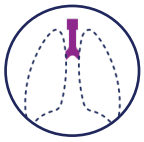
The Multidisciplinary Team (MDT) for MND should:

- include health and social care professionals with expertise in MND, and staff who see people at home
- ensure effective communication & coordination between everyone involved in the person's care and their family and carers
- provide co-ordinated care tailored to the person's needs
- carry out regular co-ordinated visits to assess people's symptoms and needs, including:

- ✓ weight and diet intake
- ✓ feeding and swallowing
- ✓ saliva problems



- ✓ respiratory symptoms & function
- ✓ non-invasive ventilation
- ✓ cough effectiveness

- ✓ muscle problems eg cramps
- ✓ physical function
- ✓ activities of daily living

- ✓ pain
- ✓ other symptoms eg constipation
- ✓ treatment's response

- ✓ speech & communication

- ✓ cognitive & behavioural changes
- ✓ psychological needs

- ✓ social care needs
- ✓ end of life needs needs

- ✓ information & support for the person, family and carers

We offer a detailed guide and online course on MDTs to support further learning.
Visit **www.mndassociation.org/mdt** to find out more

Core team consists of:

- ✓ neurologist
- ✓ specialist nurse
- ✓ dietitian
- ✓ respiratory physiologist
- ✓ physiotherapist
- ✓ speech & language therapist
- ✓ occupational therapist
- ✓ palliative care expert

It should have access to:

- ✓ clinical and neuro psychology
- ✓ social care and counselling
- ✓ respiratory ventilation service
- ✓ gastroenterology
- ✓ orthotics
- ✓ wheelchair services
- ✓ specialist palliative service
- ✓ assistive technology services
- ✓ community neurological care teams

Benefits include:

improved quality of life for people with MND

compliance with NICE guideline

facilitated access to timely support and intervention

improved communication and continuity of service

promotion of best practice and person-centred care

access to professional and peer support

MND Association
Tel: 01604 250505
Email: enquiries@mndassociation.org
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