Venue
Site/hospital: **Imperial, St Mary's Hospital**
Geographical area, eg PCN: **North West London (six PCNs)**

Frequency: 4-6 weekly

MDT type
Duration and time of day: **60-90 m**
Virtual eg Zoom (type) or F2F: **Mixture of F2F and MS Teams**
People involved every time: **General Paediatrician**, **CAMHs, GPs, Community Dietitian**
People involved some of the time: **Health Visitor, School Nurses, Physician's associates, Early Help**
Discussion of high "risk" patients – how chosen: **Anyone attending MDT can refer case to discuss; mostly GPs who do**
What are the common patients discussed: **those with complex cases – agreeing management /next steps. Those with multiple agencies involved i.e. CAMHS, GP, 2o care. Common childhood issues: Enuresis, headaches, constipation etc.**
How is it documented and how are themes disseminated: **Directly into patient record on GP system (Systm1) during discussion by a GP. Learning points from MDT distributed via email by consultant post MDT.**

Clinic
Duration of slots: **25-30m**
All new or follow up: **New, very rarely have the odd follow up but mostly follow up is handled by GPs**
Virtual or F2F: **Mixture between virtual/F2F; Clinician/patient choice**
Chosen by whom: **GP**
Criteria/Guidelines for choice: **anyone you would have referred to outpatients (bar those who need 2o care investigations i.e. x ray)**
GP sitting in – same one most times or variety or none: **rotates around each practice**
Other people sitting in: **Integrated care trainees (F1/2)**
GP practice, same one each time or rotation: **2 Hubs host at 1 site (for size and comfort) with a GP from each practice attending the host practice for the clinic. 4 Hubs rotate between practice sites. Each month**

Documentation/IT
Hospital notes/GP notes: **for clinic**, **notes documented in GP system (Systm1) and sent via NHS mail to Hospital so records can be updated. For MDT, notes documented directly into patient record during discussion.**
IT fixes and barriers: **All participating practices are able to remotely book into the MDT and clinic. Consultants are given smartcard access to host sites for documentation during clinic**

Payment
How is this funded eg PCN/CCG/secondary care/mixed: **CCG pays Hub tariff to hospital and funds backfill for GPs**
Payment of cases on a case by case basis, or session: **payment by session (MDT + clinic)**
Who funds the people at the MDT: **3 Hubs give GPs back-pay for 1 GP rep from each practice by CCG. Other 3 don't.**
Wo funds the individual, eg the GP, the consultant: **built in to consultant job plans, CCG fund GPs for clinics.**

Admin
Who does it: **Programme Manager in 2o Care; each Hub has its own Hub Coordinator**
Who pays for it: **Hub tariff from CCG for 2o care PM; practices re-allocate admin role to accommodate hub coordinator**
Brief description of how things work: **Hub Coordinator sets up MDT/Clinics on GP system, manages GP rota, sets takes admin actions from MDT e.g. book pt into next clinic. PM: dates from consultants, point of contact for Hub Coordinators, shares learning from Hub to Hub**

Communication
What methods, eg Teams, nhsnet, giving phone numbers: **Consultants exchange numbers/nhs emails with GPs/MDT, encourages communication outside of hubs too.**
How do GPs/HVs/Consultant communicate about patients between visits: **nhs mail – we have a group email with everyone included**
How do you communicate common themes/learning points/details about clinics: **Hub coordinator sends all confirmed dates beginning of year + sends reminder email with all relevant information. Post Hub, consultant sends a round up email with learning points from the MDT (written up by F1/2). Consultants from other Hubs are cc'd so as to spread learning across Hubs**

Evaluation
What evaluation do you do and how: **Improved experience of care: patient and family feedback (PREMs); Reduced per capita-cost: Observed reduction in activity: Outpatient - 81% A&E - 22% Admissions - 17%**; **Improved population health: Use of the segmentation model to proactively identify cases for discussion; Improved staff experience and learning: GP and trainee doctor feedback**
You can find a list of our publications HERE –

What makes your model sustainable/what are concerns about future: **GPs have ownership of Hub, develops with them; MDT engagement and learning comes from within, offering a mixture of F2F and virtual appointments to suit families, secondary care trainee exposure to working in an integrated way** Who/which team is the driver behind your model: **The GPs are the centre of our model. Upskilling, relationship building and making the GP the expert for patients and families**. Any governance or data protection issues/fixes: **for MDT - clinical governance sits with the clinician who brings the case; for clinic clinical governance remains with consultant**
Other comments to help