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Pennine Care NHS
NHS Foundation Trust

Health Scrutiny
CQC System Review Action Plan: Deep Dive

Diane Eaton, Director of Integrated Care
Karen Ahmed Director of Commissioning

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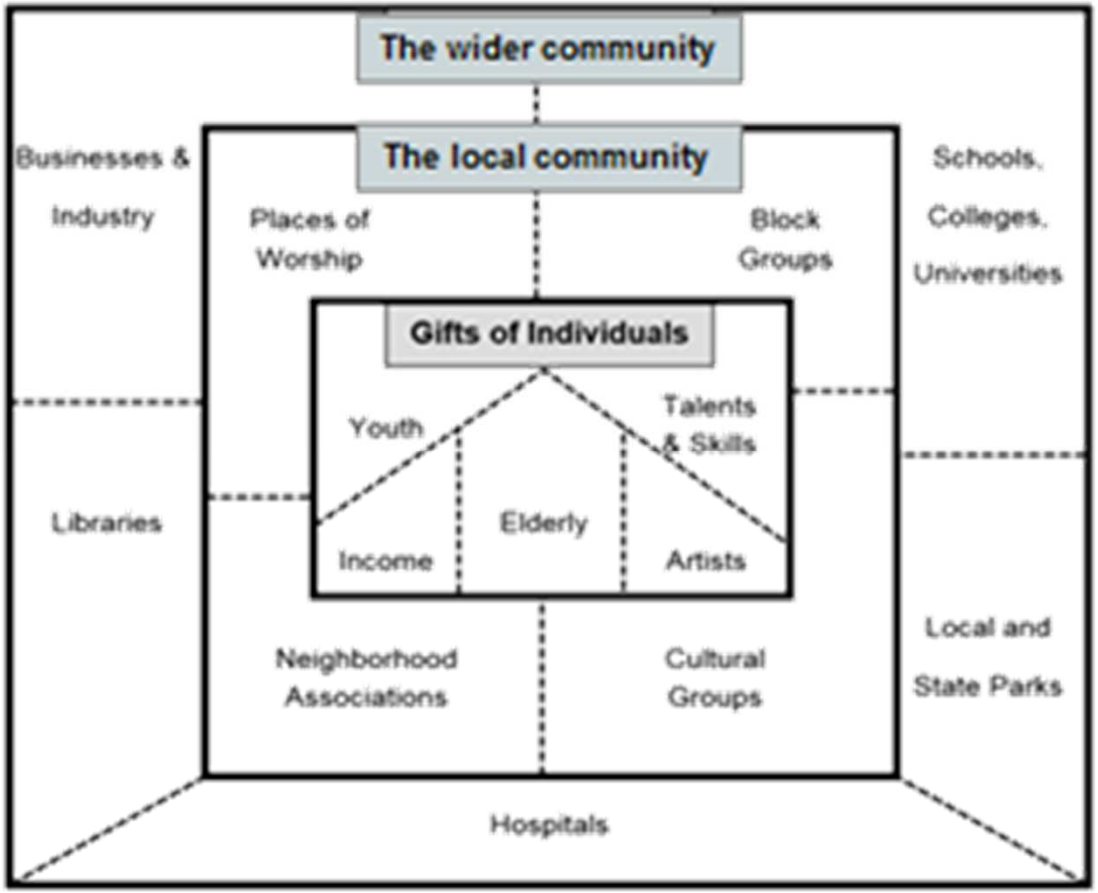
Asset Based Approach – The Trafford Way



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

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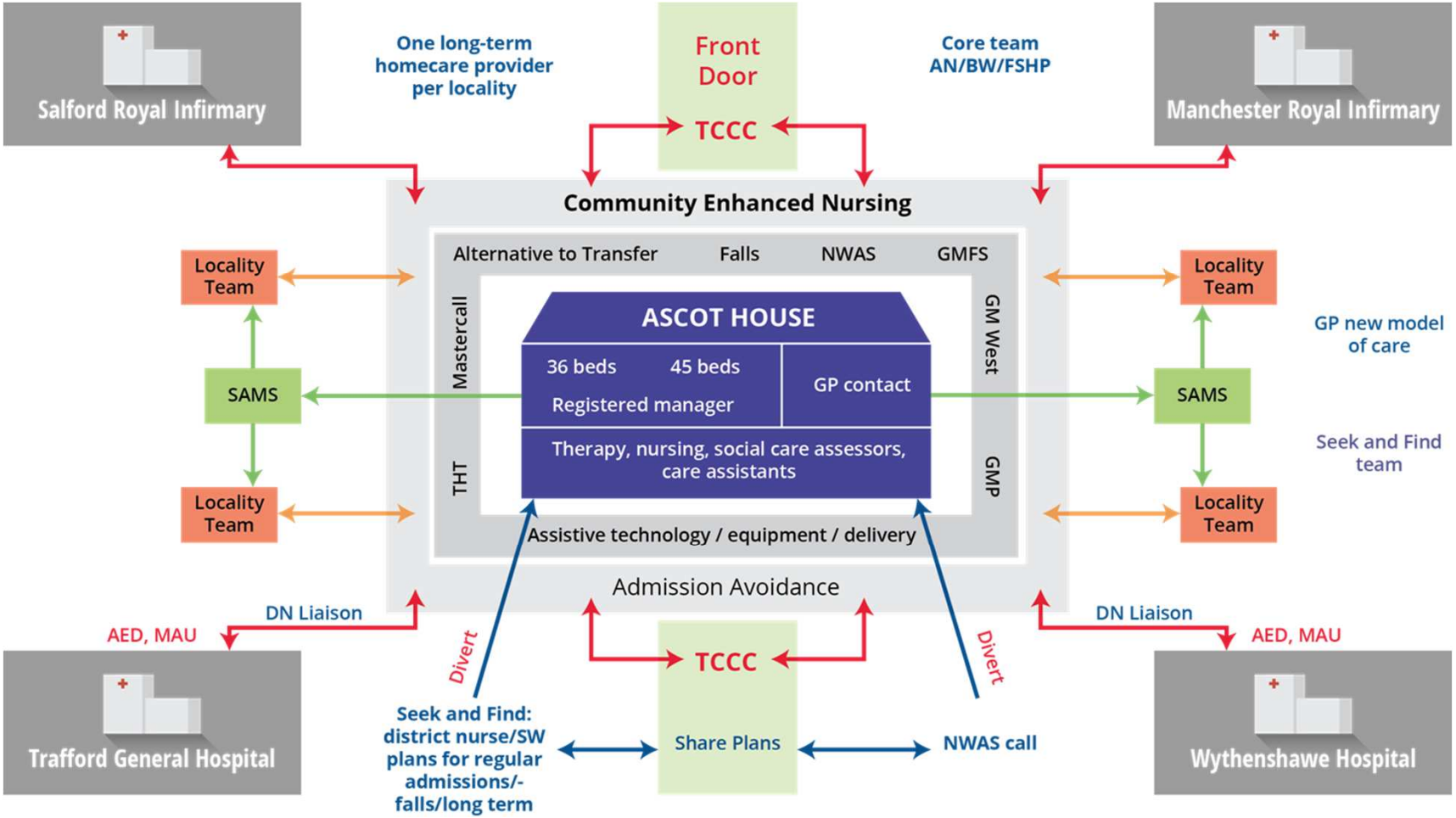
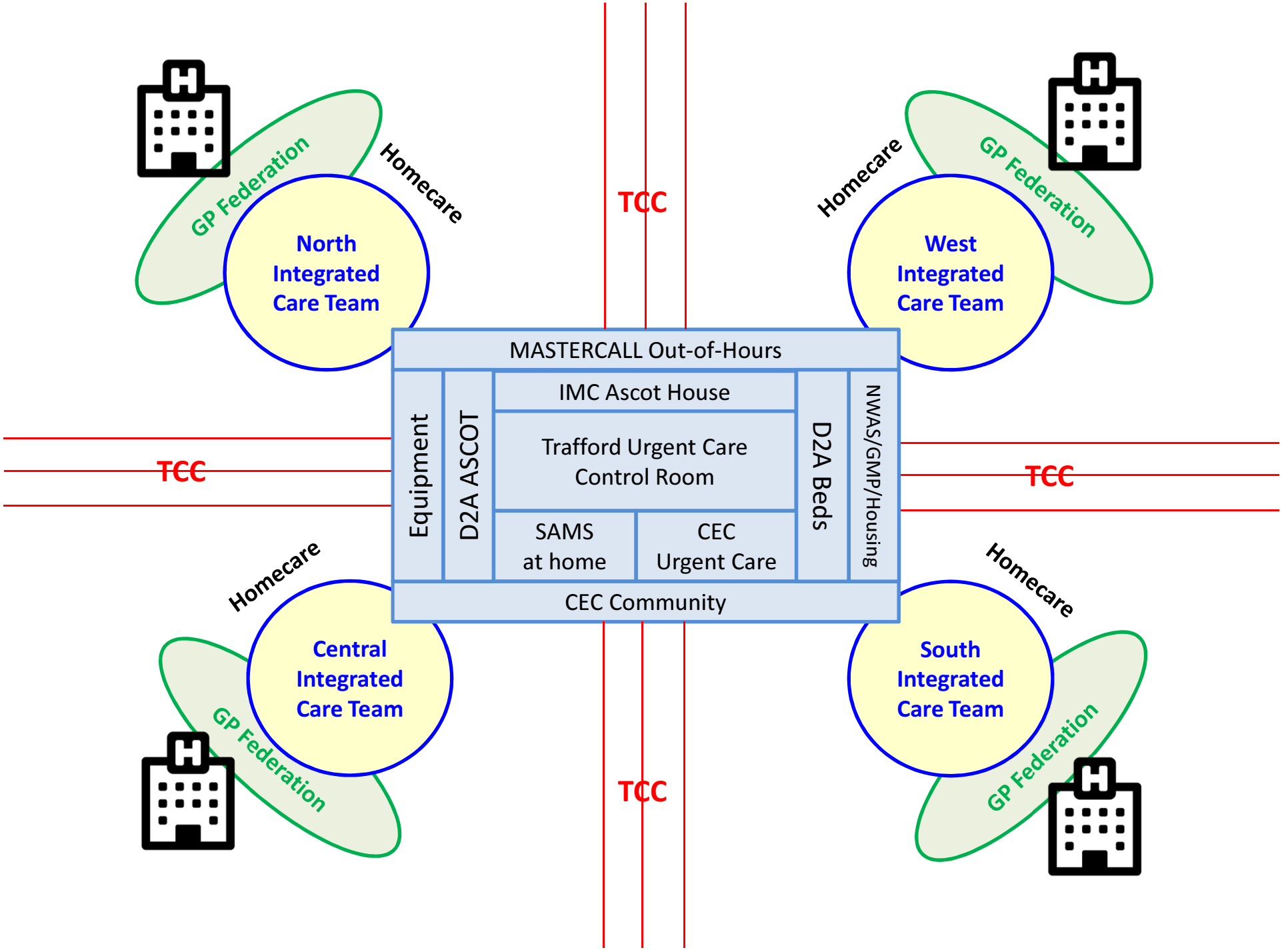
Ascot House (Therapy Led Intermediate Care Unit)




TCC
TCC
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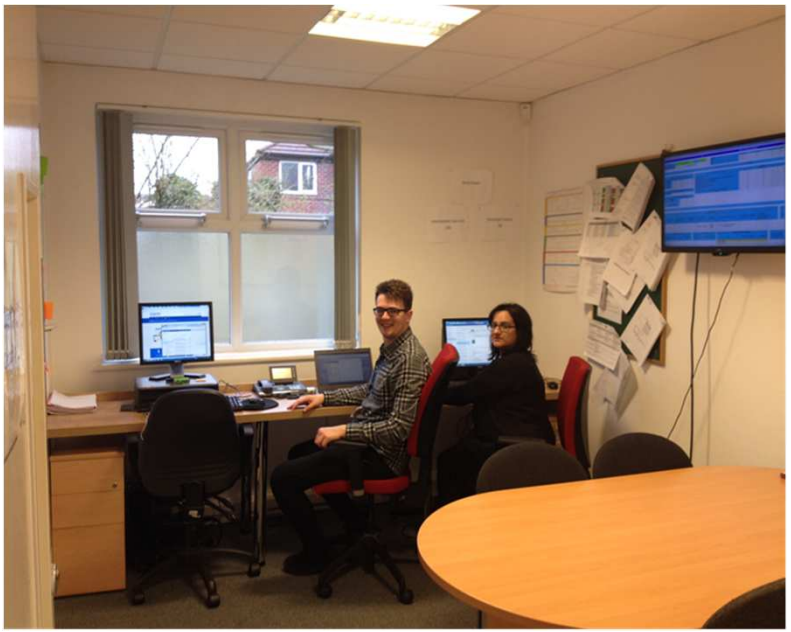
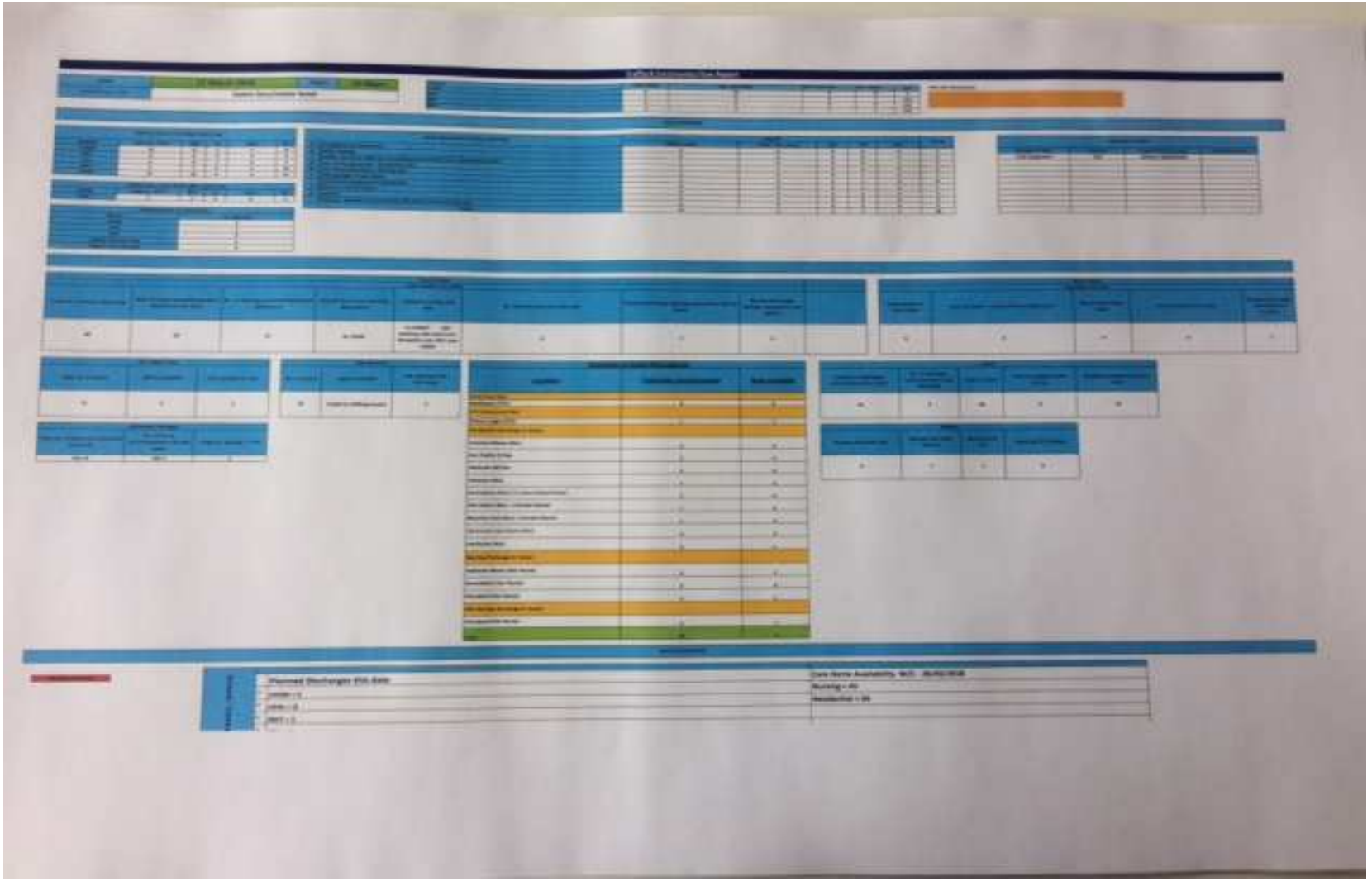
North Integrated Care Team
West Integrated Care Team
Central Integrated Care Team
South Integrated Care Team
GP Federation
GP Federation
GP Federation
GP Federation
Homecare
Homecare
Homecare
Homecare
MASTERCALL Out-of-Hours
Equipment
D2A ASCOT
IMC Ascot House
Trafford Urgent Care Control Room
SAMS at home
CEC Urgent Care
D2A Beds
NWAS/GMP/Housing
CEC Community

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



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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

Trusted Assessors	Trusted Assessors and Social Care Assessors	Trusted Assessors and Social Care Assessors	RAID, BIA, Social Workers	RAID, Social Workers, CHC Nursing
GM - Pathway 0	**GM - Pathway 1**	**GM - Pathway 2**	**GM - Pathway 3**	**GM - Pathway 4**
*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. **ALL** 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.*	*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.*	*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.*	*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 care (CHC) funding is likely*	*For patients who have a significantly specialist need and require a specialist placement and therefore cannot be discharged for assessment.*

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

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

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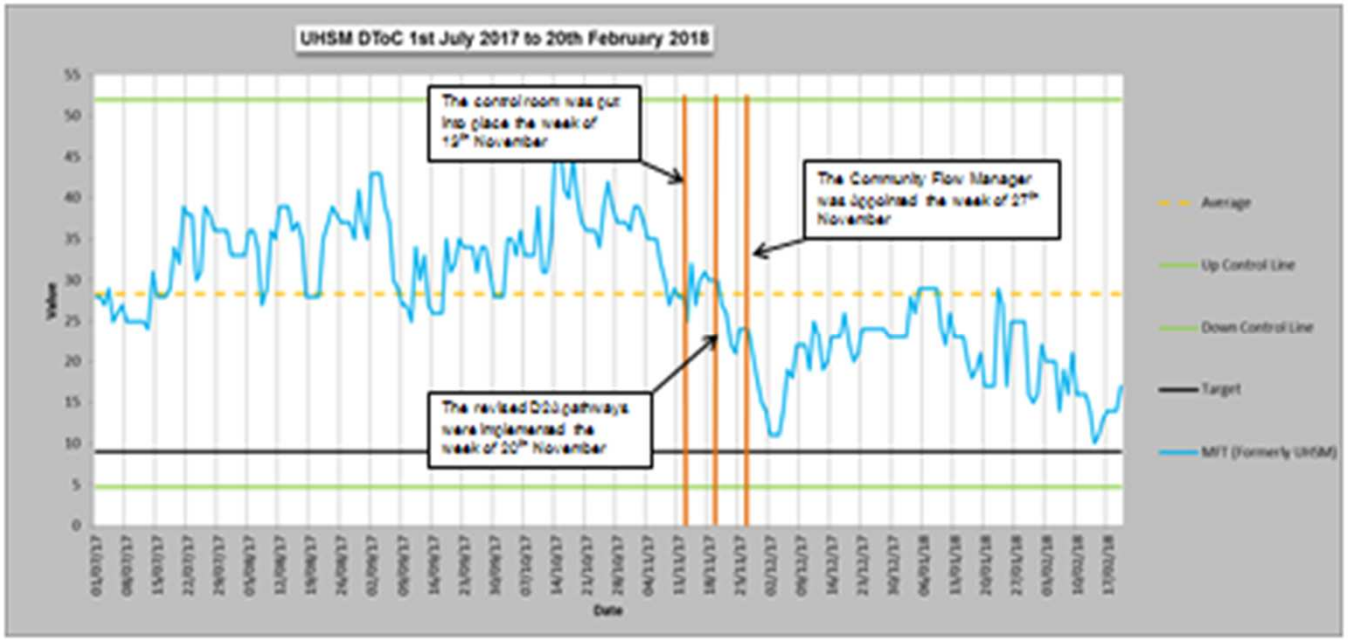
What the data is telling us



Questions and comments