after a period of time in a acute mental health hospital.



D20 =SUM(D16:G19)

Date:	27th February 2019	Time:	10:00am
Control Room Lead:	Sophie Davy/Debbie Walsh		

Hospital
Wythenshawe
TGH
MRI
SRFT

Trafford Acute DTOC (8am reporting)

Hospital	Total no. DTOC	NHS	SS	Both	MO
Wythenshawe	8	6	2	0	26
MRI	1	0	1	0	0
TGH	4	3	1	0	21
SRFT	3	1	2	0	21
TOTAL	16	10	6	0	68

Trafford Non Acute DTOC (8am reporting)

Wythenshawe	Total no. DTOC	NHS	SS	Both	MO
OPAL	2	1	1	0	8

Trafford Waits in Community

Service	No.Waiting
SAMS	2
POC	9
CEC	2
Urgent Care Nursing	0
Urgent Care Therapy	0

Delay Reason (end of day reporting)

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

Discharge to Assess Referrals Recieved Waiting for Beds

Residential	0
Nursing	2x Assessment
EMI Nursing	0
Extra Care Flats	0

Ascot House - Intermediate Care Beds

Total no. of active rehab beds	Beds Occupied (including planned admissions this date)	No. on waiting list (excluding booked admissions)	Screening	No. planned admissions this date	Planned Discharge planned for next

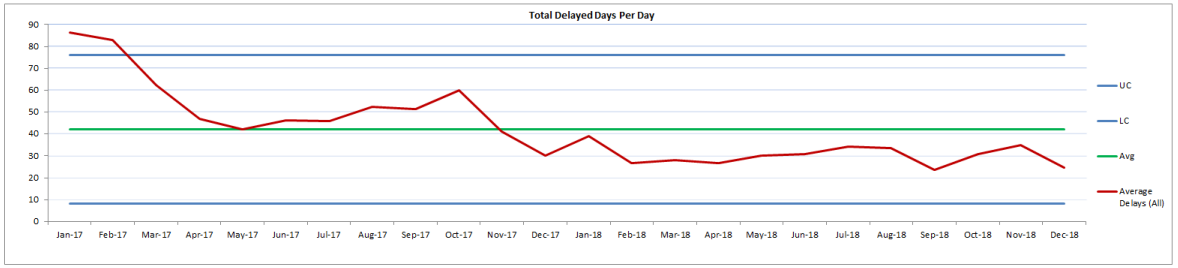
Situation Report Vers 1

Ready Average: 9.518518519 Count: 477 Sum: 1799 70%

Average Delays Per Day

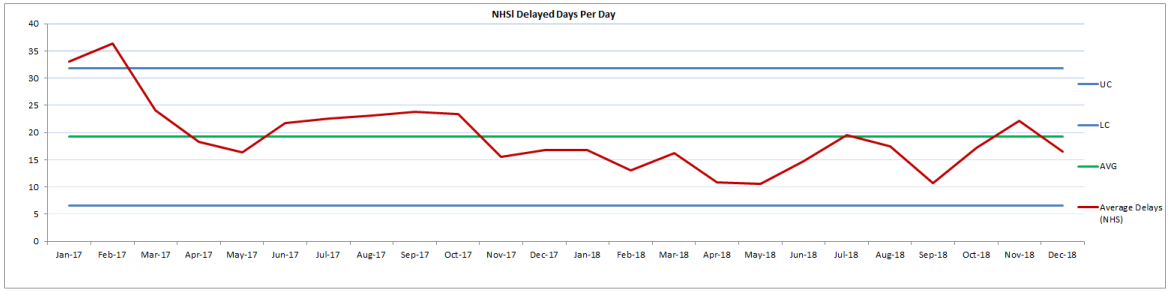
Total Delayed Days Attributed to All per day

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Average Delays (All)	86.4	83.0	62.5	47.0	42.3	46.3	45.7	52.3	51.5	59.8	41.1	30.3	39.1	26.7	28.1	26.8	30.3	30.7	34.4	33.6	23.6	30.7	34.9	24.7
Variance on Previous Year					-34.5%	-27.2%	-30.0%	-24.6%	-9.2%	4.6%	-42.1%	-61.2%	-54.8%	-67.8%	-55.1%	-43.0%	-28.3%	-33.8%	-24.8%	-35.7%	-54.2%	-48.6%	-15.1%	-18.4%



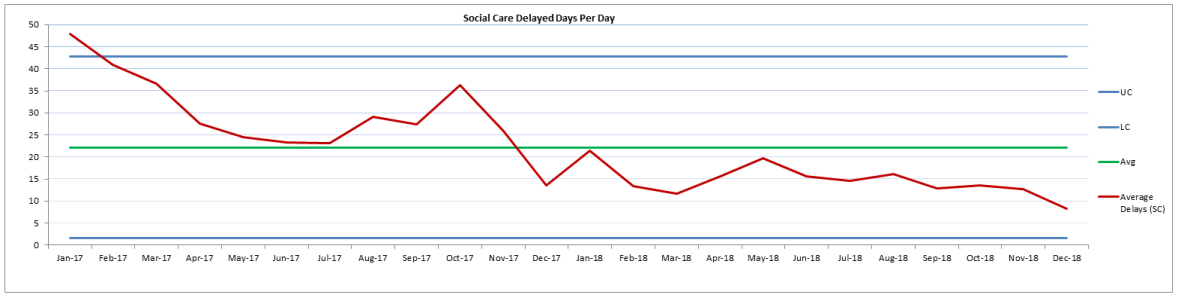
Total Delayed Days Attributed to NHS per day

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Average Delays (NHS)	33.1	36.4	24.0	18.3	16.4	21.7	22.5	23.1	23.9	23.4	15.5	16.7	16.8	13.1	16.3	10.8	10.6	14.7	19.5	17.5	10.7	17.2	22.1	16.5
Variance on Previous Year					-54.8%	-45.4%	-42.9%	-46.1%	-27.4%	-26.7%	-61.0%	-50.5%	-49.1%	-64.1%	-32.2%	-41.1%	-35.3%	-32.3%	-13.4%	-24.3%	-55.0%	-26.4%	42.6%	-1.4%



Total Delayed Days Attributed to Social Care per day

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Average Delays (SC)	47.8	41.0	36.6	27.6	24.5	23.2	23.2	29.2	27.5	36.2	25.9	13.5	21.5	13.4	11.7	15.6	19.7	15.7	14.6	16.2	12.8	13.5	12.8	8.3
Variance					3.3%	13.5%	8.4%	28.4%	32.5%	60.9%	1.4%	-67.0%	-55.1%	-67.3%	-68.0%	-43.4%	-19.4%	-32.4%	-37.1%	-44.6%	-53.3%	-62.7%	-50.5%	-38.6%



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Discharge to Assess Pathways

Discharge to Assess includes:-

- Stabilise & Make Safe (Reablement) home care delivery model.
- Intermediate Care Unit - therapy led rehabilitation.
- Community based short term Residential Care discharge to assess beds - including 9 beds in Ascot House.
- Complex Nursing in a Community Care Homes.

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Pathways

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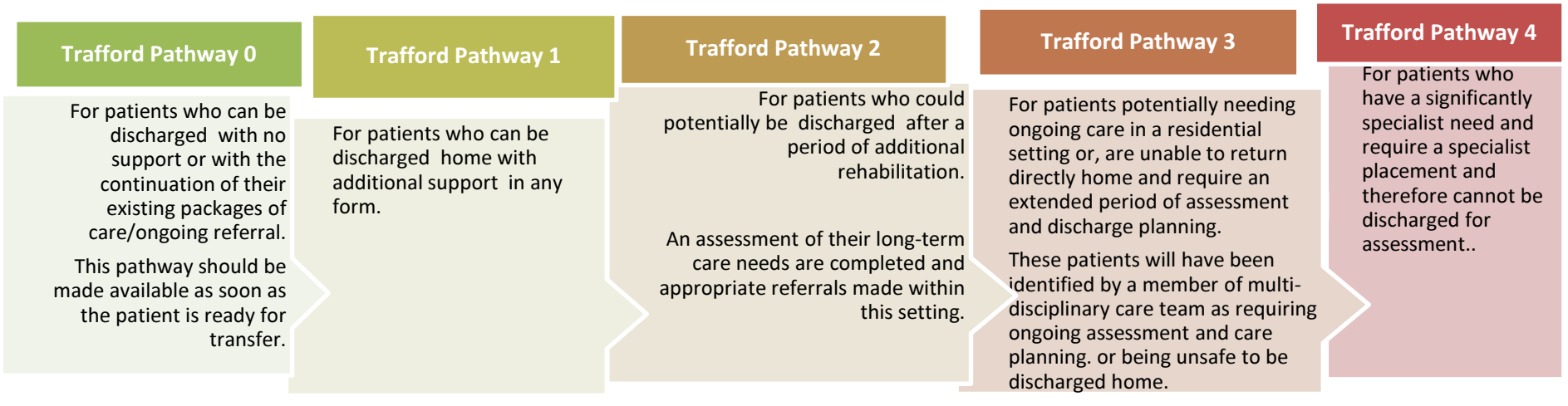
Patients staying in hospital will be involved in their discharge planning at the earliest opportunity. The discharge assessment will be undertaken by an appropriately trained staff member of the hospital ward team or the Discharge Team



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Discharge to Assess- Challenges

- The loss of 5 care homes within a short period of time took 150 beds out of the system. The homes closed were all rated as ‘inadequate’ by CQC.
- Impact – this time last year we had approximately 98 available beds in the system to day we have approximately 51. However, the beds we have lost were not of an acceptable quality.
- There are a Lack of EMI nursing beds across GM – patients are remaining in hospital longer – Local authorities across GM are working to find a solution. Trafford is developing with providers some Trafford based provision for later this year.
- Once in a D2A bed if the decision is long term care the resident is choosing to remain in the home. This is positive as they are not taking up a bed in hospital while the family choose a home. Commissioning can quickly convert the bed to a long term option and purchase more discharge to assess beds.

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Safe Discharge

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- The Social work assessment identifies barriers or potential risks to patients returning to their own home.
- Navigators based within the Emergency Department are able to prevent unnecessary admission by providing practical solutions and support.
- The control room liaises with the hospital Integrated Discharge teams to ensure discharges are planned and appropriate.
- The Care @ Home team follow patients home following a period of Intermediate Care or support from Community Enhanced care to ensure that they continue to maintain baseline and settle at home.
- Discharges are referred on to the Trafford Co-ordination Centre for telephone follow up and monitoring for people living with a long term condition or a risk of further admissions.
- Poor or failed discharges are reported via incident reporting systems. The hospital receives a copy of the report and asked to feedback learning form the actions taken. This informs further changes to the system or processes.
- Onward referral to other community services such as the community matrons, district nurses and rapid therapy is facilitated as required.
- Appropriate Equipment is provided and maintained to support independence.

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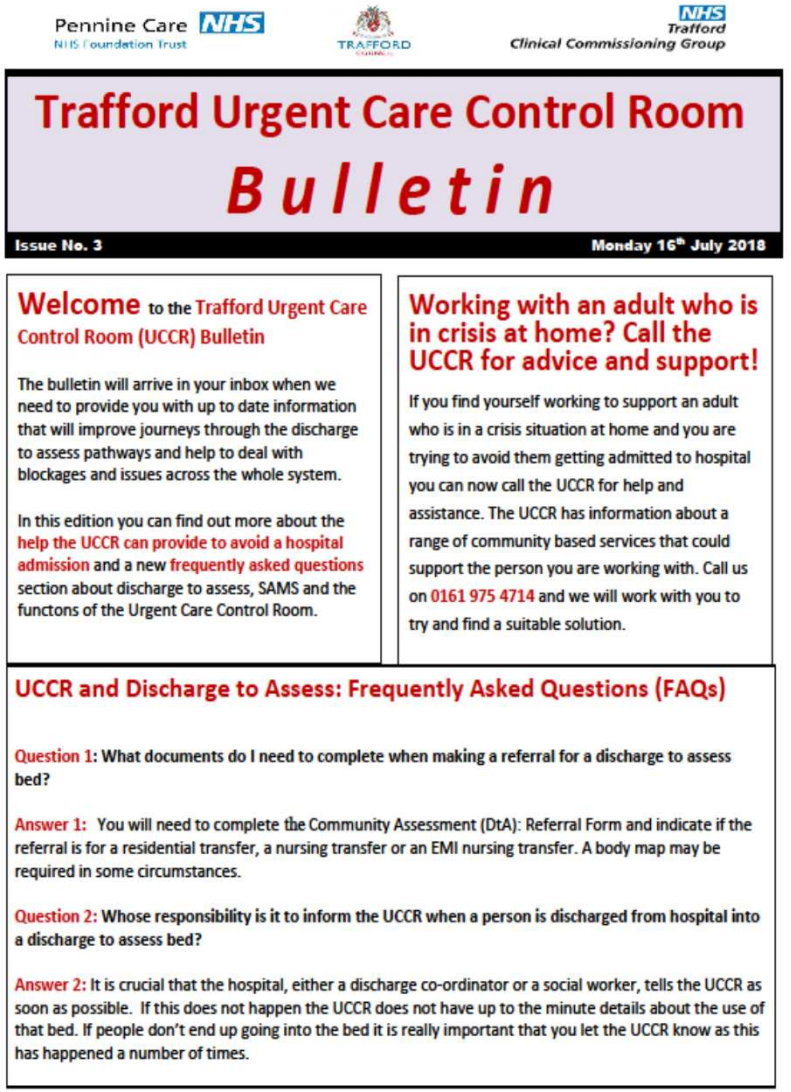
Keeping Informed



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Trafford Urgent Care Control Room Bulletin

Issue No. 3 — Monday 16th July 2018

Welcome to the Trafford Urgent Care Control Room (UCCR) Bulletin

The bulletin will arrive in your inbox when we need to provide you with up to date information that will improve journeys through the discharge to assess pathways and help to deal with blockages and issues across the whole system.

In this edition you can find out more about the help the UCCR can provide to avoid a hospital admission and a new frequently asked questions section about discharge to assess, SAMS and the functons of the Urgent Care Control Room.

Working with an adult who is in crisis at home? Call the UCCR for advice and support!

If you find yourself working to support an adult who is in a crisis situation at home and you are trying to avoid them getting admitted to hospital you can now call the UCCR for help and assistance. The UCCR has information about a range of community based services that could support the person you are working with. Call us on 0161 975 4714 and we will work with you to try and find a suitable solution.

UCCR and Discharge to Assess: Frequently Asked Questions (FAQs)

Question 1: **What documents do I need to complete when making a referral for a discharge to assess bed?**

Answer 1: You will need to complete the Community Assessment (DtA): Referral Form and indicate if the referral is for a residential transfer, a nursing transfer or an EMI nursing transfer. A body map may be required in some circumstances.

Question 2: **Whose responsibility is it to inform the UCCR when a person is discharged from hospital into a discharge to assess bed?**

Answer 2: It is crucial that the hospital, either a discharge co-ordinator or a social worker, tells the UCCR as soon as possible. If this does not happen the UCCR does not have up to the minute details about the use of that bed. If people don't end up going into the bed it is really important that you let the UCCR know as this has happened a number of times.

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The Future

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- Maintain and continue to improve performance.
- New Triage process for Trafford patients at Wythenshawe with senior oversight. Assessment commences at issue of S2 so much earlier in the patients Journey pathway agreed at ward level so ready for discharge when medically optimised. Commenced 27.2.19.
- Continued close working relationship with commissioners to evaluate capacity, blockages and demand.
- Additional Discharge 2 Assess capacity to ensure no long term decisions are made in hospital – Home First!
- Expanding 7 day working.
- Continuing to develop the home care market moving towards patched based delivery.
- Building resilience and community offer at a neighbourhood level to support people to return home quicker reducing their length of stay in hospital.
- New Team Leader role within the discharge team at Wythenshawe to support the team and manage delays.
- Pathway developed to direct GP's to the UCCR to avoid unnecessary admissions into hospital. UCCR will utilise a range of community H&SC services to provide support until a longer term solution is sourced. Pilot to commence March 2019 in one neighbourhood.

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Proposed homecare innovation pilots

Walking rounds

Supporting workforce development, values-based recruitment and place-based working though walking rounds in Trafford neighbourhoods

Rapid access to SAMS

Developing faster access to SAMS to assist people to return home safely at a much earlier stage to support better reablement outcomes

Homecare in Hospital

Homecare providers conducting wellbeing checks for hospitalised service users, discussions with hospital professionals and better planning for a safe return home

Reducing Social Isolation

Development of the Let's Talk (3 Conversations) approach to support homecare users to improve health and wellbeing by reducing social isolation

SAMS Stepdown from D2A

Automatic availability of SAMS for people in discharge to assess beds, supporting them to return home at a sooner point, with reablement support

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Recent Good News Story

Background

RB was transferred to a Discharge to Assess bed from hospital. There had been no previous involvement from Social Services but at the point of hospital discharge he was unsafe to go home and his home environment was not suitable having been condemned. He was presenting with delusional beliefs. Prior to admission he had isolated himself from his community and family, there was significant self neglect and deterioration in health leading to admission. Pre- DTA this man would likely have had long term decisions made in hospital and been discharged in to a care home and reviewed after 6 weeks.

What did we do?

Assessments started in the Discharge to Assess placement straight away and housing were contacted in relation to finding more suitable accommodation. Referrals were made to mental health services and the GP remained involved. Support was provided to access finances and rebuild relationships with family. Legal support was also provided to manage property ,affairs and a power of attorney. Arrangement agreed Care needs were assessed during period in DTA.

Discharge from DTA

Following completion of all assessments RB was discharged in to sheltered accommodation with support from rehabilitation services 3x daily. This was subsequently reduced down to no care requirements as he was managing completely independently. RB is now engaging in the scheme activities and went to Blackpool for Christmas. He is also rebuilding relationships with his family and seeing them regularly.