Trafford Patient Care Coordination Centre

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1. Principles for Trafford CCG’s Patient Care Coordination Centre

2. Progress so far

3. Benefits/Outcomes

4. 2014-15 Priorities

5. Early Intervention and Wellbeing Hub

6. Questions

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Principles

- Unique – Lots of Interest
- Visioning Document / Addendum
- Health and Social Care Proactive System
- Patients always getting the right care at the right time, through an effortless journey
- A focus on complexity and vulnerability
- Proactive and coordinated care seamlessly around the patient
- Best possible patient experience
Significant progress already achieved

- Unusual position in Trafford
- No 1:1 relationship with acute provider
- Patients attend multiple providers
- Patients treated outside of locality boundaries
  - Central Manchester;
  - Salford Royal;
  - University Hospital South Manchester; and
  - Greater Manchester West.
What have we done so far?

• Developed community services including:
  • Intermediate care;
  • IV therapies;
  • Matrons;
  • Community geriatricians; and
  • Rapid response teams.
• Single Point of Access for Community and Mental Health Services
• New Health Deal for Trafford
• Data sharing access to 70% of GP patient records
• Risk stratification

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Phases of development

Phase 1
RBMS - (Current service)

Phase 2
RBMS & Transport Bureau

Phase 3
Procurement of PCCC

Phase 4 (Clinical Decision Support)

Providers:
3rd Sector
Social Services

Others
CATS
Primary Care

Commissioning responsibility
Single Points of Access (Providers Responsibility)
Benefits / Outcomes

- Tracking of patient journey
- Close monitoring of vulnerable patients, following them through care journey
- Improved Quality
- Improved Patient Experience
- Improved Efficiencies e.g. DNA’s, Waiting Times
- Health Transport Bureau
- ‘Auto pick up’ patients as they go through the system
- Clinical Decision Support System
  - Directory of referral routes
  - Investigations/tests carried out in advance of appointments
  - Ability to view all results e.g. radiology/pathlab
  - Quality Auditing of referrals
  - Risk Stratification

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Infrastructure

• Single point of access
• Single ‘live’ directory
• Supported by IT infrastructure
• Access to all records i.e. enabling patient care plans feeding in proactive planning
• Alignment to 111 and out of hours
• Innovation e.g. Telehealth/Telecare
2014-15 priorities

Delivering Efficiencies

- Measurements to monitor IC Improvements
- Increase investment in Primary Care/Community
  - Primary Care Strategy
  - Education & Development in Primary Care
- Shift in activity from acute to community:
  - A&E Deflection schemes
  - Changes on the Trafford Site (NHD, model 3)
  - Mobile solution for Community teams
  - To deliver out of Hospital Care Standards
  - Shifting Resources from Acute to Primary and Community Care

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Health and Wellbeing Hub

- Support Increasing Demand against reducing resources
- Health and Social Care together
- Review and redesign of the Frail and Older People Service
- Review and redesign of the Palliative Care and end of Life Pathway

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Early Intervention and Wellbeing Hub

Aligned partners and services

Co-ordinated specialist services

Core Hub

Commercial Opportunities

Commissioning Support

Self assessment and self care and support function
Online resources

Community support and capacity
Benefits of the Wellbeing Hub

- Strategic Partnership approach to management of increasing demand on services
- Early Intervention – pre birth to death
- Outreach support to communities to link into integrated health and social care teams
- Build community capacity and resilience
- Early support to enable individuals and communities to provide and access the support they need through wider integration
- Holistic approach to assessment and prevention
- Reduce demand for statutory social care services
- Increase capacity for Specialist Services

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Questions?