NHS
Bromley
Clinical Commissioning Group

INTEGRATED CARE NETWORK UPDATE

FOR HEALTH & WELLBEING BOARD
December 2016

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HOW WERE STAKEHOLDERS INVOLVED?

Significant engagement has taken place with a wide range of stakeholders in order to identify issues, address concerns, co-design and test the model, and feedback on progress to date, including how issues have been addressed.

Involvement of GP Members

- October 2014 engagement meeting
- Nov 2014 / May1205 Membership Body meetings
- June 2015: Deep Dive Huddles
- May, July, October 2015, April, May 2016 Cluster meetings
- Feb / March 2016 Clinical Round tables
- March 2016: Three ICN geographies approved by CCG GB
- Regular updates at GP cluster meetings
- Regular updates at GP members meeting
- Regular GP engagement in Frailty Clinical Interface groups

Involvement of GPs as providers

- July 2915: Engagement meeting
- July 2015: LMC meeting
- Feb / March 2016: Participation in range of cross provider workshops
- March 2016: Update at LMC meeting
- April 2016: GP Alliance member of new ICN Board
- April 2016: LMC rep invited to attend ICN Board, (ongoing)
- 9 May 2016: GP attendance and presentation at Frailty workshop
- May 2016: GP Alliance involved in co-developing Provider response to the MOU

Involvement with other partners

- May-July 2015: Co-design workshops with all providers, including GP Alliance representatives
- July 2015: Patient Engagement workshop
- Feb / March 2016: Cross provider workshops further develop ICN model
- April 2016: ICN Board established all providers represented KCH / PRUH, Bromley Healthcare, Oxleas, BTSE, St Christophers
- April 2016: All Providers agree to sign joint MOU
- LBB represented at ICN Board, steering group, operational group and frailty interface group
- May 2016: Patient engagement evening and patient survey
- Frailty workshop with all stakeholder May 2016
- Ongoing Frailty Clinical Interface groups

Work in progress to continue to implement and roll out new models of care

- Ongoing engagement with GPs including a training day planned to support Proactive pathway and MDTs
- Ongoing updates and discussion with LMC Patient focus group planned re patient rep input on new frailty pathway
- Governance in place to monitor performance of Proactive pathway against MOU performance metrics
- Ongoing co design to finalise NEW Frailty pathway- joint governance in place with KCH
- ICN Board in place to continue to support new models of care delivery

PATIENT IDENTIFICATION

1

All **HEALTH AND CARE PROFESSIONALS** will case find and identify High Risk, High system users and provide their details to the **MDT LIAISON COORDINATOR** (via the Bromley Healthcare Single point of entry). *N.B. In Year 1 only GPs will be actively case finding*

The **MDT LIAISON COORDINATOR / CARE NAVIGATOR** provide **CARE NAVIGATION** and **CARE COORDINATION** support at an ICN level

PATIENT IDENTIFICATION AND CASE FINDING

2

The **MDT LIAISON COORDINATOR** support GPs in updating EMIS for any additional patient information, and where required a **NOMINATED GP CHAIR** will apply clinical judgement to non-GP identified cases to ensure consistency of assessment *(from Year 2 onwards)*;

If system capacity becomes an issue the **NOMINATED GP CHAIR** will prioritise who has the highest clinical and social priority for **INTEGRATED CASE MANAGEMENT**

CLINICAL GOVERNANCE AND DEMAND MANAGEMENT

3

Based on individual organisation consent policies, by this point the relevant **HEALTH AND CARE PROFESSIONAL** or the **MDT LIAISON / CARE NAVIGATOR** will have checked that the **PERSON** is happy to be put on the **PROACTIVE CARE PATHWAY**

PATIENTS IDENTIFIED AS REQUIRING PROACTIVE CARE PATHWAY will be placed on pathway for initial holistic assessment via a Community Matron, with the referral being managed by the **MDT LIAISON COORDINATOR**

PATIENT CONSENT

To ensure an intervention is most effective, resources must target the individuals at highest risk, and any case-finding method needs to be able to identify individuals at high risk of future emergency admission to hospital.

In practice, most programmes use a combination of a predictive case finding model and clinical judgement; the model is used to flag individuals who are at high risk, and the clinician then makes a judgement as to whether a person is likely to benefit from case management.

PROACTIVE CARE PATHWAY

4

An initial **HOLISTIC ASSESSMENT** (Guided conversation) is carried out with the patient by the most relevant person, who will usually be the Community Matron

INITIAL ASSESSMENT

5

An **INTEGRATED CARE AND SUPPORT PLAN** will be developed by the Community Matron with the patient, supported by the **CARE NAVIGATOR** role (when required)

INTEGRATED CARE PLAN

6

A **MULTI-DISCIPLINARY TEAM** carries out an initial review of the person, updates and ratifies the **INTEGRATED CARE PLAN**, and assigns a **CLINICAL LEAD** based on the agreed **PRIMARY NEED** of each person

INITIAL MDT MEETING

7

The **NOMINATED GP CHAIR** will Chair the MDT meetings to ensure all the patient's needs are considered and actioned, ensuring that the best interests of the patient are considered and prioritised

CLINICAL GOVERNANCE

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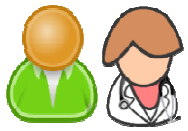

The **CLINICAL LEAD** is the first point of contact for the patient for their **PRIMARY NEED**, supported by the **MDT LIAISON COORDINATOR** who will be the main point of contact for all other needs (including self-management support)

POINT OF CONTACT

9

The updated **INTEGRATED CARE AND SUPPORT PLAN** is shared with the patient by the most relevant person and the care plan is implemented, overseen by the **CLINICAL LEAD** and coordinated by the **CARE NAVIGATOR** with support from the **MDT LIAISON COORDINATOR**

PATIENT INVOLVEMENT

10

The **MDT LIAISON / CARE NAVIGATOR** arrange **MDT** reviews at the intervals set out in the **INTEGRATED CARE AND SUPPORT PLAN** to review the care plan progress and make changes to the patient's care as required (70% of patients will require discussion at a 2nd MDT)

REGULAR REVIEW

11

When required an **HOLISTIC ASSESSMENT** (guided conversation) is carried out to re-assess the needs of the person, and where appropriate reduce the intensity of support they need

RE-ASSESSMENT

ICN MOBILISATION - RECENT PROGRESS

- Recruitment to new MDT roles is nearly complete

The first MDT was held on 18 October – Three (3) patients were referred via the Bromley Healthcare Single Point of Entry

Positive feedback was received from all professionals involved in the first MDT

More MDTs have been arranged for 24 and 28 November

Bromley Healthcare single point of entry form has been updated so GPs can select to refer a patient to the Proactive Care Pathway

RECRUITMENT TO NEW KEY ROLES

GP CHAIR	• Two Chairs appointed by the GP Alliance to provide governance to the MDT meetings • Due to start at end of November and December
MDT LIAISON COORDINATOR	• 3.6 WTEs recruited and starting in November / December • GPs will be informed of the named MDT Liaison Coordinator support for their ICN in coming weeks
CARE NAVIGATORS	• 3.6 WTEs Care Navigators recruited and starting at the beginning of December • Care Navigator Manager JD agreed and out to advert (This role also supports the Frailty Pathway)
INTERFACE GERIATRICIAN	• One of three Interface Geriatricians recruited and due to start in January 2017 • KCH are aiming to recruit a further two geriatricians
MENTAL HEALTH PROFESSIONAL	• Out to advert to provide MH input to MDTs
SOCIAL PRESCRIBING ADMINISTRATOR	• Out to advert to support the Social Prescribing Portal

Each provider organisation will cover the MDT meetings with existing staff whilst they are waiting for new appointments to start

FEEDBACK FROM FIRST MDT

"We achieved more for each of these patients in a 20 minute discussion than we would have done just spending 20 minutes alone with the patients"

"Had the practice not been looking for these patients for the ICN then we had no intention of doing anything particular over and above their management plan to date. Each patient now has multiple actions ongoing which without doubt will improve their conditions"

"It was crystal clear that everyone was very keen to help and to support those patients discussed, and it was nice to be able to contribute to this"

"It was helpful for actions to be taken away from the MDT without the need for formal referral"

"... the Community Matrons assessments were excellent and vital to ensuring an accurate action plan"

"... it was an incredibly worthwhile session and moving forwards we will really be able to transform some patient's lives"

WHAT TO EXPECT FROM A MDT MEETING

The **Community Matrons** will have done a comprehensive assessment including the patient's wishes/goals and will present this alongside your presentation of the patient

The **MDT Liaison Coordinator** will ensure relevant organisations, who should be helpful in formulating an action plan for this patient, will attend the MDT meeting

The role of the **GP Chair** is to ensure that the nature of the discussion and care plan are of good quality.

The **Care Navigators** are the point of contact into the voluntary sector e.g. Age UK/ MIND etc. and should therefore pick up these actions.

Mental health team and **Geriatricians** will be available depending on need and can pick up relevant actions.

If information is needed from **other community services** e.g. SALT/ podiatry you should expect that your Community Matron and MDT Liaison Coordinator will have accessed this information.

In the long run we will have a local care record available to help exchange information (we are looking into whether a multi-organisational care plan is feasible)

ELIGIBILITY CRITERIA FOR INTEGRATED STEP UP / DOWN FACILITY

KEY REQUIREMENTS

- Non-acute elderly care
- Patients whose condition is likely to require some medical input
- Level of Frailty: scoring at least 6-7 on the Rockwood Frailty Scale (age not deciding factor)
- Hours of decision making for referrals: proposed 8am-5pm based on availability of Geriatrician
- Patients with a Bromley GP (test impact after 2-3 months)
- Access – via step up or step down through Geriatrician gateway
- Unit is consultant led with a MDT approach - TBC
- 7 day access

STEP UP

- Referral through one of the following Gerontology gateways:
  - Geriatrician hot clinic
  - MDT referral from Proactive Pathway
  - GP referral via geriatric hotline where patient has been suitability assessed as not requiring admission to acute site
- Patients with known diagnosis or ongoing needs but cannot be treated at home, requiring a stay of less than in the region of 7 days
- Patients with delirium or dementia who require non-acute support can be discussed and considered for this support
- Step up via Rehab Home Pathway or MRT for patients who are not safe to be supported at home and require inpatient rehabilitation
- Management of venous ulcers and patients with long term conditions that have been gradually failing with an identified cause e.g. increased leg oedema
- People discharged, where the package of care is inadequate or there was a non-acute reason for the package of care not being supportive (recurrent admissions)

STEP DOWN

- All step down patients will have had a Comprehensive Geriatric Assessment started before transfer
- Recuperation/rehabilitation for patients whose condition is not currently reaching Lauriston criteria (slow stream)
- People who are medically stable but require support because their carer has been admitted
- Minor illness and falls not covered by the current fracture pathway
- Resolving Delirium / Dementia (slow stream requiring longer length of stay) - TBC

FRAILTY PATHWAY OVERVIEW FOR INTEGRATED FACILITY