NHS
Institute for Innovation and Improvement

Releasing Time to Care

The Productive Community Hospital™

Multidisciplinary Team Working

Version 1

This document is for clinical leaders, department managers and senior therapists

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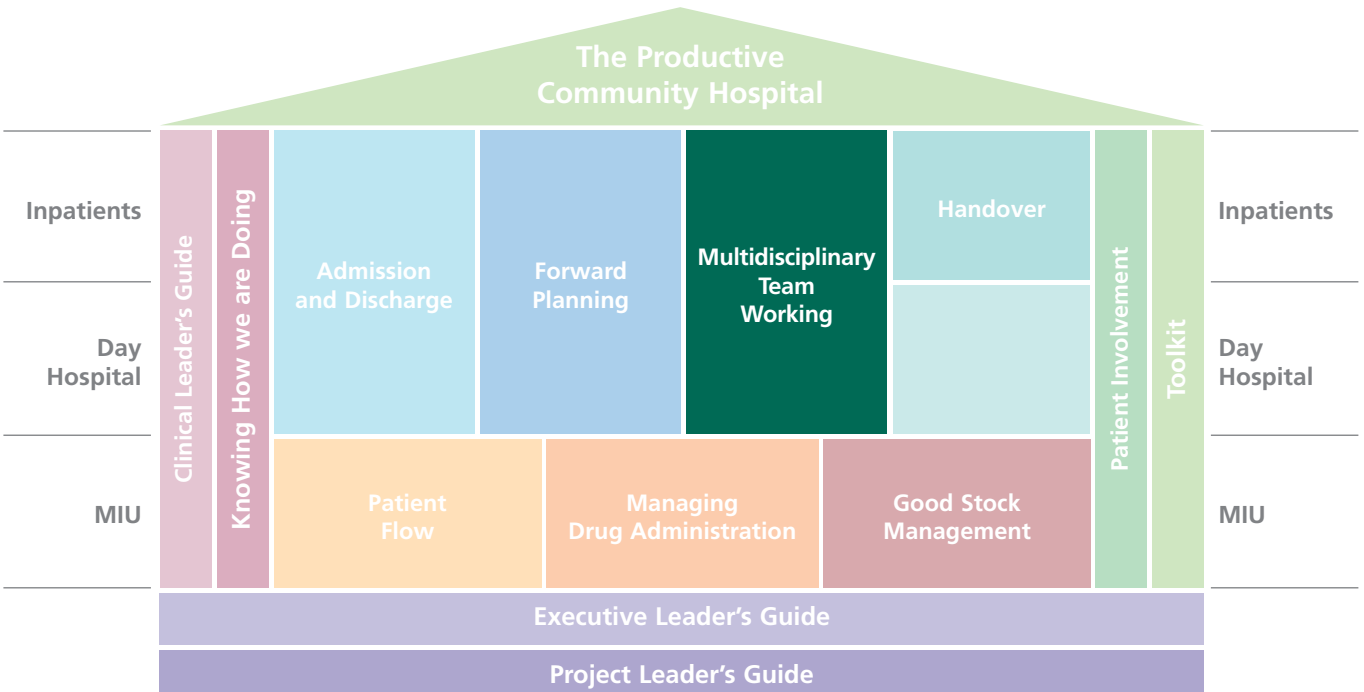
Contents

These modules create The Productive Community Hospital



Multidisciplinary Team (MDT) Working

What is it?

A practical way to improve MDT working on your ward/department, focussing on integrated working and improved communication.

Why do it?

To give patients safe, reliable and coordinated care by:
- clearly identifying roles and responsibilities
- joined-up patient assessments that remove duplication and avoid repetition for the patient
- good documentation that supports a way of working in a more productive way

To improve the experience for staff by:
- reducing repetition of information recording and transfer
- maximising the time for direct patient care
- improving the documentation by making it easier to access and to understand what is happening to the patient

What it covers

This module will help you improve your MDT working by demonstrating:

- how you currently work as an MDT
- who are the key people that should be involved
- what tools you will need to use
- how to evaluate your improved MDT working and make continuous improvement to sustain the changes you have made

What it does not cover

This module will not describe best clinical practice. It will help you identify areas that could benefit from improvement work, understand how they could be improved and help you to make it happen.

Learning objectives

After completing this module, you will:

- understand how to prepare for the module
- develop audit as an activity
- understand how the MDT currently works
- understand what is meant by productive MDT working
- develop the MDT to work more productively

How will you achieve these objectives?
The first three objectives will be met by the step-by-step approach within this module to help you to assess the current ways of working and diagnose the problem areas by performing four pre-improvement audits. These are:

- induction quality audit
- MDT meeting quality audit
- record keeping audit
- MDT meeting summary audit.

By carrying out these audits you will be able to identify what you do well and not so well in MDT working.

As you work your way through this module you will be able to identify what needs to change about the way the you work as an MDT.

By repeating these audits you will be able to measure the differences made to your MDT working.

The last two objectives will be met through a step-by-step approach to describe what a good process is and how you can achieve it.

The 6 phase process

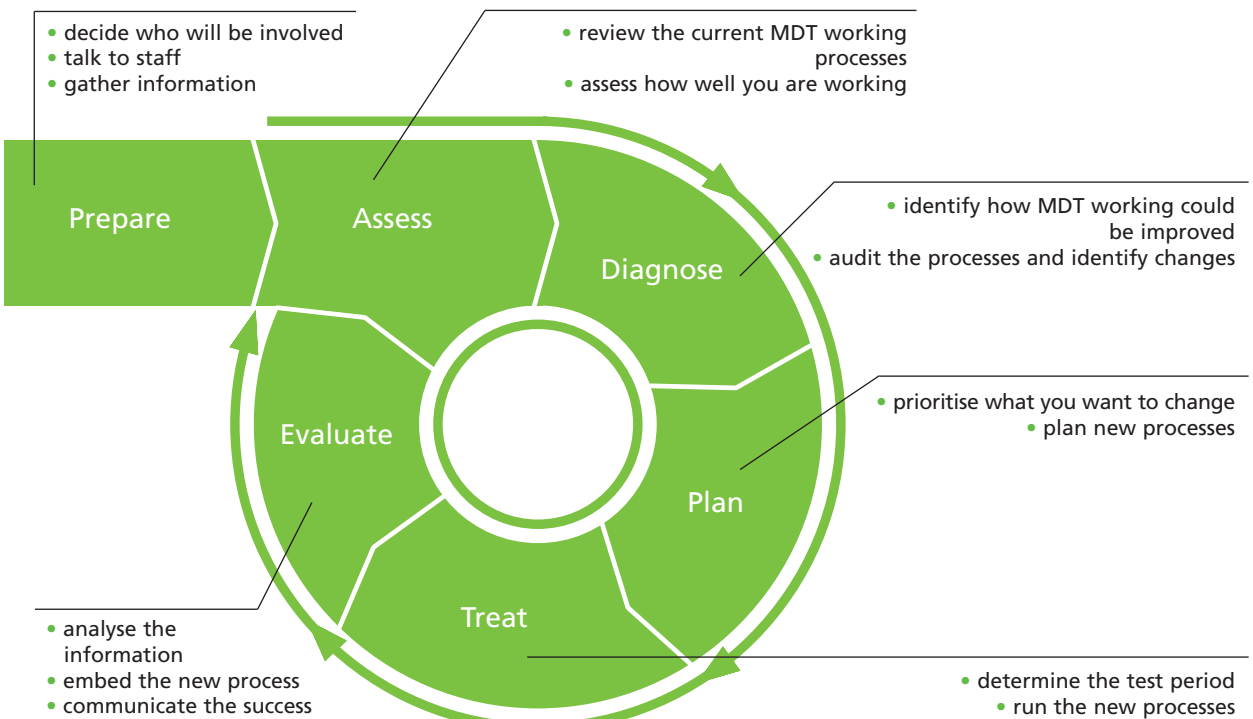
All of the modules in the Productive Community Hospital series are based on the standard nursing process of: prepare, assess, diagnose, plan, treat and evaluate.

While illustrated using a patient care cycle, the six phase process is the same as the generic improvement cycle Plan, Do, Study, Act and gives clinical staff a structured approach to improving clinical area processes that is very similar to the care cycle they are familiar with.

It is a cyclical process of continuous improvement. Once you have worked your way through this module, you should return to the assess section and repeat the steps. The results that you capture each time will show how you have improved since the last time.

As you work through the module you will be reminded about the stage of the process that you are working on.

The 6 phase process



The tools

In order to know how well you are doing and help you treat any problems that you find with your MDT processes you will need to use the tools listed below.

Tool	Toolkit reference number
Interviews	Toolkit General Section 2
Video	Toolkit General Section 4
Good Practice Induction Questionnaire	MDT Working Tool 1
Good practice Induction Template	MDT Working Tool 2
Roles and Responsibilities for Staff Induction	MDT Working Tool 3
Shared Care Records Examples 1 and 2	MDT Working Tool 4
Good Practice MDT Summary Document	MDT Working Tool 5

Copy the module checklist on page 65. Completing this will help you monitor your progress throughout the module.

Prepare

Involving the right people

Decide who will be involved
To achieve effective MDT working you will need to engage with all members of the team.

- establish a core team who will lead and take responsibility for the work in this module. These might include those listed in the box
- widen this group when you require more involvement from other members of the staff and patients

Core module team	
Who?	**What will they do?**
Ward/department manager or senior therapist	• take the lead for implementing this initiative • communicate the goals and objectives • encourage and support the team throughout the initiative • keep the focus on searching for opportunities for improvement
Ward/department MDT staff	• be willing participants in the discovery of issues and implementation of new approaches
Patient/carer	• bring a fresh perspective and a unique insight • ensure that improvements are patient focused

The 5 step process


1. Talk to staff
Use Toolkit General Section 2.
You will need to talk to staff and get their views on the way they currently structure their day:

- what currently happens?
- what causes problems?
- what they would like from improving the structure of the working day?


2. Talk to patients
Use Toolkit General Section 2.
To ensure that MDT working supports patient-centred care, the views of patients should be sought as part of your general preparation. You should seek guidance from your nursing director or your patient and public involvement lead.

- what is the patients' experience of the day?
- how would they like to be involved?
- what would they like to happen?

3. Gather information from patient complaints

- look back over the past year and identify any complaints that relate to treatment/appointments that have been missed

4. Gather information from incident reports

- look back over the last 50 incident reports and identify any regarding patients that have missed necessary treatments/care due to lack of coordination of the working day

5. Obtain your trust policy or guidelines for documentation and the policy on confidentiality.

Prepare - milestone checklist

Move on to ***Assess*** only if you have completed ALL of the items on these checklists

Checklist	Tick if complete
Decide who will be involved	
Talk to staff	
Talk to patients	
Gather information from patient complaints	
Gather information from incident reports	
Obtain your trust policy or guidelines for documentation	

Effective teamwork checklist	Tick if yes
Did all the team participate?	
Was the discussion open?	
Were challenging questions discussed and agreed by all?	
Did the team remain focused on the task?	
Did the team focus on the area/process, not on individuals?	


Statements


Statements

Assess

Assess the current MDT working processes

To assess what happens now, develop a description of how you currently work as an MDT. You can do this by taking a step-by-step approach.

There is added value in getting everyone involved in understanding how you work together, to agree on how things currently happen and what the future state should look like.

Do this by:

- identifying the key people who are involved in the MDT. These will include the ward/department manager and a representative from each staff group in the MDT, for example the physiotherapists, occupational therapists, nurses, doctors, social workers, patients and carers
- describing the current way you plan and work as a team. Focus on:
  - how often you meet as a team
  - how many of the team regularly meet
  - how long the meetings take
  - how satisfied you are with the content and outcomes of meetings
- describing what an ideal MDT working situation would look like in your team's view. This is your 'ideal future state'

Assess - milestone checklist

Move on to ***Diagnose*** only if you have completed ALL of the items on these checklists.

Checklist	Tick if complete
Understand of how the MDT processes currently works	
Ensure that all the staff have been able to give their feedback on current MDT processes	
Make sure that all members of the MDT are represented	
Understand how often the MDT meet as a team	
Understand how the ideal MDT would work	

Effective teamwork checklist	Tick if yes
Did all the team participate?	
Was the discussion open?	
Were hard questions discussed and agreed by all?	
Did the team remain focused on the task?	
Did the team focus on the area/process, not on individuals?	

Diagnose

The audit process

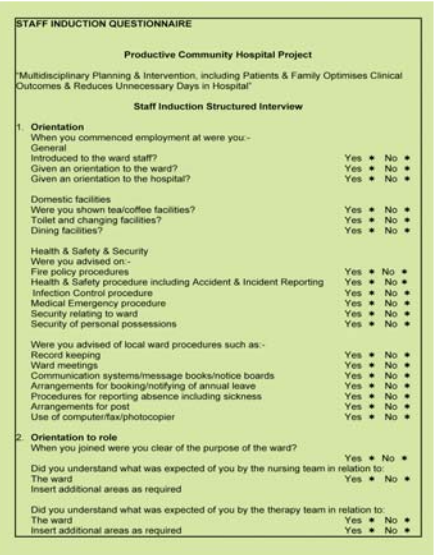
To help you diagnose the current state of your MDT process, undertake the following pre-improvement audits specific to this module. These are:

- induction quality audit
- MDT meeting quality audit
- record keeping audit
- MDT meeting summary audit

At the end of each audit, communicate your results to the team.

Induction Quality Audit	MDT Meeting Quality Audit	Record Keeping Audit	MDT Meeting Summary Audit
Staff to complete an induction questionnaire one month after they commenced employment	Take a video sample of the identified MDT meeting – approximately 45 minutes in length. Use this to assess the proportion (%) of value-adding time during the meeting, confirm the length of meeting and identify the number of people-minutes involved	Count the completeness and duplication of key quality indicators, using current caseload. Count how many pages make up your current records. Count length of time to complete assessment documentation on five patients. Count time to locate information for five patients	Count the capture of post-MDT meeting information for patients on your current caseload

Induction quality audit



STAFF INDUCTION QUESTIONNAIRE

Productive Community Hospital Project

"Multidisciplinary Planning & Intervention, including Patients & Family Optimises Clinical Outcomes & Reduces Unnecessary Days in Hospital"

Staff Induction Structured Interview

1. **Orientation**
When you commenced employment at were you:-
General
Introduced to the ward staff? Yes * No *
Given an orientation to the ward? Yes * No *
Given an orientation to the hospital? Yes * No *

Domestic facilities
Were you shown tea/coffee facilities? Yes * No *
Toilet and changing facilities? Yes * No *
Dining facilities? Yes * No *

Health & Safety & Security
Were you advised on:-
Fire policy procedures Yes * No *
Health & Safety procedure including Accident & Incident Reporting Yes * No *
Infection Control procedure Yes * No *
Medical Emergency procedure Yes * No *
Security relating to ward Yes * No *
Security of personal possessions Yes * No *

Were you advised of local ward procedures such as:-
Record keeping Yes * No *
Ward meetings Yes * No *
Communication systems/message books/notice boards Yes * No *
Arrangements for booking/notifying of annual leave Yes * No *
Procedures for reporting absence including sickness Yes * No *
Arrangements for post Yes * No *
Use of computer/fax/photocopier Yes * No *

2. **Orientation to role**
When you joined were you clear of the purpose of the ward? Yes * No *
Did you understand what was expected of you by the nursing team in relation to:
The ward Yes * No *
Insert additional areas as required

Did you understand what was expected of you by the therapy team in relation to:
The ward Yes * No *
Insert additional areas as required Yes * No *

This audit tells you how effective your induction processes are.

- set up a working team with representatives from each staff group
- devise the audit questionnaire
- review the Good Practice Induction Questionnaire
- change it so that it is right for your ward/department ie, insert names of specific departments and wards
- share the questionnaire with the team and ask for comments from the working group and wider staff
- update the questionnaire based on comments received
- identify which groups of staff you want to complete an induction questionnaire, include medical officers and therapists
- identify the members of staff from these groups who have recently joined the team (within the last 12 months)
- issue the questionnaire and ask staff to complete and return it by a specified date
- analyse the results
- record what staff found helpful and what needs to be changed

Once established as a regular audit you should ask all new staff to complete the induction questionnaire one month after they start work.

Available in the Toolkit, MDT Working Tool 1.

MDT meeting quality audit

This audit will tell you how effectively you utilise your MDT meeting and how much wasted time and effort takes place.

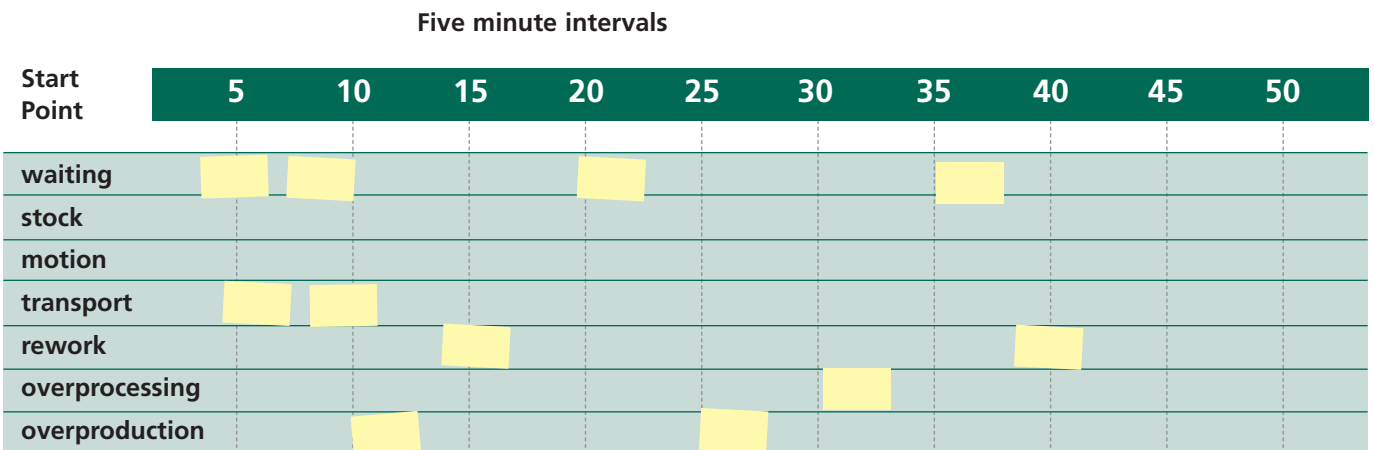
1. Inform staff when the audit will take place and why.
2. Identify an MDT meeting at random to be audited.
3. Obtain a video recorder. Refer to the Toolkit, General Section 3, for guidance on video recording.
4. Record the whole of the meeting.
5. Schedule at least two hours to review the film with a group of your team members. Invite at least one person who wasn't at the meeting to give an independant opinion.
6. Ensure that everyone is familiar with the seven types of waste (see opposite page). The seven types of waste are normally used in lean thinking. This is a way of looking at processes and identifying how they can be made more efficient by taking away the things that hold up the process. For example having to wait for people to arrive for the meeting to be able to start.

(Continued on page 24)

Summary of the seven different types of waste normally assessed in a lean process review.

Waste Type	Description
Waiting	Tasks that cannot be performed due to waiting for people, equipment, information or materials. In the context of MDT meetings this means waiting for people to arrive, waiting for the notes.
Stock	Any build-up of stock that is in excess of that which is required to meet demand. Any queuing of work and/or clients. In the context of MDT meetings this means the duplication of information from more than one party, having to read through numerous records to find the information.
Motion	Unnecessary movement of people. In the context of MDT meetings this means bringing people to the meeting that do not need to be there.
Transport	Unnecessary movement of materials and equipment. In the context of MDT meetings this means collecting and bringing records and information that are not required for the meeting.
Rework	Repeated work due to a prior failure to deliver a correct service. This could be due to poor information at the time. In the context of MDT meetings this means having to re-request actions which have not been completed as planned.
Overprocessing	Work that adds no value from the client's point of view. In the context of MDT meetings this means sharing information or talking about items that are not relevant to the meeting.
Overproduction	Doing more than is required or earlier than it is required. In the context of MDT meetings this means discussing in too much detail than is required for the meeting.

7. Draw a time-line on a big piece of paper which has the elapsed time across the top, split into five minute intervals, and rows for each of the seven types of waste. Give everyone a pad of sticky notes and a marker pen (see example below.)



8. Review the first five minutes of the video together, each person writing the waste that they see on a sticky note. Agree what was identified as waste and post it on the brown paper.
9. Replay the rest of the film in five minute intervals and get everyone to place their sticky notes on the brown paper where they believe there was waste.
10. At each stage agree what time was value adding and record this with the marker pen.
11. Calculate a value-added percentage as: (value-added time / total time) x100.

Record-keeping audit

This audit will tell you how comprehensive and complete your records are.

1. Undertake both a qualitative (quality) and quantitative (quantity) audit of record keeping. Assess your current caseload for completeness of the information. You might want to take a percentage of your records or a number of patients rather than the whole of your caseload. Include all of the MDT members' records in this audit. Identify what you and your team consider to be important indicators of quality record-keeping.

   These could include the following:
   - medical assessment
   - nursing assessment
   - allied health professional (AHP) assessment
   - care plan
   - discharge plan

2. Identify the three most important issues or presenting problems for your patients and create a simple table. For example:
   - pain
   - mobility
   - personal care requirements
   - presence of discharge plan

Create a simple table to collect your information as example below.

Important indicators of quality record keeping	Frequently presenting problems/issues for your patient		
	Pain	Mobility	Personal care
	% completed in any record		
Medical assessment			
Nursing assessment			
Allied healthcare professional assessment			
Care plan			
MDT meeting follow-up plan			

3. Using the records that you have identified, establish the percentage of completeness for each area. The example below shows five important indicators of quality in the left hand column. It then identifies three frequently presenting problems for patients - fatigue, anxiety and depression and pain. The team then assessed their current patient notes to identify if these problems were recorded in the quality indicator element of the notes.

Important indicators of quality record keeping	Frequently presenting problems/issues for your patient		
	eg, Fatigue	Anxiety and depression	Pain
	% completed in any record		
Medical assessment	20	75	100
Nursing assessment	90	50	100
Allied healthcare professional assessment	50	20	20
Care plan	75	80	100
MDT meeting follow-up plan	50	80	100

4. To provide a quantitative audit of your record keeping, start by measuring the time taken to locate the important indicators of quality. Use five typical patients and search for and summarise the information.

MDT Group	Time to locate the important indicators of quality
Nursing	
Medical	
Physiotherapy	
Occupational therapy (OT)	
Total	

5. Count the number of pages in the complete sets of all the records you currently use, by MDT group, then calculate the average.

MDT Group	Average number of pages in record
Nursing	
Medical	
Physiotherapy	
OT	
Total	
Average	

6. Now assess the length of time it takes for the individual MDT group members to complete the admission assessment documentation. Time five admissions and then average the time for each MDT group.

MDT group	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5
Nursing					
Medical					
Physiotherapy					
Occupational therapy					
Total time					
Average (Total time/no. of MDT group members)					

MDT meeting summary audit

This audit will tell you how well you document your MDT meetings.

To make a qualitative judgement on the completeness of the meeting records, undertake an audit of your information recorded in notes following the MDT patient review meeting. Use your current way of recording the outcome of the MDT meeting and follow the next steps.

1. With your team, identify the important information to record following the MDT meeting. These could include:
   - patients personal details
   - completed initial assessment
   - identification of the responsible person for the patient
   - identifying when the next review will take place
   - expected discharge date

2. Establish percentage completeness for each record that is being audited.

MDT Group	Recorded post MDT meeting
Patient's personal details	90%
A completed initial assessment	75%
Identification of the 'responsible person'	50%
Identification of when the next review will take place	65%
Expected discharge date	40%

Diagnose - milestone checklist

Move on to ***Plan*** only if you have completed ALL of the items on these checklists.

Checklist	Tick if complete
Give all staff the opportunity to fill in an induction questionnaire	
Make sure that all types of MDT are represented in the audits	
Be very clear about how effectively you use your MDT meetings	
Time how long your MDT meetings take	
Identify where there is waste in your meetings	
Know what your 'value-added' time is for your MDT meetings	
Complete a record-keeping audit to understand the completeness of the records	
Know how complete your MDT meeting summary records are	
Understand your current induction processes. What happens when staff join your ward or department now? Do you know how staff feel about it?	

Effective teamwork checklist	Tick if yes
Did all the team participate?	
Was the discussion open?	
Were challenging questions discussed and agreed by all?	
Did the team remain focused on the task?	
Did the team focus on the area/process, not on individuals?	






Plan

Planning productive MDT working

Having diagnosed the current status of your MDT working, this section will take you through the planning steps to help you to treat your MDT working and make it better.

This will help to make your MDT working better by:

- creating a common induction for all staff
- creating guidelines for effective MDT meetings
- creating a shared care record
- creating a MDT meeting summary document

Do this by using the following - MDT Working Tools 1 to 5:

- Good Practice Induction Questionnaire
- Good Practice Induction Template
- Roles and Responsibilities for Staff Induction
- Shared Care Records Examples 1 and 2
- MDT Meeting Summary Template

Creating a common induction process

Having a common induction process is important to identify the roles and responsibilities of every member of your team. This is particularly important in the MDT setting to make the best use of everyone's skills. The guidance in this module is for staff needing inducting to the ward or department. It is in addition to the trust induction and any profession/team specific induction for staff.

The objectives of the guidance on developing a common induction process are to:

- set out the expectations of new staff to the ward/department in terms of the expected behaviour of new members of the team
- formalise their integration and their role in the team
- explain how the ward/department works and what the ward/department expects of them
- provide a 'buddy' system to orientate them to the hospital
- provide the health and safety information they need
- provide a common induction to all staff

Improve your current induction process

1. Identify information that is required in the induction pack.

2. Use the information from the induction quality audit you undertook to see what new staff members reported about their induction to the ward/department.

3. Look at existing induction information and templates.

4. Draft a template with all the identified areas included.

5. Identify who the induction process is aimed at – this may include doctors, admininstrators, nursing staff and support staff.

6. Set up a working team with representatives from each group of staff.

7. Review the Good Practice Induction Template, Toolkit MDT Working Tool 2.

8. Modify the template you have drafted, taking account of the good practice example and the input from the working team.

9. Share the induction template and ask for comments from the working group and wider staff.

10. Update the induction template based on comments received.

INDUCTION CHECKLIST

Name: Job Title:

Grade: Date:

INTRODUCTION AND INSTRUCTIONS

This checklist should be used:

- When inducting a new member of staff to your ward/dept.

The aim of this checklist is to give temporary staff a smooth and comprehensive introduction to their work area so that they may quickly feel welcome, effective and able to contribute to the service whilst maintaining a safe environment for staff and patients alike.

Emergency Telephone Numbers

Medical Emergency
Collapse
Fire
Emergency/Security

Other Useful Telephone Numbers:

Switchboard
Help Desk

Introduction to key people e.g. ward manager, staff members on the same shift

Tour of ward/department

Domestic facilities:
- Tea / coffee / smoking area
- Staff room / kitchen / Dining facilities
- Toilets / cloakroom

Fire procedures including:
- Exits
- Assembly point

An example of a good induction process

1. Complete the induction over a period of two weeks.

2. Begin the induction by providing a basic overview of your role and that of your team.

3. Provide the inductee with an induction pack, based on the induction template that you developed. It will include information such as the organisation's structure, department layout, site map, how to access policies and procedures, and the ward/department philosophy.

4. Allocate a buddy to the new member of staff. The buddy will usually be a junior member of ward staff. A buddy will orientate the new staff member to the building to ensure they have sufficient knowledge to respond in an emergency situation and then provide ongoing support and guidance in the first few weeks.

5. Plan time to review the induction with the new staff member together with their line manager and to sign off the induction when it has been completed.

An example from a test site, Toolkit MDT Working Tool 3. You may wish to develop some good practice guidelines for your ward.

PCH Good Practice Guidelines for an Induction Pack

1.
ROLE OF WARD MANAGER

Hello

Welcome .....Ward./Dept

My name is ..... I am the Ward Manager of this .. give description...Ward/Dept.

I have overall responsibilities for the running of the ward/dept; the Nursing Staff; the Senior House Officers; and the Ward Administrators.

I work full-time, mainly early duties. I do not wear a uniform, as I am supernumerary.

My deputy or I meet with all new staff to outline our expectations and I expect all staff to understand my role and position.2.

DEPARTMENTS INDUCTEE SHOULD VISIT DURING FIRST 2 WEEKS

The ward/depts to visit

Name of ward/dept.....

.....provides long-term and respite care for older people. It has eighteen beds. Our emphasis is aimed at meeting resident's needs using a holistic approach. By considering physical, social psychological and spiritual needs.

We try to tailor the care needs to meet the individuals requirements.

Providing care and social interaction where appropriate.

Residents are encouraged to maintain some degree of independence where possible, to make their own decisions for example.

We have a visiting chiropodist, dietician, speech and language therapist, visits from the friends of the church and the chaplain. Musical therapy is done once a month.

As the residents reach the penultimate stage of their life, they are nursed in a relaxed and peaceful environment with staff and family in attendance, giving as much support and comfort as possible.

OTHER DEPARTMENTS TO BE INSERTED

An example of good induction material

This is a partial example, from one of the test sites, of some of the information that you might want to include in your induction pack for new staff. It will help them to understand who all the different people are and what they do.

Role	Overview
Clinical manager	Has overall responsibility for the running of the clinical area, nursing staff, visiting staff and administrators for their area
Nurse	The role of the nurse is to ensure the delivery of safe, evidence-based, quality care. They work within an interdisciplinary team of nursing, therapy and other clinical and administrative staff. They provide a broad range of therapeutic activities that will be specified by the individual programmes of care for patients/users. Nurses are also responsible for the assessment of care needs and the implementation of patient care within their clinical area; this will include admission and discharge, providing support, supervision and education to patients, relatives, and staff. The senior nurse will also deputise for sister/charge nurse/manager in their absence including team leadership and intervention in emergency situations
Health care assistant (HCA)	HCAs are responsible for supervising and assisting patients with the activities of daily living, participating in handover and reporting incidents to the nurse in charge. They should be vigilant, caring, and observant at all times and treat each individual (patient, relatives or colleague) with respect and dignity. The HCA must give clear, accurate and timely information to appropriate staff at all times
Medical staff	Medical staff form part of the MDT that manages the patient's care plan. They provide ongoing medical assessment, diagnosis and timely review of the patient. They have responsibility for liaising with MDT members, goal planning, improving outcomes and discharge planning

Holding effective MDT meetings

Making meetings more effective will reduce the time required for the meeting, as well as improving staff attendance and representation. Importantly it should lead to a better outcome for the patient.

Examples of ineffective meeting practice include:

- the team is not clear on the purpose of the meeting
- the objectives are not stated
- the right team members are not present
- participants are not prepared
- meetings are not conducted with a complete agenda
- meetings start and end late
- quieter participants are not encouraged to participate
- actions are not assigned to individuals with agreed timescales
- leaders arrive late for meetings
- leaders seem to call/attend meetings routinely rather than out of necessity

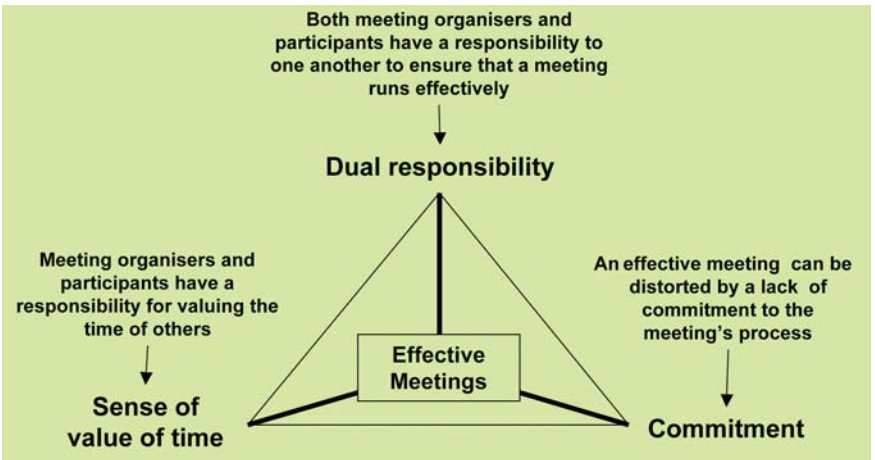
The objectives for effective meetings are to:

- reduce the amount of meetings that you attend or call unnecessarily
- improve the quality of the outcomes that you achieve in your meetings to support patient care
- improve the responsiveness to actions being followed up by participants
- improve the quality of the preparation that is undertaken for meetings
- improve the quality of conversations in the meetings
- improve the level of participation in meetings

Actions for holding effective MDT meetings

1. Ask yourself:
   - do I need to hold a meeting at all?
   - what am I hoping to achieve through the meeting?
   - who needs to be there in order to accomplish these objectives?
   - what do I know about my participants and to what level of formality do I need to go?
   - based on the answers to the above, what is the most appropriate forum for the meeting?

2. Understand the criteria for holding an effective meeting. The three key criteria for achieving this and how these can apply to you, both as an organiser and participant.



3. Identify who will attend the MDT meeting and set up a working group with representatives from all professions.

4. Review your objectives and criteria for the meeting and record these to maintain focus.

5. Agree with the working group appropriate meeting intervals to adequately address patient care. Think about the average length of stay of patients or the number of attendances in a plan of care. For example, where the average length of stay is 72 hours, daily meetings are appropriate, where the average length of stay is three months, weekly meetings may be more appropriate.

6. Agree a suitable agenda for the meeting. For every patient you will need to cover:
   - background
   - action taken to date
   - update
   - next steps

7. Allocate a time to discuss each patient. They will not all take the same amount of time. Allow enough time to confirm the next steps for each individual patient.

MDT meeting agenda	
	Lead participants
Patient name	
• action to date	Responsible clinician
• update	Active MDT members
• next steps	Chair

8. Agree a set of meeting ground rules with the working group. As a minimum these ground rules should include:
   - starting and finishing the meeting on time
   - holding the meeting in an area away from disturbance – ideally in an office where the door can be closed
   - designating members of staff to cover the ward whilst the MDT meeting is being held.
   - Appointing an appropriate deputy to cover periods of absence for every member

9. Prepare for your meeting, you should consider the following practicalities:

MDT preparation meeting checklist	
Identify the chairperson	✔
Schedule the meeting for a time and place that is convenient for all	✔
Identify the names of the patients to be discussed	✔
Book the venue, ensuring the room is suitable	✔
Book the equipment ie, projector, flip charts, tea/coffee	✔
Assign a note taker to capture minutes and actions	✔
Notify the participants (these should be only essential attendees) for cases to be discussed	✔
Send the agenda out in advance of the meeting with clear objectives for the meeting	✔
Organise the relevant patient files in order of patients to be discussed	✔

10. Agree how documentation will be updated and shared.

11. Agree a start date for the new meeting format with the working group.

12. Publicise the start date with a copy of the meeting ground rules

13. Set a date for the working group to review the success of the new meeting format after one month.

14. Once the meeting has begun it is important to allow all participants to contribute. It is important that whichever MDT member is chairing the meeting manages the dynamics of the meeting. This may mean that they have to deal with participants who are silent, dominant, or negative. Here are some tips for dealing with difficult participants:

- **members who are silent.** Make sure that you engage with all the members of the meeting where possible. This can be achieved by asking for views, or experiences such as 'What do you think x?' or 'I know you have undertaken something like this before, what were your experiences x?' If your meeting is large, you could consider breaking into smaller groups to develop input
- **members who are vocally dominant.** Try to redirect discussion to other members: 'We all recognise your expertise in this area, but let's hear from some others in case some new ideas emerge.' 'Does anyone else have something they would like to add?'
- **members who are negative.** Try to probe the negativity in order to clearly articulate and validate the concerns. Try to redirect the discussion to other members of the meeting: 'Let's not shoot down this idea prematurely; what do you think x?'. If the behaviour persists, consider speaking to them after the meeting to help them understand the impact of their negativity on the meeting

15. It can be frustrating to be in a meeting that is ineffective. Offer this guide to the participants to help make the meetings they attend more effective.

Effective meeting tips
• know why you are there
• be there on time
• stay on the subject
• don't cause problems for the leader
• be open to the ideas of others
• help the leader control the meeting
• share best practice

Creating a Shared Care Record

Using a shared care record will help to optimise clinical outcomes by standardising the care planning process where possible, and allowing for shared understanding of assessments and care delivery.

The objectives of a shared care record are to:

- increase effectiveness of the patient record as a communication tool amongst the MDT members
- reduce the number of places each disciplines' assessment is stored and the amount of repeated information
- provide a communication process that allows access to all members of the MDT, including the social worker
- provide a single document with all MDT staff contributing
- make the documentation easier for everybody to use and understand

Actions for creating a Shared Care Record 

1. Identify who will use the Shared Care Record and set up a working group with representatives from all professions.

2. Review the audits you undertook on record keeping to identify what you need to include as key requirements.

3. Identify any areas of overlap in the notes and draft an outline of a record that will reduce these into one document.

4. Review existing guidance such as NICE guidelines, National Service Frameworks (NSFs) and professional regulatory body guidance to ensure that important information is captured in your shared document. Remember your records should comply with local and national guidelines for documentation including the single assessment process (SAP).

5. Decide which parts of the document need to be uni-disciplinary (eg, just nursing) and which are multidisciplinary (eg, assessment of ability of the patient to feed themselves).

Note: the Shared Care Record is made up of two elements; Firstly it has discipline-specific information and secondly it has generic information that may be collected by any member of the MDT. Each discipline completes their own assessment on the template and as other information is obtained by the MDT, such as progress, outcomes, planned interventions; it is added to the joint section of the template.

Examples of Shared Care Records are available in the Toolkit, MDT Working Tool 4.

6. Review the examples of good practice shared/joint records.

7. Modify the Shared Care Record to reflect the audit findings and the input of the working group.

8. Consider including assessment or screening tools to improve efficiency. This choice depends on the function and purpose of the unit, but could be a functional Improvement assessment. This will allow you to quickly understand the priority issues/problems for the patient and plan your interventions and your next detailed assessment requirements. Two examples of initial assessment/screening tools are given at the end of this section.

9. Distribute the Shared Care Record to the working group and wider staff and ask for comments.

10. Update the template based on comments received.

11. Agree with the working group and your line manager how the Shared Care Record will be updated and communicated.

12. Agree a start date with the team and your line manager.

13. Publicise the start date with a copy of the Shared Care Record and guidance notes for completion.

14. Set a date for the working group to review the success of the template after one month.

Examples of Shared Care Records are available in the Toolkit, MDT Working Tool 4.

Creating a Shared Care Record - The Barthel Index

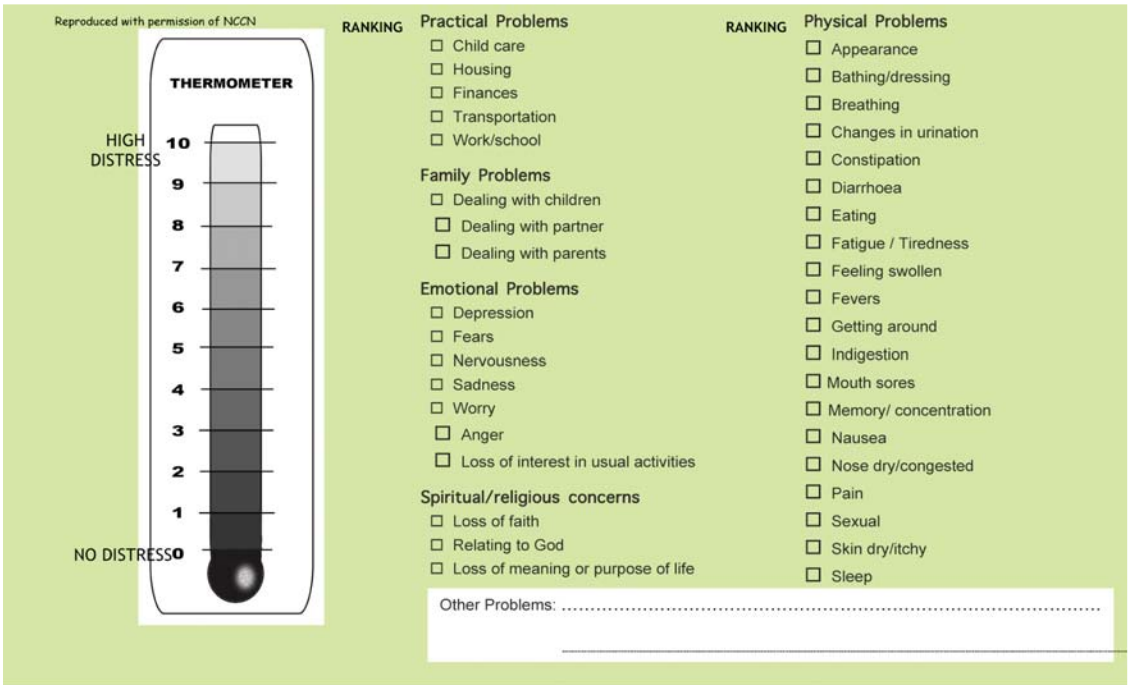
The Barthel Index is widely used in the rehabilitation setting. It is provided here as an example of a clinical outcome measure to help prioritise intervention and detailed assessment.

	With help	Independent
1. Feeding (if food needs to be cut up = help)	5	10
2. Moving from wheelchair to bed and return (includes sitting up in bed)	5-10	15
3. Personal toilet (wash face, comb hair, shave, clean teeth)	0	5
4. Getting on and off toilet (handling clothes, wipe, flush)	5	10
5. Bathing self	0	5
6. Walking on level surface (or if unable to walk, propel wheelchair) *score only if unable to walk	0*	5*
7. Ascend and descend stairs	5	10
8. Dressing (includes tying shoes, fastening fasteners)	5	10
9. Controlling bowels	5	10
10. Controlling bladder	5	10

Mahoney FI, Barthel D. "Functional evaluation; the Barthel Index."
Maryland State Med Journal 1965;14:45-61. Used with permission.

Creating a Shared Care Record - The Distress Score

The Distress Score is a palliative care assessment tool that was used by one of the test sites. It is provided here as an example of another clinical outcome measure.



Holland JC *et al*. Clinical practice guidelines in oncology: distress management. *National Comprehensive Cancer Network* 2005 (version 1).

Creating a MDT meeting summary document

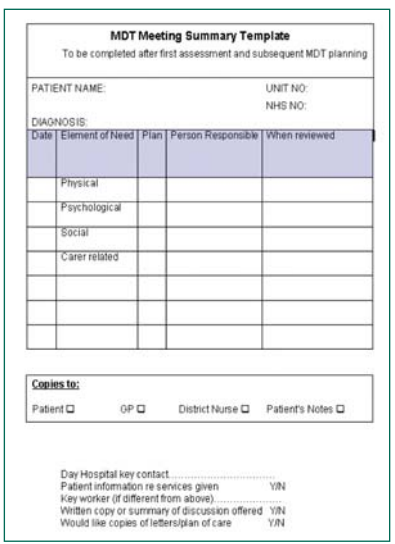
The MDT meeting involves several staff from a range of disciplines, providing their own professional perspective of each patient they care for. The meeting provides the opportunity to transfer information and come to agreed decisions on care planning.

The objectives of the MDT meeting summary document are to:

- document discussions taking place at the MDT meeting and to plan care accordingly
- facilitate good communication between the MDT members in which a summary of findings and actions are recorded as a result of the MDT planning meeting
- include a named professional and time frame for completion / review of each task
- provide information which would be useful to all MDT members

1. Identify any existing national, international or local guidance on patient assessment or MDT working.

2. Review the good practice MDT Meeting Summary Template.



MDT Meeting Summary Template

To be completed after first assessment and subsequent MDT planning

PATIENT NAME: UNIT NO:
NHS NO:

DIAGNOSIS:

Date	Element of Need	Plan	Person Responsible	When reviewed
	Physical			
	Psychological			
	Social			
	Carer related			

Copies to:

Patient ☐ GP ☐ District Nurse ☐ Patient's Notes ☐

Day Hospital key contact.....
Patient information re services given Y/N
Key worker (if different from above).....
Written copy or summary of discussion offered Y/N
Would like copies of letters/plan of care Y/N

3. Identify who will use the MDT Meeting Summary Template and set up a working group with representatives from all professions.

4. Using the record keeping audits you have undertaken, identify the key information you want to record. This is likely to include:
   - element of need
   - plan of care
   - responsible professional
   - review period

5. Modify the template for local requirements.

6. Share the template and ask for comments from the working group and wider team.

7. Update the template based on comments received.

8. Agree a start date with the team and your line manager.

9. Publicise the start date.

10. Issue a copy of the template and guidance notes for completion.

11. Set a date for the working group to review the success of the template after one month.

An example of the Meeting Summary Document is available in the Toolkit, MDT Working Tool 5.

Using the MDT meeting summary document that you have created

Once you have created the summary, you need to use it. The following steps will help you in the planning phase:

- identify who should attend the MDT meeting. It may be most appropriate to nominate 'core members' and to ensure that they are able to attend on a regular basis
- each MDT member should have a nominated deputy to cover periods of absence
- identify the average length of stay of patients on the unit and set meeting intervals to adequately address patient care. This interval will become the default time period for task completion/review
- if possible arrange for an administrator to record the meeting summary documentation. They should not need to contribute to discussions, other than to clarify administrative details
- decide which format to document the meeting (electronic, paper etc). If possible, use a projector to display electronic documentation in real time. The whole team can therefore agree the final, completed summary for each patient before it is saved. This also allows easy retrieval if more copies are required
- record in a diary the dates by which tasks must be completed, ensuring each professional has access to this diary
- agree who will receive a copy of the MDT meeting summary - patients, GP, etc.
- identify who is responsible for sharing the MDT meeting summary and how

Plan - milestone checklist

Move on to ***Treat*** only if you have completed ALL of the items on these checklists.

Checklist	Tick if complete
Create a common induction process?	
Create a shared care record?	
Create an MDT meeting summary document?	
Engage with all staff and patients (where appropriate)	

Effective teamwork checklist	Tick if yes
Did all the team participate?	
Was the discussion open?	
Were challenging questions discussed and agreed by all?	
Did the team remain focused on the task?	
Did the team focus on the area/process, not on individuals?	







Treat

Treat

During the treat phase you will be testing the agreed changes.

What are you going to test?

- have we improved the experience for patients?
- have we improved the experience for staff?
- have we reduced waste?
- does everyone in the team understand the new process?
- are we sticking to the new process?

Before the test starts:

- determine what the time period will be for the test.
- it needs to be:
  - long enough to allow for failures
  - short enough to change and retest
- identify additional temporary data collection methods
- agree the time collection method and who is going to do it
- set the start and end dates – and communicate them to everyone
- update all staff personally on progress, at meetings and across all shifts

During the test:

- get daily feedback from staff and patients (where appropriate) on how they feel the new process is working
- invite visitors and/or senior management to view your new documentation and comment on the process

Treat - milestone checklist

Move on to ***Evaluate*** only if you have completed ALL of the items on these checklists.

Checklist	Tick if complete
Test period defined	
All staff informed	
Try out (test) the new process	
Time new processes (where applicable)	
Get staff, patients and family feedback on the new MDT working process	
Film the MDT meeting process	

Effective teamwork checklist	Tick if yes
Did all the team participate?	
Was the discussion open?	
Were challenging questions discussed and agreed by all?	
Did the team remain focused on the task?	
Did the team focus on the area/process, not on individuals?	

Evaluate

Evaluate progress

1. **Collect information**
   Once you have been working in the new way for the agreed time period you will need to repeat:
   - induction quality audit
   - MDT meeting quality audit
   - record-keeping audit
   - MDT meeting summary audit

2. **Analyse the information**
   Set up a review meeting to include the original core team for The Productive Community Hospital Programme.

   Use the results from the audits to help you to evaluate the changes made.

3. **Further improvement**
   This information will help you to understand where you need to go back to. Decide where there are still opportunities for improvement and repeat the process until your future state is achieved and sustained.

4. **Communicate success**
   Don't forget to tell people, staff and patients, what you have achieved, verbally and on your communications board.

Evaluate - milestone checklist

When you have completed the checklists below, go to the module checklist on page 65.

Checklist	Tick if complete
Talk to staff, patients and relatives about the new MDT working process	
Look at the before and after process times	
Look at the before and after value added times for the MDT meetings	
Communicate success	

Effective teamwork checklist	Tick if yes
Did all the team participate?	
Was the discussion open?	
Were challenging questions discussed and agreed by all?	
Did the team remain focused on the task?	
Did the team focus on the area/process, not on individuals?	

How to sustain the change?

Monitor and audit continually	• conduct the audits regularly to ensure that the changes that you have made are being continued and are working
Ensure leadership attention	• ensure that senior managers are engaged and informed of what you are doing • give regular feedback about the progress that you are making at meetings which involve key people • ensure that you display and discuss the audit results with department staff regularly to keep up the pace of change
Do not stop improving	• encourage the department staff to continue to find new and better ways of doing things – it is not about doing this once but about improving things continuously • encourage staff to suggest and implement changes themselves

Module checklist

The grid below allows you to measure your performance against the checklists for this module. You should copy this page and shade in the boxes according to your achievement of the measure (green for complete, amber for in progress and red for not started). Your progress will then be clearly visible.

MDT module checklist	Before	After 2 weeks	After 4 weeks	After 8 weeks
All new staff receive an induction pack				
A shared care record is used to record patient care				
MDT meeting summary documentation is clear, concise and produced in a timely way, as agreed by the team				
MDT meetings are run on time and to an agreed agenda				
Duplication has been removed from the patient care record where possible				
Regular audits are carried out to monitor induction quality, MDT meeting quality, record-keeping and MDT meeting summary				
Staff feel that they receive and record all the information that they require to deliver safe and effective care every time				
Staff feel like they spend less time looking for information				
Patients don't feel that they are being asked the same questions over and over again				

Have we met the learning objectives?

Five objectives were set at the beginning of this module.

- test how successfully these objectives have been met by asking three team members (of differing grades) the questions in the grid on the next page. Ask the questions in the second column and make an assessment against the answer in the third column
- if all three team members' responses broadly fit with the answer guidelines then the learning objectives of the module have been met
- note the objectives where the learning has only been partly met and think about the way that you can approach the module next time

Remember, the results of this assessment are for use in implementing this module and are not a reflection on individual performance in any way.

Objectives	Question (ask the team member)	Answers for outcome achieved
Understand what good preparation for the module is	Describe the things that you need to do in the prepare stage of the module	• establish a core team • talk to staff and patients • find information relating to complaints • obtain policies on documentation
Understand how the MDT currently works	Explain how you learnt about the current state of MDT working	• understand how the team currently works • identify the good/bad things about the current process
Develop the MDT to work more productively	Why use a staff induction and how does it work?	• helps to ensure an understanding of the roles and responsibilities of the MDT • all new staff receive a pack and a buddy and will have a review with their line manager
Develop audits as an activity	Where do the audits fit into the MDT module and how do they work?	• they are part of the diagnosis • they give a measure of the current situation
Understand what is meant by productive MDT working	What does good MDT working mean to you?	• good performance which we can measure and show improvement • all the team know what is happening to the patients and their ongoing needs are clearly identified

Case studies

Induction for new staff - Queen Mary's Hospital

The hypothesis
Queen Mary's Hospital believed that staff who have a good quality induction are more likely to be able to work effectively as part of the MDT.

Their objectives
They wanted to assess the current induction process and develop a standardised methodology which met the needs of both the existing staff and the new members joining the team.

Rationale for development
In discussions about MDT working on their wards the subject of junior doctor rotation was raised and how they all worked very differently and as a result did not get the opportunity to feel part of the team. The MDT at Queen Mary's Hospital considered whether the ward's philosophy and expectations were ever clearly conveyed to the doctors.

It was generally considered that expectations were not set out clearly and that MDT working was affected by this. Therefore the team decided to create a junior doctor induction programme for the next rotation. Following the team discussion it was decided to develop the concept to include all new staff rather than tailor it to the doctors only.

Their measures
The induction audit assessed the perceptions of new staff on the quality of the induction process and content. This was conducted before and after the improvements to the process were made.

Measure	Result
Orientation to the ward was sufficient	28% improvement
Appointing a buddy was important to you	94% agreed

Qualitative results
New staff members felt they were better orientated to the ward and that the buddy system was beneficial.

Chippenham Community Hospital - effective meetings

The hypothesis
Chippenham Community Hospital believed that they could improve the content and process of the MDT meetings by applying good practice principles to what they do. They believed this would optimise information sharing about patients and ultimately improve patient care.

Their objectives
They wanted to analyse the efficiency and effectiveness of the MDT meeting process within an inpatient setting. This would allow them to set improvement objectives and to target improvement initiatives.

Rationale for development
Beech Ward at Chippenham Community Hospital considered patient goals to be at the centre of its rehabilitation process. It had a well defined process and tool for setting patient goals when they were admitted to the ward.

However, staff often found that the MDT goal-setting meeting was not run in a standardised format and felt that there was room for improved efficiency and quality. The staff wanted to develop a more standardised approach which would reduce the time required for the meeting, and also improve staff attendance and representation.

To do this they needed to effectively analyse their current MDT meeting and then develop baseline measures from this, which would allow them to assess the impact of improvement ideas.

Their findings
Chippenham Community Hospital found that by implementing their improvements they increased the value-added time within the meeting. The meetings were also shorter with less people-minutes taken up with the meeting. They continue to improve their meeting effectiveness and plan to repeat the video analysis.

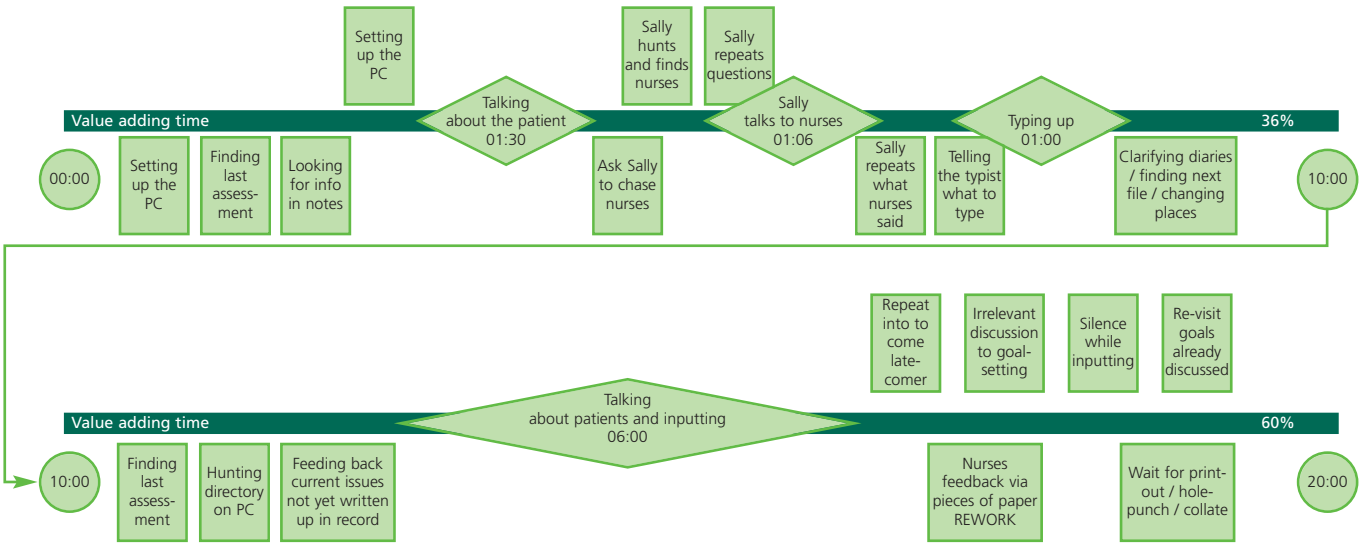
Quantitative results
The baseline audit of the MDT meeting was completed, measuring length of the meeting; number of people-minutes taken up by the meeting; and the amount of value added time in the meeting.
This was repeated after the improvements were put in place.
Refer to the table for the results.

Measure	Pre-improvement	Post-improvement
Length of meeting	90 minutes	45 minutes
No. of people-minutes involved	360	170
% Value-adding time during the meeting	48%	82%

Beech ward goal-setting meeting 22/05/07

BEFORE improvements

Process map of first 20 minutes done on 30/05/07

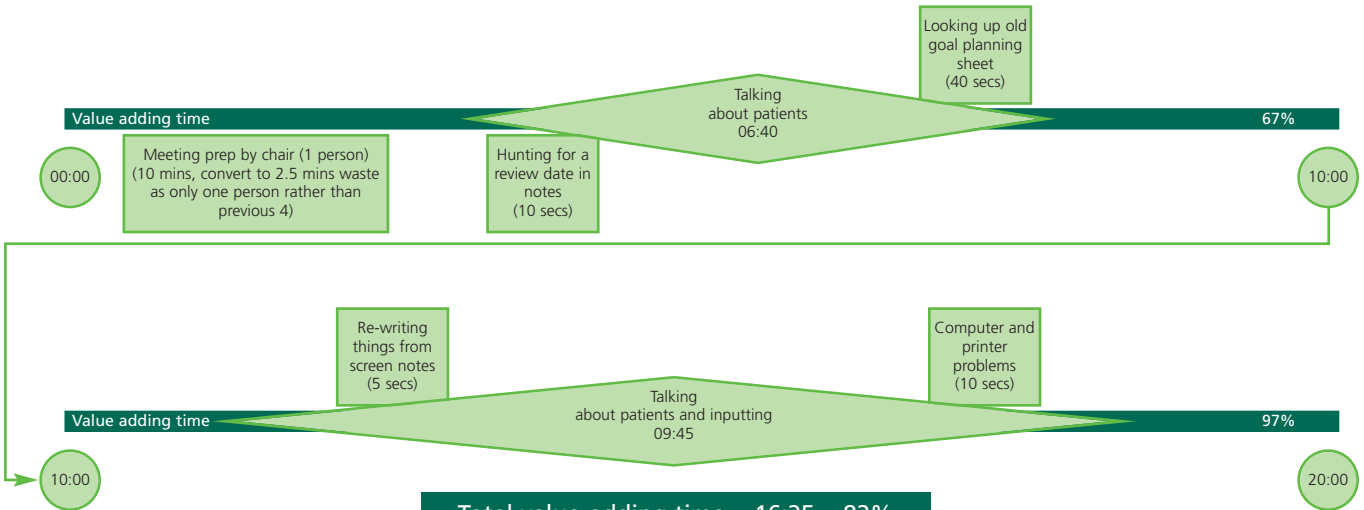


Total value-adding time = 09:39 = 48%

Beech ward goal-setting meeting 16/08/07

AFTER improvements

Process map of first 20 minutes done on 30/05/07



Notes on two other improvements

1 - The overall length of the meeting has reduced by 50% (from 90 to 45 minutes)

2 - The overall number of person-minutes involved in the meeting has reduced:
Patients discussed in batches according to the therapist input needed who can then leave the meeting.
eg, Sally (SLT) left this meeting half way through saving 40 person-minutes.
Typically meeting now consumes 170 person-minutes instead of 360 previously.

Farnham Hospital & Centre for Health - Shared care record

The hypothesis
Farnham Hospital & Centre for Health believed that having a shared document which recorded the assessment of the patient and the interventions would improve communication and continuity for the patient.

Their objectives
Farnham Hospital wanted to develop a template which enabled joint assessment by the nurses, physiotherapists and occupational therapists. They wanted the notes to be patient orientated rather than profession orientated and for information to be written on a single process sheet. They also wanted to reduce the amount of paper in the MDT documentation to improve the process for staff.

Rationale for development
In discussion with the MDT there was general dissatisfaction with where patient information was being written and how it was ineffective as a communication tool. Each discipline's assessment was in a different place with a lot of repeated information that was felt to be unnecessary. The patients were being asked the same information by different staff and they felt that this did not inspire confidence. Social Services were particularly dissatisfied as they felt the information they put in the notes was not read and also their requests for information from other members of the MDT went unanswered.

Generally there was frustration that the notes were not in a single timeline with all MDT staff contributing, instead each member of the team wrote in their own section of the patient's notes and rarely did each discipline look at each others notes. Information about the same issue was recorded in different sections of the notes and the patient was asked the same questions repeatedly.

Their findings
Farnham Hospital found developing the new documentation and new ways of working challenging and this work is still being reviewed and refined. However, the results that they are achieving make the work worthwhile.

Qualitative results

'We have had feedback from patients that it's very tiring having each discipline come in and assess when they are first admitted. We feel this was not reflected in the measures initially, it didn't really occur to us until after.'

'The time spent admitting a patient, for each discipline, is now reduced; however more significantly, the time spent with the patient is reduced even more. Normally I would argue that less time is negative, but patients like the fact that they do not have to repeat the same info.'

Before improvement

'Difficult to find information from other disciplines. Information written in so many different places'

'Poor continuity and lots of repetition'

'OT paperwork not kept in care plan'

'Very difficult to obtain a time line of patients' journey'

After improvement

'Enjoy doing joint assessments with the physiotherapists'

'Gain a lot from joint assessments and the patient is not so exhausted by continual assessment'

'Very little repetition anymore'

'Everyone is writing on the MDT progress sheet so can easily determine what has happened with the patient on a daily basis and previously'

'Much easier to feed back information to relatives'

Quantitative results

Following the introduction of the shared care record:

- the number of continuation pages had reduced from 10 pages to one page
- the time taken to determine the patient timeline (a quality indicator), from the current case notes fell from 118 seconds per patient to 25 seconds per patient
- the number of patient notes containing an MDT discharge plan increased from zero to 100%
- 100% of records had no duplicate information
- the total admission process time reduced from between 200 and 280 minutes to between 60 and 110 minutes

St Benedict's Day Hospital - MDT meeting summary and shared care record

Meeting Summary

The hypothesis

The MDT at St Benedict's Palliative Care Day Hospital in Sunderland believed that recording the outcome of the MDT meeting would improve communication between the team and with the patients and carer. This would make planning for interventions and for discharge easier and more efficient.

Their objectives

Their objectives were to document discussions taking place at the MDT meeting and to plan care accordingly. They wanted to facilitate good communication between the MDT members according to a nationally-recommended structure of holistic care[1].

Rationale for development

The MDT meeting involved staff from a range of disciplines, providing their own professional perspective of each patient they care for. The meeting provides the opportunity to transfer information and reach consensus decisions on care planning. Patient advocacy and autonomy needed to be maintained, and all care needed to be in the patient's best interests. Prior to this project, the MDT's discussions were recorded in each patient's notes, but this lacked the structured holistic approach. It was known, for example, that spiritual and carer-related issues were poorly documented. Furthermore, there was ambiguity around delegation and review of tasks. Consequently, care was planned but sometimes failed to be implemented and these failures were not identified until the next meeting (ie, 6 weeks later).

Their findings

St Benedict's found that their recorded planning of care improved significantly. Initially, whilst care was being planned successfully, there was no safety net to ensure the completion or review of interventions. They decided therefore to include a named 'responsible person' with the duty of ensuring tasks were undertaken and to set an acceptable time frame in which to do it. The first cycle of the documentation audit was completed in April 2007 and has been done twice since.

1 Richardson A, Tebbit P, Brown V, Sitzia J, on behalf of the Cancer Action Team (2006) *Assessment of Supportive & PAlliative Care Needs for Adults with Cancer,* London: King's College London.

An audit of the key information they wanted to see in the post meeting notes was undertaken for patient notes. This was repeated after the MDT meeting summary document was introduced.

The record of key information was improved in all of the areas, with significant improvements in the capturing of when the next review would be and who was responsible for the actions.

Quantitive results between April and August 2007

Quality Area	% Change
Core patient information	+48
Overall assessment of patient needs	+4
Overall identification of responsible person	+202
Overall documentation of review period	+580

Shared care record

Qualitative results

An audit of the key indicators they wanted to see in MDT patient record was undertaken for patient notes in the current caseload. This was repeated after the shared record was introduced. The record of key information was improved in all of the areas, with significant improvements in the identifying and capturing of fatigue, anxiety and depression of individual patients. This has led to the department utilising staff more effectively to provide interventions in these areas.

Between April and August 2007

Have the following areas been recorded?	% Change		
	Fatigue	Anxiety and depression	Pain
Problems	+29	+141	+257
Medical assessment	+120	+44	+7
Nursing assessment	+536	+300	+28
AHP assessment	+118	-13	+18
Care plan	+157	+406	+66
Follow up plan	+79	+43	+450

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