The Interface between Secondary and Primary Care -Realities of Integrating

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Bromley population census

www.ons.gov.uk

- 2011 census: Adult population = 310,554
- Population >65yr = 52402
- Population >85yr = 7899 (M= 2574, F= 5325)
- 16.8% of population in 2011 were >65years
- 2014 projection: 17.5% of population will be >65yr

  (56341/321278)
- The population of the UK aged >65yr was 10.4 million (16 per cent of the UK population) in 2011, 9.4 million in 2001 (16 per cent) and 2.2 million in 1911 (5 per cent).

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PATIENT IDENTIFICATION: THE PATHWAY

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.

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PATIENT IDENTIFICATION: THE PATHWAY

1

Commenced November 2016
Total number discussed : 495
Identification to discussion: 3-4/52
CGA clinic commenced April 2017
Numbers seen in CGA Clinic: 10-25%
Patients on admission: 10% (Jan '18)
Hospital attendance post ICN: TBA

ORPINGTON ICN

2

Commenced October/ November 2016
Total number discussed : >500
Identification to discussion: 3-4/52

BECKENHAM ICN

3

Commenced October/November 2016
Total number discussed: 452
Identification to discussion: 3-4/52

BROMLEY ICN

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In Progress: Measuring the benefits of community interventions.

There are early indications that patients discussed at the ICN or who are seen in a CGA clinic have fewer hospital attendances.

PROACTIVE CARE: THE 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

8

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

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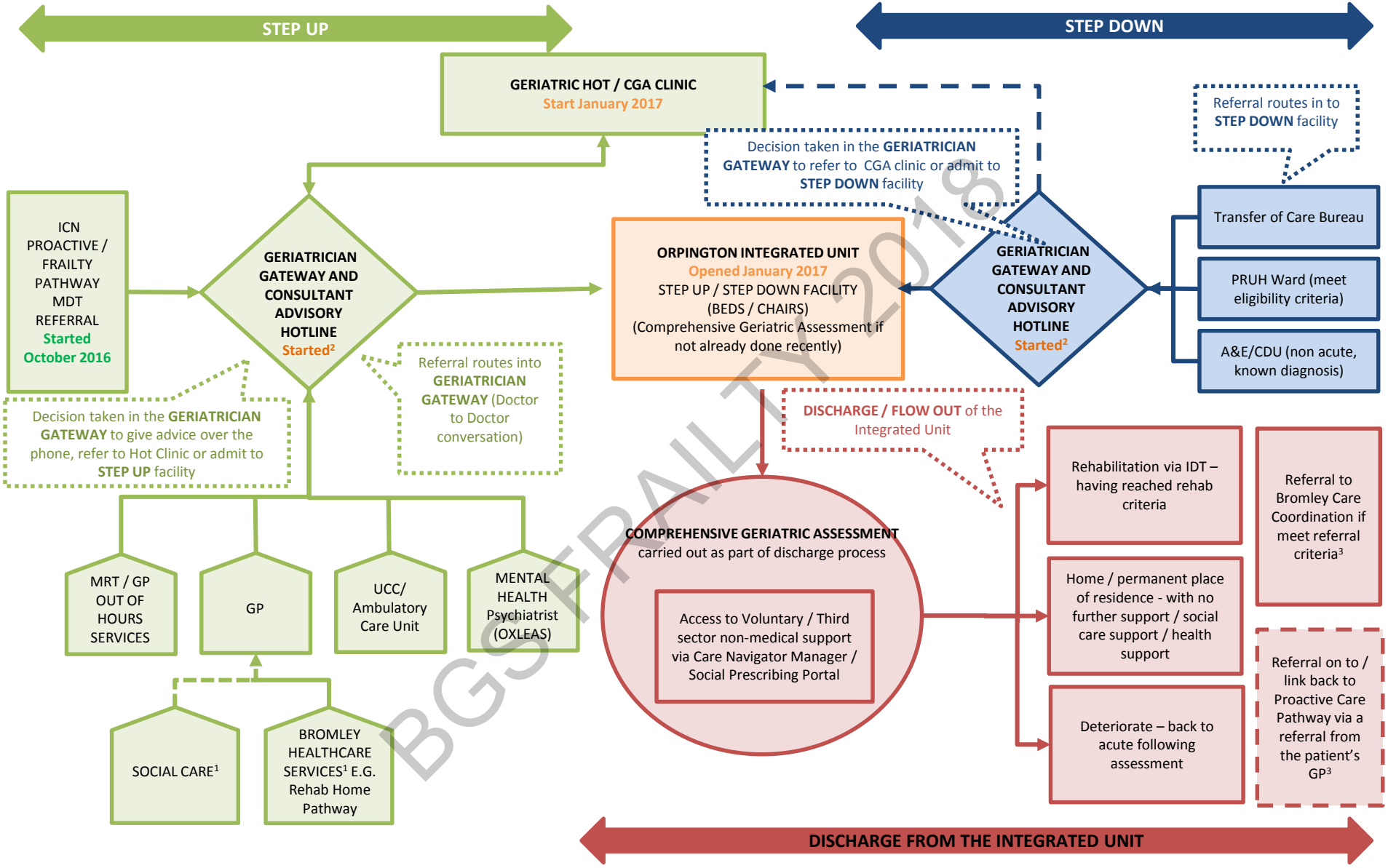
FRAILTY PATHWAY – LINKS TO STEP UP / DOWN FACILITY

Version 1.1, 19/12/16
Updated Feb 2018



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[1]Initially BHC and Social Care will need to link in with the patient's GP prior to accessing the GERIATRICAN GATEWAY

[2]Current operating hours Monday to Friday 9am to 5pm, out of hours cover TBC

[3]Blue dotted box denotes flow to existing a pathway

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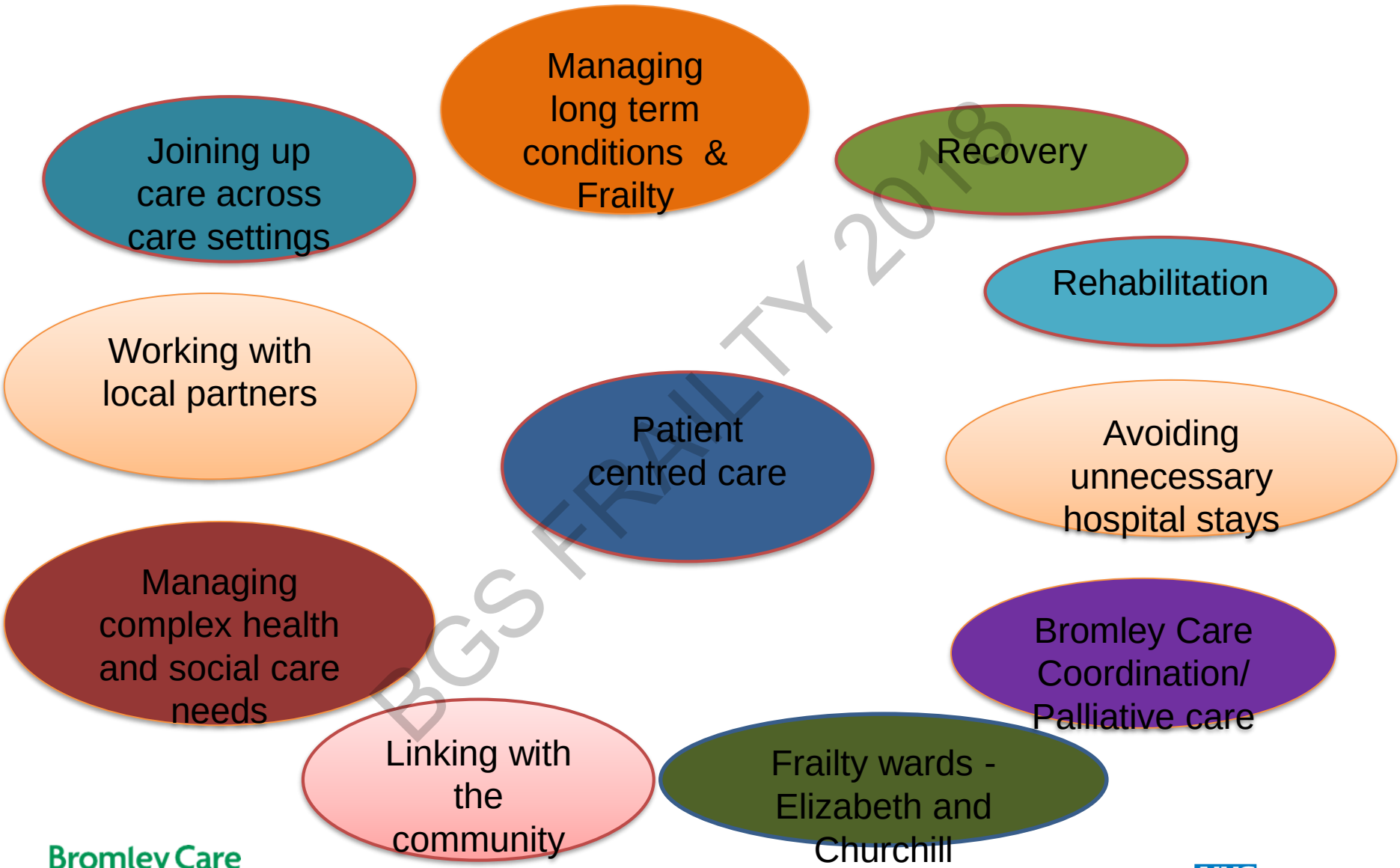

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Case Studies

Three case studies were presented to illustrate the illustrate the enablers and barriers to integrated care and facilitate a discussion

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Discussion

What ideas/questions do these cases raise for you?

How do these cases chime with your experience?

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