REPORT TO:	Health Policy and Performance Board
DATE:	7th February 2017
REPORTING OFFICER:	Strategic Director, People
PORTFOLIO:	Health & Wellbeing
SUBJECT:	Implementation of Community Multi-Disciplinary Teams (MDT)
WARD(S)	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To provide inform the Board on the development and implementation plan of the Community Multi-Disciplinary Team (MDT) model for all adults over the age of 18.

2.0 RECOMMENDATION: That:

i) The report be noted

3.0 SUPPORTING INFORMATION

3.1 There is an evidence base to suggest that a Multidisciplinary teams approach is a cost effective way of delivering improved health and social care outcomes; increased participation and compliance with treatment; reduced length of stay and bed days in hospital; increased numbers of patients discharged home; reduced admission to residential and nursing care and acute hospitals, and improved patient/service user and carer satisfaction.

3.2 A number of legislative and policy developments have contributed to the development of the community multi-disciplinary approach in Halton, which is now being implemented; further illustrating the commitment to integrated health and social care in the borough.

3.3 A dedicated Steering Group with membership from Adult Social Care, Bridgewater Community NHS Trust, Halton NHS Clinical Commissioning Group and IT services from NHS and the HBC, have developed a model for Multi-Disciplinary Team working, to provide better communications and coordination of care across health and social care and improving outcomes for people with complex needs.

The Community MDT Model

3.4 Please see Appendix 1 – MDT Model

The model for Community MDTs in Halton consists of staff from several different professional backgrounds, including GPs, Social Workers, Community Care Workers District Nurses, Social Care in Practice (SCiP) workers, Community Matrons, Continuing Health Care Nurses, and Wellbeing Officers, who are able to respond to people who require the help of more than one kind of professional.

3.5 Community MDTs are aligned to 4 localities (Widnes North, Widnes South, Runcorn East and Runcorn West), with each locality having a hub of GP practices within the locality. Adult Social Care Complex Care Teams (Widnes and Runcorn), Community Matrons and District Nursing resources have been allocated to each locality based on the GP registered populations in each area. The Community MDT process is a key enabler to ensure there is focus on case identification, early intervention, and management of people with complex needs and/or frequent users of services. This encompasses, face to face working, MDT meetings, working together across professions in the assessment process (i.e. joint home visits), joint care planning, closer joint working between district nurses and social workers on complex cases, including working closely with GPs. Referrals can be taken daily and directed to the relevant professionals in the MDT.

Anticipated outcomes of the Community MDT approach

3.6 The MDT approach was introduced to help the management of people with Complex Needs and intends to:-

- Improve the health and well-being of people with complex needs and those who are high intensity users of health and social care services;
- Increase the awareness and utilisation of a range of tools and processes associated with anticipatory care planning and support – reducing the need for, and cost of emergency and unplanned treatment, care and support;
- Support people, their significant others and all providers of health and social care to effectively utilise the full range of health and social care provision in the borough; and
- Reduce the number of non-elective admissions and A&E attendances of an identified population through the use of individualised programmes of care and support.
- This approach to integrated working is supporting the Every Contact Counts approach, a wider vision to service delivery and delivering seamless support.

Implementing the MDT Approach

3.7 Prior to implementing the approach, a number of regular cross agency meetings have taken place to plan the transition, develop the model and address any real or perceived barriers to this way of working.

3.8 The MDT Model has been implemented by :

- Working with identified shared caseloads of clients within GP populations.
- Developing a joint care plan, which offers a holistic assessment and a streamlined approach and avoid duplication.
- Having access to case files and electronic case records, where there are appropriate governance arrangements. This provides more comprehensive information on people using service which will helps to support their care needs and offer speedier assessments and better outcomes.
- The setting up of a named care co-ordinator pilot within the SCiP team, with a view to expanding the potential for named care coordinators to be drawn from any of the professionals within the community MDT.
- Named workers from within Adult Social Care have been identified to work alongside named district Nurses and Community Matrons in the community MDT model, where relationships are being further strengthened between professions.
- The research shows that developing a common 'culture' is at least as important as processes as described. This means taking time out to get staff to address issues such as professional identities, boundaries and accountabilities is essential, this will be enhanced by regular joint team meetings. We are planning a series of launch events involving district nurses, community matrons and social care staff, preparing staff for the improved joint working practices. with full implementation of the model in April 2017. The launch events will run alongside the development of the joint care plan.

Development of a Joint Care Plan

3.9 There are 2 main policy drivers for the implementation of the Joint Care Plan, which identify the positive outcomes for adults related to integrated care planning:

3.10 ***'Safe, compassionate care for frail older people using an integrated care pathway' (NHS England. Guide for Commissioners)***

- Personalised care planning, shared across all organisations

3.11 ***Older people with social care needs and multiple long-term conditions NICE guidelines [NG22]***

- Develop care plans in collaboration with GPs and representatives from other agencies that will be providing support to the person in the care planning process.
- Seamless referrals between practitioners, including the appropriate sharing of information

3.12 Work was undertaken by the MDT Steering Group to identify appropriate health and social care fields to be included in the joint care plan. The proposed health and social care Joint Care Plan has been approved by the Older People's Pathway Group and will be implemented in early 2017.

3.13 A formal launch date and work with the staff teams will ensure that there is consistency in use between health and social care. The launch will be scheduled for January 2017, to avoid launching during winter/Christmas pressures.

3.14 The care plan now includes a contingency plan to ensure that any interruption to normal care is mitigated.

Named Care Coordinator

3.15 The community MDT approach is moving towards people having a named coordinator. This is currently being piloted by SCiP (started Nov 2016), with a view to either a District Nurse, SCiP worker or other members of the community MDT taking on the role of named care coordinator.

3.16 The specification for the named care coordinator pilot began in November 2016, with the following functions in mind:

*A first point of contact.

*A lead role in the assessment process

*Liaises and works with all health and social care services, including those provided by the voluntary and community sector

*Ensures referrals are made and are actioned appropriately

Next Steps

Initial Assessment Team (IAT), Occupational Therapy, Mental Health and

3.17 IAT and Occupational Therapy - This is a small front ended team dealing with initial assessments, signposting and short term pieces of work. They refer any ongoing case work or complex work into the complex care teams (Runcorn and Widnes) and within this occupational therapy service provide initial and long term assessments from 'cradle to grave'. This process will remain with the introduction of the community MDT approach.

3.18 Mental Health – Mental Health are already working in an MDT model under the Care Programme Approach (CPA). Mental Health teams already work with agencies within the Community MDT model, and will

continue to use the established referral pathways that support joint working.

3.19 These Teams will remain as they are at present but will be subject to future consideration and planning in line with the model.

IT Solutions

3.20 The technical programme to allow GP's to access Carefirst from their own Health Computers will be via VDi (a virtual desktop view of Carefirst). The connection between Health Computers and the Council's IT is in place, and is in the process of being activated. Once this is activated, the entire Health network has the potential to access Carefirst. HBC IT has contacted Health IT and is waiting for a response to progress this.

3.21 The Council's It services have sponsored the N3 connection request, which is now on order and will be connected in early February 2017. Work is ongoing in activating the N3 connection that is required for Social Care Staff to access EMIS Web.

3.22 In addition to the above, ICT Services are looking into the potential to develop a single "View" of the client, which brings together data from Carefirst and EMIS into a single system that all Health professionals can access (via the Council-Health network link). EMIS and OLM are currently looking at usability options.

Shared Case Loads between MDT professionals

3.23 There are locality based caseloads within the 4 areas (Widnes North, Widnes South, Runcorn East and Runcorn West), where the professionals within the community MDT are working with a shared cohort of people.

4.0 POLICY IMPLICATIONS

4.1 This work work reflects the requirements of the Care Act and the integration of Health and Social Care through the NHS Halton CCG strategy for General Practice Services, Halton Health and Wellbeing Strategy and the Halton Better Care Fund plan.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 This work will be undertaken within existing resources. There could be a financial implication with one off Capital cost related to the IT infrastructure to support community MDT practice. Dedicated resource to project manage the MDT approach will be explored to enable constant and focused development.

This will be reported on through the usual routes as cost is identified.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**
None

6.2 **Employment, Learning & Skills in Halton**
None

6.3 **A Healthy Halton**
Integrated health and social care offers better outcomes for service users and patients. Unplanned, and possibly unnecessary, hospital admissions may continue at the current level if this integration of social care into MDTs and continued integration between health and social care stakeholders does not take place.

6.4 **A Safer Halton**
None

6.5 **Halton's Urban Renewal**
None

7.0 **RISK ANALYSIS**

7.1 None identified at this time

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified at this time

9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

None.