NHS
Trafford
Clinical Commissioning Group

Trafford Overview & Scrutiny Committee
1st March 2017

Title of Report	Trafford Co-ordination Centre – Progress Update
Purpose of the Report	To provide an update on the delivery of the Trafford Co-ordination Centre including performance and progress.

Actions Requested	**Decision**		**Discussion**		**Information**	✓

Prepared by	Siobhán O'Leary Donkin
Responsible Director	Gina Lawrence, Chief Operating Officer

TRAFFORD CO-ORDINATION CENTRE – PROGRESS UPDATE

1.0 BACKGROUND

1.1 Purpose of the TCC

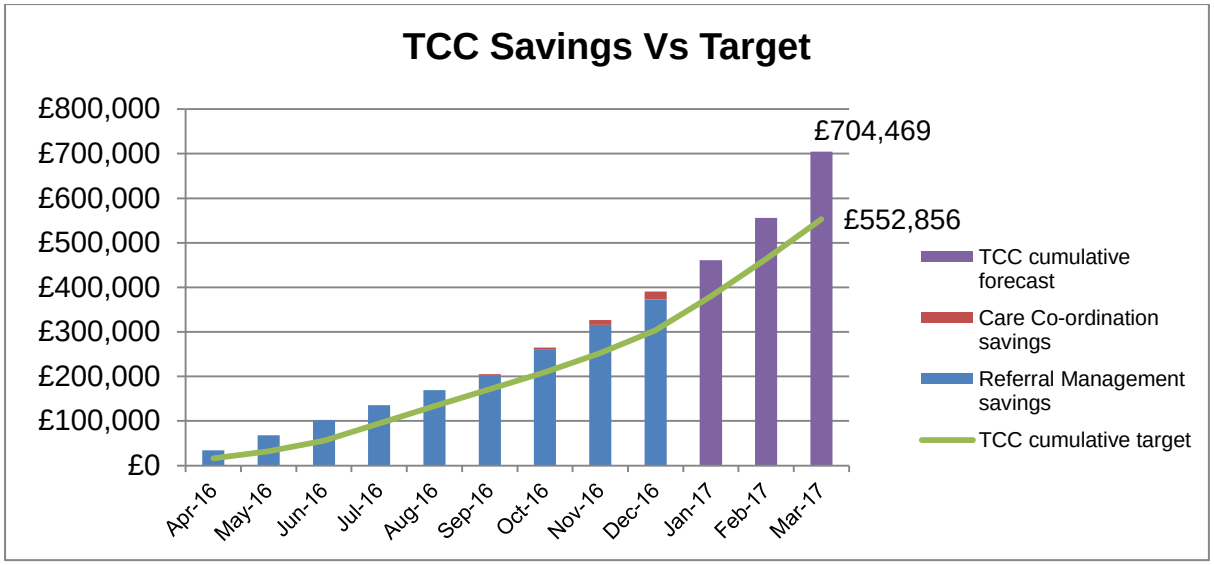
The Trafford Co-ordination Centre (TCC) aims to revolutionise the way local residents are cared for by in a co-ordinated and integrated way. Trafford has a variety of community services that work well together; however, navigating this system is complex for patients, carers and professionals. The centre aims to be a single point of access, tracking patients as they move through the system, guiding them to different services in a more efficient way.

The TCC is currently located in Sale and is open seven days a week 8am – 8pm. Operated by third party provider CSC, it is comprised of an administration team who are responsible for managing referrals and booking patient transport and a clinical team offering specialist advice and delivering Care Co-ordination. This includes a GP, a "stabilise and make safe" Social Worker and 15 nurses with a range of skills (including mental health, community and acute experience). Pennine Care's Single Point of Access for community services is also now co-located in the TCC.

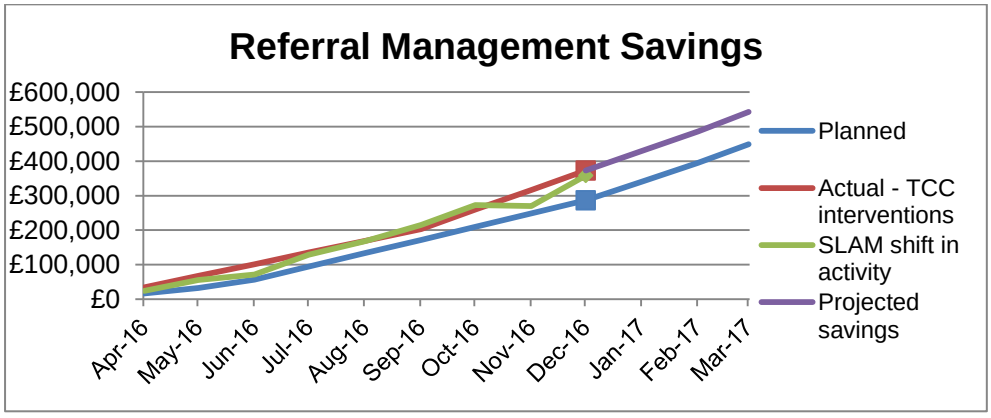
The current focus of the TCC is to deliver financial and quality service benefits via the following four key workstreams; Referral Management, Care Co-ordination, Informatics and Operational Optimisation, section 2 – 5 describes progress and next steps for each area.

1.2 BENEFITS PERFORMANCE

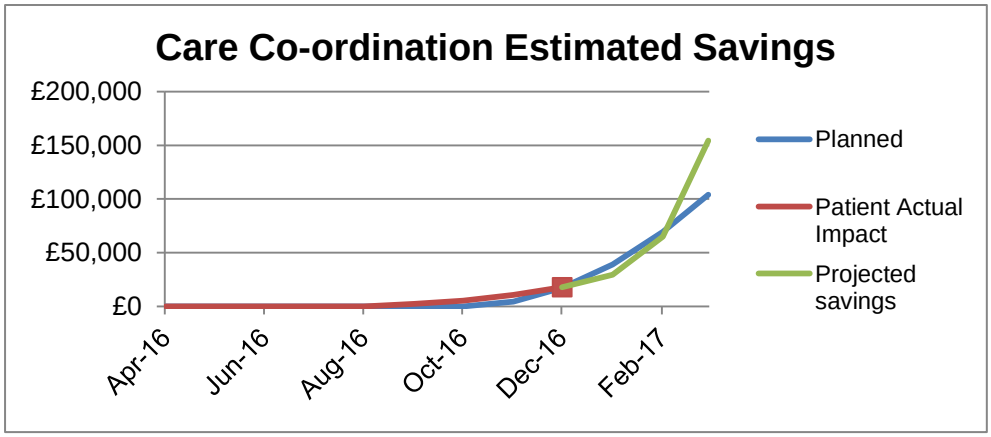
The TCC has been targeted to deliver £553k of savings in 2016/17. From April to December 16 an estimated £391k has been achieved and they are forecast to achieve £705k by the end of the year (120% of target). See chart overleaf.



The savings for Referral Management are shown below. They arise from a) diverting acute referrals to another provider and b) ensuring that all appropriate diagnostic tests are prior to the first appointment.



The savings for Care Co-ordination are currently measured by comparing the rate of A&E attendances and non-elective admissions before and after enrolment for patients in the service. However, as the service has only been live since October 16, this is currently a small sample size and a short period of data. These figures are subject to change over the next 6 months as our information becomes more accurate.



2.0 REFERRAL MANAGEMENT

Referral Management aims to eliminate all "inappropriate" referrals into secondary care by undertaking administrative and clinical reviews of the referrals and intervening when required, for example when information is missing or diagnostics have not been undertaken. Benefits for patients include:

- Better quality first outpatient appointment as all investigations will have been completed
- Reduced need to attend follow up appointments as treatment plans can be agreed at first out-patient appointments
- Improved clinical outcomes as treatment takes place much quicker

Key achievements to date include:

- 45,000 referrals have been received by the TCC from April to date
- Rolled out detailed pathway checks against 35 conditions and 11 EUR policies (4,000 clinical reviews have been undertaken)
- Redirected 1,745 appointments to alternative providers, including significant numbers to new community services MSK and Dermatology
- Established project groups to create a more robust pathway and decision support for GPs for Respiratory, Diabetes and Cardiology

Next steps:

- Implement a generic referral form to improve quality and increase auto-population (freeing GP capacity)
- Develop a protocol for rejecting inappropriate GP referrals (where there is no clinical risk)
- Roll out 50 new conditions for pathway checks by the end of December 2018
- Implement Consultant to Consultant referral reviews (if beneficial)
- Implement a technical solution to check whether diagnostics ordered by a consultant following an outpatient appointment are available in time for the follow next appointment (which wastes time for patients as well as cost)

3.0 CARE CO-ORDINATION

Care Co-ordination aims to support people in their own home avoiding unnecessary attendance and admission to acute hospitals through the deliberate co-ordination of their care. The team undertakes the following key functions:

- Regular "wellness calls" to see how the patient is and if they need any extra support and if they know their plan of care
- Diary of activities produced for medical appointments that can also be set up to include patients' personal appointments. They can arrange appointments and send reminders
- Contacts agencies to share information to ensure the patient is receiving the right care and that all involved aware of each other's input

- Acts flexibly to patients' changing needs. Arranges interventions when they are having difficulties, for example asking the doctor or community nurse to visit, arranging for some extra support or helping patients to get involved with a community group
- Support offered to unpaid carers who themselves are becoming less well, helping them to keep well and feel supported
- GP reviews patients after 3 months to identify any required actions/interventions outside of routine calls
- Identify recurrent issues and possible gaps in care

Benefits to the patient include:

- Can speak to one person who has the "whole picture" of their care, a view of all the agencies supporting the patient (the care plan). This central point of contact is also available to carers and family if they are concerned about their care
- Supported in retaining a level of independence and quality of life
- Reduction of recurrent issues as a consequence of interventions, reducing the need for an admission to hospital

Key achievements to date include:

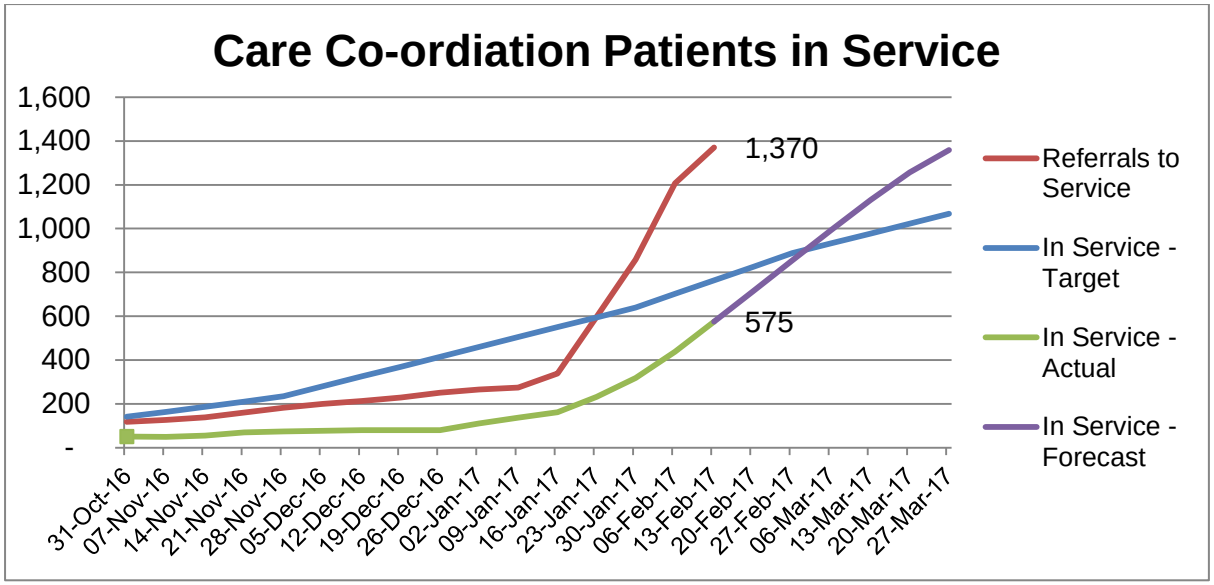
- Service established with clinical team in place and trained
- 575 patients currently enrolled into the service, receiving support
- Case finding established including a 'risk stratification' process, which identifies patients most at risk of having an unplanned admission to hospital
- Referrals being received by a variety of Trafford services, including Community Enhanced Care, acute hospital discharge teams and frailty wards, Mastercall Out of Hours, Neuro Stroke team, Stabilise and Make Safe, Continuing Health Care, District Nurses and One Stop Equipment service
- 1370 patients have been referred into the service to date (not all will be suitable and some will decline the service)
- Engagement with nursing and care homes to provide a specific offer tailored for them
- Achieved an estimated £17,000 of savings since the service went live in October 16

Mr Smith, age 72 **Patient Story**

This patient has complex needs, including mouth cancer and anxiety. He regularly called 999 and Out of Hours service.

TCC made twice weekly wellness calls and identified that he often missed taking his medication, so referred him to SAMS to get on top of this. His living conditions were identified as cluttered and posed a falls risk, TCC referred to Fire Service for a 'Safe and Well' assessment.

The patient has since made no calls to 999 or out of hours. The TCC is now his 1st point of call when he's anxious. SAMS visits have been reduced now he is on top of his medication. A fall has potentially been prevented following advice from the 'Safe and Well' assessment.



Next steps:

- Continue to enrol patients into the service, projected to be 1,300 by the end of March 2017 versus a target of 1,000
- Continue to engage other services including Heart Failure and Parkinson's lead nurses, Community Rehab, Greater Manchester Carers, Greater Manchester Mental Health Trust, and children in transition to adulthood
- Continue to develop and deliver a public facing communications plan
- Engage with voluntary services to refer patients and also as a potential resource for Care Co-ordination patients
- Explore how Care Co-ordination can be utilised to support Delayed Transfers of Care
- Continue to develop the Care Co-ordination methodology, as the approach is innovative we will continue to learn and adapt the service

4.0 INFORMATICS

The Informatics workstream comprises of development to the technical system, the development of a Directory of Services (DOS) as well as Information and Clinical Governance.

Key achievements to date include:

- Development & delivery of a sophisticated CRM system incorporating a TCC Clinical Portal which integrates patient data from a range of providers and allows the admin and clinical teams deliver the services
- Integration has been completed for University Hospital South Manchester (Referrals and OP only), Salford Royal Foundation Trust (Referrals, OP, IP and A&E), and Trafford General (Referrals, OP, IP and A&E)
- The TCC Clinical Governance framework in place (for patient safety etc)
- Compliance with the NHS IG Toolkit and assurance to the Trafford Information Governance Group
- Development of a revised Directory of Services (not yet live to GPs)

- Completion of the risk stratification process to identify patients suitable for inclusion in the care coordination service

Next steps:

- Completion of integration with the Central Manchester MRI, Pennine Care, Greater Manchester West Mental Health, Trafford Council (Adults & Children), The Christie, pathology results for all acute hospitals, and A&E and IP data for UHSM
- Creation of a standalone Clinical Portal, so that A&E staff and GPs (as a minimum) can view the summary patient record held in the TCC
- Creation of a Patient Portal to enable patients to see the summary record
- Further work on risk stratification once NHS Digital enable pseudonymised data in the Mede Analytics tool to be re-identified locally
- Provision of functionality for diagnostic ordering from CMFT / UHSM
- Explore potential for integrations with NWAS and radiology results
- Revised DOS launched to GP community
- Explore opportunities to use new technology to support patients e.g. 'wearable' monitors

5.0 OPERATIONAL OPTIMISATION

The CCG is working closely with CSC and the newly appointed Operations Director to optimise the operational services within the TCC as well as plan for future developments in line with Trafford's longer term plans for transformation and integration. Planned work includes:

- Demand and capacity review to test the operational capability of the service and continue to identify opportunities to increase efficiency
- Embed Pennine Single Point of Access (recently co-located) and maximise the opportunities from working together
- Develop and maximise the mental health resources
- Act as the key platform to enable a variety of agencies to work together as part of the Public Sector Reform pilot
- Support the development of the "All Age Front Door" model with TMBC and other services, moving towards a fully integrated TCC. This will be pursued as part of the development of the Transformation Funding Bid for Greater Manchester Health and Social Care Partnership

6.0 SUMMARY

The TCC has made great strides in recent months in developing the service model and is really starting to have an impact both on financial savings, as well as patient's lives. However, there is significant work planned to maximise the current services, as well develop innovative future offerings alongside our public and voluntary sector partners.