Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

BLMK Developing Effective Enhanced Health in Care Home MDT Meetings

Bite size educational resource pack

This is an interactive PDF. To navigate, use the arrow buttons on each page or locate a specific section using the side menu.

Introduction to the educational resource pack

Donna Holding - BLMK Lead for Enhanced Health in Care Homes

Introduction

This pack has been designed to support care home, community, general practice and primary care network staff to get the most out of the care home MDT meetings across the BLMK system with a view to ensuring best possible person centred care for each individual resident within the home.

This pack addresses and provides guidance on some of the key care elements of the Enhanced Health in Care Homes framework with a view to ensuring that all MDT meetings are valuable for all stakeholders and residents whilst ensuring that person centred care plans are developed that outline what matters most to the resident

This pack contains a number of educational resources along with an administrative toolkit that will support making MDT meetings as effective as possible for all concerned by ensuring that the right information is brought to the meeting by the appropriate participants to support meaningful discussions and care planning activities.

We also want to provide an oversight for staff to help raise awareness of some key assessments that should be undertaken, the reasons why these are important and the responsibilities of all involved in the delivery of Enhanced Health in Care Homes across BLMK as this is not only the responsibility of health or social care colleagues but it is something that needs to be approached collectively involving the resident, their families and carers to ensure complete wrap around services for the resident.

This pack can be used as a standalone resource as there are links to a number of short videos throughout the pack.

Alternatively you can skip directly to the videos that have been produced. The bitesize clips cover everything outlined in this pack and can be accessed by clicking on the button below;

This is an interactive PDF.
To navigate, use the arrow buttons on each page or locate a specific section using the side menu.

What is Enhanced Health in Care Homes

The NHS Long Term Plan (2019) outlined a commitment as part of the Ageing Well Programme to roll out Enhanced Health in Care Homes (EHCH) across England by 2024.

People living in care homes should expect the same level of support as if they were living in their own homes and this can only be achieved through collaborative working between health, social care, voluntary, community and social enterprise (VCSE) sector along with care home partners.

The Enhanced health in care homes model moves away from traditional reactive models of care and moves towards proactive care that is centred on the needs of individual residents, their families and care home staff.

There are 3 principle aims to the framework and these are:

- Delivering high quality personalised care within care homes
- Providing where possible for individuals (temporarily or permanently) living in a care home access to the right care and the right health services in the place of their choosing
- Enabling effective use of resources and reducing unnecessary conveyances to hospitals, hospital admissions and bed days whilst ensuring the best care for people living in care homes

In the EHCH model, care providers work in partnership with local GP's, PCN's Community healthcare providers, hospitals, social care, individuals and their families along with wider public services to deliver care in the care home. Services are to be wrapped around the individual and their family who are connected to and supported by their local community, ensuring that proactive personalised care and support is in place.

The Enhanced health in care homes framework

Care Element	Sub Element
1. Enhanced primary care support	Each care home aligned to a named PCN, which leads a weekly multi-disciplinary meeting
	Medicine Reviews
	Hydration and nutrition support
	Oral health care
	Access to out of hours / urgent care when needed
2. Multi-disciplinary team (MDT) support including co-ordinated health and social care	Expert advice and care for those with the most complex needs
	Continence promotion and management
	Flu prevention and management
	Wound care – leg and foot ulcers
	Helping professionals, carers and individuals with needs navigate the health and care system
3. Falls prevention, Reablement and rehabilitation including strength and balance	Rehabilitation/ Reablement services
	Falls, strength and balance
	Developing community assets to support resilience and independence

Care Element	Sub Element
4. High Quality palliative and end of life care, mental health and dementia care	Palliative and end of life care
	Mental health care
	Dementia care
5. Joined up commission and collaboration between health and social care	Co-production with providers and networked care homes
	Shared contractual mechanisms to promote integration (including Continuing Health Care)
	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

What is a care home weekly check-in

A weekly check in meeting is for the discussion of patients that Care Home and / or Health Professionals have an **urgent concern about or where the patient is acutely unwell** and to obtain information on patients new to the Care Home or discharged from hospital.

- A weekly check-in meeting allows the Care Home or Health Professionals to discuss any **urgent concerns about a resident or those that are acutely unwell.** This can be health or medication related or because patient is generally deteriorating.
- To update records of any new patients admitted to the Care Home or returning from a hospital stay. Including medication reviews.
- To update records on patients that have left the Care Home – returned home, moved to another address, been admitted to hospital.
- To check if any staff or patients have tested positive for Coronavirus and discuss care management of those individuals

It should be noted that the main difference between a Weekly check in meeting and an MDT meeting is the type of patient being discussed.

The MDT meeting is for a more in-depth, rounded discussion on a patients ongoing care, which could also include patients that would be suitable for the Weekly Check-in meeting.

What is an MDT Meeting

The purpose of the Multi-Disciplinary Team (MDT) meeting is to provide the opportunity to discuss the health and wellbeing of Care Home residents and to collectively develop a holistic care plan based on patient priorities and help Care Homes monitor progress of residents.

These meetings are being held, to give the Care Home and Health Professionals the opportunity to discuss patients about whom they have concerns.

The frameworks asks for care homes to be aligned to single practices with an aligned named GP. All residents within the home are encouraged to register with the aligned GP practice to ensure continuity of care and better outcomes for both the care home and the residents, and care homes are asked to support these discussions with residents and their families.

It is an opportunity to meet various professionals at once

An example of topics that can be discussed at an MDT can include:

- Personalised Care Plans
- Dietary concerns
- Behavioural concerns
- Medication
- General deterioration
- General medical concerns
- Mobility Concerns
- Social economic concerns

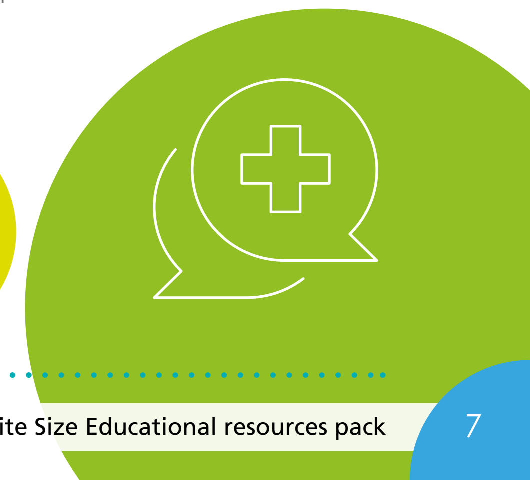
Purpose of a MDT Meeting

It provides an opportunity for all professionals involved in the care of the resident to contribute to discussions in order to address the individuals needs.

- It generally meets once every month to review residents who have symptoms of concern.
- Facilitates transparency and consistency of care for people living with multiple complex conditions.
- Supports delay in accessing care/services.

Benefits of having an MDT meeting:

- Care Home has a forum where concerns about patients can be discussed with Health professionals
- Includes professionals from different specialities as necessary to the planning for the resident
- Health Professionals can decide at the meeting, the best treatment plan for the patient and
- agree to any necessary onward referral for other services.
- Patient receives care agreed by a group of Health and social care professionals
- More efficient use of resources and faster interventions
- Improved health and wellbeing outcomes
- Improved coordination of care



What makes a good MDT Meeting

The opportunity for a group of professionals involved with care and support of Care Home residents to discuss very specific patient related issues.

- Providing dedicated time and place, to discuss patients from a holistic aspect and not just physical symptoms
- Setting clear ground rules for the meeting (Meeting TOR's can support this)
- Engagement of core team members and extended team where necessary
- Nominated scribe
- Agenda
- Notification of residents to be discussed and brief summary of reason for discussion
- Action Logging either on electronic template or through completion of Arden's care home template on S1.
- Taking Notes /Actions and sharing it with all stakeholders involved
- Following up actions and timeframes to complete
- Reviewing actions from previous meeting at next meeting to ensure all have been addressed or identify the need to take forward

Benefits of an MDT Meeting

Team Value
Mulberry Court Care Home

Family Benefit
Mulberry Court Care Home

Comms Value
Mulberry Court Care Home

Enhanced Health in Care Homes MDTs
Ivel Valley South PCN

How to identify residents for discussion at MDT

What is the criteria for discussing a resident at MDT rather then weekly check in etc

- Try to RAG rate patients prior to the MDT so there is a clear list of patients needing discussion.
- Pain issues that seem not to be responding to current therapy
- Resident that is going in and out of hospital for whatever reason or having 999 calls being made for them frequently
- Residents with a combination or multiple complex needs and coming up on GP weekly visit frequently
- Patient status is changing and care planning decisions need to be taken to help treatment escalation decisions (e.g. now end of life – aim for palliative care, needs anticipatory medication)

Rag rate examples

Red discharged, A&E attendance, falls, confusion, off legs, pain uncontrolled

Amber off food, weight loss, withdrawn, behaviour change, medication concerns

Green no change to status.

Who can identify or put forward residents for a detailed discussion with multiple professionals

Any professionals involved in patient care such as GPs, district nurses, rapid response team, mental health practitioner, HWBC, SPLW, clinical pharmacists, Care Coordinators, Care Home Managers, patients or their carerscould also include patients that would be suitable for the Weekly Check-in meeting.

Who are the core members of a care home MDT

Key participants of a Care Home MDT meeting are:

- Care Home aligned GP
- Pharmacist
- Care Coordinator
- Care Home manager or Senior Carer (s) (The Care Home manager is not always the most appropriate person to attend. Carers tend to know the patients better).

Other participants could include the following depending on which patients are being discussed and their needs;

- Community Matron/Care Home Lead
- District Nurse
- Social Worker
- Palliative Care team
- Dietician
- Dementia Nurse
- Mental Health team
- Falls team
- Physiotherapist / Occupational Therapist

What can be discussed at a Care Home MDT

The MDT meetings are for the benefit of all patients residing in Care Homes. With that in mind, any clinical or care related concerns raised can be discussed. These could be concerns about:

- Declining mobility and risk of falls
- General deterioration of a patient
- Confusion & Behavioural issues – esp related to delirium or dementia
- Mental Health concerns – diagnosis of dementia, depression and management
- Weight gain / loss
- Eating and drinking
- Patient repeatedly on weekly GP visits,
- Multiple Health concerns – eg long term conditions – management of diabetes, leg ulcers, heart failure.
- GPs unsure/need a quick geriatrician input

The KEY to raising concerns is establish a **TREATMENT ESCALATION PLAN**

What will the above concerns mean regarding future care? Will it require a change in treatment / referral? If they deteriorate what level of treatment would they require - admission to hospital? Care in the community? Does their change in status now require a different approach that we have identified as a team: is admission no longer appropriate, should symptoms be palliated? Are they now end of life? Do we need to talk to the family? Do we need to prescribe anticipatory medication? Do we need to complete DNAR or RESPECT tool so that paramedics are aware of the decision.

- Care Homes should discuss acutely unwell patients at the weekly check-in meetings or directly with the patients registered GP, not wait for an MDT meeting.
- The MDT does not cover discussion of a patient's financial situation.

What should you bring to a care home MDT

- A list of RAG Rated patients of concern – see previous slide
- Know who will record the details for each resident that is discussed
- Utilise templates within this resource pack or Systmone records
- Ensure full history of resident being discussed is available
- Have a list of residents medication to hand
- Understanding of the residents needs and preferences that can be shared
- Understanding of the relatives concerns regarding the resident that can be shared
- Referencing personalised care/anticipatory care plans
- Aim to review the plans jointly and develop treatment escalations plans so we can anticipate future care needs

Awareness of the Comprehensive Geriatric Assessment CGA

The Comprehensive Geriatric Assessment is a full holistic assessment of the patients medical physical psychological social and spiritual needs.

- **Physical ability** - long term conditions, mobility, frailty, oral health, diet, swallowing, nutritional status, pressure area MUST scoring, continence.
- **Sensory abilities** - hearing, sight, comprehension, speech, language, communication
- **Psychological** - mood depression anxiety and memory
- **Social** - ability to undertake activities of daily living (ADL's - washing dressing eating toileting) and also independent activities of daily living (iADLs – shopping, finance, planning etc). Social situation, housing family friends who support, key contacts. Activities and goals and social plans.
- **Spiritual** - religion beliefs, future plans goals, hopes, fears.
- **Care planning** - goals, treatment escalation plans, advanced care directives.

The CGA is a **lengthy assessment** because it aims to cover the whole person and their needs. It is best done by **multiple professionals** with expertise in their particular field to assess that area of care – eg Speech and language therapist is best placed to help with assessing communication problems or swallowing assessments.

System one template has a link to CGA data fields

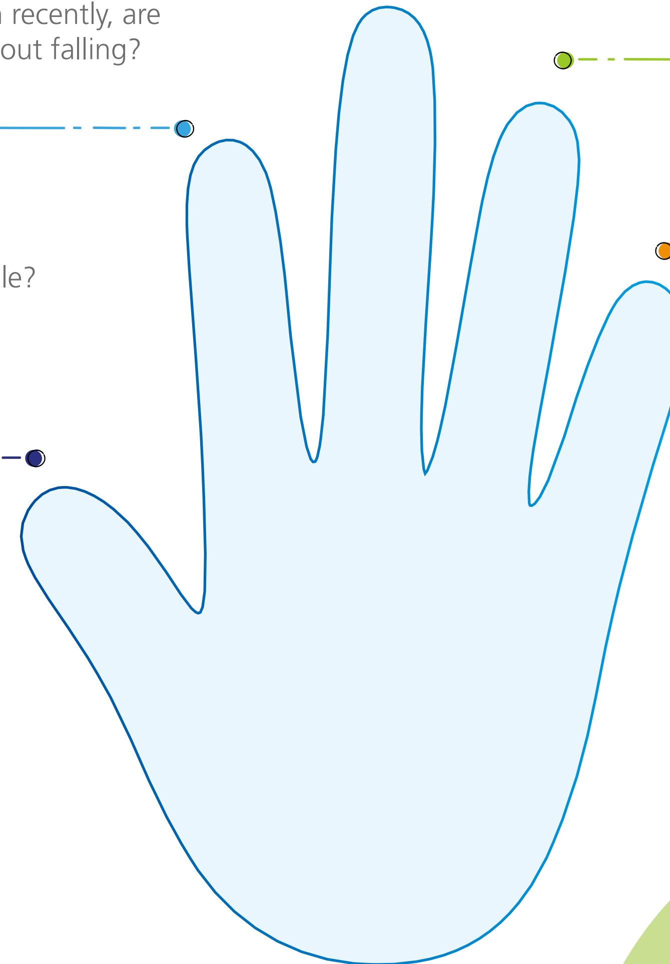
The 5 M's Summary Holistic assessment was developed by a Canadian geriatrician as a simple summary of the CGA

It is much easier to use and we recommend everyone adopts this as a basic 'aid memoir' see next slide…

5 M summary has been added to the System One Frailty template.

The 5 M's

5 Q's and 5 M's Elderly Frail Assessment tool



Mobility

Have you fallen recently, are you worried about falling?

Mind

Do you tend to forget things & struggle to recognise people?

Matters most

What matters most to you?

Medications

Do you feel confident to manage your own medication?

Multi-complexity

Who visits you, how often and what do they do for you?

How do you manage with washing, dressing, shopping, cooking and cleaning? Activities of daily living?

What long term medical conditions do you have?

Frailty and Memory Assessments

Frailty

The 5 Ms tool will give an overview of a person's medical problems and what matters to them. Clinical staff find it useful to get an overall picture of a person's frailty status (mild moderate or severe). In BLMK we use the pictorial Rockwood Frailty score to grade a persons frailty status – see next slide.

Memory

It is important to screen for memory problems when a new resident arrives in a home. Often a person with memory problems may not remember they have loss of memory. Their language and ability to answer questions sounds ok, but their answers may not be accurate if they cannot remember. So it is helpful to ask relatives if they have noticed any memory problems. The Diadem tool (see next slide) can be used by professionals to make a diagnosis of dementia in a care home; this includes the 6 CIT memory test along with information from family and blood tests. If a patient has memory problems then it is useful to establish if an assessment has been made of their mental capacity to make decisions regarding their health welfare and finances.

Rockwood Frailty Scale

Clinical Frailty Scale*

1. Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3. Managing Well – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4. Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5. Mildly Frail – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. Moderately Frail – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7. Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8. Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill – Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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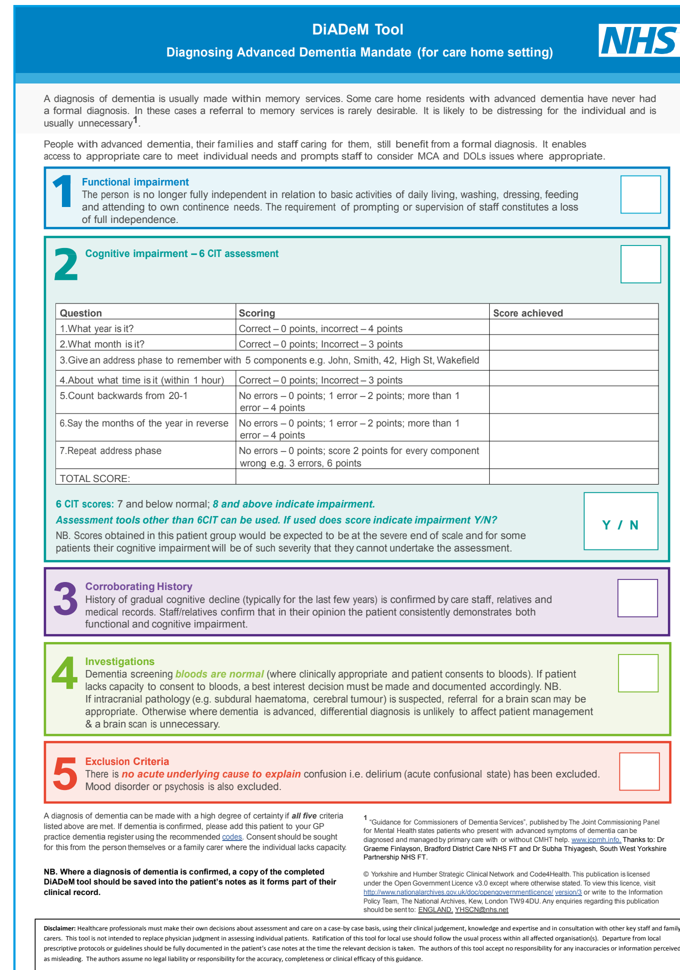
DALHOUSIE UNIVERSITY *Inspiring Minds*

Diadem Tool

The paper based Diadem Tool



DiADeM Tool

Diagnosing Advanced Dementia Mandate (for care home setting)

NHS

A diagnosis of dementia is usually made within memory services. Some care home residents with advanced dementia have never had a formal diagnosis. In these cases a referral to memory services is rarely desirable. It is likely to be distressing for the individual and is usually unnecessary[1].

People with advanced dementia, their families and staff caring for them, still benefit from a formal diagnosis. It enables access to appropriate care to meet individual needs and prompts staff to consider MCA and DOLs issues where appropriate.

1 Functional impairment
The person is no longer fully independent in relation to basic activities of daily living, washing, dressing, feeding and attending to own continence needs. The requirement of prompting or supervision of staff constitutes a loss of full independence.

2 Cognitive impairment – 6 CIT assessment

Question	Scoring	Score achieved
1.What year is it?	Correct – 0 points, incorrect – 4 points	
2.What month is it?	Correct – 0 points; Incorrect – 3 points	
3.Give an address phase to remember with 5 components e.g. John, Smith, 42, High St, Wakefield		
4.About what time is it (within 1 hour)	Correct – 0 points; Incorrect – 3 points	
5.Count backwards from 20-1	No errors – 0 points; 1 error – 2 points; more than 1 error – 4 points	
6.Say the months of the year in reverse	No errors – 0 points; 1 error – 2 points; more than 1 error – 4 points	
7.Repeat address phase	No errors – 0 points; score 2 points for every component wrong e.g. 3 errors, 6 points	
TOTAL SCORE:		

6 CIT scores: 7 and below normal; ***8 and above indicate impairment.***

Assessment tools other than 6CIT can be used. If used does score indicate impairment Y/N?

NB. Scores obtained in this patient group would be expected to be at the severe end of scale and for some patients their cognitive impairment will be of such severity that they cannot undertake the assessment.

Y / N

3 Corroborating History
History of gradual cognitive decline (typically for the last few years) is confirmed by care staff, relatives and medical records. Staff/relatives confirm that in their opinion the patient consistently demonstrates both functional and cognitive impairment.

4 Investigations
Dementia screening ***bloods are normal*** (where clinically appropriate and patient consents to bloods). If patient lacks capacity to consent to bloods, a best interest decision must be made and documented accordingly. NB. If intracranial pathology (e.g. subdural haematoma, cerebral tumour) is suspected, referral for a brain scan may be appropriate. Otherwise where dementia is advanced, differential diagnosis is unlikely to affect patient management & a brain scan is unnecessary.

5 Exclusion Criteria
There is ***no acute underlying cause to explain*** confusion i.e. delirium (acute confusional state) has been excluded. Mood disorder or psychosis is also excluded.

A diagnosis of dementia can be made with a high degree of certainty if ***all five*** criteria listed above are met. If dementia is confirmed, please add this patient to your GP practice dementia register using the recommended codes. Consent should be sought for this from the person themselves or a family carer where the individual lacks capacity.

NB. Where a diagnosis of dementia is confirmed, a copy of the completed DiADeM tool should be saved into the patient's notes as it forms part of their clinical record.

[1] "Guidance for Commissioners of Dementia Services", published by The Joint Commissioning Panel for Mental Health states patients who present with advanced symptoms of dementia can be diagnosed and managed by primary care with or without CMHT help. www.jcpmh.info. Thanks to: Dr Graeme Finlayson, Bradford District Care NHS FT and Dr Subha Thiyagesh, South West Yorkshire Partnership NHS FT.

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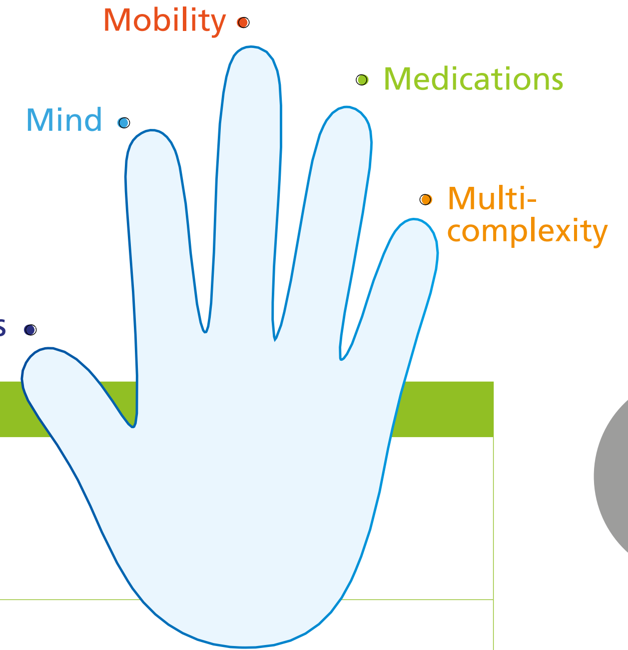
Disclaimer: Healthcare professionals must make their own decisions about assessment and care on a case-by case basis, using their clinical judgement, knowledge and expertise and in consultation with other key staff and family carers. This tool is not intended to replace physician judgment in assessing individual patients. Ratification of this tool for local use should follow the usual process within all affected organisation(s). Departure from local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken. The authors of this tool accept no responsibility for any inaccuracies or information perceived as misleading. The authors assume no legal liability or responsibility for the accuracy, completeness or clinical efficacy of this guidance.

A diagnosis of dementia can be made with a high degree of certainty if all five criteria listed are met

Personalised care planning



GERIATRIC 5Ms	
Mind	**M**entation Dementia Delirium Depression
Mobility	Impaired gait and balance Fall injury prevention
Medications	Polypharmacy De-prescribing Optimal prescribing Adverse medication effects and medication burden
Multi-Complexity	**M**ulti-morbidity Complex bio-psycho-social situations
Matters Most	Each Individual's own meaningful health outcome goals and care preferences

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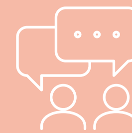
Personalised care planning

- **Personalisation** - being clear on what the resident wants, means we can write care plans and treatment escalation plans that meet their goals. E.g.Mrs B has advanced cancer and has expressed a wish not to be ressussitated (DNAR). However her granddaughter is getting married in 5 weeks and her goal is to be at the wedding if possible. She would want active treatment in hospital even if her condition worsens so she can try to be at the wedding.
- **Care Plan** - we aim to write a care plan that summarises the key contacts, 5 M's holistic assessment along with residents goals and treatment escalation plan. This will help professionals know what are the resident's wishes and who is the right agency to contact in event of an emergency.



How to do a holistic assessment and care planning

Every care home will develop a care plan on new residents. This will include a holistic needs assessment and an understanding of the resident's wishes and goals.

Use the 5 Ms summary to assess the resident.

- **Mind** - covers memory and also mental state – depression delirium
- **Mobility** - looks at safety and falls risk
- **Medication** - is a chance to review whether medication is causing problems and could be stopped or whether other preventative medication could be started.
- **Multi-complexity** - looks at the long term medical conditions that might need monitoring such as diabetes or COPD, and also the psycho-social needs of the resident
- **Matters Most** - this is the chance to ask the resident what matters most to them: what they like doing, what their aims are. Those goals will help to shape decisions about future care. That enables a plan to be drawn up that expresses their wishes for future care (eg do they want to be admitted, do they want resuscitation in event of cardiac arrest). This process is called Personalisation.

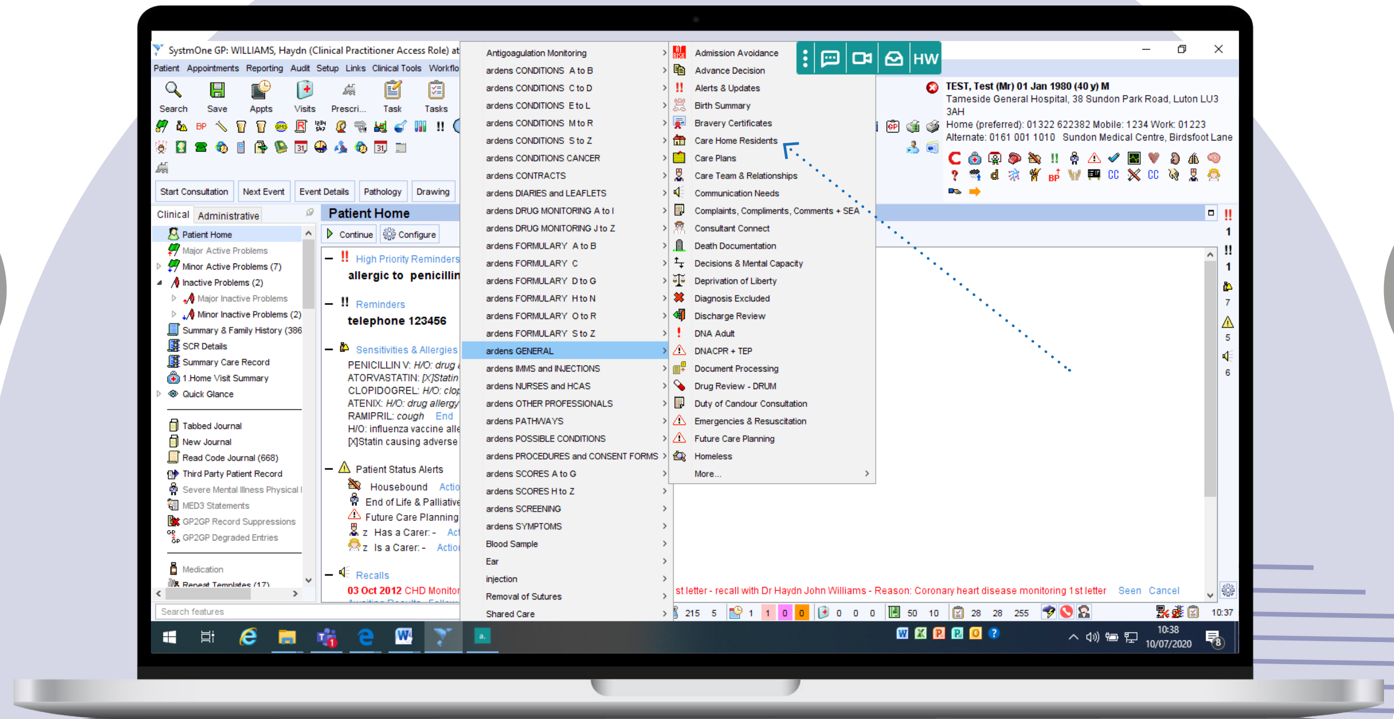
Templates to help shared data entry on SystmOne

There are a small number of templates available in SystmOne that will support with updating key information into a residents clinical record that with proxy access the care home can have access to.

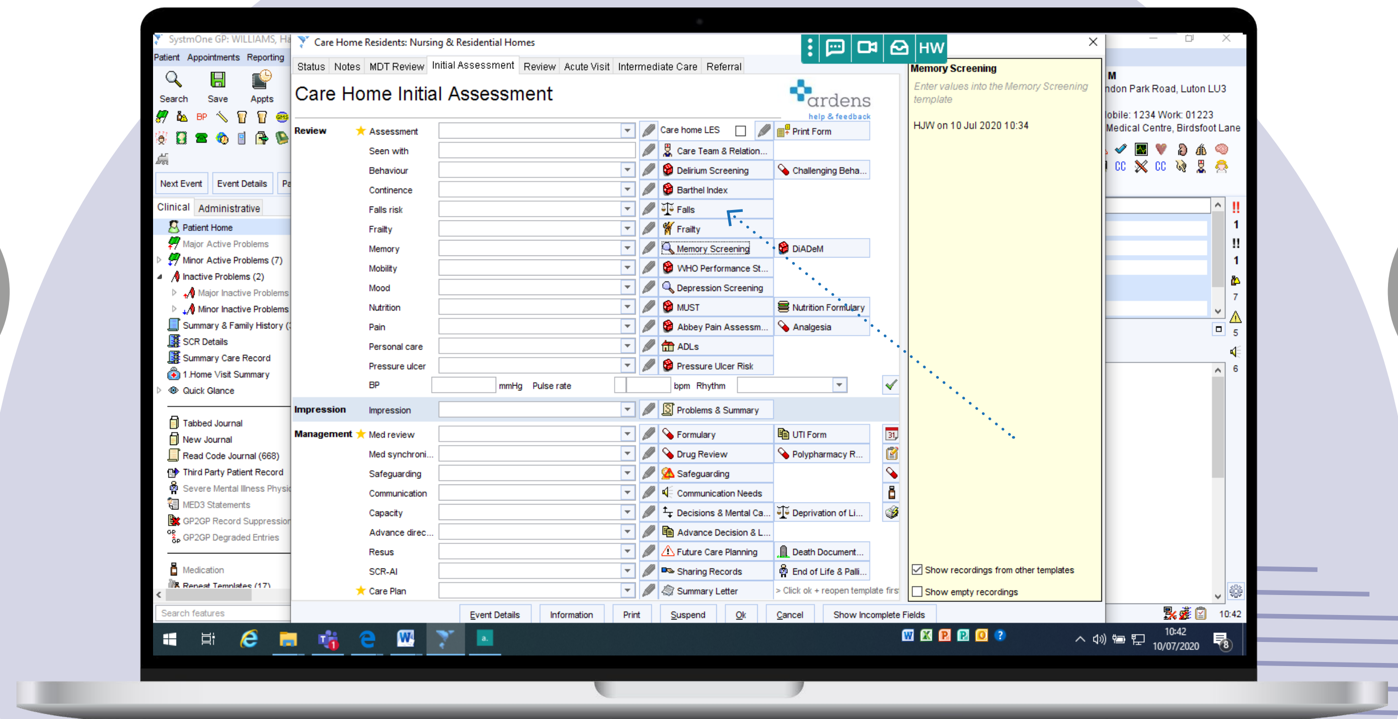
- Across BLMK Ardens templates are used in SystmOne
- There is a **Care Home template** which is useful for patient assessment and MDT's and incorporates the relevant codes for the PCN DES reporting (Service contract)
- If you click on the blue stars it will take you to the correct templates, MDT Review and Care Home ward round tabs
- There is also a **Frailty template** that uses the 5 M's categories and patient Goals section
- The template links to a Care Plan and treatment escalation plan

The next slides picture these templates and how they can be used to do an assessment and develop a care plan

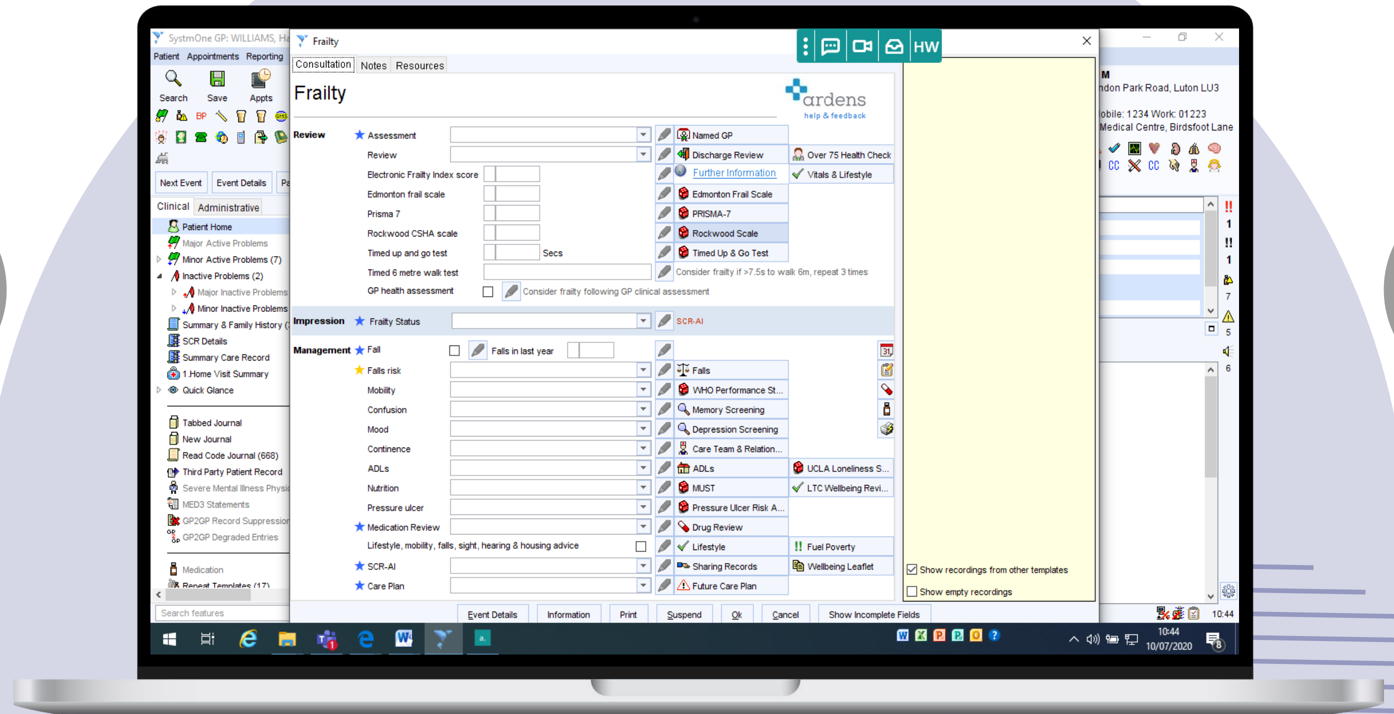
Care home template



Care home initial assessment



Frailty template



Ardens frailty template

Proactive use for frailty assessment

Identify Frailty

Geriatric 5 M's

Assess Frailty

Mobility & Falls

Mental - memory mood

Multi-complexity

Medication review

Matters Most

Other Details... | Exact date & time | Thu 24 Oct 2019 | 14:14

Changing the consultation date will affect all other data entered. To avoid this, cancel and press the 'Next' button

Consultation | Notes | Resources

Frailty

ardens
help & feedback

Review
- Assessment — Named GP
- Review — Discharge Review — Over 75's Health Check
- Electronic Frailty Index score — Further Information — Vitals & Lifestyle
- Edmonton frail scale — Edmonton Frail Scale
- Prisma 7 — PRISMA-7
- Rockwood CSHA scale — Rockwood Scale
- Timed up and go test (TUGT) seconds — Timed Up & Go Test
- Timed 6 metre walk test — Consider frailty if >7.5s to walk 6m, repeat 3 times
- GP health assessment — Consider frailty following GP clinical assessment

Impression
- Frailty Status — SCR-AI

Management
- Fall — Falls in last year
- Falls risk — Falls Risk Assessment
- Mobility — WHO Performance Status
- Confusion — Memory Screening
- Mood — Depression Screening
- Continence — Care Team & Relationships
- ADLs — ADLs — UCLA Loneliness Scale
- Nutrition — MUST — LTC Wellbeing Review
- Pressure ulcer — Pressure Ulcer Risk Assessment
- Medication Review — Drug Review — Polypharmacy Review
- Lifestyle, mobility, falls, sight, hearing & housing advice — Lifestyle — Fuel Poverty
- SCR-AI — Sharing Recor... — Wellbe...
- Care Plan — Future Care Plan — LTC R...

Information | Print | Suspend | Ok | Cancel

Rockwood Clinical Frailty Scale to confirm frailty level

Code frailty status

Use 6 CIT for memory test

Advanced Care Plan takes to
1. Treatment escalation plan
2. Future care plan template

Enhanced SCR

How can a pharmacy team help with medicines management in the care home

- 'Medicine Reviews' is within one of the 7 care elements of the EHCH framework.
- Medicines Management support including Structured Medication Reviews (also known as SMRs) can be provided to the care home by a pharmacy team employed by their aligned PCN
- A pharmacy team may consist of a pharmacy technician and/or pharmacist, each may have different roles and responsibilities
- A pharmacy team will work as part of the multi-disciplinary team and support the weekly 'home round or check in' and attend MDT meetings
- The pharmacy team are experts in medication and can offer support and guidance on various medication issues. The team can also support with medicines reconciliation, this is the process of accurately listing a person's medicines that they are currently taking e.g., following a hospital discharge
- A pharmacist (with the support of a pharmacy technician) can also conduct a person-centred Structured Medication Review (SMR)
- PCNs and their pharmacy teams are responsible for providing services to patients, including those living in care homes, and delivery of the Network Contract Direct Enhanced Service (DES)
- The BLMK ICB Care Home Medicines Optimisation team are a dedicated team that support care homes and other key stakeholders (e.g. PCNs, ICB Quality teams, Local Authorities etc). For more information, see the ICB referral pathway.

Administrative Templates (Toolkit)

There are no standard processes for how an MDT meeting should be managed or delivered. Throughout this pack we have referenced good practice and included below is a small library of actual resource templates and guidance documents that you may find useful. Please feel free to amend these to suit your needs locally.

- Preparing for EHCH MDT Meeting – Check list
- EHCH MDT Overview Development Tool
- EHCH MDT Terms of Reference
- EHCH Check In Questions & Action Log
- EHCH MDT Agenda Template
- EHCH MDT Action Log Template

Across BLMK the outcome of the MDT for each patient discussed is being recorded either manually or electronically in a number of ways. From a health perspective the preferred recording mechanism is via the Ardens Care Home MDT Template which can be found on SystmOne.

Useful links and additional resource information

NHSE Enhanced Health in care Homes framework

Download NHS framework, published March 2020

the-framework-for-enhanced-health-in-care-homes-v2-0.pdf (england.nhs.uk)

Enhanced Health in care homes

A guide for care homes (Care Provider alliance.org.uk)

Enhanced Health in Care Homes: A guide for care homes - Care Provider Alliance

BLMK Work Live Learn website

Directory of training offers for care staff (Carers, Volunteers & H&SC Workforce Development)

Home - CCG - BLMK (work-learn-live-blmk.co.uk)

Skills for Care

Practical support for care homes manager and staff training offers

Home - Skills for Care

Useful links and additional resource information

Personalised Care Institute

A virtual organisation accountable for setting standards for evidence-based training in personalised care in England

https://www.personalisedcareinstitute.org.uk

Future NHS platform

FutureNHS Collaboration Platform - FutureNHS Collaboration Platform

Care Coordinators monthly national Share and Learn sessions

Lots of presentations on best practices shared by Care Coordinators working in Care Homes

All Care Coordinator related resources and events calendar will be shared here, including case studies and discussion forum.

National Care Coordinator

Please encourage Care Coordinators to register onto this platform by sending email to;

england.supportedselfmanagement@nhs.net

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Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Contact Details for BLMK EHCH Lead

If you have any questions regarding the information in this pack please contact:

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Available Monday - Friday 9:00 am to 4:00 pm