Health Scrutiny
CQC System Review Action Plan: Deep Dive
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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
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 effects 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.

**TRAFFORD DISCHARGE TO ASSESS PATHWAYS**

Person is Medically Optimised

![Diagram showing discharge pathways]

<table>
<thead>
<tr>
<th>Trusted Assessors</th>
<th>Trusted Assessors and Social Care Assessors</th>
<th>Trusted Assessors and Social Care Assessors</th>
<th>RAID, BIA, Social Workers</th>
<th>RAID, Social Workers, CHC Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GM - Pathway 0</strong></td>
<td><strong>GM - Pathway 1</strong></td>
<td><strong>GM - Pathway 2</strong></td>
<td><strong>GM - Pathway 3</strong></td>
<td><strong>GM - Pathway 4</strong></td>
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<tr>
<td>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. <strong>ALL</strong> 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.</td>
<td>For patients who can return home with additional support. 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.</td>
<td>For patients who could potentially return home after a period of additional rehabilitation. 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. An assessment of their long-term care needs are completed and appropriate referrals made.</td>
<td>For patients likely to need ongoing care in a residential setting. 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 needs (CHC) are likely.</td>
<td>For patients who have a significantly specialist need and require a specialist placement and therefore cannot be discharged for assessment.</td>
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**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 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
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

UHSM DToC 1st July 2017 to 20th February 2018

- The control room was put into place the week of 18th November.
- The Community Flow Manager was appointed the week of 19th November.
- The revised DToC pathways were implemented the week of 20th November.
Questions and comments