Integrated Working Newsletter (June 2016)

Welcome to our latest newsletter with a particular focus this month on our **multi-disciplinary Integrated Teams and Rapid Response Service**, designed to ensure you have all the latest information to enable you to make best use of our services.

As the Co-ordinating Provider for the integrated teams, our role is to:

- work with GP practices to provide intensive case management for patients who have been identified as being at risk of future emergency admissions
- support the development of a partnership approach towards integrated working across health and social care
- support the reduction of emergency admissions through rapid response and intensive case management

What do we mean by integrated working?

Integrated working is our health and social care teams working together. To support this way of working we have aligned teams to work across the four GP clusters to promote joint working with practices (see page 3).

Key to this is the role of the MDT Co-ordinator, as they play an important administrative and facilitating role working alongside the community matron in supporting all services to take a holistic view of patients. They will over time develop relationships to liaise and work closely with GPs and practice staff, as well as staff from other local relevant health and social care teams. Co-ordinators have access to the GP computer systems. Where possible Co-ordinators work from each GP practice one day a week.

MDT Co-ordinators enable us all to work together to identify, and support patients at the right time in the right place, to promote independence and to prevent unplanned hospital admissions.

In future editions, we'll update you on work underway to develop an integrated rapid response service. The aim of this service is to develop a clear pathway in and out of hours to ensure a combined response for people requiring social care, rapid response nursing and therapy with a single telephone number to streamline access.

As a first step, we will be launching this new pathway and way of working initially to one cluster (Larkside) on 1 July 2016. Further information will be made available as this pilot progresses.

We welcome feedback

Over the next few months, Linda Sharkey, our Service Director, will be attending Cluster Meetings to hear your views on how the services outlined in this newsletter are working. We also welcome feedback at any time. Linda can be contacted as follows:

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What is proactive Intensive Case Management?

Central to the working of our integrated teams is the proactive use of Intensive Case Management (ICM). Intensive case management is a proactive service offered to a specific group of patients and carers identified in partnership with our GP practices.

Who would benefit from proactive intensive case management?

Patients suitable for ICM are those that have: **'One or more needs spanning more than one profession that requires goal planning across those professions.'** This would typically be an unmet or deteriorating/complex health need and one other care need - this could include adult social care, voluntary and/or other services.

ICM would not be suitable for patients who have 'same day' needs. There are a range of existing services/pathways for patients needing an urgent response including access to community nursing support through a single point of access (Tel: 0333 405 3000).

Why is ICM beneficial?

ICM ensures the development of a personalised care plan to meet individual patients' health and care needs. It ensures a streamlined, proactive approach to wrapping the right care around patients to avoid unnecessary hospital admissions.

What is involved in the ICM process:

- **Case-finding**: patients are identified using a risk stratification tool in combination with the GP's professional judgement.
- **Assessment:** this is undertaken at monthly Multi Disciplinary Team (MDT) meetings, held in GP surgeries to ensure clinical input. Attendance can include (this list is not exhaustive):
  - GPs
  - District Nurses, Community Matrons, Specialist Nurses
  - MDT Co-ordinators
  - Social Workers and Community Mental Health Nurses

  If it is agreed that the patient is suitable for ICM, an assessment will be carried out by a lead professional - usually the Community Matron aligned to the GP practice - to enable actions and needs to be identified. Explicit consent will then be sought from the patient for their continued involvement in the ICM process.
- **Development of a care plan**. The Community Matron will lead the development and writing of the care plan. This is where the patient's needs are fully considered and goals and objectives are identified together with agreed timescales. The plan is shared with all the professionals involved in the patient's care with the patient's consent and a copy of the care plan will be shared with the A&E department at Luton and Dunstable Hospital.
- **Care delivery:** the ongoing process of delivering care against the agreed care plan.
- **Monitor and review:** the ICM process will normally run over a 30-90 day period where the proactive care plan will continue to be developed to meet ongoing needs and will be signed off by the lead professional and the patient.
- **Step down of ICM:** This is the stage at which the ICM process concludes having identified anticipatory care planning needs in conjunction with the patient, and sharing these with all professionals involved in the patient's ongoing care.

To help our patients identify our integrated teams, we will be re-naming them 'At Home First'.

Better Together Integrated Teams – 4 Clusters

GP Cluster Lead - Dr Abbas Zaidi	GP Cluster Lead - Dr Anitha Bolantnur	GP Cluster Lead - Dr Baz Barhey	GP Cluster Lead - Dr Haydn Williams
South East (61.5k)	**Kingsway (41.4k)**	**Medics United (56.3k)**	**Larkside (58.8k)**
The Ashcroft Practice (5.6k) Stopsley Village Practice (10.2k) The Town Centre (6.2k) The Kingfisher Practice GP Surgery (8.1k) Lea Vale Medical Practice inc Walk in Centre (22.3k) Dr A Zaman's Practice (2.8k) Castle Street Surgery (10.5k)	Wenlock Surgery (3.2k) Pastures Way Surgery (4.2k) Kingsway Health Centre (8.8k) Bramingham Park Medical Centre (5.5k) Conway Medical Centre (7.9k) Medina Medical Centre (6k) Neville Road Surgery (2.8k) Sundon Park Health Centre (3k)	Gardenia & Marsh Farm Practice (10.5k) Barton Hills Medical Group (6.9k) Bell House Medical Centre (9.7k) The Moakes Medical Centre (2.5k) Medici Medical Practice (12.2k) Woodland Avenue Practice (12k) Whipperley Medical Centre (2.5k)	Blenheim Medical Centre (11.9k) Lister House Surgery (6.7k) Bute House Medical Centre (8.5k) Leagrave Surgery (7.8k) Larkside Practice (6.9k) Sundon Medical Centre (7.2k) The Oakley Surgery (4.4k) Drs Mirza Sukhani & Partners (5.4k)
Clinical Cluster Lead **Jo Shields**	**Clinical Cluster Lead** **Barbara Wilson - Start Date 1st August 2016**	**Clinical Cluster Lead** **Justine Towle**	**Cluster Lead** **Abigail Toghanro**
MDT Coordinators Nicola Williams & Marian Courtney CCS-TR.MDTCLuton@nhs.net	MDT Coordinators Nagina Khan & Akhtar Ali Juliette Edwards - Kingsway CCS-TR.MDTCLuton@nhs.net	MDT Coordinators Farah Yaqub and Juliette Edwards CCS-TR.MDTCLuton@nhs.net	MDT Coordinators Melissa Savage & Yvonne Collingridge CCS-TR.MDTCLuton@nhs.net
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Primary Care Manager - Sarah Bunn
MDT Co ordinator Team Lead - Deborah Holmes