Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 3 March 2020

Subject: Update on the mobilisation of Manchester Community Response

Report of: The Director of Adult Social Care, Manchester City Council and the Chief Operating Officer, Manchester Local Care Organisation

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Summary

This paper updates the Health Scrutiny Committee on the work of health and social care staff in the Manchester Community Response (MCR) services.

It describes the work is taking place and sets out the integrated model of service provision delivered by our health and social care staff.

The report also includes a case study and overview of current performance within the team.

In presenting this paper the positive impact on the lives of Manchester residents will be highlighted.

Recommendations

The Committee is asked to note the contents of the report, progress made to date and the work of teams with MCR to deliver person centred services to residents in Manchester.

Wards Affected: All

Environmental Impact Assessment - the impact of the issues addressed in this report on achieving the zero-carbon target for the city

Manchester Strategy outcomes	**Summary of how this report aligns to the OMS**
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	

A highly skilled city: world class and home grown talent sustaining the city's economic success	MLCO are actively engaging communities in their workforce, and through the reablement are working to support Manchester residents including those that have been economically inactive into employment. contributing the economic growth of the city.
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	The underpinning principle of MCR planning is that services are aligned to the needs of residents and delivered within community based settings.
A liveable and low carbon city: a destination of choice to live, visit, work	
A connected city: world class infrastructure and connectivity to drive growth	

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Background documents (available for public inspection): None

1. Introduction

1.1 This paper updates the Health Scrutiny Committee on the work of health and social care staff in the Manchester Community Response (MCR) service.

1.2 The Committee are reminded that MCR is one of MLCO's new models of care.

2. Background to MCR

2.1 Manchester Community Response (MCR) provides crisis, intermediate care, reablement and rehabilitation services to patients, often older people, after leaving hospital or when they are at risk of being sent to hospital. These services offer an interface between hospitals and where people live, and between different areas of the health and social care system – community services, hospitals, GPs and social care.

2.2 The three overarching aims of MCR are to:

- Help people avoid going into hospital unnecessarily.
- Help people be as independent as possible on discharge from hospital.
- Prevent people from having to move into a residential home until they really need to.

2.3 MCR is comprised of a number of different teams:

Crisis response

The crisis response team works collaboratively to provide a more rapid response to a patient in urgent need of health and social care at home. It provides a short term assessment and intervention for patients in their own homes allowing them to remain safely at home and avoid an unnecessary A&E admission.

Discharge to Assess (D2A)

D2A is about helping people home from hospital, quickly and safely. The essence of the approach is that the person, once medically optimised, goes home and is assessed for their ongoing needs in their home or other place of residence rather than remaining in hospital for these assessments. The aim is to reduce unnecessary delays in discharge when they could be back at home or in a more appropriate place to receive ongoing assessment, short term interventions and support.

Intermediate care beds

Short term bed based rehabilitation offers the patient a chance to work with a multi-disciplinary team to gain as much independence as possible and help them return home. Many patients, particularly the elderly, suffer with loss of function after a major physical illness or following a hospital admission and this can make it difficult for them to cope in their usual environment.

Intermediate care home pathway

The home pathway team supports people in receiving or completing their rehabilitation in their own homes. Short term care and therapy are provided by the community and reablement teams to support the person's recovery to independence.

Reablement

Reablement service is another evidence based approach to support maximising people's ability to return to their optimum level of independence with the lowest appropriate level of ongoing support. The service focuses on restoring independent functioning and helping people to do things for themselves rather than the traditional approach of doing things for people.

Community IV

The delivery of IV therapy* in the community setting can reduce the requirements for hospitalisation and improve quality of life. The extension to the existing IV model in the city is agreed and will go live in the autumn 2019. This will include enabling care to be delivered within the community and people's homes with a focus on independence, choice and self-care.

**any treatment administered by intravenous injection, infusion or subcutaneous infusion.*

The multi-disciplinary team

The MCR integrated team encompasses a range of community health and social care staff at various grades including community nurses, advanced practitioners in various disciplines, physiotherapists, occupational therapists, assistant practitioners, pharmacists, social workers, primary assessment officers, reablement managers and reablement staff.

2.4 Although there are discreet specialist teams and pathways within MCR, staff will flex and work across the teams and pathways when required.

3. What will Manchester Community Response deliver

3.1 The aims of MCR are to drive and deliver person centered assessment, care planning and rehabilitation to the people receiving its services. It will deliver services at the right time, by the right person and in the right setting. It will provide high quality, evidence based, safe services delivered in a personalised and compassionate way that promotes independence, self-management and proactive use of personal and community resources. It will also offer support to the carers supporting our cohort.

3.2 MCR services are delivered across the three localities in Manchester (North, Central & South) and are supported by a Service Lead or manager and a senior Clinical Lead in each locality.

3.3 MCR will provide a quality service to enable the people to live independently, receiving the support they require within their own homes and communities. MCR will:

- Provide care as close to home as safely and as cost effectively as possible.
- Support people to achieve their optimum health and wellbeing and enable a return to as much independence as possible to improve quality of life.
- Encourage and support carers to take an active role in the recovery/ rehabilitation/ reablement of the person they care for.
- Ensure effective care co-ordination and care navigation across the services.
- Provide safe care and treatment that meets a person's individual needs and aspirations.
- Provide evidence based care delivered in line with quality standards (e.g. CQC, NICE).
- Protect and safeguard vulnerable adults in line with statutory responsibilities.
- Avoid unnecessary hospital admission for people whose needs can be managed at home and in the community. This includes:

- *The NWAS Pathfinder programme and Amber Pathway which enables people to remain at home rather than be taken to A&E by the ambulance service following their assessment because their needs can be met quickly and safely by the Crisis response team*
- *deflecting people who present/admitted to A&E back home where they can be supported by service such as Crisis Response.*

- Reduce the number of avoidable admissions to residential care by providing viable interventions and support to remain as independent as possible for as long as possible.

3.4 The D2A model, which sits within MCR, supports hospital systems and flow with better outcomes for individuals by:

- Transferring people out of hospital as soon as they are medically fit, preventing 'deconditioning' and hospital acquired infections.
- Assessing people in a more suitable environment (home) which leads to a more accurate picture of their needs.
- Supporting people with short term care and rehabilitation or support, to help them gain or re-gain independence and preventing or reducing the potential need for longer term care.

3.5 There are a range of anticipated benefits and outcomes for MCR, and for the people that are in receipt of its service. These include:

- Improved quality of service for people accessing intermediate care.
- People being assessed in a more appropriate setting to understand their longer term needs.

- Providing care closer to home.
- Support for wider system flow and resilience across Manchester.
- Helping people receive additional health and care support to enable them to remain safely at home.
- Helping to avoid unnecessary or untimely transfer to long term care.
- Increased number of customers/patients in their own homes 91 days after discharge.
- Supporting a reduction in non-elective admissions and readmissions.
- Reduction in long term admissions to residential and nursing care.
- Reduced length of stay in hospital.
- Supporting carers feel involved in the assessment and planning of care for the person they support.
- Reduced care packages (number and size of package).
- Improved patient and carer experience of services.

4. Manchester Community Response and MLCO operating model

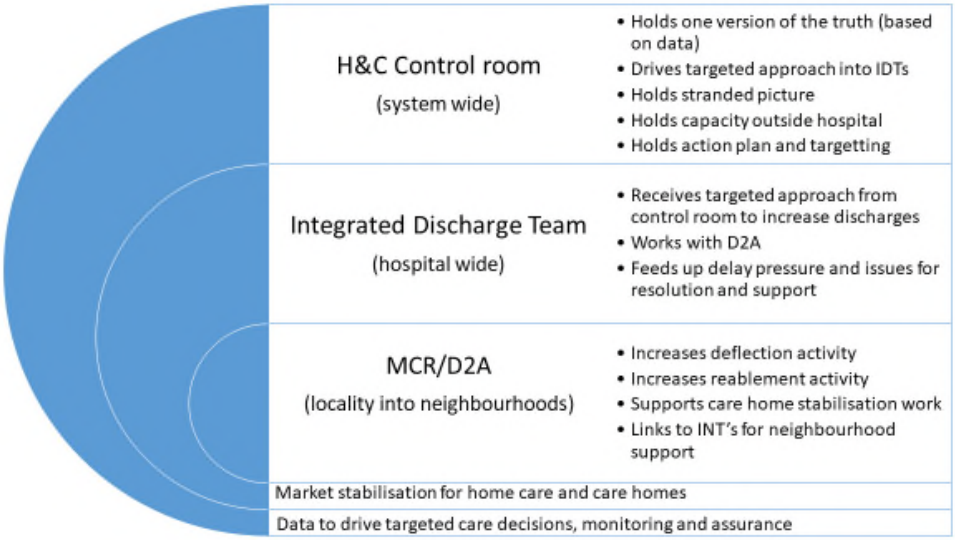
4.1 In addition to being one of MLCOs new models of care, MCR plays a key role in delivering against MLCO's four key delivery priorities, in particular 'Supporting people in and out of hospital':

4.2 As the Committee have been previously advised in November 2019 brought forward a short term plan to respond to continued and escalating pressures within the health and care system in Manchester.

4.3 As part of this process five priority areas were identified, which included expediting the mobilisation of one of the elements of MCR:

- Establishment of a control room;
- Mobilising an integrated discharge team;
- Roll out of discharge to assess;

- Market stabilisation; and,
- Data driven decision making.



4.4 A key part of work described at 4.3 is to increase deflection activity and to target health and care support into care homes. It includes increasing primary care referrals in MCR, and the expansion of the model to include medical input and a service for primary care to review patients being considered for admission.

4.5 The work builds upon the MCR model to increase deflection activity and to target health and care support into care homes. It will include increasing primary care referrals in MCR, and the expansion of the model to include medical input and a service for primary care to review patients being considered for admission.

4.6 The reablement function described at 2.3 works in conjunction with health practitioners to support discharges from hospital settings across the City. The services provide a rapid response delivering personalised support which meets the outcomes of each individual and their carers(s) to maintain they live independently in the community.

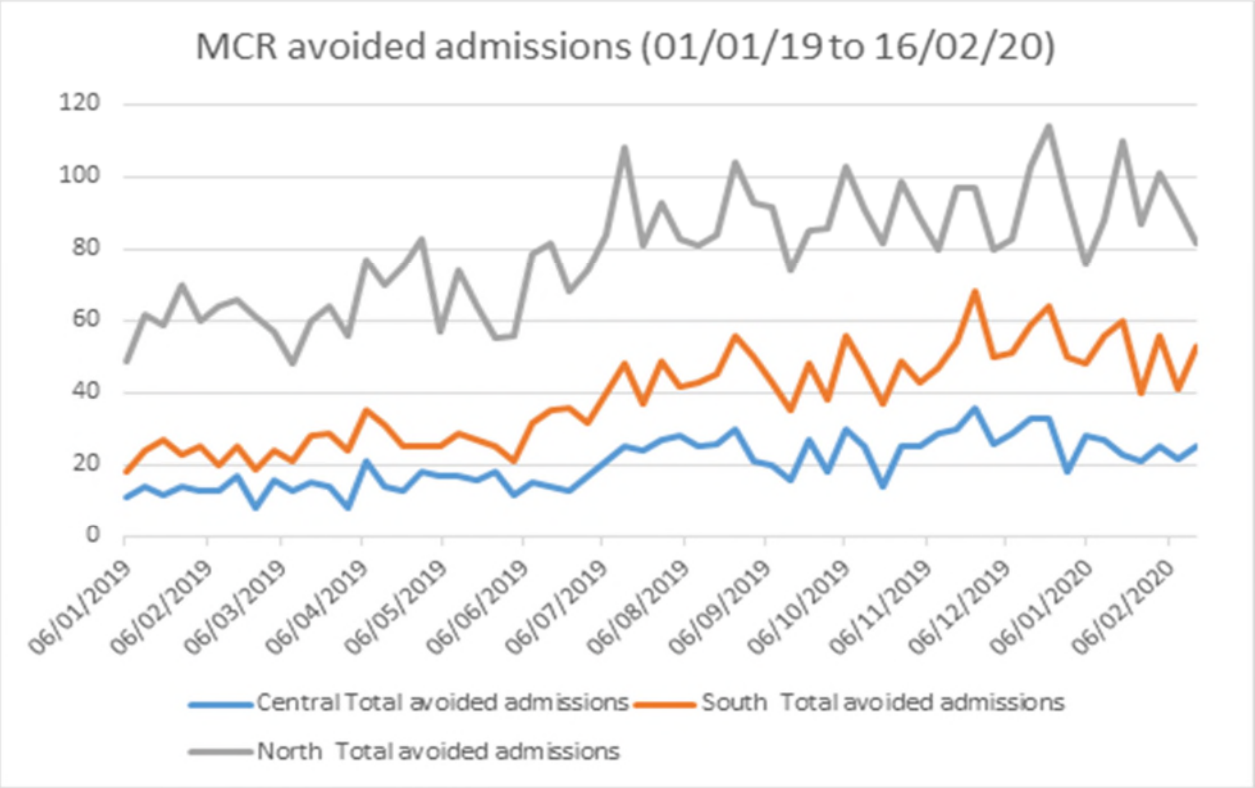
4.7 Reablement plays a critical role in supporting health and social care to manage increasing demand. Activity for December 2019 was significantly higher than December 2018 with a 61% increase in the number of referrals requesting reablement to facilitate a smooth transition from hospital to home. The total number of people in service continues to increase which has been driven by an increase in staffing levels, and continued improvements in the responsiveness of securing packages of care from homecare providers.

4.8 In addition to the work that is being delivered through Manchester Community Response, Manchester Case Management (formerly known as High Impact Primary Care) continues to work with some of the most complex residents in the city.

5. Manchester Community Response in numbers

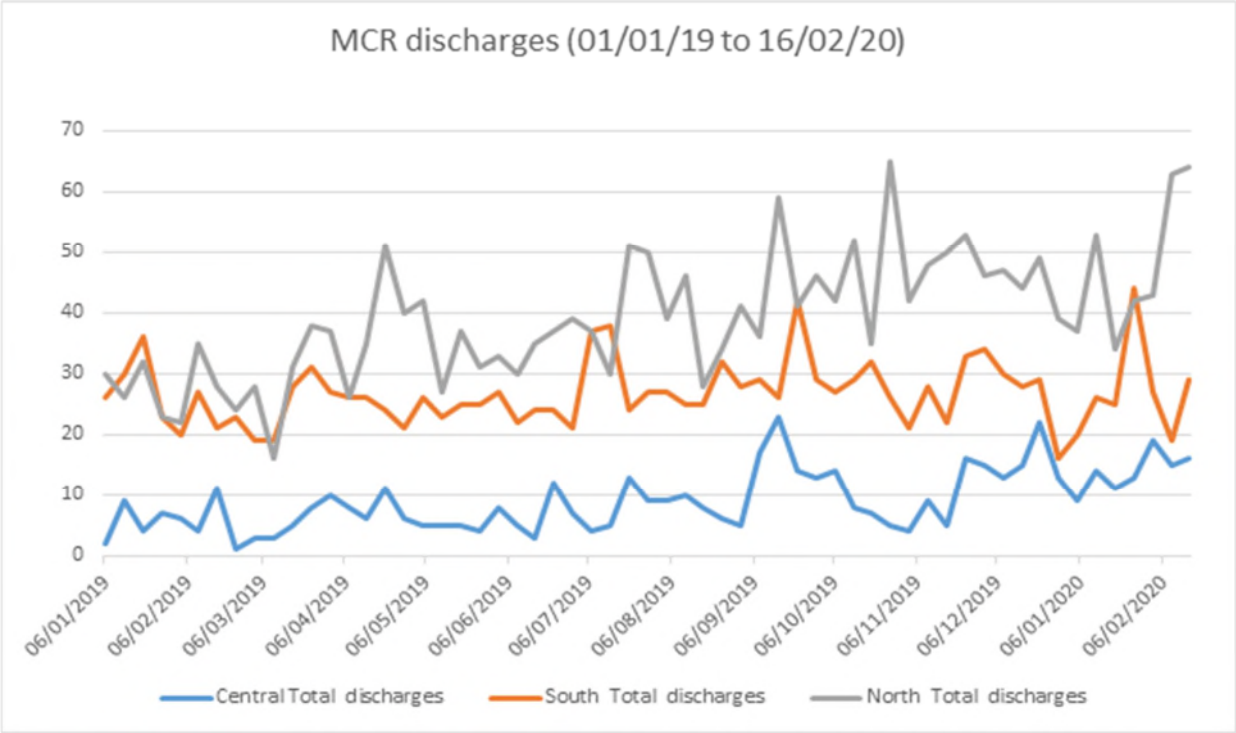
5.1 Since January 2019, MCR has avoided 4,686 admissions to hospital. This means that a significant number of people who would otherwise have ended up in hospital have been supported by MLCO into urgent care settings.

5.2 As can be seen from the graph below there is significant variation across the three localities in Manchester. The MCR service in North Manchester is the most mature in the city, and the analysis below highlights the potential and what could be achieved across both Central and South Manchester when they reach similar levels of maturity.



5.3 In addition to the numbers of avoided admissions, the MCR services support a significant number of discharges out of hospital settings. Between January 1st 2019 and February 16th 2020 MLCO supported a significant number of people into alternative care settings (including their own homes) via MCR, with the three MCR services facilitating 4,434 discharges.

5.4 The table below shows the level of discharges through the discharge to assess pathways, by week, through the period set out at 5.3.



6. Recommendations

6.1 The Committee is asked to note the contents of the report, progress made to date and the work of teams with MCR to deliver person centred services to residents in Manchester.