APPENDIX B

Integrated Care Update May 2013

Network Multi- Disciplinary Team & Risk Stratification

MDT is now operational in most of NW practices; initial review of the processes adopted revealed the need for change to enable wider roll out and these will be implemented before the planned roll out with the SW practices for June 2013.

An interim, full time MDT Co-ordinator has been appointed and is due to start May 2013. There has been a positive response from all providers; MDT participation and action planning has been agreed as a CQUIN for 2013/14 for acute, mental health and community.

Falls

The Fracture Liaison Nurse has been in post 4 months and the Community Bone Health Clinician started April 2013. The clinician is a physiotherapist and the team providing the Bone Health Service now consists of one nurse and one therapist which will enable the benefits a more multi-professional approach going forward.

The Fracture Liaison regular clinics are now taking place at St Michaels. The Fracture Liaison Nurse has now got the authority to request DEXA scans via the InHealth Contract and is referring appropriate patients to Chingford for this service. She is therefore able to negate the need for a GP appointment and is also able to act directly on the results of the scan making recommendations to the GP for appropriate pharmacological management.

The Bone Health Clinician has been networking and establishing key relationships. She will link with the Care Homes Team to help manage patients at risk of falling and identify those requiring medication for bone health. Work is being undertaken to identify the first group GP practices for her to work with. This will be linked with the risk stratification workstream once it is operational. A case load is beginning to be established with referrals from the community physiotherapy team.

Admissions Avoidance and Older Peoples Assessment Unit

Admission Avoidance schemes have been operational in A&E on both acute sites since February 2013; to date they have failed to deliver the anticipated level of reduction of emergency admissions. There is a strong consensus of challenge of turnaround in 4 hours in A&E and need to move to the 12 hour model in OPAU to avoid short stay admissions; the new model needs to remove older people from A&E as much as possible and into the OPAU model of assessment, diagnostics, some treatments and management plan.

It is therefore planned to transform both the north and south admissions avoidance service into the north and south OPAUs as part of developing new managed care system for older people.

A draft Managed Care Model for Older people has been developed and currently in discussion with wide range of stakeholders and aim to agree by July 2013.

Phase one of the OPAU operational at Chase Farm is to be completed by July 2013 and fully operational by November 2013. An agreed date for transfer of the south service has yet to be agreed with providers.

Care Homes Project

The teams to continue to work across 10 care homes. Following a review in February 2013, changes have been made to team operations for unplanned care when the team is not on site in south to maximise impact and reduce Care Home calls to LAS. This has proved successful and is being rolled out to the north team.

To date the teams have:

- Assessed 1558 residents
- Put 214 DNARs in place
- 178 Advanced Care Plans In place
- Falls audit shows 50% reduction of falls on previous years following falls training in particular homes (40 reduced to 20)
- 96% of residents died in Preferred Place of Death
- £11K saving on stopped medications

Review of 2010/11, 2011/12 and 2012/13 shows the following

- 12% reduction on 2010/11 baseline for 2012/13 emergency admissions
- 1.2% increase in emergency admissions on 2011/13 baseline against an overall increase of all emergency admissions for those aged 65 years of 2.4%
- 28.5% reduction of BCF A&E attendances for interventional care homes from 10/11 baseline to 12/13

The current model is not sustainable in the longer term. We are therefore reviewing the service to assess how this transforms as we develop Managed Care Model for Older People. It is planned to integrate the teams into the relevant OPAU. A primary care model is also being developed as part of the new sustainable model.

The projects ability to deliver reductions in LAS call outs and A&E attendances has been impacted by external changes made in the system;

- LBE Safeguarding instructed Care Homes to call LAS as default when a resident falls,

- 111 causing issues in the system in that there is no direct contact with Barndoc as OOH provider and many of 111 calls are resulting in LAS call out rather than routed through to Barndoc

Both issues have been escalated and a resolution is being sort.