Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
MULTI-DISCIPLINARY TEAM (MDT) ADULT AND OLDER AGE INPATIENT WORKING STANDARDS

Document Reference	SOP23-001
Version Number	1.1
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Instigated by: **Date Instigated:**	Paul Johnson - Clinical Care Director
Date Last Reviewed:	7 June 2023
Date of Next Review:	June 2026
Consultation:	Mental Health Practice Network Meeting Paul Johnson
Ratified and Quality Checked by: **Date Ratified:**	Mental Health Clinical Network Group 7 June 2023
Name of Trust Strategy / Policy / Guidelines this SOP refers to:	

VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*April 2023*	*New SOP. Approved at Mental Health Clinical Network Group (5 April 2023).*
1.1	*June 2023*	*Amend: 4.2 MDT Guiding Principles/Practices – addition of bullet point All Actions from the MDT will be shared/communicated to ensure relevant people/organisation are aware of their actions. This will be documented in the communications tab on Lorenzo when the person/organisation has been informed. Approved at Mental Health Clinical Network Group (7 June 2023).*

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1. INTRODUCTION

It is well accepted that Multi-Disciplinary Team (MDT) discussion improves the quality of care planning (e.g. DoH, 2007, RCP, 2009). The DoH (2009) advise that the most effective care planning, particularly in relation to risk, is a collaboration between the service user, their carer (where applicable), and the wider MDT. It is suggested that the inclusion of senior colleagues can also be beneficial in care planning pertaining to risk.

The 'MDT Care Planning: Good Practice Guidelines' for the Mental Health Division outlines the various clinicians involved in care planning, dependent on need. As a minimum, care planning should include the service user, their keyworker, and where possible, their carer/family (this is referred to as 'Direct Involvement Care Planning'). MDT meetings are considered a forum for care planning under the 'Internal Consultation Care Planning' section of these guidelines and include those within the team providing care to the service user, some may work directly with the individual, others may not. Internal Consultation Care Planning and Review incorporates the clinical views and opinions of clinicians who work within the same clinical team as the lead professional, but who do not work directly with the individual.

Multidisciplinary teams or MDTs are teams consisting of individuals drawn from different disciplines who come together to achieve a common goal, whether that be a project to introduce a new role, redesign of a patient pathway or providing care in a different way. They may also be described as interdisciplinary teams or multi-professional teams. Importantly, there is no one set form of MDT; they can and often do, include a wide range of disciplines beyond a particular service setting and beyond direct care roles; service users and carers can also sometimes play a part where appropriate. Implementation requires a flexible approach, and so measures of success will differ.

MDTs need to have a clear role and purpose, be well led and organised, have sufficient diversity of professions and disciplines, and be supported by an enabling infrastructure. MDTs must be pro-active in how they engage individuals and families in their discussions and decision making. MDTs should also connect with other services and teams in their neighbourhoods and place.

Successful joint working requires clear, realistic, and achievable aims and objectives, understood and accepted by all partners, including patients/service users, families and carers.

Common aspirations about what MDTs will achieve are:

- MDTs will enable professionals and practitioners from different backgrounds to communicate better about each other's roles and responsibilities.
- MDTs will provide a shared identity and purpose that encourages team members to trust each other.
- MDTs will lead to better communication and trust between team members and more holistic and person-centred practice.
- MDTs will prevent unnecessary errors and avoidance of related harm to individuals and their families.
- MDTs will result in resources being used more efficiently through reduced duplication, greater productivity, and preventative care approaches.
- MDTs will mean professionals and practitioners are less isolated and so will improve morale and reduce stress.

2. SCOPE

This SOP highlights best practice and current guidelines for staff working in the Mental Health Division of Humber Teaching NHS Foundation Trust, for those staff working in the Unplanned side of the Division and covers both Adult and Older Adult Inpatient Wards/Services. It applies to all clinical, non-clinical, bank and agency staff, including students who may work within inpatient wards. It highlights when to involve others in MDT reviews and who should be involved, to ensure that all aspects of the patients care needs are considered and that the views of all relevant professionals and relatives/carers are take into consideration.

3. DUTIES AND RESPONSIBILITIES

Clinical Care Directors and General Managers
Must ensure that all staff are aware and adhere to this SOP and relevant appendices for their respective services to ensure quality, patient centred and effective care is provided at all times. They are also responsible for ensuring that any deviation or errors arising are dealt with in the correct manner, according to the Incident Reporting Policy. They will, where appropriate and required, be responsible for formulating, implementing and reviewing where required this SOP or delegating responsibility to an appropriate deputy.

Responsible Clinicians/Consultants
Are responsible for all aspects of the medical side of the MDT Standards and are responsible for the decisions made in these meeting. This authority may be delegated to a suitable and competent deputy.

Modern Matrons/Senior Professionals
Will ensure systems are in place to support this SOP in their areas of responsibility and that they are regularly reviewed. Support teams in the planning and running of MDT's. Ensure that the highest standards of clinical care are paramount during a patient's admission to hospital.

Allied Health Professionals
Are responsible for ensuring attendance/representation at MDT meetings and contributing as required to the identified care needs of individual patients. Carrying out any appropriately identified assessments/interventions.

Psychology
Psychologists should be an integral part of acute adult mental health teams to promote reflective, compassionate, trauma informed care for service user's and carers, and to influence the multidisciplinary team culture.
Psychologists can offer:

- Psychological assessment, formulation and a range of brief evidence based psychological interventions (individual, family and group) to increase treatment choice, effectiveness and collaborative care.
- Reflective, psychologically led team supervision and post-incident support to promote the psychological wellbeing, resilience and retention of staff; ameliorating the emotional impact of working in challenging environments.
- Provide training to increase psychological skills in the workforce, enhancing psychologically informed care provision, and to provide supervision of psychologically informed interventions.

Charge Nurses/Team Leaders/Clinical Leads
Will ensure that timely meetings take place and operate effectively with agreed outcomes/actions. Ensure effective and timely communication between all Professionals and the patient and their relatives/carers. Ensure that staff within their area of responsibility have access to and attend any appropriate training. Ensure that best clinical care is carried out during patient MDT meetings.

Other Staff
All staff, both clinical and non-clinical are responsible for applying the principles contained within this SOP and following any relevant pathways as appropriate to their roles.

4. PROCEDURES

4.1. Key Points For Successful MDTs

Research has revealed that for MDTs to work successfully there are a set of enablers, listed below, that should be in place:

- Clear purpose: MDTs need a defined role that requires team members to interact across professional and disciplinary boundaries,
- Institutional support: the organisations which employ staff and (if in place) the partnership bodies overseeing this area of collaboration must provide support. This should include public endorsement (and so legitimacy), ensuring that the MDT has the necessary resources, and developing integrated performance systems.
- Team leadership: leaders should generally be facilitative in their approach to encourage different contributions but be directional when necessary. An awareness of team dynamics and a willingness to challenge poor collaborative practice are important competences for a team leader. To encourage this approach, the Chair of the MDT should not always be the same individual or from the same Profession. Areas to consider a rota for chairing the weekly MDT meetings. This will help to develop the collective ownership of the MDT.
- Collaborative opportunities: teams must have physical space and time for their members to engage across professions and disciplines. This enables them to improve communication and better understand each other's roles and resources.
- Person-centric: there is a danger that teams can become too inwardly focused on their own functioning. This can lead to people and their families feeling more, rather than less, excluded from discussions about their care.
- Role diversity: there is no magic formula for MDTs. Rather, the mix of professions and practitioners must respond to the needs of the population concerned while still being small enough to allow members to know each other.
- Evidence focused: teams require timely and accurate evidence of their shared impact. Structured opportunities for teams to reflect on this evidence is one of the most impactful means to strengthen their work.

Services should aspire to practice in a trauma informed way, and the ethos of this should be evident in the functioning of the MDT. There are six principles of trauma informed practice:

- Safety – services should work to avoid retraumatisation, promote safeguarding, and ensure service user safety. MDTs will ensure that safeguarding is considered within all MDTs, for all service users. MDTs will consider the role of trauma in someone's mental health needs and barriers to accessing support.
- Empowerment, choice and collaboration – service user and carer views will be validated and fully represented, a collaborative approach should be taken in working towards goals, options should be explained fully, and choice should be provided where possible. Service

user wishes and feedback will be incorporated in the MDT discussion, and where possible, the MDT forum will consider the options available to share with the service user, but not *make* choices on their behalf, in their absence.

- Trustworthiness – services should be transparent, do what they say they will, and not overpromise in terms of what they can deliver. MDTs will include feedback on discussions to service users after the meeting.
- Cultural consideration – it is the responsibility of all MDT members to advocate for cultural consideration, ensuring that assumptions or biases are not in place, based on (for example) religion, disability, race, gender, or sexuality.

4.2. MDT Guiding Principles/Practice

- Identifying who will be required to attend the MDT meetings with representation across all disciplines. For the purpose of this Guidance an MDT will be deemed quorate with a minimum of 3 different Professional groups in attendance. Where this cannot be achieved the review can still take place but will only be deemed a ward review and not an MDT. This is to encourage and prioritise these meetings from all disciplines and ensure a full and robust discussion takes place to best meet the needs of the patient.
- A suitable agenda for discussion of patient care, should include, patient background, action taken to date, updates and next steps. Other things to consider are any safeguarding concerns, sexual safety issues, supportive engagement. Areas of consideration are highlighted in **Appendix 1** These will be agreed prior to the meeting taking place.
- The MDT lead should ensure all participants are asked of their opinions and any information they are wanting to input or share into the meeting to promote fair contribution.
- Record attendance and any apologies for the meeting in the minutes to ensure an accurate log of those in attendance.
- MDT's will take place weekly on each ward on an agreed day/time and this will be shared with all ward staff and the wider Teams
- Acknowledgement as to when agreed outcomes will be reviewed to maintain continuity of care as well as when any follow up of these actions is required by the lead professional(s) responsible.
- Adequate time should be allocated to discuss patients and allow for enough time to confirm patient care planning and next steps. Time will differ for each specific case.
- Ensure an accurate reflection of the MDT is recorded in the patient's electronic clinical record under the MDT form in the care Planning Tab.
- All Actions from the MDT will be shared/communicated to ensure relevant people/organisation are aware of their actions. This will be documented in the communications tab on Lorenzo when the person/organisation has been informed.
- Previous MDT minutes are reviewed in subsequent MDTs to ensure all previous actions have been completed. Where they have not, they must be addressed at the earliest opportunity. Where actions are still within timeframe these must be logged and rolled over to subsequent meetings.
- Any changes to care/treatment plans will be communicated to the patient following the meeting and other relevant professionals and external Agencies in a timely manner.
- If required MDTs can be arranged more than weekly where specific issues/risks need to be discussed by the MDT. Where this happens, all process should be followed as per the normal weekly MDT.
- Patients should be given the option to attend the MDT in person. Where they decline this must be recorded within the MDT discussion. The patient's opinion must still be sought to be fed back to the MDT.

- Relatives/carers will be invited as appropriate and where agreement has been gained from the patient and this should be documented on the individuals contact sheet, listing all those individuals the patient wishes information to be shared with. Staff must ensure this record is kept up to date in discussion with the patient.
- Relatives/carers will be given the option to attend the MDT in person or via Teams and appropriate invites sent out as requested.
- The outcome of the MDT will be shared with the appropriate individuals following the meeting. Instances may occur where the patient declines or lacks capacity to give consent. When this occurs, staff are to follow appropriate safeguarding and mental capacity processes/guidance/policies.
- Where any specific risk behaviours or incidents have taken place and the patient is not wishing these to be disclosed to relatives/carers a clear rationale must be recorded in the MDT record on Lorenzo to highlight this. If as an MDT it is felt that disclosure is necessary due to any safeguarding concerns then this must be discussed with safeguarding, an entry recorded in the patients notes to support the rationale as well as the patient be informed of the decision to disclose.

4.3. Other MDT Reviews

- Outside of the weekly MDT all inpatient wards will conduct a daily rapid review of every patient at an agreed time with the team. This will include as many members of the MDT as practicably possible.
- Any tasks identified within the rapid review are to be actioned by those responsible within the MDT.
- Weekend MDTs take place outside of this process with external members from teams within the service to offer continuity to patient care and treatment. Those patients identified as needing further discussion as part of the daily rapid review will be discussed in the weekend MDT. This is not a full review of all patients within services.

5. REFERENCES

PowerPoint Presentation (hee.nhs.uk)

Multidisciplinary Teams: Integrating care in places and neighbourhoods | SCIE

Department of Health (2007), “Creating capable teams approach (CCTA): best practice guidance to support the implementation of new ways of working (NWW) and new roles”, London.

RCP (2009), Good Medical Practice, 3rd ed., Royal College of Psychiatrists, London.

Acute Care Pathway Briefing 2021

Appendix 1: MDT Prompts

MDT discussion prompt sheet (to be adapted for individual services areas, according to need – whilst areas may choose to add additional discussion points, it is recommended that all areas outlined here are regularly considered within an MDT forum):

- Attendance – ensure representation from multiple professional disciplines – always record who attended, as well as invites with apologies.
- **Consider** – does your immediate team have the appropriate skills and knowledge for care planning and review, or would it be useful to invite, or elicit feedback from, a professional from a different clinical area (e.g. safeguarding, learning disability services, the Complex Emotional Needs Service) – see the 'dedicated focus' section of 'MDT Care Planning; Good Practice Guidelines' for further guidance
- Service user and carer feedback – what are the concerns, wishes, and goals of the service user and their primary support network?
- Formulation and diagnosis – the primary focus (as per 'Trauma Informed Care') should be on 'what has this person experienced, and what does that mean for what they experience now?', rather than 'what is wrong with them?'. It is essential that the individual circumstances are understood, and care is tailored accordingly. Equally, there is a role for diagnosing within our systems, to guide prescribing, and the implementation of evidence based practice – consideration should be made within the MDT of NICE guidelines, the evidence base, the inclusion of others with additional knowledge in that clinical area. *The role of the MDT is to work together to find a balance between utilising guidance and evidence, with individualised, person centred care – this will often involve clinical debate, the role of the chair is to facilitate discussion and support the team in reaching a synthesis in views.*
- Safety – is the service user safe, both in our care and in their home context (e.g. suicide, self neglect, domestic violence, risk of falls)? Are those around the service user safe (e.g. domestic violence, aggression)? Are there practical steps that we can take to improve safety, and are any safety or safeguarding concerns fully documented?
- Addictions and physical health – have physical health needs and addiction been considered? Do we need to seek additional support/advice?
- 'Engagement' and medication compliance – if any issues related to medication compliance or engagement with any areas of service are noted, consider this in the context of what is known/the formulation – what can we do to support access to intervention?
- Carers – ensure carer views are represented within the MDT, and consider needs of carers, both paid and unpaid. Consider any needs of the service user as a carer for others.
- Actions and feedback – have actions from previous MDTs been reviewed? Have current actions being clearly defined, with an allocated person responsible and clear timescales? Who will feedback to the service user, and where appropriate, their carer/supporters?
- Documentation – ensure a person has been allocated to document the MDT discussion; *it is essential to document **how** decision/plans/actions were reached, including the alternatives considered.*

Risk Assessment and Formulation: Risk assessment should take into account that risk is dynamic and, where possible, specify factors likely to increase the risk of dangerousness or those likely to mitigate violence, as well as signs that indicate increasing risk.

Risk formulation brings together an understanding of personality, history, mental state, environment, potential causes and protective factors, or changes in any of these. It should aim to answer the following questions:

- How serious is the risk?
- How immediate is the risk?
- Is the risk specific or general?
- How volatile is the risk?
- What are the signs of increasing risk?
- Which specific treatment, and which management plan, can best reduce the risk?

Appendix 2: Equality Impact Assessment

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: **Multi-Disciplinary Team (MDT) Working Standards**
2. EIA Reviewer (name, job title, base and contact details): **Nigel Hewitson, Modern Matron**
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? **SOP**

Main Aims of the Document, Process or Service The main purpose of the SOP is to ensure an agreed standard approach to MDT working and to identify individual roles and responsibilities in relation to MDTs.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	**Low**	
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	**Low**	
Sex	Men/Male Women/Female	**Low**	
Marriage/Civil Partnership		**Low**	
Pregnancy/ Maternity		**Low**	
Race	Colour Nationality Ethnic/national origins	**Low**	
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	**Low**	

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Sexual Orientation	Lesbian Gay men Bisexual	**Low**	
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	**Low**	

Summary

Nothing currently identified as a risk at this time.	
EIA Reviewer: Nigel Hewitson	
Date completed: April 2023	Signature: N.Hewitson