

## Appendix B

## Telford and Wrekin Intermediate Care Action Plan V5

ACTION	WHEN	WHO	COMPLETED	COMMENTS
Whole System Consultation Workshop. Working on 'Ask and Offer' to bring Service to level of NICE recommendations <ul style="list-style-type: none"> <li>• Wrap up Meeting</li> <li>• Feedback and Planning</li> </ul> MB present at Frailty Board Presentation to the Group of the Operational Process Document Share with Service user and Making it real board Health and Wellbeing Board Therapy Workshop with Liz Sargent to look at change of hospital model	5 <sup>th</sup> Feb 2018	JS/ST/SB/MB/RAE	5 <sup>th</sup> Feb 2018	SaTH operational Staff did not attend due to hospital pressures
	15 <sup>th</sup> Feb 2018	As above	15.2.18	
	Provisional date 4.4.18			
	28.2.18	MB	Outstanding	
	16.4.18	JS/ST/SB/MB/RAE	Completion by 15 5 18	
	Tba	JS	Outstanding	
	6.6.2018	JS/SB	June H &W Board	
8.5.18	JS/ST	Ongoing work through AED		
Recommission Bed Base (20) <ul style="list-style-type: none"> <li>• Serve Notice on Cartilage</li> <li>• Serve Notice on Morris Care</li> </ul>	January 2018	SB	Jan 2018 Completed	
	9.2.18	MB/SB	completed	

<ul style="list-style-type: none"> <li>• Consider Serve Notice of Lightmoor</li> <li>• <b>Interim Block Bed Base for Nursing and Complex Need Residential sign off</b></li> <li>• <b>Tender for Interim bed base (20)</b></li> <li>• Full review for long term provision with one provider for Bed Based Intermediate Care, with onsite therapists.</li> </ul>	<p>Not to happen</p> <p>Agreed 26 3 18</p> <p>Awarded 26 3 18</p> <p>From Workshop Outcomes</p>	<p>JS/SB/MB</p> <p><b>SB/JS/SD/AH</b></p> <p>JS/ST/SB/MB/RAE</p>	<p>26.3.18</p> <p>Completed 1.4.18</p>	
<p><b>Mental Health Element</b></p> <ul style="list-style-type: none"> <li>• MH specialist Social worker</li> <li>• FastTrack to Memory Service</li> <li>• <b>Participation of MH services in MDT. To be included in Integrated Discharge Team work</b></li> <li>• <b>Close working of MH provision with Bed Provider</b></li> </ul>	<p>1<sup>st</sup> January 2018</p> <p>5<sup>th</sup> February 2108</p> <p>Started May 2018</p>	<p>TCT</p> <p>Sarah Dillon</p>	<p>1.1.18</p> <p>5.2.18</p>	
<p><b>Communication with Patients and Families</b></p> <ul style="list-style-type: none"> <li>• Pack for Patients</li> </ul>	<p>Commenced 25.1.18</p>	<p>TCT/JS/SP 2 xUsers/families</p>		

<ul style="list-style-type: none"> <li>• Feedback Survey from Patients/Families</li> <li>• Making in Real Board LA</li> <li>• <b>Multi Organisational Factsheet</b></li> <li>• <b>Operational Process to Making it Real Board and with Service User Rep</b></li> <li>• <b>Meet with Healthwatch</b></li> <li>• <b>Health and Wellbeing Board</b></li> </ul>	<p>1.5.18</p> <p>As above</p> <p>June 2018</p>	<p>JS and all partners</p> <p>JS/SB</p> <p><b>SB/JS/MB</b></p>	<p>11.5.18 awaiting all providers agreement for use</p>	
<p><b>ShropCom therapists to Used Modified Bartell</b></p>	<p>March 2018</p>	<p>Sam T</p>		
<p><b>Redefine Bed Base and admission protocol</b></p> <p><b>Admission Avoidance</b></p> <ul style="list-style-type: none"> <li>• <b>Rapid response Nurses</b></li> <li>• <b>SaTH Frailty Team Include consideration of MCA.</b></li> <li>• <b>Social Workers</b></li> </ul>	<p>16.2.18</p> <p>5.2.18</p>	<p>JS/ST/SB/MB</p> <p>SaTH Frailty, ShropCom and LA Brokers working on updating Process</p>		

<p><b>Admission and Management of Beds Operating Process</b></p> <p><b>Pathway 2</b> (Rehabilitation) ShropCom Clinical Staff with SaTH clinical Staff</p> <p><b>Pathway 3</b> (Discharge to Assess) Rule out Rehabilitation ShropCom Staff with SaTH Staff. Initial Rehab assessment in community at 72hrs to assess for rehab potential</p> <p>Education of SaTH staff on new process</p> <p><b>FFA</b> to contain structured Support Plan Therapy/Treatment/Goal Setting and ADLs from SaTH to Transition into the Community</p> <p><b>Process Maps</b> with Structured Timescales for Pathway 2 and 3, in community</p>	<p>Work from Warwickshire visit 14 .5.18</p> <p>All part of Integrated Discharge Hub workstream</p> <p>As above</p> <p>As above</p> <p>In V8 operational process</p>	<p>JS/SD/TCT/MB</p> <p>SD/TM</p> <p>JS/ST/SB/MB/RAE</p>		
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<p><b>Length of Stay Reduced (30)</b></p> <ul style="list-style-type: none"> <li>Electronic Tracking System</li> <li>Intermediate Care Tracker Post</li> <li>Social worker JD written for Rehabilitation and discharge to assess</li> </ul>	<p>Tracker- candidate appointed awaiting checks 15 5 18</p> <p>No Candidates on first round, second round to close on 18.5.18</p>	<p>JS/MB</p>		
<p><b>Red To Green Approach to</b></p> <ul style="list-style-type: none"> <li>Bed meetings</li> <li>Phone conferences</li> <li>Agenda</li> </ul>	<p>Agenda to process to be written and agreed 15<sup>th</sup> Feb 2018 in Operating Process</p>	<p>JS/ST/SB/MB/RAE</p>		
<p><b>Remaining at Home 91 days after discharge Improvement Plan</b></p> <ul style="list-style-type: none"> <li>Appoint OT for follow up across all Pathways. To prevent readmission</li> <li>BRC for lower level, to prevent readmission</li> </ul>	<p>Vicky Berry. OT commenced January 2108</p> <p>Following all complex discharges before 91 days. Working to safeguard against further admission.</p> <p>Process reviewed 1.5.18</p>	<p>CW/JS</p> <p>JS/JT/MB</p>	<p>January 2018 completed</p> <p>Ongoing review</p>	
<p><b>Performance Data</b></p> <ul style="list-style-type: none"> <li>Council</li> <li>ShropCom</li> </ul>	<p>Weekly dashboard commenced January 2018 Refined/updated 9.5.18</p>	<p>JS/JT/M</p> <p>ST</p>	<p>Ongoing review</p>	

<b>Who is the Manager/Leader of this Service</b>				
<b>Governance</b>	15 <sup>th</sup> Feb 2018	JS/ST/SB/MB/RAE		
<b>Multi partner Operational Group learning from Mistakes</b>	15 <sup>th</sup> Feb 2018	JS/ST/SB/MB/RAE		

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