Improving the co-ordination of multidisciplinary team working for people with motor neurone disease.

Stear L
Wirral Hospice St John's

Background:

Motor neurone disease (MND) is a progressive neurodegenerative condition requiring complex, multidisciplinary team (MDT) management.

The MDT framework across Wirral was fragmented, with delays in care coordination, inconsistent communication, and poor patient and carer support.

An MND key worker role was introduced to Wirral Hospice St John's team in 2021 with the intention to improve this.

Aim:

- To improve the quality, efficiency, and coordination of care for patients with motor neurone disease by overhauling the existing MDT approach.
- The goal was to create a more structured, communicative, and patient-centred system that supported timely interventions, enhanced team collaboration, and improved patient and carer experiences.

Method:

- Inconsistencies in the existing MDT approach became apparent following a review of pathways, team communication and patient feedback.
- Findings were presented at a multidisciplinary operational group meeting, where the referral process and key service gaps were collaboratively examined.
- The MND keyworker focused on strengthening relationships with external agencies, including health and social care community teams, palliative care services, and specialist clinics.
- This informed the redesign of the MDT structure and care pathways for MND patients.

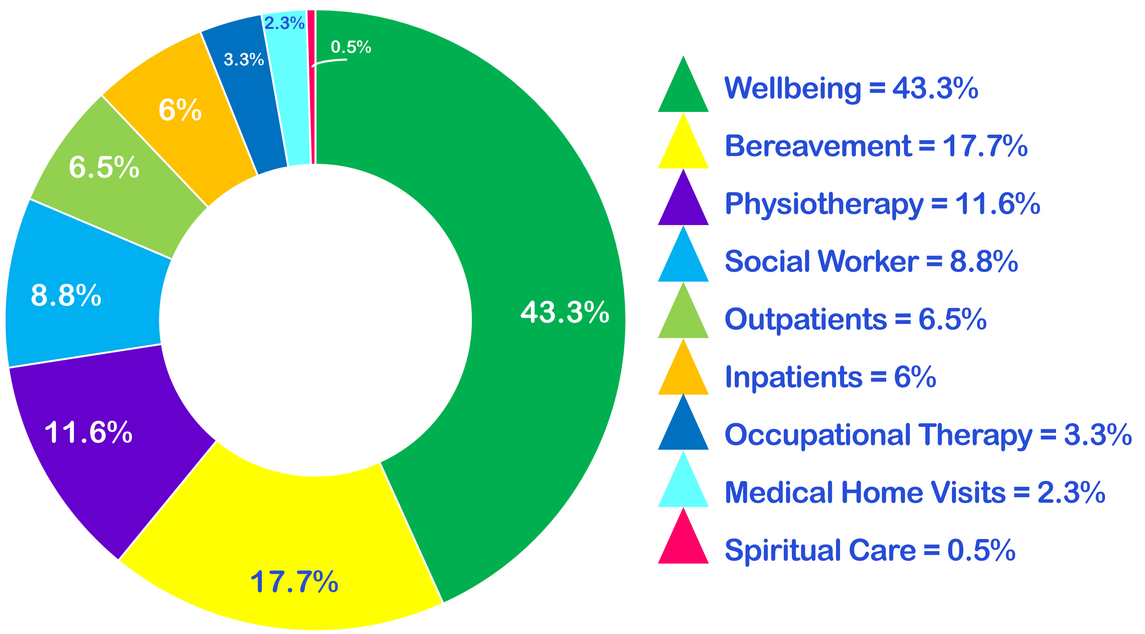
Liz Stear, MND key worker

Liz is Wirral Hospice's first MND key worker, covering the Wirral peninsula (pop. 320k) and into neigbouring areas.

In her role, Liz links with all the local health and social care agencies on behalf of people in the area who live with MND.

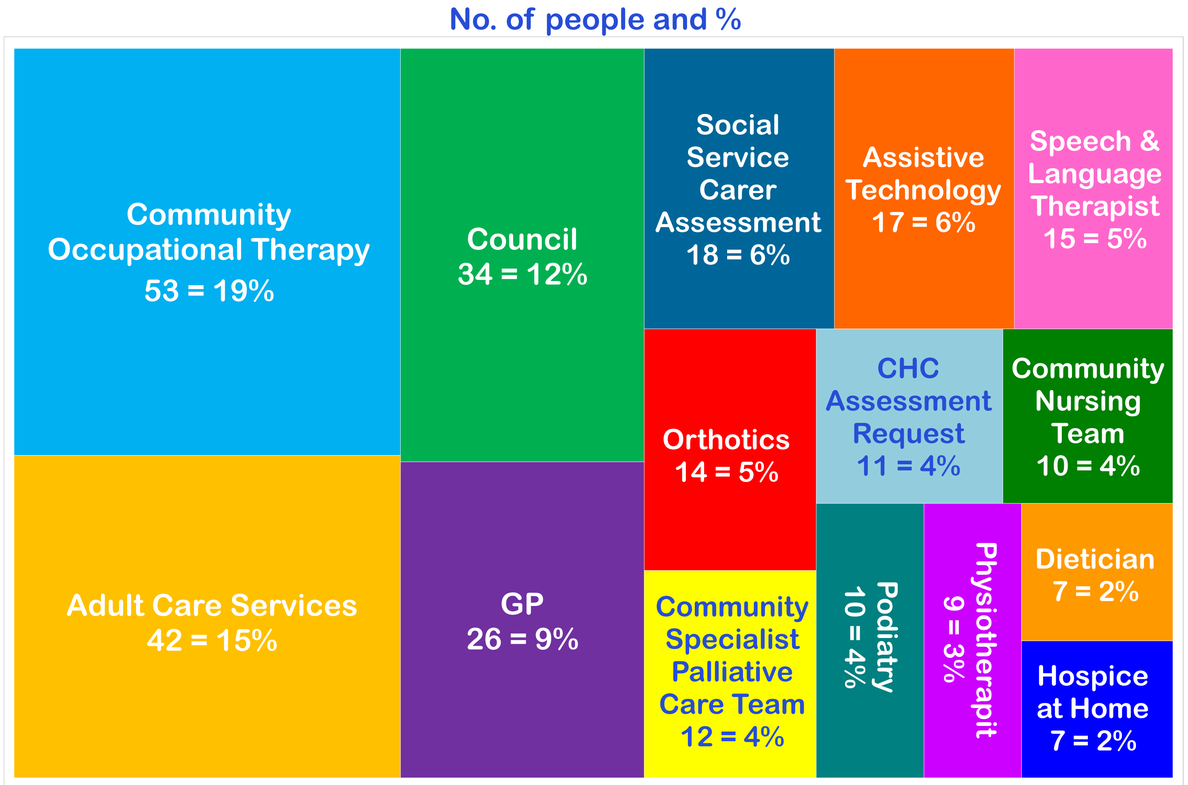
"Wirral Hospice and the Motor Neurone Disease Association are the perfect partnership. I'm able to combine my nursing experience and local knowledge to meet and represent all those people living with MND, alongside their families and other carers, so that we can get them the most suitable support for their personal circumstances."

Engagement in hospice services* accessed by people with MND



*excludes counselling and complementary therapy services

Onward referrals from the MND to external services
No. of people and %



"It enables us to offer tailored, timely support that reflects individual needs and experiences."

MNDA Community Support Coordinator

"It is great peace of mind to know that Liz is there to provide help in contacting the necessary health professionals when needed.

In the early days of my wife's diagnosis Liz gave us lots of advice on services available, and has enabled us to access mobility assistance."

"Liz was perfect in her first visit. She took us through so many things that we did not know as the diagnosis was so recent.

We feel we are in very good hands and feel comforted that Liz is there."

"These meetings enable positive planning and the ability to provide the correct support at the right time for the person and family."

Community Occupational Therapist

Results:

- An MDT was established to meet virtually every six weeks, with improved attendance and engagement from all partners.
- Monthly data showed measure improvements, including earlier referrals to the MND keyworker and allied services such as speech and language therapy, dietitians, respiratory, palliative care and other hospice services.
- This enabled earlier conversations about interventions like gastrostomy, non-invasive ventilation, and advanced care planning, supporting more proactive, coordinated care. MDT members also adapted their pathways to deliver a more responsive service.

Conclusion:

- This approach has led to people reporting feeling better supported from the onset and less isolated.
- Overhauling the MDT approach enhanced the efficiency, responsiveness, and person-centredness of care delivery.
- This model provides a sustainable framework that can be adapted to other complex, progressive conditions requiring coordinated multidisciplinary input.

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