Multi-Disciplinary Teams: Making them work

BCST National Workshop
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MDTs – why?

It’s the same kind of problems for everyone—a lack of somebody picking the ball up and running with it for you… There’s all sorts of things there, but how do you find out about them? I think there’s a lot of assumptions that you know as much as they do about it and you don’t. (Ken)

It seems like one person after another coming in to do different assessments on something else...It’s not like one person comes in and assesses for everything, it was a never ending stream of people coming. (Carole)

What they put in the discharge letter, nothing was explained to me, what she should take at home and help we would have from social care. We brought her home and I was wondering how was I going to manage her? (Nilesh)
Common elements of integrated care policies

- Multi-disciplinary teams supporting an identified population
- Risk stratification with support tailored accordingly
- Case co-ordination for those with multiple and complex needs
- Sharing of information between sectors and organisations
- Planning / commissioning through long term capitated budget with outcome based incentives
- Emphasis on co-production with people, their families and local communities
WHO: Challenges of Integrated Care Reforms

• People-related challenges
  where existing professional groups and cultures have become increasingly specialized and seek to differentiate their activities rather than work together in interdisciplinary ways that include patients and the community as equal partners in the care process.

• Organizational-related challenges
  where different stakeholders do not share a common goal to promote the welfare of people and where different values and goals are held by regional authorities, non-profit organizations and private businesses.
MDTs
What do we expect from MDTs?
What do we know about MDTs?
What support can help MDTs?
But first......a quiz
What do we expect from MDTs?
Multi-disciplinary or Inter-professional?

- **Multi-disciplinary**: those from different specialisms working alongside one another
- **Multi-professional**: those from different professions working alongside one another
- **Inter-disciplinary**: those from different specialisms working with each another
- **Inter-professional**: those from different professionals working with each another
- **Trans-disciplinary**: specialists moving out of their discipline to form new roles and undertake alternative tasks
What do we expect from MDTs?

CONTEXT + MECHANISMS = OUTCOMES
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Antecedents
- Role awareness
- Interprofessional education
- Trusting relationships among team members
- Belief that IPC improves care
- Organizational support

Attributes
- An evolving interpersonal process
- Shared goals, decision-making and care planning
- Interdependence
- Effective and frequent interpersonal communication
- Evaluation of team processes
- Engaging older adults and family members in the team
- Diverse and flexible team members

Consequences
- Redefining team composition and function
- Knowledge and confidence about older adults with chronic disease
- Comprehensive care planning and coordination of services
- Provider job and professional satisfaction
- Reorganizing of work flow
‘the way we do things round here..’

Schein 2010
Professional Cultures
Tribalism and Power
What do we know about MDTs?
“We have found that a multidisciplinary approach offers many advantages in diagnosis and treatment. A means must be found to assure that a patient receives comprehensive care, that is, care which satisfies a combination of physical, mental, and social needs. A catalyst is required to assure that all resources which may help a patient have been effectively mobilized. In our experience, designating a member of a multidisciplinary team as the coordinator met these requirements and overcame many of the potential obstacles patients faced in obtaining comprehensive care.”
Evidence for team (based) working

1. Reduced hospitalisation and costs
2. Reduced medical error
3. Increased effectiveness and innovation
4. Improved patient / service user satisfaction
5. Greater implementation of innovations
6. Lower patient mortality
7. Increased mental well-being of team members
8. Reduced turnover and sickness absence
9. More effective use of resources
10. Improved patient satisfaction
Cancer Care: Studies which explored patient outcomes (29 in total) report positive impacts. These include increase rates of survival, improved patient satisfaction, and better diagnosis and/or treatment planning. (Prades et al 2013)

Mental Health: integrated team working is supported through better management, diversity of professions, social support and fewer job demands. Overall job satisfaction of team members is associated with the level of choice experienced by users and their satisfaction with these choices. (Huxley et al 2011)

Older People: an integrated discharge team incorporating acute and community health staff, social workers, and the voluntary & community sector led to a reduction in length of stay of older people
The Healthy Prestatyn Iach model

Population split across 5 (MDT)‘KeyTeams’
4 general teams + 1 housebound & care home teams
The HPI model: KeyTeams

KeyTeams = interdisciplinary teams replacing the traditional GP role

per 6,000 pts
The HPI model: KeyTeams

Supporting all of the teams:
- Practice & Treatment Room Nursing
- In-house Physio
- Audiologist
- Mental Health Practitioners
- Research Team
KeyTeam principles

- All team members have an equal contribution to make
- Stable team – professionals get to know how each other works, strengths, interests
- Co-located in one office for all of their admin rather than in ‘own’ consulting room
- Team members are around for advice or to discuss patients they are concerned about
**Mission:**
Working together with the Native Community to achieve wellness through integration of health and other services

**Vision:**
A Native Community that enjoys physical, mental, emotional and spiritual wellbeing

**Key approach:**
Shared responsibility, commitment to quality, family wellness

“Consumer-owners”
At the core: co-located Integrated Care Teams

Some Outcomes:
36% decrease in ER visits between January 2000 and 2015
36% decrease in the rate of hospital admissions from 2000 to 2015
FIGURE 10: GROWTH IN NUMBER OF MDT DISCUSSIONS AND WTE OF STAFFING GROUPS IN ENGLAND, NORMALISED RELATIVE TO 2011 LEVELS\textsuperscript{23}
Always a good use of professional time?

- The mean length of patient discussions was **3.2 minutes**, and over half of MDT discussions were less than **2 minutes**.
- Meetings could last up to **five hours**.
- Meetings had between **7 and 27** in attendance, with an average of 14. However, the mean number of people contributing to each discussion was **only 3** – with discussions involving just one or two people not uncommon.
- In **7%** of discussions, decisions were deferred due to either missing information (usually diagnostic imaging results) or missing core MDT members.
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Danger of Pseudo teams

Working in Team and Errors, Stress and Injury
(170 acute trusts, 120,000 respondents)

Types of Team Working Patterns

www.nhsstaffsurveys.com

(West 2013)
Real Teams (and pseudo ones…)

Typical tasks require team members to work in a closely coordinated and timely manner towards common goals and objectives.

There are one or more clear shared team objectives that team members agree upon.

Team members systematically review team performance and adapt future objectives and processes accordingly.

At any given moment, team members are clear about who is a member of the team and who is not.

Typical tasks require team members to work alone or in separate dyads towards disparate goals and objectives.

There are as many different accounts of team objectives as there are team members.

Team members occasionally meet together to exchange information, often through obligation or habit with no consequent innovation.

Team boundaries are highly permeable, with team members being unclear about who is part of the team and who is not.
The five dysfunctions of a team

1. Absence of Trust
2. Fear of Conflict
3. Lack of Commitment
4. Avoidance of Accountability
5. Inattention to Results

Status and Ego
Low standards
Ambiguity
Artificial harmony
Invulnerability

(Lencioni 2002)
Dependency

The group behaves as if it expects to be fed and nurtured by an omniscient leader.
The group behaves as if its purpose is to identify an external enemy or threat, which is has either to attack or to flee from.
<table>
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<tr>
<th>Focus</th>
<th>Methods</th>
<th>Findings</th>
<th>Reference</th>
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<td>Multidisciplinary teamworking in the NHS</td>
<td>Surveys completed by around 400 primary, community or secondary healthcare teams and in-depth qualitative work with a sub-sample of teams</td>
<td>Multidisciplinary teams with clear objectives, positive leadership and appropriate communication result in higher levels of participation, greater commitment to quality, and more effective and innovative practice. Team members within effective teams experience better wellbeing, and there is lower turnover of staff. Sufficient professional diversity is another key enabler</td>
<td>Borrill et al (2001)</td>
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<td>Integration of social care staff within community mental health teams</td>
<td>National survey of mental health trusts, staff survey in four locations selected purposely for their differently constituted teams and interviews with service users</td>
<td>Staff perception that integrated teamworking is supported through better management, diversity of professions, social support and fewer job demands. Overall job satisfaction of team members is associated with the level of choice experienced by users, and their satisfaction with these choices (although the study notes the need for further exploration of outcomes)</td>
<td>Huxley et al (2011)</td>
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<td>Principle factors that enable multiprofessional teamworking to improve care for service users</td>
<td>Survey of 135 teams in 11 NHS trusts and in-depth ethnographic studies of 19 teams involved in the survey</td>
<td>Team effectiveness factors included encouragement for innovation, team participation in decision-making, trust between members, leadership, skill mix and absence of conflict. Wider contextual factors included organisational support, sufficiency of resources (in particular, staff) and external targets. Effective teams promoted engagement with service users and carers, and sought partnerships with other teams and services</td>
<td>West et al (2012)</td>
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<td>Staff engagement and its relationship with organisational performance</td>
<td>Analysis of NHS staff survey and other data sets between 2006 and 2009</td>
<td>Good management that encourages engagement is significantly associated with patient satisfaction, patient mortality and infection rates, as well as staff absenteeism and turnover. Ensuring that teams have clear objectives and teamworking is effective are key factors in developing a culture of engagement</td>
<td>West et al (2013)</td>
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Avoiding pseudo-teams through..

- Diversity of professions within a team provides greater experience and skills which can result in more holistic and creative responses to the needs of patients and service users.
- Perceived equality in status and power between team members.
- Leadership and co-ordination are essential for communication and cooperation within a team and in developing positive relationships with external teams.
- Clear objectives provide a vision of what success will look like and for team members to understand their individual contribution.
- Patients and service engaged in the working of team.
- Supportive physical, technological, organisational and policy context in which an inter-professional team operates.

Jelphs et al 2016
Leaders for quality cultures: Collective leadership

- An inspiring vision and compelling strategic narrative
- Clear priorities and objectives at every level from Board to front line
- Have supportive people in leadership and management roles
- Have high levels of staff engagement
- Learning and innovation is seen as everyone’s responsibility
- Have high levels of genuine team working and co-operation across boundaries

West et al 2014
**Inputs**

- Are the tasks to be undertaken by the team clear?
- Does the team contain the right mix of knowledge and skills?
- Is the organisation supportive of the team purpose?

**Processes**

- Does the team have achievable and agreed objectives?
- Is the team encouraged to individually and collectively reflect and adapt their practice?
- Is the leadership valuing of diversity and promoting a common vision?

**Outputs**

- Are there a common set of clinical and wellbeing outcomes?
- Is the direct experience of service users and carers being gathered?
- Are team members feeling motivated, engaged and supported?

Jelphs et al 2016
Reflect upon a multi-disciplinary team (including management teams if more relevant) that you are a member of…

- Which of these ‘inputs-processes-outputs’ are in place?
- Which ones were not clear?
- What development was provided?
What support can help MDTs?
Individual development
Community and Population Oriented

Interprofessional Teamwork and Team-based Practice

Interprofessional Communication Practices

Values/Ethics for Interprofessional Practice

Roles and Responsibilities for Collaborative Practice

Patient and Family Centered

The Learning Continuum pre-licensure through practice trajectory
### TEAM WORK

**Definition:** Ability to function effectively as a member of an interprofessional team that includes providers, patients and family members in a way that reflects an understanding of team dynamics and group/team processes in building productive working relationships and is focused on health outcomes.

- **Core Competencies (abbreviated):**
  - Clearly identify and support roles and responsibilities of all team members, including patients.
  - Represent one’s professional opinions, encourage others to do so and contribute to decision making.
  - Demonstrate practicality, flexibility, and adaptability in the process of working with others.
  - Link patients and family members with needed resources, following up to ensure that effective connections have been made.
  - Support patients in considering and accessing complementary and alternative services designed to support health and wellness.
  - Promote diversity among the providers working in inter-professional teams.
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Building Team Work Competencies

Act
as team member

Practice
as team member

Think
as team member

Prepare
self as team member

Creating Collaborative Care

Contextual Knowing

Independent Knowing

Transitional Knowing

Absolute Knowing

Transforming Ways of Knowing

Acquisition

Application

Demonstration
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Systemic Factors
(Macro)

Educational System
(eg Accreditation institutional structures)

Professional System
(eg Regulatory bodies, liability)

Government Policies: Federal/Provincial/Regional/Territorial
(eg education, health and social services)

Social & Cultural Values

Research to Inform & to Evaluate
- Understand the processes related to teaching & practicing collaboratively
- Measure outcomes/benchmarks with rigorous methodologies that are transparent
- Disseminate findings
Developing teams as teams
Different approaches

"No you can't ask a question."

"Before we get going, I'd like to start with a quick pack-building exercise."

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Teamwork Dimensions

Preparing  Doing  Reflecting
Teamwork Dimensions

Preparing

Doing

Interacting

Reflecting
General practice & social work teams

- Sharing impressions
- Sharing knowledge
- Sharing roles, values and conflict
- Sharing Future ways of working
Inter-team development
Learning across teams

Communities of Practice

“Learn from yesterday live for today hope for tomorrow”

Albert Einstein
Most scientists regarded the new streamlined peer-review process as ‘quite an improvement.’
To conclude.....
Team’s need purpose and to be developed...

“If we want to succeed as a team, we need to put aside our own selfish, individual interests and start doing things my way.”
And we must put the person at the centre.
Good places to start.....
International Foundation for Integrated Care

Leading the global movement for change
Welcome to IntegratedCare4People, a global knowledge exchange platform dedicated to supporting people-centred health service delivery reforms for universal health coverage.