Wessex Academic Health Science Network

NHS

Developing a **MDT (Multi- Disciplinary Team)** approach to meet the needs of older adults living with moderate to severe frailty in the community

Sharing of approach and insights from across Wessex

How is this guidance designed to help me?

MDTs supporting older adults living with frailty in the community vary in their composition, relationships and design. One set of guidance won't fit all; however, underlying best practice principles can be identified that lend themselves to being adopted and adapted for local needs.

This guidance was developed using the Dorset Frailty Toolkit, national best practice MDT guidance and a synthesis report by the Wessex AHSN Insight team (comprising evaluation reports on local Vanguard sites and other related projects 2016-2019 evaluating different models of integrated care). The approach was tested in Wessex on both newly developing MDT teams and already established MDT teams wanting to improve working practices.

It has been developed for health and social care professionals and those commissioning MDT services for individuals living with moderate or severe frailty in the community.

This framework has been inspired by what has worked well in Wessex. It includes:

- MDT Checklist
- Top tips, suggestions and a case examples approach to help progress areas within the MDT in need of development
- Implementation resource pack including case studies and a worked example to measure financial impact.

A four step approach

STEP 1: Review

Use the quick checklist to review your own MDT working

NHS Checklist for setting up / developing MDT working to support older adults living with frailty in the community — Wessex Academic Health Science Network

1. Ensuring virtual working and technology is enhanced to deliver exemplar MDTs	Yes /No	Plan to develop
1.1 Are all services connected to the MDT on the **same IT system** and/or **able to access MDT discussion / care plan information?**		
1.2 Is an electronic MDT discussion tool in use which: - Documents the **reason** for the MDT discussion - Records **outcomes** of the MDT discussion - Records required **actions agreed with individual living with frailty and or their carer** - Supports **follow up** of outcomes and actions		
1.3 Are the underpinning **common principles of the MDT team** clearly documented?		
1.4 Is a **process chart** from risk profiling patients for MDT discussion to MDT outcomes followed with management support?		
1.5 Are **process measures** in place and used to achieve intended outcomes?		
1.6 Are **outcome measures** in place and used to achieve intended outcomes?		
1.7 Is access to **frailty E-Learning training modules available** for all those involved in MDT discussions?		
1.8 Has the whole MDT completed the frailty e-learning training module?		
2. Sharing MDT information with other health and social care organisations	**Yes / No**	**Plan to develop**
2.1 **Do you have one shared electronic care plan that allows:** - Different health care team members to complete different parts of the **same care plan?** - **Is easy to update and amend?** - Can be shared on IT systems of all services involved in the MDT?		
3. Ensuring both the patient, their family/carers are included in MDT discussions	**Yes / No**	**Plan to develop**
3.1 Do all documentation tools (Care plan / MDT discussion/ holistic comprehensive assessment) clearly **record patient/ carers perspective and priorities?**		
3.2 Has the MDT **Care co-ordinator role** been developed to ensure family/ carers are included in MDT discussions?		
4. Standardising the MDT and who attends MDT sessions	**Yes / No**	**Plan to develop**
4.1 Are the **terms of reference for the MDT documented to** include: - **Purpose** of the MDT? - **Who should attend** the MDT including identifying key representatives from health, social care, and voluntary care? - **Clear expectations of the chairperson?** - **Clear expectations of the attendees?** - **Clear record keeping?** - **Processes**		
4.2 Are the **roles and responsibilities** of all attending the MDT documented and agreed?		

STEP 2: Highlight

Highlight areas on your MDT checklist you would like to develop and improve further

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1. Ensuring virtual working and technology is enhanced to deliver exemplar MDTs	Yes /No	Plan to develop
1.1 Are all services connected to the MDT on the **same IT system** and/or **able to access MDT discussion / care plan information?**	yes	yes
1.2 Is an electronic MDT discussion tool in use which: - Documents the **reason** for the MDT discussion - Records **outcomes** of the MDT discussion - Records required **actions agreed with individual living with frailty and or their carer** - Supports **follow up** of outcomes and actions	no	
1.3 Are the underpinning **common principles of the MDT team** clearly documented?	yes	yes
1.4 Is a **process chart** from risk profiling patients for MDT discussion to MDT outcomes followed with management support?	no	
1.5 Are **process measures** in place and used to achieve intended outcomes?	no	
1.6 Are **outcome measures** in place and used to achieve intended outcomes?	yes	yes
1.7 Is access to **frailty E-Learning training modules available** for all those involved in MDT discussions?	no	
1.8 Has the whole MDT completed the frailty e-learning training module?	no	
2. Sharing MDT information with other health and social care organisations	**Yes / No**	**Plan to develop**
2.1 **Do you have one shared electronic care plan that allows:** - Different health care team members to complete different parts of the **same care plan?** - **Is easy to update and amend?** - Can be shared on IT systems of all services involved in the MDT?	yes	yes
3. Ensuring both the patient, their family/carers are included in MDT discussions	**Yes / No**	**Plan to develop**
3.1 Do all documentation tools (Care plan / MDT discussion/ holistic comprehensive assessment) clearly **record patient/ carers perspective and priorities?**	no	
3.2 Has the MDT **Care co-ordinator role** been developed to ensure family/ carers are included in MDT discussions?	yes	yes
4. Standardising the MDT and who attends MDT sessions	**Yes / No**	**Plan to develop**
4.1 Are the **terms of reference for the MDT documented to** include: - **Purpose** of the MDT? - **Who should attend** the MDT including identifying key representatives from health, social care, and voluntary care? - **Clear expectations of the chairperson?** - **Clear expectations of the attendees?** - **Clear record keeping?** - **Processes**	yes	yes
4.2 Are the **roles and responsibilities** of all attending the MDT documented and agreed?	No	

STEP 3: Develop your MDT best practice approach

Refer to corresponding guidance suggestions - top tips and case examples

STEP 4: Implement

Utilise Implementation pack resources

Resource	Description	Link
1. Journey of developing a Wessex MDT approach	A systematic representation of the PDSA cycles involved in developing the Wessex MDT approach for those living with moderate or severe frailty in the community	Journey of developing the approach
2. Hints and tips to delivering financial impact	A stratification approach including stratification of: • 1. Clinical case load • 2. Stratified population with MDT intervention offered and those where intervention is not offered Worked examples and useful references included	Delivering financial impact
3. Fishbone describing Barriers to implementation	A representation of some of the barriers to implementation. The guidance document designed alongside the MDT checklist was designed to offer solutions to these barriers	Barriers to implementation fishbone
4. Wilshire case study example	A **case example** of how the checklist and guidance have been used in Wiltshire to: • **1. Set up a new MDT** supporting those living with moderate/ severe frailty in the community • **2. Develop an existing MDT** supporting those living with moderate / sever frailty in the community	Case Study Example

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- **Dr Jackie Chandler** – Evaluation Programme Manager, Wessex AHSN
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