**Solent’s Primary Care Programme: Review and Alignment of Adult Services and Primary Care Networks in Southampton**

**Article 6 -** **Spotlight on Community Nursing Complex Care MDT meetings – did you know that Solent NHS Trust holds weekly MDT meetings, and we’d love you come along too?**

Here at Solent, we run weekly ‘Complex Care MDT meetings’ in each of the three localities, which have recently changed names (they used to be known as ‘virtual wards’). These meetings are a really valuable space in bringing together a range of health and social care professionals to discuss individual patients in depth.

***Who are the regular attendees?***

The following people are usually present at our Complex Care MDT meetings:

* Community Nursing representative
* Consultant geriatrician
* Consultant nurse
* Community Independence Service representative (B7 Occupational Therapist / Physio)
* Social services representative
* Trainee ACP
* Older persons practitioner from UHS
* Administrator

***What is discussed at the Complex Care MDTs?***

We discuss complex patient situations, where having a MDT around the table will be beneficial in bringing their care together. We discuss:

* Patients that are currently in hospital - the older persons practitioner feeds back on their admission.
* Complex patients living in their own homes, where we discuss a plan of action to try and keep the patient at home. This could include changing medication, equipment reviews, escalated therapy reviews and referrals to the wider team.
* Any deaths that have occurred on the caseload. We discuss the date, location and a summary of the death including background, any concerns (e.g. whether the death was expected or unexpected, in or out of our care), arrange for bereavement cards to be sent to relatives and discharge the patient.

***What is the referral process into the Complex Care MDTs?***

Our teams have been working on streamlining the referral criteria to ensure the right patients are being discussed, and to support decision making in who to bring to the weekly Complex Care meetings for discussion. Whilst GPs do not currently have access to the Complex Care template on their systems, if GPs want to refer a patient, they can email the relevant team’s inbox preferably using SBAR. Our admin team can then create a referral and populate our template with the SBAR information from the email, ready for it to be discussed at the following week’s MDT.

The following referral criteria can be used when considering which patients to discuss in Complex Care meetings:

* Complex admissions where Older Persons Practitioner (UHS) and Social Care input required.
* Patients who require frequent input outside of planned visits.
* Frequent hospital admissions (more than 3 in 12 months or more than 2 in 1 month).
* Unexplained falls (community nursing).
* Safeguarding concerns.
* Concerns regarding undiagnosed cognitive impairment.
* Mental health / alcohol / drug dependency affecting ability for Community Nursing to care for patient.
* Deteriorating pressure ulcers / new category 3 or 4 pressure ulcers.
* Unstable Amber or Red GSF patients (to amend) where wider MDT input useful / decide who is coordinating care.
* Diabetic patients with unstable blood sugars.
* Multiple agencies involved and nobody coordinating care.
* Unexpected / unexplained deaths.
* General deterioration in frailty trajectory where advice / guidance required.

***How is the meeting information recorded?***

We recently started using a new template on SystmOne to record the MDT meetings. This template was first rolled out in the West locality in August 2023, and most recently to the Central locality (as of February 2024). During the meeting, our admin staff type up the information into SystmOne in real-time and everything is checked and signed off as part of the meeting. The template also uses the SBAR communication tool, and community nursing and CIS staff have all received training on SBAR to enable them to do this more effectively.

Prior to having this template, notes were taken by hand, and then put into a Word document after the meeting, before being sent round to the Chairperson for checking. Following this, the SBAR and the outcome of the MDT for each patient discussed was individually loaded onto SystmOne each week.

Using the new template has therefore had some significant impacts, including:

* Saving a significant amount of time at the meetings, meaning more time can be spent discussing the patients that need it. We estimate that we now save 4 hours of time for each 90 minute meeting!
* Saving administrative time after the meeting. Instead of writing up the notes and getting these checked and uploaded on SystmOne, our admin staff have lots less to do, releasing them to do other work.
* Ensuring the patient’s record is up to date in real-time.
* The use of SBAR makes it a lot clearer – staff can easily see the journey, discussion and action plan at a glance. When following up patients at subsequent MDT meetings, staff can go straight to the actions and review these.

***How can GPs be involved?***

In the West locality, we are carrying out a trial where we email all GP practices on a Monday to let them know which of their patients we are planning to discuss in that week’s Complex Care MDT.

We would love more GPs to come along and be present during the meetings. If GPs turn up, we will discuss their patients first so they can just stay for the part that’s relevant for them.

GPs are also very welcome to bring along their own patients for discussion at our meetings.

***What have GPs said about this?***

Here is what Dr Henrietta Idiodi from Cheviott Road surgery had to say about our meetings:

“The complex MDT meetings are a much needed and long-awaited opportunity for us health professionals to coordinate and collaborate to provide adequate care. I find it helpful and aim to attend as much as I can. The updates about patient care / patient journey and the goals set during the meeting had been very helpful. Meeting is a positive step towards achieving effective care outcomes for our patients.”

***Is there an example of how a GP’s presence has resulted in better patient care?***

Roz Lankford, Trainee ACP for the West locality reflected on a recent case, where an older gentleman, currently at home, was being discussed due to a high risk of admission to the hospital.

Roz said…

“The gentleman lives alone in his own home, with issues around mental health, increased level of self-neglect, not eating and drinking, self-harm, and low haemoglobin. He had a suspected GI malignancy but refused investigations and oral or IV Iron replacement. During the meeting, the teams were able to get background information from the GP who knows him really well. Through discussion with the consultant and geriatrician, referrals to OPMH and Safeguarding teams were made whilst also considering a MARM meeting, which his GP was keen to get involved in. Having his GP present and engaging with the plan of action really helped in putting parts of the jigsaw puzzle together.”

***Would you like more information?***

Please reach out if you’d like more information about this work, or the Solent Primary Care Review Programme by emailing sara.a’court@nhs.net or christine.horan@solent.nhs.uk.