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CCG update January 2018

Health and Social Well-being Overview and Scrutiny Commission

Erica Daley
Director of Integrated Commissioning

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Introduction

- Non Emergency Transport (TASL)
- Care Homes Pilot
- Estates Review
- Urgent Care Communications

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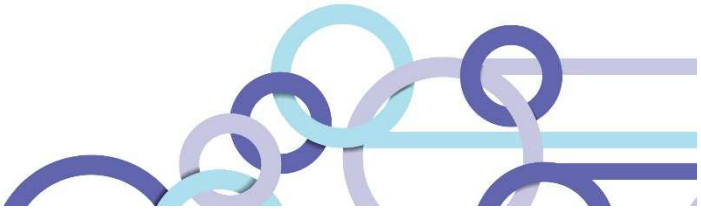
Non Emergency Transport (TASL)

Joy Dodson



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Actions Taken: Management Team

Regional Director – North

Area Manager – Humber

Team Leader – Hull

Positive relationship with hospitals

Nominated Improvement Director for Hull

Quality and Clinical Advisor (across TASL)

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Actions Taken: Capacity

- Additional driver workforce and vehicles in Hull
- Dedicated rota for Renal Dialysis patients
- New bariatric vehicle for the patch
- All effective from mid-December 2017

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Actions Taken: Discharges

- Patient Transport Co-ordinator operational in Hull Royal Infirmary – integral to hospital team
- Additional discharge driver/vehicle – 3 crews at peak time of day

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Actions Taken: Call Centre

- Dedicated Improvement Director for Control Centre
- Further recruitment and training
- Call routing in place
- Automated SMS reminder messages
- Smartphone App available

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Actions Taken: Patient Experience

- Patient experience officer in post
- Complaints response more timely
- Face-to-face joint visits to specific patients to understand and respond to issues

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Further focus

- Access to call centre – consistent and timely
- Complaints – closure and resolution of outstanding issues
- Data Quality – capture rate good, transparency good, driver recording has room for improvement
- Workforce – compliance issues being addressed

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Latest performance against KPIs

			Target	July previously reported	Nov-17 Year to Date	
KPI 1	Planned Routine Journeys	Percentage of service users picked up within 120 minutes before appointment and not after the booked appointment time	95%	86%	86%	→
KPI 2	Planned Routine Journeys	Percentage of service users arriving up to 60 mins before their appointment, and up to 15 minutes after the booked appointment time	95%	81%	81%	→
KPI 8	Planned Routine Journeys	Percentage of service users collected within 90 minutes of the informed ready time	90%	69%	69%	→
KPI 3	Same Day Journeys	Percentage of same day service users collected within 120 minutes of journey booking	95%	73%	73%	→
KPI 4	Priority Service Users	Percentage of service users should arrive no more than 30 minutes before their appointment, and up to 15 mins after the booked appointment time	95%	49%	51%	↑
KPI 5	Priority Service Users	Percentage of service users are to be collected within 30 minutes of the informed booked ready time	90%	50%	51%	↑
KPI 6	Priority Service Users	Percentage of priority service users journeys to be no more than 30 minutes from collection to destination	90%	69%	72%	↑
KPI 7	Priority Service Users	Percentage of journeys (planned routine; same day; priority service users) to be no more than 60 minutes from collection to destination	97%	89%	91%	↑

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Timeframe for achieving KPIs

- Improvement trajectory agreed
- All KPIs planned to be achieved by May 2018
- KPI 6 & KPI 7 will always be challenging due to the impact of city traffic on journey times

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Care Homes Pilot – Erica Daley

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Aims and Objectives

- A shift of care from hospital to community
- Pathways pre Jean Bishop Integrated Centre May 2018
- Residential care to home care
- Community owned, designed and delivered services
- Safely manage those patients with a higher level of risk in the community
- Clearly defined, equitable, good quality 7 day services available and responsive on the basis of need
- Trusted assessment, single care plan that is accessible across organisational boundaries
- Optimise use of the skilled workforce

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Plan

- Patients targeted and assessed within the Care Home setting will:
  - Receive a Comprehensive Geriatric Assessment from a Multi-Disciplinary Team (Consultant Geriatrician, physio and occupational therapists, Pharmacists, Nurses, voluntary services and third sector organisations)
  - Receive a Personalised Care Plan including Advance Care Plan
  - Be allocated a named Clinical Complex Care Coordinator with a clear function to ensure interventions are delivered and reviewed
  - Receive follow-up interventions, including an escalation plan for appropriate signposting in crisis and timely sharing of information

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The Pilot

- Working with 2 Practices and 2 Care Homes
  - **Northpoint Practice – Kersteven Care Home (x46 residents)**
  - **East Hull Family Practice – Alexandra Court (x47 residents)**

- Plans currently underway to extend pilot to **Rossmore Care Home**

n.b Care Homes selected due to high number of emergency admissions

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The Pilot

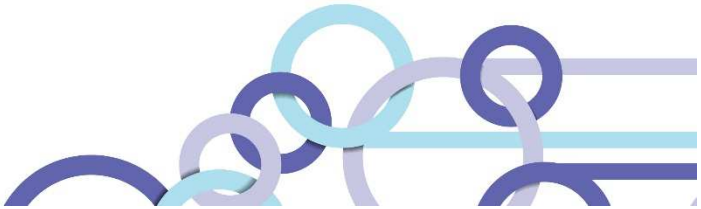
The **Winter Planning for Care Homes Pilot** will:

- Test operational processes (including MDT assessment, Care Coordination (Clinical – for Frailty), follow-up arrangements and Advance Care Planning ahead of the ICC opening in May 2018

- Provide an opportunity for training of new roles in advance of ICC opening, as they are recruited (in progress)

- Provide training and support to Care Homes staff

- Provide an opportunity to test Impact Analysis methodology



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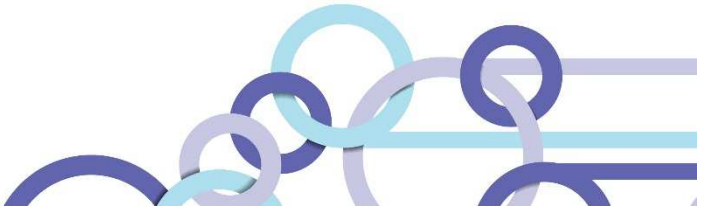
Preliminary Feedback

MDT held on 15th Dec 2017 - 5 patients reviewed by the MDT:

- 2 emergency admissions avoided (approx £3000 per admission saved)
- 1 GP call-out avoided (GP time saved on inappropriate call-out)
- 3 Advanced Care Plans put in place
- Multiple poly-pharmacy issues addressed (e.g. saving of c £600 for 1 patient, benefit for patient not being on inappropriate meds)
- Patient and relative concerns addressed ‘on the job’ and follow-up arrangements put into place



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Preliminary Feedback

Care Homes staff member:
'Really helped to resolve some of our problems very quickly and smoothly'

GP:
' It would be amazing if we could roll out across the whole of Hull'

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What have we achieved so far:

- Operational Policy agreed
- Baseline data gathered and 1st draft of proposed Dashboard developed and shared
- Regular (3-weekly) Task & Finish Group meetings established
- Work commenced to develop Care Coordination for Frailty model
- Single Assessment Tool drafted and work underway to build within Clinical Systems – will be viewable across systems
- Links made with Professors of Palliative Care who are interested in collaborating on research and evaluation

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Integrated Estates Planning - Phil Davies

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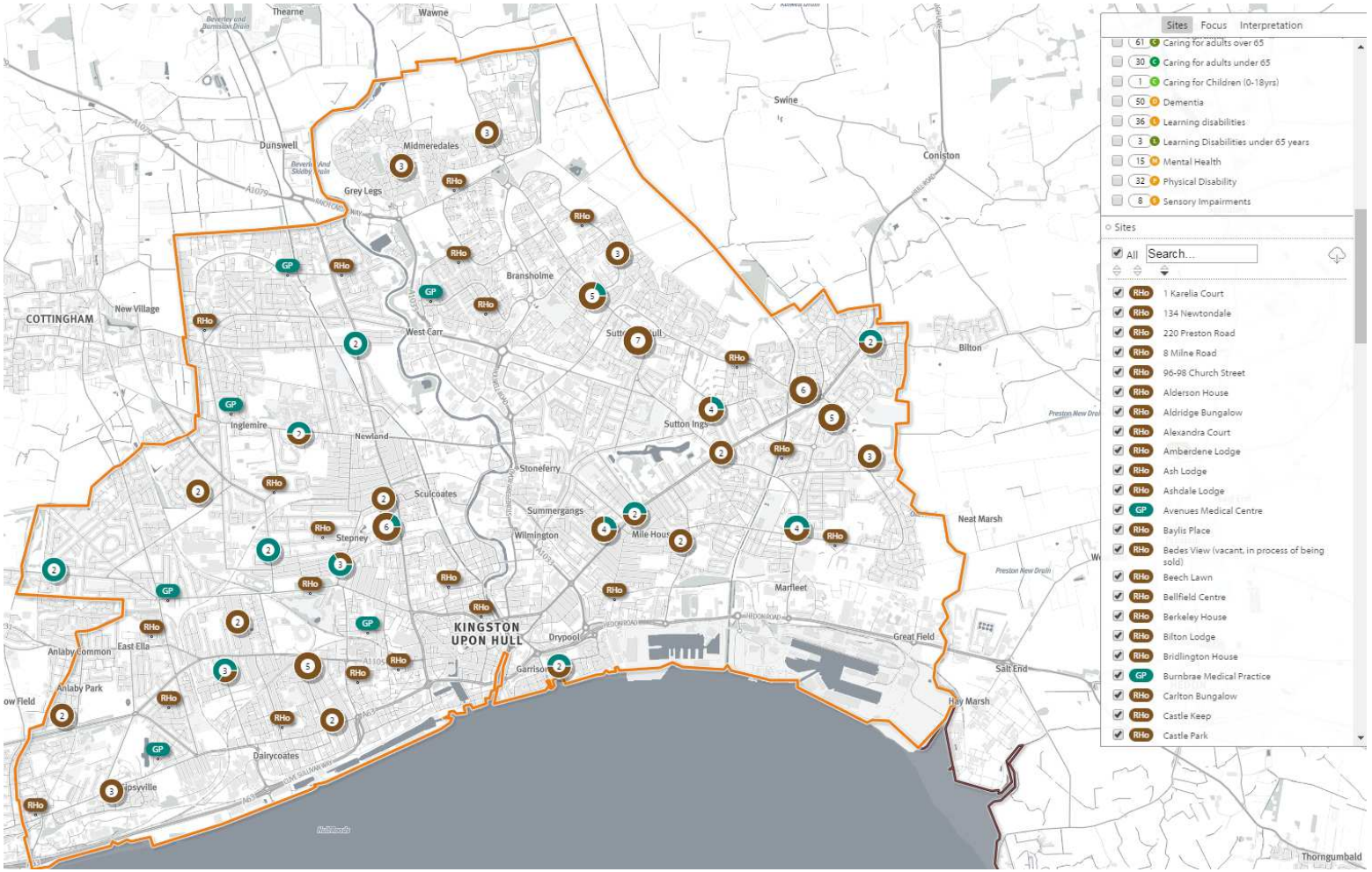
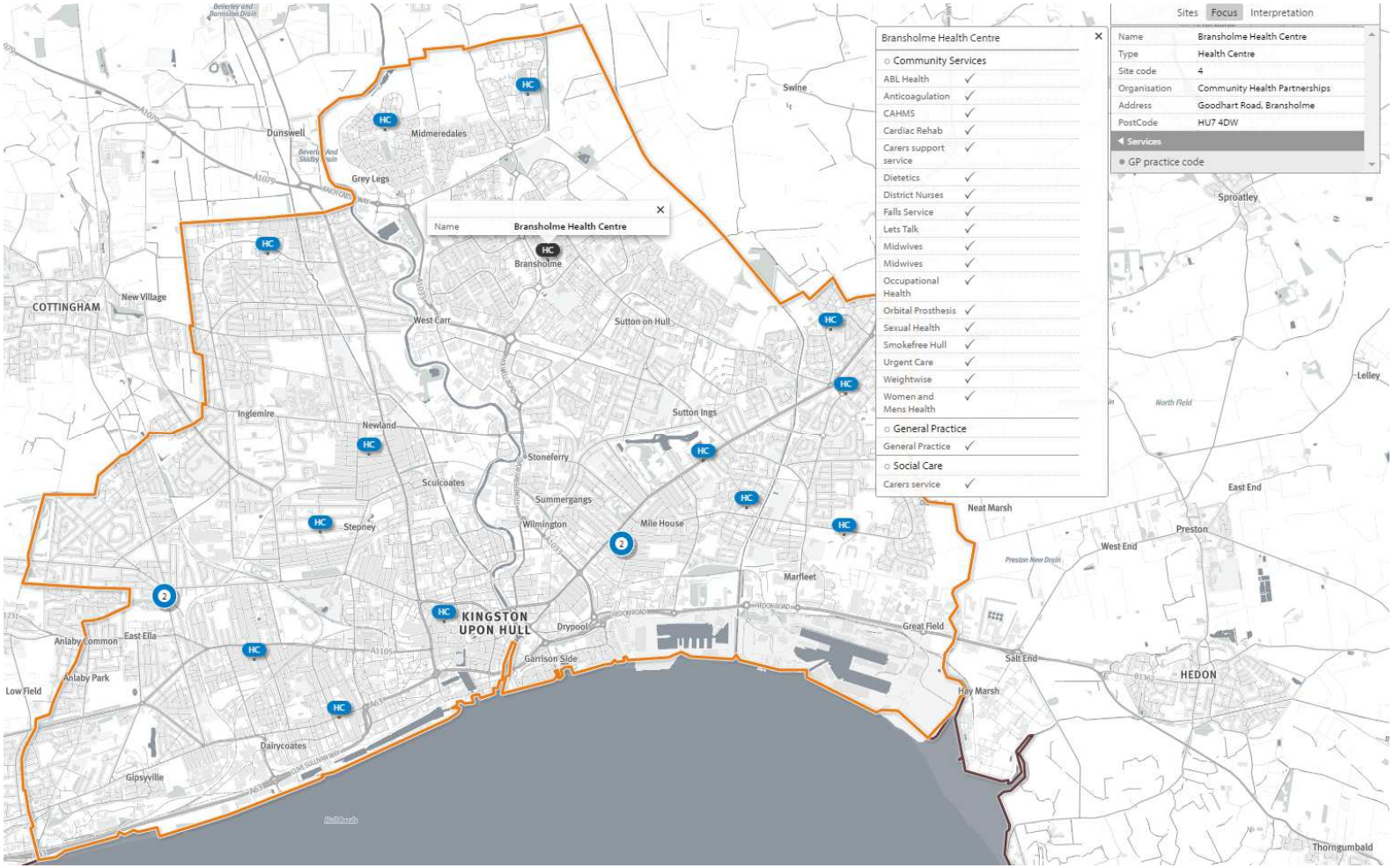
Integrated estates planning tool

- Support service and estate planning decisions (decisions currently made with limited data)
- Single database for all public service data – ease of access, sharing, consistency
- Planning in an integrated way across services and organisations
- Save time and resources

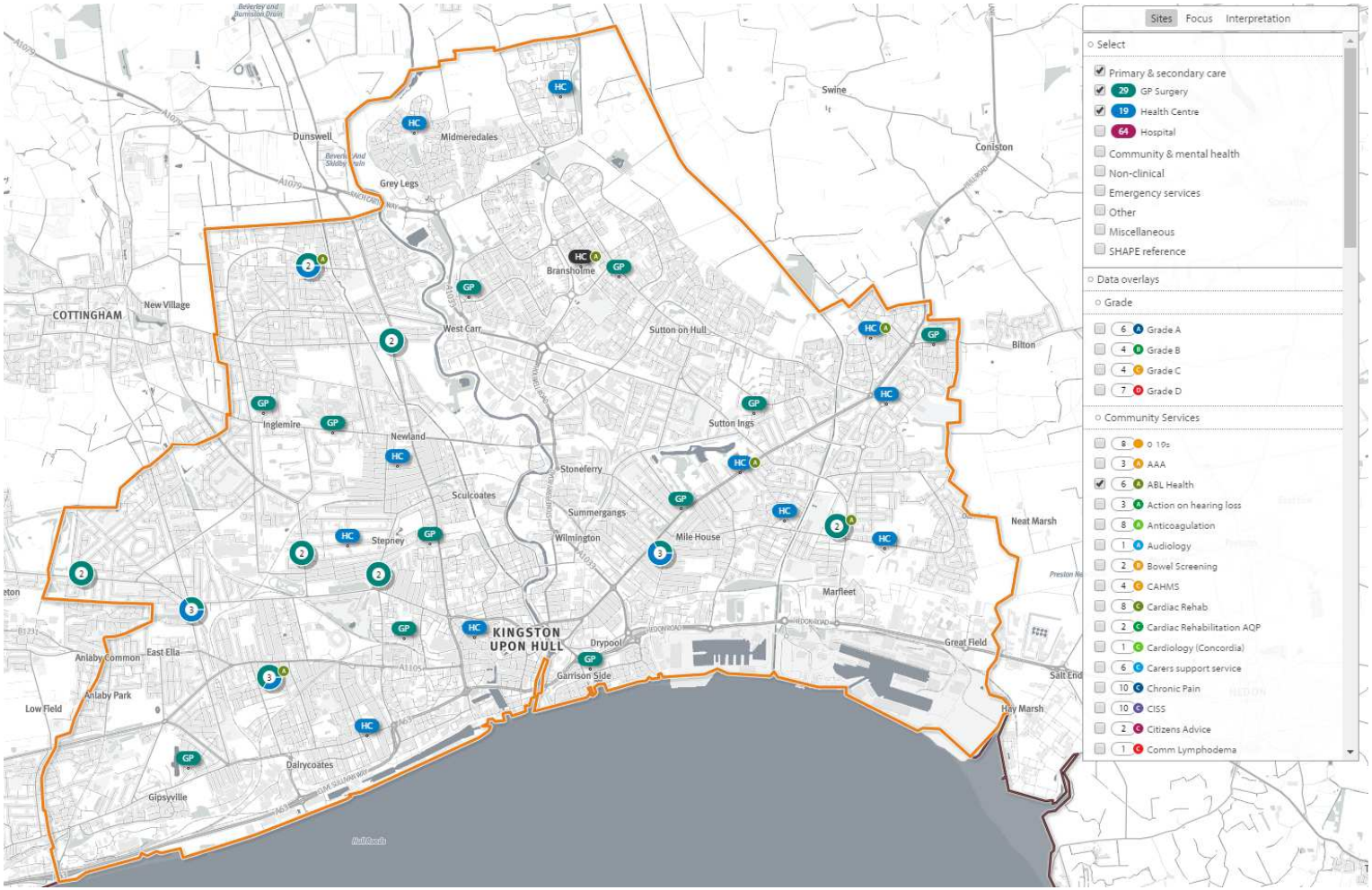


Select by property type

GP Premises and Residential Care Homes

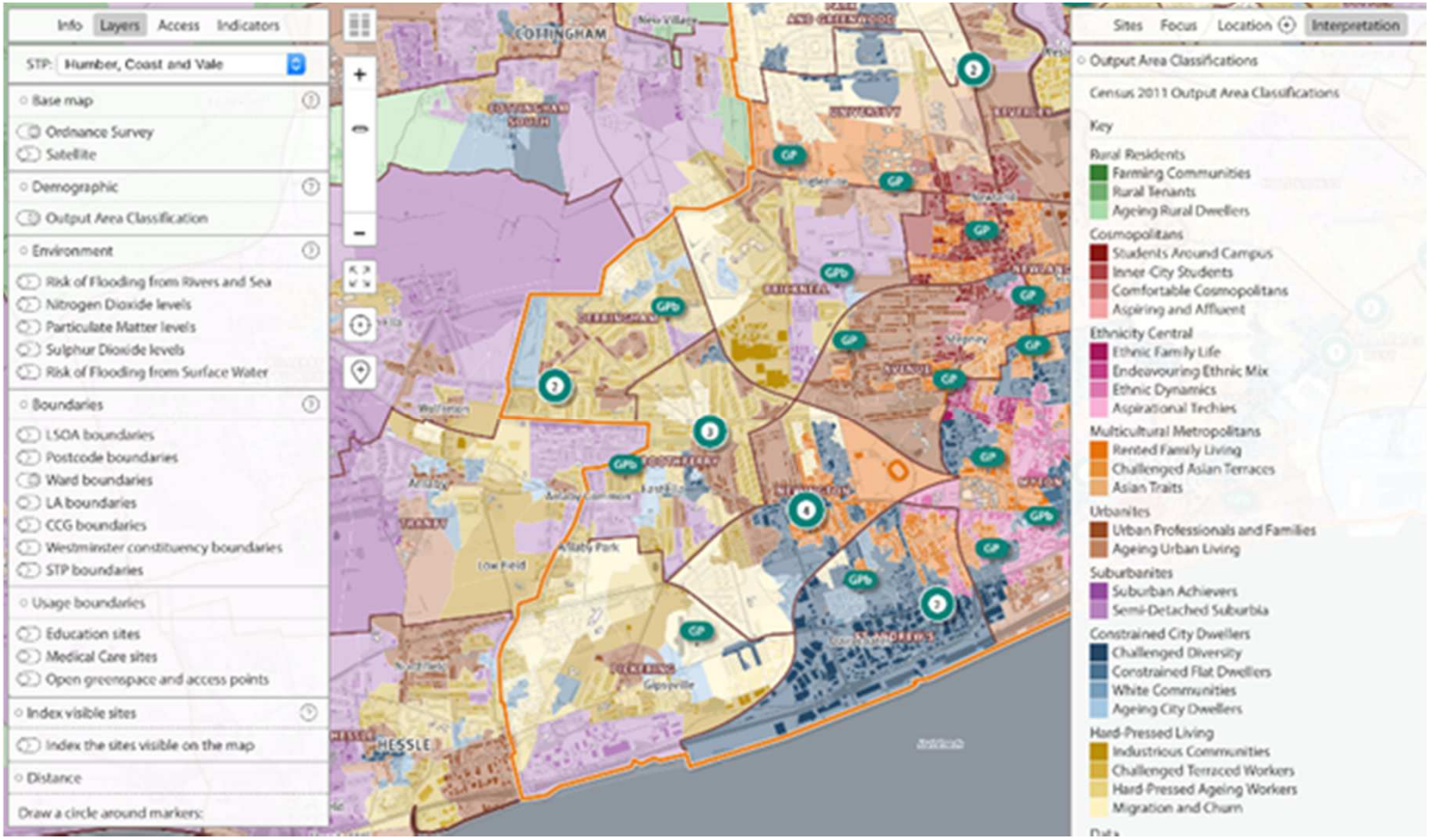


Select by services within a building
Bransholme Health Centre



Select by service type – ABL Health

Underlay – Area Classifications



Example 1

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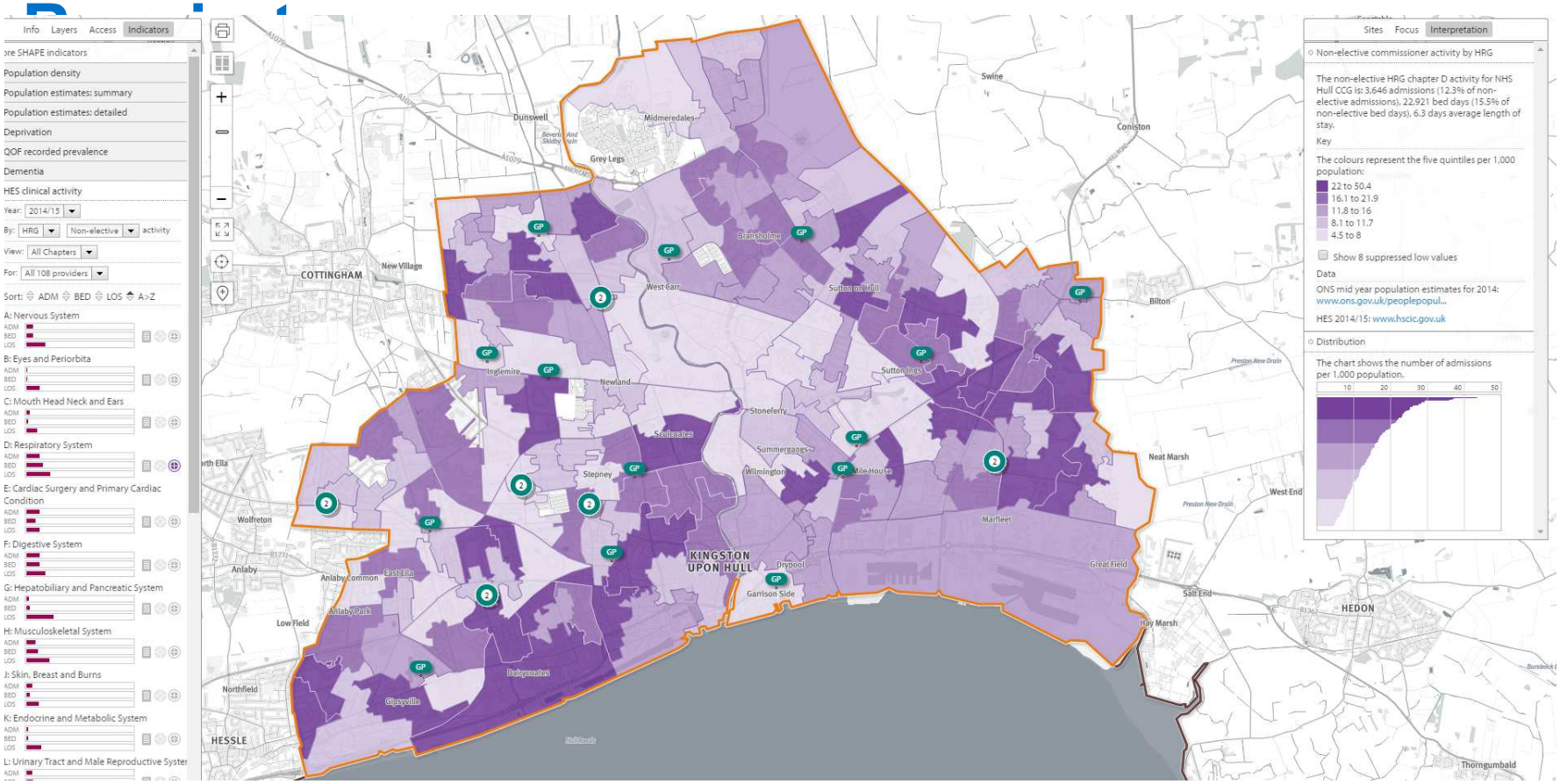
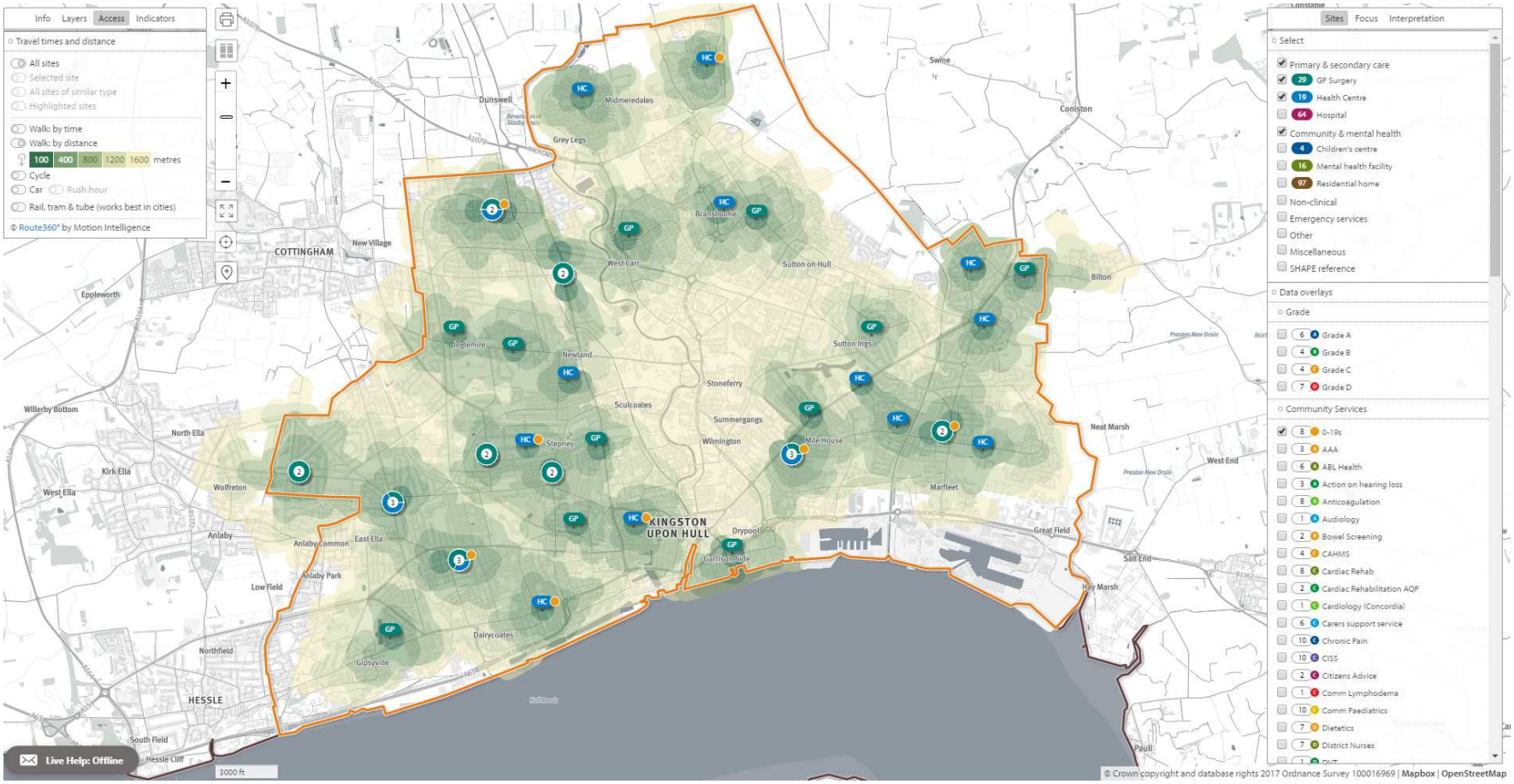
Underlay – HES Clinical Activity -



Example 2

Underlay – Access Layers
Walking Distance to 0-19 service locations



Example 3

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Usage

Support service and estate planning decisions – eg. children's services

Maintenance of a single database for all public service data – ease of access, sharing, consistency

Planning in an integrated way across services and organisations

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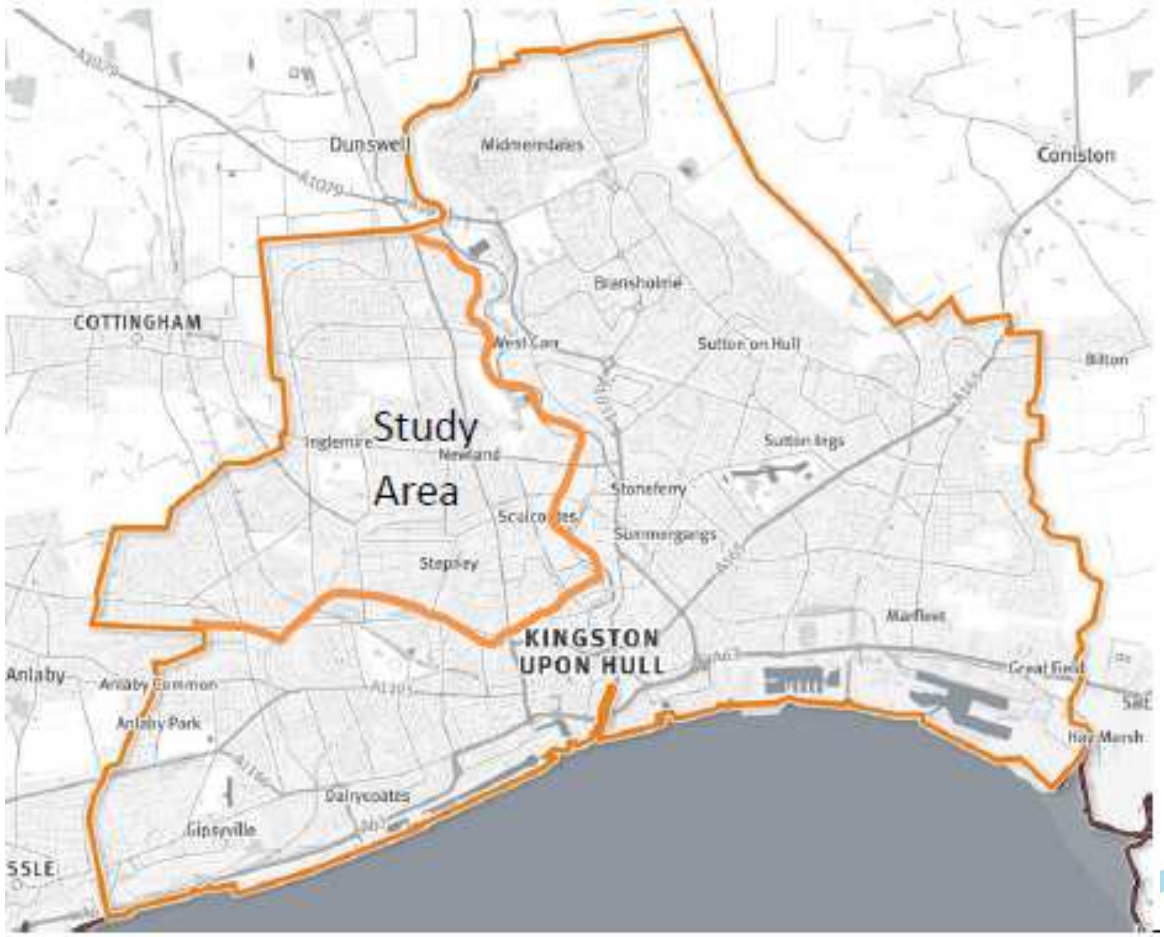
Estate review

Out of hospital services in west of city



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Estate review

Review existing accommodation and service distribution

Forecast future accommodation requirements

Develop a view on the condition and future of existing estate

Determine estates options to support future clinical service delivery

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Links to Area Committees

CCG has contacts for all Area Committees

Area Committees want area specific information

Area Committee involvement to date

- West - Springhead Medical Centre
- North Carr - Bransholme Urgent Care
- East & Park - Integrated Care Centre

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Integrated Urgent Care Communications Update

Carol Waudby
CHCP