Implementing collaborative MDT working for Supported Living

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Introduction

In Doncaster there are formulated MDT's that are allocated to each residential care home in Doncaster. This includes a representative from the CCG, a social worker, Community Learning Disability nurse and a representative from contracts who have offered support and advice around Covid-19 to try and prevent any outbreaks or hospital admissions.

This is something I have been leading on to replicate for supported living providers but also plan to enhance the MDT support by including a representative from the provider and this being a forum where they can bring any issues or concerns with regarding residents, staff or the service and the MDT are able to offer support and advice with.

Improvement methodology

- Focusing on improving Quality of care and support delivery.
- From doing the MDT's during the COVID-19 pandemic it was evident there was a gap in the support supported living providers have from professionals within the community. They often require advice and support about the care and treatment of residents or how to refer individuals for support but are unsure who to speak to.
- Data and intelligence was gathered via phone call and monitoring visits. This information was then collated and measured which identified where gaps and support was needed. This continues and is monitored and evaluated monthly. It is hoped data can be collated to identify for example how many individuals have had their annual health check and medication reviews to start with and then how many have received these in 6 months time following the implementation of MDT working.

The approach

What we were trying to accomplish

The purpose of the MDT's is to offer support, advice and guidance to the provider around the pandemic of covid-19, prevent any hospital admissions and ensure the services have everything they need to stay safe.
The plan is for the MDT's to take place once per month and to expand it's purpose from just focusing on the pandemic.
The aim of this is to improve partnership working with professionals and the providers. Improve the health and wellbeing of the people we support for example reviewing annual health checks. Whether the providers require support with behavior management, family contact etc. The hope is for the MDT's to be a quicker referral process for example. There may be an individual who the provider thinks may be eligible for some continuing healthcare funding. This can be discussed at the MDT and if the CCG representative thinks they will be eligible they are able to go straight to a DST assessment rather than have to complete a checklist first.
The MDT's can also be involved in reviewing care plans and risk assessments with the provider and the individuals using a person centered approach and meeting CQC standards.

What we measured to understand if our change was an improvement

In Doncaster we currently have 131 properties for support living across 6 providers.
I have been leading the current MDT for one provider that has a total of 42 properties in Doncaster.
These properties were rag rated red, amber and green regarding their current situation with the pandemic.
Data and information has been gathered through daily monitoring calls and monitoring visits where required.
Information collated has been specifically around the pandemic. Which includes which services may have individuals or staff with signs and symptoms.
The monitoring calls and visits from the MDT have continued to gather data, offer support, advice and training to mitigate any risk and prevent any hospital admissions.
Since this has been implemented the data collated demonstrates an improvement where properties have now been decreased to Amber due to the support and following recommendations from the MDT.
(See attached word Doc for Data and 5 PDSA'S)

What changes we made / are making

- The changes we have made/making is ensuring a provider has an appointed MDT so they know who to contact for support.
- Providing the delivery of Proactive care and support centered around the needs of the residents, staff, families and the provider.
- The MDT is to effectively act as a monthly ward round for individuals residing in supported living. Support to not just focus on the current pandemic but to continue and expand in nature. Looking at Annual health checks, medication reviews, activities, reviewing care plans, health passports, family contact and general health and wellbeing.

The impact

- Better working relationships between professionals and the provider.
- Improvement in communication and information sharing.
- Joined up commissioning and collaboration between health and social care.
- Improvement in the care, health and wellbeing of the residents and reduce health inequalities
- Using a patient centered approach.
- Quicker process for referrals meaning residents are allocated to case loads quicker and assessments in a minimum time frame.
- Supports providers to improve care plans and risk assessments which equally improve standards that are required for CQC inspections.
- Better workforce, training and development for care staff.
- Feedback from the managers of supported living is that they have found the MDT support to be useful and have been grateful for the support they have received.

Leadership learning

- From doing this project as a leader I have learnt communication is key when wanting to lead on change.
- It is important to be organised and gather Data to be able to reflect on what has worked well and what hasn't.
- To delegate tasks to others due to being unable to do everything on my own but to delegate tasks that I would be willing to do myself.
- To work as a team, listen to each others views and opinions and to act accordingly.
- To be respected, enthusiastic and passionate about the change to be able to influence and motivate others.
- Change is not always welcomed. Some mangers were obstructive in allowing monitoring visits to be carried out and felt the MDT were being Critical rather than Supportive.
- Initially it was difficult for all members of the MDT to be present during the MDT meetings, however as the MDT's are already planned months in advance and are booked for the first Tuesday of every month attendance is much better.
- It has been a good way of keeping on top of case management and having updated knowledge around the health and wellbeing of individuals on my case load.

Next steps

- The MDT meetings have been diarised with all members of the MDT, including the provider and planned for the first Tuesday of every month.
- It is impossible to discuss every home in each MDT. This has therefore been broken down into discussing 7 properties at each MDT, meaning each property will be discussed every 7 weeks. However the provider can raise any urgent issues prior to the MDT if needed.
- A Template has been drawn up and circulated to all members of the MDT and provider so they are able to include what they think should be discussed at the meetings. This also includes any actions or any other business.
- The Hope is to try and find a way of how it could be possible to have some sort of involvement from the GP.
- If the change is successful it is hoped this process can be rolled out to all supported living providers within Doncaster.

Microsoft Word Document 5 PDSA's

Microsoft Word Document Data following introduction of supportive MDT's in Doncaster for Supported Living