



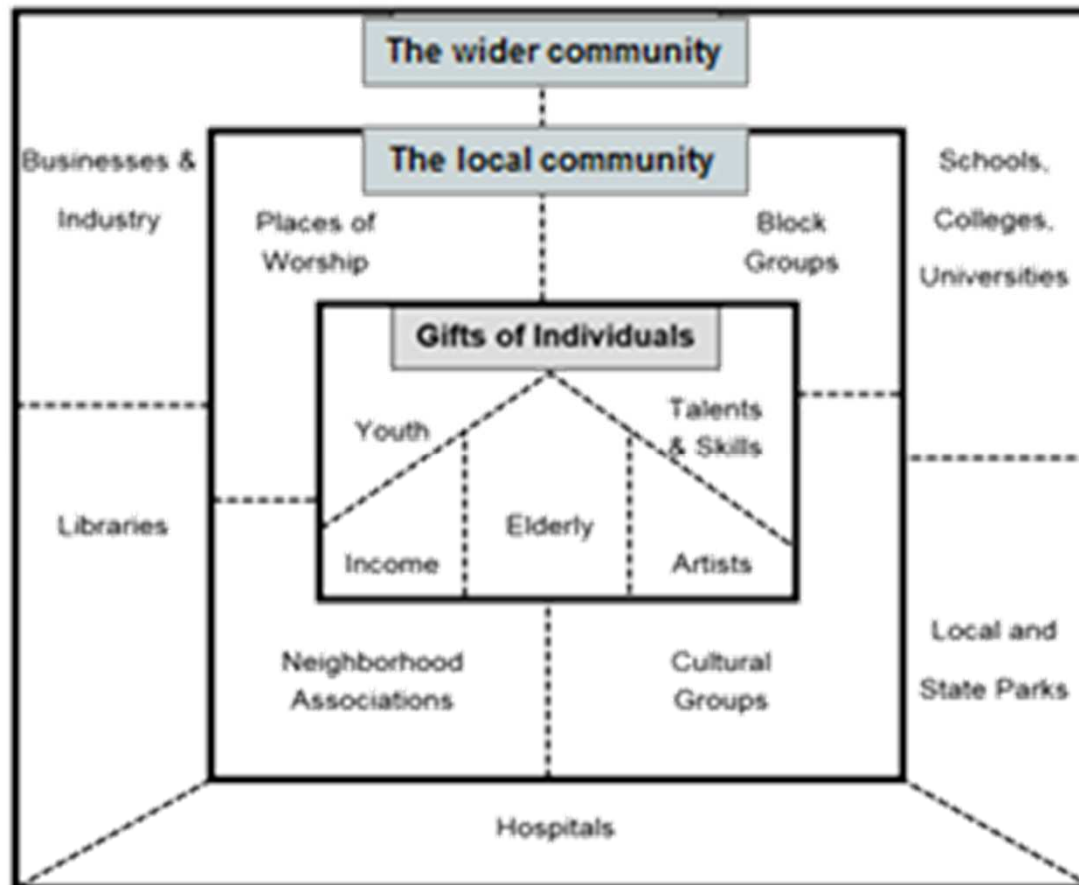
**TRAFFORD**  
COUNCIL

Pennine Care   
NHS Foundation Trust

Health Scrutiny  
CQC System Review Action Plan: Deep Dive  
**Diane Eaton, Director of Integrated Care**  
**Karen Ahmed Director of Commissioning**



## Asset Based Approach – The Trafford Way

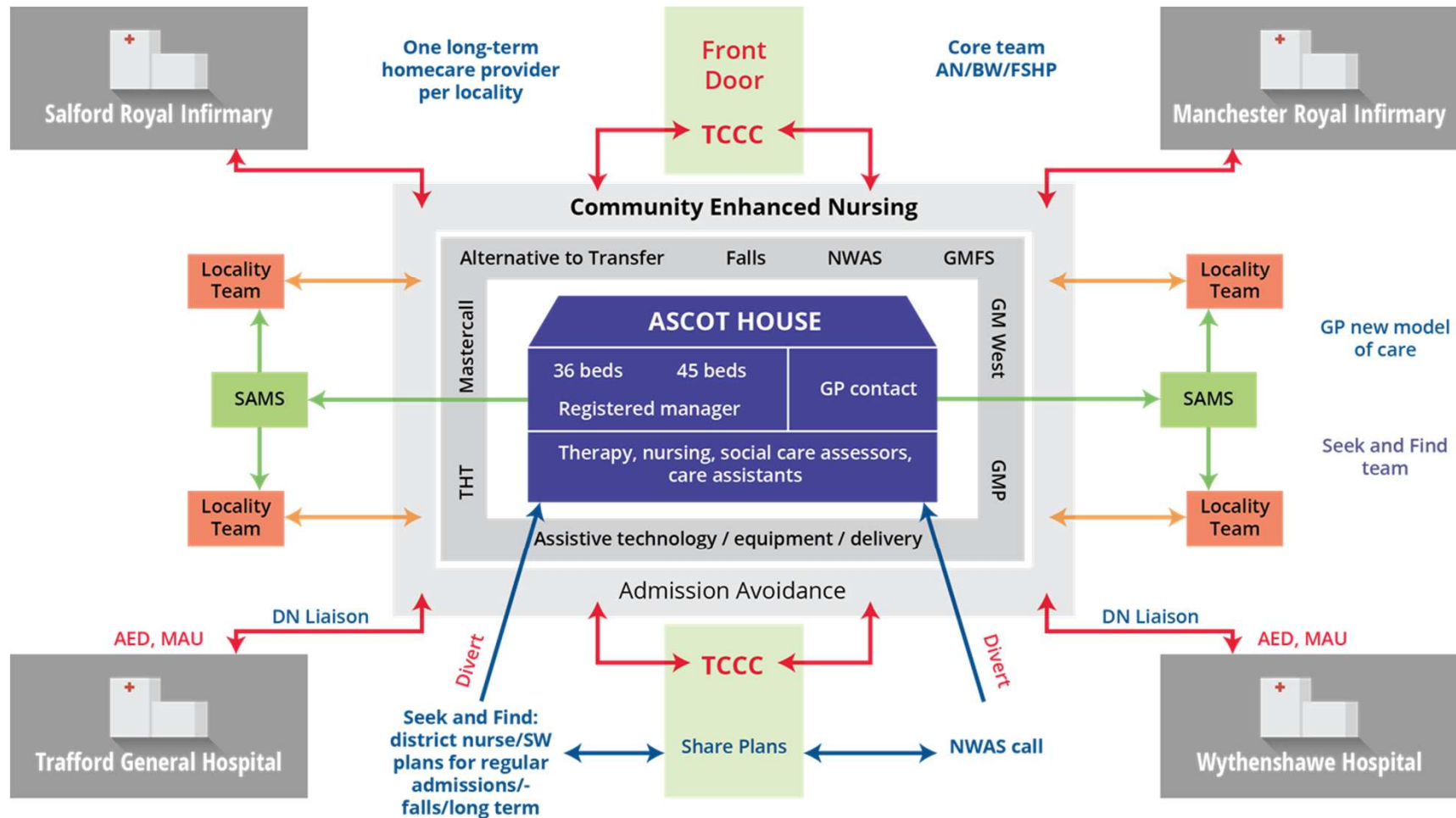


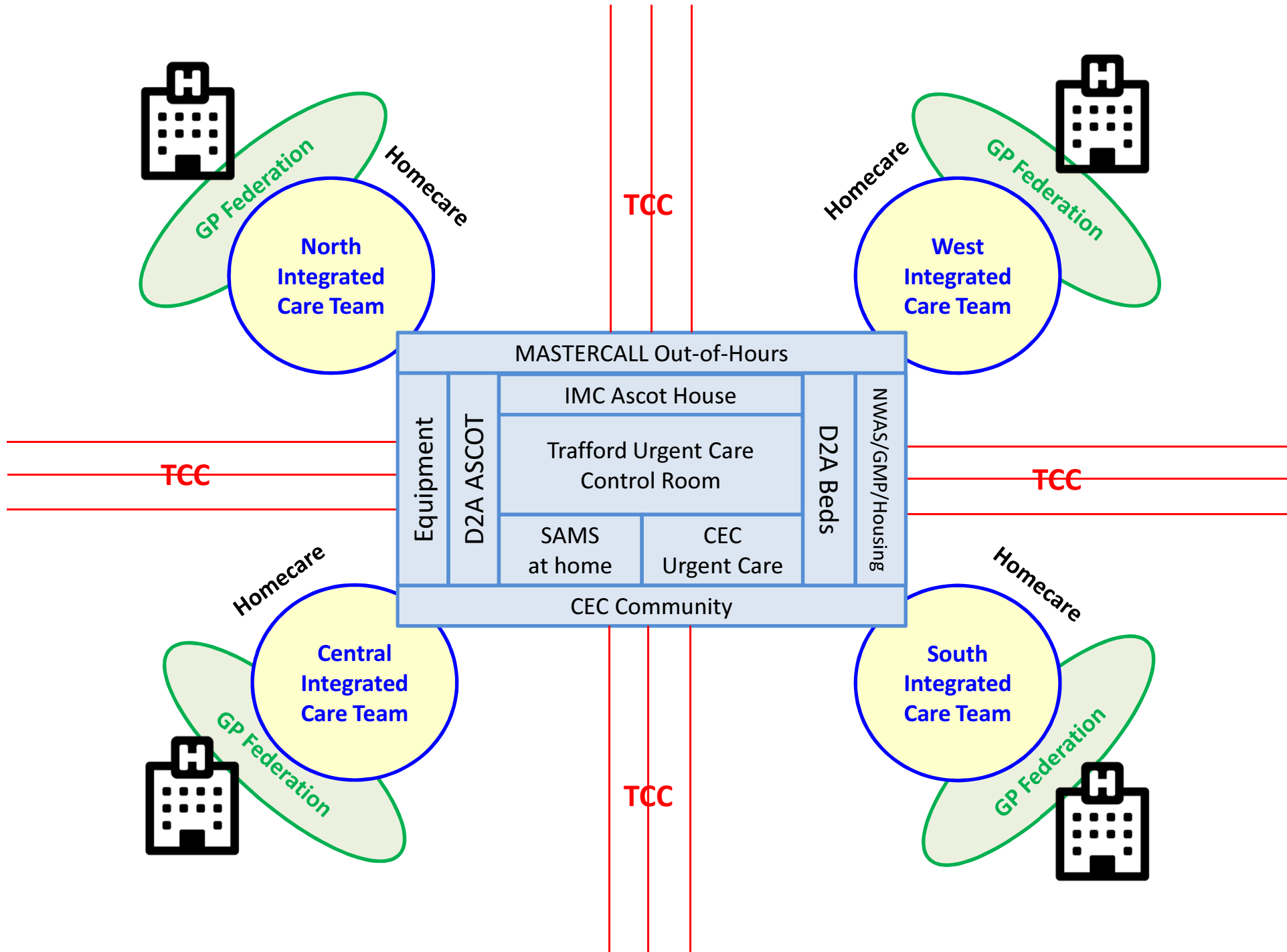
# Context

- Over the last 12 months Trafford Urgent Care work has been developing components of the High Impact Model issued by DOH
- Equipment stores in each acute setting and development of rapid minor adaptations with fire service
- Including Ascot house intermediate care unit
- ( 36 beds )
- The development of Integrated care discharge teams in each associated site
- Development of Discharge to assess methodology
- Creation of the Urgent Care Control Room



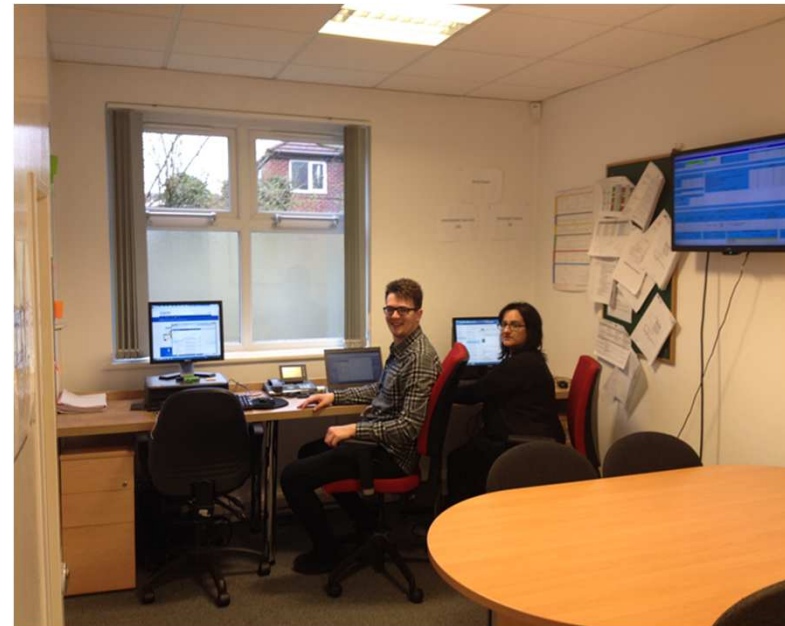
## Ascot House (Therapy Led Intermediate Care Unit)





# Urgent Care Control Room

- Opened in November in Trafford
- Meadway health centre – co-located with all the 24/7 services
- Daily information of leavers and availability of resources



# Daily community resource status reports

The image shows a detailed daily community resource status report form. It is organized into several distinct sections, each with a blue header. At the top, there are summary boxes for 'Total Available Beds' and 'Total Occupied Beds'. Below these are several smaller tables for 'Admissions', 'Discharges', and 'Transfers'. The central part of the form is a large table with columns for 'Resource', 'Status', 'Admissions', 'Discharges', and 'Transfers'. This table lists various community resources such as 'Mental Health Services', 'Substance Abuse Treatment', 'Crisis Intervention', 'Outpatient Services', 'Inpatient Services', 'Residential Services', 'Case Management', 'Support Groups', 'Family Therapy', 'Individual Therapy', 'Group Therapy', 'Counseling', 'Behavioral Health', 'Addiction Treatment', 'Mental Health Clinic', 'Substance Abuse Clinic', 'Crisis Center', 'Outpatient Clinic', 'Inpatient Unit', 'Residential Unit', 'Case Management Office', 'Support Group Room', 'Family Therapy Room', 'Individual Therapy Room', 'Group Therapy Room', 'Counseling Room', 'Behavioral Health Room', 'Addiction Treatment Room', 'Mental Health Clinic', 'Substance Abuse Clinic', 'Crisis Center', 'Outpatient Clinic', 'Inpatient Unit', 'Residential Unit', 'Case Management Office', 'Support Group Room', 'Family Therapy Room', 'Individual Therapy Room', 'Group Therapy Room', 'Counseling Room', 'Behavioral Health Room', 'Addiction Treatment Room'. At the bottom, there are summary rows for 'Planned Discharges', 'Current Status', and 'Total Available Beds'. The form is filled with data, and some rows are highlighted in yellow and green.

Resource	Status	Admissions	Discharges	Transfers
Mental Health Services	Available	10	5	2
Substance Abuse Treatment	Available	8	4	1
Crisis Intervention	Available	12	6	3
Outpatient Services	Available	15	8	4
Inpatient Services	Available	20	10	5
Residential Services	Available	18	9	4
Case Management	Available	14	7	3
Support Groups	Available	11	6	3
Family Therapy	Available	9	5	2
Individual Therapy	Available	13	7	3
Group Therapy	Available	10	6	3
Counseling	Available	12	6	3
Behavioral Health	Available	14	7	3
Addiction Treatment	Available	11	6	3
Mental Health Clinic	Available	13	7	3
Substance Abuse Clinic	Available	10	6	3
Crisis Center	Available	12	6	3
Outpatient Clinic	Available	14	7	3
Inpatient Unit	Available	16	8	4
Residential Unit	Available	15	7	3
Case Management Office	Available	11	6	3
Support Group Room	Available	10	6	3
Family Therapy Room	Available	9	5	2
Individual Therapy Room	Available	12	6	3
Group Therapy Room	Available	11	6	3
Counseling Room	Available	10	6	3
Behavioral Health Room	Available	12	6	3
Addiction Treatment Room	Available	11	6	3

**TRAFFORD  
Discharge to Assess**

**‘No decision about long-term care needs should be taken in an acute setting and as such, all adult patients should have the opportunity to access a discharge to assess pathway’ - GMCC Standards for Greater Manchester (GM): Discharge to Assess**

# TRAFFORD DISCHARGE TO ASSESS PATHWAYS

**Person is Medically Optimised**

During their hospital stay info is gathered about the person's priorities, lifestyle and resources they have available. Hospital staff should be focused on medical optimisation of the patient. They will identify and communicate the potential short or long term effect the person's condition may have on their wellbeing and desired outcomes



There will be a ward based MDT managing the patient through their acute episode in addition there will be the support of the wider out of hospital MDT supported by Ascot House, the Trafford Urgent Care Control Room and other relevant specialists

## Discharge MDT Agree Pathway

<b>Trusted Assessors</b>	<b>Trusted Assessors and Social Care Assessors</b>	<b>Trusted Assessors and Social Care Assessors</b>	<b>RAID, BIA, Social Workers</b>	<b>RAID, Social Workers, CHC Nursing</b>
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<b>GM - Pathway 0</b>	<b>GM - Pathway 1</b>	<b>GM - Pathway 2</b>	<b>GM - Pathway 3</b>	<b>GM - Pathway 4</b>
<p><i>For patients who can go home (or return to their care home) with no support or with the continuation of their existing packages of care.</i></p> <p><b>ALL</b> patients may be able to return home without any additional support. This pathway should be made available as soon as the patient is ready for transfer.</p>	<p><i>For patients who can return home with additional support.</i></p> <p>The patient is discharged home and care and therapy are provided by a community support and reablement team in order to support the patient's recovery to independence. During this time, the patient will be assessed and referred to the most appropriate ongoing care.</p>	<p><i>For patients who could potentially return home after a period of additional rehabilitation.</i></p> <p>Through this pathway, the patient is discharged to temporary residential care/intermediate care facility/community hospital/ supported accommodation setting and are provided with rehabilitation and reablement services in this setting</p> <p>An assessment of their long-term care needs are completed and appropriate referrals made.</p>	<p><i>For patients likely to need ongoing care in a residential setting.</i></p> <p>Through this pathway the patient is referred to a nursing or care home facility with recovery and comprehensive assessment. These patients will have been assessed by the multi-disciplinary care team as having complex care needs and are likely to require continuing care in a residential home. The pathway will be common for those whom continuing health care (CHC) funding is likely.</p>	<p><i>For patients who have a significantly specialist need and therefore cannot be discharged for assessment.</i></p>

## Personalised services available through each Pathway in Trafford

Deep house clean services and temporary accommodation (where appropriate)	Stabilise and making safe (SAMS) Urgent Community Enhanced Care (CEC)	Ascot House: Non-nursing rehab beds Discharge to assess nursing/residential	Discharge to assess in a residential home Discharge to assess in a nursing home	The person will remain cared for by specialist teams and will require specialist support until
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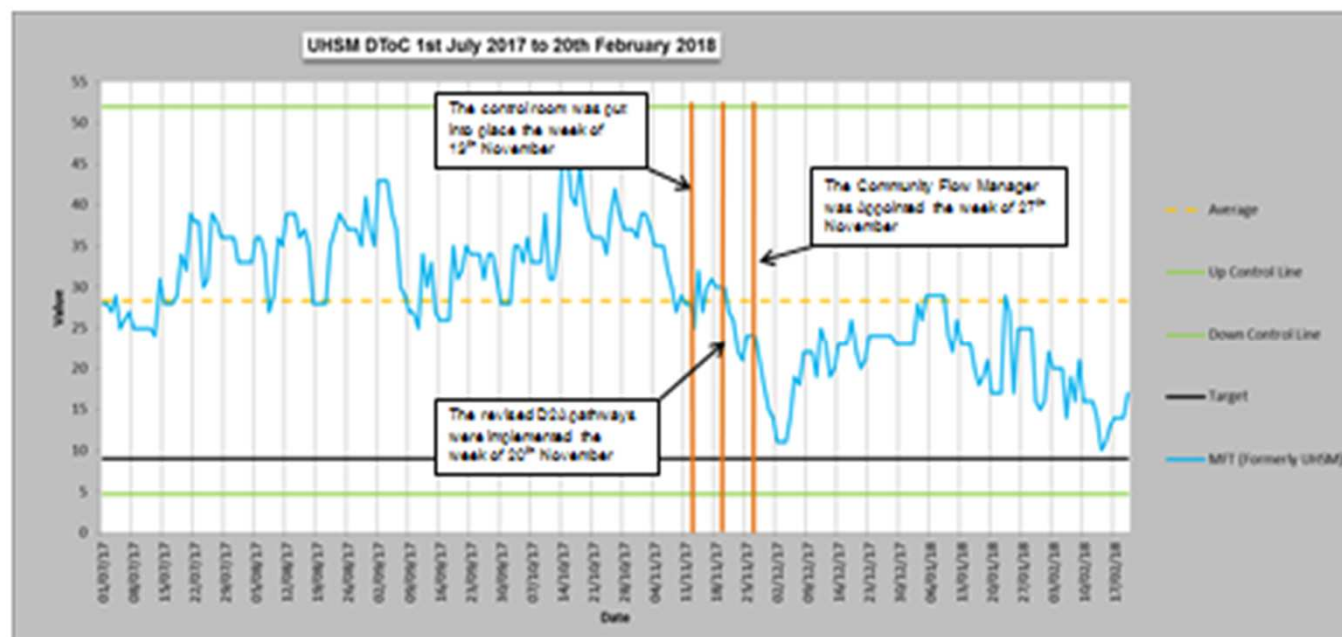
# Stabilise and Make Safe (SAMS)

- Three services in place to deliver SAMS in Trafford
- 25 places a week
- 3 weeks intervention
- 60% of people are independent after the intervention

# Discharge to Assess beds

- Time to recover
- Time to ensure we are promoting asset based assessment and recovery
- Time to choose long term destinations
- Time for the council and CCG to agree long term funding arrangements and support peoples personal choices
- 36 beds in community homes and 9 beds in Ascot house

What the data is telling us



# Questions and comments

