

**All Together
Better**

Better Health and Care
for Sunderland

Multi-Disciplinary Team Meeting Guidance and Team Compact

April 2017

**All Together
Better**

Better Health and Care
for Sunderland.

Version control

Version	Changes	Status	Author	Date
V2.0				
V2.1			F Khalil	21.5.17
V2.2			T MCGWINN	03/07/17

Table of Contents

Version control	2
Table of Contents	2
1. Key principles of care across Sunderland.....	3
2. The Team	3
3. The Patients	5
4. Care Plans	7
Appendix 1	8

1. Key principles for delivering the Sunderland Care Model and the purpose of Multi-Disciplinary Team (MDT) Meetings

Purpose of MDT meetings:

The overall aim of the multidisciplinary meeting is to enable a formal mechanism for multidisciplinary input into care planning and ongoing management and care of patients

- To identify patients that are at risk of avoidable or multiple hospital admissions, in order to proactively plan their care to reduce this risk and improve outcomes
- To identify patients whose care is better achieved through a multi-disciplinary approach to achieve
- To effectively plan patients' care and anticipate health and care needs
- To reduce the duplication and fragmentation of the care offered to patients and their carers

For Partner Organisations:

- Services will be re-aligned to wrap around locality practice populations where appropriate
- Care delivery will remove barriers between professionals and organisations to deliver seamless care
- Partners will work collaboratively
- Work underpinned by governance and safeguarding responsibilities

For Patients and their Carers:

- Care will be person centred
- Care will be proactive rather than reactive
- Decisions will take into consideration the views of all professionals involved in the care of the patient and their carers
- Patients and their carers will be engaged and supported to take responsibility for their own goals and self-management of their care where possible

2. The Multi-Disciplinary Team

2.1 Membership

2.1.1 The core membership of the MDT meetings are:

- GP or an appropriate senior clinical deputy
- MDT Coordinator
- Senior community Nurse
- Social Worker or Assessment and Review Officer
- LWLW where appropriate

- Care Home staff where applicable

2.1.2 Extended membership includes other relevant professionals/disciplines from locality wide or city-wide services that can attend when necessary or appropriate. This can include, but is not exclusive to:

- Practice Nurses
- Pharmacists
- Secondary Care Consultants
- Community Psychiatric Nurses
- Improving Access to Psychological Therapy (IAPT) staff
- Recovery at Home Reablement, Telecare, or Nursing Teams
- Community Therapists, including Occupational Therapists, Physiotherapists, Speech and Language Therapists
- Specialist Nurses, including Palliative Care, Heart Failure / CHD, Bladder and Bowel, Tissue Viability, Respiratory and Diabetes
- Third Sector, including Sunderland Carers Centre and Age UK Sunderland staff
- Podiatry
- Social housing services

2.2 Attendance

2.2.1 Meetings will take place regularly at a frequency to be determined by the weighted Practice list size, but no less than fortnightly.

2.2.2 Core members are present for discussions of all cases where their input is needed. In circumstances where a core member is not able to attend information will be sent to the MDT coordinator to be presented at the MDT in their absence. Core members should arrange for deputies who have the appropriate patient knowledge to feed into the MDT.

2.2.3 General Practice remains the medical home for the patient and provides a holistic view of the individuals being looked after. Therefore, the GP or a deputy who is a senior clinician with clinical decision making capability must attend the MDT to provide overall clinical accountability/authority for patients being discussed.

2.2.4 Any unforeseen cancellations of the MDT meetings must be made as soon as possible via the MDT Coordinator and in as much advanced notice as possible. Cancellations, with reasons, will be documented and reported via the appropriate vanguard governance structure.

2.2.5 If, due to unforeseen circumstances, the GP is not able to attend the meeting *after the other professionals have arrived*, the meeting will go ahead and the team can agree on non-clinical actions to take forward. Any clinical actions will need to be checked by the GP other than those within the normal practice of those attending

2.2.6 The MDT Coordinator will record attendance at the meetings and any concerns about attendance will be raised with the appropriate provider manager to address.

2.2.7 The GP Alliance will circulate an MDT attendance exception report to each provider organisation every month and via the appropriate Vanguard governance structure

2.2.8 The meetings can take place in a practice, a primary care centre or in a care home depending on the patients being discussed and the individual characteristics of the locality. All core members are expected to attend, regardless of where the meeting takes place.

2.3 Leadership

There is an identified leader/chair of the MDT agreed at the start of the meeting. This does not have to be the same person from one meeting to the next, and can be any core member of the MDT.

The chair:

- Has the list of the patients to be discussed at the meeting.
- Ensures there is adequate representation at a single meeting to make safe recommendations about any or all of the patients and the action to take if not.
- Ensures that all cases are discussed and prioritised as necessary.
- Ensures recommendations/actions are clearly summarised and recorded and a review date agreed prior to moving on to the next patient.

3. The Patients

3.1 Risk Stratifying/ Identifying patients to discuss at MDT

3.1.1 Patients most at risk of repeat unplanned hospital admissions identified through risk stratification, business and soft intelligence and professional judgement. These patients are usually frail elderly or those with multiple complex co-morbidities.

3.1.2 Risk stratification may use the EMIS Q-Admissions score, E Frailty tool, monitoring of hospital discharge list and other intelligence (including knowledge of frequent hospital attendees and high cost patients) to identify those who might be most at risk for unplanned hospital admission.

3.1.3 Any patient that a member feels would benefit from an MDT discussion to aid the pro-active care planning of their needs can be put forward for discussion. This includes professionals from both the core membership and the extended membership

3.1.4 The professional putting the patient forward on the list should inform them that they will be discussed at an upcoming MDT for discussion with other relevant professionals. [Specific guidance for General Practice is available that details the ways this can be done to ensure that the information governance requirements are met].

3.1.5 The MDT will discuss new patients as well as review existing patients that need either reviewing or their circumstances have changed. Care planning and co-ordination is a journey rather than a single episode of care.

3.1.6 Patients to be discussed at the next MDT;

- may be determined at the end of each meeting,

- or at 10 days before the next meeting,
- or a few days before the next meeting only where a pressing need has been identified.

This list will be held by the MDT Coordinator for distribution to the core members. Members are expected to raise awareness about potential patients that they consider would benefit from an MDT approach to their care during that meeting, or by submitting request to the MDT coordinator 10 days prior to the MDT (to ensure that adequate time is given to members to prepare for the meeting).

3.2 Distribution of patient lists

- 3.2.1 Patient lists will be put on the file and distributed to core members one week in advance of the MDT.
- 3.2.2 The patient list will also be distributed to the practice pharmacist one week prior to the MDT in order for the patient to be considered for Medicines Optimisation (MO) review. The outcome of the MO review will be provided to the GP prior to the MDT for use within the meeting.
- 3.2.3 Emails to clinicians/professionals about patients with identifiable data must be from secure nhs.net accounts.
- 3.2.4 It is the responsibility of all members of the MDT core team to access the lists via the file and to research any involvement their organisation has had with the patient, completing the appropriate section of the MDT Action Plan (MAP) and bringing relevant history to the MDT

3.3 Actions & Outcomes from the MDT meeting

- Creating a Multi-Disciplinary Team Action Plan (MAP)
 - Ensuring EHCP is in place if appropriate that promotes well informed, proactive self-care
 - Further clinical or social assessments. Geriatric assessments, medication reviews, end of life planning may be an outcome due to unmet patient needs and must be documented in the MAP
 - Discussing and sharing the EHCP with the patient, carers and other care professionals involved in their care. Plans need to be owned not just by the clinicians but also by the patients themselves
 - Identifying, documenting and following up on actions that attendees will undertake following the meeting
 - Identify carers or family members that support the patient that may benefit from actions or recommendations of the MDT
 - Agree review date
- 3.3.1 People are approaching the end of life when they are likely to die within the next 12 months (GMC, 2010). Therefore all patients discussed in the MDT to be considered for the surprise question 'Would you be surprised if this patient died in the next 12-months, be it months, weeks or days?' Early identification of people nearing the end of their life and inclusion on a palliative care register leads to earlier planning and better co-ordinated care.

- 3.3.2 Actions that require referrals to nursing and other health services will be sent via managed referrals within EMIS Web.
- 3.3.3 Actions that require a referral to social care will be made by the MDT Coordinator via existing referral routes into that service (form emailed to Council admin office or phone call to CSN). However, professional judgement can be made by the worker attending the MDT to put the referral on the system themselves where appropriate and agreed in the meeting. [Note: Referral should state the worker who attended MDT for allocation purposes when appropriate]
- 3.3.4 Referrals to Age UK Living Well Link Workers and Carer's Centre Locality Workers and other outside agencies will be made via existing referral routes into those services by the MDT Coordinator when agreed as an action from the MDT and the practice must notify the patient of the referral and notify the MDT Coordinator when this has been done.

3.4 **The MDT coordinator will:**

- Work closely with the GP providing support to ensure MDT meetings are productive and effective.
- Keep an attendance list of all those who attend the MDT, to be shared at the end of each month with all of the providers.
- Report non-attendance monthly by exception through the appropriate governance structure.
- Work with the integrated core team, providing co-ordination and support to the team in their management of patient care/pathway.
- Prepare for the core team MDT meeting by collating and distributing relevant information and patient lists in a timely manner
- Ensure that Practices accurate code all plans in the appropriate version of EMIS, are up to date and shared with all MDT members.
- Ensure Actions are documented in the MAP and are circulated to all MDT members.
- Refer to Age UK and Carer's Centre when agreed by MDT.
- In the future will have the capacity to make the necessary referrals to other partners, subject to data sharing agreements.
- Carry out any agreed actions as delegated by the GP or Senior Clinical Deputy that are appropriate and relevant to the coordination of patient care and within the remit and competencies of the MDT coordinator's role.

4. **Care Plans**

4.1 **Person-centred health and social care plan**

- 4.1.1 Every patient discussed at an MDT will have a Person Centred Health and Social Care Plan completed from the discussion and action points agreed at the meeting.
- 4.1.2 Each professional attending the MDT will fill in their section of the plan in advance with information that they have on the patient that is relevant and useful for the MDT

discussion. The MDT Coordinator will collate this information onto one plan with the actions agreed at the meeting.

- 4.1.3 After the first MDT discussion where the plan is pulled together, the MDT coordinator will send a copy of the agreed actions to those who attended the meeting. Cross-organisational tasks within EMIS Web will be used to notify members of the MDT of their actions. Once actions are complete MDT members will complete the task to notify the MDT Coordinator. Those MDT Members not on EMIS Web will receive notification of actions via email / paper.
- 4.1.4 A copy of the plan will be kept on EMIS Web and updated by the MDT Coordinator. The plan will be version controlled and the latest coded version sent to the GP Practice which must be held in the patient record. Partners can request a copy as required.
- 4.1.5 The plan is considered complete when all actions are completed by the agreed timescale and it can then be signed off.

4.2 Emergency Health Care Plans

- 4.2.1 EHCPs should be completed for those patients who are likely to experience an emergency event that may lead to a hospital admission and should be considered when reviewing agreed actions at the MDT if one is not already in place.
- 4.2.2 The plan should be completed by the GP or Community Nurse with the patient, taking into account what the person would like to have happen in the event of an emergency.
- 4.2.3 The EHCP should be shared with the patient, carers and all professionals involved in the patients care
- 4.2.4 If an EHCP is completed by a nurse, the plan must be jointly signed with the GP.
- 4.2.5 The guidance for the document is on the plan and should be followed by the person completing the plan and is available on the [Deciding Right web pages](#)
- 4.2.6 The other professionals attending the MDT should note on their system that there is an EHCP and that it is kept in the patient's home in a bright yellow envelope.
- 4.2.7 Patients with an EHCP in place will be brought to MDT for review at regular intervals as agreed at MDT.

Appendix 1

EMIS Codes for General Practice

Multi Disciplinary Team Action Plan	8CS2
Emergency Healthcare Plan	8CS9

Team Compact

The MDT Team Compact describes the expected professional relationships and actions of all team members. It will enable overall team effectiveness for the benefit of the patient, whilst ensuring effectiveness for the time and effort given by all parties. The agreement will support our overarching aims of improving the quality of care, improving patient experience and reducing avoidable non-elective admissions to hospital.

All Sunderland Care Model Multi-Disciplinary Teams will be:

Collegiate

- An MDT is a collection of peers and professionals where all members are **treated equally and respectfully**; all voices within the room need to be heard for the benefit of the patient.
- All members are expected to contribute equally and fully; therefore all members will attend meetings **prepared** of knowledge of the patients being discussed, in order to contribute actively and wholly.

Collaborative (Constructive)

- MDT working requires **team reflection** to understand whether we are collectively delivering the expected outcome. Therefore all MDTs will be provided with Business Intelligence to enable constructive and informed discussion and qualitative **audit** of the team performance.
- Participation in **peer review** of MDT working enables system-wide best practice to be shared for the benefit of the whole community, and challenges un-collaborative behaviours and practice in the interests of high quality care.

Creative

- Removing barriers between physical health, social care, mental health and voluntary services provides opportunities for **collaborative working** not achieved previously. Members must not be constrained by organisational barriers where these do not work in the interests of the patient.
- Creative ideas inform **effective care planning**, where patients are considered as individuals and plans reflect both their needs and wishes. No two care plans should be alike, given no two patients are the same.

As core members of the MDT we agree to work towards achievement of the Compact, and will be held jointly accountable (and those of the organisations we represent) in this aim.

Practice Representative Sign

Print

Date

MDT Coordinator Sign

Print

Date

Local Authority Representative Sign

Print

Date

STFT Representative Sign

Print

Date