

Right **CARE**  
Right **TIME**  
Right **PLACE**

# Health Scrutiny Committee

## 23 January 2018

Updates on:  
Changes in service delivery and  
transformation  
Trafford Co-ordination Centre

Cameron Ward  
Interim Accountable Officer

[www.traffordccg.nhs.uk](http://www.traffordccg.nhs.uk)

  
Trafford  
Clinical Commissioning Group

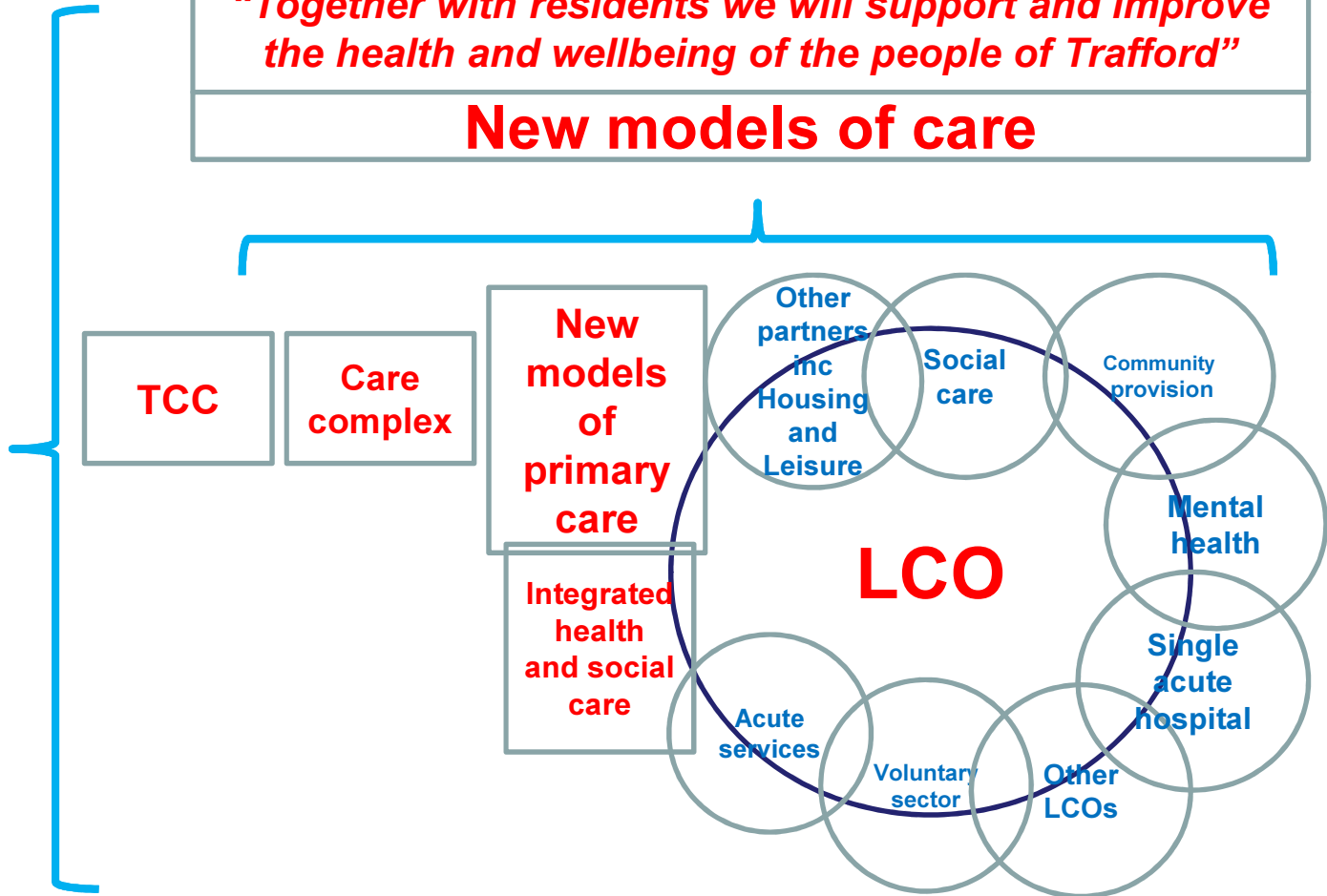
## Topics for discussion

- Transformation
- CCG and local authority integration
- CCG finances
- Proposed areas of service change
- Trafford Co-ordination Centre

# Trafford map

*“Together with residents we will support and improve the health and wellbeing of the people of Trafford”*

**New models of care**



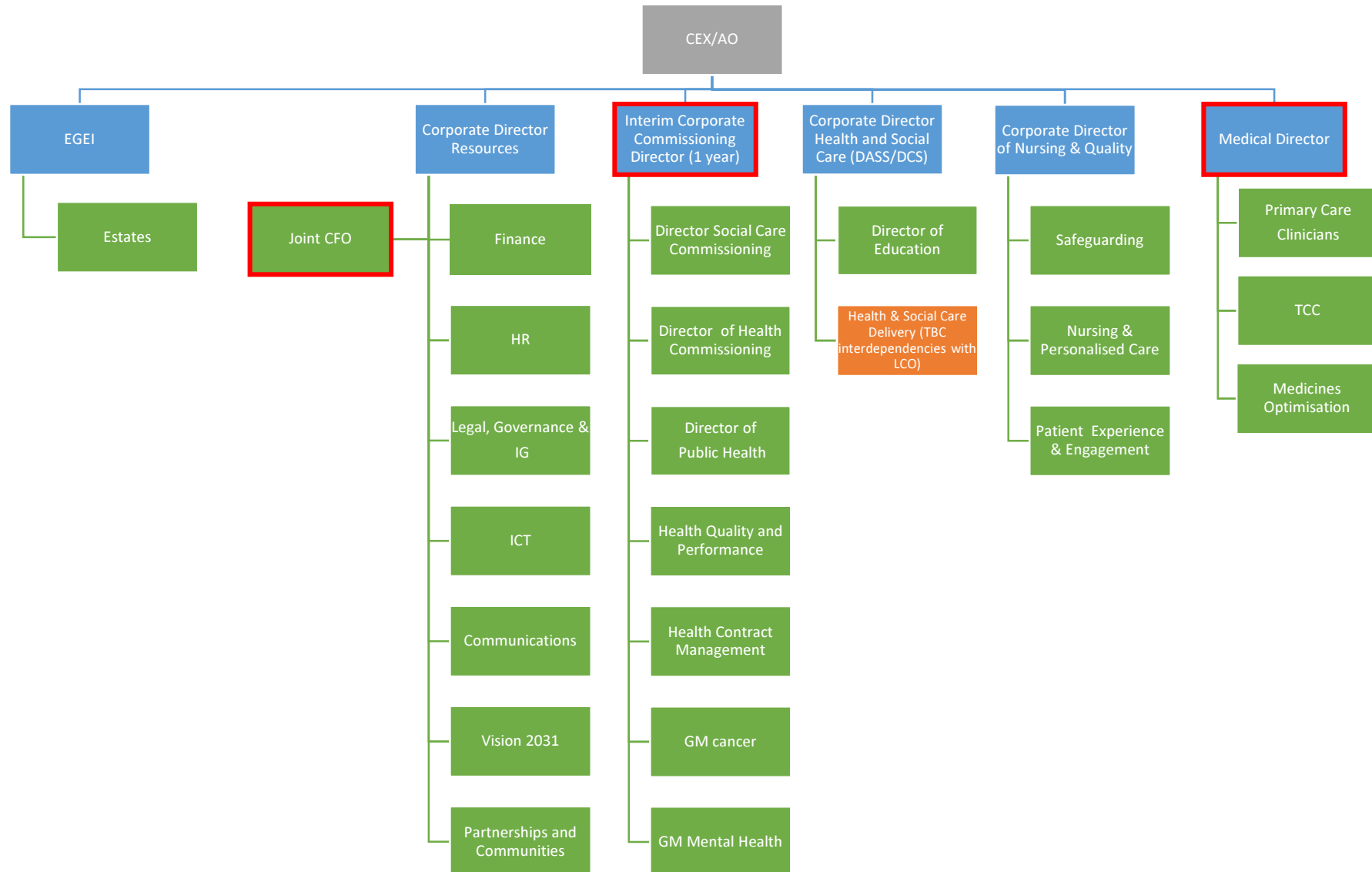
Pre-requisites	IT	Experience & engagement	Workforce	Estates	Finance including transitional funding	OD and values
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# CCG and Local Authority integration

- Part of GM wide initiative for place based strategic commissioning
- Building a strategic commissioning function
- Part of the architecture with a Local Care Organisation
- Consultation with staff October to December
- Benefits include:
  - Deliver better outcomes to all citizens, as one organisation
  - Ensure our future health and social care economy is sustainable
  - To deliver the GM devolution requirements
  - Combine expertise, knowledge and skills
  - Closer working between staff with more efficient working and streamlining systems and processes
  - Maximising our funds through the pooling of budgets
  - Deliver Trafford's Locality Plan
- Operational from 1 April 2018
- Single Accountable Officer
- Single leadership team
- Single support structure

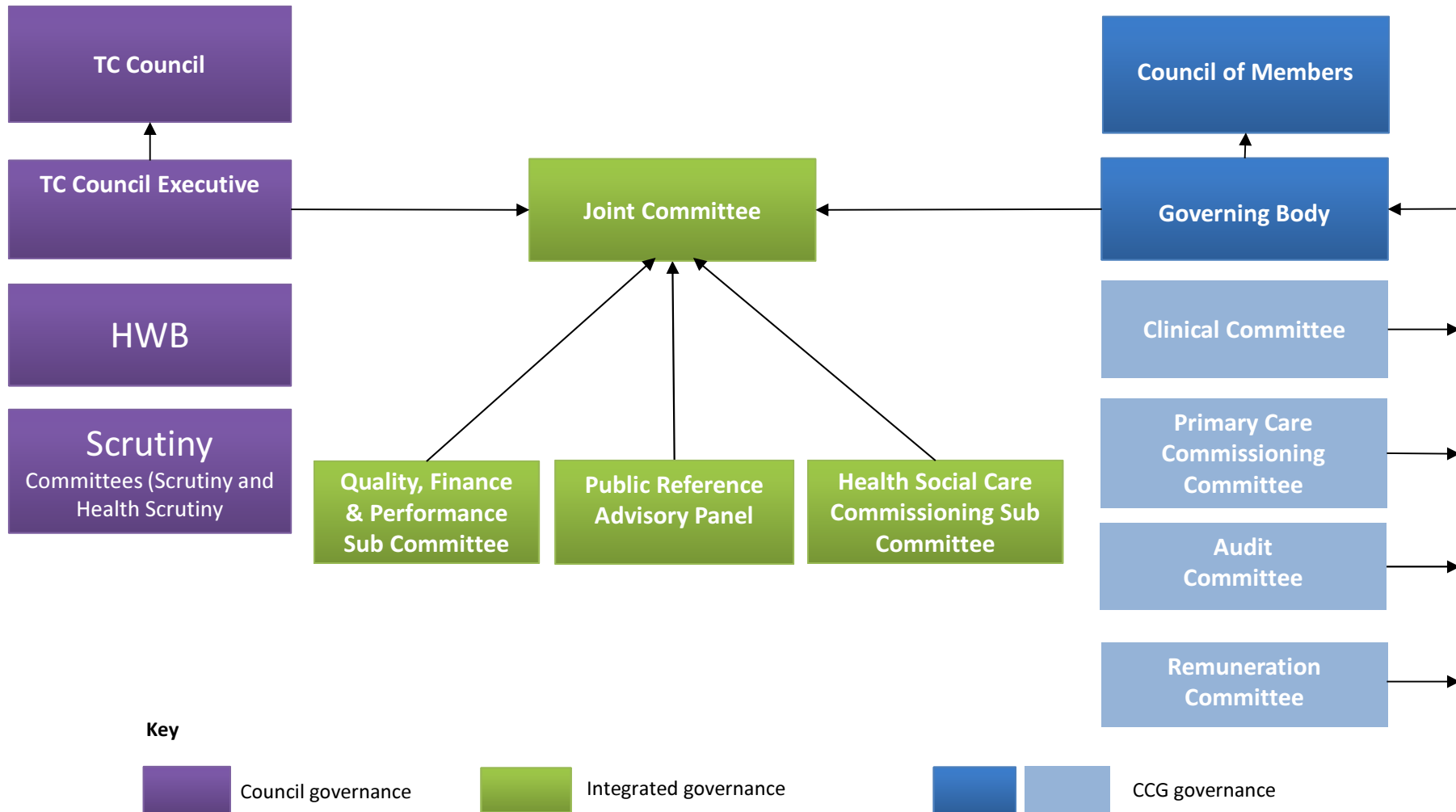
# What does it mean for me?

## Phase 1 In Scope Trafford Organisational Structure

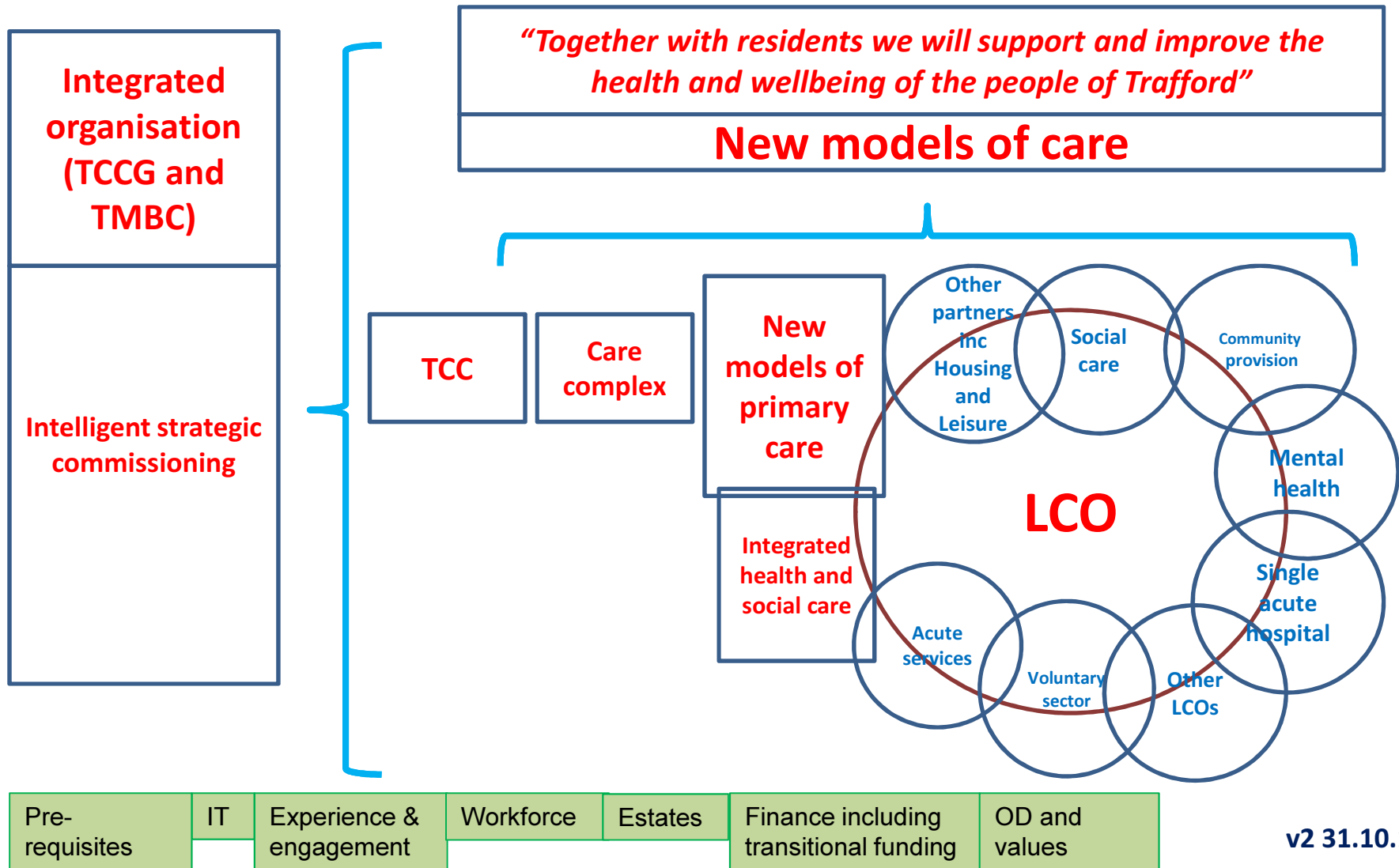


# What does it mean for me?

## Proposed Integrated Governance Structure



# Trafford map



## CCG finances

- Overall budget allocation of £335m per year
- Required to make a surplus of £6m per year ie not spending £6m of our allocation
- Currently spending in excess of our allocation
  - Risk totals £5m
- Need to ensure the CCG is in a balanced financial position over a two year period to March 2019
- Need to look to transformation and increasing the focus on prevention and self-help and new ways of working eg new models of primary care to avoid people becoming unwell and going to hospital when this should not be necessary
- All services are being considered based on evidence eg more of Trafford residents get admitted to hospital than peers; visit hospital due to falls; more die in hospital than their chosen place of death, more emergency referrals



## CCG finances

### Proposed ways forward:

- Transformation proposals looking at new models of care including general practice and community based services
- Reviewing all areas to improve efficiency and effectiveness
- Utilising existing community based services eg musculoskeletal
- Commissioning reviews of pathways including:
  - End of life
  - Alternatives to emergency admission
- Changing one cycle of IVF to exceptions only
- Medications – end prescriptions for items which can be obtained over the counter, end Gluten-free food prescribing
- Requiring healthier lifestyles before surgery, eg smoking and obesity
- Based on: evidence, population-based health needs, equality of access, and value for money

# TCC – our 9 priorities from December 2017

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Ops & Engagement	Care Co-ordination	Referral Management
Stabilise and improve internal daily operations: •Options Appraisal complete •Contract meetings •KPIs published & monitored	• Focus on onboarding patients with high risk of admission: • Risk stratification tool • Referrals from clinicians (GP/CEC) • Working with Wythenshaw site to develop protocols for discharge coordination	Improve quality of referrals from GP through support / enforcement: •Generic Referral Form introduced •Receiving all MSK/Gastro referrals in TCC
Implement a direct engagement approach with our GPs: •First round of practice visits completed •Care coordination/referral management reports - patients/benefits	Discharge those patients that will not benefit from our service: •Patients where no interventions in last 3 months •Patients are independent	Use of the DOS by GPs to support improved pathway compliance: •GP Practice Portal launched 21/9 •Working group with Clinical lead identified for further development
Rebuild relationships with key Acutes in support of admission avoidance: •Stakeholder Reference Group/meetings	Increase the clinical focus of the service: •Patient Care Plan template •Condition-based Management – Diabetes pathway produced to support pilot in primary care	Start placing diagnostic tests on behalf of GPs: •System integration not complete •Clinical protocol discussion clinical ownership of the test

# Service KPIs

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Service area	Detail	March 2018	Dec 2017
Care coordination	% of patients that meet agreed criteria	95%	57%
Care coordination	Number of patients in service	2000	1718
Care coordination	% of interventions in relation to interactions with patients	30%	12%
Care coordination	Benefits delivered	£104k	£79k
Referral management	% target referrals clinically reviewed	95%	98%
Referral management	% referrals processed within required time standard	95%	88%
Referral management	Benefits delivered	£67k	£66k
Operations and comms	Calls abandoned	<10%	12%
Operations and comms	Calls – average waiting time	<1 minute	29 seconds

## Key updates – January 2018

- New Clinical Director – Dr Sapna Tandon (Mastercall)
- New Service Director – Faizal Mangeria (DxC)
- New Programme Director – Sharon Richardson (CCG/LA)
- On track to hit in service volume by March 2018 – 2000 patients
- Frailty lists received from approx. 20 GP practices
- Reviewing all care coordination patients and classifying into level of coordination required (with Clinical Director)
- Weekly review of interventions to develop benefits methodology (financial value of interventions/outcomes)
- Agreed referral protocol for care coordination patients into the community matron service

# Next steps

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- Programme Director to finalise programme plan following consultation with stakeholders – to include how TCC can support other work-streams (e.g. One Trafford Response, New Models of Primary Care, social prescribing)
- Programme Board to be developed from Stakeholder Group
- Benefits methodology finalised
- Care Coordination Framework enhancements (lessons learnt from review cycles by clinical director)
- Integrated Clinical Portal launch to partners
- Clinical protocol for ordering TCC ordering diagnostics
- Data available for risk stratification