Community Integrated Teams and Multi-disciplinary Working

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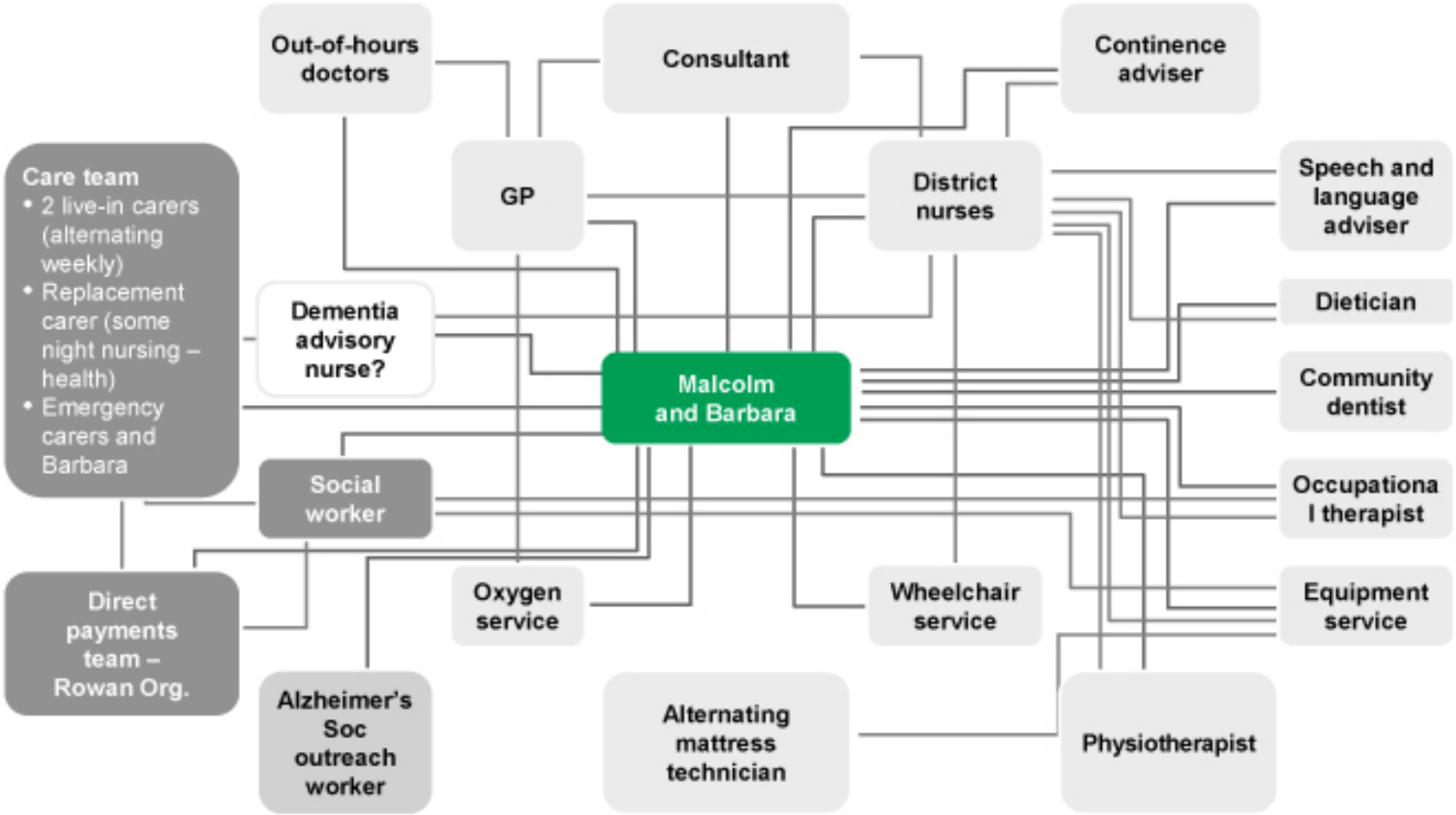
Dr Fadi Khalil

Chair of CIT Implementation Group

GP Executive lead- Out of Hospital

Malcolm's web of care – Alzheimer's Disease (last 7 years)



Source: http://www.nationalvoices.org.uk/webs-care

Key Principles of care across Sunderland

- Care will be person centred
- Proactive rather than reactive care
- Community care re-aligned to wrap around practices
- Breaking down barriers between professionals to deliver seamless care
- Shared decision making approach
- Empowering people and their carers to take responsibility for their own goals and self- management of care where possible

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Key building blocks to enable Integrated Care across Health and Social Care in Sunderland

1. Buy in and ownership from service users, providers and all 50 GP Practices
2. Co-Location of community staff across 5 hubs in the city
3. Information sharing across Health – Emis Web roll out
4. Development of Risk stratification guidance for all stakeholders
5. Development of regular MDT meetings in all 50 practices
6. New Job Roles – LWLW / MDT co-ordinators/ Care Home Nursing Support
7. Aligning community services to wrap around practice populations
8. Dedicated Nursing resource to link Practices and Care Homes
9. Care home alignment – Practices and Care Homes
10. IT Enablers - Care Home Tablets and Agile working

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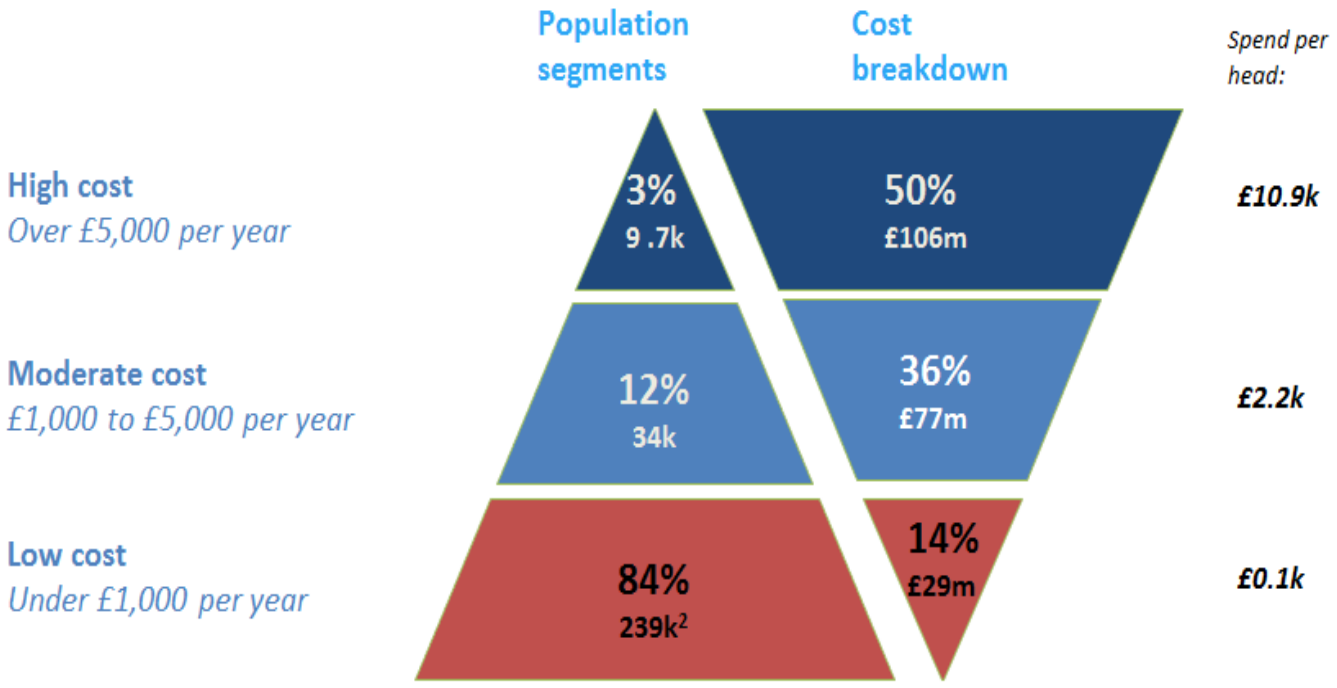
Risk Stratification approach:

Population cost pyramid: Top 3% of patients drive 50% of cost in Sunderland

Population cost segmentation, secondary care, community and mental health spend, 2013[1]



Source: Sunderland CCG secondary, community care and mental health data, Oliver Wyman analysis
1 – 2013 for secondary care and MH, March 2013 to Feb 2014 for community care
2 – 127k registered patients with no secondary, community or mental health interactions

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Risk Stratification

- The top 3% of high risk patients to be discussed at an MDT meeting and have a Person Centred Health and Social Care Plan
- The top 3% is *not* solely the printed list from Q Admissions, it is the 3% of the registered patient population of a practice who could most benefit from a proactive integrated approach and is determined through a variety of ways.
- All members of the MDT have the responsibility to identifying patients and all patients discussed count toward the 3%
- Awareness of the Regression to the mean required (robust BI infrastructure needed)

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Risk Stratification

Professional judgement of all MDT members

- Those who have had recent urgent home visits or increase in surgery visits
- Multiple organisations and professionals involved in their care
- Recent and rapid decline in health
- Increased reliance on health or social care
- Carer/Family struggling in their supportive role
- Carer/Family anxious about the patient's health
- Someone presenting with confusion
- Electronic Frailty Index

Q Admissions Score

Recent unplanned hospital admissions

Recent A&E Attendances

Evidence of Risk

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MDT Meetings

- Core Membership : GP , DN, SW, LWLW, CM and MDT Co-ordinator
- Weekly or fortnightly meetings depending on practice demographics and size
- Locality/ City Wide Networks – CPN, specialist teams, Challenging behaviour , Community Geriatricians
- Develop a shared understanding of everybody's role in keeping people out of hospital where possible and living independently in the community
- Undertakes a holistic view and comprehensive assessment of the patient's needs
- Utilisation of Deciding right documents – ADRT , EHCP
- Enables the provision of a wide range of services and resources
- Helps to provide a seamless service to patients which enhances continuity of care

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Assessment and Planning

- Ensure all risk stratified population receive a comprehensive review of medical, functional, psychological and social needs
- Develop shared care and support plans by involving people, their families and carers throughout all stages of the process.
- Many people with frailty will have cognitive impairment and dementia. Older people with dementia and frailty will have especially complex care needs, requiring a judicious approach to care planning.
- Consider end of life care planning if there is evidence of declining function, unstable long-term conditions, advancing dementia or systemic features indicating severe frailty, including weight loss and severe exhaustion – Utilising Deciding Right documents
- Whole system support- integrated care is required, working closely with specialist services such as community geriatricians, challenging behaviour teams and CPNs

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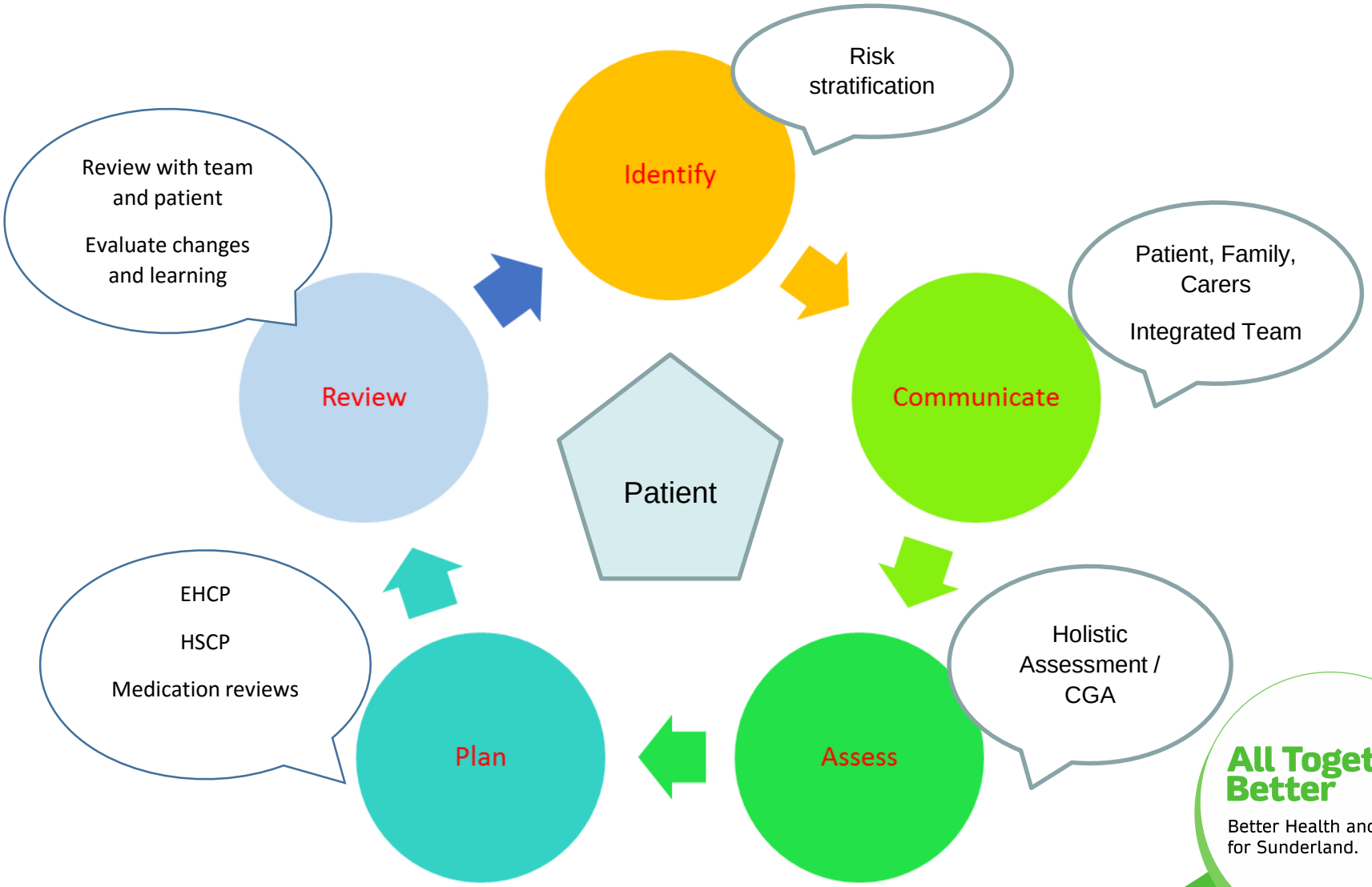
Assessment and planning function of MDT



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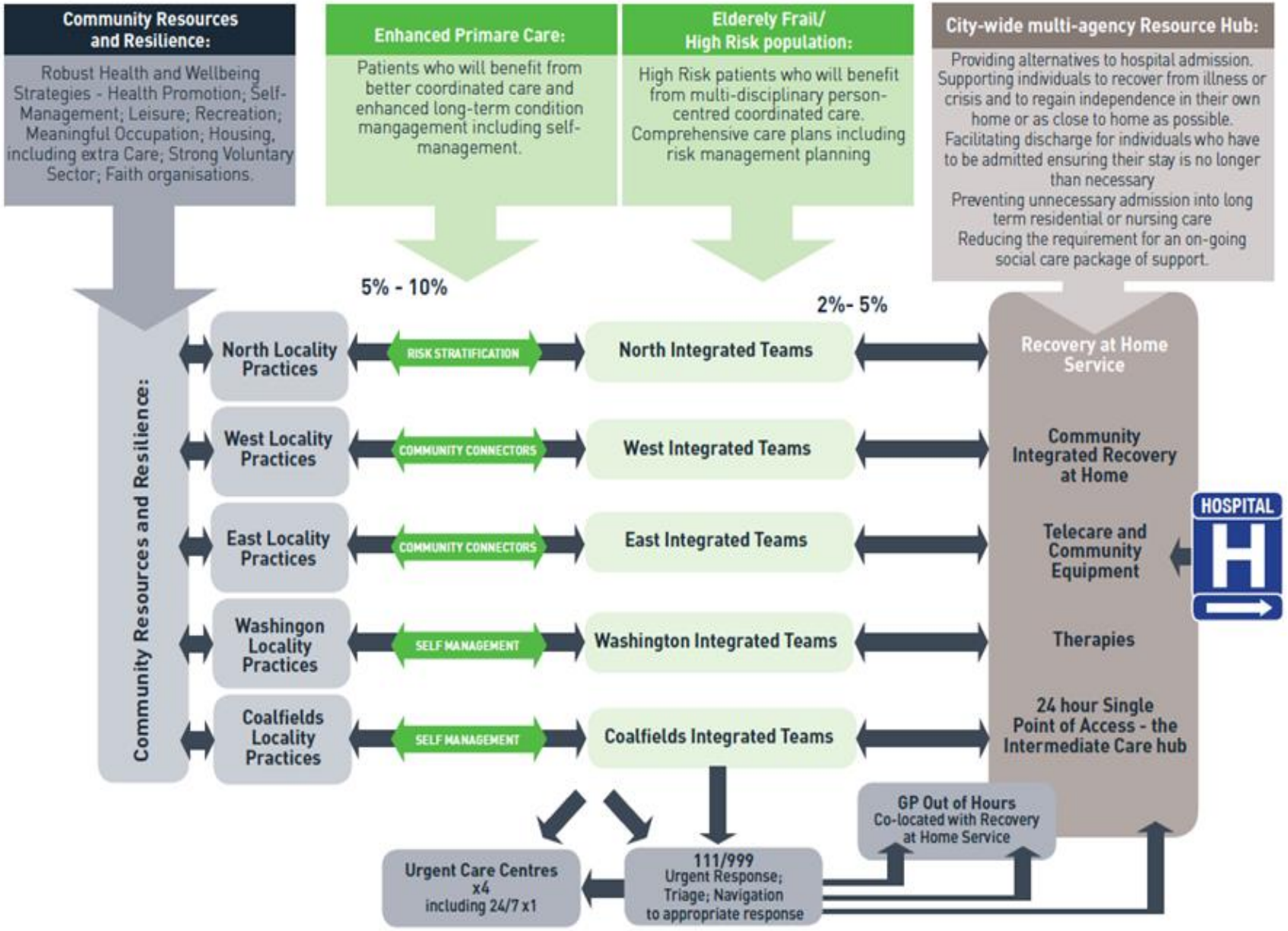
Whole system Approach- The Sunderland OOH Care Model



Key Messages

- Whole system Change – To Achieve outcomes and improve experience
- Relationships and Culture Change required
- Patient Involvement and Ownership
- General Practice is Key – Medical Home
- Enablers – Workforce, IT , Governance,
- Do not forget your Reactive care / Intermediate Care as well (Recovery at Home Service- Integrated Intermediate and Urgent Care)
- Interface with Secondary Care (OPAL – Frailsafe)

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