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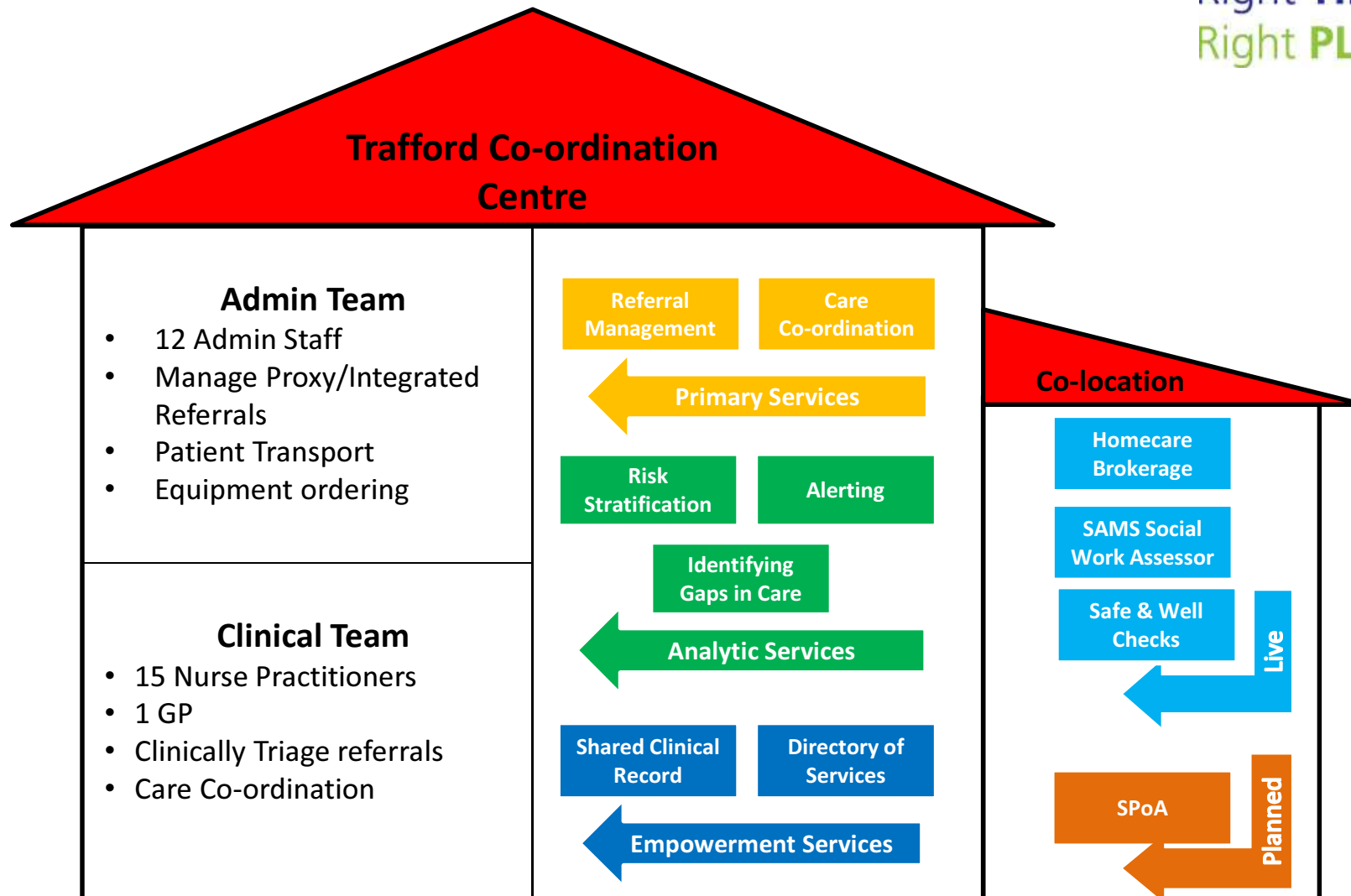
Trafford Co-ordination Centre



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TCC – Progress to Date

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Referral Management- January - November 2016

Total to date – 32,981

Care Co-ordination- June- November 2016*

Total to date - 132

** Full launch of Care Co-ordination 1st November 2016 ; 88 referrals in November*

Referral Management Update

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- 32,981 referrals have been received by the TCC since April 2016.
- Initially 22 conditions (covering 8 specialties) were selected to have the detailed pathway checks carried out.
- Two new community services have now been procured – **Community Dermatology** and an integrated Community **MSK service**
- The TCC will commence checking a further 12 conditions from December – again these have been selected by Clinicians based on Peer Review data but also where it was felt there was some gaps in GP knowledge.
- Two new specialties have been introduced – gynaecology/urology - with pathways designed by GPs with specialised knowledge in these areas.
- In December, the TCC will also formalise the checking a number of conditions covered by an Effective Use of Resources (EUR) policy. These are treatments of low clinical value and only commissioned in certain clinical circumstances. These were selected on the basis of high activity/cost to the CCG.

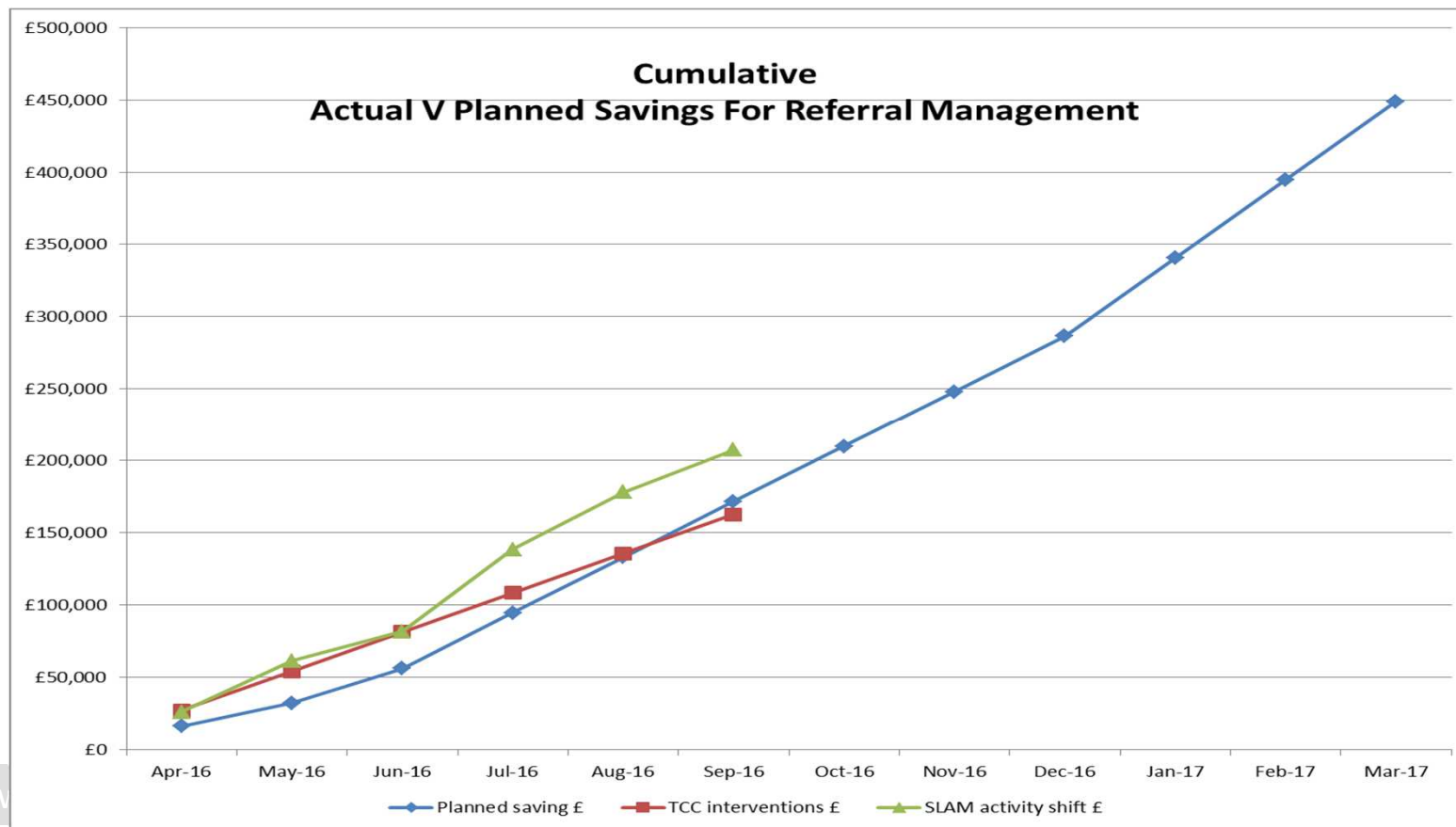
Referral Management Financial Benefits

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Planned savings of £450k for the year 2016/17, £171k to September 2016

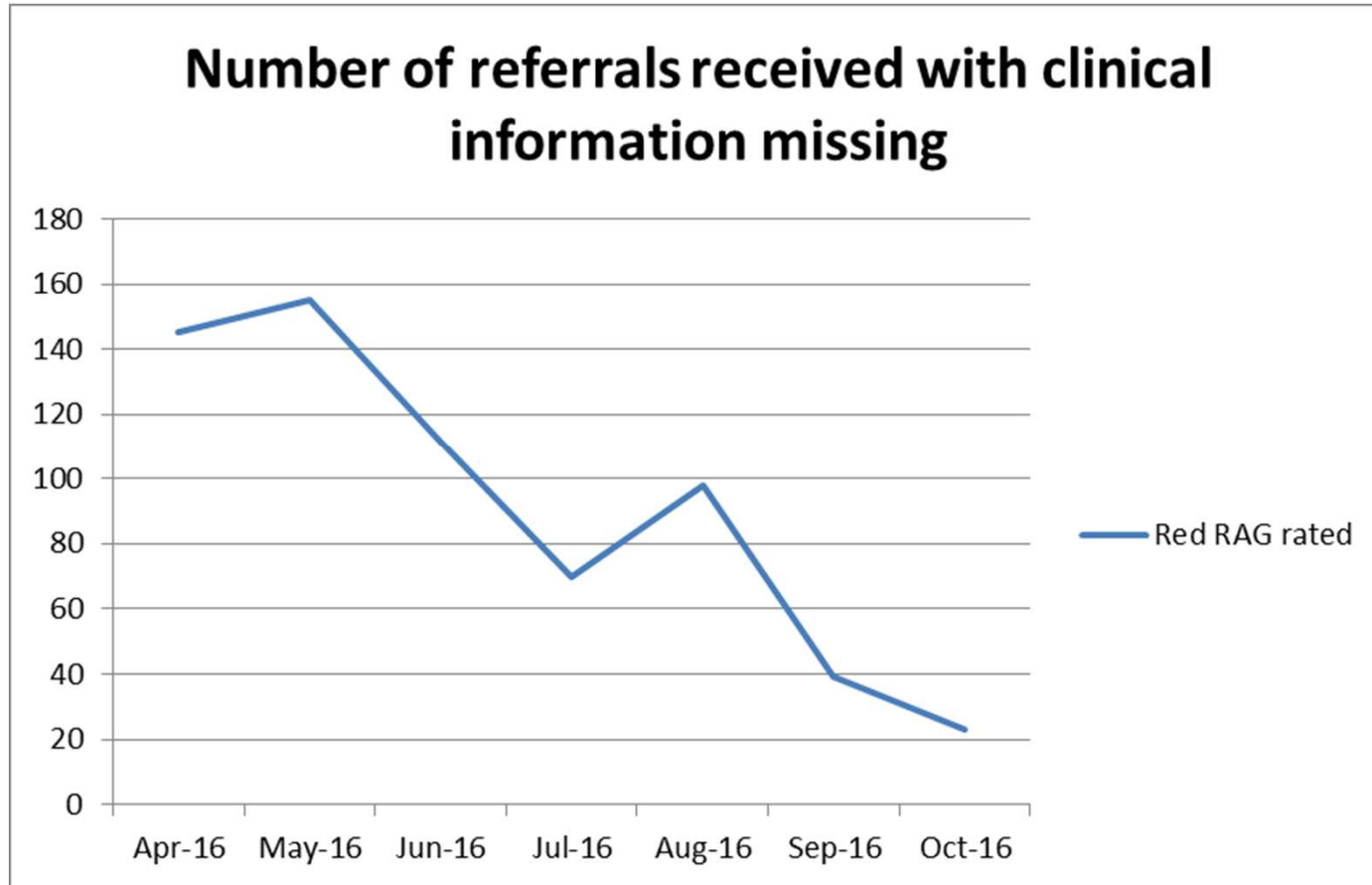
TCC recorded interventions have generated £162k savings to September 2016

SLAM activity in the relevant specialties has also reduced by £207k in the same time period



Improvement in quality of referrals

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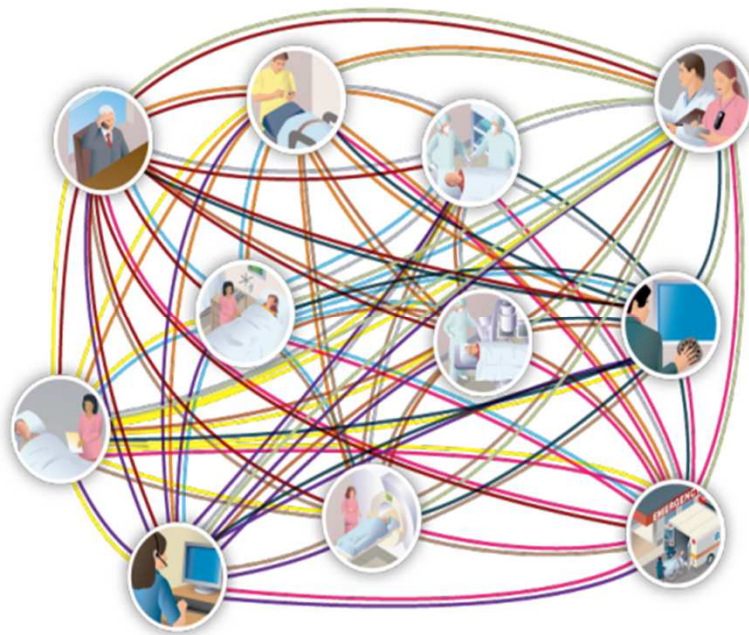


What is Care Co-ordination?

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from
Fragmented Care

to
Coordinated Care



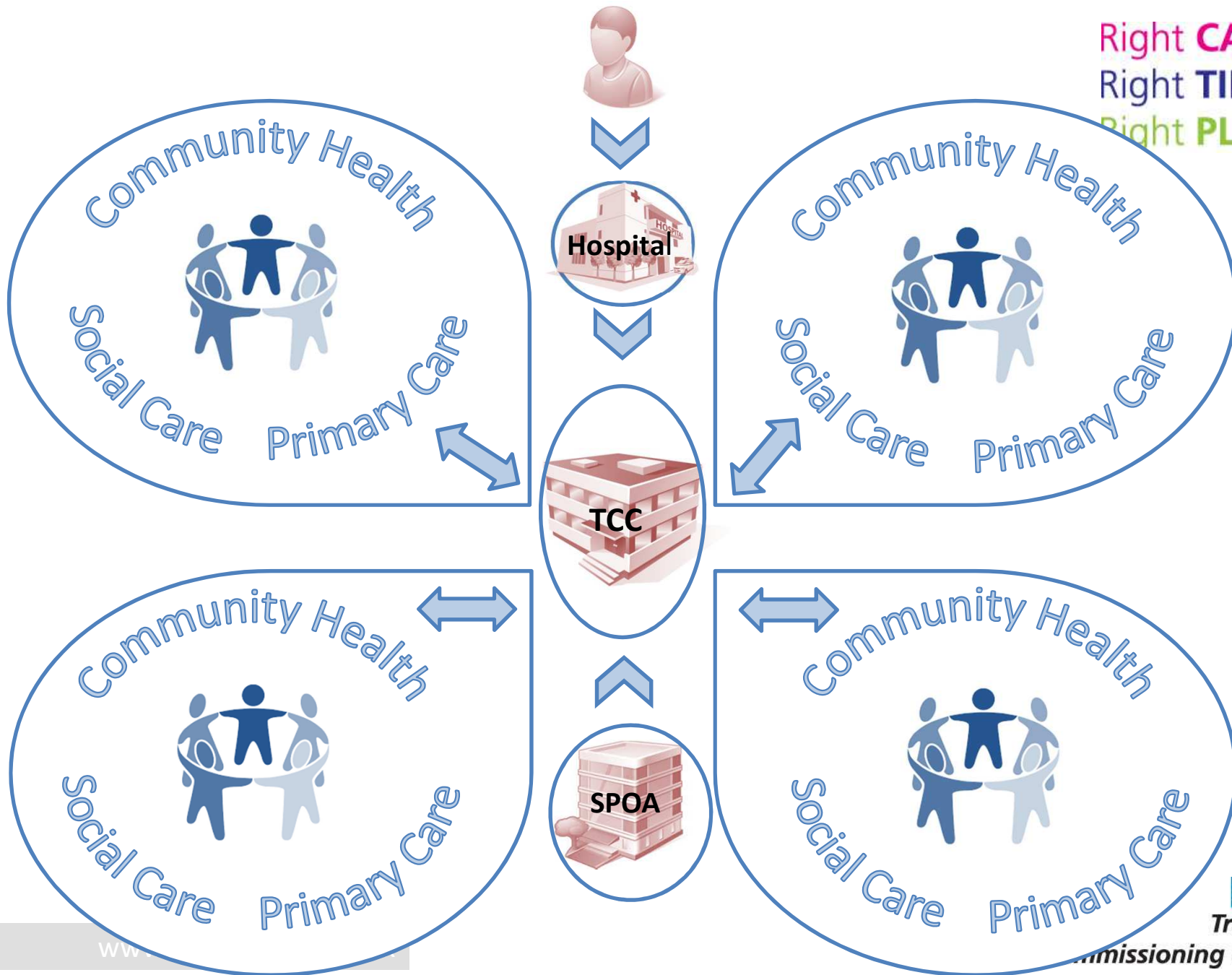
What is Care Coordination?

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Trafford Co-ordination Centre – Care Co-ordination

Suitable Patients (Cohorts)	Eligibility	TCC Actions	Outcomes/Benefits
Indications of Frailty	Registered patient with Trafford GP	Welcome and Wellness calls	Support inter-provider approach to care
Long Term Conditions	Patients who have a care plan designed to minimise unscheduled acute hospital attendance and admission	Diary of activities for medical and personal appointments	Support people in retaining a level of independence and quality of life
Support with managing physical health	OR	Contact with service providers	A 'check in' contact made to patient, even when not currently undergoing an intervention
People with Mental Health People with a Learning Difficulty Young Adults in Service Transition	Patients who have been identified as suitable for Care Coordination in community services or on hospital wards who may be at a risk of an admission or a readmission	Monitor patients via phone at agreed intervals & arrange interventions when required	Overarching Care Plan
	Patients have consented	TCC GP reviews patients after 3 months	Patient receives additional support if a need identified
		Identify recurrent issues and possible gaps in care	Reduction of recurrent issues as a consequence of interventions
			Central point of contact for patients, carers /families
			Intelligent commissioning

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Care Co-ordination in Action – Mrs Jones, 84

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- Lives with daughter sole carer, older patient, complex medical needs.
Daughter phones TCC in distress as mum verbally and physically abusive



Patient and Carers

→ 23/11/16 Daughter phones TCC in distress



TCC



Other Services
e.g. Hospital,
Community
Services, Social
Services

Through discussion with daughter TCC nurse identifies mother behaves aggressively when she has an infection (delirium). Last time this happened her mum had a lengthy hospital stay

TCC contact GP to arrange visit and prescription of antibiotics



TCC contact Community Matron to visit and monitor recovery



TCC request SAMS service support daughter for 4 days to give some rest/ respite



TCC confirm actions with daughter who confirms she would have phoned 999 if co support available

Integration Update

- Current Status
 - Phase 1: UHSM Outpatient data: Complete
- Plan
 - Phase 2: Go Live delayed to week of 16/01/17
Delay reasons: Complexity of acute trusts' IT environment; CSC resource constraint
 - CMFT Central
 - CMFT Trafford
 - SRFT
 - Phase 3 – Go Live week of 30/01/17
 - GMW
 - Pennine Care – bought forward
 - Clinical Portal
 - Phase 4 – Go Live week of 20/03/17
 - UHSM
 - Datawell for Path data – part
 - DocMan for GP letters – subject to DocMan Health's resolution of issues
 - To be determined
 - Trafford Council – subject to placing order for development and linking to N3

Before and After Integration

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- **Before Integration**



- **After Integration**

**One Integrated
Clinical Portal**



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Any Questions?

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