Transforming health and social care in Kent and Medway

Top tips for MDT working

Multi-disciplinary working: The heart of local care

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Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.

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Introduction

What this pack is based on

This pack contain the top tips for multi-disciplinary team (MDT) working based on:

- **local best practice** from across Kent and Medway
- **observations** of MDT in action
- **information** from other areas.

Across Kent and Medway there will be local variances, according to population needs, however this pack contains information on the key features for every successful MDT and will provide consistency in working practice.

The vision for local care

- Local care is a new model of delivery of **integrated health and care** services **close to where people live**. It is a **collective commitment** of the health and care system in Kent and Medway to fundamentally transform how and where we will support people to keep well and live well.
- The Kent and Medway l**ocal care workstream** was set up in November 2016 and has developed and refined a new clinical model for **adults and older people with complex needs, typified by the Dorothy model.** The model is a Kent and Medway-wide framework against which detailed local planning can continue. It has been developed from more than 12 workshops and is supported by an investment case.

The vision for Dorothy

We have initially focused on the development of local care for adults and older people with complex needs using an example service user, Dorothy to bring the model to life.

- Dorothy will no longer need to repeat her story over and over again to different professionals – key workers will help to co-ordinate care and support and ensure that her wishes and goals are at the heart of her care and wellbeing planning.
- If she needs help urgently she'll be able to access rapid response at home via a skilled professional who understands Dorothy's case and can assess her needs to get her the right support. This will help to stabilise the situation and hopefully avoid Dorothy going to hospital.
- If she does need to go into hospital, Dorothy will be supported to get home as quickly as possible with the appropriate support so she will recover faster.
- If she needs to see a specialist/expert wherever possible this will be done close to home.
- Dorothy will be supported to stay independent in her own home for as long as possible.
- She will have one number to call when she needs help, advice or support.
- She will be safe in her home free from harm and hazards.

Top tips for multi-disciplinary team working

As multi-disciplinary teams (MDTs) are at the core of the eight interventions that support the Kent and Medway Dorothy model, a key area of focus for the local care team has been to support the roll-out of MDT working at locality level (populations of 30 to 50,000) across Kent and Medway.

Here are some top tips for MDT working, informed by practical examples from across Kent and Medway, the UK and abroad. It includes:

- **the characteristics of a well-functioning MDT**
- **top tips for identification and enrolment**
- **the characteristics of an effective MDT meeting** (the appendix contains more detailed information).

1. Strong narrative and compelling vision

The team understands their purpose and "why" MDT working will support better care for people.

- Members of the MDT and others tell a compelling story which allows people to understand the need for change, the purpose and potential benefits of the new model of care for patients, staff and the wider public and the role of the MDT within that model.

The story for Kent and Medway

People are living longer, many of them with long-term conditions (LTCs) which use up to 70% of the NHS budget.

Evidence shows that each day around 1,000 people in Kent and Medway are in a hospital bed when they no longer need to be.

We know that as many as four-in-10 emergency hospital admissions could be avoided if the right care was available outside hospital.

If staffing in Kent and Medway was in line with the national average, there would be 245 more GPs and 37 more practice nurses.

The wider healthcare system is also feeling the effects of cuts in social care funding, with increased demand on the health service adding to the pressure.

There is a real need to:

- work differently to keep people well and in their own homes for as long as they possibly can be
- share resources and work in a more coordinated and joined-up way.

2. Focused identification and enrolment on to the programme of care

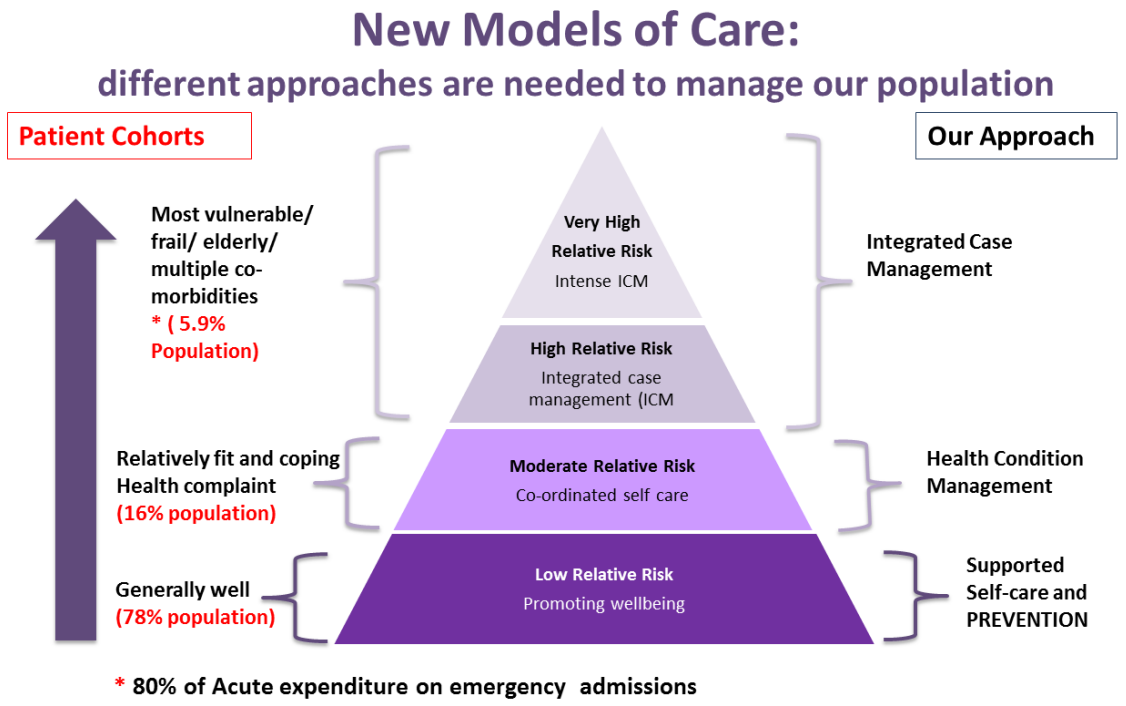
Team members are clear on who they are seeking to support in the new model of care, for example adults and older people with complex needs. People from this cohort are identified and enrolled on to, or referred into, the MDT for targeted support.

Integrated MDT working supports the management of individuals who have:

- the highest health complexity
- with multiple co-morbidities
- frequent hospital admissions
- psychosocial issues
- frailty, mental health conditions and
- poly-pharmacy (multiple medicines).

And are identified by:

- frailty risk stratification tool
- frequent attendances to A&E or other services for health related needs
- concern by any member of the MDT.

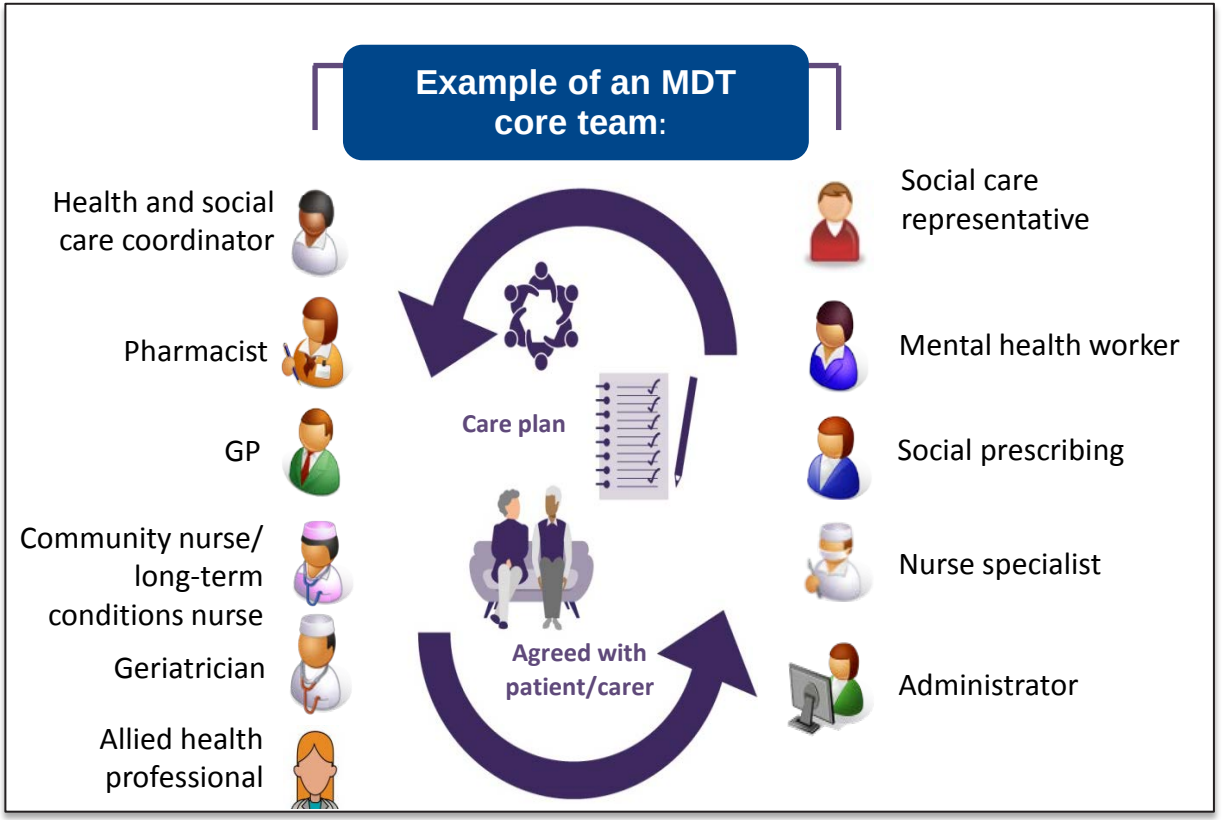


3. Multi-disciplinary membership

- Membership of the MDT should reflect the holistic (physical, social and psychological) needs, including preventative, ongoing and urgent care needs of the enrolled cohort.

- Core members of the MDT attend every MDT meeting, with additional members from related services providing input when needed;
- their input will depend on the needs of the individuals targeted and the availability of services in the local community.

- For example, it may be worth having an MDT for specific care homes, focusing on the needs of individuals in their care.



4. The patient is the main focus of care and the core member of the MDT: “No decision about me without me”

The patient is able to feed in their needs and wishes, aims and aspirations and be fully involved in all decisions taken by the MDT, of which they are the founding member! Where there are capacity issues family and carers will be suitably involved.

As mentioned, the model of care developed within the STP local care workstream is The Dorothy Model:

This model will build a vibrant social, voluntary and community sector to support individuals to look after their health and wellbeing, connect with others, manage their long-term conditions and stay independent. It will be delivered through a designated multi-disciplinary team, bringing together staff from health, social care and voluntary sectors.

Its more about the principles than the name!

- Person-centred
- Proactive
- Multi-disciplinary
- Across agencies
- Local – building on community assets.

There are other examples across Kent and Medway;

- The Buurtzorg models from the Netherlands
- The ESTHER model from Sweden and
- The Valerie model from east Kent in the Encompass Vanguard

Other models of care

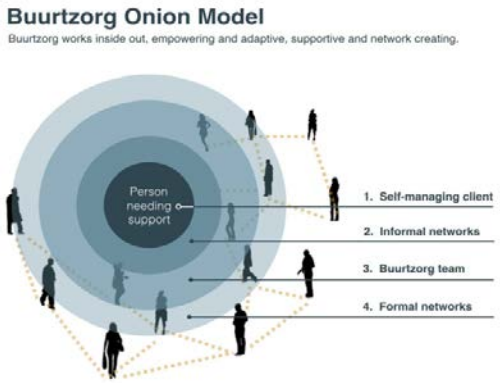
Esther:

How does the model work?

- The **Esther** model uses continuous quality improvement, cross-organisational communication, problem-solving and staff training to provide the best care for elderly patients with complex care needs such as Esther.
- The main features of the model are **Esther networks** and **Esther coaches.**

Website: Click here. **Esther brochure**: Click here.

Buurtzorg:



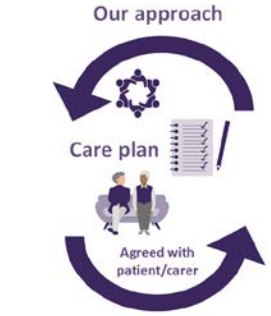
How does the model work?

Buurtzorg is a unique district nursing system providing:

- holistic assessment of the client's needs which includes medical, long-term conditions and personal /social care needs. Care plans are drafted from this assessment
- map networks of informal care and assess ways to involve these carers in the client's treatment
- plan identify any other formal carers and help to co-ordinate care between providers
- care delivery
- support the client in his/her social environment.

Website: click here

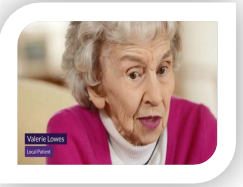
Encompass Valerie Model:



How does the model work?

Encompass, one of the NHS Vanguards, set out in 2015 to deliver new models of care. The ambition was to deliver an integrated health and social care model, delivering:

- high-quality care which met people's needs
- was co-ordinated to avoid duplication
- and is easy to access and enables people to stay well and live independently for as long as possible in their home setting, to avoid them going into hospital.



Valerie is one of the patients to benefit from the new model of integrated care. To watch her **story** click here.

5. Well-led and well-supported

There is senior capable leadership of the MDT and the programme of care. **Capability matters more than discipline.**

The chair can be any clinician within the MDT as long as they can:

- ensure smooth running of meetings
- encourage participation and clear action development
- ensure all decisions meet clinical governance and safeguarding requirements.

Dedicated administration support is vital to coordinate the work of the MDT inside and outside the meetings.

6. 'One team' culture

The MDT is one team with no professional or organisational boundaries. There is active participation of all team members at and between MDT meetings and there is equality of team member status. No referral forms are required between members and organisations represented. Members socialise together to build professional relationships and celebrate successes.

MDT working builds relationships between health, social care, the voluntary and care sector to improve health and wellbeing outcomes for individuals.

7. Clarity of where the clinical accountability resides

There is clarity around where clinical accountability for the patient sits:
(a) with the MDT
(b) with a lead GP from the person's GP practice
(c) with the person's GP.
There is also clarity around whether the MDT has the right to make decisions that may override those of hospital staff with respect to the care of patients who are under the care of the hospital but also enrolled in the programme of care.

Organisational accountability:
Across Kent and Medway the landscape is changing; we are seeing the role of commissioning being split into those functions needed to provide local care and other functions moving into a more strategic structure. Provider organisations are also starting to change the way they are working, coming together as alliances, sharing resources and working together as MDTs. **Presently each individual within the MDT works to their own organisational Governance Framework, adhering to their own organisational policies procedures and lines of reporting.** Over time this may change as organisations form Integrated Care Partnerships and may have shared policies and procedures, **but for the moment each member of the MDT will work to their organisational governance framework.**

Clarity of where the clinical accountability resides (continued from previous page)

The STP is in discussion with the CQC at present as to how this may affect inspections and meets the desired requirements for quality and safety.

THE MDT:
Decisions made within the MDT are collectively agreed and documented. All parties attending the MDT do so in their role specific capacity, providing an opinion based on their speciality and competence. For example, the role of the GP within the MDT is to provide a medical opinion; accountability for an individual's care ultimately lies with the person's registered GP and if there is a recommendation to alter anything related to the person's medication for example, a message is sent from the MDT to the GP concerned, to make the final decision.

There are different models of working across Kent and Medway;
- some MDTs providing a GP who acts on behalf of colleagues
- others where the relevant GP phones or videoconferences in and
- others where all GPs are in attendance.

It may be that the MDT makes a decision to override those of hospital staff e.g. decide an individual is safe for discharge from hospital; in this instance a nominated person from the MDT will make contact with the hospital and the individual involved to ensure there is coordinated and safe transition home.

At the MDT it may be that one individual is nominated to be the key contact person for the patient (usually the person who initially talked to them about bringing them to the meeting (but not always).

8. Regular seamless contact

There is daily contact between members of the team and with other professions (such as hospital discharge teams) as they care for all the people in the cohort. Face-to-face team meetings take place weekly and at the same time and location each week.

It is important that the team meets initially, face-to-face, to build:
- relationships
- trust in one another.

Once the team is formed and relationships built, other options to increase efficiency such as skype/video conferencing can be used.

Weekly MDTs are advised, although contact happens daily, outside the meetings via:
- email
- phone
- IT system for care plan.

9. Information sharing

All team members have remote access to the patient's care plans and relevant clinical information and have the ability to communicate easily with each other, including with the patient and carer.

Time has been given to consider what information should be shared between health and care organisations and there is an agreed process for sharing that information.

It is important that all MDTs consider how best to engage and involve individuals being discussed – any actions should start with their wishes and be based on conversations that have taken place.

General Data Protection Regulation (***GDPR)*** legislation now supports those involved in the direct care of someone being able to have conversations without the need for direct consent, however it is essential that any actions need to be fully discussed and agreed with that individual.

1. **Consent –** consent is obtained and documented by the relevant member of the MDT, before details can be discussed at the MDT meeting. It is their responsibility to ensure individuals are fully informed and understand how and why information is being shared and who it is being shared with (providing both verbal and written explanation so that the individual is making an informed choice). The GDPR gives a specific right to withdraw consent. You need to tell people about their right to withdraw, and offer them easy ways to withdraw consent at any time.
2. **Confidentiality-** all members of the MDT should have undertaken information governance training and have a legal duty to maintain the highest level of confidentiality. Anyone who views a patient GP record is under a duty of confidence, which is written into contracts of employment.
3. **Data sharing -** data sharing agreements are in place between the MDT and each GP practice to allow the viewing of real time clinical data. An integrated case management pathway data sharing agreement is in place between the GP practices and other provider organisations.
4. **PIA -** A privacy impact assessment **(PIA)** has been undertaken to identify, assess, mitigate or avoid privacy risks.
5. **Information governance -** there is a legal framework governing the use of personal confidential data in healthcare which we adhere to called Information Governance.

Website: www.itgovernance.co.uk/data-protection-dpa-and-eu-data-protection-regulation

MDT information governance (IG): Top tips

- Understand who is in your MDT and who they work for.
- Use the expertise of your IG leads to ensure the way you want to share information is lawful and properly approved.
- Ask your IG leads to complete a data protection impact assessment for your MDT.
- Check that all privacy (fair processing) notices include a statement to the effect that “processing is necessary for the purposes of medical diagnosis and the provision of health or social care or treatment” or your information sharing won’t be lawful.
- Decide who (and which organisation) will be responsible for co-ordinating and administering team meetings and keeping records.
- Decide who’s data protection officer (usually the co-ordinating organisation) will act as the main contact point for MDT data protection enquiries.
- Terms of reference should state the MDTs purpose and have a protocol for managing meetings and record-keeping.
- Your employer has a legal duty to make sure you can access relevant health records, including those held by other providers. Work with your IT service to find the best way to achieve this.
- Make sure your IT system has access controls (log-in permissions etc.) to manage who can view what stored documents and records. It must record who has viewed a record or document.
- Have data sharing or joint control agreements in place before sharing health or social care records using IT.
- Remember, face-to-face conversations, including teleconferencing and video calls (unless recorded) are not subject to GDPR. These come under the duty of confidence and are subject to professional codes of conduct.
- Understand that consent is not required to share information for an individual’s care and support. The proper legal basis under GDPR is public task.
- GDPR permits sharing of an individual’s health or social care information for their direct care without consent provided it is ‘under the responsibility’ of a registered health or social care professional (and their administration support).
- Act in accordance with your professional body’s code of conduct when sharing information (if you belong to one).

Information sharing (continued)

There is no need for consent when sharing patient data with those clinicians/carers directly involved in the care of that individual patient.

However, we need to bear in mind that there may be people attending the MDT who are not directly involved with the care of that particular patient.

The people involved in the direct care of a person are included in the sharing of information.

For those not directly involved in care, a privacy notice has to be in place, which makes it clear who we share information with.

The Kent and Medway Information Sharing Agreement (KMISA) covers all partner organisations, so check with your IG lead to ensure any voluntary organisations are included (as long as in the "purpose document", second part of the KMISA is explicit about their involvement within MDTs),

The KMISA is not a catch all for anything at all, there has to be a purpose document – which makes the reason explicit.

If the voluntary organisation is contracted, for example the carer organisations who are contracted to undertake assessments, then the sharing is in the contract not the KMISA.

Information system

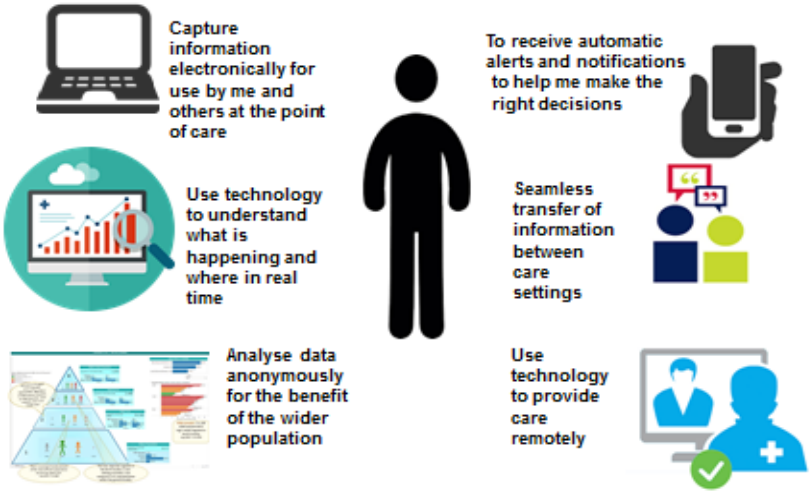
An information system is in place to ensure urgent and emergency care staff are notified that the patient is enrolled and has a care plan which needs to be taken account of, for example, call handlers in NHS 111/999, paramedics and hospital staff.

As a result, the MDT is alerted whenever people enrolled in the programme call an ambulance, go to A&E or get admitted to hospital.

There are a number of IT solutions across Kent and Medway to be able to share data. These will be superseded as the **Kent and Medway Care Record** project is implemented.

The KMCR is a crucial enabler to create a joined up health system in Kent and Medway.

- The KMCR will bring together a set of predetermined information fields from different health and social care records across the system to enable professionals to make informed decisions about care and treatment
- The system will be a repository of patient care information relating to health and care interventions
- The system will be fed with a specific set of data fields in near real time from multiple point of care systems
- The KMCR is a system transformation enabler – not an IT project.



KMCR is not a replacement system. Instead, it will bring key data together from current systems to provide an up-to-date record of the patient's care and treatment arrangements

10. Single point of access and rapid response

The patient has one number to call if they need help, advice or support. The single point of access is to a specialist call handler, specifically trained for this cohort, with access to the care plan and care record. When an urgent care need of the patient is identified, the call handler alerts an appropriate member of the MDT, who is required to respond. Any member of the MDT and the wider system can be mobilised accordingly**.**

An individual should have access to the MDT with a single number to call. Across Kent and Medway there are different solutions for this, most commonly using a care navigation service and or health and social care coordinator role as the key contact person.

As MDTs develop there is a need for linking to out-of-hours services. The **Local Care Implementation Board** has be established, where senior leaders from across health, care and the voluntary sectors have agreed collectively to work together and invest in developing local care and the solutions to providing this in, and out of, normal working hours.

11. Regular peer review

There is regular peer review of the performance and working effectiveness of the MDT. The MDT is peer reviewed by members from other MDTs in the local area, who assess data, observe meetings and provide feedback in a structure way.

As local care develops this will be further developed through the local care leads, from providers and clinical commissioning groups, as a learning set to define standards for peer review.

12. Attention to results

There is a focus on measurable outcomes, both service related as well as patient related outcomes and experience and staff experience. Successes are celebrated.

The Local Care Implementation Board will agree the metrics for measuring success, so that a consistent approach can be used across Kent and Medway. It is likely these metrics will be focussed on:

Patient outcomes:

- admission avoidance
- reduced hospital length of stay
- Satisfaction.

Staff outcomes:

- recruitment and retention
- sickness absence
- job satisfaction.

Transforming health and social care in Kent and Medway

Appendix

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Appendix

Membership skills and competencies

- **Core team:** Medical expert generalist (GP or geriatrician), social care, pharmacy, community nursing, therapy (physio or occupational therapy), mental health, peer support, health and social care coordination, health coaching, social activities support, palliative care and dementia, administration.
- **Related services (may vary locally):** GPs, specialists, housing, police, fire and rescue, community workers, hospices and care homes, voluntary sector support, paramedic, finance and benefits, relationship and family support, safeguarding (adult protection).

Top tips for identification and enrolment

- **Have holistic identification criteria:** Both professional judgement and data-driven approaches are important in identification of people for enrolment, but often just focusing on primary or acute data tells a limited story. Linked datasets are therefore crucial. It is about much more than cost and risk.
- **Be open to requests for enrolment:** Allow anyone in the community that is served by the programme to request for a patient to be enrolled in the MDT.
- **Prioritise those with greatest need for enrolment:** This allows the team to focus on getting everything right for them.
- **Upon enrolment, gain consent from the patient for all processes: E**nrolment should involve a detailed conversation with the patient about the benefits of the programme of care and consent for the model of care, including information sharing. The patient should consent for the MDT and clinical lead to be accountable as the first, and often only, 'port of call' for their care. NHS Improvement provides a useful communication tool (SBAR) to facilitate this conversation.

Characteristics of an effective MDT

1. The purpose and function of MDT meetings

- The principle objective is to agree care and support plans with patients or to agree care and support options to suggest to patients. Other objectives do not take precedence.
- In delivering the care and support, the MDT aims to fill the gaps in any support required, as opposed to overriding or duplicating services that would already be in place.
- MDT discussions result in a documented plan.
- MDT meeting objectives include local, as well as national, goals.
- Objectives of the meeting are explicitly agreed by each team.
- There is a formal mechanism for discussing recruitment to trials in MDT meetings, for example having clinical trials as an agenda item.

2. Information

- Attendees have remote access to patient care plans and relevant clinical information.
- Attendees have access to a list (in excel or on a database) of patients enrolled by practice, with indication of referrer, reason for referral, e-Frailty score, log of who has been involved, action and outcome.
- An information system is in place to allow the MDT to task the patient's GP and other members of the wider health and care community.
- All action points are recorded electronically and reviewed at each meeting.

3. MDT meeting processes

- A suitably trained chair ensures the meetings run smoothly, encourage participation and action development.
- There is a check at the start of each meeting to ensure confidentiality agreements have been signed by all attendees.
- There is clarity on who is co-ordinating the care of each patient (the care co-ordinator or case manager role).
- The case manager or care coordinator has told attendees in advance what information they need to bring on each patient.
- All new patients are discussed – even if a clear pathway exists.
- Where an MDT meeting decision is changed, the reason is always recorded.
- There is a named implementer documented for each decision.
- Implementation of MDT decisions is checked at each meeting and audited annually.

4. Administrative support

- Admin support coordinates the work of the MDT and the meeting.
- Examples of support include: booking the venue, collating paperwork prior to meetings, circulating pre-reading material, taking attendance, minutes and actions in meetings and circulating these in a timely manner.

5. Contents of discussion in MDT meetings

- The focus is on patients enrolled into the MDT programme of care. However, the MDT can also play an advisory role for patients not formally enrolled in the programme, with discussion/suggestion as to whether or not they would be suitable for an MDT approach.
- Co-morbidities, health and care activity, family and social circumstances should be routinely discussed.

6. The role of the patient in MDT Meetings

- The MDT should actively seek all possible care and support options, taking into account the patient's values and preferences and discuss these with the patient during or after the meeting.
- Patients should be given feedback about the recommended outcomes of the MDT meeting.
- Where it is potentially inappropriate to share the contents of the MDT discussion with the patient, for example where it would lead to undue anxiety, the decision should be formally agreed and noted. This should be considered exceptional (likely to be when capacity is not present) and alternatives sought.

Document tracker

Version	Date	Shared with	Comments	Action taken
5.4	03/07/2019	Local Care Leads	• MDT top tips document produced	Shared with local care colleagues across Kent and Medway
5.5	30/05/2019	Uploaded onto STP website	• Content refreshed and updated	Transferred from Word into Power Point for STP website