

A large, stylized green figure with its arms raised in a 'V' shape, composed of a circle and a 'V' shape. The figure is centered on the page. The text is overlaid on the figure.

Multidisciplinary Working

A Framework for Practice in Wales

Continuing NHS Healthcare
 **National Programme**

2011



'Multidisciplinary Working: A Framework for Practice in Wales' was published in September 2011 by the Continuing NHS Healthcare National Programme and represents the first definitive guidance on developing and improving multidisciplinary working across Wales.

Multidisciplinary Working A Framework for Practice in Wales

Document Information

Title	Multidisciplinary Working: A Framework for Practice in Wales
Date	September 2011
Purpose	<p>The Continuing NHS Healthcare National Programme supported by the Welsh Government has taken the lead in developing a national framework of guidance and practical resources to support the implementation, development and improvement of multidisciplinary working across Wales.</p> <p>This is the underpinning framework document to describe the context and scope of the work and to provide the principle reference from which to steer subsequent developments.</p>
Sponsor	<p>Jan Williams Chief Executive Cardiff and Vale University Health Bard</p> <p>Rob Pickford Director of Social Services Wales Welsh Government</p> <p>Joint Chairs: Continuing Healthcare National Programme for Wales</p>
Attention	<p>Local Health Boards Local Authority Social Services Third and Independent Sector Health & Social Care Providers Health and Social Care Educational Institutions Practicing Multidisciplinary Teams across Health & Social Care</p>
Further Information	<p>Matt Wyatt Innovation & Improvement Lead Continuing NHS Healthcare National Programme for Wales ☎ 07817887316 ✉ matt.wyatt@wales.nhs.uk</p> <p>Dr Carolyn Wallace Principal Lecturer University of Glamorgan ☎ 01443483178 ✉ cwallace@glam.ac.uk</p>

Contents

Executive Summary.....	6
Acknowledgements	6
Summary of Findings.....	6
Recommendations.....	7
Introduction.....	8
The Goal.....	8
Strategic Context.....	9
Setting the Scene	11
Step 1 – A Common Language	13
Multidisciplinary Working in Practice.....	14
Interprofessional Education.....	15
Interprofessional education Values:	16
Interprofessional Education Processes:	16
Interprofessional Education Outcomes:	17
Step 1 Actions - A Common Language.....	18
Step 2 – The Strategic Assurance	19
MDT Functions.....	19
MDT Accountabilities	20
Quality and Safety	21
Sustainable Care Planning.....	22
MDT Performance	23
Step 2 Actions – The Strategic Assurance	24
Step 3 – To Manage Expectations	25
Understanding the Roles & Responsibilities	25
When is Team not a Team?.....	27
Structure of the MDT.....	28
The Lead Practitioner:	29
Other Practitioners	31
Agreeing Ground Rules	32
Agreeing a high level purpose:	33
Agreeing intermediate objectives:	33
Agree practical processes:	33
Involvement of the Person and their Family	33
Step 3 Actions – To Manage Expectations	35
Step 4 – The Three Core Capabilities	36
Establishing Current Standards of Practice	39
First Core Capability:	41
Successful Multidisciplinary Meetings.....	41

Second Core Capability:	44
Coordinated Assessment & Planning	44
Third Core Capability:	47
Integrated Systems & Practices	47
Step 4 Actions.....	50
Step 5: A Practical Process	51
Engaging the Organisation	51
The Complex Care Collaborative	52
Learning Sessions	52
Action Periods	53
A Summary of the Story So Far	53
Step 5 Action Plan	55
Appendix 1 – Professional Roles	57
Royal College of Psychiatrists	58
Crossroads Care Cymru	59
British Dietetics Association	60
British Psychological Society	60
Royal College of Nursing.....	61
College of Occupational Therapists.....	62
Care Forum Wales	64
Chartered Society of Physiotherapy.....	64
Royal Pharmaceutical Society	65
British Association of Social Workers	65
Appendix 2 - Bibliography.....	67
Appendix 3 - Summary of Studies	72
Appendix 4 - Example Capability Assessment.....	88
First Core Capability: Successful Multidisciplinary Meetings	88
Second Core Capability: Coordinated Assessment & Planning	89
Third Core Capability: Integrated Systems & Practices.....	91

Executive Summary

The Continuing NHS Healthcare National Programme Board, supported by the Welsh Government, has taken the lead in developing a national framework of guidance and practical resources aimed at improving multidisciplinary working.

Publishing this document is the first step and provides the Framework through which organisations can target three core capabilities for effective multidisciplinary working. The Framework recommends that organisations take a collaborative approach and commit to aligning and embedding an ongoing programme of development to focus on, support and improve multidisciplinary working across Wales.

The principles, core capabilities and recommended approach within this Framework are equally relevant to any field where different disciplines are required to work together. However, this document, together with the recommended programme of development work, will focus primarily on those aspects of multidisciplinary working centred on the assessment, planning and delivery of care for those people who live with complex needs.

Acknowledgements

The Framework is written for a broad audience of people and organisations who work across the spectrum of health and social care in Wales, from novice to expert and from small independent business through to vast public institution.

The content has been gathered from within policy documents, published research, local audit evidence, commercial programmes and most importantly, from the experience of people who work in multidisciplinary practice every day. The research was a combination of a literature review, structured analysis of published evidence and case studies, semi structured interviews with expert opinion formers, facilitated workshops and many hours of filmed interviews and conversations with practitioners and managers.

"You're trained in a silo, employed in a silo and then someone says now all go and work together ... it'll be fine!"

The green coloured text panels that appear throughout the document represent a range of opinion from each of these sources. This commentary adds to the narrative style of the document, to gradually build the organisational case for focussing on, supporting and investing in the improvement and ongoing development of multidisciplinary working.

The field of multidisciplinary working touches upon a very broad scope of subjects that individually encompass an extraordinary depth of knowledge. As such, in drafting this Framework care has been taken not to produce a convenient oversimplification, or naive view of the issues. The Framework is designed as a distillation of this inherent complexity into a few simple narratives that organisations, teams and individuals can focus on collectively.

This work would not have been possible without the help and support of individuals, teams and organisations across Wales, who have volunteered their insight, experience and most importantly their valuable time. This process of dispersed engagement was used to ensure that the production methodology remained congruent with a multidisciplinary approach.

Summary of Findings

Feedback from practitioners and managers, corroborated by the evidence, suggests that the discipline of multidisciplinary working is not universally understood or applied. The scope of practice, collective capability and maturity of the teams planning and delivering care on a multidisciplinary basis, is extremely variable both within and across organisations in Wales.

In general the term 'Multidisciplinary Team' or MDT is used to describe a wide variety of structures, processes and groups of people. In practice, whether the group of practitioners involved perceive themselves to be part of a team, a participant in a shared process or just making up the numbers, is not the result of a managed system.

There is little measurable evidence and limited empirical knowledge of the effectiveness of the different MDTs and therefore, respective organisational levels of performance. Despite this, there are clearly, excellent examples of multidisciplinary working across Wales and an enormous breadth and depth of knowledge and experience, of what really works in practice.

MDTs are responsible for directing huge quantities of organisational resources despite, for the most part, recognising that they have little or no organisational identity or authority. From the MDT perspective, there appears to be a perpetual industry of new policy, procedures, tools, and techniques that directly affect their performance. Yet, there is limited support to translate these expectations into effective day to day multidisciplinary practices.

Fundamentally, the purpose of an MDT is to undertake holistic assessment, make professional recommendations and plan and provide the care for people who live with complex needs. The required decision making processes must be fully inclusive of the person and their family and organisations are accountable for those decisions in policy and law. However, there are almost no managed systems or modern information technologies in place, to capture and collate these sophisticated decisions in real time. This recurrent theme has emerged across MDTs in almost every context. Despite the fact that detailed descriptions of the level of need, the type of care being planned and the long term goals for each person exist, they are unknown to the organisation. Therefore, using the science of improvement, the value added change that is required will involve realigning organisational systems to focus resources back to supporting and responding to, the moment of decision.

Recommendations

Multidisciplinary working is neither a project nor a one off programme of work as MDTs will continue to evolve their membership and function over time. A strategic approach is necessary to embed effective practices within established organisational systems. This is the only reliable approach to providing the assurance, direction and developmental resources necessary, to deliver continuous improvement in practice, over time.

On a day to day basis, MDTs direct more resources than any other organisational function, yet for the most part, they have little formal identity or recognition within organisational structures and systems.

To connect strategic intentions to practical improvements in multidisciplinary working, organisations will need to harness the science of improvement. This will involve employing evidenced methodologies for engaging with practitioners and discovering, designing and embedding improvements into day to day practice. To support this ongoing development work, a new national Complex Care Collaborative will be established as part of the 1000LivesPlus programme of work from 2012 onwards. Partner organisations in each Health Board area are required to establish or delegate to, a joint corporate group or 'Super MDT' the responsibility for taking forward this Framework. Each of these Super MDTs will need to formally join the Complex Care Collaborative. They will then be in a position to establish local networks of practicing MDTs to plan and coordinate local developments and access the support of the 1000LivesPlus programme team.

This Framework sets out five evidenced steps to prepare for, plan and deliver improvements in multidisciplinary working, culminating in a narrative summary and outline action plan. The bold and achievable goal is to bring together the theory and the practice into a single structure that will support organisations, communities, teams and individuals to embed the most effective multidisciplinary practice for them.

Introduction

Health and Social Care is a unique industry with an eclectic mixed economy of public, commercial and voluntary organisations, set in a diverse landscape of social and personal needs, wants and aspirations.

The breadth and depth of the work our extraordinary people are able to do, day and after day, to serve the needs of our communities, is both challenging and inspirational. Sometimes the work is done in isolation, often the work is naturally aligned, but across every aspect of health and social care in the long term, successful outcomes are always complex and interdependent.

“Care is changing and individual agencies, professions and practitioners are less and less able to meet the needs of people, in isolation.”

There is no better example of this inherent interdependency than that shown in our multidisciplinary teams. Every day, groups of highly trained and committed professionals are working together with families, to share their individual knowledge and experience and serve some of the most vulnerable people in our communities.

Multidisciplinary working is not the reserve of meeting rooms, or formal committees, or predefined structures and process. Those are necessary but effective multidisciplinary working in the best of situations is the primary model of day to day practice; it happens every day, in every place, at every time and with every person who presents with complex needs.

The principles of multidisciplinary working extend beyond simply pushing different professions together under one roof and the fields of multidisciplinary practice and inter-professional education are developing all over the world. The scope of work includes; aligning group structures and purpose; agreeing methods of managing knowledge and communication; maintaining personal and professional identity; facilitating collective learning; and the design of innovative practices that span traditional professional boundaries.

Multidisciplinary working in its broadest sense exists in all forms of care with an enormous range of individuals, roles, professions and specialist fields engaged in the process. The contribution of each of those professions large and small to delivering our complex and diverse industry must not be underestimated.

The principles, core capabilities and recommended approach within this Framework are equally relevant to any field where different disciplines are required to work together. However, this document, together with the recommended programme of development work, will focus primarily on those aspects of multidisciplinary working centred on the assessment, planning and delivery of care for those people who present with complex needs.

The Goal

The Continuing NHS Healthcare National Programme Board, supported by the Welsh Government, has taken the lead in developing a national framework of guidance and practical resources aimed at improving multidisciplinary working.

Publishing this document is the first step and provides the Framework through which organisations can target three core capabilities for effective multidisciplinary working. The Framework recommends that organisations take a collaborative approach and commit to aligning and embedding an ongoing programme of development to focus on, support and improve multidisciplinary working across Wales.

To support and coordinate this ongoing work a new national Complex Care Collaborative will be established as part of the 1000LivesPlus programme of work from 2012 onwards.

Strategic Context

Over many years the practice and particularly the ineffectiveness of inter-agency and inter-professional working has been raised in the public consciousness. The popular press have reported at length on high profile cases of young and old vulnerable people, who have been harmed or let down, by the services designed to care for them.

Through difficult and extensive investigations each of these cases has proven to be a complex and unique combination of acts and omissions. However, at the heart of each case is a story of how systems have failed to act upon the combined knowledge of the people involved, which in hindsight, was there all along.

“The strategic frameworks are all there. The challenge is to learn from what’s worked and make this the norm ... not something that I do on top of the day job.”

Despite this within every agency, organisation and profession involved in health and social care, there are numerous examples of brilliant practice, innovative services and improved outcomes, all based upon great relationships and committed multidisciplinary teams of people.

We instinctively know that working well across traditional boundaries is the right thing to do, whether between organisations through formal partnerships, or between professions through integrated services. This instinct has been well researched, evidenced and supported within a broad range of academic, professional and service led developments.

Subsequently, effective multidisciplinary working in both strategy and practice has been defined, formalised and reinforced in a long list of publications and policies within Wales over the past 10 years. The Welsh Government (WG) has published many documents that advocate a multidisciplinary approach, for example:

- Health and Social Care for Adults: Creating a Unified and Fair System for Assessing and Managing Care (2002)
- Mental Health Policy Guidance: The Care Programme Approach for Mental Health Service Users (2003)
- Making the Connections: Delivering Better Services for Wales (2004)
- Designed for Life: Creating world class Health and Social Care for Wales in the 21st Century (2005)
- Beyond Boundaries: Citizen Centred Local Services for Wales (2006)
- A Therapy Strategy for Wales: the Contribution of Therapy Services to Transforming the Delivery of Health and Social Care in Wales (2006)
- Fulfilled Lives, Supportive Communities: A Strategy for Social Services in Wales over the Next Decade (2007)
- Living Longer Living Better: The Strategy for Older People in Wales (2007)
- Working Together to Reduce Harm: The Substance Misuse Strategy for Wales (2008)
- Designed to Add Value: A Strategic Direction for the Third Sector in Supporting Health and Social Care (2008)
- All Wales Child Protection Procedures (2008)
- Eating Disorders: A Framework for Wales (2009)
- Setting the Direction: Primary and Community Services Strategic Delivery Programme (2010)
- The Mental Health Wales Measure (2010)
- Sustainable Social Services for Wales: A Framework for Action (2011)

‘Delivering a Five-Year Service Workforce and Financial Strategic Framework for NHS Wales’ produced by the Health & Social Services Directorate (WG 2010) sets out the process to deliver transformational change in the delivery of health services in Wales over the next 5 years, with the four strategic objectives identified as:

- To improve performance, quality and financial stability by reducing harm, waste and variation
- To capture the opportunity of integration
- To empower front line staff
- To enable services to be delivered through good governance and strong partnerships

Achievement of these outcomes was predicated upon the establishment of 12 national programmes that have the potential to deliver high impact change and improvement across the NHS and its partners within Wales. The Continuing NHS Healthcare National Programme was established in June 2010 to design, plan and enable such improvements.

A number of published reports and strategies over recent years have identified key areas that are contributing to challenging independence and increasing demands for longer term care. This has clear implications for Health Boards and Local Authorities in planning and delivering appropriate service models. These include:

- Disruption to usual living arrangements leading to a loss of daily activities and delays in establishing new support services
- Inappropriately prolonged stays in hospital leading to loss of independence and an increased reliance on support services
- Access criteria and referral procedures that cannot respond quickly to a change in need and make it difficult to obtain low level support services
- A poorly coordinated, inconsistent or fragmented community based health and social care service response that can lead to inappropriate admission to secondary care
- Poor management of the hospital inpatient episode, with little proactive planning in place to address complex care needs and support a rapid return to home
- The rate of growth in the older population and improved survival rates for children and younger adults with complex needs

All of these factors and many others, result in an increasing number of people with complex needs and greater reliance on complex packages of care such as those provided through Continuing NHS Healthcare. At present up to 10% of NHS Wales funding is spent on providing complex packages of care.

Continuing NHS Healthcare (CHC) is the name given to a package of services that is arranged and funded solely by the NHS where it has been assessed that the person's primary need is a health need. Welsh Assembly Government Policy for CHC is set out within Circular 015/2010: Continuing NHS Healthcare: the National Framework for Implementation in Wales.

To determine if a person is eligible for CHC, a comprehensive assessment of their needs is undertaken. This process involves a range of assessments by several health and social care practitioners such as an occupational therapist, physiotherapist, social worker, doctor, nurse or psychologist amongst others.

This group of professions usually includes as a minimum, a social worker, nurse and doctor but can include any practitioners who are involved in the persons' care. This group is known as the Multidisciplinary Team (MDT).

Although Health Boards may have systems in place to monitor and quality assure the CHC process, the work of assessing need, determining care packages and recommending eligibility for CHC, rests solely with the MDT. Effective multidisciplinary working is fundamental to delivering care for people who live with complex needs. Therefore, the ongoing support and development of practitioners that have a clear understanding of roles, responsibilities and accountabilities within the MDT, is essential.

Setting the Scene

In September 2010 the Continuing NHS Healthcare National Programme for Wales, launched the document '10 High Impact Changes for Complex Care'. Although the programme is focussed primarily on improving the effectiveness of the CHC system, the proposed changes are designed to support frontline services to be more effective at managing the wider cohort of people with complex needs.



High Impact Change Number 4 – describes the vital role that 'Effective Multidisciplinary Working' plays in planning and caring for people with complex needs.

The nature, role and responsibilities of the MDT have been reinforced in case law, legislation and health and social care policy. The requirement to work effectively with other disciplines is also explicit in almost every professional code of conduct and job specification.

This is not new and Practitioners and Managers across public, independent and third sector services describe multidisciplinary working, as an essential ingredient in delivering a personal and effective journey through care. This view is also reinforced by the people, families and carers who experience those services and undertake that journey through care.

Yet relatively few people in any discipline have ever been specifically educated or trained, to work within the dynamic professional environment that is created around those people, who need support from a number of disciplines at the same time.

Health Boards, Local Authorities and Independent and Third Sector organisations across Wales have undertaken a wide range of training and development, within their own organisations that complement improved multidisciplinary working.

Collectively, the breadth and depth of this work has been extensive, ranging for example; from individual negotiation and communication skills; through internal team development programmes; and onto specialist interagency schemes in areas such as child protection.

Furthermore, supporting organisations including Public Service Management Wales, the Social Services Improvement Agency and the National Leadership and Innovation Agency for Healthcare, have developed programmes of work that have contributed to the capability of organisations to work across traditional professional boundaries.

During the initial research for this Framework, information and opinion on multidisciplinary working was gathered from a number of forums, informal communications and formal publications.

As a result, many people from across the spectrum of different sectors, organisations and agencies came forward. They offered insight, experience and overwhelming support for the development of a national approach to multidisciplinary working.

The acronym 'MDT' is therefore used to describe everything from a one off meeting of a small group of independent professionals to discuss one patient, through to a diverse integrated team with a dedicated budget and permanent staff (Johanssen et al 2010; Xyrichis & Lowton, 2008; Webster 2002; Proctor-Childs 1998).

This feedback, supported by advice from expert practitioners, is that the discipline of multidisciplinary working is not universally understood or applied. The scope of practice, collective capability and maturity of the teams planning and delivering care on a multidisciplinary basis, is extremely variable both within and across organisations in Wales.

Without doubt, there are very experienced practitioners in every discipline and examples of innovative and effective multidisciplinary working in practice, exist within almost every organisation. Harnessing and focussing this experience will be vital to delivering improvement.

While multidisciplinary approaches to comprehensive assessment are advocated, Challis et al. (2010) found that a systematic approach involving a range of professionals is largely absent. In the multiple care settings across 150 Local Authorities in England in which they conducted their study, assessment by a single professional was the most common practice in three out of four care settings.

Some of these examples have been developed as organisational responses to formal policy, whereas others have evolved over time, through the drive and commitment of individuals and teams. In some more specialist areas, for example within Mental Health and Learning Disability Services, multidisciplinary working has been embraced within the formal structures as the primary model of practice.

Subsequently, many organisations already hold a great deal of knowledge, skill and experience and have developed resources to support practitioners in multidisciplinary working.

The challenge is therefore to take a more strategic approach to the development of multidisciplinary working and ensure that organisations are able to support practitioners and develop practice through a common framework of core capabilities and standards.

The Framework is designed to build upon this wide range of existing experience and practice, and describe a set of congruent principles to draw the evidence and experience together. The principles will help to reinforce the importance of the MDT as an organisational function, with responsibilities in practice and accountabilities in law. Furthermore, the Framework will enable organisations and professions across sectors, to work together to plan and deliver the ongoing development and improvement of multidisciplinary working.

Ultimately the MDTs must be fully engaged to ensure that practitioners can access the support they require, to develop effective multidisciplinary working in practice. The Framework sets out five steps to get there:

- Step 1:** **A Common Language** around which organisations can agree to take forward the framework in partnership.
- Step 2:** **The Strategic Assurance** necessary to demonstrate that organisations are able to deliver effective multidisciplinary working.
- Step 3:** **To Manage Expectations** in an open and inclusive way so that everyone can participate to the best of their abilities.
- Step 4:** **The Three Core Capabilities** that together form the underpinning principles for effective multidisciplinary working in practice.
- Step 5:** **A Practical Process** to support practitioners to develop and embed the knowledge, skill, talent and values for effective multidisciplinary working.

Step 1 – A Common Language

The quality of communication, the process for capturing information and particularly the use of language are universal challenges in every industry. To develop expertise in any field of work practitioners must learn and understand their field to a depth, and a degree that requires a new vocabulary to explain and communicate that acquired knowledge. Words that have a distinct meaning for example, in a Dictionary, can have a whole different meaning, interpretation and connotation when used in a professional context.

Furthermore, when any group of people work together over time, they share experiences and develop a shared understanding that similarly, generates a subset of language, vocabulary and meaning that is unique to that group of people.

“We use the same term ‘MDT’, to refer to a wide range of different structures involving different people working in different ways.”

This challenge is never more evident than when a group of experts from different fields attempt to work together towards the same goal. Therefore in any multidisciplinary environment and despite the best of intentions, the use, misuse and interpretation of language can become an extraordinary barrier. The solution to this challenge is to invest a relatively small amount of dedicated time in being explicit about the language used and the meaning it is intended to convey.

Over several decades, considerable resources have been committed across the world in defining, researching and developing working practices that cross traditional professional boundaries. Within this work, considerable time has been invested in defining and refining the terminology that pervades the field of multidisciplinary working. Subsequently, it is important to avoid attempting to formally redefine terms and instead, to take an opportunity to convey the meaning of some of the phrases used within this Framework.

Practitioner – is being used to describe a member of staff from any agency, organisation, profession or discipline.

Multidisciplinary – is being used to include the whole range of practitioners, employed jobs and other roles involved in the planning and delivery of services.

Multidisciplinary Working - is being used as the overarching term for the approach, methods and practices used when different practitioners need to work together in any context.

Multidisciplinary Team - is being used to describe the group of specific practitioners who are involved in planning and delivering the care for a particular person.

Care Coordinator – is being used to describe the role that is adopted by a member of the multidisciplinary team, to be the main point of contact and communication for the person, their family and any other practitioners or organisations involved.

Person – is being used wherever possible to describe the patient, service user, client, resident, citizen or individual who needs the support of the multidisciplinary team.

Family – is being used as a collective noun to describe any members of the direct family, informal carers or friends that the person wishes to be involved to support them and where appropriate, any third party appointed to represent the person concerned.

Multidisciplinary Working in Practice

In general the term 'Multidisciplinary Team' or MDT is used to describe a wide variety of structures, practices and groups of people. MDT is often used interchangeably with the acronym MDM or 'Multidisciplinary Meeting', particularly in situations where multidisciplinary working takes place only or predominantly within, formal meetings.

In practice, whether the group of practitioners involved perceive themselves to be part of a team, a participant in a shared process or just making up the numbers, tends to be random, rather than the result of a managed system. Similarly the degree, to which the group of practitioners are truly multidisciplinary with equal opportunities for engagement and influence, tends to be driven by the maturity of interpersonal relationships.

Within the Continuing NHS Healthcare National Framework the MDT is defined as:

'... a team usually from both health and social care backgrounds. It does not refer only to an existing multidisciplinary team such as on an acute ward. It should include those who have an up-to-date knowledge of the individual's needs, potential and aspirations.'

These characteristics do not directly reflect on the effectiveness of each MDT, moreover, that they illustrate different levels of understanding and the sophistication of supporting systems and practices that have evolved over time.

The scope and scale of multidisciplinary teams and meetings extends from a small discussion between two or three practitioners, through to formal case conferences that involve several statutory organisations.

In practice the nature of an MDT dealing with complex care, can be categorised within one of three broad descriptions:

- An MDT that forms at an irregular meeting of a small number of practitioners who don't generally work together, convened to discuss a particular person. Whether the person concerned attends the meeting is dependent on the purpose of the meeting and is usually determined by the practitioners involved. One of the practitioners will normally take responsibility for involving and communicating with the person concerned and their family (Webster, 2002; Proctor-Childs et al. 1998).
- An MDT made up of a group of practitioners who regularly work together and liaise with other departments, professions and organisations to plan and coordinate their work. These groups often get together in formal MDT Meetings, to share information, discuss professional opinions and make joint decisions as in the scenario above. If the discussions are related to one person they are usually in attendance, but are always involved and engaged through a care coordinator (Long et al, 2003; Webster, 2002).
- An MDT comprised of a range of permanent staff from different professions who are employed in the same team or under the same department. They work together all the time and often develop and use tools, techniques and practices that are common to all the professions involved. Much of the multidisciplinary working is integrated into the day to day working arrangements although more formal meetings are often scheduled to take place regularly. The whole MDT works closely with the person and is led at different times, by the most appropriate practitioner for the person concerned (Long et al, 2003; Webster, 2002).

Within the breadth of research, the term 'inter-disciplinary' is sometimes used. This term has been similarly characterised by; the sharing of exclusive knowledge within the professional team, in order to ensure that the person's needs are best served by the most appropriate professional (Webster, 2002).

The different terminology is often used to reflect nuances in the stages of practice development on a continuum from independent practice to fully integrated working. However,

the common element in successful systems is that the professionals practice consensus based decision making and have regular face to face meetings (Boon et al, 2004).

Many different fields of work across health and social care are working towards similar goals in achieving effective practice across agencies, organisations and professions. The following is taken from the All Wales Child Protection Procedures (2008):

"The effective protection of children cannot be achieved by a single agency acting on its own. The procedures clarify how individuals and agencies should communicate and work together effectively in partnership in order to identify vulnerable children, keep them safe from abuse and neglect and improve outcomes for them.

The implementation of the procedures can only be effective when supported by good practice, and the exercise of professional skill and judgement based on thorough assessment, supported by evidence, and critical analysis. The promotion and development of professional skill and judgement requires training, supervision and support for individuals engaged in this difficult and complex area of work."

It therefore follows that in a multidisciplinary environment, practitioners need not only the specific knowledge and skills of their profession, but also the insight and capabilities necessary to interpret, rationalise and respond to the knowledge and skills of the other professions.

This interprofessional capability has been described as the ability to work with other professions, where the practitioner adopts the values of, and engages in, a collaborative method of working that transcends the usual professional boundaries (Whittington, 2003).

For most practitioners, overcoming these cultural or professional barriers, such as the use of language, is a matter of experience. Learning over time; the perspective of the different professions; their motivations; the communication style of the people involved; and ultimately the meaning each person is trying to convey.

A recent study by Furness et al (2011) evaluated two practice based interprofessional initiatives which involved practice staff, managers, IPE facilitators and people who used the services. They found that participants had increased communication skills including confidence, conflict management and team-working skills. Skilled staff gained 'novel insights' about service user and carer issues' which weren't otherwise communicated. People using the services felt that the experience had made the students think about communicating more and "... maybe not jump to conclusions, stereotypical conclusions about you've got this illness, therefore you behave like this".

It therefore becomes critical to accelerate this experiential learning and provide opportunities for practitioners to come together not just to learn the topical issues together, but also to learn from one and other about those topical issues. This process of combining formal and tacit or emergent learning across different fields is known as Interprofessional Education.

Interprofessional Education

Interprofessional Education (IPE) is used to define the occurrence when two or more professions learn with, from and about each other to improve collaboration and the quality of care (CAIPE, 1997). This relates learning to practice within a coherent rationale informed by an understanding of personal, group and organisational relations and processes (Barr, 2000). It is widely acknowledged that IPE has a positive effect on professional communication (Barnes et al, 2000; Pollard et al, 2008).

Current evidence for IPE has provided greater understanding of the impact on students, skilled practitioners and ordinary people who use the services and has been identified as effective in several countries, including Norway and the UK.

The Centre for the Advancement of Interprofessional Education (CAIPE) has produced the following principles for IPE. The principles are drawn from the experience of its members and the interprofessional literature, for the consideration of all who are engaged in commissioning, designing, delivering and evaluating interprofessional education.

A source of conflict can arise from the fact that professionals working within MDTs have a dual role, that of a team member and also as a member of their own professional discipline. Where the interests demanded by each role diverge, this conflict may maintain the demarcation of professional boundaries and ultimately hinder effective communication within the team (Webster, 2002). Ovretveit (1995) argues that poor decision-making in MDTs emanates less from personality clashes between its members but more often is a consequence of a person's professional responsibilities preventing them from agreeing or reaching collective decisions.

Interprofessional education Values:

- Focuses on the needs of individuals, families and communities to improve their quality of care - health outcomes and wellbeing; keeping best practice central throughout all teaching and learning
 - Applies equal opportunities within and between the professions and all with whom they learn and work - acknowledging but setting aside differences in power and status between professions
 - Respects individuality, difference and diversity within and between the professions and all with whom they learn and work - utilising distinctive contributions to learning and practice
 - Sustains the identity and expertise of each profession - presenting each profession positively and distinctively
- Promotes parity between professions in the learning environment - agreeing 'ground rules'
 - Instils interprofessional values and perspectives throughout uni-professional and multi-professional learning - permeating means and ends for the professional learning in which it is embedded

Interprofessional Education Processes:

- Comprises a continuum of learning for education, health, managerial, medical, social care and other professions - sequencing interprofessional learning progressively throughout pre-registration and post-experience studies
- Encourages student' participation in planning, progressing and evaluating their learning - Including them with teachers and others in working groups
- Reviewing policy and practice critically from different perspectives - subjecting policy and practice to critical analysis against experience and evidence
- Enables the professions to learn with, from and about each other to optimise exchange of experience and expertise - facilitating interaction, exchange and co-reflection as they compare perceptions, values, roles, responsibilities, expertise and experience
- Deals in difference as it searches for common ground - showcasing different yet mutually reinforcing roles and expertise in collaborative practice grounded in mutual understanding working towards shared objectives

- Integrates learning in college and the work place - teachers and practice supervisors planning, delivering, assessing and evaluating classroom and practice-based learning together
- Synthesises theory and practice - deriving theory from and applying it to practice
- Grounds teaching and learning in evidence - citing findings from research including those in systematic reviews of process and outcomes from interprofessional learning
- Includes discrete and dedicated interprofessional sequences and placements - building in dedicated interprofessional learning based on these principles
- Applies consistent assessment criteria and processes for all the participant professions - including summative assessment by the same means to the same standards
- Carries credit towards professional qualifications - negotiating ways in which satisfactory fulfilment of interprofessional assignments meets requirements for professional awards
- Involves service users and carers in teaching and learning - including them in planning, delivery, assessing and evaluating teaching

The findings from Clark (2011) showed the linkages between IPE delivered in University and interprofessional working in practice. The study explored attitudes towards the relevance of IPE to student development as professionals. The elements receiving the highest support (95.9%-100%) agreed that; interprofessional learning helps students to understand their own professional limitations and; patients will ultimately benefit if students work together to solve patient problems. The finding noted that students learned mutual trust and respect whilst helping them to become better team workers.

Interprofessional Education Outcomes:

- Engenders interprofessional capability - devising outcome-led learning delivering collaborative capabilities
- Enhances practice within each profession - enabling each profession to improve its practice to complement that of others
- Informs joint action to improve services and instigate change - applying critical analysis to collaborative practice
- Improves outcomes for individuals, families and communities - responding more fully to their needs
- Disseminates its experience - contributing to the advancement and mutual understanding in interprofessional learning in response to enquiries, at conferences and via the professional and interprofessional literature
- Subjects developments to systematic evaluation and research - collecting data systematically to test against the requirements and expectations of stakeholders, funding, validating and regulatory bodies and to contribute to the evidence base

There is a wealth of experience in developing and delivering IPE across Wales and therefore, IPE is recommended as the underpinning approach to improve multidisciplinary working in practice.

Subsequently, implementation of the Framework will be a developmental process and will require partner organisations to establish a joint leadership function. Ideally, a senior multidisciplinary group responsible for coordinating this ongoing development work.



Step 1 Actions - A Common Language

1. Convene, or delegate to, an appropriate multidisciplinary group to lead this work and hold responsibility for taking forward the Framework on behalf of partner organisations.
2. Commit to jointly align training and resources to support multidisciplinary working using the principles of Interprofessional Education.
3. Facilitate joint learning and wherever possible offer training and education to functioning MDTs as a group.

Action Notes:

Step 2 – The Strategic Assurance

It is recognised that developing and sustaining effective Multidisciplinary Working will not be a one-off task and will require organisations to align and mainstream training and supporting systems within their existing infrastructure.

As such, this Framework represents a first stage, enabling tool to provide the consistency from which Health Boards, Local Authorities, WAG and partner organisations will be able to work together, to develop ongoing supporting systems and resources.

“How many MDTs are working across our organisations, how effective are their decisions and practices, what help and support do they need?”

MDT Functions

MDTs should function wherever complex needs are identified and the level of care warrants an integrated approach to assessment, planning and coordination. In essence, the three different types of multidisciplinary working represent steps on a continuum of increasing integration in practice (Johansson et al 2010).

The varying level of coordination is proportionate to the number of complex cases encountered by the MDT and the complexity of each person's needs. The more complex the case, the greater the level of both communication and coordination needed to support effective practice. Time is a key factor to delivering this coordinated assessment and planning effectively. This means that the more complex cases will require more time to deliver a coordinated assessment, or integrated plan of care (Leutz, 1999; Leutz, 2005; Alter & Hage, 1993).

It is not sufficient to simply expect MDTs to function independently from the established organisational systems. The work of each MDT needs to be recognised and through the appropriate management structures, sufficient resources put in place to enable the MDT to function effectively. This should be in terms of both practitioner's time and administrative systems and facilities.

“The MDT is the only recognised method for delivering holistic assessment, planning and care coordination and therefore, it functions at the centre of some of the most complex, profound and accountable decision making within the participating organisations. Through a variety of governance arrangements, MDTs are ultimately and collectively responsible for directing greater volumes of public resource, than any other single organisational function.”


Subsequently, within a complex, multifaceted professional environment, MDTs make legally responsible decisions and organisations will be held to account, for what the MDT does in practice. The organisation must be able to provide assurance and demonstrate that their MDTs are:

1. competent to perform this responsibility
2. adequately supported in practice

Throughout any large health and social care organisation, common management structures are used to identify different buildings, specialties, departments and even individual rooms are often named. Yet it is relatively rare for the MDT to be similarly named or identified within the management structures and information systems. The reason for this is complicated.

A large Hospital Ward, for example, may have more than one MDT, only some of the patients may require the input of an MDT and that MDT is made up of people from several separate

departments. However, in other areas of practice, the functioning MDT is discrete and synonymous with the management structure, for example a Community Mental Health Team.

 In whichever context, it is vital that organisations recognise and identify their functioning MDTs and establish the scope and scale of their practice:

1. How many MDTs do you have?
2. Where and when do the MDTs function?
3. What training have they received as an MDT?
4. How effective are the MDTs supporting processes?
5. What outcomes does each MDT achieve?

The first three questions can be answered quickly and easily with a simple structured survey across operational teams. The last two questions will require the development of more comprehensive mechanisms to quantify and demonstrate the ongoing performance of an MDT.

“Many organisations have established through wider governance arrangements, managerial systems and processes to quality assure the individual decisions and recommendations of their MDTs when dealing with CHC. Where there are mature, open and communicative relationships with established MDTs, these processes have been viewed as a valuable aid in gaining insight, improving processes and commissioning gaps in service. Other practitioners have experienced a disconnection with assessments, recommendations and decisions overruled or undermined. In this context the MDT can feel in conflict with managerial structures and the process becomes bureaucratic, time consuming, endangers relationships and exposes the organisation to legal challenge.”

MDT Accountabilities

In essence the MDT is the organisational mechanism for generating an assessment of a person's individual needs and responding to that assessment with appropriate care planning. The specific composition should be flexible and will always be defined or triggered by the needs of the person at the centre. Person focussed planning is the enabler and should always be the central tenet when dealing with challenges and problem solving across professions or agencies.

The structure of this function is described in 'Health and Social Care for Adults: Creating a Unified and Fair System for Assessing and Managing Care (2002)' commonly known as the UAP. When used as the standardised assessment framework for sharing information, the UAP aids professionals and organisations to work together, with a shared awareness and understanding. This leads to more effective communication and enhanced care (Wallace & Davies, 2009).

The CHC Framework for Wales, like many other publications, is unequivocal about the direct link between effective multidisciplinary working and the wider process of UAP. The CHC Framework also describes the specific role of the MDT and outlines a list of subjects for which the MDT should have received training.

One of the principle legal concerns is how organisations can secure and assure the integrity of the MDT. Its responsibilities must not be eroded or undermined by institutional priorities, convenient bureaucratic processes or hierarchical decision making. In legal terms the organisation will be judged on whether it has acted reasonably and rationally in its assessment and decision making processes:

- Health Boards and Local Authorities in law, are obliged to take into reasonable account Welsh Government guidance
- The guidance has determined that the MDT drives the CHC process
- The CHC process interfaces with the established systems of UAP

- The composition of the MDT and process for undertaking the UAP, may vary according to the case and nature of the decisions
- A flawed MDT process forms a basis for a public law challenge

The transactional cost in time and money to manage and assure these systems can be considerable, whilst adding little or no value to the experience of the person at the centre. In the long term it is more cost effective to invest in high performing MDTs than in bureaucratic mechanisms to limit the risks associated with poor performance.


Delayed Transfers of Care (DToC) are possibly the most notable example of this. DToC is in fact, a symptom of either a failure in timely assessment and care planning, or a failure to provide access to appropriate service. Health and Social Care organisations across Wales all have systems and processes in place to report and monitor these cases considered to be blocked within the secondary care system. According to the Wales Audit Office DToC Report (2009) the financial cost of these prolonged stays in hospital alone, was reported at £65,000,000 per annum across Wales.

There are at present, no common systems for capturing decisions made by MDTs in real time. Any decisions reached usually sit within individual case records or are evident only by retrospective audit. That is, by association to subsequent processing of documentation, such as a referral form or an application for funding.

Organisations are essentially ignorant of these complex decisions and cannot determine demand in real time. Detailed descriptions of the level of need, the type of care being planned and the long term goals for each person exist, but are unknown at a system level. Consequently, organisational systems and processes to enable these decisions to be identified and proactively supported are fragmented, or for the most part non-existent.

The support required to enable MDT working has been well researched. Some has been identified as helping individuals to overcome barriers such as interagency and interprofessional conflict. This can sometimes occur through role blurring, overlapping competencies, limited knowledge of each other's skills. Performance can be captured and analysed to ensure that any weaknesses are strengthened, improving communication and coordination (Kapral, 2011; WHO, 2011).

In simple terms, despite the fact that most people with complex needs will have a detailed plan of care within a few days of entering a service; at an organisational level, the number of people planned to receive care at home, or to be transferred to a bed or requiring a specialist placement is unknown. The organisation's resources are only brought to bear at the point of failure and the system becomes "blocked". The system is operated by the escalation of processes to manage failure rather than being centred on the identified needs of the person.

Organisations must start to consider how to capture MDT decisions in real time within electronic information systems, so that resources can be planned, directed and measured from the moment of decision. 

Quality and Safety

There is globally, a substantial evidence base that demonstrates a direct correlation between effective team working and quantifiable improvements in the quality and safety of healthcare. This evidence has been acknowledged and reinforced within Wales as a core tenet of the 1000LivesPlus improvement methodology.

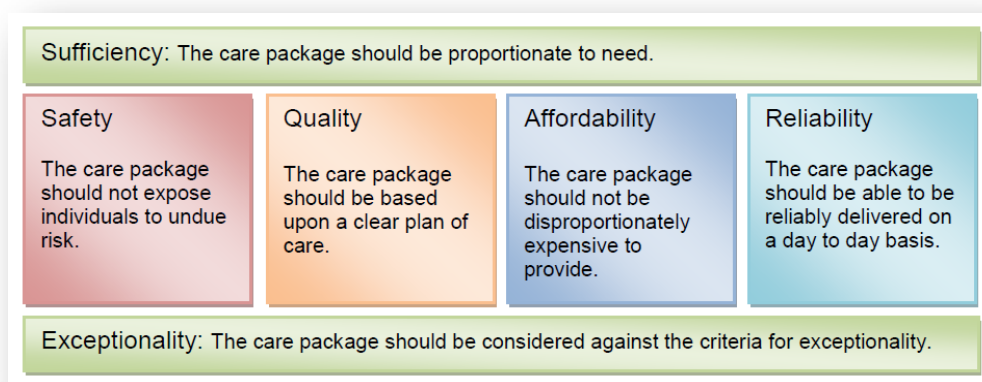
'The Quality Improvement Guide' (2011) suggests that to achieve improvement across a whole organisation there needs to be teamwork and strong leadership. One person working alone, or groups of people working in an uncoordinated way, will not achieve it.

Increasing the relative effectiveness of MDTs to deliver improved outcomes cannot be assumed in isolation of other complementary technical and cultural changes in practice. However, teamwork and team composition alone do have positive effects on quality and safety (Oandasan et al 2006). The range of observed improvements extends from high level aims such as; the perceived increase in quality of the patient experience and greater practitioner wellbeing over time; through to tangible improvements in the use of resources; and a direct reduction of medical errors. For example, Morey et al (2002) describe a trial of team training for emergency room staff in US hospitals, over a 12 month period, with the resulting reduction in clinical error rates from 30.9% to 4.4%.

The effectiveness of multidisciplinary working must be encompassed within each organisations planned programmes and structures aimed at improving the quality and safety of care.

Sustainable Care Planning

From March 2011, Health Boards in Wales formally adopted a common operational policy for 'Sustainable Care Planning in Continuing NHS Healthcare'. The policy recommends an integrated approach across organisations and between individuals to embed it's principles within everyday processes and practices. It is predicated on a robust and engaged working relationship between the MDTs undertaking the assessment and care planning, and the strategic planning and commissioning functions of their respective organisations. They are required to consider six critical criteria when planning care for people with complex needs, described as the model for sustainable care planning, illustrated below:



The aim or overriding principle of the policy is to promote equality and fairness. The policy has no part whatsoever in the determination of eligibility for CHC, it is however, a model designed to help consider the most effective options for an individual package of care. Subsequently the policy also complements the requirements and ongoing implementation of the Equality Act (2010). There is an important distinction between observing the generally expressed principles of equality and diversity and specific compliance with the requirements of the Act. In relation to the latter, effective MDTs will make a significant contribution in practice:

- Decisions may be made about the care or treatment of a person whose rights are specifically protected under the Equality Act. A person with a protected characteristic may be discriminated against in various ways. This may include how a professional or group of professionals may behave towards the person, or how decisions are made about the persons' access to specific health and social care services?
- A failure by an MDT to respond to the requirements of the Act could lead to the making of a discriminatory decision which would leave the Health Board and potentially partner organisations vulnerable to legal challenge. Members of the MDT should have a sufficient understanding of the law to identify what needs to be done to make sure a person is neither directly nor indirectly the subject of discrimination.

The ability to demonstrate the effectiveness of an individual MDT, its care planning decisions and recommendations; and established systems to monitor the qualitative and quantitative outcomes of those decisions; will provide organisations with invaluable evidence to demonstrate the effectiveness of its MDTs and ongoing compliance with the Act.

MDT Performance

This Framework provides an opportunity to establish joint expectations for MDTs across partner organisations.

An agreed or joint standard for effective multidisciplinary working in practice will help to strengthen governance arrangements. It will also provide a platform from which the development needs of individual MDTs can be considered, the right support provided and performance improved.

Older people admitted to accident and emergency often have complex medical and social needs and it has been shown that multidisciplinary interventions with comprehensive assessments is the best means of mitigating loss of functional impairment (Leah & Adams, 2010). In the study, contemporary comprehensive geriatric assessment is described as a multidimensional and diagnostic process focused on developing a co-ordinated and integrated plan for treatment and long-term follow-up. The study describes the establishment of a multidisciplinary assessment team for older people (ATOP) attending A&E in a district general hospital and concludes that the team was successful in preventing admissions, improving patient outcomes and was cost-effective.

Most functioning MDTs would agree that their work needs greater recognition and support from within partner organisations. However, it must be accepted that with greater organisational significance, comes greater shared accountability for demonstrating effective practice.

The publication '10 High Impact Changes for Complex Care' (2010) sets out the rationale and potential impact of aligning ten interdependent improvements to systems and practices that contribute to complex care:

- Change 01: Avoid disruption to the usual care setting
- Change 02: Identify complex needs as early as possible
- Change 03: Agreed triggers and timely assessment
- Change 04: Effective multidisciplinary working
- Change 05: Proactive discharge planning
- Change 06: Rapid systems of escalation
- Change 07: Responsive long term care
- Change 08: Focus on the data for complex care
- Change 09: Integrated services & effective partnerships
- Change 10: A workforce designed to serve complex needs

Although Change 4 is explicit, the effectiveness of multidisciplinary working underpins all of the proposed changes, ranging from simple process measures through to workforce strategy. A suite of primary performance measures has been produced for each of the ten changes and will be developed further through the establishment of the new national Complex Care Collaborative. This will form part of the 1000LivesPlus programme of work from 2012 onwards. A new 'How to Guide to Complex Care' will be published to steer the work of the collaborative, detailing the required interventions and measures using the 1000LivesPlus established driver diagram methodology.

'High Impact Change Number 8: Focus on the data for complex care' is summarised in a primary measure that requires participating organisations, to report the number of individually identified MDTs that have dedicated performance information. Adopting this measure will enable organisations to demonstrate the evidence required to provide assurance over the quality of their MDTs.



Step 2 Actions – The Strategic Assurance

4. Identify the scale and scope of functioning MDTs across the partner organisations.
5. Adopt the 10 High Impact Changes for Complex Care as the structure for measuring improvement.
6. Implement operational and technological systems for producing MDT based performance information.

Action Notes:

Step 3 – To Manage Expectations

People who provide health and social care have not in the past had significant contact with one another during their formal education, after which they have been expected to work together in a team (Baldwin & Baldwin, 2007).

Upon entering professional practice those same people are often employed through similarly independent organisations, professional silos and management structures.

“First, we must understand and agree the different roles and relationships. Only then, can we really focus on the person at the centre of everything.”

This prolonged separation results in practitioners being unfamiliar with each other's values, skills or competencies. The limited opportunities to develop interprofessional understanding in either education or practice, can impact upon the ability to develop trusting relationships with other practitioners, and those working in different agencies. This can also lead to a process of professionalisation whereby a hierarchical power structure develops within the MDT. This results in the greatest amount of authority being given to a particular practitioner, who may have neither the skills nor the time, to manage the responsibility of delivering the MDTs working outcomes (Kapral, 2011).

It follows that organisations cannot simply invest a group of practitioners with the title 'MDT' and leave them to independently deliver the complex and intricate responsibilities, expected of an MDT in policy, law and public perception.

Understanding the Roles & Responsibilities

To gain insight and understanding of another profession requires each practitioner to first, have a clear picture of their own role, responsibilities and perceptions.



At the same time we must recognise that it is common for an individual practitioner to adopt several different roles. This depends on the purpose, type of group and context of the work in which they are involved.

Most practitioners will normally be involved in several different groups of people. In each slightly different group they may be seen by the other people involved to represent different status, values, objectives and responsibilities.

In response, a practitioner will naturally change or adapt their communication style, language and behaviour accordingly.

In essence, they perform and conform to several similar but different identities. This is not to say that practitioners have to consciously or otherwise, change the nature of who they are as a person or the scope of their professional practice. The adjacent diagram is a crude illustration of how many different groups or roles that a practitioner may be associated with during any normal working week.

Given that there are broadly three types of functioning MDT, it is reasonable to expect that each practitioner may be required to adapt their perceived role or identity to align with the characteristics of the MDT they work within. The collective goal could be described as, to become interdependent individuals who are confident in themselves and their abilities, yet recognise that to perform effectively requires acknowledgement, adoption and respect of others (Powles 2009).

This requirement for practitioners to be willing to adapt their personal approach and expectations to align with different groups; does not detract from the specific and expert contribution that their profession is able to add to the MDT. In practice and in different situations, practitioners move from a state of 'willingness to collaborate' through to openly sharing specialised knowledge and authority to meet the needs of the service user more efficiently (Carrier & Kendall, 1995; Sims, 2011).

This distinguishes the knowledge, skills and adaptability required for practitioners to work in different groups; from the specific and accountable, technical contribution or expertise of the profession that they represent. This can in itself, create an additional pressure for individual practitioners, often left to develop this balance within their own personal practice.

To inform this distinction within the Framework, an informal piece of research was undertaken. The adjacent brief was sent to a range of organisations that represent the professional groups that work within MDTs dealing with complex care. Wherever possible the organisations were contacted through their structures established within Wales:

"The brief ... a section of the initial publication is dedicated to summarising the distinct role or contribution of each profession within the Multidisciplinary Team. The people best placed to articulate that role are those organisations that collectively represent practitioners within those professions. Subsequently, I would be grateful if you would agree to write a vignette up to 300 words or roughly one side of a page, to describe your professions' unique role within the MDT. Please be specific to the profession, rather than general issues such as conduct, and write in a style and with language that would make sense to a layperson."

- Royal College of Psychiatrists
- Crossroads Care Cymru
- British Medical Association
- British Dietetics Association
- British Psychological Society
- Society of Chiropractors & Podiatrists
- Royal College of Nursing
- College of Occupational Therapists
- General Practitioners Committee
- Care Forum Wales
- Chartered Society of Physiotherapy
- Royal Pharmaceutical Society
- British Association of Social Workers
- Royal College of Physicians
- Royal Society of Speech & Language Therapists

Each of these organisations was invited to provide a contribution to this Framework and describe the unique role of their profession within the MDT.

The contributions were purely voluntary and the submissions from organisations who agreed to participate, have been collated in Appendix 1. The first and most significant finding was: that there was almost no suitable information immediately available, irrespective of congruence with the request. Reasonable explanations may well already exist within published literature, but if they do exist, they were unavailable or unknown to the majority of practitioners and their representatives.

It is clear from the narrative received that there are distinct elements of technical insight and care capability that define the specific professions in practice and in law. It is also clear, however, that much of the knowledge, skills, talent and values required to practice effectively are for the most part, synonymous with every profession across health and social care.

In 2009 the National Leadership & Innovation Agency for Healthcare and the Faculty of Health Sport & Science at the University of Glamorgan, co-hosted a development seminar on multidisciplinary working. The event took 60 experienced people from across sectors, organisations and professions through a programme to explore the roles of the different practitioners and apply that knowledge to a structured case study. The feedback from this event reflected a fundamental and often invisible barrier in working across boundaries. Most of the assumed knowledge and understanding of the different professions was based on generally unchallenged stereotypes.

This stereotyping in practice leads to a cycle of implicit and explicit defensive behaviours. It reinforces not just professionalisation, but also the fragmentation of the same profession from different parts of the same organisation; for example, hospital versus community. The normal ability to openly share information and opinion is easily overwhelmed in this context.

It therefore becomes important for allied organisations to actively overcome this potential barrier and provide opportunities for practitioners to develop meaningful working relationships.

Ideally an element of this developmental work needs to take place outside of the day to day transactional structures, taking time to consider two broad questions:

- Do you recognise and understand your own role, responsibilities and behaviours in delivering effective multidisciplinary working?
- Do you recognise and understand those aspects of the other practitioners and what they consider is their contribution to multidisciplinary working?

In studies undertaken to explore the Readiness for Interprofessional Learning Scale (RIPLS) in both undergraduate and post graduate contexts, the researchers asked whether professionals were ready for interprofessional learning. They found that GPs had a stronger sense of professional identity than nurses, pharmacists or allied health professionals which they surmised was as a result of 'pre-conceived maps of their own roles based on the learned culture, beliefs and cognitive approaches of their specific disciplines' (Reid et al, 2006; Morrison et al, 2004)


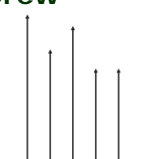
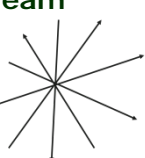

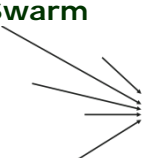
When is Team not a Team?

In addition to the perception of each practitioner or participant, there are a wide range of different types of human groups, identified in different fields of study, including those described within social, psychological, economic and anthropological literature.

A plethora of researchers, institutions and publications have identified, analysed, named and described the characteristics of different types of group. These descriptions vary greatly depending on the intellectual field of the author and the purpose of making the distinctions. However, there is a general consensus that different types of group work within a consistent range of capabilities that in context, can be both strengths and weaknesses. In simple terms, a team is not universally the best type of group to achieve a particular outcome.

In reality the word 'team' is often used as an umbrella term for any regular collection of people, whether or not they perceive themselves to be, or actually do conform to any of the characteristics that are synonymous with a high functioning team.

The following table provides a brief overview of five types of group that have been summarised from the extensive literature. The table is included to illustrate some of these distinctions between form and function. The descriptions are necessarily, very broad generalisations for example, although group sizes are indicated, any group could theoretically be any size. Furthermore, one type of group may exist as a sub-set within another larger type of group.

Type & Ideogram	Description	Strength	Weakness	Example
A Family 	≈5 people who are together often by circumstances rather than choice. Can exist for a life time	Able to survive any change, mature relationships highly skilled in practical terms for a narrow range of activities.	Love each other one minute hate the next, predictably resilient and resistant to rapid change or external influence	An unusual specialist company or a very small department in a big organisation eg sub-specialists
A Crew 	5≈25 people put together because of distinct roles, standard identities or qualifications. Can exist for decades	Defined independent identities within a system, able to be very consistent even with different people in the roles	Don't know each other so inflexible to changing context, rigid practice that lacks creative problem solving	A procedural group who form in response to emergencies or are responsible for a specific task eg committees
A Team 	≈25 people with lots of similarities best chosen from within the existing group. Can exist for several years	A shared identity, socially and emotionally bonded beyond their basic purpose, resilient under pressure	Play and break rules when the pressure is off, separated from other people by inter-group identity and competitiveness	An established group who work together most of the time delivering a specific service eg gardeners
A Community 	25≈125 diverse people, self selected around a shared interest. Each manifestation can last a year or two	Consensus driven, internally motivated and knowledgeable about the common interests, expert problem solvers	Difficult to influence or direct, able to generate social resistance quickly and prone to getting tied up in detail	A highly active group of people who campaign for their favoured activity eg social networks
A Swarm 	≈125 or more people included by their proximity to an external event or desire to cause one. Exist for a day or two	Highly energised and creative with novel or innovative actions and outcomes externally motivated by a moral objective	Unpredictable and inconsistent activity, impossible to direct and irreproducible, good and bad causes and effects all mixed	Instantaneous responses to a major incident or unplanned event eg sudden celebrations

With this in mind, it becomes important to first recognise and work with, the characteristics or behaviours that already exist within any particular group. In aiming to make improvements in practice the tools, techniques and processes employed need to be congruent with the group dynamics. This Framework does not advocate any one type of group as the best approach to effective MDT working, or that effectiveness is synonymous with one description of processes. It would certainly be counterproductive to insist that an MDT conform to a particular type of group. Each MDT should determine or better, develop over time, a method of working together that is best suited to their own membership, purpose and working environment.

Within the acronym MDT the word “team” is being used as the umbrella term. There are however, a consistent set of factors that are necessary to structure the work of the MDT and create the optimal conditions for effective multidisciplinary working in any context.

Structure of the MDT

Whether in the setting of a formal meeting or an integrated team, there are a small number of critical responsibilities that enable the MDT to function effectively. These roles are adopted by participants within the MDT and are distinct from the professional role or contribution of the practitioners involved.

The roles will vary in detail depending on the scale and scope of the MDT but their essential contribution to effective practice is universal. There are a wide variety of different terms currently in use that refer to these same three roles:

- The Lead Practitioner
- The Care Coordinator
- The Administrator

In most established MDTs these roles move or rotate between different practitioners, to reflect the individual needs of the person concerned and their ongoing plan of care. Although not routinely possible, there are also examples of MDTs functioning effectively with participants such as, informal carers or family members adopting these roles within the MDT. In practice the effectiveness of the MDT can be undermined if adoption of these critical roles is subject solely to the professional, hierarchical or silo based stereotypes. Furthermore, the practitioners who do take these roles in practice should be able to demonstrate an appropriate level of competence through qualification or experience.

In developing effective multidisciplinary working, organisations should encompass the expectations and performance outcomes of these roles within local operational policies. Subsequently, practitioners working within MDTs should be provided with opportunities for training, supervised practice and mentorship to develop the necessary skills, as part of their personal development process.



The Lead Practitioner:

Dependent on the type of MDT, this role can encompass a range of expectations from simply the person who adopts the Chair for the duration of a meeting, through to the recognised Head or Manager of an established care team. In general the Lead Practitioner will:

- Ensure that the MDT abides by its own ground rules for practice
- Steer the MDT to maintain its agreed purpose or goals
- Ensure that appropriate people are able to fully participate in the MDT
- Ensure that the MDT discussions and activities are person centred
- Guide challenging discussions and seek to generate consensus across the MDT
- Ensure that where appropriate, decisions are made and understood
- Ensure that decisions and actions are properly recorded and communicated
- Hold participants to account for agreed decisions and actions
- Prepare and respond to communications on behalf of the MDT
- Act as the Chair for formal meetings

"The best MDT I've ever been involved in, was probably all down to the person who chaired the meetings. He was really skilful and authoritative in a gentle sort of way. Kept everybody to time and brought us all back to the point when we drifted off. Everyone knew exactly what they had to do and by when. It wasn't until right at the end of the first meeting I attended, that I realised he wasn't a member of staff. He was the patient's father!"

Evidence suggests that the role of Lead Practitioner within an MDT is rarely identified, described or defined within existing organisational systems and policies. Although not prescribed, or universal by any means, it is common in Healthcare environments for this role to default to the most senior Doctor in the room, at the time.

The Care Coordinator:

Several established policies recommend the development and implementation of roles with similar titles and responsibilities. For example, the CHC Framework requires local agencies to agree joint protocols for care coordination. There are a number of formal descriptions for the role of Care Coordinator and a range of practitioners in different fields of work who use this and similar job titles.

Within 'Interim Guidance for CPA in Mental Health Services' (WG 2010), the Care Coordinator is recommended to have a long term relationship with the person concerned, irrespective of

the care setting. In other fields, it is recognised that the role of Care Coordinator should be adopted by the practitioner who is best placed to manage the immediate or next steps of the journey through care. Each approach, in context, has different strengths and weaknesses and in general the Care Coordinator will:

The CHC Framework says ... the role of the Care Coordinator is pivotal to ensuring continuity and consistency in the assessment and care planning process. Ideally, one member of staff should have a coordinating role to oversee an individual's care package. Often the role is best handled by practitioners with a long term role with the individual. Where needs are mainly health related, a nurse or other health worker should act as co-ordinator. Where social care needs are to the fore, a social worker might be expected to coordinate.

- Act as the primary point of contact for the person and their family
- Ensure that the person and their family are fully informed and involved
- Identify and organise any specialised support to enable full participation
- Collate all relevant assessment and care planning documentation
- Maintain an accurate and up to date plan of care
- Liaise with participants of the MDT to share information
- Schedule MDT discussions and other relevant meetings
- Chase the progress of agreed decisions and actions
- Liaise with any relevant external organisations
- Provide advice and signposting to relevant support services

The implementation of this role into practice is different within and across organisations and is dependent on historical context and established local structures. A number of different terms are in use for this role and several organisations have made distinctions between the general requirement for care coordination and the responsibilities for people appointed to roles such as Nurse Assessor, Case Manager, Discharge Liaison and Placement Advisor. The vast majority of care coordination work is undertaken on a less formal basis, as an implicit element of the day to day responsibilities of the traditional health and social care professions.

The Administrator:

"Without dedicated administrative support, the burden of secretarial work falls in most cases to the unfortunate Care Coordinator. This is a professional practitioner in their own right. They cannot possibly be expected to properly contribute to the intense deliberations of the MDT, while advocating for their patient, mediating the egos and furiously scribbling some notes."

The involvement of administrative staff, particularly in formal MDT meetings, has developed significantly in recent years. A formal record of MDT deliberations has been proven to be the most effective mitigation for legal challenge to clinical decision making. Subsequently, administrative support is increasingly provided to ensure that; firstly individual practitioners are able to fully participate as a professional within the MDT; and secondly that the subsequent decisions and actions are accurately recorded and communicated. In general the Administrator will:

- Provide administrative support for the work of the MDT
- Receive, direct and track any relevant correspondence
- Collate, copy and file relevant documentation within case records
- Circulate and track individual case records for MDT participants
- Where appropriate ensure relevant electronic systems are updated
- Plan meetings arrange venues and organise and track invitations
- Collate and prepare any necessary documentation for meetings

- Attend, facilitate and take formal minutes of MDT meetings
- Ensure that minutes are properly approved, circulated and stored
- Provide general organisational support to members of the MDT

Where the MDT is well established and functions within more formalised settings, for example in Child Protection or Cancer Care, participating organisations usually have agreed structures in place, to provide appropriate supporting resources.

These resources may include access to equipment and facilities, but the critical components will define the protected time for practitioners to participate and the extent of dedicated administrative support. These resources are provided to enable the MDT to be more organised and cost effective.

Other Practitioners

Various members of the MDT will adopt one of the three specific roles that enable an MDT to work effectively. The people in those roles will also have a contribution to make within the MDT as a participant in their own right. They should be able to contribute fully, as any other Practitioner who, in general will:

- Develop an open and trusting working relationship with the person and their family and other members of the MDT
- Develop and maintain the highest standards of communication across the MDT and with the person and their family
- Maintain up to date and accurate knowledge of the person involved
- Provide professional expert opinion and advice within their recognised scope of practice
- Undertake general and specialist assessments to establish needs identify unmet need and describe the associated consequences
- Prepare professional advice and recommendations for consideration within the wider MDT
- Provide appropriate care and intervention as per the agreed plan of care
- Engage in multidisciplinary discussions, problem solving and contribute to the collective decision making processes
- Ensure that decisions and actions accurately represent the full extent of MDT knowledge and opinion.
- Devote sufficient time to preparing for and acting upon formal MDT meetings.

Elissen et al (2011) describe a study in the Dutch region of Limburg which although had a high number of chronically ill and older people (which warrants coordinated care) traditionally had limited multidisciplinary cooperation. The study aim was to develop an explanation for the limited extent of MDT working in the primary care sector of Limburg.

The study found that MDTs formed little more than a supplement to individual care delivery and much of the joint work was in the form of ad hoc consultation. They felt that cooperating in a more formal manner would compromise their individual tasks such as house visits and consultations. Therefore they were rare and seen as an add-on towards the end of a week. They understood that MDT working was part of the job but that meetings were not productive hours spent.

Ultimately the study concluded that legal rules did not hamper cooperation, they were sufficient for information exchange. However, organisational rules were seriously lacking. There were almost no guidelines for multidisciplinary cooperation between providers, describing feasible task division and the link to organisational structures. Existing organisational rules confirmed and fixed current single discipline based care delivery which was reinforced in communication with patients. There was little information or insight into how processes will happen or the extent of the engagement, exacerbating the lack of coordination.

Some practitioners will see themselves as core members of a particular MDT, while others may contribute as peripheral members of a number of different MDTs.

The way in which each of these three roles are adopted and function in practice will vary with the characteristics, scope and scale of each MDT. Participants may have high levels of expertise as practitioners, or have extensive experience in adopting one of the enabling roles with the MDT. However, none of these roles whether informal or prescribed, can perform effectively in the absence to some degree, of an explicit agreement about how the MDT will function in practice. This sort of agreement can take many forms for example a formal written terms of reference or a standard agenda, but they are essentially a set of agreed common ground rules.

Agreeing Ground Rules

Having some basic rules for how a group of people will work together seems to be a matter of obvious common sense. Yet in practice the establishment of ground rules is predominantly implicit in all but the most immature or newly formed functioning groups. New or short term committees or project teams often begin by defining terms of reference, but these tools are less and less explicit, relevant or even available to read, as relationships become more established and patterns of practice emerge over time.

Many of the characteristics associated with running successful meetings, making shared decisions and developing good relationships are common and represent the ground rules for effective multidisciplinary practice in any context.

The first task is to recognise the value of each other's contribution and agree a few simple principles which will guide the behaviour of members of the group. This is especially relevant to steer future situations, where issues may become emotive or involve differences of opinion. A common and successful method of working out and agreeing ground rules is to facilitate a moral conversation.

"In my experience there are some fairly obvious characteristics found within an effective MDT. They include practitioners with the authority to act on the discussions without having to defer decisions. They demonstrate great interpersonal communication and negotiation skills, with challenging conversations that are open, unbiased, person centred and respectful. Most of all the MDT has a recognised level of authority and therefore the confidence to make difficult decisions."

This method requires a different sort of language from that used in the day to day transactional conversations that normally take place between practitioners. There are numerous and varied examples of existing organisational development tools and techniques aimed at guiding this sort of interpersonal and team development work. A useful example of using different forms of language in practice is described in the widely recognised, Human Rights Based Approach. It advocates five themes for consideration:

- Freedom
- Respect
- Equality
- Dignity
- Autonomy

Using FREDA to structure a conversation about what each member of the group feel is important in working together, will inevitably identify a small list of important narratives or rules. Groups can then agree to apply these narratives in their relationships with one and other and then most importantly, with the person and family at the centre of their work.

Once this basic behavioural agreement is in place it becomes easier to work out some of the more tangible or practical arrangements, for example:

Agreeing a high level purpose:

- Engaged team members and the person and their family
- Achieve a person centred outcome through joint decision making
- A primary goal eg “our default plan is to help you get home!”

Agreeing intermediate objectives:

- Agree a clear objective for each person being considered
- Capture and identify need and the effects unmet need
- To escalate issues beyond the MDT in a timely way
- Keep to our initial ground rules and let them develop over time

Agree practical processes:

- Where and when we meet formally
- Each practitioner must know the person (have done the assessment)
- Be organised and work to a timescale (planned and purposeful)
- Make decisions and appoint responsibility for timely actions
- Communicate accurate notes of discussions and agreed actions
- Agree a time to review the case again or the date of discharge/transfer

In the development of effective multidisciplinary working, the experience gained within the MDT of undertaking this sort of work and developing the ground rules is, in most situations, more significant than the eventual set of final written rules. This is essential preparation for multidisciplinary working in any context and prepares the MDT to engage in the most important relationship.

Involvement of the Person and their Family

It is often stated that the person concerned and their family, should be considered as full members of the MDT. However, it is not good enough to simply assume that the person and their family can be treated just like any other members of the MDT.

Whereas the sentiment is properly motivated, in reality, the person and their family need more than just to be considered a member of a team that they may know little about. The MDT often discuss a number of patients at any one time and often continue to function, learn and adapt over time, long before and after a particular person needs their services.

In other words, practitioners should have developed a clear understanding of their role and the functioning of the MDT. A patient and their family will not initially have that same level of understanding and will not be able to fully participate without direct support.

That means the person and their family should be considered as extraordinary members of the team, or more commonly, ‘VIPs’. Practitioners need to consciously recognise and adapt their approach, language, relationships and processes to meet the needs of each new person, who for a short time becomes the most important member of their MDT.

In practical terms many MDTs consider that the person or their family do not need to be part of every conversation with every practitioner. It seems perfectly acceptable for practitioners to have technical debates, investigate issues, challenge each other and consider different care

An example of committee definitions is that by the International Federation of Social Workers, which the Department of Health quotes as a definition of social work:

“The social work profession promotes social change, problem-solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.”

processes and options in a professional context. However, there is an important balance to be had to ensure that each person feels fully engaged in any and every decision making process. Subsequently, the levels and standards of communication must be actively maintained throughout an episode of care, so that ultimately the person and their family are satisfied with their level of engagement, information and autonomy.


A comparative evaluation of interprofessional training in home care for district nursing, dieticians, physiotherapists, occupational therapy and nursing students in Sweden was undertaken by Tornkvist & Hegefjard (2008). The study found that using a realistic environment (such as a flat in this study) and a realistic case study (based on real people with complex needs) provided a rich learning opportunity and demonstrated the need to have representatives from all the professional groups in attendance in order to gain an understanding of each other's professional responsibilities. This also strengthened their own understanding of their own individual roles and responsibilities.

The practicalities of having family at every MDT meeting especially if they live some distance away, can be very difficult. It therefore becomes critical to adapt and make additional efforts as part of the extended multidisciplinary working, to contact the family on numerous occasions.

This can be carried out at different times by different members of the MDT, with appropriate coordination, to update the family and exchange information, advice and opinion.


Using the principles of IPE in the development of practitioners, provides them with a suite of experiences, methods and simple processes to better empathise and engage with a diverse range of people. Preparing the MDT with a clear picture of individual and collective roles and responsibilities and supporting the development of ground rules for effective practice, is a natural next step.

All of this development culminates in providing the best possible context to establish a better informed, more dynamic, trusting and resilient relationship with the person being served.

 This work is all about managing expectations and the person at the centre of care is best placed to determine whether those expectations have been met. Therefore, to enable this meeting of work and expectation, organisations should engage with the public to raise awareness of multidisciplinary working.

Information should be available to the public outlining the purpose and principles of multidisciplinary working and the practicalities of how it works in their organisations. The most significant message is the right of every person, to ongoing and active participation throughout a journey through care.

This public engagement work should mirror an organisational commitment to develop joint expectations for practitioners involved in multidisciplinary working. Some practitioners already have criteria for multidisciplinary working incorporated within individual job plans and specifications. However, these criteria need to be agreed within a more formal policy to provide a common approach across disciplines and partner organisations. The description should set agreed organisational standards for some of the common operational issues such as; reasonable time for planning and preparation; effective participation and decision making; quality of communication; and the responsibility for acting on decisions.

 Finally organisations will need to consider information, training and where appropriate facilitated support to provide the opportunity for MDTs to translate the policy into operational ground rules for day to day practice. This process will essentially provide a small, but significant example of interprofessional education leading to more effective engagement with people and their families.

Step 3 Actions – To Manage Expectations

7. **Develop joint standards for the involvement of practitioners who participate in MDTs**
8. **Engage with MDTs to translate standards in to ground rules for day to day practice**
9. **Develop a public engagement process to explain the ground rules and promote individual rights to active participation in MDTs**

Action Notes:


Step 4 – The Three Core Capabilities

The three core capabilities for multidisciplinary working are predicated on a clear distinction between the skills, knowledge and structures required to work in the MDT; and the individual competence of each practitioner within their profession. It is therefore, assumed that any practitioners involved in MDTs are individually competent to work to the standards required of their chosen profession and employed role.

“MDTs represent a significant step on the continuum of professional development, moving people away from traditional silos and towards integrated practices.”

The Framework has drawn from recognised research, evidence and expert opinion to distil a simple but meaningful model. It is designed to enable individually competent practitioners to work together to maximise that individual talent and experience. The model is related to Leutz (1999) description of integration levels from linkages to coordination and on to full integration. It is described as the first law of

integration: “you can integrate all of the services for some of the people, some of the services for all of the people, but you can’t integrate all of the services for all of the people”.

 This model is equally relevant from a strategic perspective, providing a continuum of development along which organisations can also work together corporately, to align and agree the resources and mechanisms required for an ongoing joint multidisciplinary development plan. The basic model contains three core capabilities for effective multidisciplinary working:



1. **Successful Multidisciplinary Meetings:** the MDT is able to organise and manage formal meetings, record and communicate discussions, decision making processes and actions.
2. **Coordinated Assessment & Planning:** the MDT is able to initiate and coordinate multidisciplinary assessment and care planning activities with allied organisations.
3. **Integrated Systems & Practices:** the MDT is able to lead and develop multidisciplinary systems of practice that are integrated across traditional organisational boundaries.

Each capability is distinct but also integral to the next and none is more important or advanced than the other. The three core capabilities simply represent three states along a continuum that reflect the nature of multidisciplinary working in different circumstances:

- First Capability: Linkages with professionals are required usually for people with fewer needs. There are rules, there is a process of referral between services and professionals, and some feedback is required.
- Second Capability: Coordination is required for people who have needs which are of mild to moderate complexity. Here the person will be cared for simultaneously by more than one professional or agency and requires a care coordinator to plan across professional and agency borders. This includes planned regular meetings.
- Third Capability: Integration is required for a smaller number of people with the greatest complexity of need. The person is simultaneously cared for through interdisciplinary assessment and integrated care planning. It requires regular face to face communication by two or more agencies or professions who will make decisions by consensus.

Skills in a single capability may be relevant to one group of practitioners and be sufficient to deliver effective multidisciplinary working, whereas other practitioners may need to develop skills in all three capabilities. The following examples are based on real scenarios and are used to illustrate this continuum:

“There are three clear messages within these core capabilities: know your people, know your professions and be prepared”

1. A Carer working in a small community service has been invited to a multidisciplinary meeting convened to review a care package. In this context the Carer needs to understand the purpose, processes and role they play in these meetings. They do not usually work with the other professions on a day to day basis, but do need the capability to participate in successful multidisciplinary meetings.
2. A Nurse in an acute ward has identified a patient who will need additional support when they are discharged. The Nurse needs to trigger a full unified assessment, contact practitioners in other departments, liaise between three different organisations and keep the patient and family fully involved. All of this activity must be coordinated alongside the day to day care and treatment of the patient. Although the practitioners work together they sit in different departments. All of the practitioners are likely to need the skills to participate in multidisciplinary meetings however; in this context the Nurse needs the capability to coordinate the required assessment and care planning.
3. A Social Worker employed within a Community Resource Team is visiting a new client for the first time and identified that they have recently fallen. To determine what to do next, an initial falls assessment is needed which includes elements of work that traditionally apply to social workers, doctors, therapists and nurses. To do a consistent assessment, the Social Worker will need to have a clear understanding of the purpose of the work, shared terminology, common documentation and knowledge of the triggers that would require a specialist opinion. This team will need to have developed a multidisciplinary system of practice, within which there will be coordinated assessment and care planning, within which there will be joint meetings. The Social Worker will require the capability to practice within an integrated system.

In each of these scenarios, the practitioners need to recognise the capabilities required to work not just within their own profession, but with and alongside other practitioners. This often involves learning and developing knowledge and skills that extend beyond the traditional single discipline curricula and scope of practice.

For example, practitioners from different disciplines who work together in the same field or subspecialty, often recognise that they have, in isolation, developed a similar subset of

additional interpersonal and social expertise. This may include learning in subjects such as; negotiation, behavioural interpretation, building trust or multimedia communications.

Blurring of disciplinary boundaries can facilitate the team to adopt a holistic approach to meeting older people's needs (Proctor-Childs et al. 1998). According to Xyrichis & Lowton, 2008, not having a clear understanding of each member's roles and responsibilities within the team can be resolved by setting clear team goals. This practice of joint planning and establishing goals enables team members to become aware of the different professional values and beliefs within the team and to learn to work together within the team (Proctor-Childs et al. 1998). An absence of team goal setting and evaluation has been found to hinder effective multidisciplinary working (Atwal & Caldwell, 2006).

These extended skills, although initially aimed at more productive relationships with service users, have led to greater and more resilient interprofessional and team relationships. This is most likely due to the practitioners having an additional depth of common knowledge, experiences and a subset of new language with which to engage each other.

Within the research and informal practitioner based experience a common developmental pattern has been recognised. In different settings, as multidisciplinary working escalates along the three states of the continuum, effective practice becomes less and less about the explicit working processes and more and more about, the personal commitment to an implicit team culture.

Overall the conclusion is that it naturally takes time to build consensus into ways of working and enduring relationships become the most important component of effective practice.

This is reflected in the multidisciplinary model and as MDTs develop along the continuum, the work is more focussed on the perception of being part of a common culture and valuing the team identity. This change is often predicated by the formal establishment of a common team objective for example "to agree a planned date of discharge within 4 days" and over time is translated into a more profound goal, "our first aim is always to help you get home".

The knowledge, skills, talent and values of the whole team can then be brought to bear on any situation and in the traditional adage, 'the whole becomes greater than the sum of its parts'. At a more pragmatic level, understanding the total insight and capabilities available across the MDT allows the practitioners to be more open and adaptable, in assuming tasks and responsibilities, suited to each particular situation. Rather than a process of delegation to a profession to determine who does a job, the practitioner and their individual talent determines who can do any particular job, in parallel processes aimed at the common goal.

"Multidisciplinary working is a great way of reinforcing how important every profession is and what each can do in a way that the others can't. Then when the going gets really tough, turning to the most senior and most important one of the lot and saying ... quick ... go and put the kettle on!"

The development of multidisciplinary working is not an underhanded approach to dismantling professional boundaries, identity and scope of practice into a single generic pool of people.

On the contrary, where multidisciplinary working is seen to be effective, it is a proven method of more clearly defining the specific responsibilities of each profession. Meanwhile the MDT recognises that much of the day to day delivery of care relates to a common core of insights, capabilities and ordinary activities.

The CHC Framework highlights the importance of a strategy for joint staff development and includes a key list of subjects that are required within an educational programme:

- philosophy and purpose of assessment
- policies in relation to long term care

- the CHC Framework
- health and social care boundaries and their respective responsibilities in meeting long term needs
- the range of patients involved
- Person Centred Assessment
- capacity and consent
- the role and responsibilities of the MDT
- development of competencies using appropriate assessment tools
- procedures and responsibilities for assessment, care planning and decision-making
- effective recording of assessments and decisions
- achieving validity, reliability, transparency and equity
- implications and outcomes for patients' holistic care management
- working in multi disciplinary teams
- the protection of vulnerable adults
- understanding the role of advocacy

None of these subjects are agency, profession or specialty specific. Although there will inevitably be components of practice that relate to specific roles or professions, a collective understanding of the significant influencing factors is necessary for effective implementation.

Establishing Current Standards of Practice

There is a wide range of literature, tools, techniques and entire programmes of work available to organisations to assess, support and improve multidisciplinary and team development. Many organisations across Wales are familiar with or have formally committed to, a targeted programme of team development activities. These programmes are designed, developed and delivered by a wide range of commercial companies and academic institutions.

Without exception, each of these initiatives advocates a bespoke method of assessment to determine the levels of practice and existing needs of each team. These processes are often designed to define or measure, a benchmark of performance, from which improvements in practice can then be determined, designed and measured over time.

Borrill et al's (2002) study of factors that contribute to effective teamwork in a national study of team working in the NHS, identified factors associated with a lack of clear leadership. This issue correlated with; poor team working processes and outcomes; lower levels of participation; a lack of clarity about objectives; low commitment to quality of care; and low levels of support for innovation in the delivery of care.

Practitioner's perceptions and beliefs about role identity, knowledge and skills shape the kind of multidisciplinary working that takes place. Different professionals sometimes emphasise the importance of maintaining and clarifying professional boundaries and roles and the core competencies related to their profession. At the same time, they accept that there is scope for sharing and exchanging knowledge and skills, and identify instances where blurring of traditional boundaries is necessitated (Baxter & Brumfitt, 2008).

Several other studies reported similar findings (Field & West, 1995; Rutherford & McArthur, 2004; Wiles & Robinson, 1994) cited in Xyrichis & Lowton (2008), noting the effectiveness of team working is very much dependent on the willingness of organisations to support and implement the necessary changes. Failure in this regard is most often associated with the inability of large organisations to align work that bridges competing corporate functions.

As with many other practice based interventions and developments, an organisation's responsibilities to assure the effectiveness of functioning MDTs, can be met through the process of auditing. Audit is recognised as an important factor in ensuring effective teamwork,

but has generally not been strongly advocated in published literature, nor taken advantage of organisationally in practice.


Established structures for internal audit and review, whether regulatory or voluntary exist in every health and social care organisation. Therefore, aligning with formal audit programmes is a practical strategy to incorporate multidisciplinary practice development within the organisation's formal structures for evaluation. This also provides access to professional and corporate support to gather evidence of tacit practices, to better inform the more traditional management structures for analysing and reporting organisational performance.

For example, the Audit Commission has reported investigations into rehabilitation and remedial services for older people in England and Wales. The findings reported weaknesses in team working strategies in relation to care coordination, identifying a lack of shared note keeping, shared care planning and goal setting (Audit Commission, 2000 cited in Long et al, 2003).

In terms of multidisciplinary working this audit work will involve monitoring and evaluating both individual and team performance in order to identify and reward good practice and implement any necessary improvements.


To underpin and evidence the three core capabilities, information has been drawn from IET (2010) Interprofessional Capability Framework, Skills for Health GEN 39 'Contribute to effective multidisciplinary team working', CMC5 Build a partnership between team, patients and carers, and relevant publications and research studies such as Barr (1998), Sims (2011), Kendall et al (2011) and Aston Team Workbook (2009). There are three distinct messages within the core capabilities:

- Know the professionals and gain an understanding of one and other's roles and that of the agencies who participate within the MDT and other wider or allied networks
- Be prepared and know how to conduct yourself in an MDT having the knowledge, skills and attitudes which will effectively contribute to both serving the person's needs and delivering the MDTs outcomes
- Know the people involved and put the person and their family at the centre of the business

 To begin the process of developing and improving multidisciplinary working, organisations therefore will have to engage with MDTs and other appropriate functioning groups, to support an initial assessment of their practices, capabilities and development needs.

The following tables contain a summary of the competencies and subject areas that have been identified to support improved practice in each of the three core capabilities. Appendix 4 contains an example of an organisational assessment tool that includes three further aspects of information, to help capture and assess local levels of capability:

- The degree to which the individual MDT feel themselves competent or sufficiently experienced in each field of work
- Identified existing corporate policy or procedures designed to instruct or support operational practice in each field of work
- The organisational resources currently available to support achieving the competency or improving practice in each field of work

 It is recommended that partner organisations undertake this baseline training needs analysis to inform ongoing implementation of the Framework. This is a practical process to assist organisations in aligning their MDT development needs with existing resources. This analysis will need to identify strengths, weaknesses and priorities to inform the ongoing programme of improvement work within a single Multidisciplinary Development Plan.

First Core Capability:

Definition	Successful Multidisciplinary Meetings
Narrative	<p>MDTs are able to organise and manage formal meetings, record and communicate discussions, decision making processes and actions.</p> <p>In situations where operational working relationships are less established or organisational systems and practices are immature, practitioners need to be able to deploy a set of core skills and understanding to enable information, analysis and judgements to be shared. This requires a level of structure and formality suited to the purpose of the MDT that enables participants to actively contribute everything they think is valid or valuable. This exchange must be accurately recorded and communicated to ensure that decisions and actions are effectively carried out to agreed timescales, minimises any misinterpretation and avoids subsequent inappropriate or unilateral decisions and actions.</p>
Rationale	<p>IET (2010) Interprofessional Capability Framework, Skills for Health GEN 39 'Contribute to effective multidisciplinary team working', CMC5 Build a partnership between team, patients and carers.</p> <p>This first core capability demonstrates knowledge skills and attitudes which are considered to be common between all professional roles (Barr, 1998). Poor team working is often found as a result of a breakdown in communication across individual professionals and across and within their agencies (Anderson et al, 2006). Therefore the focus in this first core capability is on enabling the MDT worker to cultivate and promote conditions within which information, professional judgement or individual views are freely and clearly exchanged between participants of the MDT resulting in effective decision making.</p>
Competency	<p>The practitioner is able to demonstrate knowledge and skills in communication, collaboration and decision making in order to achieve identified individual outcomes. This is progressed in partnership with the person and family as the focus of the MDT:</p> <ul style="list-style-type: none"> • Cultivate and promote conditions within which information, professional judgement or views are freely exchanged between participants of the MDT resulting in effective decision making • Apply knowledge and skills in communication both verbal and written with appropriate questioning, listening skills and ability to summarise, how to document MDT meetings. • Demonstrate knowledge of the person including their level of participation, roles and responsibility of professionals and agencies required to attend the MDT in order to achieve the expected individual outcome. • Applies knowledge and skills in decision making eg seven temporal stages of decision making (Carrol and Johnson, 1990) <p>At this level the MDT should:</p> <ul style="list-style-type: none"> • Demonstrate a clear identity and purpose with organisational recognition • Generate agreed ground rules, including setting objectives, response times and language for operating

	<p>the MDT</p> <ul style="list-style-type: none"> • Demonstrate early engagement with the person and family, identifying approaches taken to ensure CHC processes and structures of meetings are clear and accessible to them eg consider capacity, vulnerability, advocacy, interpretation • Demonstrate an effective range of verbal and written flexible communication skills, and understanding of the appropriate communication modes and structures to be used when communicating with different people and organisations • Identify and address the information sharing needs of the person, family, practitioner and their agencies • Demonstrate basic knowledge and practice of effective team working • Identify the roles, responsibility and availability of individual members required to participate in the MDT • Generate records of all communication within and around the MDT eg e-mails or letters of invitation to the meeting, minutes of meetings held, and actions agreed, evidence of person and family participation within the process, agreed decisions. Ensuring that timely distribution is made to allow for individual preparation • Identify the key roles of MDT chair, the care coordinator and the administrator for each MDT • Demonstrate effective and timely consensus decision making • Identify a quorum ie a fixed minimum number of members (which are proportionate to the needs of the person) who must be present in order to conduct the MDT meeting • Actively foster positive attitudes towards colleagues from other professions and agencies • Audit the knowledge, skills and outcomes of the MDT in order to promote learning and sustainability
Subject Areas	<p>Examples of topics covered in training and practice development:</p> <ul style="list-style-type: none"> • Introduction to purpose and benefits of multidisciplinary working: <ul style="list-style-type: none"> ○ An introduction to person centred planning ○ Communication skills and styles ○ Organisational culture and structure ○ General meeting skills and experience ○ Consensus decision making ○ Recording and auditing skills ○ Customer care, engagement and consent • An understanding of the policy and regulatory frameworks relevant to the person concerned: <ul style="list-style-type: none"> ○ CHC Circular 015/2010 ○ Mental Capacity Act 2005 ○ Human Rights and Advocacy ○ Equality and Diversity ○ Information Sharing ○ Commissioning and Contracting Long Term Care ○ Sustainable Care Planning ○ Protection of Vulnerable People

- Understanding the roles and responsibilities of different professions and the enabling roles within the MDT and processes for determining appropriate membership
- Developing of effective ground rules for MDT meetings and establish individual roles at each meeting ie Lead, Coordinator and Administrator
- Adapting to working in different locations and in a different context to change the form and function of meetings and preparation necessary to work effectively
- General tools and techniques for care planning:
 - Triggers for multidisciplinary assessment
 - Assessment tools and techniques
 - Writing and reviewing care plans
- Effective communication within a multidisciplinary team:
 - Involvement and participation with people and families
 - Use of communication aids, range of media and the use of interpreters
 - How early engagement with the person and carers can lead to more reliable care plans and better outcomes.
 - Practical techniques to ensure people are engaged and involved, as equal partners in the care planning process
- Tools and techniques for identifying triggers for complex care:
 - Scope of normal living arrangements
 - Scale and consequence of existing needs
 - Agreement of longer term personalised goals
 - Levels of intervention, care and support to address needs
 - Planned next step to achieve goals

Standards

Practice standard to be reached and assessed:

- The practitioner can form, develop and sustain the structures and processes of successful multidisciplinary meetings
- Assessed through undertaking team audit of MDT working (including structures and processes) to evaluate team performance in order to identify good practice and implement necessary changes

Second Core Capability:

Definition	Coordinated Assessment & Planning
Narrative	<p>The MDT is able to initiate and coordinate multidisciplinary assessment and care planning activities with allied organisations.</p> <p>The second core capability demonstrates knowledge, skills and attitudes required for those practitioners who are endeavouring to effectively coordinate person centred assessments and planning. Generally, for people who are considered to have needs of mild to moderate complexity. This is often whilst undertaking day to day care for other people in their service. Therefore in order to successfully achieve the 2nd Core Capability, the 1st Core Capability is also relevant and serves as a foundation as MDT meetings may also take place.</p>
Rationale	<p>Managing conflicting opinion is a key feature to delivering timely person focussed decisions. As the complexity of the task increases proactive management of each journey through care is required. This ensures that the coordination of the agreed tasks continues and practitioners do not revert back to silo conversations, without engaging with the MDT. This proactively avoids multidisciplinary 'disequilibrium', practitioner conflict and resulting gaps in multidisciplinary performance (Alter & Hage, 1993).</p> <p>Another source of conflict can arise from the fact that professionals working within MDTs have a dual role, that of a team member and also as a member of their own professional discipline. Where the interests demanded by each role diverge, this conflict may maintain the demarcation of professional boundaries and ultimately hinder effective communication within the team (Webster, 2002). Poor decision-making in MDTs emanates less from personality clashes between its members but more often as a consequence of a person's professional responsibilities preventing them from agreeing or reaching collective decisions (Ovretveit 1995).</p>
Competency	<p>The practitioner is able to demonstrate knowledge, skills and attitudes in the three further components of coordinated assessment and planning, which are summarised as comprehensiveness, accessibility and compatibility. This is achieved in partnership with the person and family as the focus of the MDT:</p> <ul style="list-style-type: none"> • Effectively coordinate assessments and plans to ensure that the person received appropriate assessment and services in a timely manner • Have a clear understanding of the contributions that different professionals can make to the individual's assessment, plan and review of service delivery • Establish clear person focussed goals with the individual and MDT members • Know their context of practice including the law, guidelines, protocols, pathways, organisational and professional constraints which may prevent the realisation of consensus decision making <p>At this level the MDT should:</p> <ul style="list-style-type: none"> • Demonstrate knowledge and understanding of the CHC Circular 015/2010 and guidance • Demonstrate an ability to easily communicate knowledge and understanding of the CHC Circular 015/2010 to the

	<p>person and family as the focus of any CHC meetings</p> <ul style="list-style-type: none"> • Summarise detailed knowledge of the person, their family including disease trajectories and needs • Discriminate between all assessments required, planning and reviews necessary to produce clear person focussed outcomes and individual MDT worker actions (Comprehensiveness) • Demonstrate knowledge of all potential services (including eligibility criteria and triggers for referral) available to the service user and family (accessibility) • Demonstrate knowledge and understanding of the timely linking and sequencing of assessments and service planning that should occur ensuring a fit between assessment, need and service delivery (Compatibility) • Identify all assessor and service information needs during the development of the assessment process and care planning in order to avoid conflict • Demonstrate a working knowledge of the Unified Assessment Process • Generate and demonstrate a willingness to work together • Execute appropriate actions which are required in accordance with the unique context of practice (defined by the individual needs) and may include the law, protocols, pathways, constraints which may prevent the realisation of consensus decision making
Subject Areas	<p>Examples of topics covered in training and practice development:</p> <ul style="list-style-type: none"> • Detailed knowledge of Unified Assessment and Care Management Process (UAP) and Care Programme Approach (CPA) and CHC Circular 015/2010 Practice Guidance • Passing the Baton: A Practical Guide to Discharge Planning: <ul style="list-style-type: none"> ◦ Understanding personal knowledge and skill ◦ Professional communication and negotiation skills ◦ Engagement with the person and their family ◦ Person centred care assessment and planning ◦ Sustainable care planning options and recommendations ◦ Legal and regulatory framework specific to the field of practice ◦ Development of operational tools and techniques • Specialist tools and techniques for comprehensive assessment of need <ul style="list-style-type: none"> ◦ Introduction to team working ◦ Working in networks and coordinating care • Local operational system knowledge: <ul style="list-style-type: none"> ◦ Management of Resources ◦ Service Portfolio and Availability ◦ Eligibility Criteria ◦ Referral Management ◦ Interagency Processes and Agreements • Interprofessional working: <ul style="list-style-type: none"> ◦ Professional roles and responsibilities ◦ Professional practice and supervision ◦ General knowledge of governance

- Contingency and collaborative theory
- Working with unpredictability and problem solving:
 - Complex judgement and decision making
 - Dealing constructively with conflict, disputes and general differences of opinion
- Meeting the needs of carers:
 - Carer involvement information and advice
 - Carers' Assessment
- Tools and techniques for managing outcomes for complex care:
 - Scope of normal living arrangements
 - Scale and consequence of existing needs
 - Agreement of longer term personalised goals
 - Levels of intervention, care and support to address needs
 - Planned next step to achieve goals

Standards	<p>Practice standard to be reached and assessed:</p> <ul style="list-style-type: none"> • The practitioner can effectively initiate and coordinate multidisciplinary assessment and care planning to ensure that the person centred outcomes are achieved in a timely manner • Assessed by undertaking audit of individual and team performance in order to identify good practice and implement necessary changes
------------------	--

Third Core Capability:

Definition	Integrated Systems & Practices
Narrative	<p>The MDT is able to lead and develop multidisciplinary systems of practice that are integrated across traditional organisational boundaries.</p> <p>This Third Core Capability recognises the importance of professional and organisational 'reciprocal interdependence' (Alter & Hage, 1993). MDTs should understand the policy context for working across professional and organisational boundaries. Plus, the responsibility to develop the right working relationships that produce the best outcomes for people with complex needs. This capability should not be considered in isolation from the first two capabilities. They both underpin the evidence for the third capability and the needs of practitioners who work with those people and families who have the greatest complexity of need.</p> <p>Interdisciplinary practices are the normal work! Practitioners share records and assessments and engage with the person throughout the journey through care. Meetings are productive and quick, described as specific, succinct and sincere but less formal in structure and process. Information is shared in a single comprehensive record rather than in a selection of forms, meeting notes or other standardised independent documentation.</p>
Rationale	<p>The third capability draws on the Organisational Competence (OC) L3 (IET, 2010) and the review of considerable published literature. The most effective and enduring systems contain high performing groups of people who have established intelligent, mature and resilient interpersonal relationships.</p> <p>Professional's perceptions and beliefs about role identity, knowledge and skills shape the kind of interprofessional working that takes place. They will often emphasise the importance of maintaining and clarifying professional boundaries and roles and the core competencies related to their profession. Meanwhile, acknowledging that there is a need to work outside the established professional structures. There is scope for sharing and exchanging knowledge and skills and instances where blurring of boundaries is necessitated (Baxter & Brumfitt, 2008). This blurring can facilitate the team in adopting a more rigorous and holistic approach to meeting needs (Proctor-Childs et al. 1998). The practice of joint planning and establishing goals enables team members to become aware of the different professional values and beliefs within the team and to learn to work together (Proctor-Childs et al. 1998). In complex situations, an absence of team goal setting and evaluation will hinder effective multidisciplinary working (Atwal & Caldwell, 2006).</p>
Competency	<p>The Practitioner is able to demonstrate knowledge and skills in leadership, managing change and integrating multidisciplinary practices into systems of work:</p> <ul style="list-style-type: none"> • Lead or participate across teams in wider inter-agency work to ensure responsive and integrated, person focussed services • Demonstrate awareness of the services provided within and across organisations and can accurately relay examples of how these are appropriately delivered • Interact and co-operate with others within and across organisations in providing person focussed services • Apply knowledge of the services provided within and

	<p>across organisations to participate in the delivery of, and where appropriate to take a lead, in the services provided</p> <ul style="list-style-type: none"> • Undertakes audit of MDT working to evaluate individual and team performance in order to identify good practice and implement necessary changes <p>At this level the MDT should:</p> <ul style="list-style-type: none"> • Demonstrate effective participation in interdisciplinary assessment • Demonstrate an ability to systematically share tasks which are common across disciplines • Generate and review shared care plans together • Generate common terminology to promote understanding to different people • Consistently execute the practice of consensus decision making • Consistently execute an effective balance of impersonal methods (e-mail, face-to face) and group methods (MDT debate) of communication • Critically analyse research evidence to enhance MDT practice and manage change • Identify, list and demonstrate a wide network of colleagues across agencies with whom the practitioner actively problem solves on behalf of the individual and family in accordance with identified need • Demonstrate leadership (as appropriate) in the delivery of specialist knowledge or services within or across disciplines or agencies in order to provide person centred care and planning • Generate and disseminate knowledge of services provided within and across agencies, to others including the individual and family • Generate evidence for appropriate measures which identify gaps in evolving individual and service requirements • Ensure that of the core members are identified and recognise themselves as such (eg people dedicated to role and team) and have a common view of their collective identity
Subject Areas	<p>Examples of topics covered in training and practice development:</p> <ul style="list-style-type: none"> • Advanced methodologies for developing and improving multidisciplinary working and team performance: <ul style="list-style-type: none"> ○ Establishing and maintaining team identity ○ Working to a collective high level purpose ○ Balancing individual and professional practice and experience ○ Collective and individual accountability for performance • Leadership and management: <ul style="list-style-type: none"> ○ Service integration levels and mechanisms ○ Service improvement knowledge, skills and techniques ○ International and speciality specific health and social care policy ○ Management of access systems and triggers for service ○ System's thinking and working in complex human systems

- Understanding performance management and outcome measures
- Advanced interprofessional practice and development
 - Models of professional decision making
 - Interprofessional assessment, planning and review
 - Developing and implementing common processes and documentation
 - Creating shared interprofessional language and terminology
 - Professional delegation and escalation
 - Coaching and mentoring and practice development
 - Counselling and interpersonal communication tools and techniques
- Research, audit and evaluation of practice:
 - Production and analysis of information on MDT performance
 - Quality assurance of interprofessional decision making
 - Design and management of safe systems of care
 - Effectiveness of outcomes in individual care plans
 - User and provider participation and satisfaction
 - Reflective practice and active case review
- Tools and techniques for developing practice for complex care:
 - Scope of normal living arrangements
 - Scale and consequence of existing needs
 - Agreement of longer term personalised goals
 - Levels of intervention, care and support to address needs
 - Planned next step to achieve goals

Standards	<p>Practice standard to be reached and assessed:</p> <ul style="list-style-type: none"> • The practitioner is able to lead, develop and integrate practices in wider inter-agency work to ensure timely and integrated, person focussed services. • Assessed through individual and family satisfaction and performance outcome measures team and wider impact on performance in order to identify good practice and implement necessary changes.
------------------	---

Step 4 Actions

10. Undertake a self assessment of MDT performance against the three core capabilities
11. Production of MDT based development plans aligned with local organisational development strategies
12. Agree the ongoing process for the identification, alignment and production of resources to support an overarching joint MDT Development Plan

Action Notes:

Step 5: A Practical Process

Engaging the Organisation

Across organisations in Wales there is already a large and diverse group of people who provide organisational and technical support, development and advice to practitioners working alongside and within MDTs. They can be found in a wide range of roles and settings:

- Placement Advisors
- Specialist Assessors
- Case Managers
- Complex Care Advisors
- Discharge Liaison Nurses
- Practice Development Leads
- Technical Advisors eg Law, Benefits, Health & Safety

"We have to make it easier for people to come together to coordinate care and turn multidisciplinary working into the normal method of day to day practice."

Organisations will need to review the scope and availability of experts and other specialist practitioners and managers who provide organisational and practice developmental support and advice to MDTs. The role of these experienced people in the ongoing development and improvement of multidisciplinary working will have to be considered and agreed.

Furthermore, both the MDT's membership and functions will change over time and improving practice will need to become an ongoing developmental programme of work. It will require aligning and mainstreaming activities across supporting corporate functions that also have a role in supporting, or working alongside the practicing MDTs. The existence, scope and scale of such functions will be different across partner organisations but could include, for example:

- Information and Communication Technology and Management
- Organisational Development and Training Departments
- Commissioning, Contracting and Procurement Teams
- Professional Development and Education Units
- Research and Development Departments
- Quality Assurance and Audit Committees
- Governance and Corporate Policy Units

Ideally, this pool of expertise then needs to be shared across the partner organisations to promote the best examples of multidisciplinary working corporately and drive the adoption and adaptation of a common action plan. Organisations will then be able to align local development needs with the recommendations of this Framework summarised below.

The first recommendation is therefore, to establish or delegate to an appropriate group the responsibility for taking forward this Framework on behalf of partner organisations. The nature of the work requires that this group must include people from across agencies and professions and encompass a range of experience and expertise from both operational and corporate organisational functions. This group is a form of corporate or 'Super MDT'.


"Nothing works better to stimulate and lead the change than demonstrating the same method, commitment and practice at the highest levels of the organisation. The things you think, the things you say and the things you do, have to be consistent!"

Partner organisations will need to select an appropriate mix of people from existing services and structures to form this Super MDT. Clearly it will be necessary to ensure that within each community partner organisations and agencies are appropriately represented, as the work will

inevitably span existing organisational and professional boundaries. However, as a broad guide it is recommended that this group consists of, or has close access to:

- An executive level sponsor to provide the mandate and reporting line
- Senior professional leads to engage with practitioners
- Senior management to influence business and resource planning
- Technical care assessment and planning advisors to validate new practices
- Development and training leads to help plan and align activities
- Quality or service improvement specialists to provide support in practice
- Experienced members of MDTs to champion the development work

The Super MDT will need to establish or connect to appropriate organisational structures to fulfil its primary role and lead the development and implementation of this Framework. The Super MDT will then, through adoption of the Framework action plan, identify a range of local functioning MDTs to connect with and engage in the ongoing programme of improvement. The subsequent programme of work will be a combination of organisational development aligned with the design and delivery of operational improvements in processes and practices.

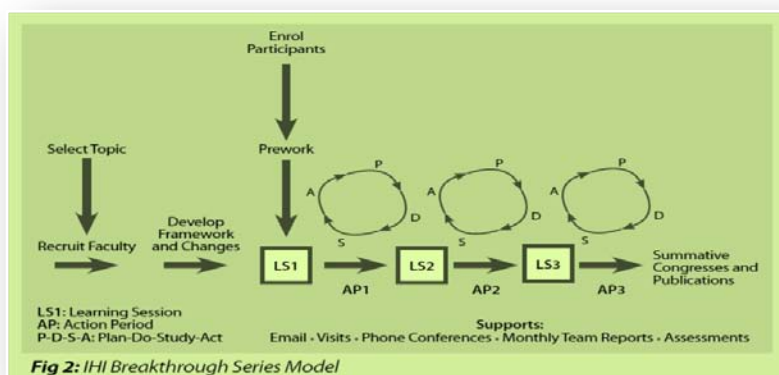
 To coordinate this work at a national level it is recommended that each Super MDT, will on behalf of their partner organisations, formally join the new 1000LivesPlus Complex Care Collaborative.

The Complex Care Collaborative

A collaborative is defined as a time-limited effort of multiple organisations that come together with facilitated support and professional guidance, to learn about and create improvements in a specific area of practice. The goal is to enable teams to share expertise and information with each other so that “everyone learns, everyone teaches”.

The expectation is that the collaborative will include Super MDTs from partner organisations across each of the Health Board areas in Wales. Plus there is an opportunity for any nationally coordinated organisations and other smaller independent services to also formally take part. Although the whole process is coordinated centrally from within 1000LivesPlus, a great deal of communication and sharing of information and experience takes place on a day to day basis using email, internet resources and other modern media.

Each specific collaborative programme is supported and guided by a steering group known as a Faculty. This high level group is formed from several key stakeholders and expert advisors, brought together to help plan, steer and validate the ongoing work of the Collaborative.



Learning Sessions

There will be 3 to 4 national learning events per year, designed to enable Super MDTs and a variety of functioning MDTs from each area, to come together present progress, analyse the outcome of local developments and collectively share the learning.

These events are the major integrative milestones, during which all of the participating organisations and teams meet with experts and collaborate to examine key challenges. This includes how to plan and implement identified changes. The collaborative methodology

advocates a single Model for Improvement, as a common approach, for accelerating improvement and overcoming obstacles to change.

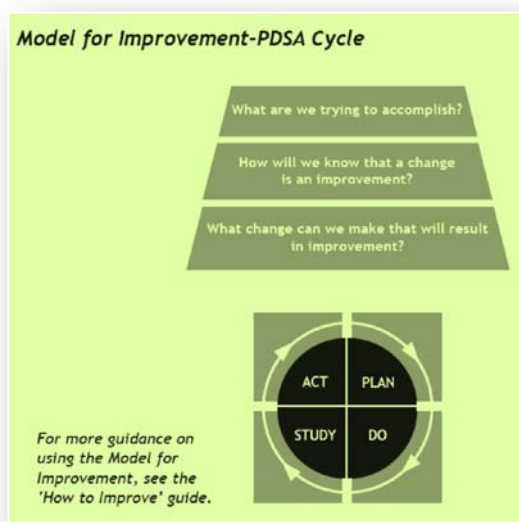
Teams leave these learning sessions with new knowledge, skills and materials that prepare them to make immediate changes. Through plenary sessions, small group discussions, and facilitated team meetings, participants have the opportunity to:

- Learn from colleagues and other invited experts
- Receive individual coaching and signposting to supporting resources
- Gather new knowledge on the subject and improvement science
- Share experiences and build collaboration into improvement plans

Action Periods

The time between the learning sessions is called an Action Period. During these periods, participants work within their organisations to create major breakthroughs in service improvement. In practice, this means achieving reliable delivery of a set of agreed interventions and spreading the practice from early testing to system wide implementation.

Although participants focus on their own organisations, they remain in continuous contact with other collaborative participants and the 1000LivesPlus programme team. This communication takes the form of conference calls, written communications and site visits to allied organisations. In addition to this, participants will share the results of their improvement efforts in regular reports.



Participation in activities during the Action Periods is not limited to those who attend the Learning Sessions. There is an expectation that a wide range of practitioners will participate in and contribute to, these periods of improvement in practice.

In summary, it is intended that establishing a national Complex Care Collaborative will provide the overarching stimulus to engage partner organisations in a collective programme of improvement. Subsequently, at a local level the collaborative will support organisations to engage with practicing MDTs and help to discover, develop and embed operational tools and techniques to improve multidisciplinary working and the management of complex care. Instructions and requirements for joining the collaborative will be published separately.

A Summary of the Story So Far

STEP 1 is 'A Common Language' around which organisations can agree to take forward the framework in partnership.

Organisations, professions and teams are working together in developing the resources required to support effective multidisciplinary working in practice. They commit to the principles of interprofessional education as the method of delivering effective multidisciplinary working going forward.

Some new resources and training programmes are necessary, but for the most part, the first steps are philosophical, taking a universal approach to educate groups together and in their functioning MDTs. The work is properly managed and planned to be gradually mainstreamed

into organisational structures and activities linking with existing allied corporate functions. The work is led by an appropriately accountable Super MDT.

STEP 2 is 'The Strategic Assurance' necessary to demonstrate that organisations are able to deliver effective multidisciplinary working.

Organisations begin the process of jointly undertaking a review of multidisciplinary working in practice. This involves adopting the 10 High Impact Changes for Complex Care as the framework for measuring improvement and conducting a review to identify MDTs, how many and how and where they currently operate.

Performance management arrangements are agreed to provide MDT based information and analysis to inform the implementation of the Framework going forward. This includes the development of operational and electronic systems to identify, capture data and demonstrate the performance of individual MDTs.

STEP 3 is 'To Manage Expectations' in an open and inclusive way so that everyone can participate to the best of their abilities.

Partner organisations establish the extent of the workforce engaged in MDTs and agree a set of core principles for multidisciplinary working in practice. These expectations are encompassed in a joint organisational policy that clarifies responsibilities for delivering the three key roles that enable effective multidisciplinary working. Organisations provide support and facilitation to help MDTs translate and embed those core principles in to ground rules for day to day practice.

A corporate campaign focuses on multidisciplinary working to raise levels of awareness in the public and allied organisations. This ensures that everyone involved is able to properly participate and are able and happy to, hold one and other to account.

STEP 4 is 'The Three Core Capabilities' that together form the underpinning principles for effective multidisciplinary working in practice.

Organisations develop a joint operational plan to address identified needs and encourage teams to drive their own practice development. Support is provided and participating MDTs undertake a self assessment to identify, plan for and address their range of capabilities against the model for effective multidisciplinary working.

Corporate coordination and facilitation is provided so that each MDT has developed its own outline training needs analysis. Joint training is developed and delivered to support practitioners to collectively achieve the skills, knowledge, talent and values required within their MDT. Bespoke support, facilitation, coaching and mentorship are provided for ongoing development of the participating MDTs.

STEP 5 is 'A Practical Process' to support practitioners to develop and embed the knowledge, skills, talent and values for effective multidisciplinary working.

The wealth of established knowledge in multidisciplinary working, together with the breadth and depth of experience in practice, across partner organisations is harnessed and focussed.

The work is coordinated nationally through the Complex Care Collaborative formed from the Super MDTs who in turn, establish local networks with functioning MDTs to support and implement improved practices. The bold and achievable goal is to bring together the theory and the practice into a single structure that will support organisations, communities, teams and individuals to embed the most effective multidisciplinary practice for them.



Step 5 Action Plan

Ref	Description of Action	Exactly Who; Does What; By when
1	Convene, or delegate to, an appropriate multidisciplinary group to lead this work and hold responsibility for taking forward the framework on behalf of partner organisations.	
2	Commit to jointly align training and resources to support multidisciplinary working using the principles of Interprofessional Education.	
3	Facilitate joint learning and wherever possible offer training and education to functioning MDTs as a group.	
4	Identify the scale and scope of functioning MDTs across the partner organisations.	
5	Adopt the 10 High Impact Changes for Complex Care as the structure for measuring improvement.	
6	Implement operational and technological systems for producing MDT based performance information.	
7	Develop joint standards for the involvement of practitioners who participate in MDTs.	

Ref	Description of Action	Exactly Who; Does What; By when
8	Engage with MDTs to translate standards in to ground rules for day to day practice.	
9	Develop a public engagement process to explain the ground rules and promote individual rights to active participation in MDTs.	
10	Undertake a self assessment of MDT performance against the three core capabilities.	
11	Production of MDT based development plans aligned with local organisational development strategies.	
12	Agree the ongoing process for the identification, alignment and production of resources to support an overarching joint MDT Development Plan	
13	Review the scope and availability of experts and other specialist practitioners and managers who provide support and advice to functioning MDTs.	
14	Partner organisations through their Super MDTs formally sign up to the national Complex Care Collaborative.	
15	Super MDTs complete this action plan to detail local actions and timescales for delivery and the review of progress against the Framework.	

Appendix 1 – Professional Roles

The following request for information was emailed to contacts of Professional Representative Organisations in Wales, including: Royal College of Psychiatrists; Crossroads Care Cymru; British Medical Association; British Dietetics Association; British Psychological Society; Society of Chiropractors and Podiatrists; Royal College of Nursing; College of Occupational Therapy; General Practitioners Committee; Care Forum Wales; Chartered Society of Physiotherapists; Royal Pharmaceutical Society; British Association of Social Workers; Royal College of Physicians; Royal Society of Speech & Language Therapists.

The Continuing NHS Healthcare National Programme supported by the Welsh Assembly Government has undertaken to produce a national framework of guidance and practical resources to support the implementation, development and improvement of multidisciplinary working across Wales. The attached briefing outlines the background and plan to develop the initial guidance by the end of March 2011. Over the next two months, the Programme will be working in partnership with the University of Glamorgan to develop and draft the initial guide together with the production of a short teaching film aimed at explaining the framework and the underpinning philosophy for multidisciplinary working. Dr Carolyn Wallace and Mrs Janine Davies from the Faculty of Health Sport & Science are dedicating time to the project and will undoubtedly be in touch as the work progresses.

To steer this development the project team has established an expert reference group made up of practitioners across a number of professions and agencies that have practical experience of, or intellectual interest in this field of work. A number of people from across Wales are already involved and this group will be the equivalent of a super MDT to debate, validate, comment and advise on the developing framework. The reason for contacting you is twofold:

- Firstly, a section of the initial publication is dedicated to summarising the distinct role or contribution of each profession within the Multidisciplinary Team. The people best placed to articulate that role are those organisations that collectively represent practitioners within those professions. Subsequently, I would be grateful if you would agree to write a vignette up to 300 Words or roughly one side of a page, to describe your professions' unique role within the MDT. Please be specific to the profession, rather than general issues such as conduct, and write in a style and with language that would make sense to a layperson. Hopefully, you already have access to some text that fits the bill and there will be an opportunity to see every other contribution and make amendments prior to the final draft. It would be really helpful if your contribution could reach me by the end of February.
- Secondly, I need to ensure that there is an opportunity for professionals to engage with the Project Team. We already have a number of practitioners who have volunteered to support the work and join the reference group however, a more formal link with yourselves would be really helpful as a source of insight, advice and signposting from a professional perspective. If you'd like to nominate someone, other than yourself, they need only email me to confirm their contact details.

So far I have a list of 32 different professions and have not contacted everyone. I am not underestimating the contribution of any particular group, however, this initial work will concentrate on those professions that regularly engage in multidisciplinary care planning for people with complex needs. So one last request, if you know the contact details of any other appropriate professional groups in Wales that you feel should be involved, please let me know.

It's been quite a task trying to track down the right people, so apologies if you are not the right person. If you require any further information, please feel free to get in touch with me directly.

Regards

Matt Wyatt

**Continuing NHS Healthcare National Programme
Innovation & Improvement**

☎ (+44) 02920742504

☎ (+44) 07817887316

✉ matt.wyatt@wales.nhs.uk

📍 Monmouth House, UHW, CARDIFF CF14 4XW

Responses are as follows:

Royal College of Psychiatrists

(Extract: 'The Role of the Psychiatrist in health services' Professor D Bhugra 2009)

A psychiatrist is a medically-qualified doctor who deals with mental illness, as well as the interaction between physical and mental illness. It is well established that a significant proportion of physically ill patients will also suffer from mental illness. An equally large number of patients with mental illness will have physical problems, either contributing to their illness or as a sequel of their mental illness. A major advantage of psychiatry training is learning about psychological and social causation in addition to medical knowledge in aetiology and the management of mental illness. Psychiatrists are thus best placed to use integrated bio-psychosocial models in understanding the aetiology of mental illness and managing mental illness, emotional disturbance and abnormal behaviour. This is what makes us different from other disciplines.

Psychiatry, like other branches of medicine, is a patient focused speciality. Patient-centred Psychiatry depends upon delivering care which is patient focused. Patient-centred care is defined as "(Care) which explores the Patients' reasons for their visit, their concerns and need for information, seeks an integrated understanding of the patient's world i.e. their whole person, emotional needs and life issues and finds common ground on what the problem is and mutually agrees on management, enhances prevention and health promotion and enhances the continuing relationship between the patient and the doctor" (Stewart 2001:445).

The core of the therapeutic intervention is doctor-patient interaction which has six components as illustrated in 'six interactive components of the patient-centred process (After Brown et al 2003):

- Exploring both the disease and the illness process
- Understanding the whole person
- Finding common ground
- Incorporating health promotion and prevention
- Enhancing doctor-patient relationship
- Being realistic

As professionals, psychiatrists are committed to the mental well being of their patients and treating mental illness using ethical practice, following professional standards, high personal standards and setting high standards with self-regulation. Elements of professionalism will be expanded in a later document but include among others: altruism; integrity and honesty; compassion and caring; morality and codes of ethics; responsibility to self, profession and society; commitment to excellence; accountability and self-awareness. A good psychiatrist will be able to demonstrate commitment to their patients, profession and society through ethical practice, self-regulation and sustainable practice.

A psychiatrist is a clinician – dealing with mental illness in all its variations – who delivers expert clinical care for mentally ill individuals, usually within a team. They are able to diagnose and manage the complex end of the illness spectrum (diagnosing and managing complicated and complex cases and working with the society and communities they serve to prioritise cases and function effectively within available resources). They are also experts in managing simple cases which may become complex in the hands of inexperienced clinicians. They also have a role in running services, managing resources, teaching, training, researching, developing and delivering acceptable and accessible services with clear involvement in leadership roles and abilities. According to the BMA, the consultant (psychiatrist's) role is to:

- Demonstrate the competence and experience to cover complex cases e.g. more than one condition (or simple conditions that may have become complex as a result of handling by inexperienced clinicians)
- Train, supervise (and mentor) trainees and junior doctors
- Accept ultimate responsibility for the care of all patients referred to their service (under their leadership even if treatment is being carried out by others)

- Provide definitive (clinical) opinion and treatment that cannot be provided or managed in primary care

The central role of a consultant is as a medical expert to provide high quality patient care. Delivery of care is interconnected with other roles such as ability to communicate, manage, innovate, educate and train. The primary objective of a psychiatrist is to use expert knowledge of psychiatry and personal skills to diagnose and treat patients with mental illness, retaining ultimate clinical responsibility for their care. An awareness of the evidence base or lack thereof and consequent acknowledgement of this is crucial in functioning well in clinical settings. The spirit of scientific enquiry is vital in clinical functioning. Healing may not be evidence based, but treatment can be. Medical and psychiatric decision cannot be automated. The patient must be viewed and treated in their world – with proximal factors such as employment, family and distal factors such as community, society, and cultures. Delivery of optimal health care which will be accepted by the patients and their carers depends on accurate diagnosis, treatment plans and adequate resources along with effective communication. Psychiatrists must be good role models and try to inspire and motivate colleagues and team members.

Crossroads Care Cymru

(The Carers contribution to the multidisciplinary team)

There are approximately 350,000 carers in Wales of whom 75,000 of care for more than 20 hours per week. Recent information suggests that there are also approximately 46,000 young carers who are at increased risk of being disregarded by professionals due to their age. Health and Social Care in Wales therefore has a large unpaid and in many cases untrained workforce.

Carers are valuable members of the MDT as they can give unique information about the person concerned gathered from observations of normal life often over 24 hours a day 365 days a year. This extent of understanding is particularly useful when assessing, planning and delivering care for those people whose behaviour patterns can change considerably depending on their immediate environment.

Carers need a full explanation of any assessed changes in need, the effect of any resultant treatments or interventions and the rationale for recommendations, actions and services that form part of the ongoing plan of care.

This is particularly pertinent when the cared for person, will be returned to their carer and for that treatment to be carried through effectively the members of the MDT need to ensure the carer understands and has any relevant training and information. Furthermore, that any subsequent needs of the carer are properly identified assessed and incorporated into forward planning.

The format and sometimes the timing of an MDT, needs to follow an underpinning ethos of inclusion and valuing all participants including carers, particularly those carers in full time employment.

Carers are partners in care and as such are entitled to be listened to and heard and supported by a range of relevant information and services, to enable them to have choice and control over their own health and wellbeing. The Welsh Government is taking this forward with the Carers Measure and partner organisations have individual and collective responsibilities for engaging with carers. With the right education and support carers can be expected to:

- Have a clear understanding of their role within the MDT
- Make reasonable arrangements to participate in MDT processes
- Fulfil the role of advocate for the person concerned
- Be helped to seek advocacy and support for themselves
- Bring insight into MDT of normal activities of living and support arrangements
- Where appropriate provide written information and advice

- Proactively participate in all decision making processes
- Ensure decisions and decision making processes are properly documented
- Ensure explanations of professional opinion are properly explained
- Receive copies of appropriate documentation
- Help to predict consequences of care planning options
- Contribute to a comprehensive carer assessment
- Where appropriate help to communicate and explain MDT processes and care planning options and consequences with the person concerned

British Dietetics Association

(The Dietitians' Role within the multi-disciplinary team)

Dietitians work across all areas of the care pathway from prevention and community health services through to specialist tertiary services and across a variety of different settings. As such, they are working in a wide range of multi-disciplinary teams and there is an increased emphasis on an interdisciplinary and transdisciplinary team approach to care for people at both the acute and community level.

The role of the dietitian can be wide-ranging from the traditional nutritional management through to a whole systems approach encompassing screening, assessment, diagnosis and organisation of the modified prescription within a dynamic nutritional framework. A person-centred approach is essential to provide nutrition in a modality which not only sustains nutrition and hydration integrity but also serves to enhance the individual's quality of life.

Dietitians within multidisciplinary teams will:

- Translate the most up to date scientific research on food, health and disease, into practical guidance to enable people to make appropriate lifestyle and food choices
- Provide clinical expertise and leadership in the assessment and diagnosis of diet and nutrition problems
- Advise on nutritional requirements and appropriate feeding routes
- Educate/support service users/carers/patients in relation to nutrition
- Provide advice and training to members of the multi-disciplinary team in areas of nutrition and diet
- Provide expertise in the area of nutrition strategy/policy development

More specifically, a dietitian's role will differ depending on the multi-disciplinary team they work within. Dietitians for example, as key members of stroke teams will be involved along the length of the care pathway in: primary prevention through public health nutrition, early intervention through assessment and advice on nutritional requirements, dysphagia and the management of eating, drinking and swallowing difficulties, rehabilitation and advice on nutritional requirements, long term review and monitoring, secondary prevention with advice on diet and lifestyle changes to reduce the risk of second strokes and improve the management of conditions such as hyperlipidaemia, diabetes and hypertension. 4

British Psychological Society

('The role of the clinical psychologist in the multi-disciplinary team': J Hunt)

The clinical psychologist applies psychological theory to clinical practice in work with individuals and families, groups, teams and organizations. Clinical psychologists as reflective scientist practitioners draw on the evidence base to inform practice. Within a multi-disciplinary context the clinical psychologist brings a psychological understanding to practice alongside the perspectives of other disciplines.

The clinical psychologist would also see it as part of their role to help the multi-disciplinary team to develop a shared understanding of work with clients, thereby clarifying and facilitating

roles of team members and interventions. This would be achieved through the process we call formulation, which involves bringing the team together to share information and perspectives and applying bio-psychosocial frameworks to this information in order to obtain a coherent understanding of the issues.

The clinical psychologist will often offer consultation and peer supervision to support multi-disciplinary colleagues and inform them of psychological aspects of their practice. This may be with individuals or with groups. Another way we might bring a psychological perspective to clinical work is to deliver teaching to our colleagues.

More generally clinical psychologists recognise there is a relationship between the effective working of the team and organization and the effectiveness of work directly with clients. In order to facilitate effective practice the clinical psychologist may through the application of psychological theory work with the multi-disciplinary team or organization in order to enhance effective team working and organizational practices.

Clinical psychologists undertake audit and research in a multi-disciplinary setting in order to evaluate, deliver and innovate services. Findings from such research may be used to lead service developments and in some multi-disciplinary teams the psychologist may have a more defined leadership role.

Royal College of Nursing

(The Role of Nursing in the MDT)

Nursing is described as “the use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death” (RCN, 2003)

A meeting at RCN Congress, 2002 considered the purpose of nursing, and there was a clear consensus among 100 participants. Six key purposes emerged.

- To promote and maintain health.
- To care for people when their health is compromised.
- To assist recovery.
- To facilitate independence.
- To meet needs.
- To improve/maintain well being/quality of life. (RCN, 2003)

The conditions that give rise to a need for nursing most commonly relate to the following:

A self-care deficit: The person's inability to manage unaided those physiological, psychological, or social processes which are necessary to recover, maintain, or improve health.

A knowledge or motivational deficit: The person's lacks of knowledge, understanding or will to behave in ways that are necessary to recover maintain or improve health.

- Physiological or psychological instability.
- Pain or discomfort (physical, psychological or spiritual).
- An identified risk of any of the above. (RCN, 2003)

Manley K et al (2011) describe the contemporary focus for nurses, as for other members of the healthcare team, as being increasingly on healthcare outcomes and their measurement, rather than the processes through which outcomes are achieved.

In its definition of nursing, the RCN (2003) makes explicit the outcomes of nursing in relation to health, specifically health maintenance, improvement, recovery, coping and achievement of the best possible quality of life for each person.

The RCN (2009a) suggests that the way nursing achieves outcomes is primarily threefold:

- By providing individualised patient care. Today, this is perceived not only as an outcome in its own right, but also as one bound up with the achievement of health outcomes.

- By providing safe and effective care, based on blending different types of evidence to support decision making aimed at achieving health-related outcomes and quality of life, as judged by the person.
- By developing the context and culture that enables person-centred, safe and effective care to be sustained by all members of the healthcare team. (From Manley, 2011)

In this environment, the Principles of Nursing Practice (RCN, 2010) have been developed as a set of overarching statements that describe what can be expected of nursing. They cover quality nursing care in all settings, regardless of whether the immediate provider is a registered nurse, healthcare assistant, assistant practitioner or nursing student. The Principles of Nursing Practice describe what everyone can expect from nursing:

- Nurses and nursing staff treat everyone in their care with dignity and humanity – they understand their individual needs, show compassion and sensitivity, and provide care in a way that respects all people equally.
- Nurses and nursing staff take responsibility for the care they provide and answer for their own judgments and actions – they carry out these actions in a way that is agreed with their patients, and the families and carers of their patients, and in a way that meets the requirements of their professional bodies and the law.
- Nurses and nursing staff manage risk, are vigilant about risk, and help to keep everyone safe in the places they receive health care.
- Nurses and nursing staff provide and promote care that puts people at the centre, involves patients, service users, their families and their carers in decisions and helps them make informed choices about their treatment and care.
- Nurses and nursing staff are at the heart of the communication process: they assess, record and report on treatment and care, handle information sensitively and confidentially, deal with complaints effectively, and are conscientious in reporting the things they are concerned about.
- Nurses and nursing staff have up-to-date knowledge and skills, and use these with intelligence, insight and understanding in line with the needs of each individual in their care.
- Nurses and nursing staff work closely with their own team and with other professionals, making sure patients' care and treatment is co-ordinated, is of a high standard and has the best possible outcome.
- Nurses and nursing staff lead by example, develop themselves and other staff, and influence the way care is given in a manner that is open and responds to individual needs.

College of Occupational Therapists

(The role of the Occupational Therapist in a multidisciplinary team approach to the management of complex care)

Occupational therapy is based on the knowledge that human beings are occupational in nature: that what we do each day gives purpose and meaning to our lives. There is clear evidence that being in good work is good for our mental and physical health and wellbeing. Not feeling we have achieved anything meaningful has a detrimental effect of health, development and life satisfaction. Occupations are not just work but all the things we do in our lives and daily routines: showering, dressing, cooking, playing working or caring for others.

The unique contribution of occupational therapy is the focus on enabling people to maximise their independence and control, resulting in increased life satisfaction, health and social inclusion.

The core skill of the occupational therapist is analyzing the individual, their chosen occupation and the social and physical environment to create a practical solution to any barrier to

participating in occupations. We maximise skill of the individual through rehab programmes, but we also adapt or amend the task to make it suit the abilities of the person and we amend or adapt the environment. That includes the physical environment so we may use equipment of adaptation of homes and workplaces, or the social environment and looking at groups, family relationships, social inclusion and participation

Complex health care, packages of care are not easily definable, are not straightforward and are not reproducible. They have to be individually tailored to meet individual's unique needs. It takes a range of health, social care, and third sector staff to contribute to these complex interventions which in turn creates a complex system of work. An Occupational therapist working within the MDT is therefore part of whole which is greater than the sum of its parts. They are an essential member of the MDT and can be generalist or specialist.

An Occupational therapist working in the area of complex health care can work with all age groups in a variety of settings. They can work in: -

- a primary care setting such as a GP practice providing rehabilitation, advice and counselling
- a hospital setting providing rehabilitation and providing a vital contribution to safe discharge planning by ensuring discharge destination is suited to the persons needs
- an intermediate care setting where their focus is on working with the person in their own home and their local community, on facilitating early discharge from hospital and preventing admission to hospital
- in the community providing ongoing community based support geared towards maintaining that person in the place they choose to live. This may be via the provision of rehabilitation or the provision of equipment and adaptations to the home environment

An Occupational Therapist is interested in Occupational Performance. This means that they look at the occupations or activities which the individual needs or wants to do, but are prevented from doing so as a result of physical or mental illness, disability or ageing. The ultimate goal is to:

- Work in a person centred way to Promote and maximise independent living thus minimising the need for external support or ensuring any external support required is appropriately targeted.

In order to achieve this, the Occupational therapist will liaise extensively with other members of the MDT to establish person centred goals. This can result in a range of interventions, for example:

- Rehabilitation of optimal function following illness or disease. For example, using meaningful activity to achieve optimal recovery.
- Working with formal or informal carers, to deliver support in a way which maximises the person's choice, control, dignity and independence.
- Anticipation of needs in order to provide timely intervention for example to ensure the right equipment is available at the right time
- Incorporating therapeutic principles into the persons 24 hour daily care plan in order to optimise safety, care delivery and independent function. For example 24 hour postural management to ensure sleeping and sitting postures are optimised and secondary deformity or pressure damage is avoided.
- Advocate self help for condition management , for example fatigue management and relaxation / anxiety management
- Optimising symptom management, for example spasticity management and splint fabrication

Care Forum Wales

(Multi Disciplinary Team Contribution of the Independent Provider)

Whilst historically the independent sector have never been considered a member of the multi disciplinary team (MDT), circumstances have forced the NHS in particular, to consider the independent sector on a more equal footing.

The independent sector consists of individual providers providing care and support in Care Homes offering nursing and residential care and also in the domiciliary care setting. The care home provider or domiciliary care agency would not normally provide advice whilst a patient is residing in hospital (unless it is specialist advice which is required i.e. behaviour management). Once the clinicians agree that the patient is fit for discharge and the patient (who may have complex needs) requires the multi disciplinary team to devise a care package to meet their needs, the team should work closely with the care home provider or the domiciliary care home agency to devise the most suitable package of care.

In residential homes the care manager will be an experienced individual who knows what care can be provided in their home. Domiciliary Home Care agencies often work with other professionals in the community i.e. district nurses, some of these care packages provide support to individuals who previously would not have been managed in the community. Nursing Homes provide support to individuals with increasing complex needs the trained nurses who provide a contribution to the MDT are skilled in understanding the levels of support required and what potential the individual may have for recuperation.

Patient dependency on discharge from hospital has increased, in particular the frail elderly and elderly mental infirm. The independent sector have an insight to what care can reasonably be provided in care homes and in the community, without their support a care package could fail and the patient admitted back into hospital.

Chartered Society of Physiotherapy

(Distinct Role of Physiotherapy within the Multi Disciplinary Team)

Physiotherapy enables people of all ages (children, young people and adults) to move and function as well as they can, maximising their quality of life, potential for education and life-long learning, social wellbeing, physical and mental health.

Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity; to support people in managing their own condition and maintaining their independence; and to prevent future episodes of ill health and disability. This may involve the provision of specialist equipment, mobility aids, splints and supports.

Physiotherapists work across the whole spectrum of the population (from cradle to grave) and across a wide variety of sectors; such as hospital, community, homes, schools and workplace settings. Physiotherapists will therefore be members of a wide range of multi disciplinary, inter disciplinary and multi-agency teams.

Physiotherapists have a key role to play in health promotion through the promotion of the health benefits of regular physical activity and in encouraging people to adopt and maintain a healthy lifestyle.

Physiotherapists also facilitate early intervention, support patient self-management, promote independence and help prevent injuries and falls. Through early intervention they can help minimise episodes of ill health and prevent them developing into chronic conditions.

Physiotherapy brings evidence based knowledge and clinical skills to the multidisciplinary team in relation to identifying what limits an individual's movement and performance and to helping individuals decide how to address their needs. The Royal Charter gives physiotherapy a broad

scope of practice that includes manual therapy, exercise and movement, electrotherapy and other physical approaches.

Physiotherapy is an autonomous profession. This means that physiotherapists can accept referrals for assessment from a range of sources: from an individual themselves (self-referral) or from other people involved with that individual.

Royal Pharmaceutical Society

(The role of pharmacy in multidisciplinary team working)

Pharmacists, working in hospital, community and primary care settings are the experts in medicines. They perform a crucial role in the treatment and management of almost every medical condition and contribute to quality care across care pathways in the NHS; prescribing, preparing, dispensing and monitoring the effectiveness of medicines.

The role of pharmacists shouldn't be viewed in isolation from care services provided by other health professionals however. Planners of services should instead focus on the additional value to patients and the NHS that can be achieved when pharmaceutical care is harnessed through formalised collaboration between pharmacists and other health and social care professionals. Pharmacist membership of multidisciplinary teams engaged in the systematic management of health conditions has great potential to deliver better health outcomes for patients, make better use of NHS resources, support transfers of care from hospital to community settings, and in certain cases help to release capacity in parts of the NHS.

There are already excellent examples in Wales where pharmacists are making a difference to patient care as part of multidisciplinary teams. For instance a multidisciplinary model of care was developed in the Abertawe Bro Morgannwg and Cwm Taf Health Board areas to replace a haematologist-led service and improve the capacity of the NHS to address the administration and monitoring of patients taking high risk anticoagulants including Warfarin and Heparin. This community based model was developed to provide a one-stop-shop service with accredited pharmacist and nurse prescribers working with other professionals to provide consultations, point of care testing, results, changes to dosage, and counselling to deal quickly and efficiently with any anomalies in INR results. This service utilises the skills of a range of health professionals to help increase patient safety, improve health outcomes, and improve the capacity of the NHS to see the most complex cases in a timely manner.

Other examples in Wales include the redesign of a secondary care service to treat rheumatoid arthritis with biologic agents. Such therapy requires intensive monitoring and the role of the pharmacist in the team is crucial. Working alongside the Consultant Rheumatologist and the Specialist Rheumatology Nurse, this service utilises the skills of the pharmacist in a joint role to assess patients in accordance with NICE guidelines, review their medication response, adjust or stop their medication as appropriate, and to take steps to ensure the response to the biologic agent is maximised. This service model has demonstrated the value of multidisciplinary care and the need for service redesign. It has made considerable savings and has enabled greater numbers of patients requiring biologic therapy to be treated.

For more information on the role of the pharmacist in multidisciplinary care please contact the Royal Pharmaceutical Society in Wales on 02920 730310 or Wales@rpharms.com

British Association of Social Workers

(The Social Work role within Multi-disciplinary Teams taken from the British Association of Social Workers 'Code of Ethics for Social Work')

The British Association of Social Workers (BASW) Cymru has adopted the following definition of social work issued by the International Federation of Social Workers and the International Association of Schools of Social Work. It applies to social work practitioners and educators in every region and country in the world.

- 'The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work (2001).

Social workers attempt to relieve and prevent hardship and suffering. They have a responsibility to help individuals, families, groups and communities through the provision and operation of appropriate services and by contributing to social planning. They work with, on behalf of, or in the interests of people to enable them to deal with personal and social difficulties and obtain essential resources and services. Their work may include, but is not limited to, interpersonal practice, group work, community work, social development, social action, policy development, research, social work education and supervisory and managerial functions in these fields.

Social Work is committed to five basic values:

- Human dignity and worth
- Social justice
- Service to humanity
- Integrity
- Competence

Social work practice should both promote respect for human dignity and pursue social justice, through service to humanity, integrity and competence.

Appendix 2 - Bibliography

- Allen, D., P. Lyne, et al. (2002). Studying complex caring interfaces: key issues arising from a study of multi-agency rehabilitative care for people who have suffered a stroke. *Journal of Clinical Nursing* 11(3): 297-305.
- Anderson, E., Manek, N., Davidson, A., (2006) Evaluation of a model for maximising interprofessional education in an acute hospital. *Journal of Interprofessional Care* 20(2) 182-194
- Alter, C., Hage, J., (1993) Organizations working together. Newbury Park, Ca. Sage Publications
- Atwal, A. (2002). A World Apart: How Occupational Therapists, Nurses and Care Managers Perceive Each Other in Acute Health Care. *The British Journal of Occupational Therapy* 65(10): 446-452.
- Atwal, A. and K. Caldwell (2006). Nurses' perceptions of multidisciplinary team work in acute health-care. *International Journal of Nursing Practice* 12(6): 359-365.
- Baldwin, D.C. Jr., & Baldwin, M.A. (2007). Interdisciplinary education and health team training: A model for learning and service. *Journal of Interprofessional Care*, 21(S1), 52-69.
- Barr, O (1997). Clinical management. Interdisciplinary teamwork: consideration of the challenges. *British Journal of Nursing* 6(17): 1005-1010.
- Barr H (1998) Competent to collaborate: towards a competency-based model for interprofessional education. *Journal of Interprofessional Care*. 12(2): 181-8
- Barr, H., (2000) Working together to learn together: learning together to work together. *Journal of Interprofessional Care*. 14; 177-9
- Barnes, D., Carpenter, J. and Dickinson, C. (2000) Interprofessional education for community mental health: Attitudes to community care and professional stereotypes. *Social Work Education* 19(6) 565-583
- Bauer, M., L. Fitzgerald, E. Haesler & M. Manfrin (2009). Hospital discharge planning for frail older people and their family. Are we delivering best practice? A review of the evidence. *Journal of Clinical Nursing* 18: 2539-2546.
- Baxter, S. K. and S. M. Brumfitt (2008). Professional differences in interprofessional working. *Journal of Interprofessional Care* 22(3): 239-251.
- Beech, R., W. Russell, R. Little, Sherlow-Jones, S. (2004). An evaluation of a multidisciplinary team for intermediate care at home. *International Journal of Integrated Care* 4: e02-e02.
- Boon, H., Verhoef, M., O'Hara, D., Findlay, B., (2004) From parallel practice to integrative health care a conceptual framework. *BMC Health Service Research*. [online] available from <http://www.biomedcentral.com/1472-6963/4/15> [accessed on 24th October 2009]
- Borrill, C. S., J. Carletta, A. J. Carter, J. F. Dawson, S. Garrod, A. Rees, A. Richards, D. Shapiro & M. A. West (2002). *Team Working and Effectiveness in Health Care* [WWW document]. Aston Centre for Health Service Organisation Research, University of Aston, Aston.
- Brown, J (1992). Profession in teams, in: Thompson T & P. Mathais (eds.) *Standards and Mental Handicap: Keys to Competence*. Bailliere Tindall. London: 371-85.

- Bull, M. J. and J. Roberts (2001). Components of a proper hospital discharge for elders. *Journal of Advanced Nursing* 35(4): 571-581.
- Carrier, J. & Kendall, I. (1995) 'Professionalism and interprofessionalism in health and community care: some theoretical issues', in *Interprofessional Issues in Community and Primary Health Care*, eds P. Owens, J. Carrier & J. Horder, Macmillan, Basingstoke.
- Carroll J & Johnson E (1990) *Decision Research: A field Guide*. California. Sage
- Centre for the advancement of Interprofessional Education: Principles for IPE January 2011 [online]
<http://www.caipe.org.uk/resources/principles-of-interprofessional-education/> [Accessed on 4th September 2011]
- Challis, D., M. Abendstern, et al. (2010). Comprehensive assessment of older people with complex care needs: the multi-disciplinarity of the Single Assessment Process in England. *Ageing & Society* 30(07): 1115-1134
- Clark, P G., (2011) Examining the interface between interprofessional practice and education: Lessons learned from Norway for promoting teamwork. *Journal of Interprofessional Care* 25: 26-32
- Clarke, D. J. (2010). Achieving teamwork in stroke units: The contribution of opportunistic dialogue. *Journal of Interprofessional Care* 24(3): 285-297.
- Dainty, P. & J. Elizabeth (2009). Timely discharge of older patients from hospital: improving the process. *Clinical Medicine* 9 (4): 311-314.
- Ellis G, P. Langhorne (2005). Comprehensive geriatric assessment for older hospital patients. *British Medical Bulletin*. 71(1): 45-59.
- Elissen, A., van Raak, A., Paulus, A., (2011) Can we make sense of multidisciplinary co-operation in primary care by considering routines and rules? *Health and Social Care in the Community* 19(1) 33-42
- Furness, PJ., Armitage, H., Pitt, R., (2011) An evaluation of practice-based interprofessional education initiatives involving service users. *Journal of Interprofessional Care* 25: 46-52
- Gair, G. and T. Hartery (2001). Medical dominance in multidisciplinary teamwork: a case study of discharge decision-making in a geriatric assessment unit. *Journal of Nursing Management* 9(1): 3-11.
- Hallett, C. & Birchall (1992). *Co-ordination and child protection*. London: HMSO.
- Healy, J., C. R. Victor, A. Thomas & J. Seargeant (2002). Professionals and post-hospital care for older people. *Journal of Interprofessional Care* 16(1): 19-29.
- Interprofessional Education Team (2010) *Interprofessional Capability Framework 2010: Mini-Guide*. Sheffield University. Higher Education Academy . Health Sciences and Practice [online]
<http://www.health.heacademy.ac.uk/doc/resources/icf2010.pdf>
- Johansson, G., K. Eklund, G. Gosman-Hedstrom. (2010). Multidisciplinary team, working with elderly persons living in the community: a systematic literature review. *Scandinavian Journal of Occupational Therapy* 17(2): 101-116.
- Kapral O, (2011) Healthcare Managers on Interprofessional teams. *Journal of Interprofessional Care* 25 (1) 77-78

Kendall, E., Muenchberger, H., Catalano, T., Amsters, D., Dorsett, P., Cox, R., (2011) Developing core interprofessional competencies for community rehabilitation practitioners: findings from an Australian study. *Journal of Interprofessional Care* 25(2) 145-151

Leah V, J. Adams (2010). Assessment of older adults in the emergency department. *Nursing Standard* 24(46): 42-45.

Leutz, W N.,(1999) Five laws for integrating Medical and Social Services: Lessons from the United States and the United Kingdom. *The Millbank Quaterly*, 77(1), 77- 110

Leutz, W., (2005) Reflections on Integrating Medical and Social Care: Five Laws Revisited. *Journal of Integrated Care*, 13(5), 3-12

Lliffe, S. (2008) Myths and realities in multidisciplinary team-working. *London Journal of Primary Care* 1: 100-102.

Long, A. F., R. Kneafsey & J. Ryan (2003). Rehabilitation practice: challenges to effective team working. *International Journal of Nursing Studies* 40(6): 663-673.

Manley K *et al* (2011) in *Principles of Nursing Practice: development and implementation. Nursing Standard*. 25, 27, 35-37

Mead G, Ashcroft J (2005). The case for interprofessional collaboration in health and social care. CAIPE Blackwell Publishing

Monaghan, J., K. Channell, D. McDowell, A. K. Sharma (2005). Improving patient and carer communication, multidisciplinary team working and goal-setting in stroke rehabilitation. *Clinical Rehabilitation* 19(2): 194-199.

Morey, J.C., R. Simon, G.D. Jay, R.L. Wears, M. Salisbury, K.A. Dukes and S.D. Berns. 2002. Error Reduction and Performance Improvement in the Emergency Department through Formal Teamwork Training: Evaluation Results of the MedTeams Project. *Health Services Research* 37(6): 1553-81.

Morrison S, Boohan M, Moutray M, Jenkins J. Developing pre-qualification interprofessional education for nursing and medical students: sampling student attitudes to guide development. *Nurse Education Practice* 4: 20–9.

Morrison, S., (2004) Holism and interprofessional learning: from the whole patient to the whole team. *Journal of holistic Healthcare* 1(1) 15-18.

Oandasan, I., G.R. Baker, K. Barker, C. Bosco, D. D'Amour, L. Jones, S. Kimpton, L. Lemieux-Charles, L. Nasmith, L. San Martin Rodriguez, J. Tepper and D. Way. 2006. *Teamwork in Healthcare: Promoting Effective Teamwork in Healthcare in Canada*. Ottawa: Canadian Health Services Research Foundation.

Older People's Commissioner for Wales (2011) *Dignified Care: the experiences of older people in hospital in Wales*.

Oliver, D. (2005). Medical input, rehabilitation and discharge planning for patients with hip fracture: Why traditional models are not fit for purpose and how things are changing. *Current Anaesthesia & Critical Care* 16(1): 11-22.

Ovretveit, J. (1995). Team decision-making. *Journal of Interprofessional Care* 9(1): 41-51.

Pethybridge, J. (2004). How team working influences discharge planning from hospital: a study of four multi-disciplinary teams in an acute hospital in England. *Journal of Interprofessional Care* 18: 29-41.

Pollard, K. (2008) Non-formal learning and interprofessional collaboration in health and social care: The influence of the quality of staff interaction on student learning about collaborative behaviour in practice placements. *Learning in Health and Social Care*, 7 (1) 12-26.

Powles D (2009) Team Working the 7 Habits Paradigm (Power point slides) (Retrieved from [https://blackboard.glam.ac.uk/webapps/portal/frameset.jsp?tab_tab_group_id= 5_1&url=%2Fwebapps%2Fblackboard%2Fexecute%2Flauncher%3Ftype%3DCourse%26id%3D_24069_1%26url%3D](https://blackboard.glam.ac.uk/webapps/portal/frameset.jsp?tab_tab_group_id=5_1&url=%2Fwebapps%2Fblackboard%2Fexecute%2Flauncher%3Ftype%3DCourse%26id%3D_24069_1%26url%3D))

Proctor-Childs, T., M. Freeman, C. Miller (1998). Visions of teamwork: the realities of an interdisciplinary approach. *International Journal of Therapy and Rehabilitation* 5(12): 616-635.

Reid, R., Bruce, D., Allstaff, K., McLernon, D., (2006) Validating the Readiness for Interprofessional Learning Scale (RIPLS) in the postgraduate context: are health care professionals ready for IPL? *Medical Education* 40:415-422

Royal College of Nursing (2003) *Defining Nursing*. RCN, London.

Royal College of Nursing (2009a) *Measuring for Quality in Health and Social Care*. RCN position statement. RCN, London.

Royal of College of Nursing (2010) *Principles of Nursing Practice*. RCN, London

Sims, D (2011) Achieving Collaborative Competence through Interprofessional Education. Lessons Learned from Joint Training in Learning Disability Nursing and Social Work', *Social Work Education*, 30: 1, 98 — 112

Tierney, A. J. and J. Vallis (1999) Multidisciplinary teamworking in the care of elderly patients with hip fracture. *Journal of Interprofessional Care* 13(1): 41-52.

Tornkvist, L., Hegefjard, C., (2008) Evaluation of interprofessional training in home care. *Journal of Interprofessional Care* 22(5) 509-520

Victor, C. R., J. Healy, A. Thomas & J. Seargeant (2000). Older patients and delayed discharge from hospital. *Health & Social Care in the Community* 8(6): 443-452.

Webster, J. (2002). Teamwork: understanding multi-professional working. *NURSING OLDER PEOPLE* 14(3).

West, M. A. (1994). *Effective Teamwork*. Leicester: BPS Books.

WEST, M. A. & B. C. Poulton (1997). A failure of function: teamwork in primary health care. *Journal of Interprofessional Care*, 11: 205-216.

While, A. and K. L. Barriball (1999). Qualified and unqualified nurses' views of the multidisciplinary team: findings of a large interview study. *Journal of Interprofessional Care* 13(1): 77-89.

World Health Organization (2011) Management for Health Services Delivery: Partnership Management [online] <http://www.who.int/management/partnerships/en/>
Williams, G. and P. Laungani (1999). Analysis of teamwork in an NHS community trust: an empirical study." *Journal of Interprofessional Care* 13(1): 19-28.

Xyrichis, A. and K. Lowton (2008). What fosters or prevents interprofessional teamworking in primary and community care? A literature review. *International Journal of Nursing Studies* 45(1): 140-15

Wallace C., Davies M., (2009) *Sharing Assessment in health and social care. A practical handbook for interprofessional working.* London, Sage Publications Ltd.

Whittington, C. (2003). *Learning for Collaborative Practice with other professions and agencies. A study to inform the development of the degree in social work* London. Department of Health.

Whittington, C. 2003. *Collaboration and Partnership in Context* in Weinstein, J., Whittington, C., and Leiba T. eds. *Collaboration in Social Work Practice.* London. Jessica Kinglsey.

Appendix 3 - Summary of Studies

Study: Allen, D., P. Lyne, et al. (2002). Studying complex caring interfaces: key issues arising from a study of multi-agency rehabilitative care for people who have suffered a stroke. *Journal of Clinical Nursing* 11(3): 297-305.

Study aim: To examine some the challenges of providing integrated care across a number of agencies.

Study Design: Study Design: ethnographic case studies in 2 separate health authorities of health and social services provision to adults recovering from a first acute stroke with complex continuing care needs. The continuing care of each client – as they progressed from acute to community care – was explored for 6 months. Interview addressed issues such as team working, collaboration, communication, conflict, individuals' perceptions of their own and colleagues' legitimate work roles and responsibilities, and the role of clients and their carers. Interviews were also undertaken with the clients and their carers, focusing on their experiences of service provision.

Findings: Integrated care provision was achieved where flexible and collaborative working practices were adopted by staff from a range of agencies. At the same time, the success of delivering care packages for service users involving a range of agencies was fraught with difficulties, as it was largely dependent on negotiated arrangements that could be challenged where responsibilities were contested or trust between staff could not be established or disintegrated.

It was difficult to identify a key worker in at least half of the cases studied and this had clear implications for service provision. Recommendation that the role of lead professional be formalised and contingency plans drawn up for absences.

Co-ordination of care was deemed most effective where the lead professional in the multidisciplinary team was the person most relevant to the social and health needs of the client.

The pressures to discharge patients that hospital and social services staff face could engender conflict between planning agencies and the client's family and hinder effective partnerships.

Conclusion: The findings underline the need for investment in intermediate care and the importance of allowing a period of adjustment after hospital discharge.

Study: Atwal, A. (2002). A World Apart: How Occupational Therapists, Nurses and Care Managers Perceive Each Other in Acute Health Care. *The British Journal of Occupational Therapy* 65(10): 446-452.

Study aim: To explore occupational therapists, care managers and nurse's perceptions of discharge planning.

Study Design: Convenience sample recruited from acute wards in orthopaedics and acute medicine and in elder care.

Findings: Role ambiguity, division of labour, poor communication and personality factors were all issues that impeded teamwork.

Conclusion: Professionals need to clearly define their roles within the team and ensure that they understand the roles of other professionals.

Study: Atwal, A. and K. Caldwell (2006). Nurses' perceptions of multidisciplinary team work in acute health-care. *International Journal of Nursing Practice* 12(6): 359-365.

Study Aim: To explore nurses' perceptions of multidisciplinary teamwork in acute health-care.

Study Design: Interviews with 19 nurses-conveniently selected-nine nurses from orthopaedics, six from acute medicine and four from elder care. Direct observations of interactions between nurses and allied health professionals in meetings.

Findings: The findings of this study identified three barriers that hindered teamwork:

- Differing perceptions of teamwork resulting in ineffective teamwork. It was observed that there was no evidence of multidisciplinary team goal setting or evaluation.
- Different levels of skills acquisitions to function as a team member; Assertiveness and confidence were regarded as essential skills that one needed to possess in order to function as an effective team member.
- The dominance of medical power that influenced interaction in teams. In team meetings, there was evidence that nurses were reticent about expressing an alternative opinion for fear of being scapegoat by other members.

Conclusion: The evidence suggests that members of the medical team exerted the most power and that nurses are reluctant to voice their opinions in the multidisciplinary team and appear willing to withholding 'unpopular' information, particularly in relation to the social aspects of care.

Study: Barr, O (1997). Clinical management. Interdisciplinary teamwork: consideration of the challenges. *British Journal of Nursing* 6(17): 1005-1010

Study Aim: This article outlines a definition of and the rationale for successful interdisciplinary teamwork. It considers key organizational, professional and interpersonal challenges that need to be addressed if the present level of teamwork is to be enhanced.

Note: Interdisciplinary teamwork and Multidisciplinary teamwork are used interchangeably throughout.

Study: Bauer, M., L. Fitzgerald, E. Haesler & M. Manfrin (2009). Hospital discharge planning for frail older people and their family. Are we delivering best practice? A review of the evidence. *Journal of Clinical Nursing* 18: 2539–2546.

Study aim: This paper examined the available evidence concerning hospital discharge practices for frail older people and their family caregivers and what practices were most beneficial for this group.

Background: Hospital discharge practices are placing an increasing burden of care on the family caregiver. Discharge planning and execution is significant for older patients where inadequate practices can be linked to adverse outcomes and an increased risk of readmission.

Study Design: Literature review. A review of English language literature published after 1995 on hospital discharge of frail older people and family carer's experiences.

Results: Numerous factors impact on the hospital discharge planning of the frail older person and their family carer's that when categorised focus on the role that discharge planning plays in bridging the gap between the care provided in hospital and the care needed in the community, its potential to reduce the length of hospital stay, the impact of the discharge process on family carer's and the need for a coordinated health professional approach that includes dissemination of information, clear communication and active support.

Conclusion: The current evidence indicates that hospital discharge planning for frail older people can be improved if interventions address family inclusion and education, communication between health care workers and family, interdisciplinary communication and ongoing support after discharge. Interventions should commence well before discharge.

Relevance to clinical practice: An awareness of how the execution of the hospital discharge plan is perceived by the principal family carer of a frail older person, will allow nurses and others involved with the discharge process to better reconcile the family caregivers' needs and expectations with the discharge process offered by their facility. The research shows there is a direct correlation between the quality of discharge planning and readmission to hospital.

Study: Baxter, S. K. and S. M. Brumfitt (2008). Professional differences in interprofessional working. *Journal of Interprofessional Care* 22(3): 239-251.

Study aim: To examine joint working amongst professionals involved in stroke care, and to explore elements which impact on functioning, such as organizational conditions, team relationships, and communication systems.

Study Design: Qualitative (interviews and observation) multiple-case study-stroke care. Sample purposively selected across a typical stroke care pathway of hospital ward, specialist stroke unit, and community stroke team.

Findings: three elements of professional groupings which are significant in interprofessional working:

- Professional knowledge and skills: core competencies specific to profession but scope for exchange and sharing.
- Professional role and identity: emphasis on maintaining professional boundaries and roles and the importance of clarity re roles. Also, distinction drawn between medically orientated roles e.g. doctors and nurses and rehab orientated roles e.g. therapists. Role blurring and role substitution could also occur where necessitated
- Power and status: While hierarchical team structures were perceived to be absent or inappropriate, doctors were key to signing off on final discharge decisions.
- It was also perceived that the particular context of stroke care impacted on traditional power and status assumptions. The community site had no allocated medical staff, and participants reported that this created differences between hospital-based and community interprofessional working in terms of leadership and responsibilities.

Conclusion: The findings from this study suggest that organizational factors such as team size and regular contact were important in establishing a team rather than professional identity. Despite the prominence of medical staff in relation to decision-making, non-medical staff often joined together to influence decisions.

Study: Beech, R., W. Russell, R. Little, Sherlow-Jones, S. (2004). An evaluation of a multidisciplinary team for intermediate care at home. *International Journal of Integrated Care* 4: e02-e02.

Study aim: This paper describes an evaluation of a multidisciplinary Rapid Response Team (RRT) providing a home based alternative to care previously provided in an acute hospital bed for the population of Hereford. The RRT comprised, a senior nurse, a senior social worker, 4 general nurses, 4 (2 part-time) generic workers (unqualified staff who are trained to become competent in general tasks which cross disciplinary boundaries), and a part time administrator.

Study Design: A mixed-method descriptive design using quantitative and qualitative techniques. Over the 1 year of the service, a descriptive evaluation design was used to

monitor: the characteristics of the users of the service; the types and amounts of care that they received from the RRT; any 'adverse' events arising from that care; and the acceptability of the service to patients, carers, and health and social care professionals.

Findings: All patients received care at home (mean duration 5.6 days) with only 5.7% of patients having to be re-admitted to acute care-suggests positive outcomes for patient care. Overall, patients and carers had positive attitudes to the new service but some expressed concerns about their ability to influence the choice of care option (24.1% and 25.0% of patients and carers, respectively), whilst 22.7% of carers were concerned about the quality of information about care.

Conclusion: The findings of this evaluation suggest that the Rapid Response Team provided an 'acceptable' alternative to an extended period of care in an acute setting.

Study: Boaden, N. and J. Leaviss (2000). Putting teamwork in context. *Medical Education* 34(11): 921-927.

Study aim: Discusses professional education in relation to multidisciplinary practice and makes recommendations as to how it can be improved.

Study: Borrill, C. S., J. Carletta, A. J. Carter, J. F. Dawson, S. Garrod, A. Rees, A. Richards, D. Shapiro & M. A. West (2002) *Team Working and Effectiveness in Health Care*[WWW document]. Aston Centre for Health Service Organisation Research, University of Aston, Aston.

Study aim: This report details the findings of a major national study of team working in the NHS on the factors associated with effective team working, and the effects on quality of care and well-being of staff.

The objectives of the research were to establish:

- which team member characteristics such as age, gender, occupational group, experience, qualifications, and team size, influence how well the teams work together
- how team working processes, such as participation, reflexivity, communication, decision-making and leadership contribute to the effectiveness of teams, particularly the quality of health care and the development of innovative practice.

Study Design: Information on team working was gathered from some 400 health care teams over a three year period. Research methods included questionnaire surveys, telephone interviews, in-depth interviews, observation, focus groups and video and audio tape recordings of team meetings. Data collection from 100 primary health care teams (PHCTs), 113 community health care teams (CMHTs) and 193 secondary health care teams (SHCTs), and in-depth work with a sub-sample of teams.

Findings: Nurses working in well functioning teams were less likely to leave their organisations or professions over the one year period than those working in poorly functioning teams.

Primary health care teams that include many different professional groups, deliver higher quality patient care and implement more innovations in patient care. In primary health care teams, the research shows that in those teams that have regular meetings there are higher levels of innovation in patient care, and teams which have at least one meeting a week have introduced a greater number of (and more substantial) innovations in patient care than those which have fewer meetings.

Lack of clear leadership is also associated with poor team working. Teams without clear leadership report lower levels of participation, lack of clarity about objectives, low commitment to quality of care and low support for innovation in quality of care.

There is a significant and negative relationship between the percentage of staff working in teams and patient mortality in these hospitals, taking account of both local health needs and hospital size.

Conclusions: Health care teams that have clear objectives, high levels of participation, emphasis on quality and support for innovation, provide high quality patient care. Such teams also introduce innovations in patient care:

- Members of teams that work well together have relatively low levels of stress.
- In primary health care teams particularly, a diverse range of professional groups working together, is associated with higher levels of innovation in patient care.
- The quality of meetings, communication and integration processes in health care teams, contributes to the introduction of new and improved ways of delivering patient care.
- Clear leadership contributes to effective team processes, to high quality patient care, and to innovation.

Study: Bull, M. J. and J. Roberts (2001). Components of a proper hospital discharge for elders. *Journal of Advanced Nursing* 35(4): 571-581.

Study aim: To identify the components of effective discharge planning for elders and factors that impedes planning.

Study Design: Setting: 78-bed geriatric rehabilitation hospital in Southwest London. 24 semi-structured interviews were conducted (14 from the hospital team and 7 from the community team, two with elders, and one with a family carer). Also documentary analysis and observation.

Findings: The findings indicated that a proper discharge occurred in stages and was characterized by involvement of all MDT members, interacting circles of communication, and sufficient time to involve the various members of the team in identifying the elder's need for aftercare.

3 characteristics of an effective team were identified. These were development of trust to facilitate exchange of opinions, blurring of disciplinary boundaries whereby the focus becomes a holistic approach to the elder's needs and the third is someone with responsibility for the co-ordination of the team. The study found problems in communication between the MDT and the community team .E.g. illegible discharge summaries.

Study: Cameron, I. D., G. R. Murray, L.D. Gillespie, MC. Robertson, KD. Hill, R.G Cumming, N. Kerse (2010). Interventions for preventing falls in older people in nursing care facilities and hospitals. *Cochrane Database of Systematic Reviews*

Study aim: To assess the effectiveness of interventions designed to reduce falls by older people in nursing care facilities and hospitals.

Study Design: Randomised controlled trials of interventions to reduce falls in older people in nursing care facilities or hospitals. Primary outcomes were rate of falls and risk of falling. Two review authors independently assessed trial quality and extracted data. Data were pooled where appropriate.

Findings: Where provided by a multidisciplinary team, multifactorial interventions reduced the rate of falls and risk of falling.

Note: Not reviewed in full.

Study: Challis, D., M. Abendstern, et al. (2010). Comprehensive assessment of older people with complex care needs: the multi-disciplinarity of the Single Assessment Process in England. *Ageing & Society* 30(07): 1115-1134.

Study Aim: To investigate evidence of multidisciplinary approaches to comprehensive assessment across different settings.

Study Design: Self completion questionnaire by leads responsible for SAP implementation in 150 LAs in England.

Findings: Evidence that different professional groups are more prominent in multidisciplinary assessment in some settings compared to others. When multidisciplinary is defined as three or more professionals involved in an assessment, it occurred in only one sector, placements in care-home-with-nursing and not in intermediate care, placement in care home or domiciliary care. The findings suggest that, in three of the four settings, an assessment by a single professional was most common. Patterns in multidisciplinary assessment were most distinctive in intermediate care with social workers often having a co-ordinating role while a community nurse was as likely as a social worker to either assess alone or to co-ordinate the assessment by requesting the involvement of a second professional.

Conclusion: A systematic approach to comprehensive assessments involving a multidisciplinary component across the country was largely absent.

Study: Clarke, D. J. (2010). Achieving teamwork in stroke units: The contribution of opportunistic dialogue. *Journal of Interprofessional Care* 24(3): 285-297.

Study Aim: To understand and explain how teamwork was achieved and maintained in two stroke rehabilitation units.

Study Design: Grounded Theory approach: Participant observation, interviews and documentary analysis. The two units chosen from the database met the RCP Sentinel Audit standards for multidisciplinary Team working and had been operating for four years at the time of the study. They shared similar characteristics. Purposive and theoretical sampling of participants. Transferability of findings limited.

Findings: Meaningful interactions between team members were characterised by spontaneous dialogue unfolding through informal joint working rather than emerging from more structured settings and processes. Co-location led to increased joint-working, problem oriented opportunistic dialogue meant team members understood their interdependence in realizing rehabilitation goals. Theory of opportunistic dialogue: Opportunistic dialogue is characterized by exchange of perspectives, information and ideas and commonly included negotiations relating to planning, problem solving and decision making. Opportunistic dialogue goes beyond our common understanding of conversational interaction and represents a process of engagement in thinking at a collective level, that is, a conscious exploration of knowledge, values and experiences.

Conclusion: This study has demonstrated that, over time, participation in opportunistic dialogue episodes directly contributed to effective interdisciplinary team working.

Study: Corner, J. (2003). The multidisciplinary team– fact or fiction? *European journal of palliative care* 10 (2).

Summary: Briefly discusses the extent to which multidisciplinary team working exists in palliative care and the challenges it faces.

Study: Dainty, P. & J. Elizabeth (2009). Timely discharge of older patients from hospital: improving the process. *Clinical Medicine* 9 (4): 311-314.

Study Aim: Reviews the literature-based evidence on the safe discharge of elderly patients back into the community in order to inform practice in this area.

Study Design: Review of literature

Findings: The research indicates that that proactive assessment and case management by a MDT following admission and continuing after discharge can have a range of positive outcomes not only for the patient in relation to improved functional status and independence but also for the acute sector in relation to reduced rates of admission and length of stays for elderly patients.

Study: Gair, G. and T. Hartery (2001). Medical dominance in multidisciplinary teamwork: a case study of discharge decision-making in a geriatric assessment unit. *Journal of Nursing Management* 9(1): 3-11.

Study aim: To investigate the degree of medical dominance in multidisciplinary teams in a geriatric assessment unit by focusing on decision-making with regard to patient discharge.

Study Design: Two MDT in a geriatric assessment unit attached to Scottish hospital. Observation of case review meetings and semi-structured interviews with team members.

Findings: The amount of discussion dedicated to the patient's medical issues during meetings was not perceived to be excessive among members and did not indicate medical dominance. All other issues such as patient functioning, family issues, patient's wishes and motivation were contributed to by all professionals. This functioning of the multidisciplinary teams was seen to stem from the opportunistic acquisition of information by members. Discharge decision-making is predominantly initiated by the senior doctor. Analysis of team meetings suggests that discharge initiation by nonmedical staff is not a random activity, but stems from significant professional concerns. There was no evidence of medical dominance during the discharge proposal and implementation process.

Overall, the evidence from the study shows that the senior doctor exercised a disproportionate degree of power and influence on certain counts, namely in the chairing of meetings and the initiation of discharge, but not on other counts, namely overall amount of contribution, types of issues raised and perhaps most significantly of all responses to discharge proposals.

Conclusion: Explanations cited for a lower than expected level of medical dominance include the existence and expression within the teams of a positive consensus as to the value of teamwork in geriatric assessment and the level of team stability which engendered a degree of trust among members.

Study: Healy, J., C. R. Victor, A. Thomas & J. Seargeant (2002). Professionals and post-hospital care for older people. *Journal of Interprofessional Care* 16(1): 19-29.

Study Aim: To identify which factors predict the services that older people receive upon discharge from hospital, and in particular, to investigate whether the kind of professional (OT, social worker or nurse) who took the lead in co-ordinating the care assessment process was a significant predictor.

Study Design: Patient data collected from case notes (n=456)-included patient characteristics, referral patterns, and the types of service received in the month after leaving hospital. Post-hospital outcomes were: referral of patients for care assessment, the receipt of

post-discharge community services by patients, and entry to nursing/residential homes. Multivariate analysis performed.

Findings & Discussion: The occupational therapy-led team was eight times more likely than the nurse-led team and nearly four times more likely than the social work-led team to refer patients for an occupational therapy care assessment.

The social work-led team was nearly six times more likely to refer patients for a social services assessment than the other teams and also referred frequently to other professionals. And their patients received the greatest range but not the greatest amount of services. These results suggest that while referrals for social services assessments were professional led, the receipt of services was also constrained by resources.

The nurse-led team was least likely of the teams, however, to refer patients for a specialist nursing assessment (usually to the community liaison nurse). The fewer referrals by the nurse-led team for a specialist nurse assessment, however, may be because this team undertook assessments for home nursing rather than refer to a co-professional. The nurse-led team had the most patients whose discharge was delayed, controlling for patient characteristics, suggesting that slowness to refer to other professionals for a care assessment was a factor in these delays (Victor et al., 2000).

The occupational therapy-led team was over 5 times more likely to arrange occupational therapy services for their patients than the nurse-led team and nearly four times more likely than the social work-led team. The occupational therapy-led team, however, worked in the social services department area with the highest per capita budget, which perhaps allowed better access to aids and equipment.

Patients of the nurse-led team did not receive more home nursing than other patients. Patient characteristics, rather than the team model, were a better predictor both of referrals for a nursing assessment and the receipt of home nursing services.

Patients of the social work-led team were slightly less likely than those of the occupational therapy-led team to receive community services, but 1.8 times more likely than the nurse-led team.

The social work-led team was the most multidisciplinary, however, in undertaking the most care assessments and involving the most staff.

Conclusion: Organisational factors, in particular the type of professional team model, affected the receipt of post-hospital community services, as there were significant differences in service patterns between the three teams. There appeared to be least agreement on which patients should receive social care services (although living alone did predict home care), suggesting that such needs are more difficult to assess, particularly in the absence of a national policy or assessment instrument. The receipt of such services was influenced, therefore, by professional (professional led) and budgetary (services led) considerations as well as by patient characteristics (needs led).

Study: Johansson, G., K. Eklund, G. Gosman-Hedstrom. (2010). Multidisciplinary team, working with elderly persons living in the community: a systematic literature review. *Scandinavian Journal of Occupational Therapy* 17(2): 101-116.

Study Aim: To explore literature concerning the benefit of multidisciplinary teamwork as it applies to teams working with the elderly in the community

Study Design: Systematic literature review

Notes: Highlights a number of potentially relevant UK studies.

Study: Jones, K. (2010) Integrated care pilot programme: ensuring people with dementia receive joined up care." *Nursing Times* 106(10): 12-14.

Study aim: This article outlines the aims, elements, challenges and benefits of working as part of a multidisciplinary team, from a nursing perspective.

Study Design: A multidisciplinary team in Bournemouth and Poole set up a nurse led project focusing on memory loss and dementia in older people. The multidisciplinary team included GPs (four local surgeries are involved in the project), acute care consultants, specialist nurses, social workers, mental health intermediate care assistants, a dementia support worker, third sector agencies and local community groups.

This article describes the pathways, processes and personnel roles involved in the establishment, implementation and evaluation of integrated care plans for people with dementia living in the community.

Findings: Services considering implementing a similar programme should:

- Understand their local population and identify unmet needs;
- Involve nurses and other healthcare professionals in the initial planning and service design period;
- Set clear objectives and measurable outcomes;
- Promote integration as a team philosophy;
- Devise the most effective, efficient way to integrate working practices to offer a seamless service for clients and review its success regularly;
- Review outcome data regularly and frequently to enable improvements to be implemented at the earliest opportunity.

Study: Leah V, J. Adams (2010). Assessment of older adults in the emergency department. *Nursing Standard* 24(46): 42-45.

Study aim: This article describes the establishment of an assessment team for older people (ATOP) that was created to address inappropriate admissions and length of stays among older patients with complex medical and social needs attending a & e in a district general hospital.

Study Design: An assessment team for older people (ATOP) was established in the emergency department and medical assessment unit of Broomfield Hospital, a district general hospital in Chelmsford, Essex.

Findings: In the four months of the study period, the ATOP prevented admission of 178 of the 666 patients seen. Of these 178 patients, 19 re-attended the hospital and six were admitted.

Conclusion: A more comprehensive assessment process has been successful in preventing some admissions, with consequent improvement in outcomes, a probable financial saving for the trust, and quality-of-life benefits for patients.

Note: There was no benchmark against which the 'improvements' in admission rates, patient outcomes, savings etc. could be objectively measured.

Study: Liffie, S. (2008) Myths and realities in multidisciplinary team-working. *London Journal of Primary Care* 1: 100-102.

Summary: Briefly addresses the development of multidisciplinary working within primary care and the challenges it faces.

Study: Long, A. F., R. Kneafsey & J. Ryan (2003). Rehabilitation practice: challenges to effective team working. *International Journal of Nursing Studies* 40(6): 663-673.

Study aim: The study set out to explore the role and contribution of the nurse within the multi-professional rehabilitation team and the relevance of nurse education as preparation for this role.

Study Design: Ethnographic approach (Observations and interview) and expert workshop to assess findings and to explore implications in relation to professional education for nurses.
Sample: Selected purposively in line with theoretical sampling. 49 participants: clients with any of these conditions: fractured neck of femur, rheumatoid arthritis and stroke, receiving rehab treatment in any of these settings: home, outpatient clinic, hospital ward or nursing home.

Findings: Overall the study illustrates how effective team working is shaped by a number of factors, including nurse's and other professional's perceptions about the appropriate role of the nurse in rehab therapy practice and planning, and the degree to which professional role boundaries were differentiated or overlapped. For example, while therapy 'carry on' whereby nurses integrated the therapeutic strategies and approaches initiated by other team members within the provision of physical nursing care, was perceived to be a legitimate function of nursing duties within rehab care, other aspects of care, such as assessments were disputed domains with opposing professional perspectives over who was responsible. Structural factors relating to systems of work and resource constraints, such as, availability of each professional's time and workload can constrain effective team working.

Study: Monaghan, J., K. Channell, D. McDowell, A. K. Sharma (2005). Improving patient and carer communication, multidisciplinary team working and goal-setting in stroke rehabilitation. *Clinical Rehabilitation* 19(2): 194-199.

Study aim: To complete a detailed assessment of the efficacy of three forms of MDT care on a stroke rehabilitation ward.

Study Design: Compared standard MDT using standard form, standard MDT meeting using newly devised form and weekly ward round also using new documentation.

The success of each form of care was measured by the extent to which the guidelines set by the National Service Framework (NSF) for rehabilitative care in stroke were met.

These guidelines state that characteristics of the team care should include:

- Clearly documenting plans for treatment and care [and] ensuring identified needs for treatment, care and early rehabilitation are met (NSF standard 5.22)
- Patients and their carers should be involved in their care and safe discharge from hospital (NSF standard 5.25)
- Ensuring all professionals involved share a common understanding of the goals agreed for each patient' (NSF standard 5.22)

Findings: Compared to meetings, the ward rounds lead to significant improvements in the following areas: documentation of all patients' needs including medical and nutritional needs; increase in the number of SMART goals set for each patients; significantly more patients were involved in their rehabilitation; improved team members communication and agreed objectives. However, more time required and therefore more costly.

Conclusion: While improved standards of care were evident from this kind of MDT working, it was by no means optimal. However, the results of this study demonstrate the success of the MDT ward round in contrast to the serious downfalls of the MDT meeting in achieving NSF guidelines.

Study: Oliver, D. (2005). Medical input, rehabilitation and discharge planning for patients with hip fracture: Why traditional models are not fit for purpose and how things are changing. *Current Anaesthesia & Critical Care* 16(1): 11-22.

Summary: Older patients with hip fracture tend to have a wide range of medical illness and require co-ordinated discharge planning and multidisciplinary care. These skills and emphases do not generally reside in traditional orthopaedic teams. Evidence from the UK-wide audits suggests that patient outcomes and bed utilization are better when co-ordinated medical liaison and interdisciplinary care is available. This is backed up by a growing number of controlled clinical trials, an imperative from the NSF for older people and emerging evidence from managed care. A model of proactive specialist medical input allied to a multidisciplinary team can offer: early pre-operative optimization; avoidance of unnecessary operative delay; incorporation of elements of good practice (e.g. in pressure area care, analgesia and fluid balance); early discharge planning and rehabilitation goal setting; attention to medically reversible causes of "failure to thrive" such as poor nutrition, iatrogenic problems, delirium, sepsis and medical co-morbidity.

Study: Ovretveit, J. (1995). Team decision-making. *Journal of Interprofessional Care* 9(1): 41-51.

Study Aim: Presents concepts linked to the barriers to and facilitators of decision-making in MDT based on action research with primary and specialist community multidisciplinary teams in the UK.

Findings: Argues that poor decision-making in MDT is not attributable to personality clashes between its members but more often is a consequence of a person's responsibilities preventing them from agreeing or reaching collective decisions. Recommends improvements to both formal and informal features of team organisation and formal decision-making procedures. Also clarification on what team members should decide, and what the team should decide, or influence through a team policy.

Conclusion: Neglect of decision-making procedures makes it difficult for teams to work effectively and make the best use of the variety of skills and abilities of people in the team.

Study: Pethybridge, J. (2004). How team working influences discharge planning from hospital: a study of four multi-disciplinary teams in an acute hospital in England. *Journal of Interprofessional Care* 18: 29-41.

Study Aim: To critically analyse through investigation what factors in a multidisciplinary context inhibits or promotes the discharge planning process for patients returning home from hospital.

Study Design: Grounded theory approach: observations, informal interviewing and focus groups. Setting: two wards with rehab team in acute hospital in London.

Findings: Factors that emerged as encouraging good team working were sharing, consensus and agreement, trust, being in a learning culture and good leadership. For leadership, acting as a nerve centre for pivoting information, orchestrating and representing the team, and ensuring outcomes were important factors that contributed to decisions-making in discharge planning. Teams varied in their modes of multi professional working partly depending on the composition of the team, and the styles and personalities of team members and coordinators. Where team working was absent, accountability and responsibility were affected causing duplication, service gaps and time delays in discharge planning with poor decision-making.

Conclusion: Careful consideration for the leadership/management needs should be taken for different wards and specialties, questioning whether the needs are different for acute, rehabilitation, intermediate care and community and who should fill these roles, doctors, nurses, therapists, social workers or general managers. Also important is to consider how best to prepare the leaders/managers to identify and provide for the needs of patients and other staff to develop successful leadership, team working and communication to make the service more patient centred.

It is essential to develop multidisciplinary documentation, goal setting including patients, joint multidisciplinary training and team building sessions and to consider housing all team members together on or very near to the wards.

Study: Tierney, A. J. and J. Vallis (1999) Multidisciplinary teamworking in the care of elderly patients with hip fracture. *Journal of Interprofessional Care* 13(1): 41-52.

Study Aim: To describe and compare systematically the service structure and process of care for elderly hip fracture patients in four orthopaedic units.

Study Design: Case study

Findings: Observation of ward rounds and multidisciplinary team meetings showed that the extent of multidisciplinary collaboration and team working varied greatly with some disciplines being absent from ward rounds or team meetings and therefore clinical decision-making. There were notable variations in modes of multidisciplinary team working whereby some staff perceived team working as democratic and other staff in other centres perceived it to be consultant-dominated and professional roles were contentious. The differences noted in relation to the composition of multidisciplinary teams in terms of staffing levels, medical and nursing grade mix and extent of involvement of therapy staff and social workers in the care of elderly hip fracture patients accounts for this variation in multidisciplinary modes of working.

Note: No evidence of how varied multidisciplinary practices affected outcomes.

Study: Victor, C. R., J. Healy, A. Thomas & J. Seargeant (2000). Older patients and delayed discharge from hospital. *Health & Social Care in the Community* 8(6): 443-452.

Study Aim: To examine the relative contribution of a range of factors, both individual and organisational, to the delayed discharge of older people from hospital.

Study Design: Retrospective casenote review. Each of the three hospitals selected for the patient case review had over 40 beds in designated elderly care wards, served a similar socio-economic area, was covered by one social services department, had access to adequate (according to staff) post hospital services, and kept comparable patient medical records data. Each of the three hospitals coordinated the care assessment of older patients using different staff: nurse (Hospital A), occupational therapist (Hospital B) and social worker (Hospital C).

Findings: Type of multidisciplinary team (i.e. lead) in addition to lack of a family carer, and entry to residential or nursing home care independently predicted delayed discharge. Hospital A (nurse lead) was significantly more likely to experience delayed discharge than the other two hospital teams.

Also, Hospital A was least likely to refer patients for a multidisciplinary care assessment; these patients were also least likely to have post-hospital social services arranged. This suggests that late referrals, and less emphasis upon multidisciplinary teamwork, may be factors in causing delays in hospital discharge.

Study: Webster, J. (2002). Teamwork: understanding multi-professional working. *NURSING OLDER PEOPLE* 14(3).

Study Aim: Explores models of multi-professional working and some of the challenges it faces. It also attempts to underline the distinction between multi-disciplinary, inter-disciplinary and transdisciplinary team working. Addresses some of the barriers to multi-professional working from a sociological/psychological perspective.

Study: While, A. and K. L. Barriball (1999). Qualified and unqualified nurses' views of the multidisciplinary team: findings of a large interview study. *Journal of Interprofessional Care* 13(1): 77-89.

Study Aim: To explore qualified and unqualified nurses' views of multidisciplinary teams.

Study Design: Survey (n=449). Multivariate analysis.

Findings: More than a quarter of the sample (28%) were not familiar with the term MDT and a similar proportion were unable to give a clear description of a MDT. Multivariate analysis also indicated that familiarity with the term MDT was associated with the status of participants within the organisation. For example, some nurses to comment upon their experience of the MDT despite its existence because in some way they felt 'out of it' either due to their working hours, lack of seniority or recency of appointment.

Conclusion: The study underlines the importance of an inclusive approach to continuing professional education if all qualified nurses are to share a common understanding in their approach to care delivery.

Study: Williams, G. and P. Laungani (1999). Analysis of teamwork in an NHS community trust: an empirical study." *Journal of Interprofessional Care* 13(1): 19-28.

Study Aim: To investigate team functioning in four different types of team working.

Study Design: Survey of 259 members of 30 teams. Nineteen of the teams were multidisciplinary clinic or health centre teams. Six of the teams were primary health care teams, two were single-disciplinary teams, and three were NHS management teams.

West (1994) theorised that there are four core factors that characterise innovative, effective teams. These are team vision (whether the team share common vision and goals), participative safety (This factor relates to the general climate of trust and participation within the team), support for innovation (This factor is concerned with whether suggested innovations are taken seriously, tried out, and provided with adequate time and resources) and task orientation (means that team members are sufficiently focused on each others' roles, skills, and the tasks required to meet their clients' needs). Team Climate Inventory (TCI: Anderson & West, 1994) measured team climate on these four factors: participative safety; innovation; task orientation; and team vision.

Findings: The study measured the scores on the four dimensions of team functioning. Small teams (1-11 members or less) had higher levels of participative safety (M = 40.93) and support for innovation (M = 25.35) than the larger sized teams and surprisingly were significantly lower than larger teams in terms of team vision. They did not differ in other measures of team functioning. Multidisciplinary clinic teams (M = 22.87) scored significantly more highly than primary health care teams (M = 9.74) in terms of team objective setting. No team differences in relation to support for innovation and task orientation.

Conclusion: Primary health care teams are less effective in executing multidisciplinary working.

Study: Xyrichis, A. and K. Lowton (2008). What fosters or prevents interprofessional teamworking in primary and community care? A literature review. *International Journal of Nursing Studies* 45(1): 140-153.

Study Aim: This literature review aimed to explore the factors that inhibit or facilitate interprofessional teamworking in primary and community care settings.

Findings: Two main themes emerged that had an impact on inter-professional team working: team structure and team processes.

Team structure: 3 elements

- Team premises: was considered as important as it was reported to enhance information transaction, facilitate communication, and increase personal familiarity- illustrated in Wiles and Robinson's (1994) report
- Size of the team: Poulton and West's (1999), Molyneux's (2001) and Rutherford and McArthur's (2004) findings indicate that smaller teams seem to function better than larger teams.
- Composition of team: Borrill et al. (2000) found that teams with greater occupational diversity reported higher overall effectiveness and the innovations introduced by these teams were more radical and had significantly more impact both on the primary care trust (PCT) and on patient care.
- Status of team members: Molyneux (2001) and Rutherford and McArthur (2004) identified that the status of team members has implications for the effective working of the team, as it may inhibit members from participating in the decision-making process and from providing input in team meetings.
- Team Leadership: Lack of clarity over who lead and lack of leadership is associated with poor quality team working. Demonstrated by findings of Field and West (1995), Rutherford and McArthur (2004), Borrill et al. (2000) and Wiles and Robinson (1994).
- Stability of team: Instability of team membership acted as a barrier to the effective working of the team (Field and West, 1995; Borrill et al., 2000; Cashman et al., 2004).
- Organisational support: Lack of organisational support in relation to rewards for team working and support to implement changes could cause demoralisation among staff (Field and West, 1995; Cashman et al. 2004). On the flip side, support for innovation and change in organisations contributed to effective team working (Borrill et al., 2000; Poulton and West, 1999).

Team processes: 3 elements

- Team meetings: In spite of the fact that regular team meetings are not always practiced (Wiles and Robinson (1994); Field and West, 1995), nonetheless they are integral to effective team working as they assist in breaking down professional barriers and improving inter-professional communication (Rutherford and McArthur, 2004), they facilitate innovation (Borrill et al., 2000). In short, enhanced communication achieved through team meetings was identified as an important facilitator for effective teamworking enabling the resolution of interprofessional conflict and promoting positive interpersonal relations.
- Clear team goals: Improves team functioning and team's effectiveness (Borrill et al., 2000; Poulton and West, 1999) and mitigates against the lack of clear understanding of each professional's role and responsibility that has been found to create the conditions for professional conflict and ineffective team performances (Wiles and Robinson 1994; Field and West, 1995).
- Audit: Monitors and evaluates individual's and team performances and has the potential to recognise achievements, identify improvements to team working and provide the necessary supports to implement changes. Has been an overlooked factor when considering facilitation of teamwork.

Study: Ros Boddington, Howard Arthur, Dave Cummings, Sue Mellor, Denis Salter, (2006) "Team Resource Management and patient safety: A team focused approach to clinical

governance", Clinical Governance: An International Journal, Vol. 11 Iss: 1, pp.58 - 68

Purpose: To review three key areas of work managed by the Team Resource Management and Patient Safety Team (TRM), itself part of the Clinical Governance Support Team.

Design/methodology/approach – Information has been collected from TRM staff, UK NHS Trust staff, research publications and reports.

Findings: As treatment programmes become more complex and health care is delivered by multidisciplinary teams, the quality of care and of patient safety is ever more dependent on effective team working. External support and expertise can be effective in helping clinical teams achieve their full potential. Safety and team work practices from other domains such as aviation can be successfully translated into the work of clinical teams. Specific coaching input can also improve the effectiveness of teams and, where teams are recognised as having difficulty working together, external support in particular approaches and techniques can resolve team working problems.

Originality/value: This review summarises the benefits of a healthcare support function which is specifically dedicated to the understanding, supporting and shaping of clinical teams.

http://www.epsc.org/data/files/PRISM/Best_Practice_Guidance_On_Teamworking_and_Safety_Final_Version_2.pdf

Study: Zeitz K; Kitson A; Gibb H; Bagley E; Chester M; Davy C; Frankham J; Guthrie S; Roney F; Shanks A (2011) Working together to improve the care of older people: a new framework for collaboration . Journal of advanced nursing; 67(1) 43-55

Aim: This paper is a report of a study identifying the care issues experienced by older people in the acute setting that could be improved through a collaborative approach to action. Background. Actively involving consumers in the governance of healthcare organizations is viewed positively, although there is less agreement on how to do this. Co-operative inquiry is a useful approach to involve consumers and clinicians in structured dialogue about understanding and changing care, whereas traditional quality improvement methodologies are often singular in their dimensions of change.

Method: Using a co-operative inquiry approach, five workshops were facilitated over a 4-month period in 2008 with four volunteer older people, four clinicians and three facilitators (n = 11). All participants were actively involved in generating ideas and actions using a range of facilitation techniques and data collection methods. Findings. There was increased awareness, understanding and acceptance of clinicians' and consumers' experiences and expectations of care. The complexity behind changing so-called simple care (providing warm drinks, appetizing food), which were the key concerns for consumers, relied on the active management and broader transformation of the system, including teamwork, communication processes and organizational and individual values and beliefs.

Conclusion: Consumers and clinicians put different emphasis on perspectives related to improving care of older people in the acute hospital setting. The disconnect between what consumers viewed as 'simple' organizational behaviours to change and what the clinicians viewed as complex, led to a recognition that the approach to organizational change needs to be reconceptualized.

Study: Benson, A (2010) Creating a culture to support patient safety. The contribution of a multidisciplinary team development programme to collaborative working. Z. Evid. Fortbild. Qual. Gesundh. wesen (ZEFO) 104 (1) 10–17

Summary: Effective teamwork is crucial for ensuring the provision of safe high quality care. Teams whose members collaborate through questioning, reflecting on and reviewing their work, offering each other feedback and where reporting is encouraged are more likely to promote a safe environment of care. This paper describes a multidisciplinary development

programme intended to increase team effectiveness. The teams that took part developed their ability to work collaboratively together with levels of open dialogue, critical reflection and direct feedback increasing. The paper goes on to discuss aspects of the programme which were helpful in enabling these positive changes and concludes with a number of recommendations for those commissioning and facilitating team development initiatives. These include:

- the need for people from different disciplines and different levels within the hierarchy to spend time reviewing their work together,
- the need to explicitly address issues of power and authority,
- the usefulness taking an action orientated approach and requiring participants to work on real issues together,
- the importance of providing sufficient time and resource to support people to work with the challenges associated with implementing change and addressing team dynamics,
- The importance of skilled facilitation.

This articles states that effective teamwork is increasingly recognised as a key element in ensuring patient safety, giving these references.

[10] National Patient Safety Agency Teamwork for safety' why we need it and how to do it. Available online at: <http://www.npsa.nhs.uk/nrls/improvingpatientsafety/humanfactors/teamworking/PSA> accessed (accessed 29th August 2009).

[11] D.C. Kayes, The 1996 Mount Everest climbing disaster: The breakdown of learning in teams, *Human Relations* **57** (2004), pp. 1263–1284. [Full Text via CrossRef](#) | [View Record in Scopus](#) | [Cited By in Scopus \(16\)](#)

[12] M. Stein, The critical period of disasters insights from sense making and psychoanalytic theory, *Human Relations* **57** (2004), pp. 1234–1261.

[13] K. Mearns, R. Flin and P. O'Connor, Sharing "worlds of risk", improving communications with crew resource management, *Journal of Risk Research* **4** (2001), pp. 377–392. [Full Text via CrossRef](#)

Appendix 4 - Example Capability Assessment

REF	Field of work or subject area MDT Score against criteria: 1=Fully capable; 2=some capability; 3=little or no capability	MDT Score	Name of relevant organisational policy	Named lead or group providing support
First Core Capability: Successful Multidisciplinary Meetings				
	Cultivate and promote conditions within which information, professional judgement or views are freely exchanged between participants of the MDT resulting in effective decision making			
	Apply knowledge and skills in communication both verbal and written with appropriate questioning, listening skills and ability to summarise, how to document MDT meetings.			
	Demonstrate knowledge of the person including their level of participation, roles and responsibility of professionals and agencies required to attend the MDT in order to achieve the expected individual outcome.			
	Applies knowledge and skills in decision making eg seven temporal stages of decision making (Carrol and Johnson, 1990).			
	Demonstrate a clear identity with organisational recognition			
	Generate agreed ground rules, including setting objectives, response times and language for operating the multidisciplinary team			
	Demonstrate early engagement with the person and family, identifying approaches taken to ensure CHC processes and structures of meetings are clear and accessible to them e.g. consider capacity, vulnerability, advocacy, interpretation.			
	Demonstrate an effective range of verbal and written flexible communication skills, and understanding of the appropriate communication modes and structures to be used when communicating with different people and organisations.			

REF	Field of work or subject area MDT Score against criteria: 1=Fully capable; 2=some capability; 3=little or no capability	MDT Score	Name of relevant organisational policy	Named lead or group providing support
	Identify and address the information sharing needs of the person, family, practitioner and their agencies.			
	Demonstrate knowledge and practice of effective team working			
	Identify the roles, responsibility and availability of individual members required to participate within the MDT			
	Generate records of all communication within and around the MDT e.g. e-mails or letters of invitation to the meeting, minutes of meetings held, and actions agreed, evidence of person and family participation within the process, agreed decisions. Ensuring that timely distribution is made to allow for individual preparation.			
	Identify the key roles of MDT chair, the care coordinator, the note taker for each MDT			
	Demonstrate effective and timely consensus decision making			
	Identify a quorum i.e. a fixed minimum number of members (which are proportionate to the needs of the person) who must be present in order to conduct the MDT meeting.			
	Actively foster positive attitudes towards colleagues from other professions and agencies.			
	Audit the knowledge, skills and outcomes of the MDT in order to promote learning and sustainability.			
Second Core Capability: Coordinated Assessment & Planning				

REF	Field of work or subject area MDT Score against criteria: 1=Fully capable; 2=some capability; 3=little or no capability	MDT Score	Name of relevant organisational policy	Named lead or group providing support
	Effectively coordinate assessments and plans to ensure that the person received appropriate assessment and services in a timely manner.			
	Have a clear understanding of the contributions that different professionals can make to the individual's assessment, plan and review of service delivery.			
	Establish clear person focussed goals with the individual and MDT members			
	Know their context of practice including the law, guidelines, protocols, pathways, organisational and professional constraints which may prevent the realisation of consensus decision making.			
	Demonstrate knowledge and understanding of the CHC Circular 015/2010 and guidance			
	Demonstrate an ability to easily communicate knowledge and understanding of the CHC Circular 015/2010 to the person and family at the focus of the CHC meeting			
	Summarise detailed knowledge of the person, their family including disease trajectories and needs.			
	Discriminate between all assessments required, planning and reviews necessary to produce clear person focussed outcomes and individual MDT worker actions (Comprehensiveness)			
	Demonstrate knowledge of all potential services (including eligibility criteria and triggers for referral) available to the service user and family (accessibility)			
	Demonstrate knowledge and understanding of the timely linking and sequencing of assessments and service planning that should occur ensuring a fit between assessment, need and service delivery (Compatibility)			
	Identify all assessor and service information needs during the development of the assessment process and care planning in order to avoid conflict			

REF	Field of work or subject area MDT Score against criteria: 1=Fully capable; 2=some capability; 3=little or no capability	MDT Score	Name of relevant organisational policy	Named lead or group providing support
	Demonstrate a working knowledge of the Unified Assessment Process.			
	Generate and demonstrate a willingness to work together			
	Execute appropriate actions which are required in accordance with the unique context of practice (defined by the individual needs) and may include the law, protocols, pathways, constraints which may prevent the realisation of consensus decision making.			
Third Core Capability: Integrated Systems & Practices				
	Lead or participate across teams in wider inter-agency work to ensure responsive and integrated, person focussed services			
	Demonstrate awareness of the services provided within and across organisations and can point to examples of how these are appropriately delivered.			
	Interact and co-operate with others within and across organisations in providing person focussed services.			
	Apply knowledge of the services provided within and across organisations to participate in the delivery of, and where appropriate to take a lead, in the services provided.'			
	Undertakes audit of MDT working to evaluate individual and team performance in order to identify good practice and implement necessary changes.			
	Demonstrate effective participation in interdisciplinary assessment			
	Demonstrate an ability to systematically share tasks which are common across disciplines			

REF	Field of work or subject area MDT Score against criteria: 1=Fully capable; 2=some capability; 3=little or no capability	MDT Score	Name of relevant organisational policy	Named lead or group providing support
	Generate and review shared care plans together			
	Generate common terminology to promote understanding to different people			
	Execute the practice consensus decision making			
	Execute an effective balance of impersonal methods (e-mail, face-to face) and group methods (MDT) of communication			
	Critically analyse research evidence to enhance MDT practice and manage change			
	Identify, list and demonstrate a wide network of colleagues across agencies with whom the practitioner actively problem solves on behalf of the individual and family in accordance with identified need			
	Demonstrate leadership (as appropriate) in the delivery of specialist knowledge or services within or across disciplines or agencies in order to provide person centred care and planning			
	Generate and disseminate knowledge of services provided within and across agencies, to others including the individual and family.			
	Generate evidence for appropriate measures which identify gaps in evolving individual and service requirements			
	Ensure that of the core members are identified and recognise themselves as such (eg people dedicated to role and team) and have a common view of their collective identity			



**Continuing NHS Healthcare
National Programme**

