Trafford Care Co-ordination Centre

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Trafford Overview and Scrutiny Committee
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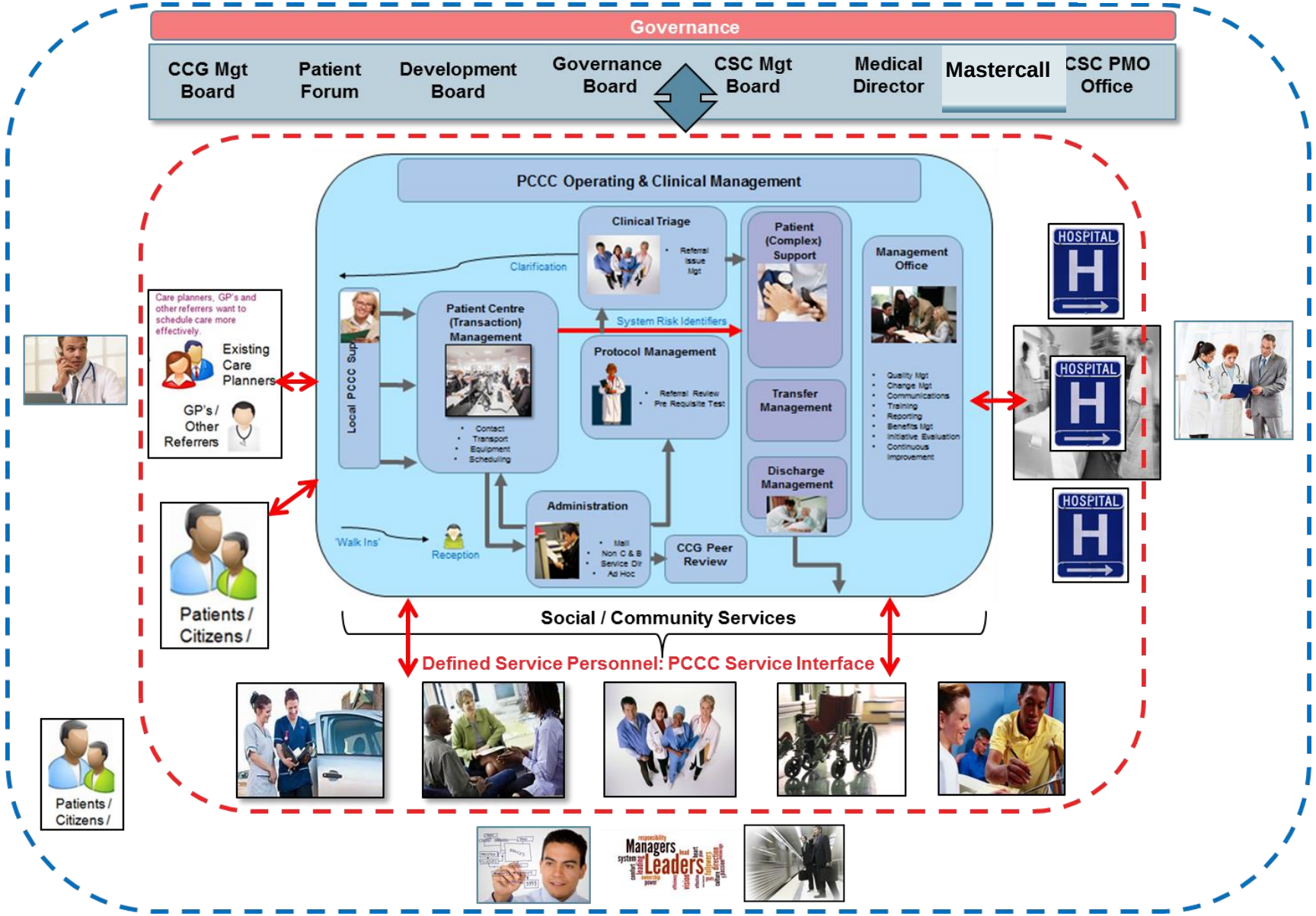
Service Model (Alternative view)



Outcomes to May:

- **14,203** referrals in first five months
- Basic errors in referrals declined from **25% to 5%**
  - Reducing appointment DNAs
- **135** diagnostic tests arranged
  - Reducing follow up appointments
- **399** (3%) appointments diverted to community provider or stopped altogether as unnecessary
  - Better care at lower cost
- **75** patients through discharge management, **29** of which under post discharge care
  - Reducing delayed discharge and preventing re-admissions

What are the Financial Savings Projections?

- Based on current outcomes and activity projections **annual savings of £2.7m** to local health economy in year 1 for referral and discharge management alone with *staged go live*

- Equates to a steady state saving for year 2 of **£3.6m** for referral and discharge management

- Current projection for Coordinated Care and Enquiry Management is **£1.9m** per annum

- Current projection is to deliver **£18m** of savings over 5 years

Next phase…

- Improving effectiveness of care pathways
- Providing insights for intelligent commissioning
- Driving better health and social care outcomes the population
- Organising holistic care around individuals
- Driving efficiency across health and social care

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Case Study – Admission Avoidance

NHS Trafford Clinical Commissioning Group

Trafford Care Co-ordination Centre

History

- *Female patient with multiple complex medical needs, and a high risk of falls*
- *Discharged home after any extended period of time in hospital with input from carers to attend to personal care*
- *Patient had requested female carers only due to very specific personal beliefs*
- *Patient referred to TCCC for 28 day post discharge monitoring*

Approach

- TCCC Clinician contacted the patient and family with 28 day post discharge monitoring support as arranged pre discharge from hospital
- Identified during the initial call that the patient was receiving care from both male and female carers, and refusing elements of care from the male carer, and therefore compromising a positive outcome

Solution

- Quickly identified by the TCCC Clinician that the condition of the patient would deteriorate and readmission would result if essential elements of personal care were not provided
- Acting as the patient advocate, TCCC liaised with agencies – Stabilise and Make Safe (SAMS) and social care to coordinate care by female carers. This provided the patient with the level of care required to enable her to remain at home

Outcome

- The patient remained at home with the appropriate care required provided by female carers
- TCCC continued to monitor this patient for any additional input that could be provided to reduce the need for hospital readmission

Benefits

- Early intervention by the TCCC Clinician :-
  - Enabled the patient to remain at home, maintaining patient /family morale and a more positive experience
  - Prevented an unnecessary hospital readmission and the associated risks from hospital acquired infections
  - Cost saving on hospital bed days and associated nurse/AHP/Social Worker input

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Case Study – Admission Avoidance

NHS Trafford Clinical Commissioning Group

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History

- *Female patient with multiple complex medical needs, and progressive degenerative condition resulting in poor mobility, coordination and pressure ulcers*
- *Admitted to hospital following a fall from her wheelchair*
- *Patient referred to TCCC for 28 day post discharge monitoring*

Approach

- TCCC Clinician contacted the patient and family with 28 day post discharge monitoring support as arranged pre discharge from hospital
- Identified during the initial call that the patient's husband had difficulties caring for his wife's challenging medical needs and providing them both with adequate nutrition

Solution

- The TCCC Clinician organised for patient's carers to recommence visits that day and used the DoS resources to find a service to deliver hot food for both the patient and her husband
- Whilst in regular contact with the carer, it became evident that the patient's swallowing reflex was deteriorating. The TCCC Clinician acted quickly to contact the District Nurse (already aware of the patient), who arranged for a referral to the Speech and Language Team for assessment

Outcome

- The patient remained at home with additional care in place to address the ongoing and progressive personal and medical needs
- TCCC continued to monitor this patient for any additional input that could be provided to reduce the need for hospital readmission

Benefits

- Early intervention by the TCCC Clinician :-
  - Enabled the patient to remain at home, allowing the patient's husband to spend valuable time with his wife, confident that resources and the appropriate care was in place
  - Prevented an unnecessary hospital readmission and the associated risks from hospital acquired infections
  - Cost saving on hospital bed days and associated nurse/AHP/Social Worker input

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Case Study – Admission Avoidance

NHS Trafford Clinical Commissioning Group

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History

- *Elderly female patient*
- *Assessed by hospital team and additional care and support at home not indicated on assessment*
- *Patient referred to TCCC for 28 day post discharge monitoring*

Approach

- TCCC Clinician contacted the patient with 28 day post discharge monitoring support as arranged pre discharge from hospital
- Identified during the initial call that the patient had difficulties with basic activities i.e. personal hygiene needs and making meals and had very little family support

Solution

- With the patient's agreement, the TCCC Clinician contacted Age UK and SAMS with an urgent referral for assistance
- Regular contact with the patient ensured that she was aware that she would rapidly receive care and assistance

Outcome

- The patient remained at home with SAMS in place with immediate effect to support her during the early stages of her discharge from hospital
- TCCC continued to monitor this patient for any additional input that could be provided to reduce the need for hospital readmission

Benefits

- Early intervention by the TCCC Clinician :-
  - Enabled the patient to remain at home, whilst supporting her independence in a safe and familiar environment
  - Prevented an unnecessary hospital readmission and the associated risks from hospital acquired infections
  - Cost saving on hospital bed days and associated nurse/AHP/Social Worker input

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Case Study – Early Discharge

NHS Trafford Clinical Commissioning Group

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History

- *Elderly female patient*
- *Admitted to hospital following a fall*
- *Patient declared medically fit for discharge (Friday) with a package of care required to enable the patient to return home*
- *Package of care could not be provided until 3 days later*

Approach

- TCCC Clinician contacted by Trust Discharge Team for assistance with bridging care until a package of care was available, as the patient was medically fit for discharge
- TCCC Clinician established the level of care and input the patient would require for a safe discharge from hospital

Solution

- TCCC assessed the information and contacted Trafford Community Enhanced Care (CEC) who agreed to bridge the care over the weekend
- Voluntary agencies were also used to provide services i.e. shopping
- Hospital Social Worker contacted with outcome and agreed that level of care would be adequate for a safe discharge

Outcome

- The patient was discharged home on Saturday (TTO's not ready for discharge on Friday) with all the appropriate services and care in place
- TCCC continued to monitor the patient to ensure that the package of care commenced on time

Benefits

- Patient discharged early:-
  - Bed released early for next patient admission
  - Early discharge whilst the patient is medically fit
  - Cost saving on hospital bed days and associated nurse/AHP/Social Worker input
  - Patient back in familiar environment resulting in improved patient experience and increased confidence as carer available for assistance