Community MDT's delivering Proactive Care

Open Forum Events

INTEGRATED CARE: DELIVERING THE LONG-TERM PLAN

Tuesday 11th October 2022

Pendulum Hotel & Manchester Conference Centre

In Collaboration with:

AGENDA

INTRODUCTION
Dr. Richard Haddad, GP

THE PROCESS
Helen Holmes, ANP

PROJECT MANAGING
Ayeesha Qureshi, Project Manager

CASE STUDIES
Laura Benjamin, Care Coordinator
Sarah Hardy, Physiotherapist
Chloe Seabright, Occupational Therapist

CARE HOMES
Helen Homes and Sarah Hardy

CURRENT CHALLENGES
Rebecca Walters

THE FUTURE
Rebecca Walters

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WHO ARE PACT?

PRO- ACTIVE CARE TEAM

- We are Windhill, Idle, Saltaire, Happy and Healthy.
- The Saltaire and Windhill Partnership Group, and Idle Medical Practice
- Community Partnership Team – VCS, Pharmacist, Council Wardens, Local Councillors, District Nurses, CCG
- PACT is made up of a team of Care Coordinators who deliver holistic reviews for patients who qualify for PACT intervention
- Care Coordinators work with other services to put in place better support and manage patients better

"An integrated approach to providing holistic, person centred care. PACT is based on a multi-agency approach so that it can use a holistic approach to providing support, which includes developing community assets and promoting self-care"

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WHERE DID PACT ORIGINATE?

PATIENT POPULATION AND THEIR NEEDS

- 200 elderly patients admitted to hospital around frailty and falls

INTEGRATED CARE

- Worked with patients at high risk of admission (risk stratified) in the Integrated Care for Adults programme

DATA DRIVEN

- 1,629 – moderately frail, 561 severe frailty

AGE UK ON FRAILTY

- Previous research work with AgeUK & BIHR had showed mild frailty interventions had a limited impact

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*Data from Public Health Data

WHAT WE DID

CP SEED FUNDING

- Seed funding from the CP frailty project – Care Coordinator seconded from BDCFT.

OD & WORKSHOPS

- Co-Working to develop PACT further
- Community Matron, District N and MH buy in from the start.

INVESTMENT

PCN's added investment opportunities:

HCA pilot role became substantive
Physio
…. then OT
Project management
Several Care Coordinator roles

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THE PROCESS

Commitment

Multidisciplinary team

Interdisciplinary working

Cohesive working

PACT REFERRAL

Re-active

GP Referral

Referrals to PACT from ANP, D/N, O/T, Hale and SS referrals

Pro-active

E-Frailty

Patients identified from Public Health Data and RAIDR

Care- Coordinator

Care – coordinator will arrange a visit to see the patient to conduct a holistic review and send to Project Manage to input onto the secure PACT Database

MDT

Care – coordinator discusses patient with the MDT Team. Details are logged on a secure dashboard. Referrals are made dependant on discussion

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THE MDT

PACT MDT MEETING STRUCTURE

START

PACT PROJECT MANAGEMENT

- Update on how are we improving the PACT Process ?

RECAP

Care Home Update

- Discuss open tasks (close or investigate further – What needs to
d by who)
fully completed tasks (Outcome for patient)

- Each Practice (Saltaire and Windhill and Idle to give feedback on Care Homes in their PCN
- Status and barriers to moving forward
- AGREE

Strategy Meeting Update

Identify the patient / where

Identify Registered Surgery and review medical record on Systm1

- Direction of the Strategy meeting, What changes to implement?

receives and discuss lifestyle

TEAM visit / review with the team

Performance Metrix Update

END

MDT suggest changes and identify what help is required

Agreement on whether to open tasks on Dashboard

Make note of who the patient needs to be referred to and ensure this is done by most appropriate professional

Agree any other MDT Meetings to escalate to Surgery weekly MDT or safeguarding

Repeat process for each patient

PROJECT MANAGING

Support

Development

Streamlining

Commitment

Processes

Adapting

Our model is being used in 4+ PCNs in Bradford

PACT is a being recognised as “system changer” for integrated working

Constantly identifying ways to improve our service to meet our patients needs

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CASE STUDIES

LAURA BENJAMIN
PACT CARE COORDINATOR

SARAH HARDY
PHYSIOTHERAPIST

CHLOE SEABRIGHT
OCCUPATIONAL THERAPIST

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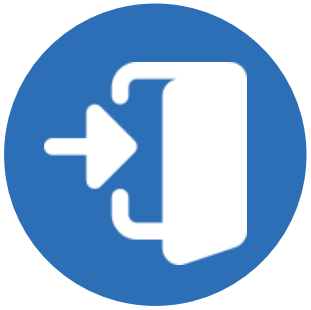
PACT & CARE HOMES

Multidisciplinary working

Access to all Services and Care

Support carers to provide quality care

Therapy ward round / screening



Direct access to physiotherapy/ occupational therapy

Nominated therapist

Future /looking ahead

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CURRENT CHALLENGES

Access to each other's records

BI and IT challenges

Evaluation Tool and Impact Assessments

Increased face to face joint working

Wider system pressure

Increased integration – working collaboratively across services

Engaging with Practices – awareness of facilitates / services

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PACT & THE FUTURE

Team Development

Improve Collaborative working

Digital Solutions

Housebound Team - Paramedics

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