Manchester Health and Wellbeing Board
Report for Information

Report to: Health and Wellbeing Board – 22 January 2020

Subject: Winter Pressures

Report of: Director of Adult Social Services

Summary

This paper provides an overview of progress made by MLCO against agreed winter planning priorities.

Recommendations

To note, consider and comment on the information in the report.

Wards Affected: All

Alignment to the Our Manchester Strategy Outcomes (if applicable):

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	None
A highly skilled city: world class and home grown talent sustaining the city's economic success	Skilled multi-disciplinary health and social care workforce to be resilient meeting the demands of the city
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	Working across boundaries to maximise capacity of all hospital and community based services to support system wide flow
A liveable and low carbon city: a destination of choice to live, visit, work	None
A connected city: world class infrastructure and connectivity to drive growth	None

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Background documents (available for public inspection): None.

1. Introduction

1.1 This paper sets out the progress that Manchester Local Care Organisation has made in delivering against agreed winter planning priorities to support the people of Manchester to receive the right care and support, in the right place and in a timely manner.

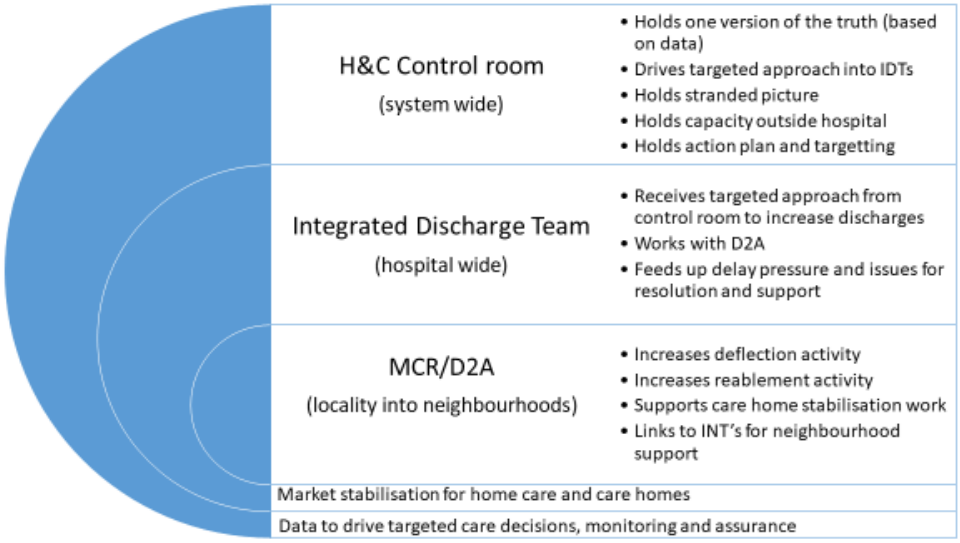
1.2 The partnership approach brings together key health and social care resources and includes commissioners, primary care, mental health providers, and acute providers. The paper describes the work that has been, and continues to be undertaken in conjunction with the three hospital sites in Manchester: Manchester Royal Infirmary; Wythenshawe; and North Manchester General Hospital.

2. Manchester Local Care Organisation (MLCO) winter delivery priorities

2.1 In November 2019, the MLCO Partnership Board, requested that MLCO bring forward a response to meet need and continued escalating pressures within the health and care system in Manchester over the winter period.

2.2 Five priority areas were identified and became the focus for work:

- Establishment of a Control Room;
- Fully mobilise integrated discharge arrangements/teams;
- Roll out of discharge to assess;
- Market stabilisation; and,
- Data driven decision making.



2.3 The five priority key areas were identified to address the key challenge of supporting people closer to home and in a timely way, thereby reducing the numbers of patients remaining in hospital over 7 days (stranded) and

addressing longer length of stay (patients in hospital over 21 days). This work also supports reducing delayed transfers of care.

2.4 **Standing up a Control Room function**

This work stream creates one place within MLCO where the effective movement of people between different care settings (known as flow) can be supported and managed within our system. Using 'a single view' of the MLCO position, the Control Room team works with IDTs to target actions for people who are in hospital and need support to move back into their communities.

As at the beginning of January the Control Room was in place, with a clear focus and supporting people to move between care settings or return to their home with support from community health and social care services (eg. primary care, district nursing, adult social care home care or movement to a building based community resource such as care homes, extra care or one of the short term community apartments across the city).

The team receives information from a range of services and uses this to understand the numbers of people who need to move on from acute hospital services and the capacity of community services able to respond to support people, giving a more holistic view.

Further work is underway to increase the capacity within the Control Room team to maximise the benefits for Manchester people.

2.5 **Integrated Discharge Team (IDT) implementation (MRI focus and city wide) and improving D2A**

The principle focus of this work stream is to develop an Integrated Discharge Team in MRI and improvements to city wide integrated discharge arrangements, improving the MLCO contribution to mandated urgent care targets. As part of this work MLCO will create an effective and sustainable seven-day Integrated Discharge Team and increase MLCO capacity in and around MRI to better manage flow into and out of the hospital site.

As part of this work significant progress has been made including:

- Programme governance structure designed and implemented
- Discharge Programme Board established
- Senior analytical capacity supporting the team with a short term focus on developing robust reporting.
- Reflective learning across Wythenshawe and North Manchester being undertaken to embed best practice across the City.
- A Multi agency discharge event (MADE) has been undertaken with system partners and the national support team from NHS Improvement (ECIST) across Wythenshawe and MRI.
- Funding has been secured, recruitment is underway for the additional roles required with some staff in post.

2.6 **Increasing deflection activity through Manchester Community Response (MCR) and avoiding admissions**

The MCR model is well established and will be supported through this work stream to increase deflection activity away from hospitals 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 to enable a primary care review.

Highlights from across the work stream include:

- The mobilisation of the Manchester Case Management service. This is a service targeted to high end users of primary, secondary and social care, with Task and Finish groups established in each Locality to oversee the work.

- Increased contribution of therapists within the model to provide home or community based rehabilitation options for people.

- Further drive to improve the uptake of Discharge to Assess with hospital based teams, challenging the culture of attempting to fully optimise people whilst they remain in hospitals as opposed to supporting them to achieve goals in their own environment.

- Extra capacity is coming on stream and includes 9 additional Health Care Support staff (5 recruited to) that will support discharge home and the work of the reablement service in south Manchester, providing a short term intervention function with trusted assessment ahead of movement to the reablement service.

- Flow diagram being developed by the teams to articulate the model and shared care arrangements

- Continued examination of data to support improvements in pathways and access to appropriate care in the right setting.

2.7 **Market stabilisation**

The principal focus of this work stream is to stabilise the care market in the short term in Manchester. This includes completion of the roll out of the new home care contracts in Manchester, improving capacity and relationships with providers and supporting care homes through a range of interventions.

As part of the delivery of this programme of work a number of key actions have been taken:

- There has been an increased use of spot contract arrangements for home care and care homes to supplement capacity across the city and maximise utilisation of the market
- The ongoing and safe mobilisation of the new home care contract is utilising a process of gradual re-procurement and reconfiguration of home care services into Neighbourhood areas. Completion of this is expected by

April 2020, which will mean that c1800 people will have been transitioned to new service providers

- To support increased levels of discharge from the hospital sites additional step down beds have been commissioned from an independent sector.
- Current fees are in the process of being reviewed.
- The National Direct Enhanced Primary Care Service (DES) in relation to care homes and prioritisation has been released. This changes some aspects of our plans in relation to targeted clinical support interventions. However, a revised plan will be mobilised to reflect the national requirements in relation to this, working closely with the 14 Primary care Networks in Manchester.

2.8 **Data to drive care decisions**

In pursuing the delivery of the five areas set out at 2.2 MLCO has identified the importance of the utilisation of core data in the approach to care delivery which enables the system to understand how much more activity we could flow through the new care models that form part of the MLCO approach. It is believed that consistent application of this approach and the growth in the number of pathways available within the new care models will contribute to the medium term stabilisation of urgent care in Manchester.

Compiling and using one master report creates one version of the truth of MLCO performance, utilising increasingly 'real time' information, from which decisions are made.

Significant progress has been made to develop the information that is available from health sources. A key part of this has been to create and launch a visualisation tool which is in pilot phase and will be rolled out to key staff within MLCO.

The next phase of this work will be to build a broader understanding of information that supports other elements of the discharge programme. Currently MLCO understand the capacity available in certain parts of the community and work is ongoing to develop a complete understanding of what is available in order to match demand.

3. Progress Against Key Outcomes

3.1 As set out in Section Two, the MLCO response to winter challenges was primarily focussed on achieving a reduction against nationally mandated targets in regards to: delayed transfers of care; stranded patients (longer than 7 days in hospital) and the average length of stay.

3.2 To ensure that MLCO delivers on pace and scale at supporting timely discharges, the Chief Executive has established a weekly System Resilience Group consisting of executive and senior MLCO leads. The group keeps focus on delivering against the agreed improvement trajectory as part of its commitment to deliver against system expectations.

3.3 Supporting the operational delivery of the discharge programme, MLCO has established a robust programme infrastructure and internal governance that looks to continue oversight of:

- Continued implementation and development of the MRI Integrated Discharge Team
- Support the wider deployment of system improvement across the North and South Integrated Discharge Teams.
- Supporting flow changes across the wards to support timely discharges
- The establishment of a Control Room for the MLCO
- The integration of Mental Health services across the discharge pathway.

3.4 As part of the work that has been undertaken, ECIST are providing practical application and support to the delivery of site changes which include the IDT. With ECIST, Site and MLCO leadership have supported the delivery of Length of Stay reviews, MADE events and are currently developing a proposal in regards to a relationship with the MLCO discharge programme to jointly create a national blueprint for Integrated Discharge Teams.

3.5 In addition, the Greater Manchester Association of Directors of Social Services, in line with urgent care work across Adult Social Care, have agreed two key projects as part of the 2019 winter plans. The first related to Out of Area repatriations. This consists of each Local Authority assessing for care requirements for all patients with their acute hospital site and forwarding a set of agreed assessment papers to the resident's local authority to be accepted to acted upon. This is now live in Manchester, trusted assessors have been identified and training delivered. Secondly, the Directors group has developed, with Principal Social Workers across Greater Manchester, a set of slides to support discharge teams and acute partners with the implementation of the best interest process, which ensures choices that aren't available are not used as the options within the best interest processes.

3.6 Despite the work that has been undertaken and some success in reducing numbers, long length of stay and the number of stranded and super stranded patients continues to be an issue across the hospital sites in Manchester, experiencing higher numbers than anywhere across Greater Manchester. Therefore, a sustained period of focus is still required to maintain the reduction in the numbers of stranded patients that has been recently achieved, as it still remains above the target set by NHS Improvement/England (NHSI/E).

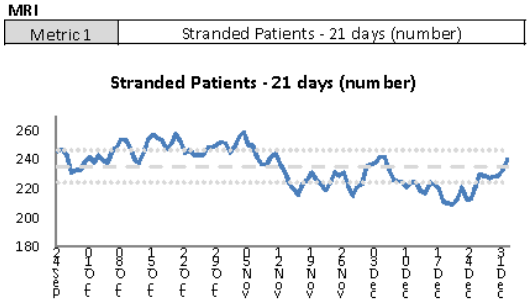
3.7 The reduction of these numbers is a key focus area for MLCO resilience planning: the MLCO will continue to actively participate in weekly ward length of stay reviews, which are identifying over 21 patients a day and is currently in the process of securing additional GP support for these reviews.

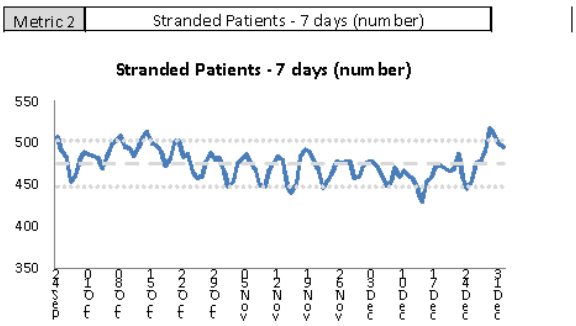
3.8 In support of this further work has been identified with colleagues in MHCC and MFT to ensure that through the Integrated Discharge Team, MLCO get earlier sight of those patients that will likely need discharge support. This is particularly important when set in the context of the complexity of discharges associated with increased length of stay.

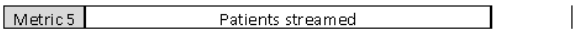
3.9 Despite this intense period of MLCO activity recommencing at a time when hospital attendances ordinarily increase, as can be seen from the tables below the average length of stay has decreased steadily (daily fluctuations notwithstanding) since 2nd November 2019 across MRI, Wythenshawe and Trafford.

3.10 **Stranded patients – Week Ending 1st Jan 2020**.

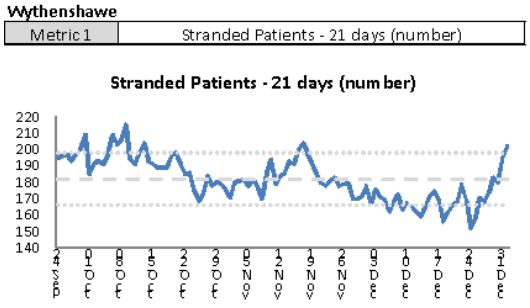
MRI

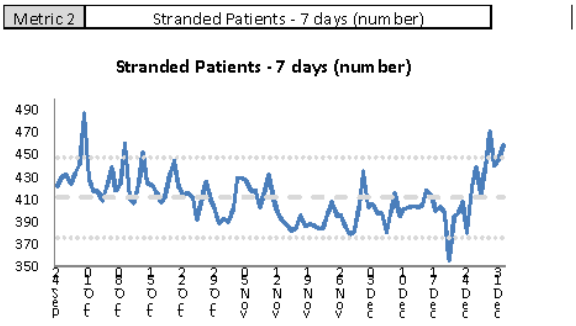


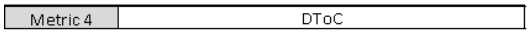


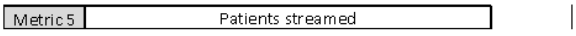


Wythenshawe

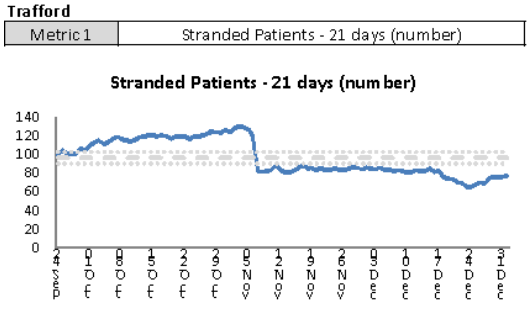


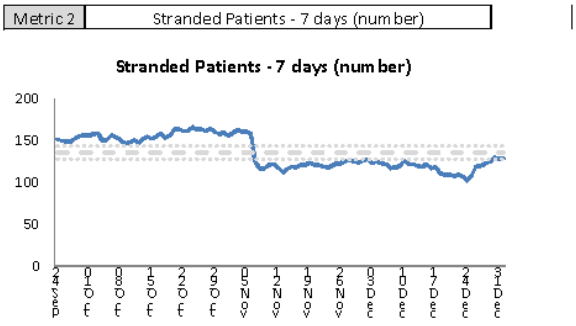


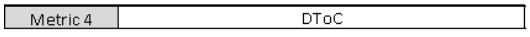


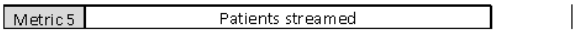


Trafford









3.11 In addition to the broader work that MLCO have led to facilitate increased levels of discharge, MLCO also continue to track all Manchester and non-Manchester resident patients who are admitted at the MRI and have a LOS of 70 or above days. As the Integrated Discharge Team at MRI becomes mobilised MLCO will maintain an oversight of a broader cohort of patients.

3.12 As of 7th January 2020 MLCO had facilitated the discharge of 241 people with excessive length of stay at MRI of which 184 have been Manchester residents (with 57 being non Manchester residents). Up to the point of discharge these patients had accumulated a combined length of stay in excess of 21,033 days.

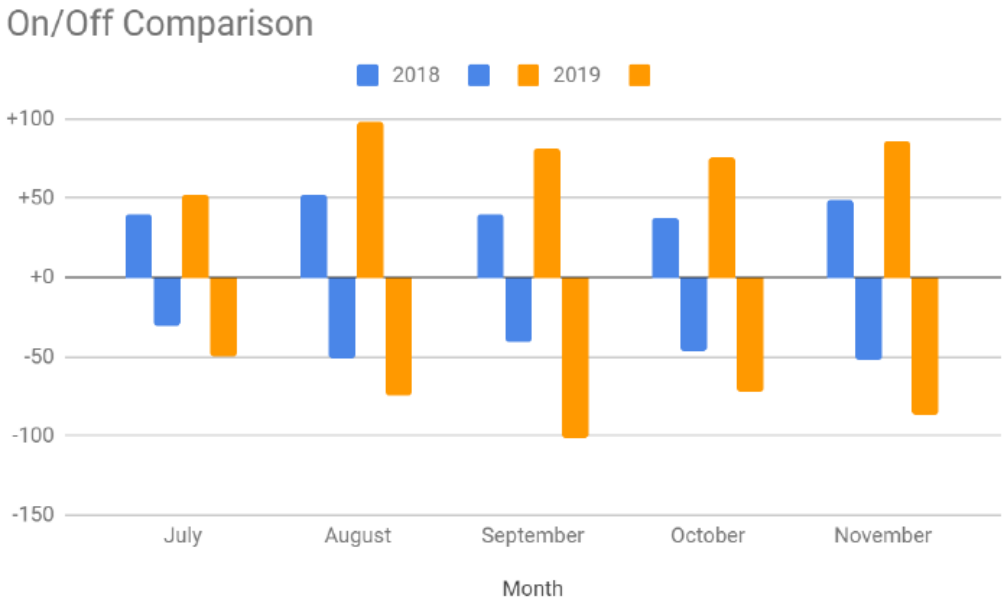
3.13 Despite the number of discharges that have been facilitated by MLCO, there have been a number of readmissions for people over the Christmas period.

4. Delayed Transfer of Care Position

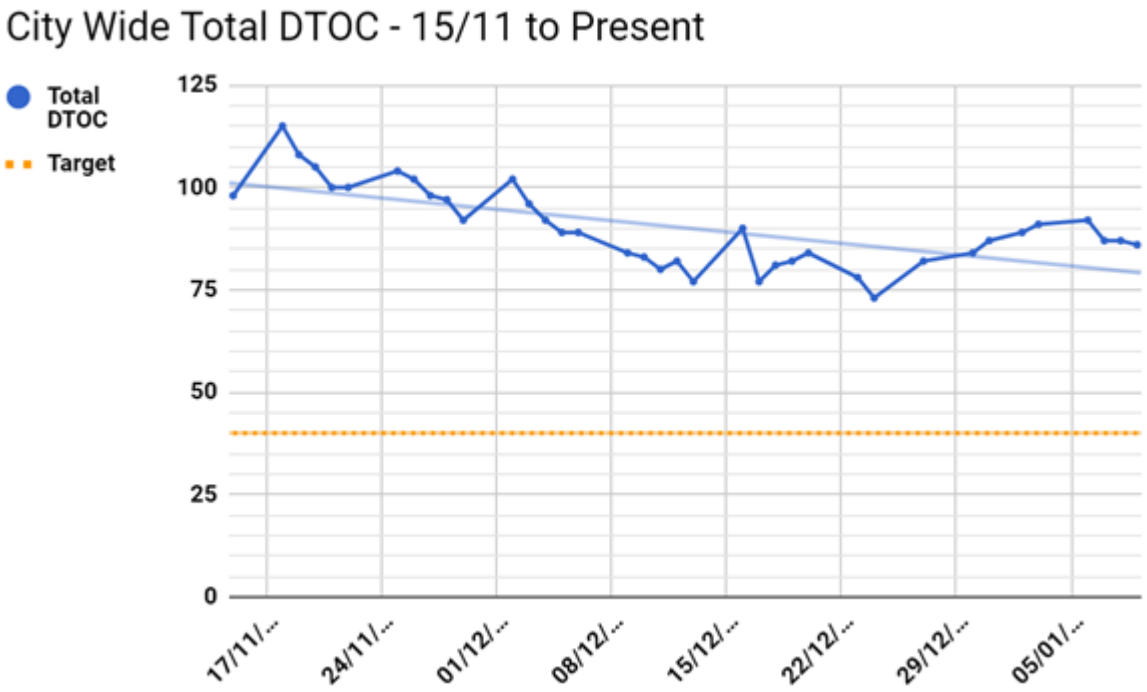
4.1 In July, and in response to request from GMHSCP and NHSE/I, MHCC set a DTOC improvement target of 40 for Manchester. This is a system wide improvement target the achievement of which is not the sole responsibility of MLCO. However, MLCO is a core partner to the delivery of associated improvement programmes.

4.2 As part of work to understand the efficacy of MLCO led interventions in regards to DTOC, initial high level work has been undertaken to understand comparative levels of activity compared to this time last year (2018).

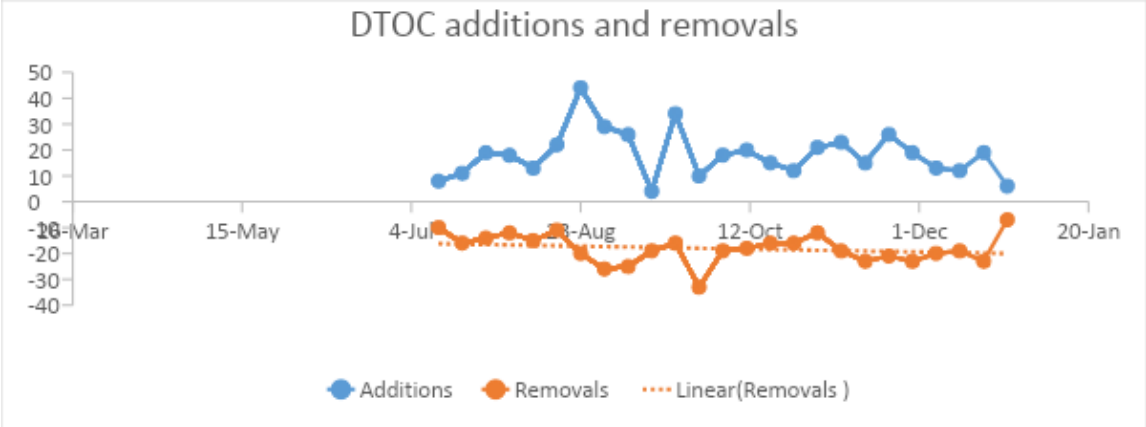
4.3 This early piece of analysis shows that across the three sites there have been more discharges facilitated by MLCO than at the same time last year. This is set in the context of an increased level of DTOC, i.e. there has been a significant increase in the number of people that have been classified as DTOC.



4.4 At the time of writing this report, the overall DTOC position was worse than the target position. However, it should be noted that the position represents a significant improvement against the position in early November 2019.



4.5 It should be noted that whilst the overall position remains challenged there continues to be significant movement across the three sites with significant numbers of patients being supported into alternative care settings. This is particularly the case at MRI where high numbers of patients have been supported into more appropriate care settings:



5. Manchester Community Response

5.1 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.

5.2 There three main 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.

5.3 The different teams within MCR are:

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.

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.

5.4 The reablement team 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.

5.5 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. In December 2019 the reablement team supported 152 citizens which relates to 12,000 visits to citizen's homes.

5.6 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. Despite the number of people in contact with the service being lower than planned there is a demonstrable positive impact on the urgent and emergency care activity for those people that are in service (i.e. the level of activity in the cohort is lower than it would otherwise have been).

5.7 However, despite the majority of MCR services performing in line with expectations, performance against Discharge to Assess (D2A) service in Central is not where we would expect the team to be performing. Work is underway to understand this and the inclusion of D2A senior leads into MRI processes will look to resolve this position.

6. Homelessness support

6.1 Whilst not directly falling under the remit of the MLCO, the response to people experiencing homelessness forms an integral part of the winter programme led by the Director of Adult Social Services (DASS) who is also responsible for the delivery of homelessness services with Manchester.

6.2 One of the teams that comprises the homelessness service in Manchester is the Housing Solutions Hospital Discharge Team. MCC have four Housing Solutions Officers (HSO's) based across the three hospitals, two of which are based in MRI. The role of the HSO is to complete a homeless assessment and work with patients to either prevent or relieve their homelessness. There is a Private Rented Sector Officer attached to the team who works to try and secure private tenancies and arranges the rent in advance and deposits. The staff have been in place in the hospital since Autumn last year.

6.3 At the end of November 2019 Manchester City Council secured a unit of 10 flats (available to the team until July 2020) to be used for hospital move on to provide temporary accommodation for patients for whom emergency accommodation in a B&B would not be appropriate and would otherwise likely have a longer stay in hospital. This is comprised of six ground floor wheelchair accessible flats and four first floor flats. The accommodation is staffed during office hours by two Move on Support Workers and there is security on site

when staff are not present. The flats are for single people only. To access this accommodation a duty to refer must be received by the Hospital Housing Solutions Team and a homeless assessment must have taken place. The maximum stay at the accommodation is 12 weeks. The Move on Support Workers work with residents to support them to move either to their own tenancy or to support accommodation.

6.4 There are currently eight flats occupied and there is a waiting list of patients appropriate for the accommodation but not yet medically optimised i.e. not able to be discharged from hospital.

6.5 Amongst the first residents is a gentleman who was sofa surfing in London due to a relationship breakdown. He was diagnosed with leukaemia whilst in a London hospital and transferred to MRI to be closer to family in Manchester. Family members offer support but are unable to accommodate him. This man is currently receiving chemotherapy treatment and needs self-contained accommodation. We were able to offer a flat and resettlement support was put in place by social care. An ambulance transports him to the hospital for his chemotherapy treatment. Without this accommodation and support in place he would probably still be in hospital.

6.6 Another positive case example is the support to a gentleman to move from hospital into one of the flats. He is an amputee, uses a wheelchair and has a history of infections to both his legs leading to multiple hospital admissions and increased lengths of stay. He also has a history of rough sleeping and lodging at various addresses. His previous accommodation history has meant that he has not engaged with his GP and not accessed community medical care resulting in his hospital admissions. Since moving into the accommodation he has engaged with staff, had visits from his GP and regular dressing changes by the District Nurse. He is recovering well physically and he is motivated to move on into his own tenancy for the first time in several years.

7. Recommendations

7.1 Health and Wellbeing Board is asked to note the contents of the report.