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Making MDTs work

Governance, roles and practical delivery for neighbourhood health.

Webinar Two – Rachel Edwards, Alice Benton & The Agilio Team

Neighbourhood Health: 1 Year on

What's actually changing – Rachel

An operating model, not a policy.
The concept gave you permission; delivery asks for proof.

Multi-organisation footprints.
Practice, PCN, federation, community, local authority, VCFS.

Informal to governed.
Defined pathways, named accountability, contracted expectations.

The quiet consequence.
An assurance load practices have never carried at this scale.

What it means in the room – Alice

NINT – not your payroll, not your policies.
The people round the MDT table increasingly don't share your employer or line management.

MDT – Goodwill to infrastructure.
Goodwill gets the first meeting; it won't survive an IG query or a CQC “show me.”

Nothing lives in one place.
Inboxes, a shared drive, someone's laptop – and a WhatsApp group nobody quite admits to.

Choosing your MDT

Why this cohort?

What will this MDT give you that current working doesn't — and can you write that down as a short case for doing it?

Who needs to be there?

Which partners and roles are genuinely required — and, just as important, what does each organisation get out of taking part?

Information sharing that actually works

Who needs access to what, with what consent, under which ISA – and with which system permissions actually switched on.

Governance

Different employers, different terms. Different management and supervision. Indemnity and professional accountability Compliance: the unglamorous scaffolding.

Pathways, roles and governance

Start with the cohort, not the team

Cohort, referral criteria, exclusions, escalation points, intended outcomes. A vague pathway produces a vague team – it will invent its own criteria, in about seven different ways.

Design the roles – note the overlaps

Care coordinators, social prescribers and link workers often exist two or three times over across partners: the same patient contacted by three people, or by none.

Assess before you commit. What can be gained for all partners?

A short checklist – purpose, partners, cohort, capacity – forms the assessment of why this project, now.

Hearts and minds from day one

Relationships are built before the first meeting, not in it — and reiterated at every meeting after. Not a one-conversation job.

Prove it, embed it, business as usual

Measure from the start

Decide measures before you begin.
What you'll capture at the start, during and at the end – and what success looks like at each point.

Count the soft stuff too.
Some measures are quantifiable; some are softer – confidence, learning, relationships, plus projected change.

New pathways are evidence.
If those engaged now use pathways that didn't exist before, that is proof of change, capture it.

Patients, carers, service users.
Engagement is evidence – their voice belongs in the record, not just the room.

Beyond the meeting room

Engage wider than the MDT.
Not just the team and cohort — the wider practice and partner organisations too.

Share the learning.
Information sharing about key services; feedback on advice given and the outcomes it produced.

Blueprint the next project.
Strong processes underneath the MDT become a repeatable template members recognise and can dip back into.

Plan the route to business as usual.
How does this stop being a project and start being simply how care is delivered here?

From pilot to structured delivery

The delivery discipline – Rachel

The real business case.
Model, cost, return — and sustainability past the pilot money.

Risk assessment up front.
Operational, HR, clinical, IG and delivery risks, mitigated before launch.

Pathway ownership.
A named owner whose actual job is keeping the pathway current.

Standardisation.
SOPs and templates: the same delivery whichever partner is on shift.

Learning loops.
A pilot that never adapts isn't a pilot – it's a habit.

The Evidence – Alice

Data capture from day one.
Not bolted on in month eleven – memory is not an audit trail.

Agree the measures early.
Activity, quality, safety, experience, outcomes – reported how often, and to whom.

Reporting cycles.
Monthly operational, quarterly governance, annual evidence – different audiences, different grain.

Ready for “show me.”
A deeply uncomfortable conversation if the evidence is spread across nine inboxes.

Example process

Getting the right people in the room

Relationships come first.
Built before the first meeting, and introductions reiterated at every one — not a one-conversation job.

The invitation is a big deal.
Create a little FOMO; remind services they're missed when absent — and reassure them the links aren't broken.

Pursue the hard-to-reach.
Safeguarding, tissue viability — go outside your usual contacts, physically find them, and politely hound them until they attend.

Every voice matters.
Time invested so care homes see the MDT as theirs too — now attending more often, speaking up, and confident they're heard.

Making it stick

Structure people recognise.
Strong processes underneath, so members can dip in and out and still know exactly how to slot back in.

Learning built in.
A mix of case discussion and service information-sharing — in-person connections turn “that team exists” into a clear action.

Close the loop, always.
Actions followed up with strong oversight; feedback given on advice received and the outcomes it produced.

A well-briefed coordinator.
A PCN manager in tune with it all — filling gaps, updating contacts, taking actions and prompting conversation.

Your readiness pre-checklist: is this clear at the start and where we want to evolve

- ✓ Which shared cohort of patients are we building the MDT around – and is the scope clearly defined?
- ✓ Have we agreed the referral criteria, exclusions, escalation points and intended outcomes?
- ✓ Which partners and roles are needed — and where do similar roles, responsibilities or accountabilities overlap?
- ✓ Who will chair, Is there a named lead for pathway ownership, governance, compliance, reporting and evidence capture?

Your readiness pre-checklist: engagement codesign

- ✓ Are information-sharing, access permissions, document control, SOPs and escalation routes agreed?
- ✓ Have we agreed the referral criteria, exclusions, escalation points and intended outcomes?
- ✓ Which partners and roles are needed — and where do similar roles, responsibilities or accountabilities overlap?
- ✓ Who will chair, Is there a named lead for pathway ownership, governance, compliance, reporting and evidence capture?

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Over to you

Bring us your questions – especially the awkward ones!

The checklist will be shared with everyone who registered
Suzie, Rachel and Alice are here for the live Q&A
Want the full readiness diagnostics? Lets chat further!