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ITEMS PRESENTED AT THE
HEALTH SCRUTINY COMMITTEE

Date: Wednesday, 13 July 2016

7. **TRAFFORD CARE COORDINATION CENTRE**

To receive a presentation from the Chief Operating Officer of Trafford Clinical Commissioning Group (CCG). 1 - 10

8. **ASCOT HOUSE**

To receive a presentation from the Chief Operating Officer of Trafford CCG and the Director of Integrated Services for Trafford Council & Pennine Care. 11 - 16

9. **CQC INSPECTION OF CMFT RESULTS**

To receive a report from the Head of Nursing, Trafford Hospitals and the Director of Strategic Projects from CMFT. 17 - 24

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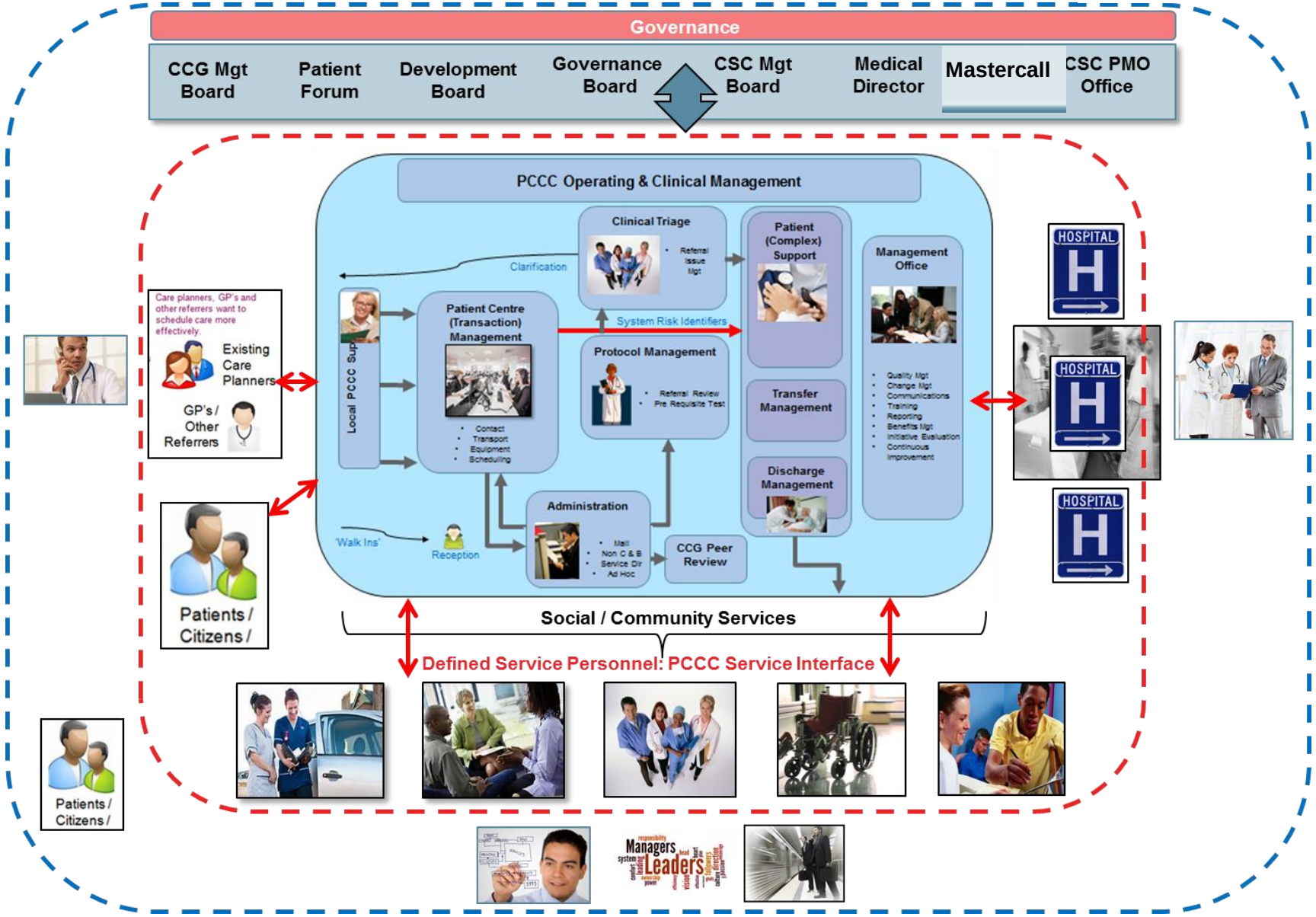
Trafford Care Co-ordination Centre

Gina Lawrence, Chief Operating Officer, Trafford CCG

Trafford Overview and Scrutiny Committee
13 July 2016

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

Trafford Care Coordination Centre

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

Trafford Care Coordination Centre

Case Study – Admission Avoidance

NHS Trafford Clinical Commissioning Group

Trafford Care Co-ordination Centre

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

Trafford Care Coordination Centre

Case Study – Admission Avoidance

NHS Trafford Clinical Commissioning Group

Trafford Care Co-ordination Centre

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

Trafford Care Coordination Centre

Case Study – Early Discharge

NHS Trafford Clinical Commissioning Group

Trafford Care Co-ordination Centre

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

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Urgent Care

Community Model Redesign

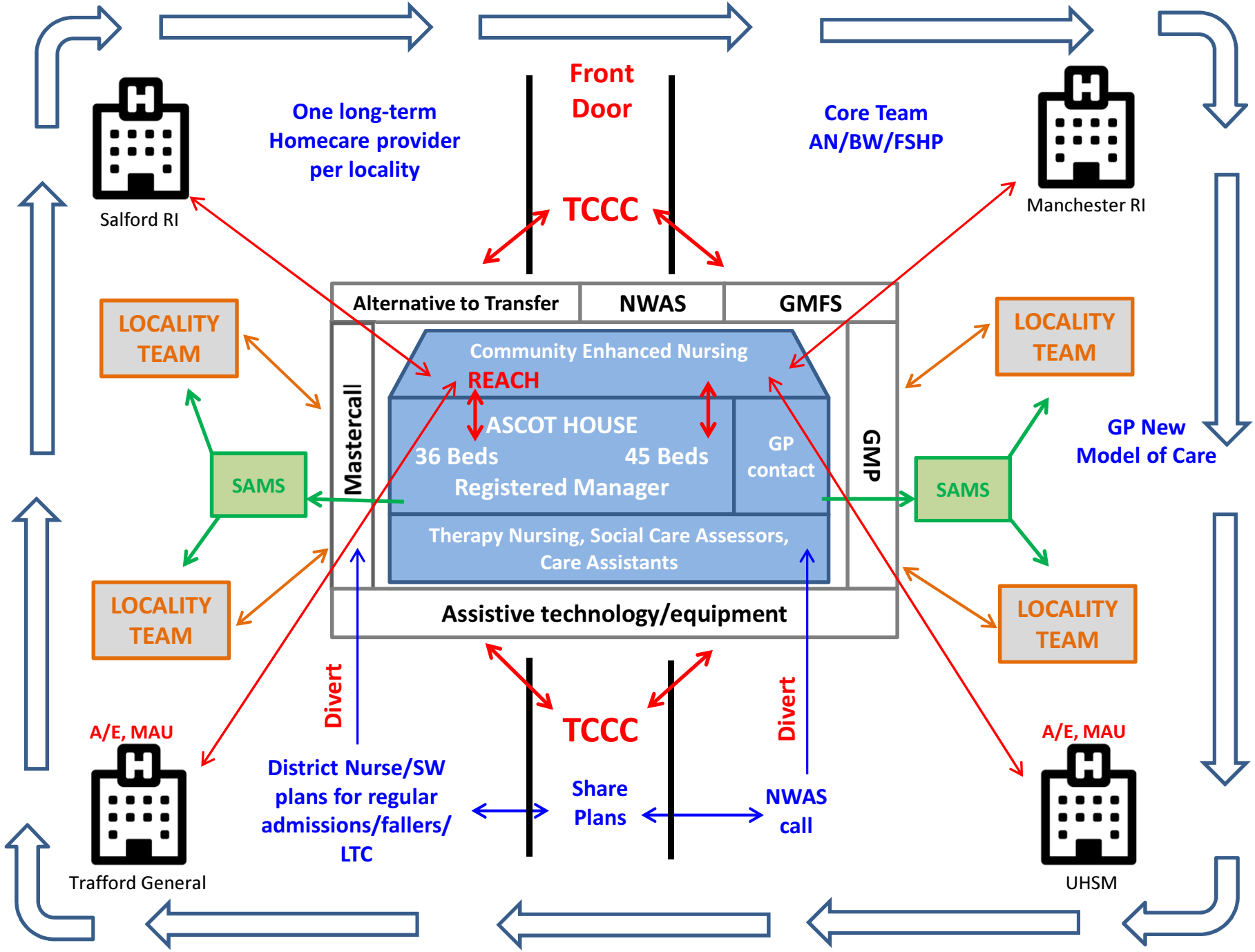
Diane Eaton
Gina Lawrence

Current Situation

- Closure of beds currently used for Trafford patients at Wellington House.
- Approx. 40 Delayed Transfers of Care (DTOCs.) at any one time
- Unacceptable length of stay in hospital
- Long term residential and nursing care placements occurring due to low numbers of IMC beds
- Limited intermediate care beds in Trafford.

Objectives

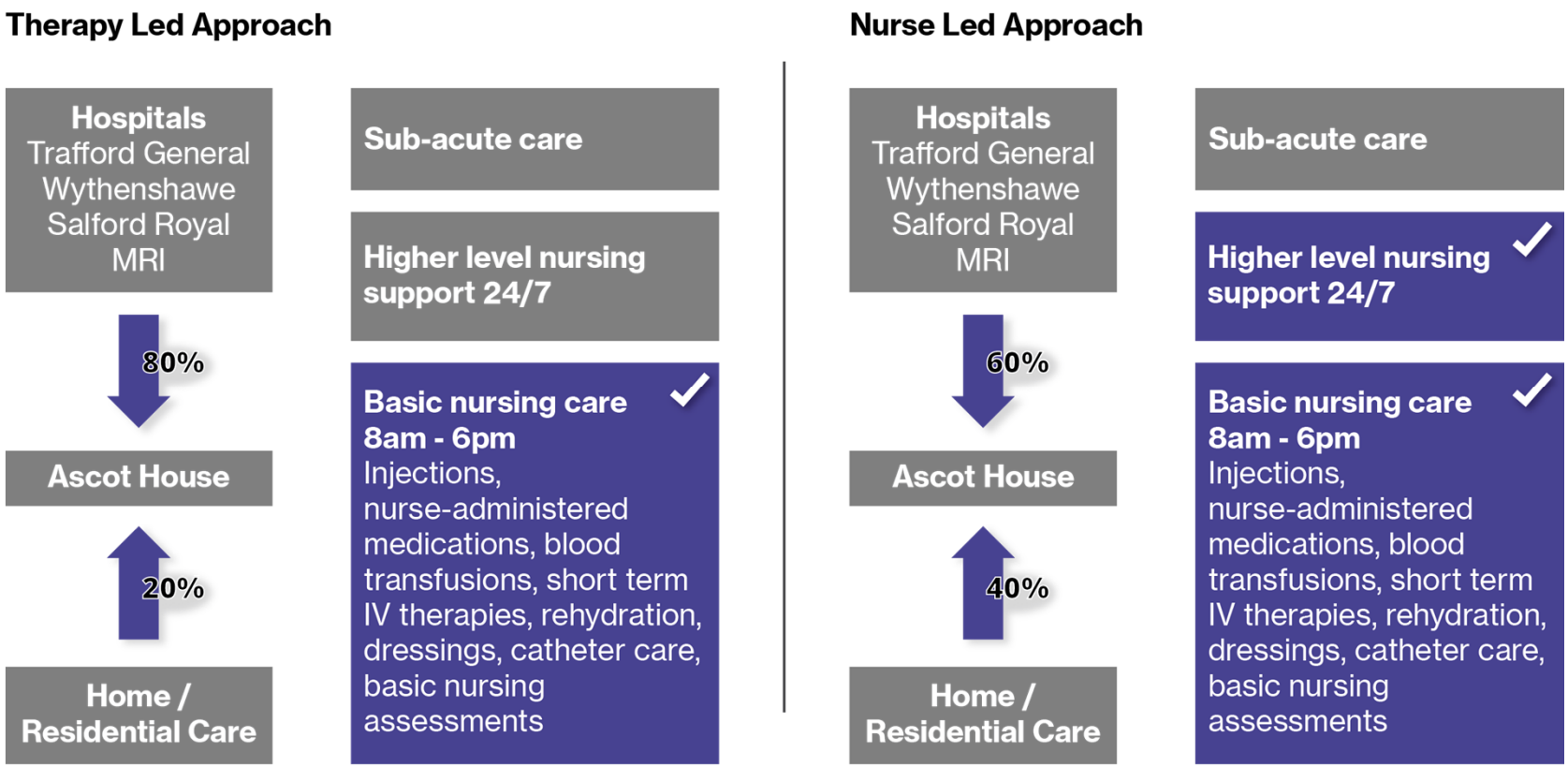
- Developing an integrated community response to Urgent care.
- Focus on independence and rehabilitation possible.
- Consistent offer for residents following an episode in hospital (Salford, University of South Manchester, Manchester Royal infirmary and Trafford General Hospital).
- Improved experience
- Care in the right place at the right time
- Reduced Delayed transfers of care and length of stay


Front Door
TCCC
One long-term Homecare provider per locality
Core Team AN/BW/FSHP
Salford RI
Manchester RI
Alternative to Transfer
NWAS
GMFS
LOCALITY TEAM
LOCALITY TEAM
Community Enhanced Nursing
REACH
ASCOT HOUSE
36 Beds
45 Beds
Registered Manager
GP contact
Mastercall
GMP
SAMS
SAMS
GP New Model of Care
Therapy Nursing, Social Care Assessors, Care Assistants
LOCALITY TEAM
LOCALITY TEAM
Assistive technology/equipment
Divert
Divert
TCCC
A/E, MAU
A/E, MAU
District Nurse/SW plans for regular admissions/fallers/ LTC
Share Plans
NWAS call
Trafford General
UHSM

The Opportunity

- Convert Ascot House into a dedicated intermediate care facility, bringing a number of provisions under one roof.
- Opportunity to convert all 36 beds to intermediate care. Office space upstairs could be converted to house a further 9 beds.
- Intermediate care could be delivered on a nurse-led or therapy-led basis.
- Use Ascot House as the foundation of an integrated intermediate care offer for the whole of Trafford.

Therapy-led vs Nurse-led



Central Manchester University Hospitals NHS
NHS Foundation Trust

CMFT CAMHS
CQC RATING JUNE 2016

- Are services safe?
  - » **Good**
- Are services effective?
  - » **Good**
- Are services caring?
  - » **Outstanding**
- Are services responsive?
  - » **Outstanding**
- Are services well-led?
  - » **Outstanding**

Why Outstanding?

- Are Services Safe?
  - Bespoke Risk Management Policy and Procedure
  - Supported by Risk Assessment and Management Meetings
  - Bespoke Safeguarding Pathway
  - Supervision – clinical and managerial with agreed activity levels per clinician
    - "All staff we spoke to said that they were well supported by senior management in managing their caseloads. Senior management are well known, supportive and approachable"

Why Outstanding?

- Are Services Effective?
  - Evidence Based Integrated Care Pathways
  - Integrated Multi Agency Access Pathways
  - High level of CYP IAPT trained staff and trainers
  - Supervision audited and monitored
  - Outcome measures used and monitored within management supervision
    - "We spoke to Senior staff members from the local authority and police that worked closely with the service. They identified that the service were an invaluable source of support to their teams and at times had exceeded their expectations"

Why Outstanding?

- Are Services Caring?
  - Annual CHI
  - Strong Participation Group and Events
  - Deliver training to staff and interview staff
    - "Young People said that they had been inspired to help others who have emotional health difficulties because of the high level of support they had received from the service, this is why they attend the participation forum"
    - " Yp said that the CAMHS Team had positively transformed their lives and whilst they would miss CAMHS when 18, the service had provided them with the skills and self confidence to cope in the future
    - "Carers/Parents talked about how CAMHS had exceeded their expectations in the emotional and practical support they offered"

Why Outstanding?

- Are Services Responsive?
  - Duty Practitioner
  - 8 week from referral to treatment maximum
  - Information whilst you wait and data collection
  - Integrated Teams/Pathways
    - CAMHS LAC
    - CAMHS YOS
    - SCAIT
    - Federation of Schools
  - Open Referral
  - Strong Teaching/Awareness Commitment to Wider Networks
  - Lessons Learned from complaints and incidents
    - “The SCAIT Team was set up in response to a high level of demand for more targeted support for children with challenging behaviour’
    - “staff empowered yp to design and deliver a staff training DVD that addressed dilemmas for yp in relation to gender”

Why Outstanding?

- Are Services Well Led?
  - Single Line and Professional Management
  - Transformational Agenda 2010
  - Vision 2 Action
  - iThrive
  - Strong Research and Audit Culture
  - Clear KPI's relating to quality as well as quantity
    - "Senior Management visited teams regularly and demonstrated a strong commitment to improving quality of services"
    - "All staff praised the supportive professional culture in which they worked, they said there was no hierarchy between different grades and professions.
    - "Staff felt that Senior Management were genuinely concerned for their well being as well as that of the yp. Despite high demand and challenging role, staff thrououghly enjoyed their job.

How Do We Do It?

- Organisational and Professional Structure
  - 1 Clinical Lead (interviewed and can by any professional background with sufficient experience)
  - 1 Managerial Lead – all professions are managed and held to account for their clinical inputs

- Clear Transformation Indicators and Performance Targets

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