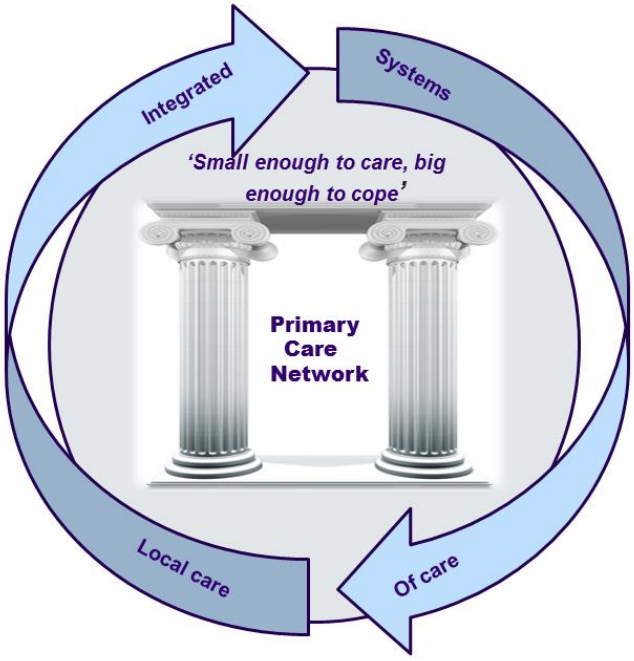
Local Care Multi-Disciplinary Team Framework

For Primary Care Networks

Kent and Medway STP

September 2019



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Transforming health and social care in Kent and Medway

Across Kent and Medway Groups of GP practices are coming together in partnership with community services, social care and other providers of health and care services, typically servicing populations of 30-50k as multi-disciplinary teams. These Primary Care Networks, (PCNs), provide a platform for providers of care to be sustainable in the future -

"Small enough to Care, and Big enough to cope"

The following document has been co-designed with partners across Kent and Medway and provides a framework for the PCNs which provide consistency of practice yet allows for variation locally.

Related Documents

Title	Reference
MDT Top Tips	LC002

Document Tracking Sheet

Version	Status	Date	Issued to/approved by	Comments / summary of changes
1.0	Approved	04/09/19	Kent and Medway Local Care Board	

1. Background

1.1 Scoping workshop

The Kent and Medway Sustainability and Transformation Partnership (STP) were asked to support a scoping workshop with East Kent Clinical Commissioning Groups (CCGs) to explore content ideas for an MDT standards document. It was suggested an MDT **framework** would be helpful and would give structure to MDT meetings, a place to start and then adapt locally. The main items discussed were collated into a first draft document and circulated to the group for comment.

2. Engagement

Following the scoping workshop and feedback, the draft MDT framework was circulated to colleagues across Kent and Medway for comment. The feedback has been really valuable in helping to develop and shape the framework.

2.1 Engagement tracking sheet

Version	Status	Date	Comments
V0	Workshop	11/01/19	Initial scoping workshop held with East Kent.
V0.1	Draft	06/02/19	Circulated to Local Care Lead for comment. Change made.
V0.2	Draft	11/02/19	Circulated to East Kent CCG Scoping workshop members for comment.
V0.3	Draft	19/02/19	East Kent Scoping workshop members feedback and comments included.
V0.4	Draft	28/02/19	Local Care Lead additional comments included following feedback from Medway LC Steering Group.
V0.5	Draft	14/03/19	Circulated to Local Care Leads, LMC and GP Federation Local Care Board Members for comment.
V0.5	Draft	22/03/19	Discussed at the Local Care Directors Meeting.
V0.5	Draft	26/03/19	Discussed with the Leader of Kent County Council. Check list added.
V0.6	Draft	26/03/19	Local Care Lead additional check list items following feedback from Medway LC Steering Group.
V0.7	Draft	08/04/19	Addition by Local care Lead, aligning to Primary Care Network (PCN) Development. Amendments to Federations and Organisational Development from STP Primary Care Lead to align to PCNs.
V0.8	Draft	11/04/19	Feedback from Medway Clinical Lead for Mental Health. Amendments to: Leadership, defining the core membership including adding diagram, output and items to record in the care plan, referrals, criteria for patient identification, adding palliative care to the check list and ensuring the triage is by a clinical member of the MDT.
V0.9	Draft	12/04/19	Feedback from Medway CCG. Amendment to Practice MDT/Cluster MDT, consolidated throughput and quality, added effectiveness of meetings impacted by frequency, meeting themes are occasional, facilities of location added, clarity about who has overall responsibility.
V0.10	Draft	17/04/19	Feedback from Virgin Care, DGS and Swale CCG. Amended Co-ordinator role to say some are trained as trusted assessor as not in all CCGs, Referrals made in consistent way-such as SBAR-as not all areas use SBAR, query about who will triage-addressed in v0.8, suggested that checklist is added into referral form, Federation amendments made in v0.7, meeting themes amendments made in 0.9.
V0.11	Draft	16/05/19	Feedback from Social Care Older People & Physical Disability Senior Management Team Meeting. Frequency of meetings for Social Care should be fortnightly, added a glossary of terms, added individuals within MDT work to their own organisational governance framework policies and processes, added housing and public health to additional MDT members, added patient list circulated 'minimum of 2

Version	Status	Date	Comments
			working days' before meeting, example of what the referrer expects to gain from the referral such as social care assessment, changed actions to 'smart' actions. Vulnerable adults added to patient identification.
V0.12	Draft	28/05/19	Health, Housing and Social Care Sub-Group meeting. Linked leadership with OD toolkit, domestic abuse, mental wellbeing.
V0.13	Draft	19/07/19	Added safeguarding guidance in safeguarding section: 'Multi-Agency Safeguarding Adults Policy, Protocols and Practitioner Guidance for Kent and Medway', following advice via the Kent and Medway Adult Safeguarding Board.
V0.14	Draft	24/07/19	Discussed with STP Mental Health Lead. Mental Health questions edited in check list.
V0.14	Draft	30/07/19	Tested by Northgate MDT
V0.14	Draft	13/08/19	Tested by Gravesend MDT
V0.14	Draft	22/08/19	Circulated to the Clinical and Professional Board for information
V0.15	Draft	29/08/19	Comments from the east Kent Local Care Implementation Group to add in access to end of life specialist within the MDT

3. MDT Framework Indicators

Twenty one indicators of effectiveness have been identified and refined by colleagues during the development process of this document to produce an MDT Framework for Kent and Medway. This will remain a live document and will continue to be refined as MDTs develop and processes evolve.

3.1 MDT Top tips

Teams need to be aware of the 'Top tips' for MDT working which supports this **MDT Framework**. This is available on the kentandmedway.nhs.uk website (link below).

To download the 'Top tips' go to:
https://kentandmedway.nhs.uk/workstreams/local-care/

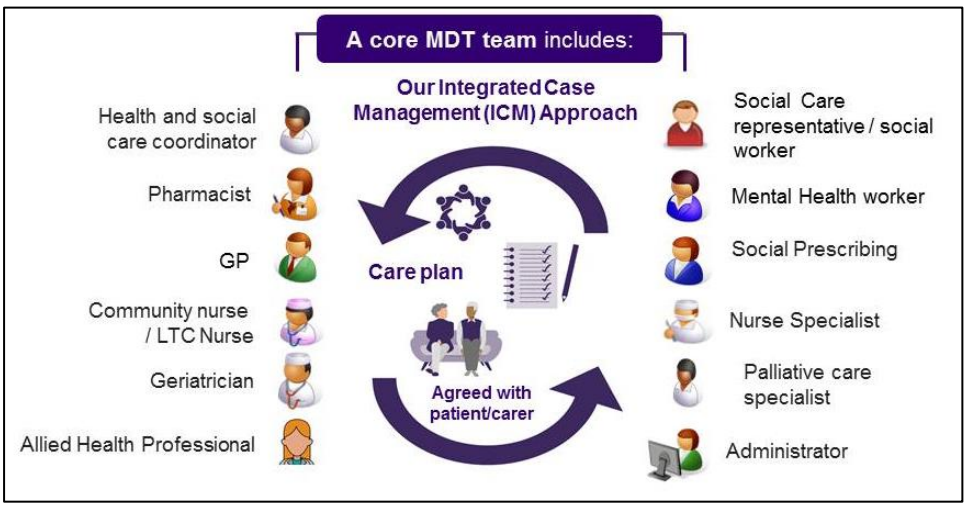
3.2 Leadership

The meeting needs to be led / chaired. This varies within each MDT. Examples of chairs/ those leading the group include: GP, Geriatrician, Practice Staff Member, Co-ordinator and Long Term Condition Nurse. Any decisions made need to be agreed by the team and clinically signed off. There may be a need for development in order for individuals to feel comfortable and confident to chair/contribute. For further information and support with the development process see the Organisational Development section 3.20.

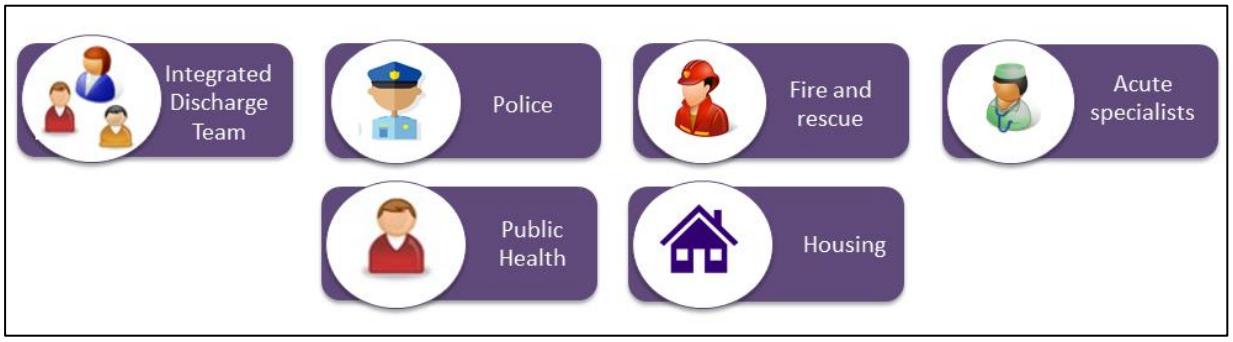
3.3 Membership and attendance

The membership of the meeting may vary with a **core** membership team attending every meeting and **additional** members attending when needed (example shown in diagram 1). This will often be determined by the needs of the **individual being discussed** and availability of services in the local community. If a member is unable to attend ensure an update is sent or if another person is representing the person from the previous meeting ensure there has been sufficient handover to facilitate comprehensive feedback.

Diagram 1



Example of additional members which vary locally:



3.4 Information Technology:

This is a key enabler in the running and management of the MDT. Examples of the use of technology include; EMIS Clinical Services, The Medical Interoperability Gateway (MIG), video conferencing, data inputting templates, care plan templates, Patient Tracking List (PTL) and teleconferencing.

3.5 Data Sharing

There is an agreed process for data sharing. Joint Control Agreements are in place between the MDT and GP practice to allow the viewing of real time clinical data. An Integrated Case Management Joint Control Agreement is in place between the GP Practices, Providers Organisations and Local authorities.

3.6 Practice MDT/Cluster MDT

Practices will work together in clusters, developing economies of scale and making best use of resources at scale such as attendance of services at the MDT meeting. It is recognised that in the early stages of development some MDTs may be held at individual practice level, however as the MDTs develop these practices will move towards cluster working.

3.7 Output

There is an agreement within the MDT of what relevant and required information will be collected; this is collated on the MDT care plan template. During the meeting the template is updated with key actions, agreed by all. The MDT will agree who leads and feeds back on the actions.
The MDT will agree when to safely discharge a patient after they have done all within their remit to support the patient.

3.7.1 The patients care plan needs to accurately document:

- The patients consent for referral to the MDT
- The patients goals/wishes and referral such as SBAR (which is a nationally recognised communications tool developed by NHS improvement)
- The referrers concerns
- Key actions discussed
- A nominated point of contact for questions/discussions/concerns

3.7.2 The MDT Case Load Check List has been completed:

- This is in appendix (1) on page (10). This can be added to the referral form to ensure consideration before the MDT.

3.8 Federations and Primary Care Networks

Practices are forming Primary Care Networks (PCN) in 2019/20.
Over time PCNs may form part of a larger working arrangement, such as a federation or other business model that achieves economies of scale. This may provide support services to the networks such as organisational infrastructure and governance, contract management, specialist staff and services, employment and career development, model design and population wellbeing and enable strategic partnerships. This may also be a way of ensuring a strong Primary Care voice within the Integrated Care Partnership (ICP) and Integrated Care System (ICS).

3.9 Co-ordinator

Each MDT will have a Co-ordinator. The Co-ordinator will ensure that the list of patients is circulated prior to the meeting (minimum 2 working days) and actions are followed up and completed. The Co-ordinator also ensures the referral form, such as SBAR (Situation, Background, Assessment, and Recommendation - a nationally recognised communications tool developed by NHS improvement) is populated and has recommendations for outcomes of the referral. In some areas the Co-ordinators are trained as trusted assessors and can initiate first visits and refer on as appropriate. They are the pivotal link between all services. Ideally Co-ordinators will also support practices to proactively identify potential patients for MDT discussion.

3.10 Referrals

Referrals into the MDT are made in a consistent way such as the SBAR format: Situation, Background, Assessment, and Recommendation. The referral form is populated as much as possible from a clinical system to avoid duplication. The referral will state who the referral is from, what the referrer expects to gain from the referral such as social care assessment and clearly documents the patient's consent. The checklist in appendix (1) on page (10) could be added to the referral form to ensure consideration before the MDT.

3.11 Quality

The quality of discussions needs to remain meaningful with smart actions being identified and person centred: proactive care remaining at the heart of the team:

- Enough time should be given for each individual discussed so that all members of the MDT are able to input into the MDT care plan as appropriate
- To hurry the process may result in missing vital information/actions to the detriment of the MDT care plan.

3.12 Criteria for patient identification

Team members are clear on who they are seeking to support.

3.12.1 MDT working supports the management of individuals who have:

- a high frailty score
- the highest health complexity,
- with multiple (3 or more) co-morbidities (long term conditions),
- frequent hospital admissions,
- complex psychosocial issues,
- frailty, complex mental health conditions and

- poly-pharmacy
- multiple vulnerable adult issues

3.12.2 and are identified by:

- Frailty risk stratification tool such as the eFI (electronic frailty index)
- Other patient identification tools as they are developed such as the Patient Tracker List
- Frequent attendances to A&E or other services for health related needs
- Concern by any member of the MDT and acute hospital staff including Rapid Transfer Service
- Frequent Area Referral Management Service (ARMS) and Client Support Service contacts that may benefit from wider support
- Vulnerable adults with a multitude of issues identified below:
    - Self-neglect and choosing not to engage
    - Unable to engage
    - May require support from a range of services and may have multiple needs
    - Appears to be at risk of harm to self and/or others
    - Difficult to assess their capacity
    - Has a chaotic lifestyle, substance/alcohol user, homeless
    - Care Leaver

3.13 Action LOG

An action log will be populated ensuring momentum is maintained and progress updates are given.

3.14 Contact frequency

The frequency of face to face MDT meetings varies across the county from weekly (most common), fortnightly (such as Social Care) and monthly. Effectiveness of MDTs may be impacted by the frequency of meetings.

Contact between members of the team and other professions (such as hospital discharge teams) will be more regular. Once the team are formed and relationships built (see section 3.20 for Organisational Development information and support), other options to increase efficiency such as skype/video conferencing can be used. **Contact will also happen regularly outside** the meetings via e-mail, phone and through technology.

3.15 Meeting themes (grouping clients/patients)

It may be beneficial to schedule some themed meetings focusing on a specific theme such as Care Homes or Mental Health, so that key individuals are involved for the appropriate time period, to make best use of their valuable time.

3.16 Triage referrals

Referrals are triaged by a clinical member of the MDT to ensure the patients that would benefit most from the MDT are supported.

3.17 Location

Face to face team meetings generally take place at the same time and location at the agreed frequency (see section 3.14) intervals (most commonly, weekly). Locations are usually

central to the team, easy to access and IT linked (see section 3.4 for examples of the use of technology). Often the meetings take place in a GP practice. There are examples of other settings such as a Care Home.

3.18 Terms of Reference

The MDT will have a Terms of Reference (TOR) clearly describing the vision and purpose of the team. An example TOR is shown in appendix (3) on page (12).

3.19 Shared responsibility

The MDT is one team with active participation of all team members at and between MDT meetings. This is a meeting where all voices are heard, with no hierarchy. Decisions made within the MDT are collectively agreed and documented. There is agreement as to who holds overall responsibility for the patient. Each individual within the MDT works to their own organisational Governance Framework, adhering to their own organisational policies, processes and lines of reporting.

3.20 Organisational Development

Investing time in Organisational Development to build MDTs into the core working of Primary Care Networks is encouraged and supported to deliver joined up care for their populations.

3.20.1 Kent and Medway Organisational Development toolkit

The STP has developed an OD Toolkit to support the OD process. This is available on the kentandmedway.nhs.uk website (link below). If you would like support to use this toolkit or have any questions please e-mail Karen Ray: karen.ray@kent.gov.uk or Lisa Webb: l.webb5@nhs.net

To download the OD toolkit go to:
https://kentandmedway.nhs.uk/workstreams/work-force/

3.20.2 Learning Library

Federations or similar organisations may support the learning process through the Primary Care Networks by supporting them to come together and review cases to inform future practice. These could be collated into a 'learning library' so that every Primary Care Network and patient benefit from learning made and share best practice across their Primary care Network.

3.21 Safeguarding

Each member of the MDT will have undertaken safeguarding training and will adhere to the; Multi-Agency Safeguarding Adults Policy, Protocols and Practitioner Guidance for Kent and Medway

Any safeguarding issues for the patient being discussed or carer or family member will be considered and recorded. Safeguarding will be considered as part of the check list in appendix (1) on page (10).

Appendix 1

MDT Case Load Check List

The following checks are considered and recorded for patients that are on the MDT case load:

Description	Yes	No
1. **Flu or pneumococcal pneumonia:** If the patient is eligible for flu or pneumococcal pneumonia have they had the appropriate vaccination?		A
2. **Home safety assessment:** Does the patient require a home safety assessment from Kent Fire and Rescue?	A	
3. **Mental Illness:** If the patient has a diagnosed Mental Health condition is there a link to mental health services either at the MDT or a way of referring?		A
4. **Mental wellbeing** Have we fully considered the individual's mental wellbeing (are they becoming socially isolated or showing signs of low mood or indications of hording behaviour)?		A
5. **Carer:** If the patient is a carer are they are linked to care and support services?		A
6. **Cared for:** If the patient is cared for are they linked to care and support services?		A
7. **Safeguarding:** Is there a safeguarding issue for the patient being discussed or carer or family member?	A	
8. **Palliative care:** Where appropriate use the SPICT (**S**upportive and **P**alliative **C**are **I**ndicators **T**ool) and consider a discussion with the patient regarding the palliative care register	A	
9. **Falls:** Is there a risk of falling or a need for a falls assessment?	A	
10. **Patient's needs:** Have we met the needs of the individual (what matters to Esther)?		A
11. **Communication:** Are there any barriers to communication? (if yes consider sign language or interpreter etc.)	A	

This check list can be added to the referral form to ensure consideration before the MDT.

Note: A **tick** in a box marked with A indicates an Action is required

Appendix 2

Glossary of terms

ARMS	The **A**rea **R**eferral **M**anagement **S**ervice is a Kent County Council referral management service
A&E	**A**ccident & **E**mergency department (**A&E**)
Buurtzorg model	**Website:** https://www.rcn.org.uk/about-us/policy-briefings/br-0215
eFI	Electronic frailty index uses existing information within the **electronic** primary **health** care record to identify populations of people aged 65 and over who may be living with varying degrees of **frailty**. https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/efi/#what-does-the-new-frailty-identification-requirement-in-the-gp-contract-mean-for-general-practice
Encompass Valerie model	**Website:** https://www.youtube.com/watch?v=1xNnnFv8FCY&feature=youtu.be
Esther model	**Website:** https://www.kent.gov.uk/social-care-and-health/information-for-professionals/design-and-learning-centre-for-clinical-and-social-innovation **Brochure:** https://www.kent.gov.uk/__data/assets/pdf_file/0007/69748/What-matters-to-ESTHER-brochure.pdf
ICP	**I**ntegrated **C**are **P**artnership
ICS	**I**ntegrated **C**are **S**ystem
MDT	**M**ulti-**d**isciplinary **t**eam
MDT Care Plan	Care plan created during the MDT meeting
MIG	**M**edical **I**nteroperability **G**ateway. The MIG makes it possible for other clinicians treating patients to view parts of the GP clinical record, including the patients MDT care plan.
OD	**O**rganisational **D**evelopment
PTL	**P**atient **T**racking **L**ist
Poly-pharmacy	This is the use of 'many' or multiple medicines
PCN	**P**rimary **C**are **N**etwork
SBAR	**S**ituation, **B**ackground, **A**ssessment and **R**ecommendation. It is a nationally recognised communications tool developed by NHS Improvement
Social Care and Support Plan	The Social Care and Support Plan is a Local Authority Care and Support Plan that is a legal requirement of the Care Act 2014
SPICT	**S**upportive and **P**alliative **C**are Indicators **T**ool - http://www.spict.org.uk/the-spict/
STP	**S**ustainability and **T**ransformation **P**artnership
Trusted assessors	A 'trusted assessor' has the qualifications, skills, knowledge and experience needed to carry out health and social care assessments, and to formulate plans of care on behalf of adult social care providers. – Source: CQC guidance

encompass
Working together for better health and care

Appendix 3

Example of an MDT Terms of Reference

Terms of Reference
COMMUNITY HUB OPERATIONAL CENTRE, MULTI-DISCIPLINARY CARE PLANNING (MCP) MEETING

Document Control

Version	Draft/Final	Date	Author	Summary of changes
1.0	Draft	5 Sept 2016	Cathy Bellman	First Draft
1.0	Final	20 Oct 2016	Cathy Bellman	Agreed
1.2	Draft	12 April 2017	Cathy Bellman	Statement of purpose amended to include greater detail of purpose and make reference to the CHOC Integrated Case Management (ICM) pathway. Section 2 altered following Contract Negotiations to include greater clarity around organisational accountability and governance (sections 2.2 and 2.3)
1.3	Draft	18 April 2017	Cathy Bellman	Added Health and Social Care Coordinators to membership (3.1)
1.3	Final	Agreed virtually via email	Cathy Bellman	

1. STATEMENT OF PURPOSE

Community Hub Operating Centres (CHOCs) are a means whereby all professionals come together and share their knowledge and skills to co-ordinate how local people are supported to improve their own health and well-being and when they are ill or need help, they receive the best possible joined up care. The CHOC Integrated Case Management process (pathway version 1.3) develops a joint care plan for high risk patients in order to anticipate crisis and keep then in the community and support hospital admission avoidance. This process can be face to face or virtual.

2. OBJECTIVES

The MCP is a “step up” to intensive multi-disciplinary team (MDT), differing from the normal practice MDTs; a way of proactively working with a health and social care integrated team to

review existing assessments, identify gaps in care and address these in a joined up co-ordinated way to help avoid hospital admission, for those most at risk of accessing A&E.

The CHOC MCP will;

- Produce one integrated care plan agreed by the patient and shared across all services
- Increase efficiency by avoiding duplication of data and appointments
- Identify gaps in care and address these holistically
- Ensure that health and social care needs of the individual are identified and addressed
- Bring social prescribing into the process (the intensive may not only be medical but there may be a social care need such as carer breakdown for example).

(CHOC patients are escalated to the CHOC MCP at a time of increased risk for a period of time until their need stabilises and then they go back into the normal system of care).

3 RESPONSIBILITY AND GOVERNANCE

3.1 All members are responsible for identifying patients who require more intensive MDT intervention. These patients may be identified through;

- GP risk stratification process
- Local knowledge from the teams involved
- Attendance at A&E
- Patient concerns.

3.2 All members will abide by their own organisational governance (policies, procedures and existing line management arrangements).

3.3 All members are expected to work openly and transparently, raising any issues to with the CHOC MDT (clinical or operational), and attempt to resolve locally. If this route fails then individuals are expected to escalate through their organisational line management.

4 MEMBERSHIP AND ATTENDANCE

4.1 Membership

Representation from all parties in Health and Social Care;

- GP,
- Community Nursing,
- Paramedics,
- Intermediate Care Team,
- Long Term Conditions,
- Health and Social Care Coordinators,
- Specialist Nurses,
- Allied Health Professionals,
- Adult Social Care,
- Mental Health Services,
- Voluntary and Care Sector including Red Zebra for social prescribing.

4.2 Chairmanship

Clinical Lead for each CHOC locality or otherwise selected by the membership.

4.3 Quorum

The success of the CHOC MCP meetings will depend on attendance from all parties concerned; it is expected a deputy will attend in place of a substantive member.

4.4 Attendance by Others at Meetings

Others may be invited at the discretion of the MCP team.

5 FREQUENCY OF MEETINGS

CHOC MCP meetings are held weekly for an hour in each CHOC locality.

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6 SUPPORT ARRANGEMENTS

Each CHOC MCP will be supported by an administrator who will annotate the care plan and distribute to all members.

7 REVIEW

TOR are to be reviewed yearly or sooner if any changes are agreed by the members.

8 CONFIDENTIALITY

All individuals discussed at the CHOC MCP will have consented to having their information shared.

All members of the CHOC MCP will be bound by their own organisational “code of Conduct” for confidentiality.