Centre of Excellence for **Information Sharing**

Trafford Care Co-ordination Centre:

Executive summary

Leadership, collaboration and co-design: the initial development and impact of the Trafford Care Co-ordination Centre (TCCC)

Background

Greater Manchester (GM) has led the way for devolution to local places[1] and aspires to do the same with information sharing. As a result, the devolved powers set out across a series of devolution agreements cover not only services such as health, transport, housing and skills, but also cross-cutting enablers such as governance and information sharing.

Information sharing is seen as fundamental to delivering GM's public service reform ambitions. A fact highlighted by the creation of GM-Connect - a new data commission who's role is to champion, co-ordinate, facilitate and deliver data sharing activity across GM - as a key enabler for integrated public service reform and devolution.

In this case study we focus on the role of information sharing in supporting health and social care integration, another area where GM is leading the way - with devolved control over integrated health and social care budgets since 1 April 2016. A key strand of GM's devolution ambitions, health and social care integration aims to deliver not only improved health but also improve wellbeing, reduce worklessness and support people back into employment as a result.

[1] In April 2011, GM established the first combined authority in the country (GMCA), and has since agreed a series of devolution agreements with central government in 2014, March and July 2015 and most recently March 2016.

[2] A series of locality plans, one for each of the ten local authority areas of Greater Manchester, underpin Greater Manchester's five-year plan for health and care devolution – known as 'Taking Charge of our Health and Social Care in Greater Manchester'. Locality plans set out what will be delivered in their area and how the savings from the integrated better care models and prevention will be delivered.

Health and Social Care integration in Trafford – a care co-ordination approach

Care co-ordination is at the heart of Trafford's approach to health and social reform, and as such is described as "our big idea" in Trafford's Locality Plan.[2] The TCCC is not only seen as a key 'transformational development' itself, but is also central to supporting Trafford's other transformational priorities.

The TCCC provides a single point of contact for patients, their families and health professionals. Operating like an air traffic control system, tracking patients as they move through the system, and guiding them to different services.

Local people's care will begin with their GP making a referral to a clinician at the centre, which will result in their onward journey being mapped out on a patient care pathway. Once the patient is assigned to a particular pathway, their ongoing management will be overseen by a single care coordinator who will be responsible for arranging all their outpatient appointments, social care support and transport to and from hospital.

One of ten boroughs in GM, Trafford has a diverse population of over 230,000 with a wide range of healthcare needs. These needs are met by healthcare organisations both within the district and in nearby areas, including clinical commissioning groups (CCG'S), council's, and hospitals. This can often make a patient pathways confusing and difficult to follow - TCCC aims to make it simpler for both patients and the professionals who support them to keep track of their care.

Aims and expectations of the TCCC

Designed ultimately to avoid unnecessary hospital admission through better informed clinical decision making process, the TCCC is expected to:

- Improve the quality and alignment of referrals to specialist services, though the use and monitoring of agreed clinical pathways (referral management).
- Reduce bed-blockages in hospitals by medically fit patients (discharge management).
- Improve outcomes for patients, and families, with chronic conditions by helping them co-ordinate multiple health and social care needs (complex care co-ordination services).
- Divert demand away from acute, hospital-based services, to community-based services and social support, by signposting patients and healthcare practitioners to the most appropriate service, third party providers, and/or self-help resources (enquiry management).
- Drive intelligent commissioning of services based on real evidence of patient journeys/needs, and support earlier identification of patients' complex care requirements (analytics).

More importantly, as a result of providing co-ordination, oversight and accountability between transitions of care, the TCCC will deliver tangible benefits for patients, such as:

- Reduced waiting times.
- Fewer hospital visits.
- Care for patients and their family.
- Proactive health management.
- Single point of contact for patients, and family/carers.
- Help to find and engage with community support groups.
- Swifter discharge from hospital, as co-ordination ensures both practical and medical needs are being met.

Challenges faced and approaches to tackling them

During the development of the TCCC there were a number of challenges which Trafford CCG and their partners had to tackle in order for information sharing to be embedded throughout the process. The overarching themes are outlined below:

- Complexity of large health organisations.
- Practitioner engagement across all levels.
- Making time to build relationships.
- Prioritising information governance from the start.
- Developing a shared approach to managing dissent.
- Agreed data sharing delayed by technology issues.
- Supporting patient communication and understanding.
- Providing real-time insight from pseudonymised data.

More detailed explanations of how the challenges were overcome are available in the full case study available online by visiting at **www.informationsharing.org.uk/GM**

Key learning and next steps

TCCC is still in the early stages of delivery, but the model is already creating impact locally and offering key learning which can be applied locally and further afield, including:

- The importance of a shared vision with strong leadership to support new ways of working and the information sharing which underpins them.
- The value of early, proactive and ongoing engagement with key stakeholders (such as GPs and information governance leads) to developing agreed approaches to consent and dissent.
- The need to embed information governance into programme management arrangements at an early stage to enable co-ordination with other cross-cutting workstreams.
- The benefit of collaboration with partners, including clinicians, frontline practitioners and patients in the development of effective communications materials (to raise awareness of both the service and the information sharing which underpins it).
- The value of 'clinician to clinician' collaboration in building trust and shared objectives.
- The importance of carefully selecting language when working with partners through periods of change.

Further learning will no doubt be provided by the continued development of the care co-ordination centre and the evaluation of services which the TCCC's data will support. Next steps for the TCCC, offering opportunities for further learning, include:

- The development of a secure web portal to give role-based access to views of combined patient records to GP, hospital clinicians and social workers. Alongside exploring the potential for limited access to such a portal for other public sector organisations.
- The extension of the data sharing arrangements to include a wider range of services with a role to play in supporting wellbeing, such as housing associations, patient transport / ambulance services, care homes, hospices and healthcare focused charities. Starting with discussions to identify what data fields might be needed, and why, in order to plot scenarios.
- The planned move towards self-management, by service providers themselves, of information about local services contained within the directory of services, to support a broader scope covering services provided in neighbouring areas.
- The development of patient access to the directory of services (via an enquiry management portal or tab), to enable the public to tap into self-help areas such as help and advice for healthy living.

Exploring the potential for this learning to be applied more widely across GM will also be a key opportunity for both the TCCC and GM-Connect.

Find out more

To find out more about our work in GM visit **www.informationsharing.org.uk/GM**