New care models

Enhanced Health in Care Homes

Vanguard learning guide

EHCH Element 2:
Multi-disciplinary team (MDT)
working with care homes

This is a live document:
Version 1.0
16/11/2017

Our values: clinical engagement, patient involvement, local ownership, national support

Contents

What do the vanguard learning guides do?

- Focus on a key element or sub-element of the Enhanced Health in Care Homes (EHCH) care model.
- Identify interventions put in place by the enhanced health in care home vanguards that have worked particularly well, and which could be readily replicated at clinical commissioning group (CCG), local authority, Sustainability and Transformation Partnership (STP) and/or regional level.
- Reference learning from relevant good work going on outside of the vanguards, where it is improving the lives of care home residents (includes residential, nursing and other settings).
- Describe a step-by-step approach to support implementation in non-vanguard areas, including first steps, roles and responsibilities, things to consider and the resourcing and benefits associated with these interventions.
- Support a consistent implementation of the core elements of the EHCH care model.
- Include practical materials such as job descriptions, referral criteria and operating models that can be easily adapted and adopted by other areas.
- Set out the key practical challenges arising from implementation of the care model, together with learning from the vanguards to help you overcome them.
- Link to national guidance and NHS England's series of 'Quick Guides' where relevant.

How does multidisciplinary team (MDT) working support the EHCH care model?

Care element	Sub-element
1. Enhanced primary care support	Access to consistent, named GP and wider primary care service
	Medicine reviews
	Hydration and nutrition support
	Access to out-of-hours/urgent care when needed
2. Multi-disciplinary team (MDT) support including coordinated health and social care	Expert advice and care for those with the most complex needs
	Helping professionals, carers and individuals with needs navigate the health and care system
3. Reablement and rehabilitation	Rehabilitation/reablement services
	Developing community assets to support resilience and independence
4. High quality end-of-life care and dementia care	End-of-life care
	Dementia care
5. Joined-up commissioning and collaboration between health and social care	Co-production with providers and networked care homes
	Shared contractual mechanisms to promote integration (including Continuing Healthcare)
	Access to appropriate housing options
6. Workforce development	Training and development for social care provider staff
	Joint workforce planning across all sectors
7. Data, IT and technology	Linked health and social care data sets
	Access to the care record and secure email
	Better use of technology in care homes

- A multidisciplinary team (MDT) approach provides individuals with care and support needs with access to the right care when they need it.
- There are two sub-elements:
  - 2.1 Expert advice and care for those with the most complex needs.
  - 2.2 Helping professionals, carers and individuals with needs navigate the health and care system.
- Health and social care staff, working together with care home staff and the voluntary sector as a single team helps improve the care of complex conditions by making full use of the knowledge and skills of team members from multiple disciplines and service providers, in a co-ordinated manner.
- MDT working with care homes can also support effective triage and use of NHS 111, as timely and safe transfers of care, including supported discharge from hospital.
- This team-based approach also supports and enhances all the other clinical elements and sub-elements of the framework.

About MDT working with care homes

Sub-element 1: Expert advice and care for those with the most complex needs:

- The MDT provides both preventive care and reactive support to the people on its caseload, using a partnership approach to clinical governance and decision-making, with social care provider staff being core members of the team.
- The MDT facilitates personal care – through support for holistic care planning, effective information sharing amongst professionals (including access to sections of the integrated care record that are appropriate to their role) and care tailored to the individual's goals, needs and condition
- The resident, their family and their carers are kept at the centre of the MDT's decision-making process at all times, by following the principles set out in the NHS' personalised care and support planning handbook, and the Care Act 2014's statutory guidance.
- A ward round-approach identifies people who need referral or pro-active input, based on the Comprehensive Geriatric Assessment or another holistic assessment approach such as 'Aristotle' (East Lancashire). Where useful risk stratification tools are used to ensure the MDT focuses its attention on those individuals with the greatest potential to benefit, in care homes and in the community.
- Membership of the MDT will vary depending on the local expertise and resources available, and the needs of the people on the MDT's caseload. Social care and other specialist input is available and these roles form an equal part of the MDT as needed.
- The MDT decides the frequency and nature of its meetings (e.g. face-to-face or virtual ward rounds, via telecare or tele-hub solutions, or through joining up with rapid response teams or hospital-at-home services).

About MDT working with care homes

Sub-element 2: helping professionals, carers and individuals with needs navigate the health and care system:

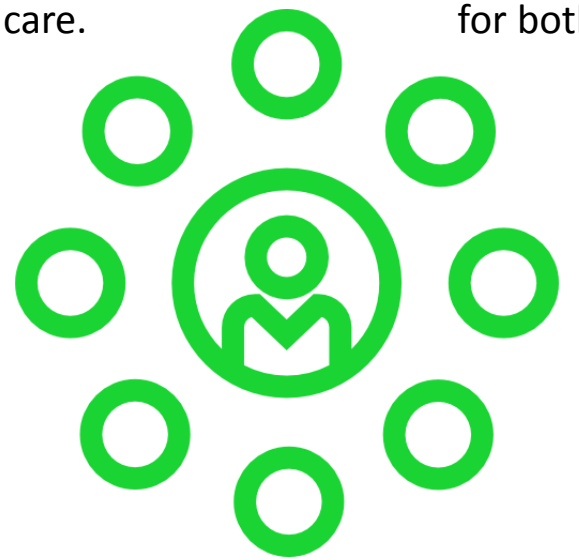
- Care and support is co-ordinated and consistent, and interventions are offered as early as possible, tailored to the individual's needs.
- Families and carers get access to the support, advice and information they need, and are treated with respect.
- Care coordination is provided through dedicated roles or building on services and teams already provided in the community by health or social care provision. This help residents and their carers who are having multiple simultaneous interactions with different services.
- Care provider staff have easy access to reliable and trusted advice and triage.
- The care home facing MDT helps facilitate more timely discharges to Care Homes via improved information sharing, including working with dedicated discharge to assess teams where these are in place.

Key messages from the Enhanced Health in Care Homes vanguards

This is about equitable access to NHS care for care and nursing home residents, with a focus on pro-active, patient-centred and coordinated care.

To be most effective care home MDTs must be a combined approach across mental and physical wellbeing – with parity of esteem for both mental health and physical needs.

Care planning should be supported by the MDT and focus on personal goals and outcomes for individuals. The MDT should monitor and reflect on outcomes to identify success, progress or challenges – work in a cycle of continuous improvement.



This is an interagency model at the primary and secondary care interface – also involving wider community services, social services and mental health services as equal members of the MDT when needed.

The views and needs of the resident, their family and their carers should be at the centre of the MDT's decision-making process. They should be empowered and enabled to influence MDT decision-making and attend MDT meetings where possible and appropriate.

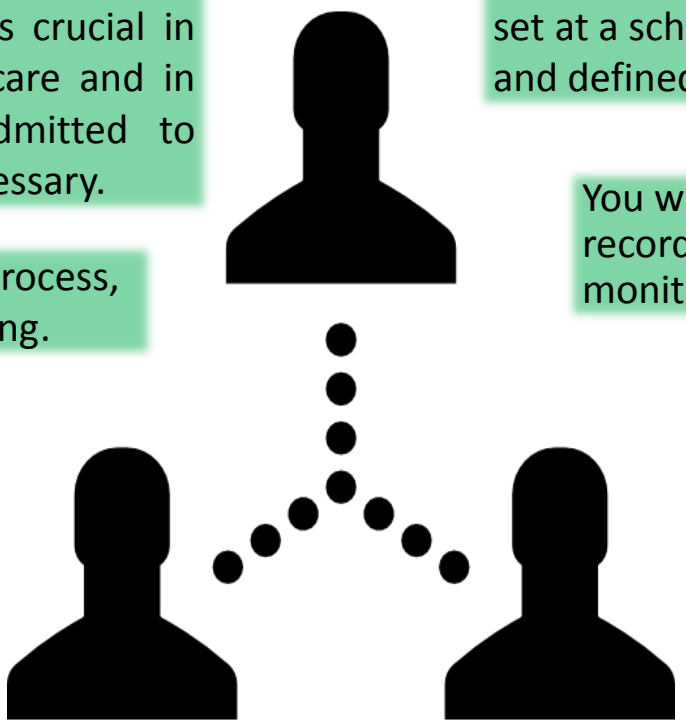
Key messages from the Enhanced Health in Care Homes vanguards

The MDT is not an 'add-on' to other clinical activity, it is vitally important. It is crucial in ensuring joined-up, personalised care and in ensuring that individuals are admitted to hospital when appropriate and necessary.

Time should be protected for regular meetings set at a scheduled time and place, with a clear and defined membership.

You will need a standardised approach to recording of discussions and decisions, monitoring, and use of a action log.

Risk sharing is integral to the MDT process, through collaborative decision making.



Sharing of best practice, supported learning and skill development is an integral part of the approach for both care home and NHS staff, including opportunities for peer-peer reflection and learning.

Real time access to care records is crucial, with appropriate information collected and made available prior to the meeting if necessary.

Digital solutions such as shared access to care records and use of NHS Mail with care homes are ideal, but should be seen as a longer-term goal rather than immediate barrier.

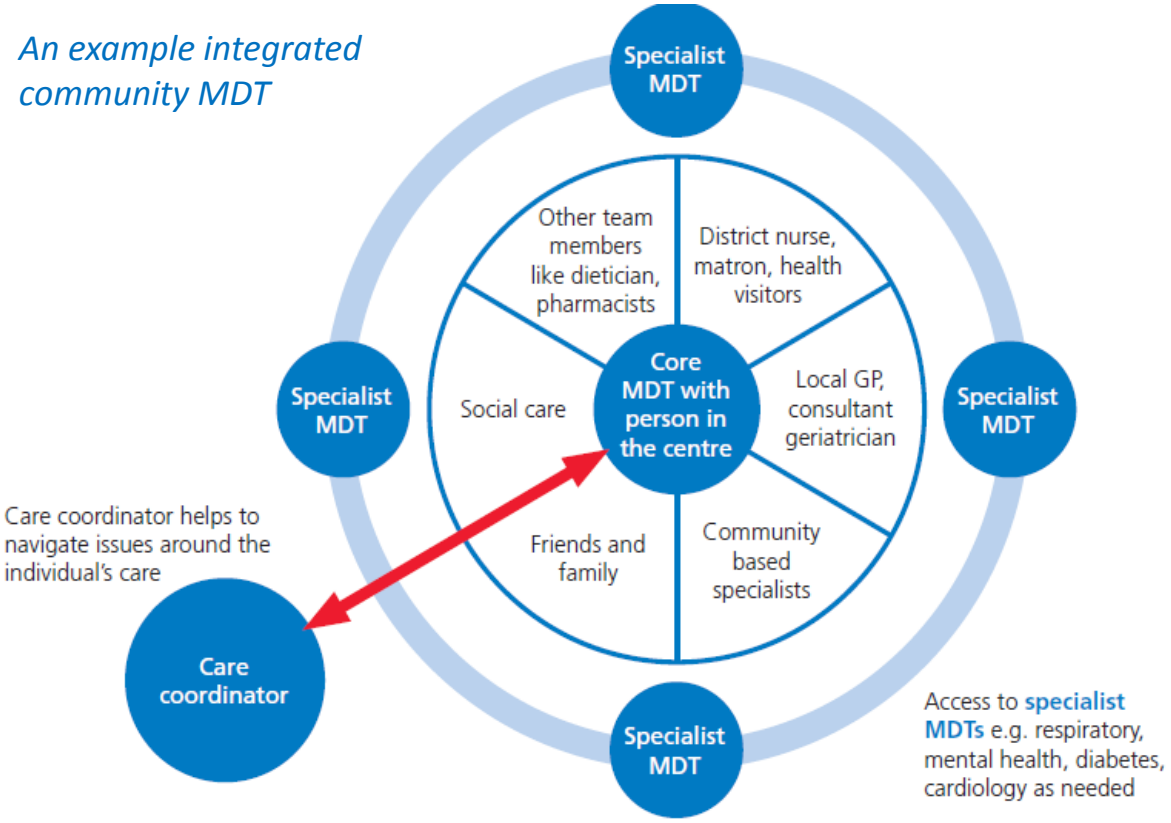
A part of the local health and social care system

There is no single model for MDT working with care home which fits all.

A service that works for your area:

- There is no single model which fits all. Every care setting is different, and pressures on primary and secondary care vary around the country.
- Whilst every area will have a different mix of existing teams and personnel in place, the core ***functions*** of MDTs working with care homes will be the same.
- The MDT needs to form part of mainstream services as opposed to a discreet standalone care homes team.
- It will require expertise across primary care, mental health, acute sectors within health, social care and also importantly – the community and voluntary sector.
- The following slides set out the approaches taken by a number of the care home vanguards.

An example integrated community MDT



MDT models - Wakefield

Service model and resourcing:

- An operational MDT - often referred as support team, which focuses on care homes based on CQC ratings.
- The MDT reviews new patients and where referrals have been made. It also supports the discharge process for care homes.
- The MDT currently supports 15 care homes (residential and nursing).
- Referral to MDT is via GPs and Care Homes (this has been positive, as has allowed staff in care homes to feel empowered).
- The MDT meets on a Monday morning (Nurse; Physio; OT)
- Team lead nurse for the MDT is at Band 7, all other colleagues are Band 6.
- The service is funded through vanguard monies, however the CCG has now made a commitment for recurrent funding for the MDT, with the decision based on our positive outcomes so far.

Key learning points:

- Teams need to ensure that families and carers are part of MDT decision making.
- Making funding available to recruit specific administrative support to support the MDT reduces the pressure on clinicians and caregivers.
- Access to a consultant geriatrician has been challenging – try to agree protected time with acute trust partners from the start.
- Consultant psychiatrist – this has been a gap and learning to date suggest that this needs to be a permanent post, to support MDTs. Currently a very informal process in place, based on previous good relationships .
- Aligned GPs help deliver a good MDT process.
- Ideally want to achieve one local authority social care colleague as a contact, for all care homes, as opposed to multiple colleagues.

MDT models - Wakefield

Evolving the service:

- Scalability is going to be a challenge, a move from 15 homes to full coverage across the area may require introduction of a 'hub MDT' approach to best meet the needs of the care home population.
- Wakefield are aiming to implement SystmOne in care homes, as this will support MDT discussions.
- Currently linked with community pharmacy and a pharmacy technician, hope to develop this further.
- Airedale's telehealth model will be installed in 3 homes within the next few weeks to support the MDT and SystmOne is in 1 care home so far.
- We have not included care coordinators in our model, but we are exploring the better use of the skills of healthcare assistants working closing with senior physiotherapist in the hospital with patients to help a swift and smooth transition back to the care home for these residents, and making sure staff feel confident about rehab for that person.
- Tracking of impact has allowed Wakefield to evidence the difference made by the team and thus secure recurrent funding for the service.

Key challenges and solutions

- One of the main key challenges was originally recruitment of staff on fixed term contracts, this is now recurrent funding so if we do get any vacancies we have a better chance of filling the posts.
- Be involved as much as you can with the recruitment, then people are very clear about the programme and the outcomes.
- Don't under estimate the amount of time it takes to recruit/second staff.

MDT models – East Lancashire

Service model and resourcing:

- Five locality Integrated Neighbourhood Team (INT) models (all different) with consistent principles and required outcomes.
- The established INTs comprise GPs, Community nurses, therapists, medicine management, social worker, third sector and specialists. Specialist mental health and Consultant Geriatrician input is being strengthened during 2017/18.
- Monthly MDT meetings facilitated by INT Clinical Co-ordinators for the whole population based on risk stratification including care home residents.
- Specialist Nurse Practitioners work as part of the locality primary care teams provide support and clinical expertise into care homes.

Evolving the service:

- Aspire to enable MDT with the ability to utilise video conferencing and virtual assessment, linking with specialist services and enabling the possibility of GP virtual ward rounds.
- Seek to provide a more pro-active service including a greater educational element.
- An established Intermediate care model is currently under evaluation) which comprises cohorts of dedicated beds across four care homes. These are supported with a team of therapists and social workers, and assist discharge from acute care.

Key Principles:

- Transform the care of patients, reduce avoidable admissions and ambulance conveyance.
- Identify people living with frailty.
- Use the MDT to support the process of Comprehensive Geriatric Assessment (CGA).
- Develop locality / neighbourhood place-based care models rather than care home specific.
- Be aspirational – aims for digital first.

Challenges:

- Uniformity and equity across localities.
- Access to Geriatrician time.

MDT models – Newcastle Gateshead

Service model and resourcing:

- GPs and Older Person's Nurse Specialists (OPNS) provide weekly proactive ward rounds in the care homes alongside care home staff. Complex cases are identified and referred into a 'virtual ward model' where they are discussed by the multidisciplinary team.
- The virtual ward enables quality care to be provided at a person's home by a multi-disciplinary team, with the resident remaining under the clinical responsibility of the hospital consultant or GP. Like a hospital ward, patients are admitted and discharged, however the ward is termed virtual as the 'beds 'are not real.
- Up to 30 patients are discussed at an MDT meeting. The MDT collaborate to make recommendations that facilitate quality patient care.
- Management centres around proactive, holistic care planning. Following the MDT actions include care home visits by consultants, medication changes, investigations and other interventions, the outcomes of which are discussed at future meetings.
- MDT members meet weekly for 1.5 to 2 hours in a centrally based care home. Half an hour of the meeting is dedicated to education on topics relating to clinical practice in this area such as safeguarding.
- *Core membership:* OPNS, Community Geriatricians, Old Age Psychiatrist, Administrative support.
- *Extended membership:* GPs; Dietetics; Therapies e.g. SALT; Pharmacy; Frailty Nurse.

Key principles:

- Bringing care closer to home, wherever that may be.
- Rapid access to specialist advice (including home visits).
- Recognition of the close interaction of mental and physical health in care home residents .
- A person-centred approach to care planning.
- Integrated working between primary and secondary care.
- Better coordinated care.
- Improved multi-agency safeguarding for patients.

MDT models – Nottingham City CCG

Service model and resourcing:

- A **dementia outreach team** is commissioned by the CCG and provided by the Mental Health Trust, specifically for care homes.
- The team has 8 Community Psychiatric Nurses (at Band 6), 4 Senior Occupational Therapists (Band 6), 2 Specialist Physiotherapists (Band 6), 1 Assistant Practitioner (Band 4) and 3 Community Support Workers (Band 3) and a Head of service (Band 7). The team currently support 50 care homes, and 400 - 450 residents with complex needs at any one time.
- The team benefits from dedicated Consultant Psychiatrist input – 4 visits per week jointly with a clinician. Referrals are via the GP, Continuing Care Team or Inpatient mental health wards.
- All patients in receipt of CHC are case managed by the nurses – this is for as long as funding is in place. All other patients may remain on caseload medium or long term as determined by patient need.
- The dementia outreach team provide training to care homes on dementia-related care and also co-ordinate a care home forum with care provider staff and a forum for activity co-ordinators.
- There is no third sector input into team directly, but the CCG have commissioned Age UK to support all their care homes.
- This team delivers mental health support to patients with organic mental health needs.

Learning points:

- A big success has been the nurses from the team co-ordinating a care home forum for local staff.
- However there is a challenge to avoid overly focusing this forum on dementia.
- The dementia outreach team is really valued and relied upon by care homes.

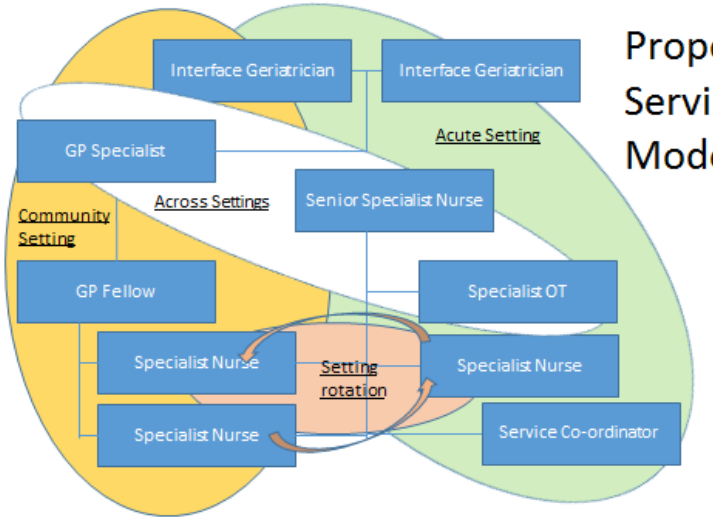
MDT models – East and North Hertfordshire

Proposed service model and resourcing:

- Combined use of Service Co-ordinator, Nurses and Interface Geriatrician means patients will be seen by the appropriate level of professional i.e. triaged by co-ordinator, nursing needs by nurses and only highly complex patients seen by Interface Geriatricians.
- Interface Geriatricians will co-ordinate service via a weekly "virtual board round" to co-ordinate team and discuss active patients across the service and agree plans across the MDT and ensure a CGA-style approach to person centred care.
- Frailty Service Model including Frailty Clinic, Frailty Unit, Hotline, Community activity.
- Service co-ordinator for referrals to clinic and phone line queries.
- Weekly virtual board round via conference call to each nurse allocated two E&N Herts localities, however there should be flexibility across boundaries in response to daily patient lists. Acute and Community setting teams with IG/Specialist GP oversight with staff rotation between settings.
- Links to social workers and therapy through core teams / rapid response.

Key principles:

- Co-ordinated whole system support for older people, and integrated working.
- Greater use of geriatric liaison services in the acute setting.
- Clear, easy to understand and easily navigated system.
- Integrated service including case management, comprehensive geriatric assessment, multidisciplinary/agency working, and continuity of care.
- Person centred-care tailored to the individual.



Proposed Service Model

Benefits for the resident

- The MDT functions as one to provide specialist care coordination. It responds to what residents with frailty, long-term conditions or complex needs require - and *this* is how to facilitate good quality, safe, relevant care.
- Effective MDT working provides an integrated and coordinated multi-professional approach to care, which includes mental and physical health, primary and secondary care. It provides holistic patient care, including working with GPs and allied health professionals to facilitate Comprehensive Geriatric Assessment and care planning.
- MDT working enables quicker and more appropriate access to specialists than the traditional hospital referral route which is not always suitable or appropriate for care home residents.
- Rehabilitation and reablement is promoted in maximizing an individuals' quality of life and enabling them to set and achieve goals which matter to them and their families/carers.
- There is less duplication of requests upon the resident and their family, continuity of understanding and care across professionals is improved, and transfer of care is improved.
- As a result of this approach, patients require less acute hospital care (both inpatient admissions and outpatient clinic appointments), there is less duplication, transfer of care is improved, and patients' care is coordinated around them. When healthcare is needed, the care individuals do receive is more personalised and coordinated around them.

Benefits for staff and the health and care system

For staff:

- Enables and ensures consistent support for care home staff.
- Clarity of where to go for help, advice and clinical guidance.
- Better signposting and referral to appropriate services and support.
- Improved relationships between care providers and clinicians.
- Increased staff confidence and skill level.
- Training, education and insight from different disciplines.

For the health and care system:

- Promotes rehabilitation and reablement in order to maximize individuals' quality of life.
- Reduction in inappropriate or unnecessary outpatient appointments due to a better shared understanding of condition of each person and use of technology (e.g. NHS 111 *6 and telehealth) to provide advice.
- Supports challenges associated with Discharge Transfer of Care and patient flow.
- Potential, as part of the wider Enhanced Health in Care Homes care model, to reduce number of bed days in Acute care as inappropriate admissions are prevented.
- Potential to support residents to be discharged from hospital quicker due to more robust systems and better knowledge of individuals and their needs and functional levels.

Workforce principles

Principles

- Utilise your existing workforce differently and link in wider teams to generate capacity.
- Recognise the contribution of everyone who works in or into a care home.
- Protect time in staff schedules for joint decision-making and for reflection.
- Ensure that all staff have the right skills and competencies to deliver effective care.
- Put the resident/patient at the centre of the care provided and reduce duplication through effective use of shared competencies.

Workforce roles and responsibilities

Roles and responsibilities

- Team members may include, but are not limited to:
  - Input from Care home staff including nurses and carers
  - Primary care (GPs, advance nurse practitioners, district nurses, as well as other allied health professionals)
  - Pharmacists and pharmacy technicians
  - Older Person's Specialist Nurses
  - Social workers
  - Acute care (especially where there are, or are likely to be planned or unplanned admissions to hospital)
  - Specialist clinical advice (e.g., Mental health and dementia input, Geriatricians, Old Age Psychiatrists, Speech and Language Therapists)
  - Locality workers – e.g. from voluntary sector -

Meeting population health needs through workforce redesign

- This report from the New Care Models programme describes the learning about workforce integration from vanguards, Integration Pioneers and Primary Care Homes.
- An accompanying workforce support guide supports staff to put the document's learning into practice.

Key characteristics of success:

- **Designing a Workforce around Population Health Needs**
  - a) **Modelling and planning the workforce** through a population health management approach - not letting organisational or professional boundaries block your way.
  - b) **Personalisation of care** by using people's needs as the key design principle to improve outcomes and resource efficiency – target the real need.
- **Workforce Redesign**
  - a) **Design of team and design of roles that deliver integrated working** – recognising 'skill and competency' rather than 'role and rank'.
  - b) **Training and education networks** that support workforce development.
  - c) **Technology which drives and delivers improvements** – embrace and learn from technology.
- **Leading change**
  - a) **Involve and engage** the workforce, people and carers in designing services across health, social care, voluntary and independent sector – recognise that your whole workforce are your greatest asset.
  - b) **Collaborative leadership** that builds trust and relationships and supports system wide collaborative working – focus on common goals and a common purpose.

Things to consider as you implement

Effective and joined-up case management

- Whilst virtual wards are good for rapid access to specialist advice, building in mini-MDT meetings as part of the weekly ward round provided by your GP/aligned nurse service can be very effective.
- Both physical and virtual MDT meetings and discussions have a key role in ongoing learning and education for both care provider and health staff, including work-based learning.
- Try to ensure consistency in the chair and membership of the MDT meeting where possible so that trust and confidence between MDT members can be built steadily.
- Recognise the MDT working for residents of care and nursing homes is different to the MDT model in other settings – such as within hospitals. However many of the principles are similar.
- The MDT will need to be flexible in its approach – each individual and care home is different.

Evolve and improve

- MDT working with and within care homes also allows the local system as a whole to review admissions and conduct root cause analysis.
- Consider how to build time for reflection, learning and celebration, as well as new cases or issues into MDT meetings.
- Work to map how care home facing MDTs can support challenges in acute care around patient flow, avoidable demand and delayed transfers of care, liaising with hospital discharge teams and trusted/local authority social care/hospital based needs assessors.
- Administrators can use standardised templates to capture the actions from MDT meetings.
- Ensure that the MDT meets frequently enough to be fit for purpose and facilitate personalised care – adding actual value for residents and health and social care staff rather than an obligation.

Things to consider as you implement

Supporting residents, carers and families

- Recognise the MDT working for residents of care and nursing homes is first and foremost about safe and good quality care , which is patient-centred and well coordinated. Alongside effective care planning this in turn should reduce inappropriate admissions.
- Consider what formal and informal mechanisms are in place, or need to be, to engage residents and carers. A top-down approach to implementing MDT working or a virtual ward will not be sufficient to guarantee personalised care.
- MDT working can help provide quality time with family members and care home staff who would not be part of the virtual MDT.
- Patient consent must be carefully considered when establishing and running a multidisciplinary team. MDTs must carefully balance the need to respect patient privacy, and the right of patients to opt-out of certain healthcare practices, whilst trying to proactively identify patients for consideration (by using risk stratification for example).

Using technology effectively

- Providing your care homes MDT with the ability to use video conferencing and virtual assessment can unlock new ways of working. There is potential to reduce community team visits by supporting care home team remotely to develop skills and undertake clinical activity safely (e.g. venepuncture, verification of death, sub-cutaneous fluids).
- Enable care home teams to access virtual training and clinical supervision, overseen remotely by Registered Practitioners.
- Access to NHS Mail can facilitate much improved communication between healthcare professionals and colleagues employed by care and nursing homes.
- The work of **Airedale [case study]** and **Nottingham City CCG [case study]** illustrates how MDTs can use technology to enable more cost effective, efficient working models and effectively and safely share information. Be aware that co-operating on shared processes and learning is as important as provision of technology.

Measuring success

Tips and approaches:

- Identify and track outcomes to ensure that your services are truly having an impact and meeting local health and care needs.
- Use feedback from carers, residents and local advocate groups to get a rounded picture of whether or not the changes your area is implementing are successful.
- Connected Care Wakefield use an activity framework to pull out data from SystmOne, which helps inform conversations when discussing impact with the MDT. See the resources pages for more information.

Metrics to consider:

- Avoidable hospital admissions
- Reduced A&E attendances
- Reduced GP reactive / emergency home visits
- Reduction in polypharmacy
- Reduction in inappropriate or unnecessary outpatient appointments
- Impact on staff satisfaction and retention.

Things to note:

- The Enhanced Health in Care Homes framework is a package of changes, which work best if they are all implemented together, in a systematic manner, across residential and nursing home setting.
- You will need to evaluate the impact of new or improved use of MDTs with care homes alongside the other changes you introduce as part of your local model.

Challenges and solutions

Challenges	Solutions to consider
• Building trust across the system.	• Understand your starting point – consider developing a survey or questionnaire to gather care home staff's views on working relationships with health and social care. Consider commissioning an independent organisation to do this. • Don't underestimate the time needed to get the relationships and partnerships in the MDT going. Equal relationships between care home managers and wider staff and the teams working with them need to be built and supported, not presumed to already be in place. It is worth the effort – good relationships are the foundation of sustained MDT working. • Cultivate team ethos – shared learning / peer-peer development across organisations and roles.
• Risk (perceived or real) that care home staff may lack specialist knowledge and that decisions may be taken with a degree of naivety.	• Your local initiatives need to be backed up with an educational programme for both health and social care staff. • Consider joint training programmes across health and social care, rotations into care homes, and shadowing opportunities for carers, nurses in acute and nursing home settings, and GPs. • It can be an important message to hold the MDT meeting in the care home to raise the profile of the care home as part of the health system.

Challenges and solutions

Challenges	Solutions to consider
• Multiple MDTs working in silos. • Lack of whole system understanding of interagency and MDT working.	• Map which teams and individuals are working with individuals, care homes and localities • Work to understand how they link up in terms of pathways and transfer of care, and where the interfaces are (e.g. integrated discharge teams and dedicated MDTs working in community) • Looks at your processes for referrals and caseload management. Bring together the key clinicians and care home nurses/managers to discuss what can be improved.
• Acute care sector may not fully understand the range of services available and not available in care homes.	• Ensure that hospital-based discharge teams have a good awareness of the care home sector – what needs fit residential care, what needs are likely to require nursing care, what is available in the local market.
• The wider healthcare workforce may have a poor understanding of care homes and frailty.	• Involvement of secondary care as well as primary and community care roles (e.g. Physiotherapist, Occupational Therapist, Dietician) helps with continuity of care and long-term condition / frailty management. • Consider joint training programmes across health and social care, rotations into care homes, and shadowing opportunities for carers, nurses in acute and nursing home settings, and GPs.

Challenges and solutions

Challenge	Solution
• IT and technology. Communication and record keeping can be difficult when different organisations are involved in the MDT.	• Look at information sharing early in the design of your scheme to work out what's needed and begin work to identify and address barriers. • In advance of the MDT, it is recommended that all information available on the patient from primary, secondary and social care is compiled into a single record and circulated to the MDT group. Dependent on the patient's needs, additional information may also need to be provided relating to a specific condition or issue. • Sharing the information ahead of the meeting will give the group opportunity to review the patient's condition. • Shared care records enable the information sharing but when not available, in the vanguards, hasn't stopped MDTs from being effective.
• The EHCH care model requires experienced clinicians and specialist input for complex decision making – for example there is a lack of Geriatricians nationally.	• Explore innovative approaches in the design and implementation of new ways of working. A virtual ward approach can maximises the number of patients able to benefit from specialist clinical input. • Mental health input is also important, especially around dementia. This input from consultants and specialists should be made explicit and agreed. Likewise it is vital for specialists to be supported contractually to set aside time for care home-focused work.

If viewing as a PowerPoint document, please right click each link below, then click 'Open Hyperlink' to access the resources.

Vanguard material to support implementation

Service specifications

- Newcastle Gateshead - Virtual ward MDT - terms of reference
- Integrated rapid response team - Essential ingredient framework - NE Herts
- Early Intervention Vehicle process mapping
- Service proposal - Integrated Frailty Service
- Service proposal - Interface Geriatric Service
- Wakefield – Variation to Standard NHS Contract for Acute Services
- Wakefield – Variation to Standard NHS Contract for Acute Services - CCG covering report

Evaluation and lessons learned

- Wakefield – Covering report - Dedicated Multi-disciplinary Team Mid Yorkshire Community Services 2015/16
- E+N Herts - Early intervention vehicle – lessons learned log

Tools for MDT staff

- Wakefield – screening tool I objectives
- Wakefield – activity framework for care homes MDT
- Clinical frailty score
- Early Intervention Vehicle Dashboard
- Wakefield – MDT poster
- Wakefield - Care Homes Vanguard Support Team (MDT) – guide for families and carers

Job descriptions

- JD - Consultant Physician Medicine for the Elderly and General Medicine (Interface Geriatrics)
- JD - Frailty Specialist Nurse
- Early Intervention Vehicle Practitioner JD

MDT case studies

- Airedale and Partners
- Nottingham City CCG

Implementing MDT working with care homes - to do list

1	Discuss the needs of care home residents as a system
2	Identify gaps and priorities
3	Define the scope, purpose and objectives of your MDT
4	Assess the skills of the workforce & identify available workforce
5	Co-design an interagency approach to ways of working
6	Provide joint training and focus on trust and team-build
7	Ensure there is sufficient administrative and project support for your team
8	Support effective communication through I.T. and agreed processes
9	Foster supported decision making – an environment to share and learn

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