Implementation of Clinical Team Meetings in the Midwest

Enhanced Community Care

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Background

Primary Care Clinical Team meetings were in place in the Mid-West. However, the COVID pandemic meant that meetings had ceased. Following engagement with PCT staff, led by the Community Healthcare Network Manager, areas for improvement in the PCT meeting structure were highlighted. The lack of a structured approach to MDT working emerging as a strong theme in these engagements. With predominately informal case discussions, a Clinical Team Meeting (CTM) structure would offer a streamlined, transparent approach to joint working.

Aims and Objectives

1. Develop a CTM procedure with staff and service user engagement at the core.
2. Streamline the roles such as Clinical Coordinator (CC), Key worker and PCT admin
3. Enhance ICT and establish virtual meetings to facilitate GP attendance
4. Develop KPIs to measure impact of the CTM
5. Ensure service user involvement in their care plan

HSE MID WEST COMMUNITY HEALTHCARE

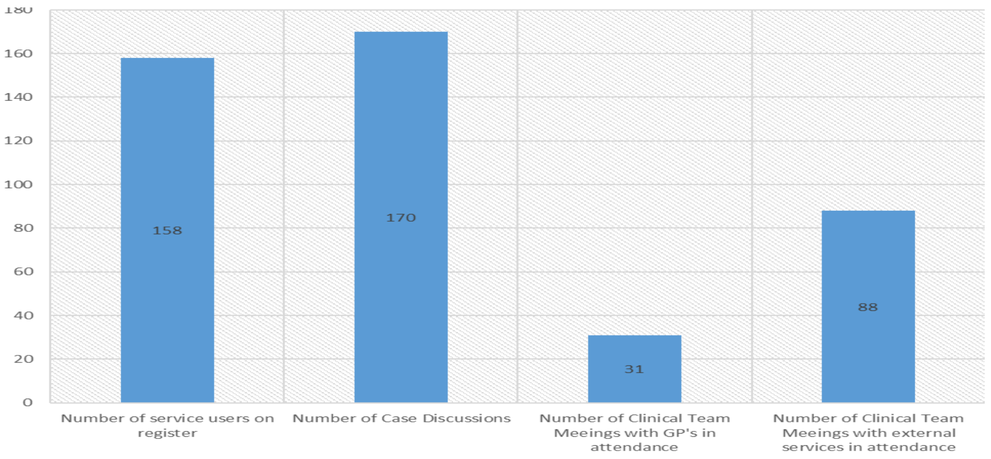
Procedure for Clinical Team Meetings in Mid West Community Healthcare, Primary Care (PART B)

Is this document a:

Policy ☐ Procedure ☒ Protocol ☐ Guideline ☐

Mid West Community Healthcare, Primary Care Service

Title of PPPG Development Group:	**Procedure for Clinical Team Meetings in Mid West Community Healthcare, Primary Care**
Approved by:	Mary Ryan HOS.



6 Live CHNs - Statistics from February 2023 to July 2023

Clinical Team Meeting – Overcoming Challenges

Challenge and Impact	Work Around
Recruitment of Clinical Coordinators (CCs) is challenging **Impact:** ➢ Delay of network model implementation ➢ MDT working and coordinated approach hindered ➢ Delay in establishment and sustainability of CTMs ➢ Fragmented cross divisional integration ➢ Reduced network performance activity	❖ Ongoing recruitment of new staff. ❖ CTM Procedure completed in CHO3. ❖ Educational workshops delivered ❖ Training for CCs i.e., Meetings Management, Leadership skills and Communication skills ❖ FAQ doc to assist understanding of CC role ❖ CHNM chairing where vacancies exist
CHNM chairing meetings in the absence of CC **Impact:** ➢ Additional workload impacting operational management, strategic planning role ➢ Deviation from the network model ➢ Unsustainability of the CTMs	❖ Nominating staff to chair CTMs ❖ Ongoing recruitment of CCs through staff engagement ❖ Education of all staff regarding the value of the CC role within the PCT ❖ Role clarity CC vs Key worker
Poor GP engagement and attendance at CTMs **Impact:** ➢ MDT working and relationship building impacted ➢ Risk to implementation of the model with the absence of a key stakeholder ➢ Risk of poor access for patients to primary care services ➢ Increased risk of unplanned hospital attendance	❖ GP lead driving engagement with GPs ❖ Virtual meeting attendance option ❖ Healthlink referrals ❖ GP service planning engagement and webinars ❖ Written GP report accepted in advance of meeting ❖ Meeting update sent to GP
ICT – poor internet connections in remote areas or lack of ICT skills. **Impact:** ➢ Poor attendance on virtual meetings ➢ Negative experiences and poor communication ➢ Inefficient and ineffective meetings	❖ Ensure staff have appropriate equipment ❖ Trial run before first attendance ❖ Support and education for staff and external services on use if ICT ❖ Face to face meeting or phone in option if more appropriate
Lack of Knowledge of roles/referral pathways across MDT and external services **Impact:** ➢ Inappropriate referrals ➢ Lack of coordination and joint working ➢ Fragmented care ➢ Risk to a coordinated approach to prioritisation	❖ Bespoke staff engagement workshop – "role clarity" ❖ HSCP and key services presentations at CHN staff meetings and GP engagements ❖ Staff webinars and education sessions ❖ Focus on relationship building ongoing

Clinical Team Meetings – Suite of KPIs

CTM Meetings management	Number of Clinical Coordinators in place (WTE) No. of Clinical Team Meetings held in the month No. of Clinical Team Meeting case discussions held in the month (include initial and reviews)
CTM Referrals	**Total number of new Referrals** No. of new referrals not accepted to CTM No. of new referrals accepted to CTM in the month 0 - 17 years 11 months No. of new referrals accepted to CTM in the month 18 - 64 years 11months No. of new referrals accepted to CTM in the month > 65 years **Total number of new referrals accepted** No. of new referrals to CTM from GPs No. of referrals that met the criteria of ECC Integrated Case management No. of referrals with >2 unplanned hospital admissions in the last 12 months
CTM Activity	No. of cases discussed =/< 2 weeks of referral to the CTM No. of cases discussed >2 weeks of referral to the CTM Total no. cases discussed Number of case discussions at CTM with GP input. Number of case discussions at CTM with Mental Health Services input Number of case discussions at CTM with Older Persons Services input Number of case discussions at CTM with Disabilities Services input Number of case discussions at CTM with External Community Services (e.g. Alone, Alzheimer's society, Headway, An Gardai, etc) Number of onward referrals to ICPOP from CTM Number of onward referrals to Chronic Disease Management Team from CTM
CTM Register	Total Number of patients on the CTM register at month end. Total number of patients on the CTM Register with an open MDT Care plan at month end.

Conclusion

The implementation of CTMs is central to integrated patient centred care. The shift from acute to community services necessitates a responsive and timely MDT primary care service. The CTM is a forum where MDT working can be formalised, and teams can grow and develop to respond to the needs of the local population. Key enablers include Clinical Coordinator, ICT, GP participation and strong relationships across community care and external services. However, implementation of effective CTMs has presented challenges. A clear CTM procedure, informed by service users and frontline staff, a suite of workshops and education sessions, have enabled its implementation. The foundations are laid, where the provision of integrated patient centred care can be built upon. Full CC capacity and staff engaging in frequent meetings will ensure their success.