DELIVERING INTEGRATED PERSON CENTRED CARE

Title:	**Operational Procedure Salford Integrated Care Programme** (ICP) **Multi-Disciplinary Groups** (MDGs) **& Care Coordination.**
Reference:	Version 2
Purpose:	To inform all staff of the operational function of MDGs.
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This operational procedure will be subject to amendment in line with service change and development.

Document Control

Version Number	1.1
Target Audience	All staff who work within this guidance

Change Control

Date	Author	Version	Change Description / Reviewer	Document Status
01/10/14	Sarah Cleverly	0.1	Document Initiated	Draft 1
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28/11/14	Sarah Cleverly	05	General Update from MDG Working Group	Draft 5
03/12/14	Sarah Cleverly/Steph Webb	0.6	General updates from MDG Working Group members.	Draft 6
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17/09/15	ICP Operations Board	2.0	For Ratification at the ICP Operations Board	Final Version

Contents

1. Introduction

Salford's Integrated Care Programme (ICP) is transforming the health and social care system, by promoting greater independence for older people and delivering more integrated care[1]. It has a triple aim of:

1. delivering better care outcomes,
2. improving the experience of service users and carers
3. reducing care costs

The purpose of this paper is to describe the six essential elements of the model required to deliver person centred care[2] for people requiring a level of care co-ordination between health and social care services to promote wellbeing and independence. The six elements are

1. A **holistic assessment** of health and social care needs.
2. **Joint working** and decision making with all organisations/agencies involved in order to deliver person centred co-ordinated care.
3. Regular **MDG reviews** to plan person centred care, review and amend care and to signpost to community support as required.
4. The appointment of a named **Care Coordinator**.
5. Using the electronic **Shared Care Record** to enable essential information to be shared between statutory agencies.
6. An agreed **Shared Care Plan** within the Shared Care Record shared with the individual and supported by Multi-Disciplinary (MDG) working.

Integrated Care Programme Performance Management Measures.[1]:

1. Reducing emergency admissions and re-admissions
2. Reducing permanent admissions to residential and nursing homes
3. Improving quality of life for users and carers
4. Increasing proportion of older people that feel supported to manage own conditions
5. Increasing satisfaction with the care and support provided to older people
6. Increasing flu vaccine uptake
7. Increasing proportion of older people that die in their preferred place
8. Early diagnosis of dementia (Better Care Fund (BCF) measure)

2. Vision

Salford's vision for health and social care is to create an integrated system of support services that responds to local needs, gains public trust and helps people to help themselves to improve lives and the long-term health of the population. This is a key component of Salford's Health and Wellbeing Strategy [3,] which aims to improve the lives of citizens of Salford by improving health, wellbeing and removing health inequalities

3. Who Should Read This Document

All clinicians, practitioners, managers and administrators involved in the ICP MDGs.

4. Key Messages

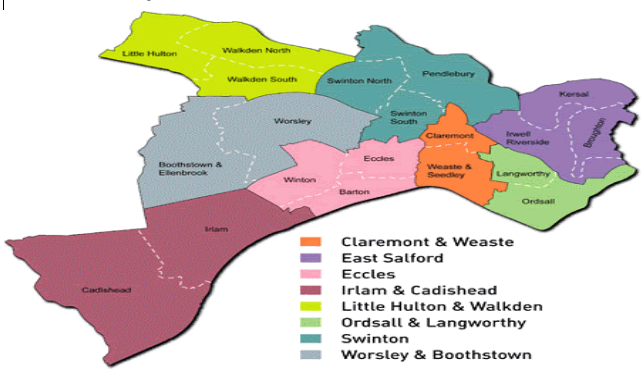
- A Multi-disciplinary Group (MDG) is a group of health and social care professionals who unite as a team for the purpose of improved decision making, planning and delivery of co-ordinated person centred care to promote wellbeing and independence.
- The aspiration of the MDG is to achieve greater independence and improved wellbeing for people aged 65 and over in Salford by integrating care and support within neighbourhood communities. The MDG focus is to formulate and subsequently review a shared care plan for people identified through a process of risk stratification in order to promote independence and improve care delivery where necessary.
- A care coordinator will be identified to work with the person at risk and the carer/family if involved to ensure an appropriate care and support plan is delivered and reviewed as required.

5. Model of Service Delivery

5.1 Geographical Area

There are seven MDGs in Salford aligned with the eight Neighbourhood communities and GP Practice Clusters.

Neighbourhood Community
Irwell Riverside, Kersal, Broughton
Eccles (Winton, Barton, Eccles)
Irlam and Cadishead
Ordsall and Langworthy
Claremont and Weaste
Little Hulton and Walkden, Worsley and Boothstown
Swinton (Swinton North, Swinton South, Pendlebury)



5.2 Eligibility Criteria

1. People with a level of risk requiring MDG review and care coordination.
2. The Integrated Care Programme is primarily designed to support those aged 65 and above, however it is recognised that vulnerable adults under the age of 65 may be similarly supported by the MDG and care co-ordination approach.
3. All Salford residents meeting the above.
4. Non-Salford residents registered with a Salford GP meeting the above supported through liaison with the host local authority where appropriate.

5.3 Non-inclusion criteria

1. People living permanently in 24 hour care provision under the Salford Care Homes Practice. These residents are reviewed in a separate MDG process.
2. People managed via the separate End of Life Care Gold Standard Framework (GSF) process.

5.4 Risk Stratification

The ICP has taken an approach of risk stratification [4] to classify all people aged 65 and above to support appropriate person centred planning and management. The MDGs will risk stratify each person within the four levels of Sally and record with the appropriate GP READ code. See Appendix a, and b.

Level of Sally	Level Descriptor	READ Code
L1	**Able Sally**: Able to support and sustain own health and wellbeing needs	**13CI**
L2	**Needs Some Help Sally**: Likely to have contact with at least one service agency. A need for education/intervention to enable self-management. Lower level of social care needs. Provides informal care to another individual. Early diagnosis of dementia.	**13CK**
L3	**Needs Some More Help Sally**: Regular visits from health (inc Mental Health) and/or social care services. Intermediate Care/reablement. Meets social care eligibility criteria under the Care Act [5`], receives formal or informal care	**13CM**
L4	**Needs a Lot of Help Sally**: Needs 24/7 care either in a residential, nursing or EMI home. Or at home with high level of need e.g. often over a 24 hr period. Meets social care eligibility criteria under the Care Act.[5]	**13CN**

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The process for trigger' points for activating an MDG referral/discussion can be seen in appendix c. Triggers discussion can include:

- Lives alone/socially isolated/self-neglect
- Non-compliance potentially resulting in increased risk to health or wellbeing
- Low mood/anxiety/depression/mild cognitive impairment/dementia
- Multiple long term conditions
- Increased use of services
- Providing informal care/receiving informal care

The MDGs will operate alongside the work for the *'National Direct Enhanced Service – Proactive Care Programme, Avoiding Unplanned Admissions* [6] where GPs are required to identify 2% of high risk vulnerable patients (over 18 years of age) who would benefit from a proactive case management approach, to reduce unplanned admissions to hospital. Within Salford GPs are using a variety of methods to risk stratify and identify patients who would benefit from this approach.

6. Process of Service Delivery

6.1 WHO

Core Membership of MDGs for attendance, pre & post work at MDG (across each area of Salford) are:

- GP
- Practice Nurse/Advanced Nurse Practitioner
- Social Work Advanced Practitioner
- Community Nurse
- Mental Health Professionals
- MDG Administrator
- Consultant Geriatrician

All core members are responsible for ensuring alternative cover is arranged if they are going to be absent (for any reason) from the meeting. This will include attendance and also the completion of any pre or post work.

Wider MDG membership if involved in direct care or support for the individual (not exhaustive) are:

- Health Improvement Officer
- Other GMW Mental Health Practitioners (Community OT, Social Worker, Clinical Psychology)
- Community OT
- Physiotherapy
- COPD Assessment Service Team
- Pharmacist
- Housing Officer
- Intermediate Care Practitioner
- 3rd Sector organisations (where appropriate/necessary; Age UK, Carers Centre, Stroke Association, etc
- Care on Call

It is recognised that other health and social care workers and other professionals have a significant role to play in supporting vulnerable older people. Their contribution will be managed via liaison with core members of MDGs, where it is agreed as an action from discussion within MDG meetings.

MDG Care Coordinator

The Care Coordinator within the MDG process is defined as a designated practitioner with the appropriate level of authority, qualification, training and/or experience, who has responsibility for coordinating the delivery of the agreed care plan. They will work with the patient/service user and their carer/family and/or with the other professionals/workers involved to ensure that the care plan is delivered and reviewed as required.

The Care Coordinator will usually be the person best placed to oversee care planning and can be of any discipline depending on capability and capacity. Care Coordinators must be employed by one of the statutory services; Health. Mental Health or Social Care

Care, support or therapeutic input may be provided by a number of people and the Care Coordinator is not necessarily the person who has most contact with the patient/service user

In a situation where two people are living in the same household and both require Care Coordination, it will be for the relevant MDG to decide if this person should have the same Care Coordinator. This will be based on need and best interests. For role detail see appendix d.

MDG Chair

The MDG chair will be a designated qualified practitioner with either a health or social care background with delegated responsibility to chair and manage the MDG meetings effectively and hold attendees to account, see appendix e.

MDG Administrator

The MDG Coordinator will provide the administrative support pre, post and within the MDG meetings, see appendix f.

6.2 WHAT

Holistic Assessment

The MDG assessment process will rely on the existing assessments being carried out by the relevant professionals based on the presenting need(s). All assessments will continue to be recorded in accordance with each organisation's existing process. However the aim of the MDGs is to ensure a summary of key information from each of the assessments and a coordinated plan is documented on the shared care record. It will be the responsibility of the appointed Care Coordinator to have the overview of the key information within the Shared Care Record

Joint working and decision making

An essential feature of the model to ensure delivery of coordinated care is joint working and decision making between all the relevant professionals and services who are working with older people, from the four statutory organisations and third sector providers. Based on the assessment outcomes and joint decision making, patients/service users will be risk stratified against agreed criteria and a shared care plan based on level of need will be devised in conjunction with the person.

Shared Care Record

The Shared Care Record is an electronic summary record which holds the background details of the patient/service user, as well as their current health and social care needs that professionals involved in care delivery will have access to, subject to consent and appropriate authorisation, for the benefit of delivering personalised care planning. All individuals requiring MDG support will

have a shared care record and a shared care plan including an anticipatory and/or crisis plan where appropriate.

The shared care record enables all people involved, including the patient/service user to have a common record of the care plan. The detail of specific treatments and intervention of care delivered by each professional or organisation will still be documented within existing organisational records/plans in accordance with existing policies and processes. See appendix g for the Shared Care Record Recording Standard.

Shared Care Plan

The Shared Care Plan is a summary of the patient/service user's current health and social care needs and the plan of the intervention, support and care required to meet those needs. This plan will be accessed by relevant, authorised professionals and the MDG meeting to review and update. The Shared Care Plan will be shared with the patient/service user.

6.3 WHERE

The MDG meetings will take place in each neighbourhood in a GP surgery or suitable community location. Dates and venues will be arranged by the MDG Administrator.

6.4 WHY

The focus of MDGs is to provide a focused forum for complex case discussion for people who meet the criteria of the Risk Stratification or any of the 'Trigger' points listed above, and appendix c.

It is evident that some people meet the criteria of the Risk Stratification, but are essentially well supported by their current care packages. They have not become unstable, and as such have not had multiple A&E attendances or increased their use of services elsewhere. In these circumstances, an MDG discussion may not need to take place. However, this would be in agreement of the MDG Core Group 'offline' with the Shared Care Record being updated by the Care Coordinator accordingly.

By contrast if a person does not meet the criteria within the Risk Stratification, they may meet the 'Trigger Points' for discussion instead, evidencing a need for a discussion to take place in an MDG forum. Here, some proactive discussion can take place, which could reduce a person's need for further services to be involved.

The MDG will develop personalised plans jointly owned by the person, carer (if involved), named accountable GP and/or care coordinator. MDGs will look to innovative solutions to the way people navigate through the health and social care system and seek wider support.

MDG Objectives/outcomes

- People at risk (see risk stratification appendix a) will receive coordinated, high quality care or support from a range of services, when needed, including diagnostics closer to home (e.g. ECG, tele-care, community support)
- Improved multi-disciplinary and cross organisational working

- People will be seen by the right person, at the right time in the right place
- Improved communication and information sharing with the person and between MDG members
- People are supported to maximise their independence and remain at home for as long as possible
- More pro-active risk management

MDG reviews and other multi-disciplinary meetings

It will often be the case that other meetings are required to help coordinate care, particularly when the care/support requires significant adjustment, e.g. at hospital discharge, when receiving intermediate care services, or a person is at risk of harm.

These planning meetings may have different terms dependent on the function and/or setting in which they take place, e.g. Multi-Disciplinary Team (MDT) meeting, Safeguarding strategy meeting, care planning meeting, review, case conference, best interest meeting. The MDG process will not replace planning that should be undertaken through these processes/meetings. The ICP MDG review has a wider brief to ensure co-ordination across all parties involved.

6.5 HOW

Referral to MDG

Referrals for discussion at MDG will be managed via Choose and Book, see appendix h. The process for referral into MDGs is described in appendix i.

Housekeeping

MDG meetings will take place every two weeks which enables the timely review of any previous A&E admissions from each GP practice. Meetings will be a maximum of two hours case load depending. A target of 15-20 patients per MDG meeting has been identified to be discussed however this can vary across MDGs.

Pre Meeting

- All people involved in the MDGs will use the Risk Stratification tool with supporting guidance/checklist documentation provided by the Integrated Care Programme (proactive planning). Any requests from services to discuss complex patients should be sent to the MDG Administrators no later than 1 week in advance of the discussion. Any requests should be emailed via secure email to MDG Administrators stating why they wish for the individual to be discussed, highlighting what the individual is at risk of.
- A&E data (people with 2 + admissions in 3 months) will be sent by SRFT Business Intelligence to be reviewed by the GP practice and agree exclusion/inclusion in the MDG discussion (reactive reviews). Where requests for patients for discussions come from GP practices, the requests should be sent to the MDG Administrators for liaison with MDG Chairs.

- All MDG Core members to review discussion lists sent in advance of the meeting and liaise with named Care Coordinators. Where patients are deemed to be 'stable', the Care Coordinator should then contact the other professionals involved to carry out an informal review and ensure there are no other issues arising from other services. If all services agree the patient is stable, the Care Coordinator should set a future review date, updating the Shared Care Record to inform that discussion at MDG meeting is not required at this time and a future discussion date has been set.
- Care coordinators to have the necessary discussions with individuals ahead of the meeting, wherever possible, to ensure the individuals preferences and choices will be voiced and considered
- Instructions asking MDG members to log into the EPR site will be distributed by the MDG Administrator, where a list will have been generated for discussion with all NHS numbers, Dates of Birth and all other relevant information needed. The MDG members will provide summary information of their respective care plans from each service. All people involved in MDG to review and update the shared care records of those on the list, with up to date information at least one week in advance of the meeting, including:
    - Update of any issues/actions since last meeting
    - Investigation of any information/knowledge of new patients on the list.

- Professionals who don't have access to EPR should send updates to the MDG Administrator via secure email to enable the SCR to be updated.

- The MDG Administrator will distribute the final discussion list no later than 3pm the day before the meeting. Any cases requiring urgent discussion after the cut off period can be brought as an exception for discussion at the meeting. The administrator should be notified as soon as possible.

Attendance at MDG Meeting

- Arrive punctually and complete the sign in sheet.
- Chair to open meeting, confirm apologies and introductions
- Each Care Coordinator or relevant person to lead discussion on the list by order of practice groups.
- Care Coordinator (if in attendance) to outline issues pertaining to each person being discussed, including risk issues
- Attendance at MDG for GPs can be staggered by prior arrangement with MDG Administrator.

It is expected that Social Care, Community Nursing and Mental Health and Consultant Geriatricians should be in attendance for the whole meeting to give feedback on individuals discussed in each of the practices and to offer professional input for all cases where required.

It is preferable for GPs to attend the meeting in full, to gain or share knowledge and experience. This can also be useful for co-dependent couples or co-dependent carers registered at different GP practices. However, it is acknowledged that there will be other GPs in attendance to discuss their own patients.

MDG Meeting Process

For each individual discussed:

- Chair to manage effective discussion regarding issues, clarify actions to be taken and outcomes expected, assigned to individuals.
- Where a referral is required into a service within the MDG discussion the attending person representing that service will accept this as a formal referral and a further referral following the meeting is not required.
- Confirm the 'Sally level' the person is, if it has changed, or remains the same
- MDG Administrator to document within EPR agreed decisions and actions within the MDG meeting including details of the agreed shared care plan.
- The Chair is to clarify who the Care coordinator is.
- Care Coordinator to ensure the plan is shared appropriately with the individual and other people involved in the care and support
- Chair to check with MDG Meeting that notes, decisions and actions are an accurate reflection of the discussion
- Chair to confirm the next review date. Depending on the individual being discussed, the next MDG review could be held in 2 weeks/4 weeks/8 weeks/etc dependant of need, trigger point and/or set review date.
- If a person is presented at MDG more than twice in a three month period the chair should formally raise the efficacy of the current shared care plan in the following context:

  a) Is the current care plan appropriate?
  b) Is the care plan appropriate but agreed actions have not been implemented?
  c) Has the plan not been effective due to non-engagement of the service user/patient?

- The Chair will ensure that appropriate action will be taken to address the above issues and escalate if required in order to minimise any risks.
- If the patients on the discussion list are deemed to be stable or doesn't meet criteria for inclusion at MDG, there should be a brief record within the Shared Care Record of the reasons why a full MDG discussion is not required at this time. Any subsequent actions will be followed up by Care Coordinator or appropriate professional.
- If the MDG is unable to reach consensus, consideration should be given on how to proceed outside of the meeting, for example a formal case conference with minutes.

Post Meeting

- MDG Administrator circulates the updated discussion list to all core MDG members on the same day or the day following the meeting
- All MDG members to review list on EPR
- All MDG members to undertake their respective actions and update own service professional care record

- Care coordinators or most appropriate other professional to share the Shared Care Plan with individual discussed and check that it meets the person's needs
- MDG Administrator to book future review dates for patients discussed

7. ICP MDG Governance Arrangements

7.1 Line Management Supervision

The line management of all the core members of the MDG will remain within existing organisational structures.

The line management of the MDG Administrators will be undertaken by the Project Manager for the MDGs.

7.2 Staff Training and Development

1. Induction and mandatory training for MDG Members will remain within existing organisational structures.
2. Appraisal and IPR/PDR/PDP will remain within existing teams, but will include feedback from MDG participation.
3. ICP Role specific training will be provided through the ICP Programme, if required.
4. Training with access to EPR will be undertaken by all core members. Training will take approx. 1.5 hours
5. MDG Team Building will be provided through the ICP Programme as required.

7.3 Recruitment

The ongoing recruitment of core members of the MDG will aim to ensure the interview panel reflect the partnership of the ICP members.

8. Patient/Service User Involvement

8.1 Care coordinators will have the necessary discussions with individuals ahead of the MDG meeting, wherever possible, to ensure the individual's preferences and choices will be represented and considered

8.2 Patients/Service users will be actively encouraged to participate in their assessment and care planning. This will follow a commitment to equality, inclusion, recovery and diversity that supports people in living independent and valued lives. The approach puts the individual person's strengths, goals and aspirations as well as needs and difficulties at the centre, builds confidence and promotes social inclusion and recovery.

8.3 Care Coordinators will work with the patient/service user, their carer/family and with the other professionals/workers involved to ensure that the care plan is delivered and reviewed as required.

8.4 A copy of the care plan will be shared with the patient/service user in an accessible format appropriate to their needs.

9. ICP MDG Monitoring & Evaluation

9.1 There are a number of performance targets that relate to the MDGs will include the following metrics:

- Number of times a person is discussed
- Increased level of Sally
- Decreased level of Sally
- Number of maintained level
- New discussions per month
- Frequency of discussions
- Number transferring off the MDG list (GSF, Care Homes etc)
- Number of Shared Care Plans in place
- Number of SCPs handed back to the individual

9.2 The Reporting framework for MDG monitoring is continuing to evolve. There are currently two reporting formats in development. A monthly MDG dashboard report produced by Haelo is reported monthly to the ICP Operations Board.

A live MDG dashboard is also in development with SRFT business intelligence and this is the reporting framework which is intended to be used to regularly monitor the targets listed about, in the following forums:

- MDG Chairs Meeting – monthly
- MDG Working Group – bi weekly
- ICP Operations Board- monthly
- Alliance Board – bi monthly

9.3 Qualitative and satisfaction evaluation will be delivered via the CLASSIC academic research study. The National Institute of Health Research call 12/130 is to evaluate new models of care for people with long term conditions. The research programme led my Manchester University in collaboration with the Salford ICP will generate some high impact research which will provide commissioners and providers with evidence when re-designing services across a whole care pathway. It will provide a rigorous test of the ability of SICP to:

- Improve user/carer experience
- Improve well-being and quality of life
- Reduce costs and improve cost effectiveness

10 Glossary of Terms

Term	Definition
BCF	Better Care Fund
CAST	Chronic Obstructive Pulmonary Disease Assessment Team
CLASSIC	Comprehensive Longitudinal Assessment of Salford Integrated Care

COPD	Chronic Obstructive Pulmonary Disease
EPR	Electronic Patient Record (Allscripts/Sunrise)
FI	Frailty Indicator
GSF	Gold Standard Framework
ICP	Integrated Care Programme
IPR/PDR/PDP	Individual Performance Review/Personal Development Review/Personal development plan
MDG	Multi-Disciplinary Group
MDT	Multi-Disciplinary Team
Person Centred Care	The Health Foundation [2] has identified a framework that comprises four principles of person-centred care:* 1. Affording people dignity, compassion and respect. 2. Offering coordinated care, support or treatment. 3. Offering personalised care, support or treatment. 4. Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.
Risk stratification	A statistical process to determine detectable characteristic associated with an increased chance of experiencing unwanted outcomes [4]
SCR	Shared Care Record
SCP	Shared Care Plan
W/E	Weekend

11 References and Supporting Documents

1. Salford Integrated Care Programme for Older People Service & Financial Plan (2014/5 – 2017/8) Version 2.1 April 2014.

2. The Health Foundation, Inspiring Improvement. Person Centred Care Made Simple. October 2014.

3. Salford's Health and Wellbeing Strategy. October 2013.

4. Risk stratification: A practical guide for clinicians. Cambridge University Press UK 2001.

5. Care Act 2014 – The national Local Authority eligibility criteria as defined within The Care Act 2014. www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation.

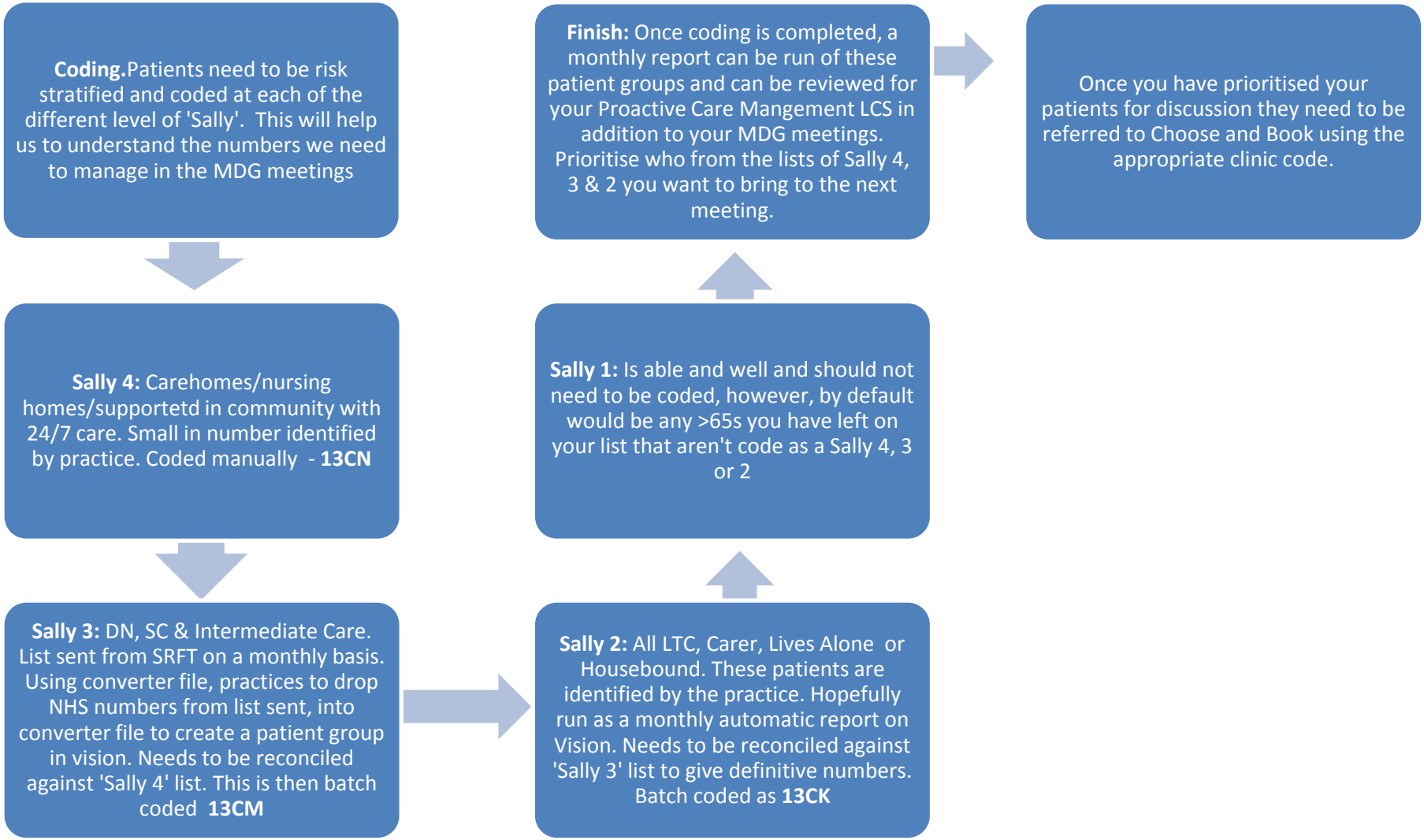
6. Enhanced Service Specification Risk Profiling and Care Management Scheme- NHS Commissioning Board.

12 Appendices

a. Risk Stratification and Review Process for Older People at Risk
b. GP READ Coding Groups Flow Chart
c. MDG Process chart
d. Role of Care Coordinator
e. Role of MDG Chair
f. Role of MDG Administrator
g. Standards of recording in the Shared care Record
h. Referring via Choose & Book
i. Referral into MDGs Process
j. MDG Key Contacts

Level	Criteria	content and detail expected within the shared care plan	triggers for review
Able Sally (Level1)	• Active and self-managing	**Wellbeing plan**- Owned and completed by individual with support if required. Includes **5 Ways to Wellbeing & personal preferences/things that are important** in their life. May include Independence plan (following Needs Some Help Sally episode- but now able to self-manage)	• Emergency admission escalated following provisional GP screen • 2 or more attendances to A&E within 3 month period escalated following provisional GP screen • Newly diagnosed long term condition • At risk of isolation/ recent bereavement
Needs Some Help Sally (Level 2)	• Diagnosed with early/mild dementia • Co-dependent couple • Carer (informal) • Newly diagnosed long term condition requiring short term input till able to self- manage • Lower level social care needs but not eligible for LA funded care	**Care plan** with input from Health/Social Care Professional (HSCP) who provides direct support to the individual such as GP, practice, nurse, specialist nurse, social worker or therapist. **Named care coordinator** - most likely to be HSCP in most regular contact- could be GP. **Contact number**- in & out of hours **Anticipatory care plan**- what to be aware of and do should condition appear to deteriorate.	As above **OR** • Have an unstable long term condition
Needs Some More Help Sally (Level 3)	• Newly diagnosed with moderate/severe dementia • Eligible social care needs, e.g. receives home care • Diagnosed with multiple long terms conditions/co morbidities (including polypharmacy) requiring continuous support from services • Receive regular visits from Community Nursing (those seen over W/E) • Requires co-ordinated multi-professional support	As above **but** shared care plan will be **MDG care plan**. Initiates discussion with individual for consideration of **'advance care' planning**	• Emergency admission escalated following provisional screen for MDG REVIEW. • 2 or more attendances to A&E within 3 month period - escalated following provisional screen. • Escalated by HSCP due to concerns re-present management plan ***MDG Reviews-Excludes individuals on GSF***
Needs a Lot of Help Sally (Level 4)	• Requires 24/7 care (includes anyone in permanent residential or nursing care) • Eligible social care needs and high level of needs/risk. May be supported at home with large package of care	Shared care plan **includes EOLC plan**. May be discussed within MDG or with community team & care home.	• Under regular review

Appendix b – GP READ Coding Flow Chart



Appendix c

Level 1	Level 2	Level 3	Level 4
Able Sally	Needs Some Help Sally	Needs Some More Help Sally	Needs A Lot of Help Sally

Patient triggers

- Emergency admission
- 2 or more A&E attendances in 3 months
- Change in condition or circumstances moves Sally into a high risk level Lives alone/socially isolated/self-neglect
- Non-compliance potentially resulting in increased risk to health or wellbeing
- Low mood/anxiety/depression/mild cognitive impairment/dementia
- Multiple Long Term Conditions
- Increased use of services
- Providing informal care/receiving informal care
- **Brought forward by Care Coordinator or concerns raised by a specific service**

Follow Ups & 'Stable'

- **If Patient review date imminent (follow up)- patient screened by Care Coordinator to see if requires formal MDG review- Care Coordinator to liaise with GP/DN/SC/MH/Geriatrician to ensure no other concerns**
- **Review outside of MDG conducted by individuals of each core service (patient reviewed by GP/MH/DH/SC/Geriatrician)**
- **Where there is a consensus patient is stable**
- **IF concerns raised from ANY service, move to patient triggers**

MDG review required

Excludes individuals on GSF

MDG NOT REQUIRED

Patient managing on present plan OR changes required but MDG not required

Put on next available MDG meeting

Patient consent/informed

MDG Administrator informed

New review date set *

For able Sally this may not be required

Reviewed by MDG

Care plan with review date agreed /Sally level agreed

Care Coordinator agreed

Care Coordinator discusses plan with Sally, and her family/ carers

Appendix d

Role of Care Coordinator

The Care Coordinator within the MDG process is defined as a designated practitioner with the appropriate level of qualification, training and/or experience, who has responsibility for co-ordinating the persons care. They will work with the patient/service user and their carer/family and ensure that the care plan is delivered and reviewed as required. The role of the Care Coordinator is to:

- Co-ordinate the on-going assessments, intervention or support of the patient/service user's needs and associated risks, involving the patient/service user, and taking into account the views of carer's and of other agencies e.g. care providers, , housing, voluntary sector.
- In conjunction with the other professionals/providers/carers involved, formulate a shared care plan, clarifying the patient/service user's needs and how they will be met. The patient's/service user's wishes and preferences must be included wherever possible.
- The Care Coordinator will ensure the Shared Care Plan is accurate, kept up to date and shared with the patient/service user and, subject to consent, with carer/family and relevant practitioners including wider community services where appropriate.
- Ensure the patient/service user is always given a copy of the Shared Care Plan (in development).
- Act as a first point of contact for professionals
- Act as a point of a contact for patient/carer
- Ensure that emergency out-of-hours contact number(s) are specified in the shared care plan for the patient/service user and carers, with an appropriate 'out of hours' crisis plan.
- Detail contingency plans made with the patient/service user if a situation changes (e.g. carer breakdown).
- Monitor the overall care plan and call/attend MDG reviews as required.
- Distribute Shared Care Plan details to professionals and providers as appropriate and with consent.
- Ensure that when a patient/service user moves out of the area appropriate liaison with receiving authorities takes place.

Appendix e

Role of MDG Chair

The Chair will be a designated District Nurse and/or Advanced Social Work Practitioner with delegated responsibility to

- ✓ Open meeting and confirm apologies and introductions
- ✓ Ensure good time keeping
- ✓ Hold people accountable for actions and secure review dates for individuals
- ✓ Ensure appropriate recording of actions from the MDG for inclusion in the shared care record
- ✓ Ensure the recording and distribution of discussion documentation in a timely manner via MDG Administrator
- ✓ Refine the discussion agenda by prompting named Care Coordinators to review their caseloads to ensure appropriate discussion
- ✓ Ensure a named Care coordinator is identified and if not present, agree who will confirm with the named person
- ✓ Ensure the Shared Care Plan is agreed and key details recorded within the Shared Care Record
- ✓ Confirm/deny requests for individual discussions from other service referrals
- ✓ Prompt engagement from other MDG members to find solutions where no immediate resolve is apparent. Prompts to include:
  - What are the person's views about their circumstances?
  - Are there any capacity issues?
  - Are there informal carers involved?
  - What are the person's strengths and abilities?
  - What are the key issues? What are the reasons for their being included in this MDG?
  - Do they have Social Care input?
  - Do they have Community Nursing input?
  - What is the person's age? (Frailty indicator)
  - What is their BMI? (FI)
  - Are they Socially Connected? (FI)
  - Are they Physically Active? (FI)
  - What else can be done for the individual?
  - Have we reduced or managed the risk of the person?
  - Will the Shared Care Plan taken into account the persons choices/preferences?
  - How the plan has/will be shared with the person?
  - What are the risks where it is indicated the person may be non-compliant?
  - Check that the meeting is happy that the meeting notes accurately reflect the considerations and decision of the MDG?
  - Escalate issues to a senior manager if actions have not been completed or if the MDG cannot reach consensus.

Appendix f

Role of MDG Administrator

- ✓ Support the MDGs by Coordinating the administrative requirements of the meetings
- ✓ Make requests for information as appropriate ahead of MDG meetings in a secure and sensitive way
- ✓ Share information ahead of, and following the meetings in a secure and sensitive way
- ✓ Track patients progress through MDG discussions and provide reports, indicating where Shared Care Plan has been agreed, and where it has been shared with the individuals they pertain to
- ✓ Bring forward reminder dates for individuals where a review date has previously been agreed (via Rolling Discussion Document)
- ✓ Liaise closely with meeting Chair and Care coordinators to ensure smooth and effective running of MDG meetings
- ✓ Act as key contact/communication link between the Salford Integrated Care Programme Office, MDG members, and other external agencies.
- ✓ Communicate sensitive and highly complex information about performance or change with a high level of sensitivity and diplomacy.
- ✓ Develop cooperation with the other MDG Administrators.
- ✓ Organise dates, venues and attendance of MDG meetings within locality, as a core member of the MDG
- ✓ Where necessary, stage the timing of attendance at the MDG for specific members of the group, ensuring all other key members are in attendance
- ✓ Work with meeting Chair, agree agenda and requests for information, to be distributed in a timely and secure manner.
- ✓ Complete requests for information by the Integrated Care Programme Office in addition to the MDG members as required.
- ✓ Track, monitor and record patient progress through MDG process recording where Shared Care Records have been agreed, what actions have been taken and where follow up is required

Appendix g

Shared Care Record/Shared Care Plan guidance

The purpose of the guidance is to ensure consistency in the use of the Shared Care Record

1. Purpose of the Shared Care Record (SCR)

- An electronic record which holds **summary** details of a person's health and social care needs
- To improve personalised care planning by enabling better sharing of information between the person and professionals involved
- All people requiring MDG support will have a SCR

2. Inputting and updating the SCR

- **Who?**
  - The named care co-ordinator will have lead responsibility for ensuring the SCR is populated appropriately
  - Other clinicians/professionals involved (where trained and authorised) should update the SCR following any significant change/issue
  - If clinicians/professionals are unsure about updating the SCR they should notify and/or discuss the issue with the care co-ordinator
  - MDG (Admin) Co-ordinators will primarily update during the MDG meeting to record a summary of the discussion and decisions made
- **When?**
  - Prior to an MDG meeting to ensure the SCR is up to date
  - During the MDG meeting the focus will be on the 'MDG Review Details' section in order to evidence consensus decision making, agree actions, confirm the care co-ordinator and set the next review date
  - At any point between MDG review dates to record **significant** changes/issues. Examples of a significant change/issue are a hospital admission or discharge, increased number of nursing visits, change in a package of care, change in informal caring arrangements, mental health risk or a notable bereavement.
- **What and how?**
  - Any recording in the SCR must be clear, concise, factual and free from jargon or abbreviations
  - If an opinion is given and recorded this should clearly be stated as such
  - Differences of views/opinions should be recorded appropriately
  - Clinical/professional recording standards as defined by governing bodies, local policies (or similar) should be adhered to
  - Every amendment/update should be dated
  - There will only ever be one active SCR for each person (most recent date) which can be modified when/where appropriate

- A new SCR can be created at an MDG review meeting which pulls through all the most recent details. The previous SCR will be retained

3. Recording in the different sections of the SCR

- The care co-ordinator may input into any section of the SCR
- It is expected that other clinicians/professionals involved will most likely record in the sections: 'Baseline Functional Ability' and 'Summary of health and Social Care' (includes separate parts for medical, community nursing, social care and mental health for ease of use)
- The MDG details section will always be updated and agreed at the MDG meeting
- Some sections/details will automatically pull through information from Patient Administration System (PAS) or other parts of EPR, e.g. demographic information, hospital discharge summary

NB: The SCR does not replace other primary clinical or professional records

4. Person's involvement in their SCR and Shared Care Plan (SCP)

- As part of person centred care the person should be involved as much as possible in discussions and decisions
- The Care Co-ordinator should, wherever possible and appropriate, inform the person of the MDG process/reviews and ensure the person's views are represented within the SCR
- The Care Co-ordinator should, wherever possible and appropriate, feedback any decisions following the MDG
- The SCR is being further developed to produce a 'user friendly' summary shared care plan (SCP) that can be printed off and given to the person where appropriate

NB: It can never be guaranteed that a printed version of the SCR/SCP held by the person is the most up to date

5. Consent and data sharing

- Whenever possible consent must be obtained from the person to record information within the SCR which may be accessed by staff with a legitimate reason
- Where it has not been possible to obtain consent, information may still be shared in the person's best interest to ensure appropriate care and treatment to meet their needs in accordance with Data Protection Act, Caldicott and CQC guidance
- Use of the SCR will be audited under the SRFT governance arrangements in conjunction with individual professional/service standards
- There is a data sharing agreement (DSA) for MDGs in place

Appendix h

Salford Integrated Care Project - Referring via Choose & Book

Searching for the MDG clinics

- Specialty – Geriatric
- Clinic Type – Not otherwise specified
- Choose the MDG clinic for your neighbourhood

Neighbourhood	Service Code (EBM)	Clinic Code
Swinton	ICMDGS	CMDTSWL
Eccles	ICMDGE	CMDTEGW
Irlam & Cadishead	ICMDGI	CMDTICM
East Salford	ICMDGB	CMDTES
Ordsall & Langworthy	ICMDGO	CMDTPGW
Claremont, Seedley & Weaste	ICMDCL	CMDTCWC
Worsley, Walkden, Boothstown, Ellenbrook & Little Hulton	ICMDGW	CMDTWGW
Salford Care Homes Practice	ICMDGC	CMDTCHP
Health Coaching referrals		CMDTCHC

Booking an "appointment"

- You are booking into the **referral clinic** (see codes below)
- There are choose and book slots available every day every 5 mins between 8am and 5am
- You do not need to book them on the same date or time as the MDG meetings (in fact it's less confusing for the coordinator if you avoid these!)
- You will then need to email the MDG ADMINISTRATOR to let them know you have made referrals. The MDG Administrator will then pick up your patients and book them into the MDG clinics (as advised by referrer) from patient centre (these slots are not available on choose and book)

Doctor Codes for Clinic Bookings

Neighbourhood	Referral Clinic	Assessment	MDG
Swinton	ICMDRS	N/A	ICMDMS
Eccles	ICMDRE	N/A	ICMDME
Irlam & Cadishead	ICMDRI	N/A	ICMDMI
East Salford	ICMDRB	N/A	ICMDMB
Ordsall & Langworthy	ICMDRO	N/A	ICMDMO
Claremont, Seedley & Weaste	ICMDRC	N/A	ICMDMC
Worsley, Walkden, Boothstown, Ellenbrook & Little Hulton	ICMDRW	N/A	ICMDMW
Salford Care Homes Practice	ICMDRCHP	ICMDACHP	ICMDMCHP
Health coaching referrals	ICMDRCL	N/A	ICMDMCL

Appendix i.

Referring into MDGs

Non ‘Core Membership’ Referrals

If a service within any of the partner organisations believes they have identified a patient/service user that may be appropriate for discussion at MDG, they should first identify who will present that patient/service user at the MDG meeting. Non-members of the MDG are welcome to attend to discuss an individual and can arrange to do this at a specific time within the MDG by liaising with the MDG Administrator.

Any requests from services to discuss complex patients should be sent to the MDG Administrators no later than 1 week in advance of the discussion. Any requests should be emailed via secure email to MDG Administrators (pg 27) stating:

- Who/Which service (from core membership) they wish to represent their patient/service user case
- Why they wish for the individual to be discussed
- What the individual is at risk of
- How urgent the discussion required is

Any referrals sent without this information will not be actioned.

Core Membership Referrals

Services **without** access to Patient Centre or Choose and Book should follow the procedure for ‘noncore-membership’ referrals, however, it will be expected you will present your patient/service user yourself.

Services **with** access to Patient Centre or Choose and Book can use the codes for referring a patient into our ‘virtual clinics’ by neighbourhood as detailed in Appendix H. Once the referral is made, the request should be sent to the appropriate MDG Administrator as above, no later than 1 week in advance of the anticipated discussion, with all information included pertaining to risk and urgency.

Appendix j.

Key MDG Contacts

Name	Role	MDG Area	Secure Email
Stephanie Webb	Project Manager	Swinton & Pendlebury Eccles, Barton & Winton Broughton, Irwell Riverside & Kersal Walkden & Little Hulton Worsley & Boothstown	stephanie.webb@srft.nhs.uk.
Satty Boyes	Project Manager	Irlam & Cadishead Ordsall & Langworthy Claremont & Weaste	satty.boyes@srft.nhs.uk.
Shana Howard	MDG Administrator	Swinton/ Pendlebury Irlam/Cadishead	Shana.howard@srft.nhs.uk
Heather Critchley	MDG Administrator	Walkden/Little Hulton Broughton	Heather.critchley@Srft.nhs.uk
Andy Ashton	MDG Administrator	Claremont Eccles Ordsall/Langworthy	Andrew.ashton@Srft.nhs.uk