Trafford MSP Workshop – Group Activity

Activity aims:

- To identify gaps in the market (outside of staffing, inflation and bed vacancies which have already been identified), any risks and solutions to enable providers' views to be included in the final iteration.
- To jointly develop what the care market in Trafford should look like so we can secure the future together.

GAPS

Excludes: Staffing, inflation, bed vacancies.

1. SAMS Process:
   -Lack of efficiency; Providers are not contacted by the social workers during the 21 day period and then at the end of the 21 day period an extension is requested at a lower rate of £25 per day.
   -Mis-selling/marketing of SAMS to service users; When providers are able to discharge from the service within a week the service user is not accepting this as they insist they are entitled to their free 21 days.
   -Creating unnecessary work for providers where hospital discharges are cancelled at the last minute or when service users declined the services stating that they were never consulted/asked.
2. Social inclusion-Service user lack of community integration.
3. Lack referral for Sus to Access low level support i.e. falls
4. Age of staff; The current workforce are 50 years+ This impacts on completing moving and handling.
5. Available staff that drive.
6. Lack of Respite beds; for service users who are cared for at home by relatives.
7. Transition into Care Homes.
8. Currently the council have responsibility for completing social care assessments. The assessments are not being completed in a timely manner.
9. Understanding the current and future needs of Trafford.
10. Lack of mixed economy; Private/Council funded.
11. Lack of OT's/Physios and equipment; The time it takes for a one stop referral to be actioned and equipment to be implemented.
12. Lack of awareness of ATT/ATT+.
13. Unsafe discharges; Lack of information, medication not sent or GP not receiving up to date info and delaying meds request.
14. Lack of MDT visits from key professionals and weekly visits from GPs.
15. Lack of personal contact from organisations such as One Stop, automated systems are in place.
16. DN/GP service is inconsistent. Some DNs within certain GP surgeries have lack of support for service users i.e. SU's that may require IV Treatment in the community or care home.
17. Lack of out of hours social care support and resources; Homecare provider visited a service user in the evening who expressed suicidal thoughts, but the relevant service could only offer a call back 3 hours later therefore the provider had to deal with the situation without support.
18. Lack of awareness of TECS https://traffordlco.org/services/adult-community-

RISKS

1. Current SAMAS process becoming inoperative.
2. Service users are isolated leading to depression/housebound and therefore mat result in an increased demand on other services such as Mental Health.
3. Service User deterioration resulting greater needs and support. Increase hospital admissions and increasing the requirement to access high level support care services.
4. Reduction of staffing due to retirement. Increased sickness due to poor moving and handling.
5. Walking rounds only.
6. Emergency hospital admissions. Breakdown of care. Urgent placements required.
7. Placement breakdown.
8. Delays in care packages. Hospital discharge delays. Bed blocking in care homes. Homecare packages extended. All leading to increased costs.
9. Relationship breakdown between provider and LA.
10. High level of private referrals could affect capacity to accept LA referrals.
11. Delays in outcomes/increased falls. People staying in bed longer, increased risk of pressures and depression.
12. Service users not receiving relevant support could lead to increased hospital admissions.
13. Readmission, bed bound if equipment not insitu.
14. Service users needs not being reviewed.
15. Reduction of communication dissolves relations with organisations.
16. Unnecessary hospital admissions and delayed discharges. It can also cause distress to the service user.
17. Increased demand for 999 services and hospital admissions. Increased costs where staff work additional hours to support the SU. Staff Mental Health.
18. See point 17.

SOLUTIONS

1. Whole System review.
   To Trust the Homecare providers to do the assessment of reablement at point of hospital discharge.
   Direct social care link to discuss issues i.e. system portal that providers and social workers can access.
2. Voluntary Sector to link in with Homecare providers.
   Homecare Providers buddying up.
   Residential/Nursing Homes accommodating a Hub.
   Linking with schools/colleges/playgroups.
3. Falls prevention – better care from the start.
4. Higher Education Apprenticeships.
   Fund driving lessons and fund insurance through salary sacrifice to encourage younger staff.
5. Double cover where one is the main driver.
   Fund driving lessons and fund insurance through salary sacrifice to encourage younger staff.
6. Link in with Carers Centre.
   Allocating dedicated beds.
7. Gradual introduction into what care homes are, so that SU's have familiarity. Coffee mornings, and joints activity sessions via Homecare providers supporting SU's to visit care homes.
8. Review of the current Assessment Process.
   Trusted Assessor to sit outside of the council; Upskilling provider's staff to become trusted assessors.
9. Partnership working and communication.
10.
11. Train the trainer.
12. Invite ATT+ back to provider forum. Circulate information.
13.
14. ICS to reiterate GP processes and responsibilities. Social Care to ensure all reviews/assessments and MDTs are carried out in line with current processes. Identify issues and reasons why MDTs are not taking place,
15.
16. See point14.
17. Review current processes.
18. LA to follow up with ICS.

services/enhanced-care-service/#1663512008552-10bc9808-6fbf the community matron aspect of the service – is this still operation and if not how can it be replicated?		

Barriers/Challenges

- Communication with Social Care Team – Home providers are told to liaise with Commissioners but some queries require a direct link to the social care team.
- Homecare packages of care no longer include tasks such as shopping, cleaning, support to access community settings.
- Available funding.
- Currently a high turn around, if providers were to assess on hospital discharge this would delay the process.
- Funding driving lessons and insurance would require a signed agreement to stay with the provider or payback funds.
- Reduced services due to lack of staff.
- Some areas are outside of LA control and therefore solutions will be dependant on joint working/collaboration and good relationships.
- Capacity across health and social care.