North of England Commissioning Support

Care Home Capacity Tool
Case Study
July 2018

Partners in improving local health

This template has been designed to showcase some of the work that has been undertaken in the roll out of the Care Home Capacity Tracker Tool

It has been designed to illustrate the challenges, successes, and outcomes that systems have faced during implementation., which may allow others to understand some of the critical factors and processes that have enabled change, how this was achieved and the benefits realisation on the reduction of Delayed Transfers of Care, quality indicators and patient experience

These case studies have been requested by NHS England North will be collected by the North of England Commissioning Support Unit and shared with colleagues from health & social care systems to promote and share good practice

Where possible please ensure that data is included

The bullet points are meant to be a guide and should not preclude inclusion of other pertinent information.

Please add a key contact so that people who would like to learn more can do so.

Contents

Key Contact - Lisa Lowe – 0114 305 1167

Introduction

1. What CCG / STP does this case relate to: Sheffield CCG & SYB ICS

2. Provide a ***brief*** background to the CCG/STP current issues

3. What is your understanding of your current DToC status - It is important to illustrate with data.

4. What did you to better understand and diagnose the root causes and potential solution?

Identified issues

- Care homes not updating
- Do the correct people have an account
- Need to review non care home accounts

Potential Solution

- Provide resources to care homes to update their bed vacancies in real time

Intervention

Was there any investment either financially/manpower to assist in this roll out /is it phased? Yes manpower as part of the business support role and responsibilities

What were the challenges you faced? Historic problems which have now been resolved

How did you adapt the roll out for your own system? Roll out was completed in September 2017

What were the key successes you experienced? Initially 104 care homes out of 113 homes signed up to use the system.

How is success being monitored weekly review meetings of RAG ratings of homes updating the system

How is this process being embedded into BAU - as above

Our Approach

What we did	How we did it	Action key to success
Communicated with care homes advising them the system was coming	Contacted all the homes in Sheffield via Phone & email	Calling round each home & talking through how to log in and update the system

What Impact Did This Have On The Patient Group/Service User

	Tick relevant
Mothers & Newborn	
People with need for support with their mental health	
People with learning disabilities	
People who need urgent & emergency care	
People who need routine op	
People with long term conditions	√
People at end of life	√
People with continuing health care needs	√
Impact Up to date bed availability for those medically optimised for discharge	

Outcomes & Benefits

Outcomes	
Engaging with care homes	

Benefits	
Booked visits with managers to go through the portal	

Next Steps

Are there plans to improve upon what has been delivered? ongoing

Is there a stepped approach and has this changed following evaluation from work to date? Yes,
work with care homes
Work with senior leaders to raise awareness
Work with non-care home users

Does more work need to be done to make this sustainable? Yes monitor over the next 12 months

Can this work be adopted into the STP? Yes but would need resource and capacity