UNIVERSITY OF BIRMINGHAM | COLLEGE OF SOCIAL SCIENCES

MDTs: What does research tell us?

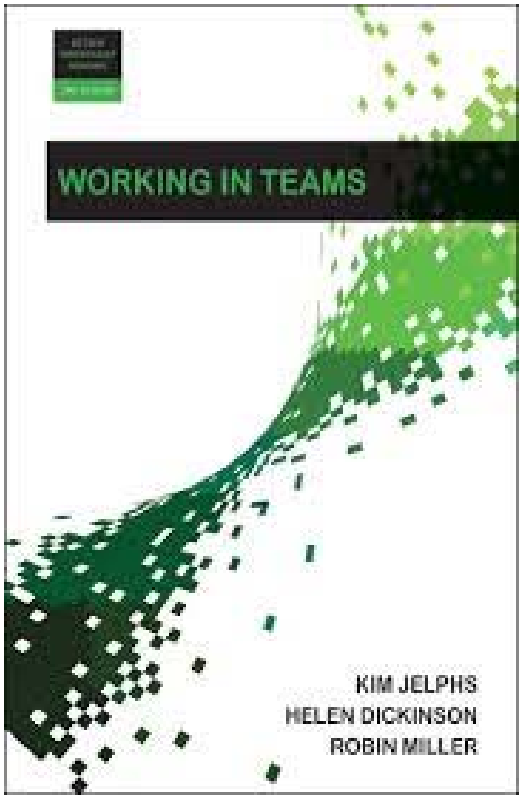
Dr Robin Miller, Senior Fellow
Health Services Management Centre

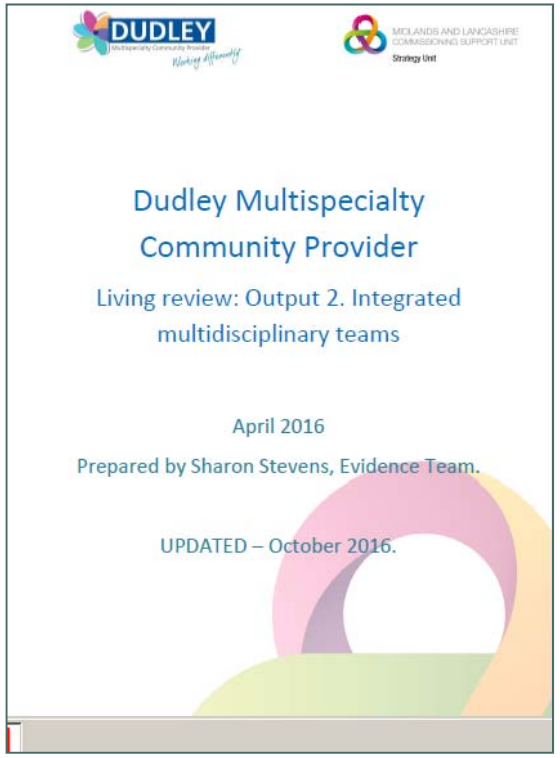
Alison Turner, Head of Evidence Analysis
Strategy Unit

What will we cover....

- What do mean by a ‘multi-disciplinary team’?
- How and why are they being promoted in policy?
- What impacts do they have in practice?
- What enables and what prevents MDTs from making a positive impact?
- What are the emerging issues to be considered?

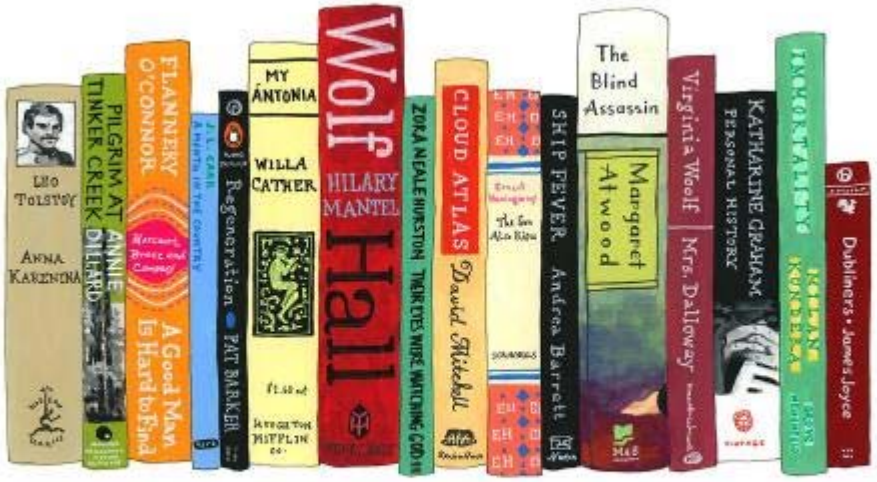
Key sources


WORKING IN TEAMS
KIM JELPHS
HELEN DICKINSON
ROBIN MILLER

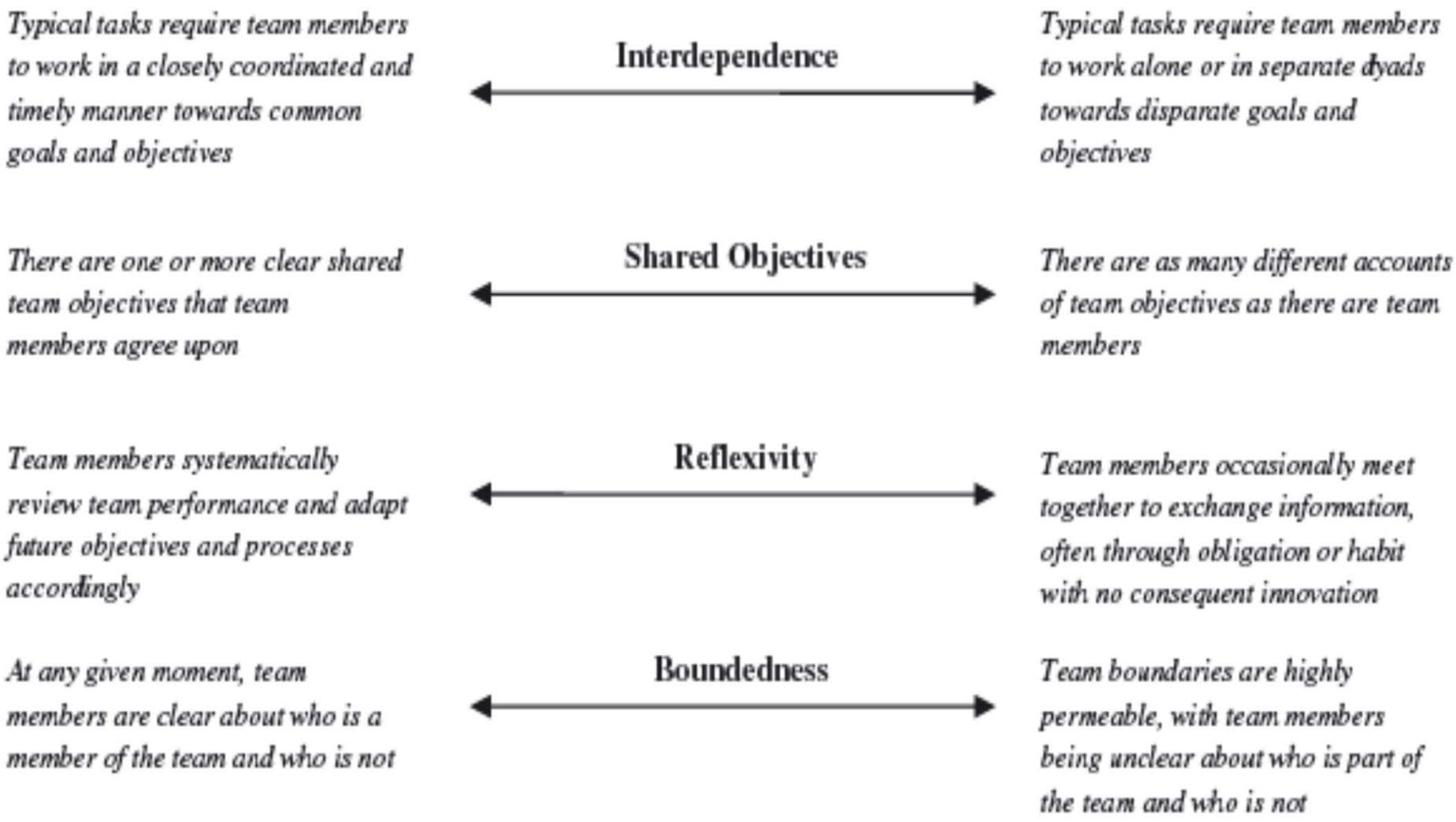

DUDLEY
Dudley Multispecialty
Community Provider
Living review: Output 2. Integrated multidisciplinary teams
April 2016
Prepared by Sharon Stevens, Evidence Team.
UPDATED – October 2016.

But firstly.....a quiz

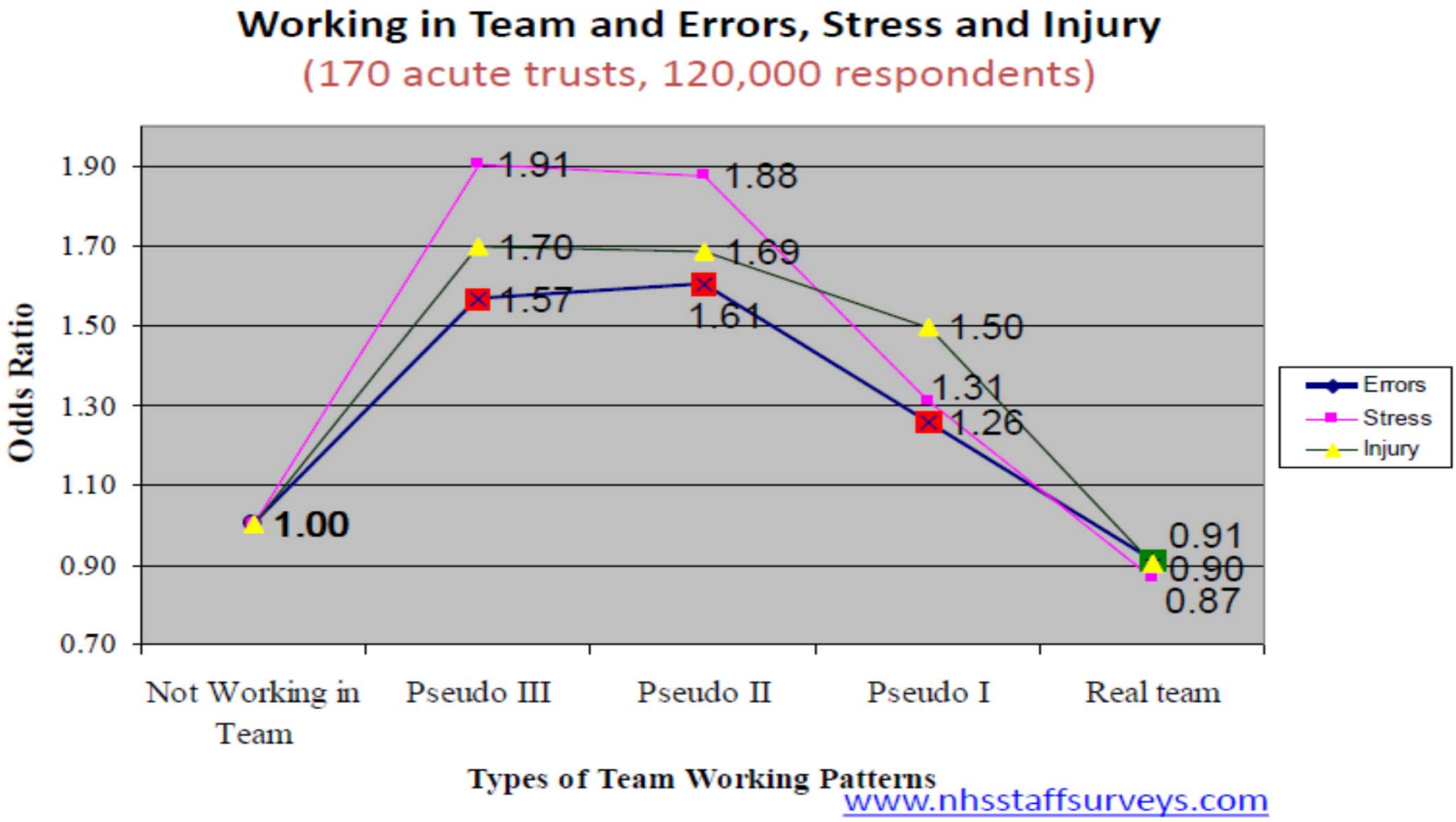
Groups...


Leo Tolstoy
Anna Karenina
Flannery O'Connor
A Good Man Is Hard to Find
Annie Dillard
Pilgrim at Tinker Creek
Pat Barker
Regeneration
Willa Cather
My Ántonia
Hilary Mantel
Wolf Hall
Zora Neale Hurston
Their Eyes Were Watching God
David Mitchell
Cloud Atlas
Andrea Barrett
Ship Fever
Margaret Atwood
The Blind Assassin
Virginia Woolf
Mrs. Dalloway
Katharine Graham
Personal History
James Joyce
Dubliners

Real Teams (and pseudo ones...)

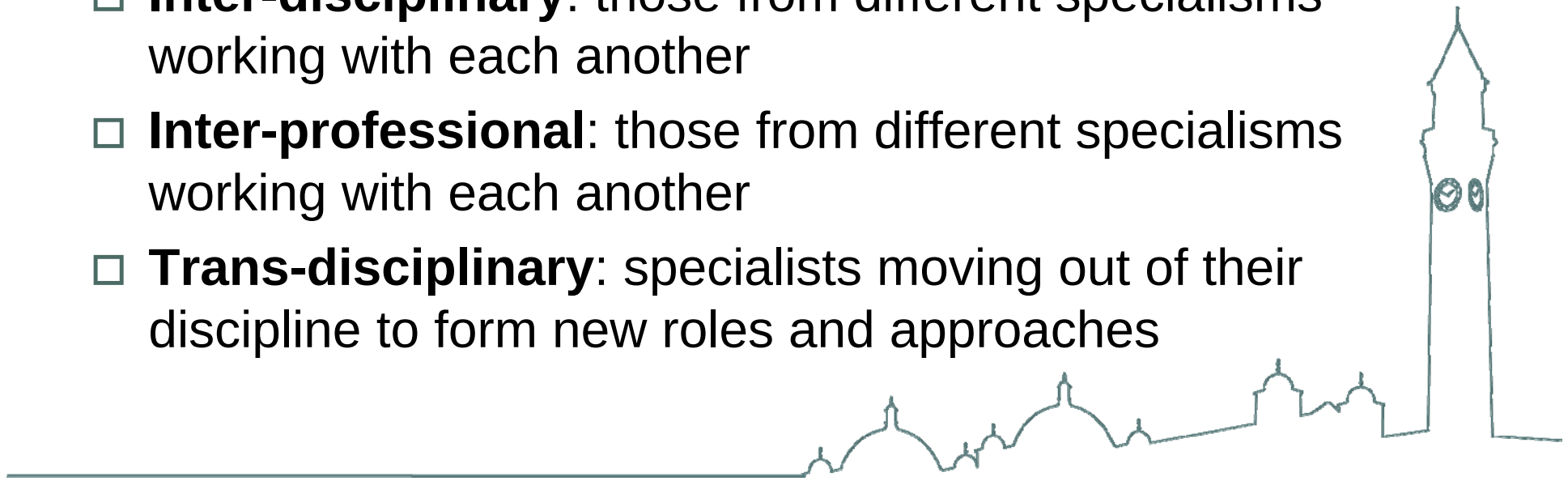


Pseudo teams (West 2013)



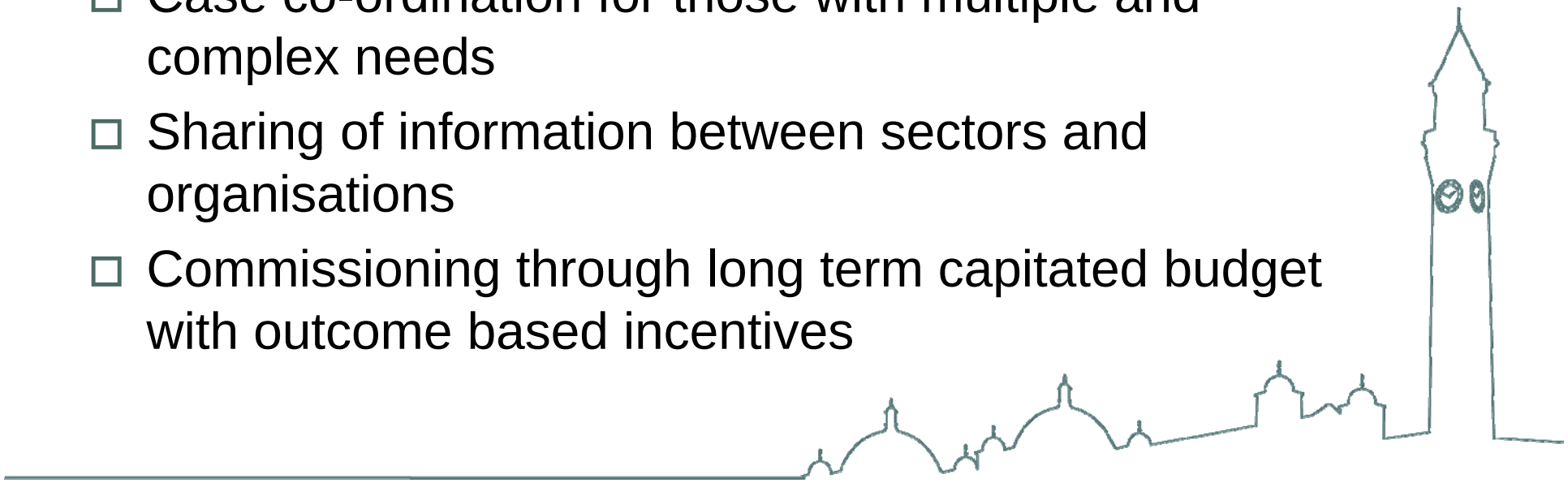
Multi-disciplinary or inter-professional

- **Multi-disciplinary**: those from different specialisms working alongside one another
- **Multi-professional**: those from different specialisms working alongside one another
- **Inter-disciplinary**: those from different specialisms working with each another
- **Inter-professional**: those from different specialisms working with each another
- **Trans-disciplinary**: specialists moving out of their discipline to form new roles and approaches



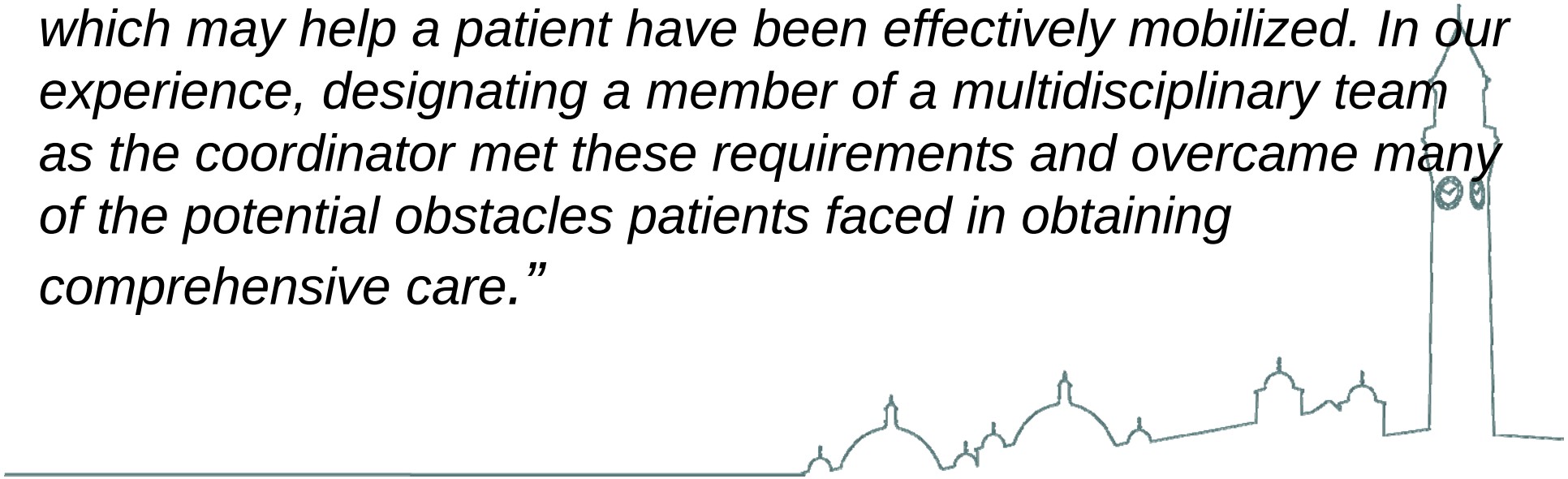
Common elements of current local & national innovations

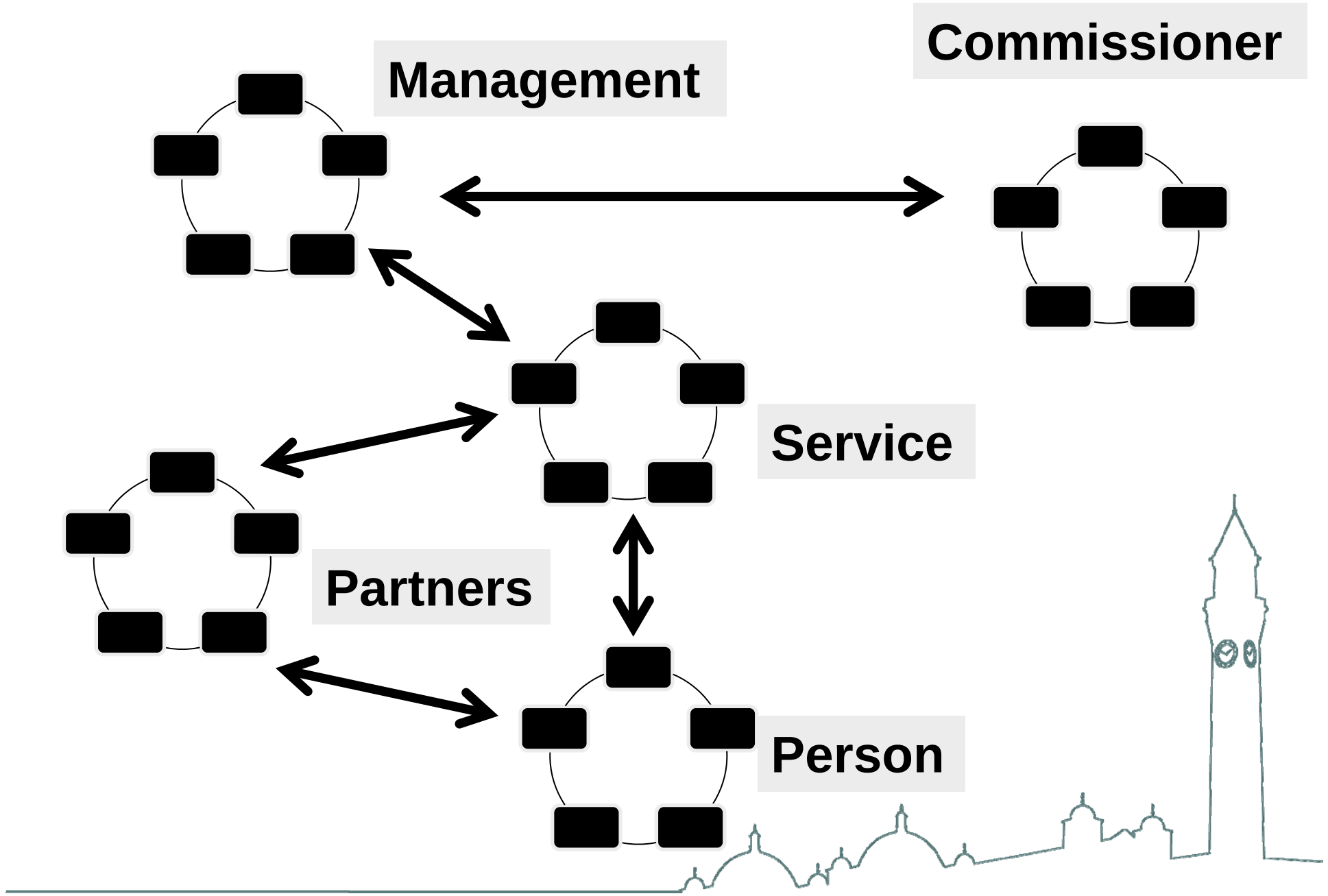
- Partnership body with oversight of funds from multiple agencies
- Multi-disciplinary teams supporting an identified population
- Case co-ordination for those with multiple and complex needs
- Sharing of information between sectors and organisations
- Commissioning through long term capitated budget with outcome based incentives



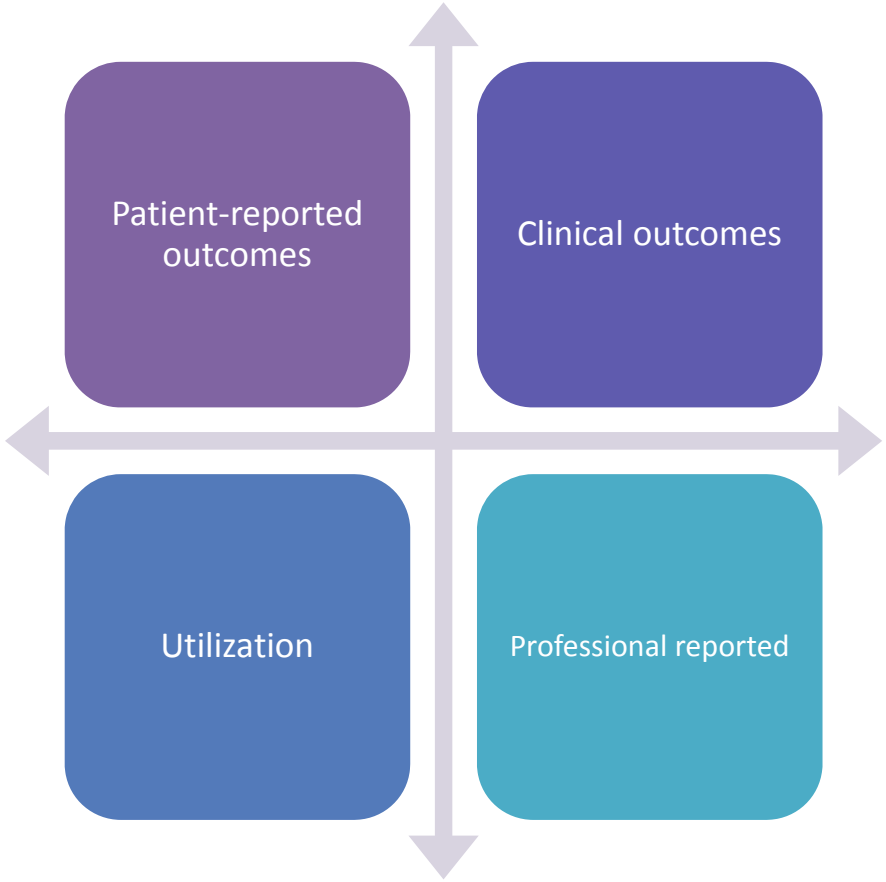
The year.....?

“We have found that a multidisciplinary approach offers many advantages in diagnosis and treatment. A means must be found to assure that a patient receives comprehensive care, that is, care which satisfies a combination of physical, mental, and social needs. A catalyst is required to assure that all resources which may help a patient have been effectively mobilized. In our experience, designating a member of a multidisciplinary team as the coordinator met these requirements and overcame many of the potential obstacles patients faced in obtaining comprehensive care.”




Commissioner
Management
Service
Partners
Person

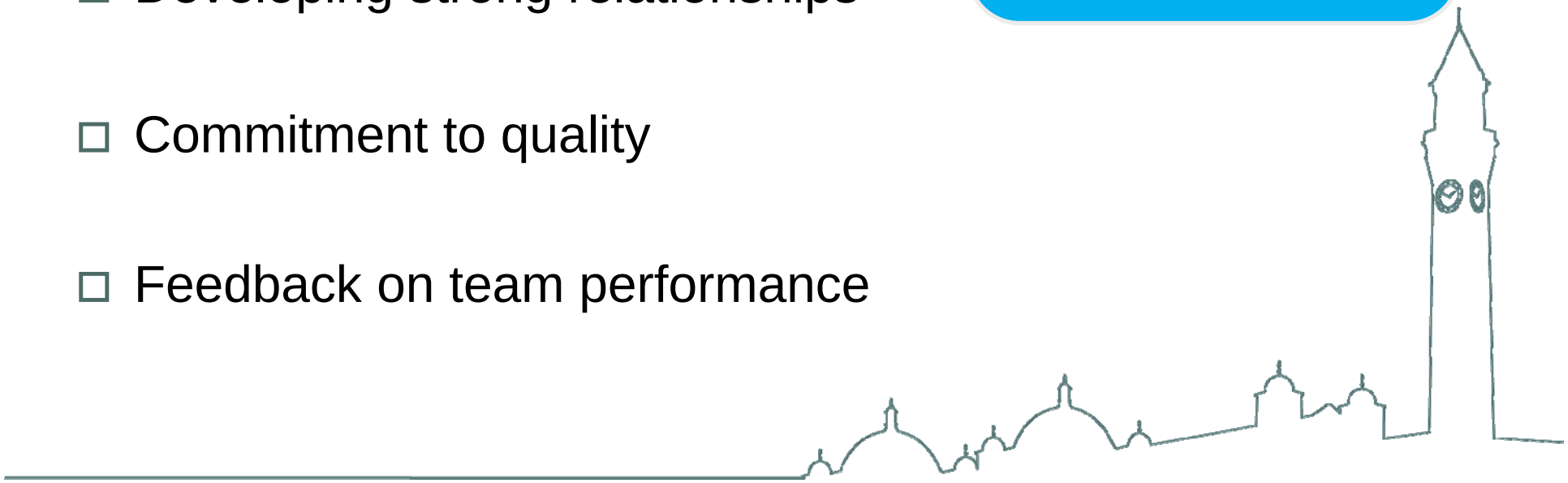
Evidence of impact



Enablers and blockages

- Clear and common vision
- Engaging people
- Building commitment
- Developing strong relationships
- Commitment to quality
- Feedback on team performance

Leadership

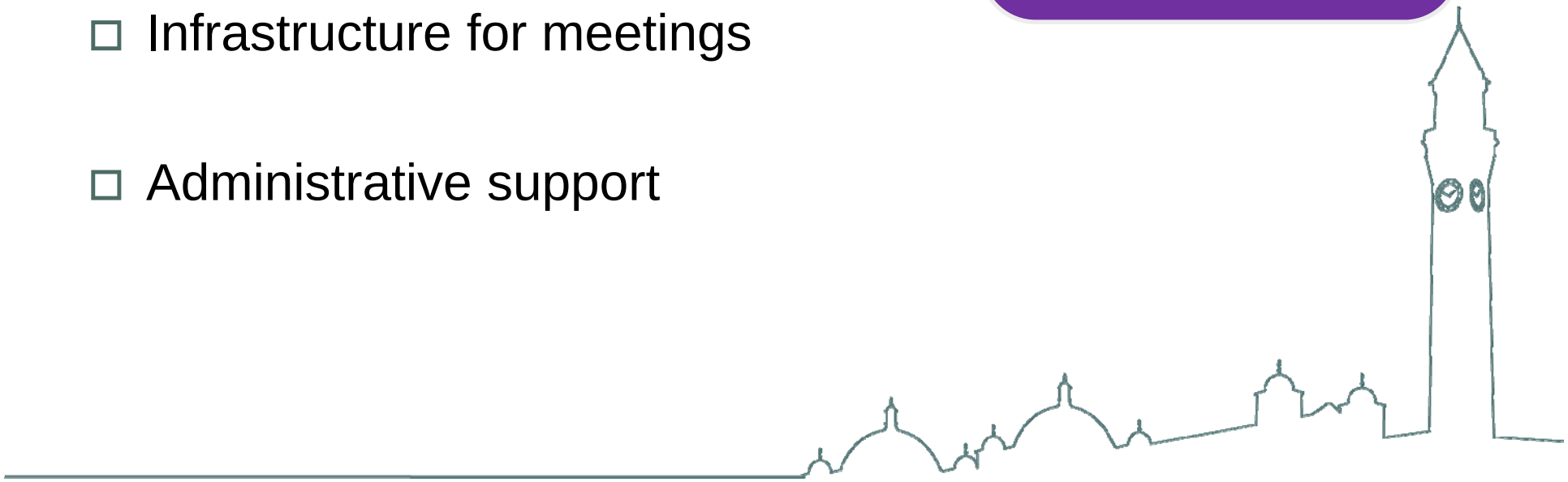


- Working across organisational boundaries
- Work needed to understand how to facilitate within current systems
- Case studies include Hampshire Health Record

Information Sharing

- Opportunities for informal communication (space, time, tools)
- Technology and equipment
- Infrastructure for meetings
- Administrative support

Resources

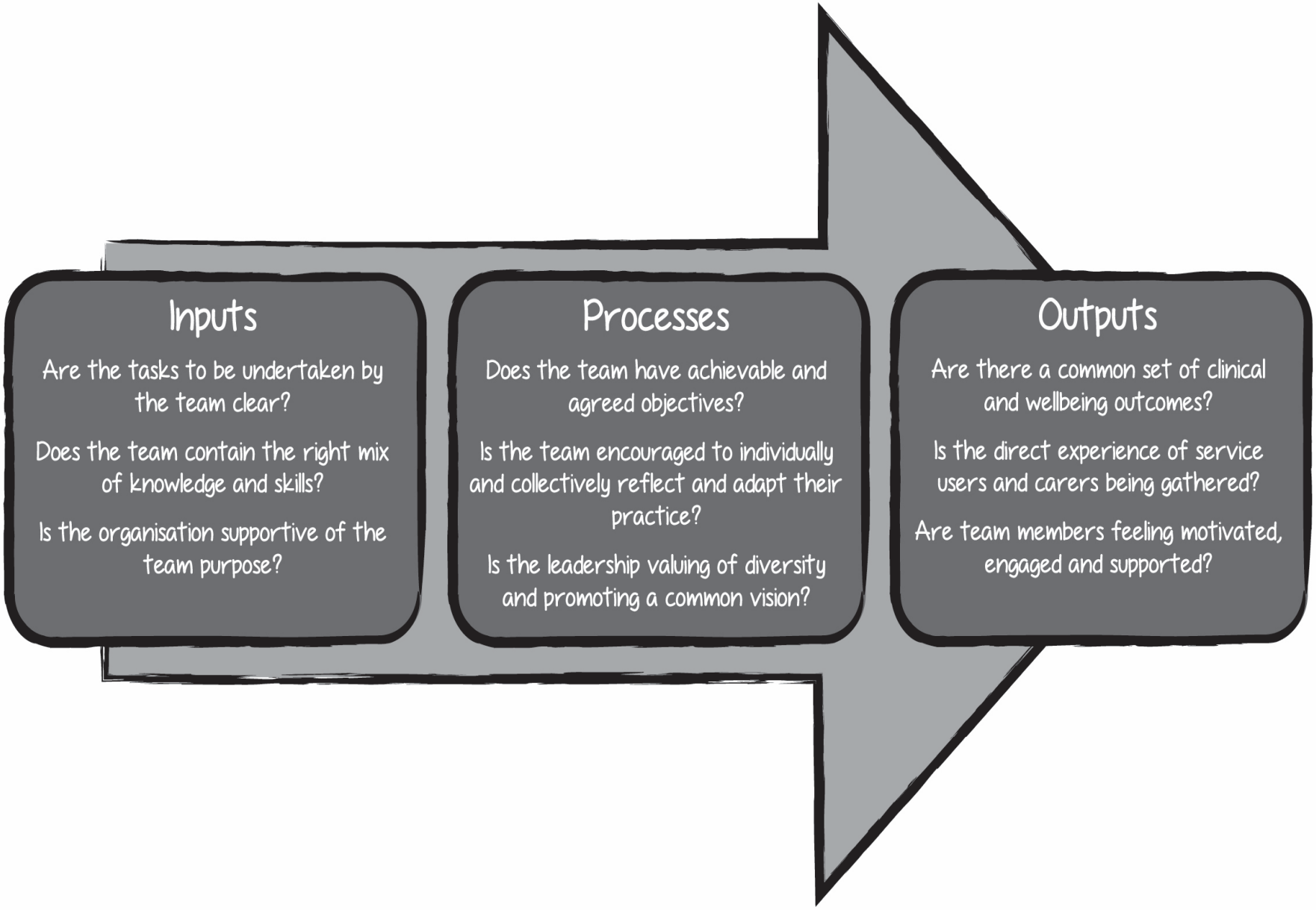


- Clear and agreed objectives
- Link between shared purpose and implementation of decisions
- Aligning working practices & formal processes
- Shared outcome measures
- Clear roles & responsibilities

Shared purpose

- Some examples of perceived medical dominance
- Sense of ownership
- Feeling about to contribute about patient management/ design of meetings
- Ongoing reflection to support continuous improvement
- Building relationships & trust through multidisciplinary learning

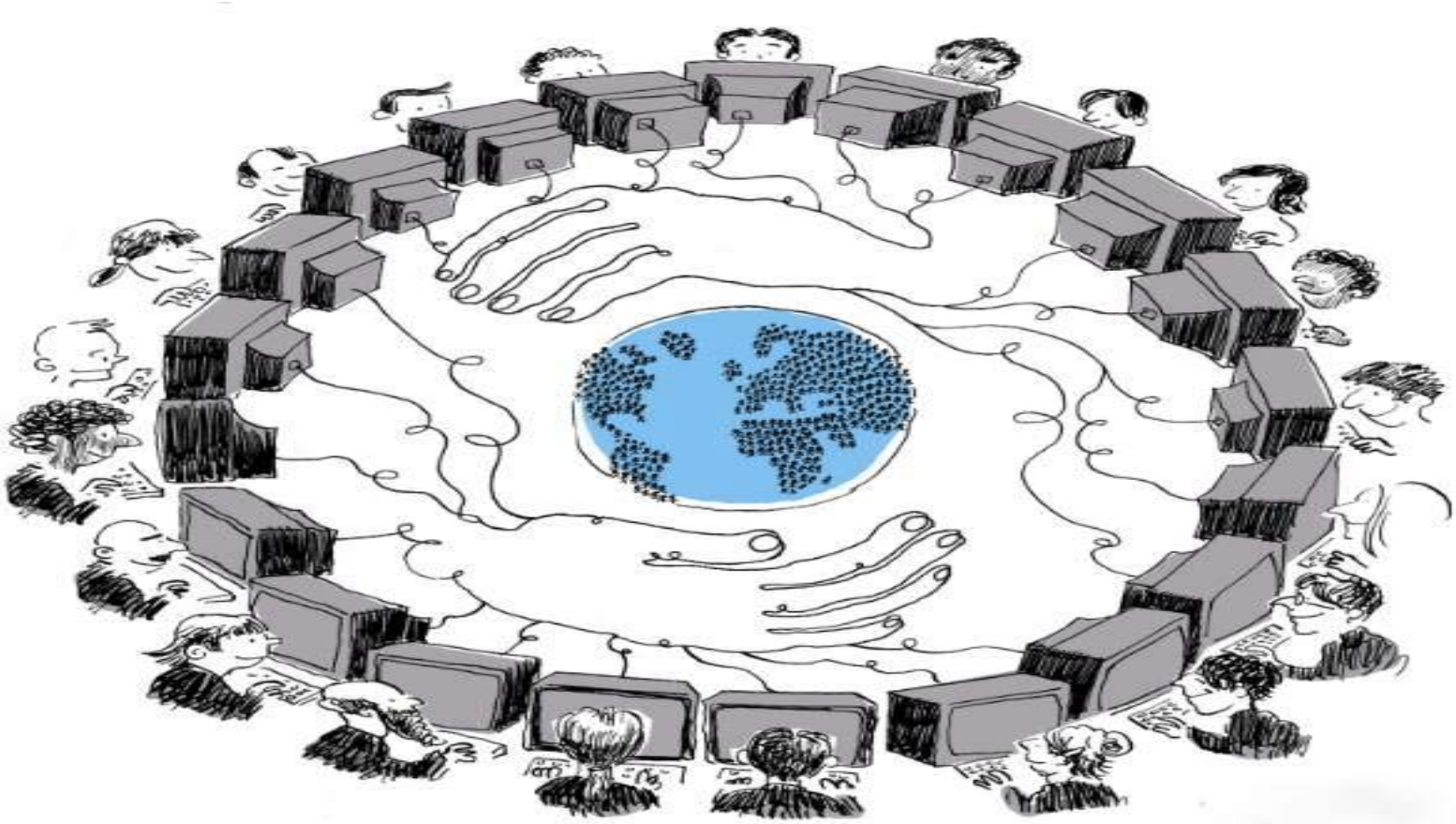
Team dynamics


Inputs
Are the tasks to be undertaken by the team clear?
Does the team contain the right mix of knowledge and skills?
Is the organisation supportive of the team purpose?
Processes
Does the team have achievable and agreed objectives?
Is the team encouraged to individually and collectively reflect and adapt their practice?
Is the leadership valuing of diversity and promoting a common vision?
Outputs
Are there a common set of clinical and wellbeing outcomes?
Is the direct experience of service users and carers being gathered?
Are team members feeling motivated, engaged and supported?

Emotional Labour

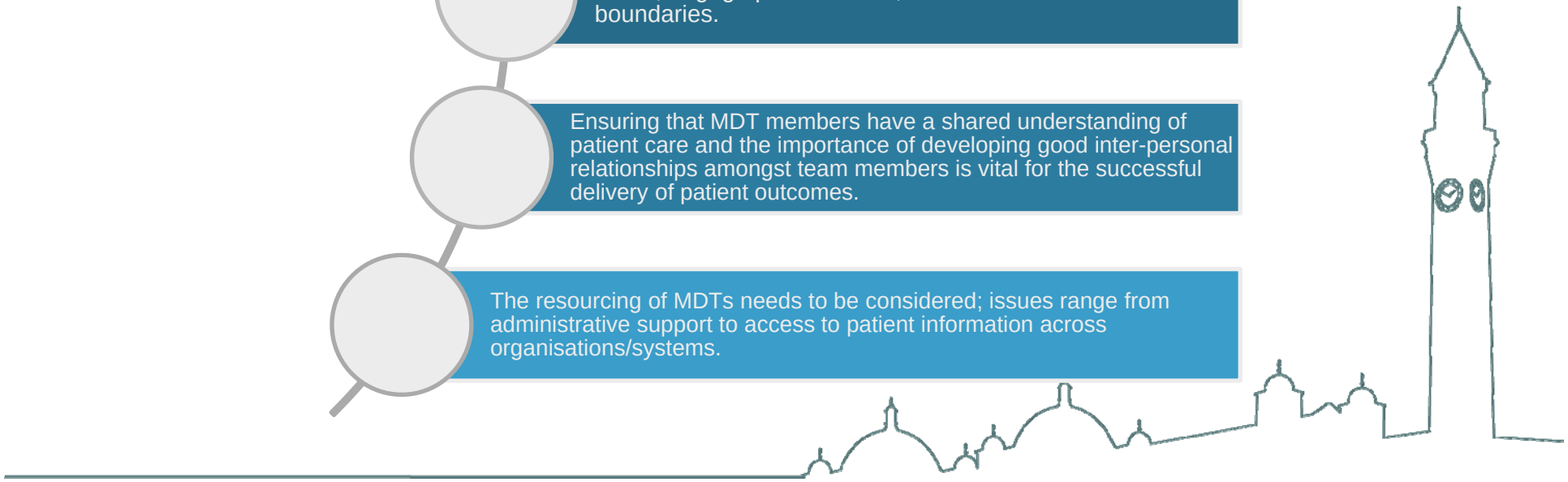
Culture and Safety

Virtual teams



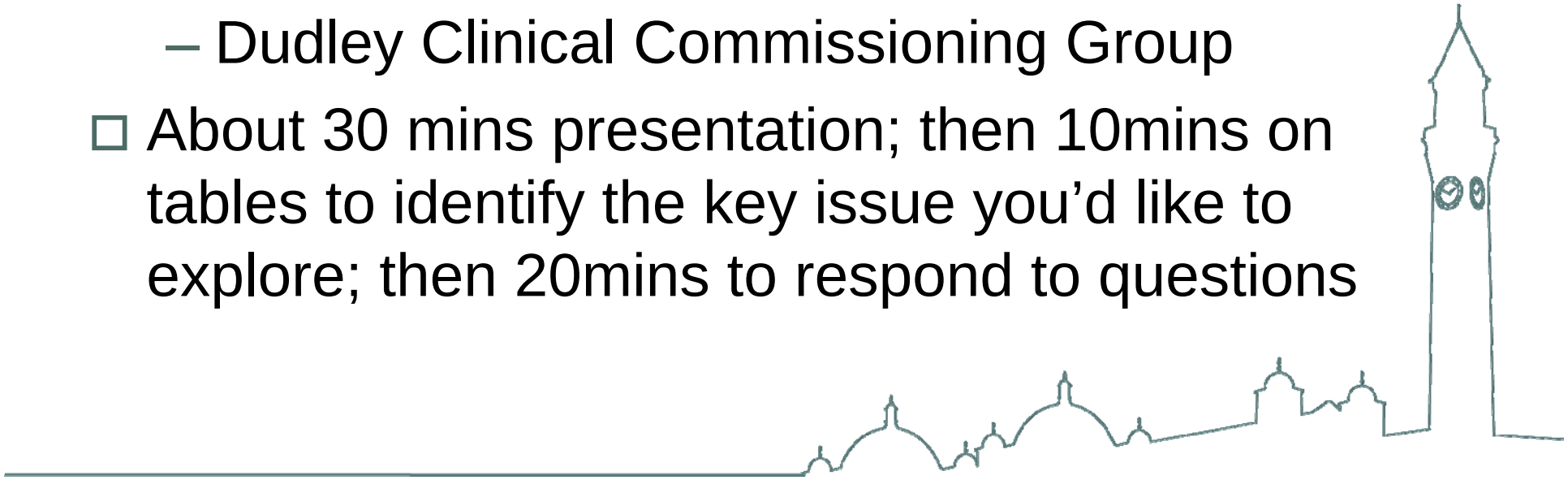
Summary slide

- There is a need to define outcomes and agree measures, including patient and staff experience and wider system impact e.g. social return on investment and health inequalities.
- How are patients targeted? There are a number of predictive models available; increasingly some health economies are basing risk stratification on multimorbidity.
- Leadership at a strategic level is needed to build a common vision, engage professionals, and work across service boundaries.
- Ensuring that MDT members have a shared understanding of patient care and the importance of developing good inter-personal relationships amongst team members is vital for the successful delivery of patient outcomes.
- The resourcing of MDTs needs to be considered; issues range from administrative support to access to patient information across organisations/systems.



Next session

- Two case studies will present their experience of developing MDTs
  - North Manchester Macmillan Palliative Care Support Service
  - Dudley Clinical Commissioning Group
- About 30 mins presentation; then 10mins on tables to identify the key issue you'd like to explore; then 20mins to respond to questions



North Manchester Macmillan Palliative Care Support Service

Alicia Waite

NMMPCSS Service Manager

Christine Mathewson

NMMPCSS Programme Manager

How it was funded

Macmillan Cancer Improvement Partnership (MCIP)

- NMMPCSS - phase 1 MCIP Project – Oct. 14 – Nov. 16
- £560k Macmillan grant
- £200k recurrent funding –North Manchester CCG

- Business case to North Manchester CCG
- CCG Investment reviews alongside MCIP project monitoring

Why North Manchester?

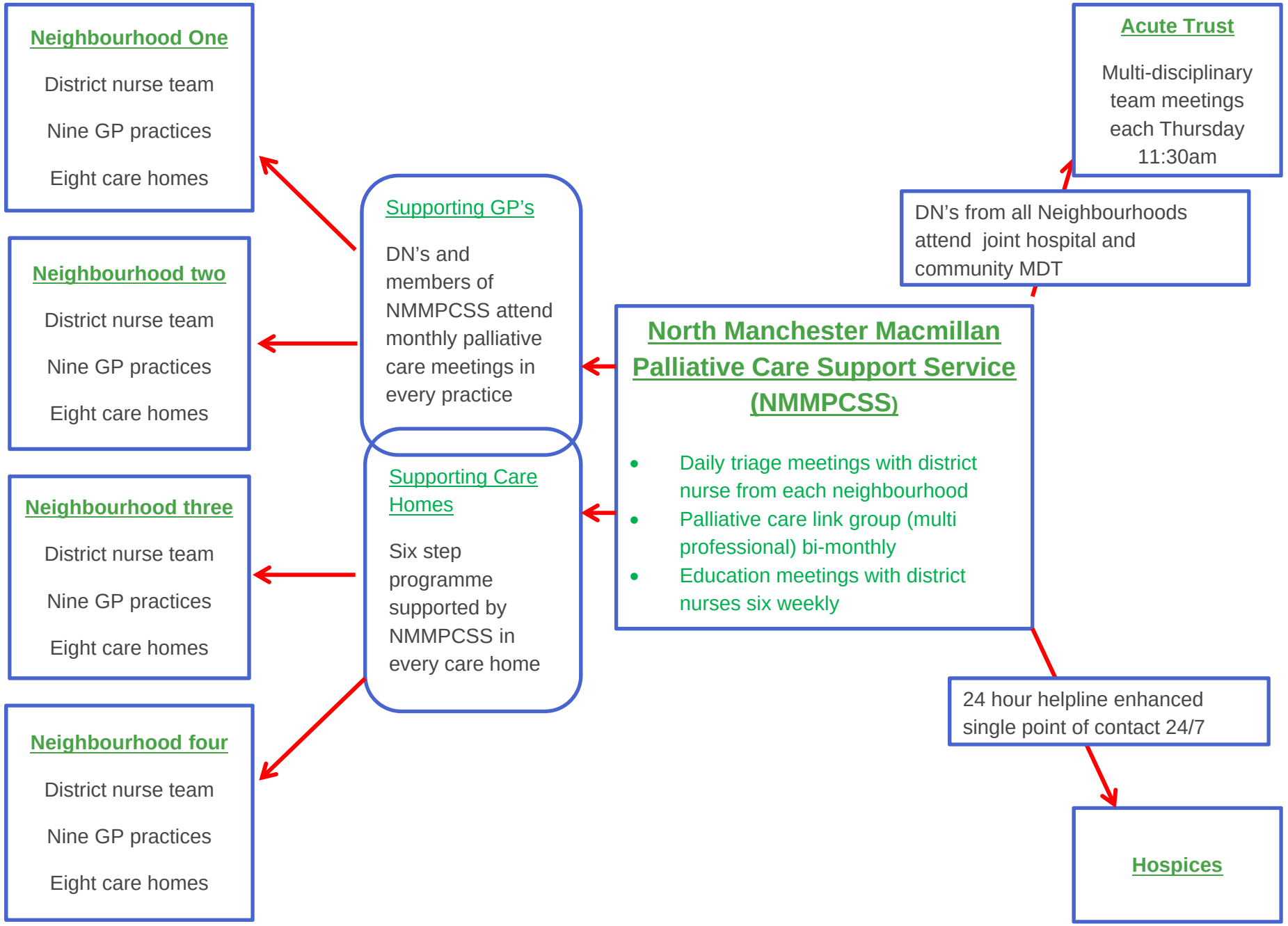
- A higher than national average number of deaths in hospital – 40% have no medical need to be there
- 59% of people state they are frightened of dying in hospital and 70% prefer to die at home.
- No hospice, deprived population – low car ownership
- Higher than national average deaths from cancer
- To create learning that can be shared across the city.
- To increase patient choice and co-ordination of care at the end of life.

Palliative Care in North Manchester prior to NMMPCSS

- Depleted Macmillan team
- Service closed to referrals in summer of 14/15. Crisis
- District nurses struggling with palliative care caseload
- GP palliative care registers unpopulated
- Basic MDT meeting in place and some GP palliative care meetings but attendance poor due to depleted team.
- Many crisis admissions and deaths in hospital

New Model Summary

- Consultant led service
- Enhanced team (Service Manager, Nurses, Therapists, Assistant Practitioners, Volunteer Co-ordinator, Admin)
- 8am-8pm Service, 7 days a week
- Triage by clinician during all working hours
- One point of access 24/7 – patients and professionals
- Enhanced integration – District nurse link role
- Multi level MDT's


Neighbourhood One
District nurse team
Nine GP practices
Eight care homes
Neighbourhood two
District nurse team
Nine GP practices
Eight care homes
Neighbourhood three
District nurse team
Nine GP practices
Eight care homes
Neighbourhood four
District nurse team
Nine GP practices
Eight care homes
Supporting GP's
DN's and members of NMMPCSS attend monthly palliative care meetings in every practice
Supporting Care Homes
Six step programme supported by NMMPCSS in every care home
North Manchester Macmillan Palliative Care Support Service (NMMPCSS)
Daily triage meetings with district nurse from each neighbourhood
Palliative care link group (multi professional) bi-monthly
Education meetings with district nurses six weekly
Acute Trust
Multi-disciplinary team meetings each Thursday 11:30am
DN's from all Neighbourhoods attend joint hospital and community MDT
24 hour helpline enhanced single point of contact 24/7
Hospices

Project Outcomes

- 109% increase in patients on GP palliative care registers. Equaled the national average for first time.
- 88% of patients achieved their preferred place of care
- Deaths in hospital – less than target of 20% since April 2015
- Access targets – all 100% as patients all contacted on day of referral to assess urgency
- 78.9% of patients have an advanced care plan
- Increasing number of patients with life limiting illnesses other than cancer
- 25% increase in referrals for volunteer support
- No complaints since the service commenced
- Awarded ‘outstanding’ at recent CQC inspection

Multi-disciplinary working – layer by layer

- First things first– NMMPCSS work as one – referrals to team rather than an individual discipline. Therapists expand their role to undertake triage.
- District nurses from each neighbourhood attend daily triage (MDT) meetings with NMMPCSS
- Revived and well attended GP Palliative Care Meetings
- District nurse link facilitates timely discharge
- Weekly acute trust hosted MDT is redesigned

Meeting daily!

Redesigned Weekly MDT

- Membership expanded: Consultants, GP's, NMMPCSS, District nurses, Spiritual, Heart failure, Psychiatry, Oncology, Discharge team.
- Function – enhanced to include direct involvement of new members. Much more inclusive and holistic approach.
- Operation – not only medically led – changed to allow 'key worker' to present patients
- Contemporaneous and focused on current key issue faced by patient and family

Expanded Membership

Sharing, thought, discussion and learning

OUTCOMES OF REDESIGNED MDT

- Access improved for a wide range of professionals – benefits all – especially patient and carers. Co-ordination of care much improved.
- Spiritual team extend support into community
- Ensures staff only spend time in MDT when needed
- Time for continuing professional development between part 1 & 2. Staff development
- Assistant practitioner role – proved invaluable – support all professional groups
- Reduced hospital admissions, especially unnecessary crisis.

MDT Feedback

GP's in North Manchester:

- "Better communication between all teams is improving patient outcomes"
- "Improved patient care/ patient management following move to 7 day service"
- "Continuous care provided to cross border patients"

District nurses in North Manchester

- "Staff felt that communication had been greatly improved between District Nursing teams and palliative care speciality staff."
- "Staff felt they learned from each other during the discussions of palliative care cases"

Assistant Practitioners in NMMPCSS

- "It is an opportunity for all disciplines from the hospital and community to meet and discuss patients to ensure excellent patient care, it also allows all disciplines to meet and work together more effectively"

Now we can engage much more

The patient is the most important decision maker

- “The final decision on the way forward needs to be made by the patient in discussion with their clinician”

We invite you to watch our video

https://www.youtube.com/watch?v=5aX1tbTcJgI

Pride in Pennine | Quality-Driven Responsible Compassionate

The Pennine Acute Hospitals NHS NHS Trust

Thank you
Contact details

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Email: alicia.waite@pat.nhs.uk

Christine Mathewson – Programme Manager.

Mob. 07917 650229

Email: chris.mathewson@nhs.net

Improving the effectiveness of multidisciplinary team (MDT) meetings in NHS cancer services

Rose Gray, Policy Adviser

CANCER RESEARCH UK

POLICY AT CANCER RESEARCH UK

TEST CANCER SOONER

OUR RATIONALE

2

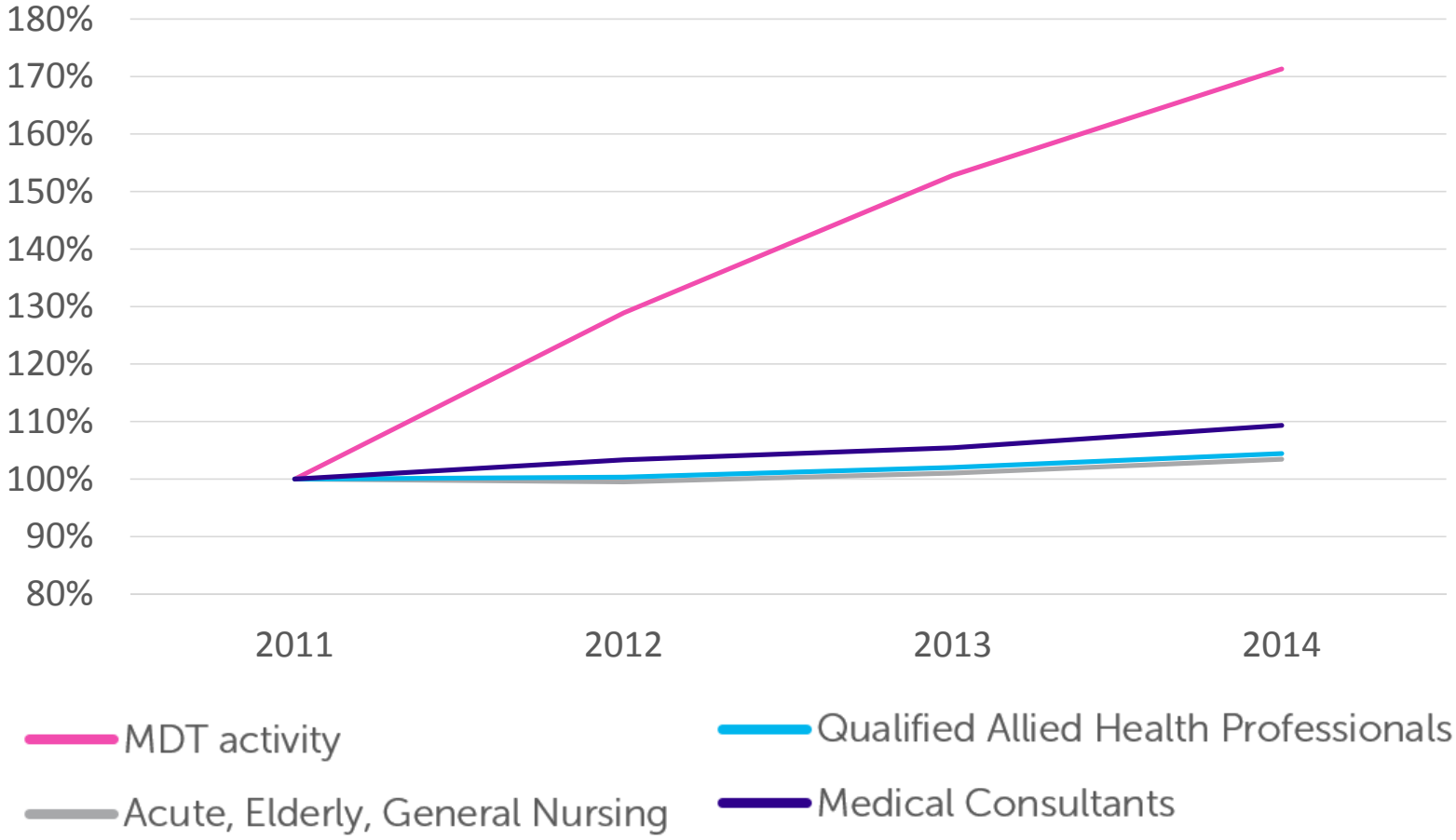
THE EVOLUTION OF THE MDT

Calman K, Hine D, 1995: *"A policy framework for commissioning cancer services: a report by the expert advisory group on cancer to the chief medical officers of England and Wales."* London: Department of Health
Scottish Cancer Co-ordinating and Advisory Committee, 1996: *"Commissioning Cancer Services in Scotland: report to the Chief Medical Officer, SODoH."* Edinburgh: the Scottish Office

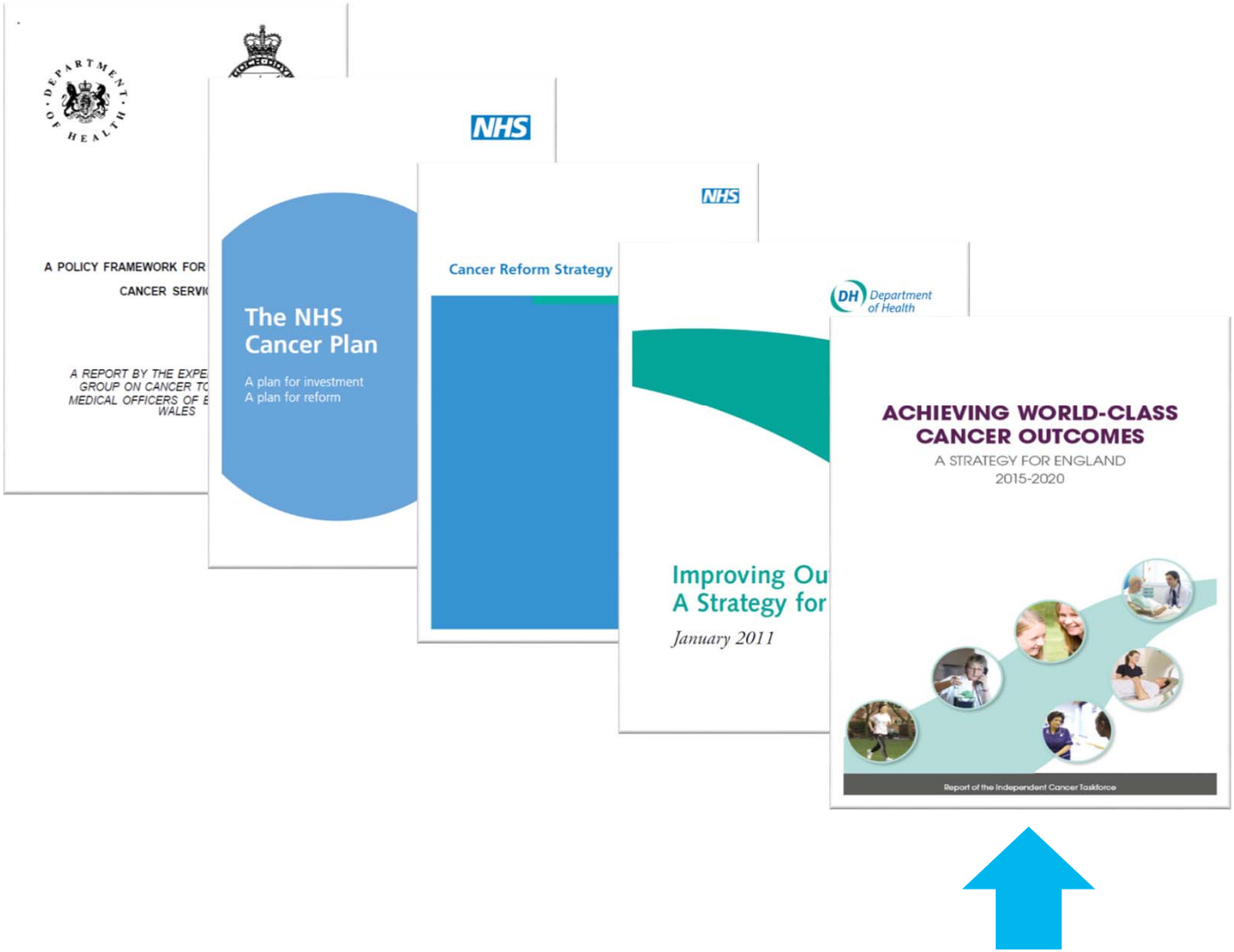

A POLICY FRAMEWORK FOR
CANCER SERVI
A REPORT BY THE EXPE
GROUP ON CANCER TO
MEDICAL OFFICERS OF E
WALES
NHS
The NHS
Cancer Plan
A plan for investment
A plan for reform
NHS
Cancer Reform Strategy
DH Department of Health
Improving Ou
A Strategy for
January 2011
ACHIEVING WORLD-CLASS
CANCER OUTCOMES
A STRATEGY FOR ENGLAND
2015-2020
Report of the Independent Cancer Taskforce

THE CURRENT CHALLENGES

WORKLOAD & CAPACITY TRENDS:



NATIONAL PEER REVIEW: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2015-2020
Report of the Independent Cancer Taskforce

38

39

40

OUR QUESTION

SHOULD THERE BE A DIFFERENT WAY OF WORKING FOR MDTS?


COMMISSIONING &
METHODOLOGY
2

A MIXED METHODS APPROACH:

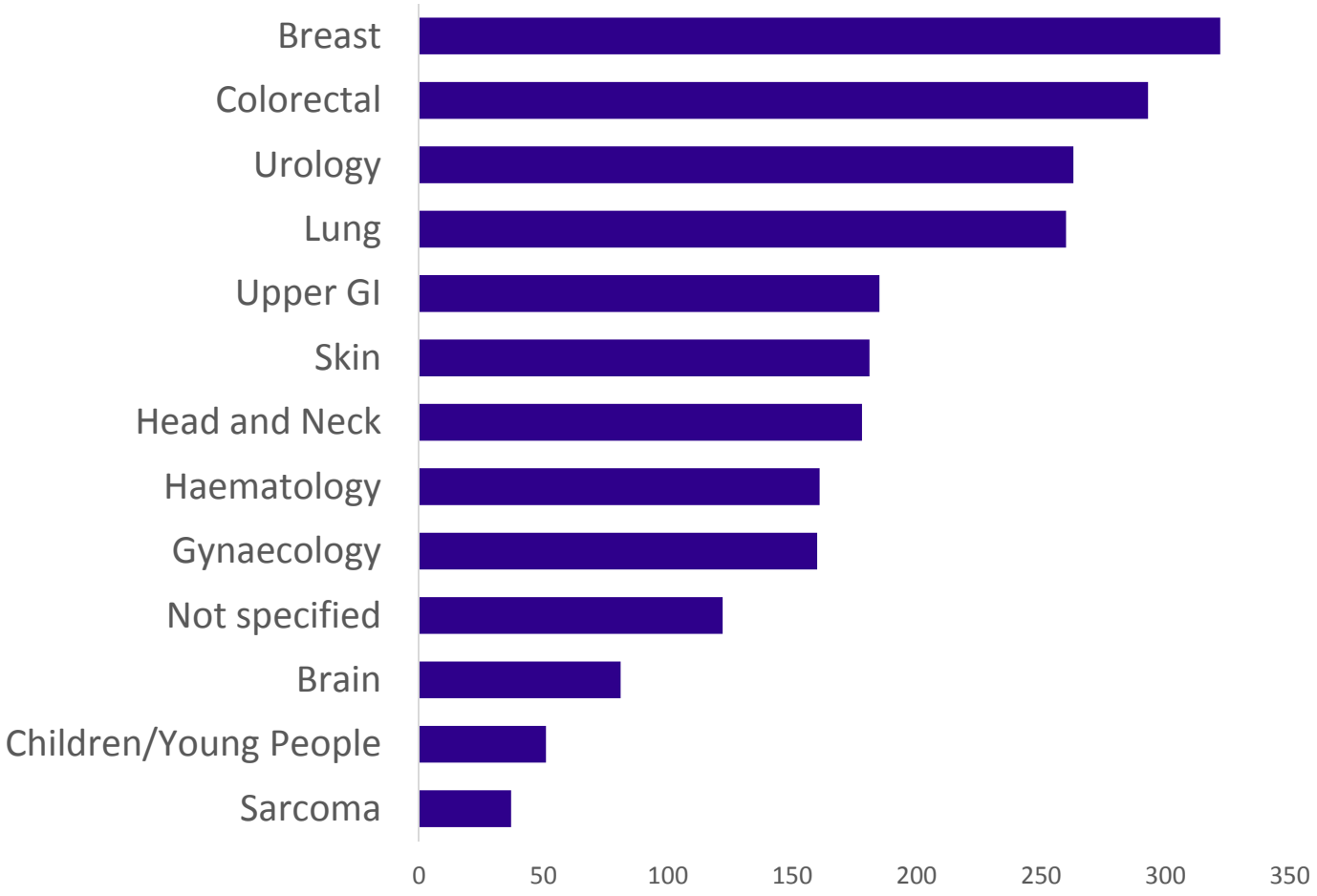
- Quantitative analysis and projections
- Literature review
- Two semi-structured online surveys
- Fieldwork: observational audits of MDTs, interviews

EMERGING FINDINGS

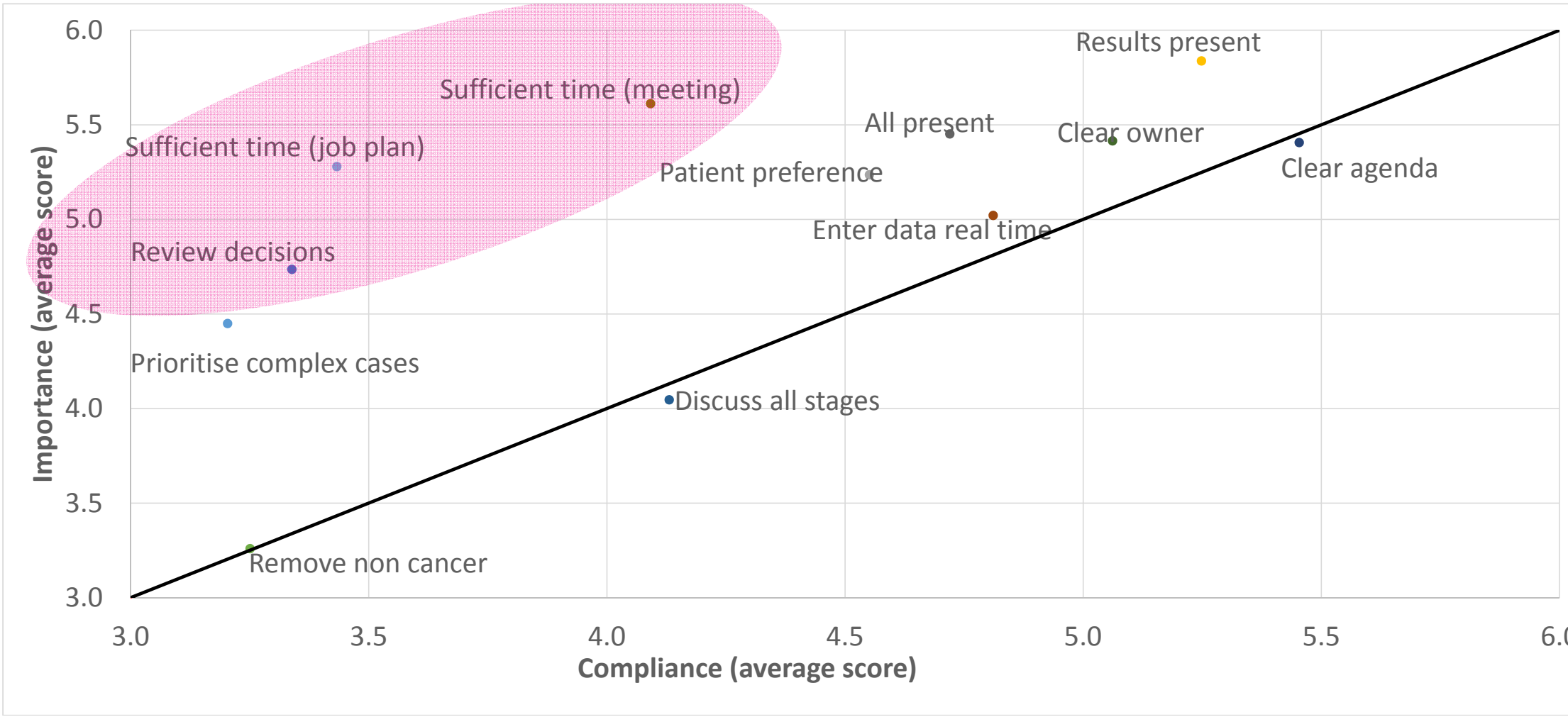
3

INITIAL SURVEY: 2300 RESPONSES

INITIAL SURVEY: 2300 RESPONSES



INITIAL SURVEY: 2300 RESPONSES



FIELDWORK

624 PATIENT DISCUSSIONS

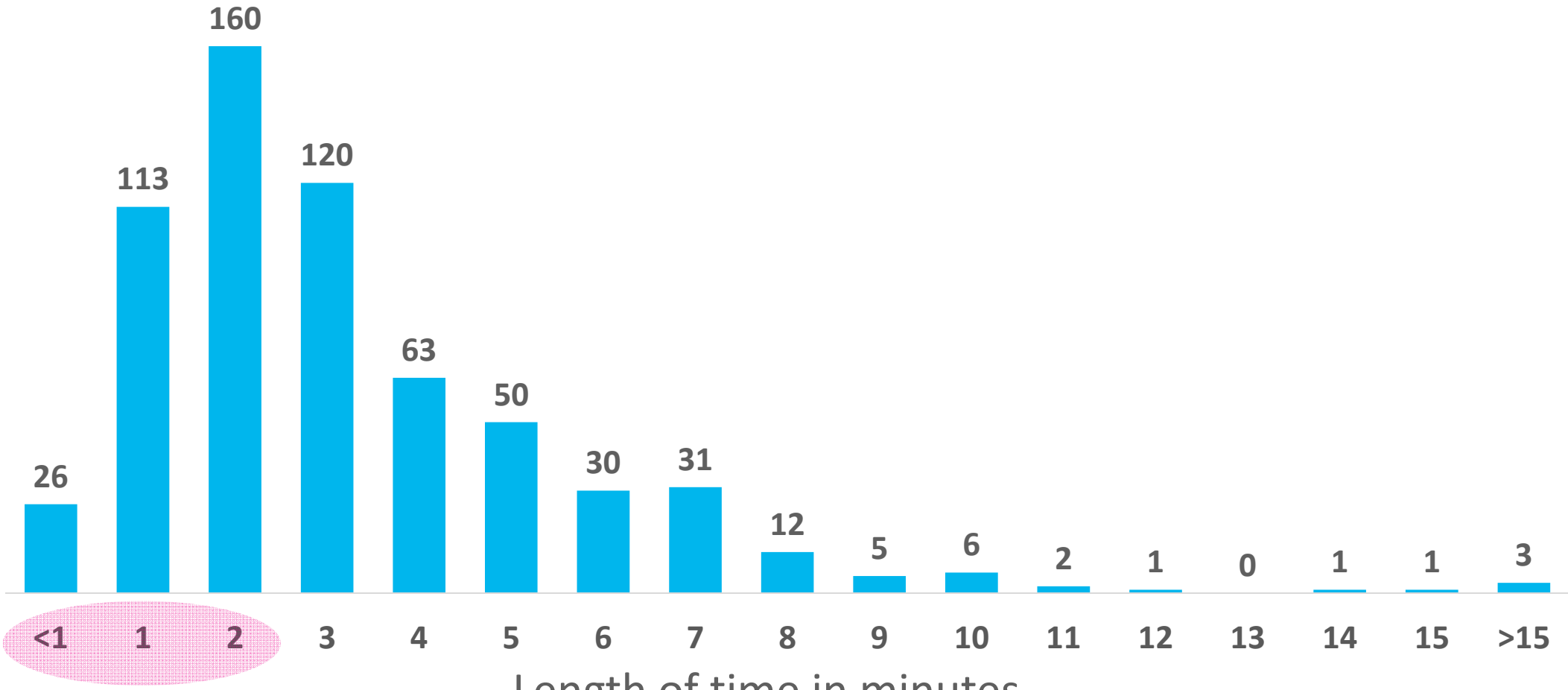
24 MDT MEETINGS

11 TUMOUR SITES

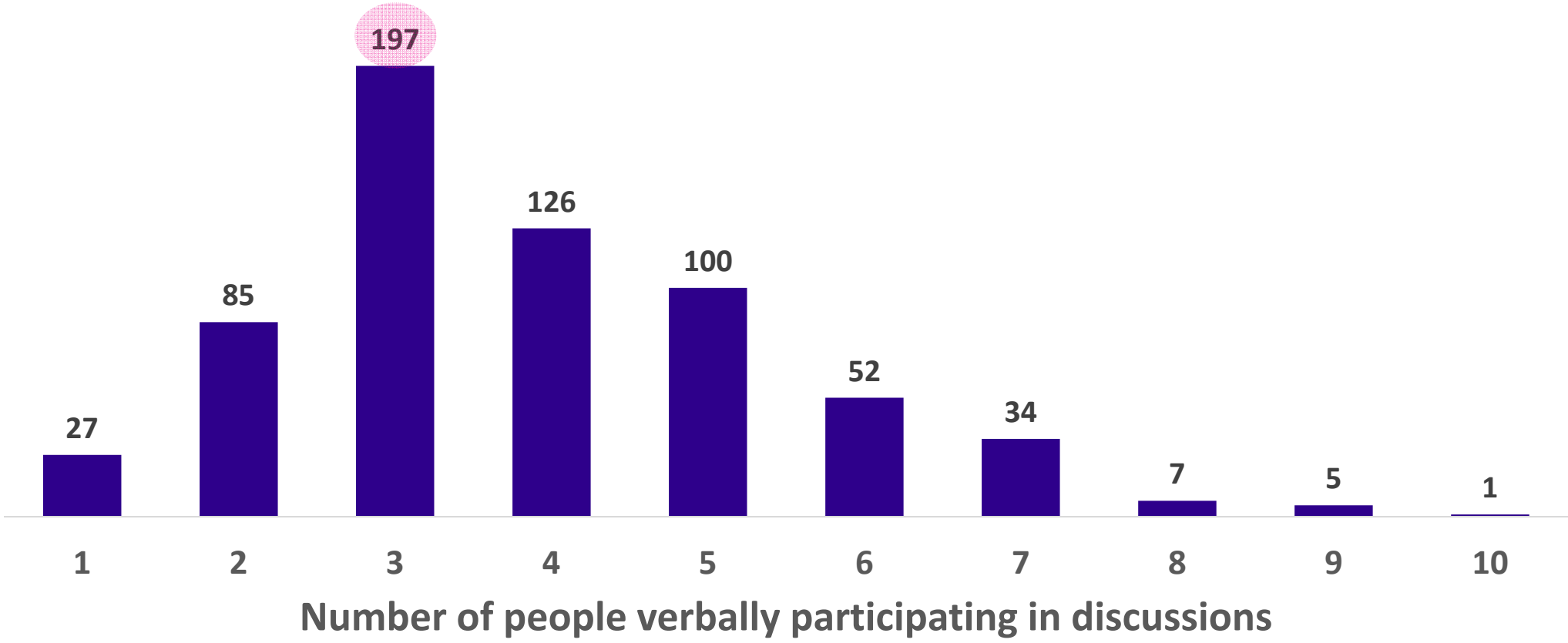
10 TRUSTS

- Observational audit using MDT-MOT (Green Cross Medical Ltd) and MDT-MODe (Lamb et al)
- Interviews with MDT leads, coordinators and other attendees.

FIELDWORK: LENGTH OF PATIENT DISCUSSIONS



FIELDWORK: PARTICIPATION IN DISCUSSIONS



OTHER KEY FINDINGS

- 7% of discussions were deferred because of missing information or members.
- Variation in how patient-centred decision-making was.
- In over 75% of meetings, Clinical Nurse Specialists didn't speak at all.
- Issues with the quality of videoconferencing facilities.

FOLLOW-UP SURVEY

1. ATTENDANCE

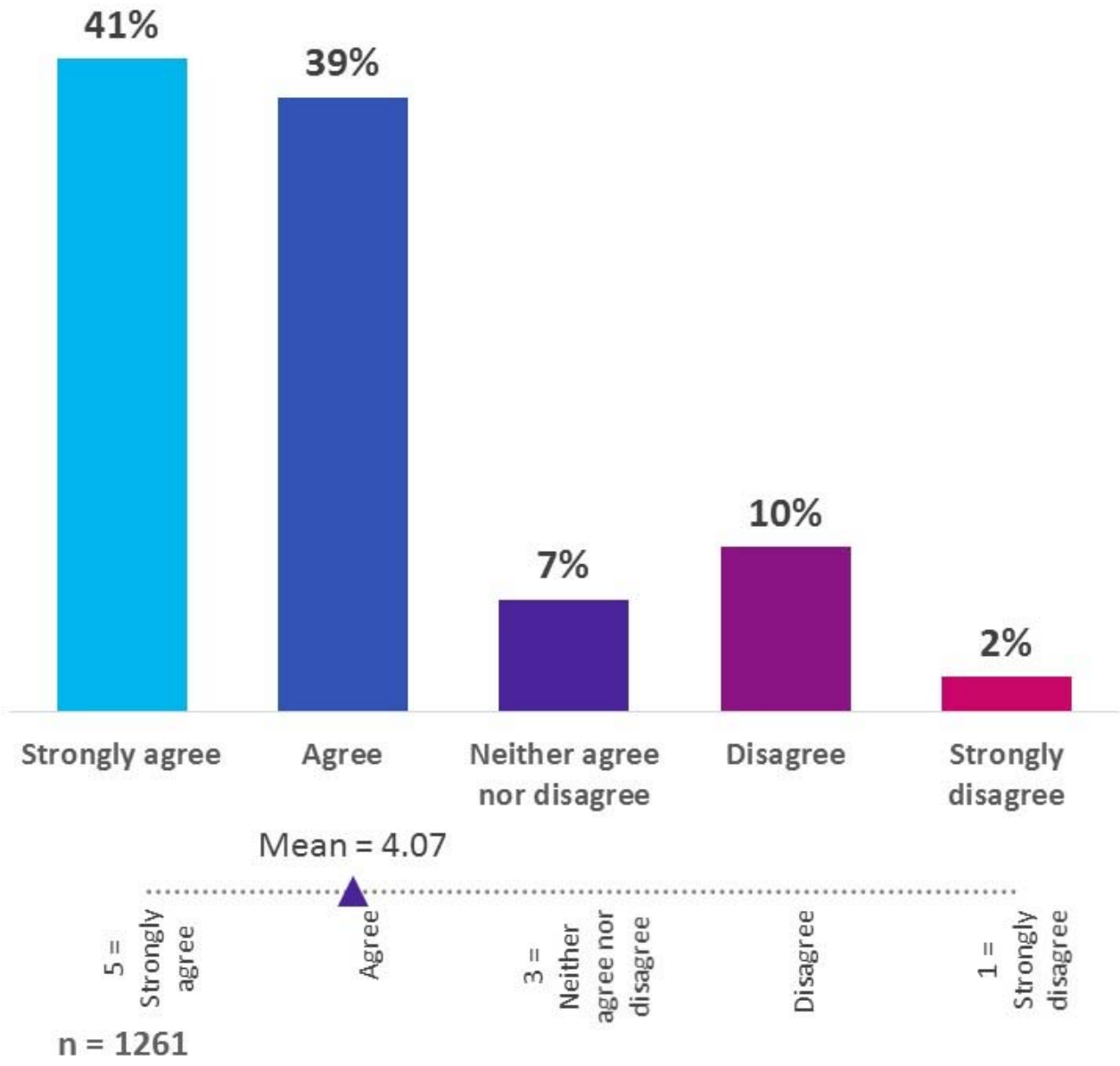
2. STREAMLINING DISCUSSIONS

3. ENSURING PATIENTS ARE READY FOR MDT

4. NON-CASE DISCUSSION BENEFITS OF MDTS

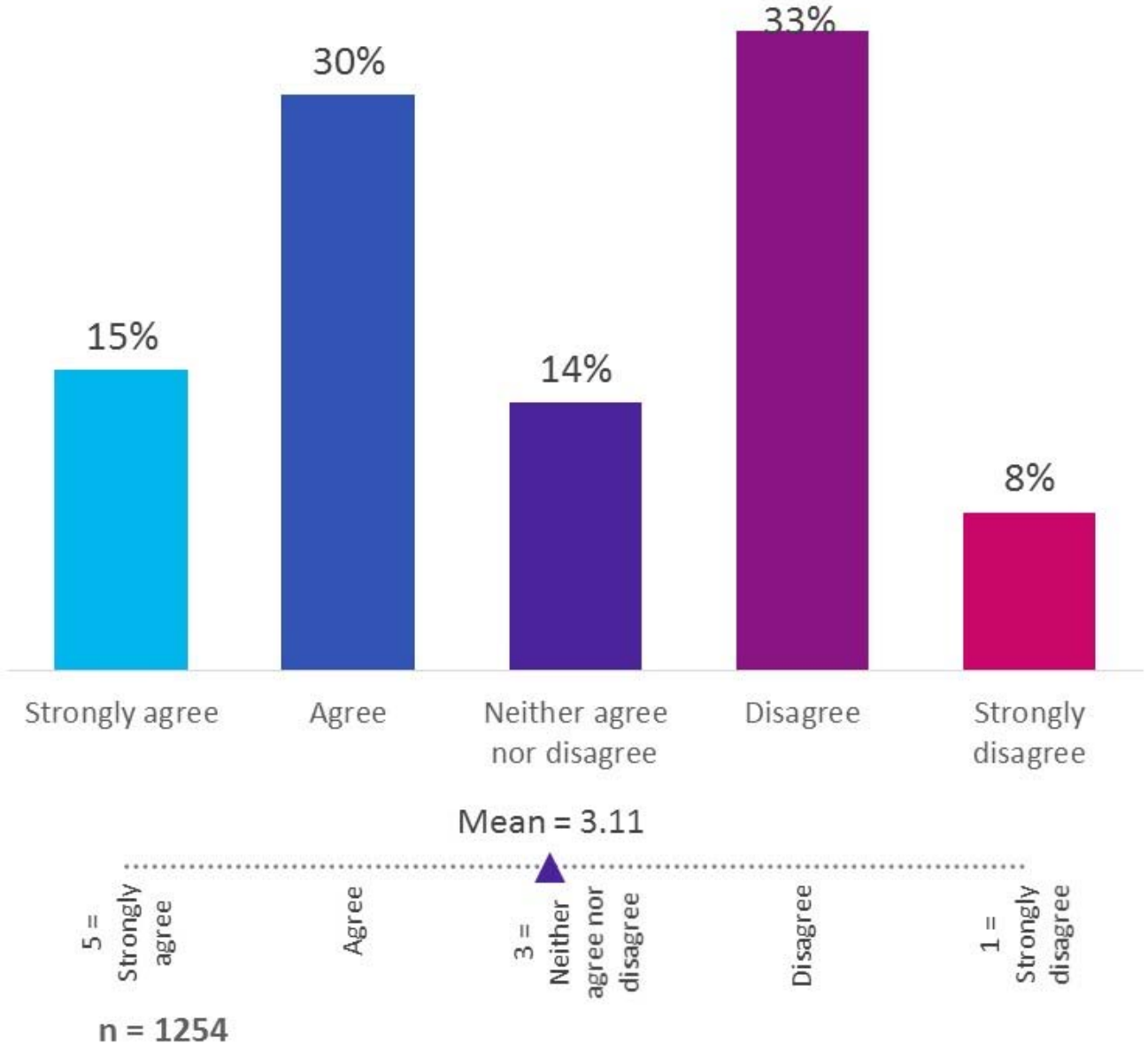
ATTENDANCE

INDIVIDUAL SPECIALTY COVER RATHER THAN INDIVIDUAL MEMBER ATTENDANCE

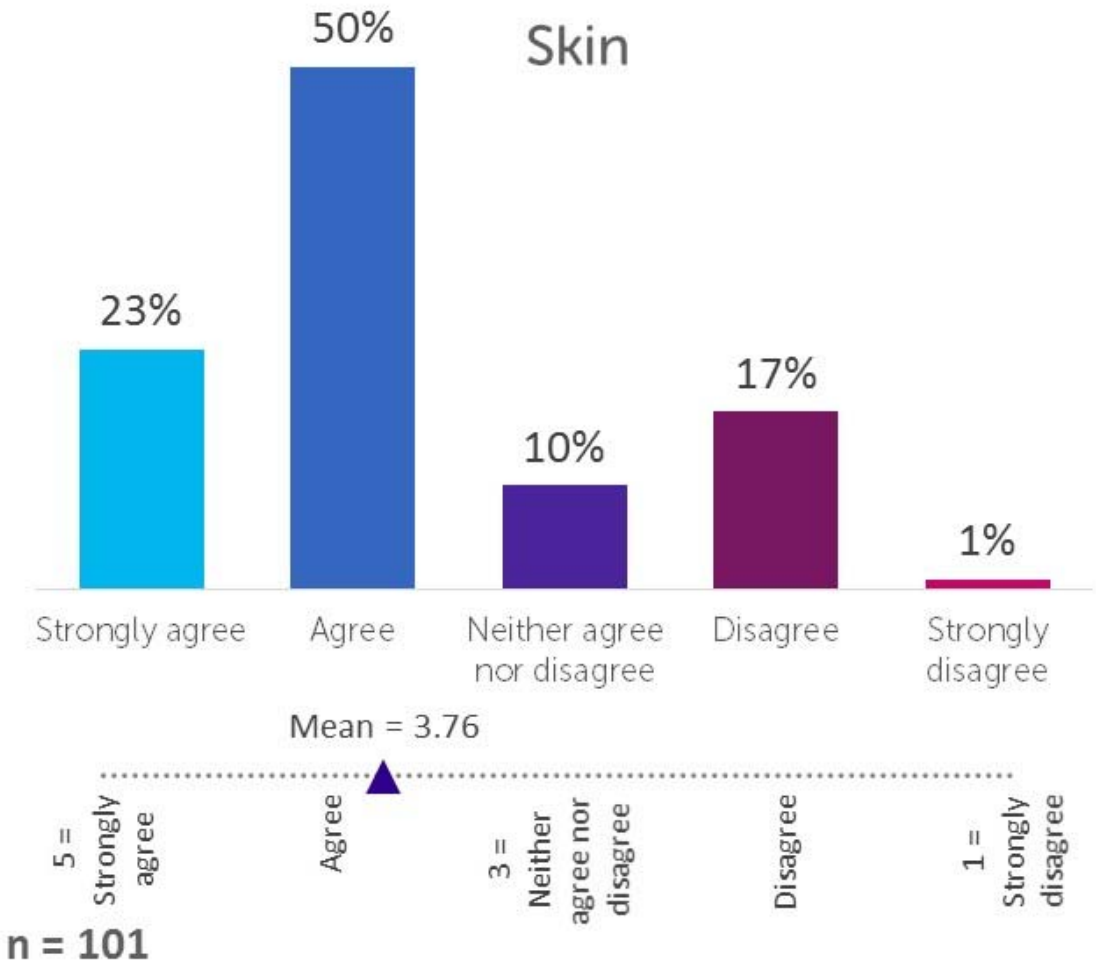


STREAMLINING

COULD SOME PATIENTS BE PLACED ON PROTOCOLISED TREATMENT PATHWAYS & NOT BE DISCUSSED AT MDT?



SPLIT FOR DIFFERENT TUMOUR TYPES:



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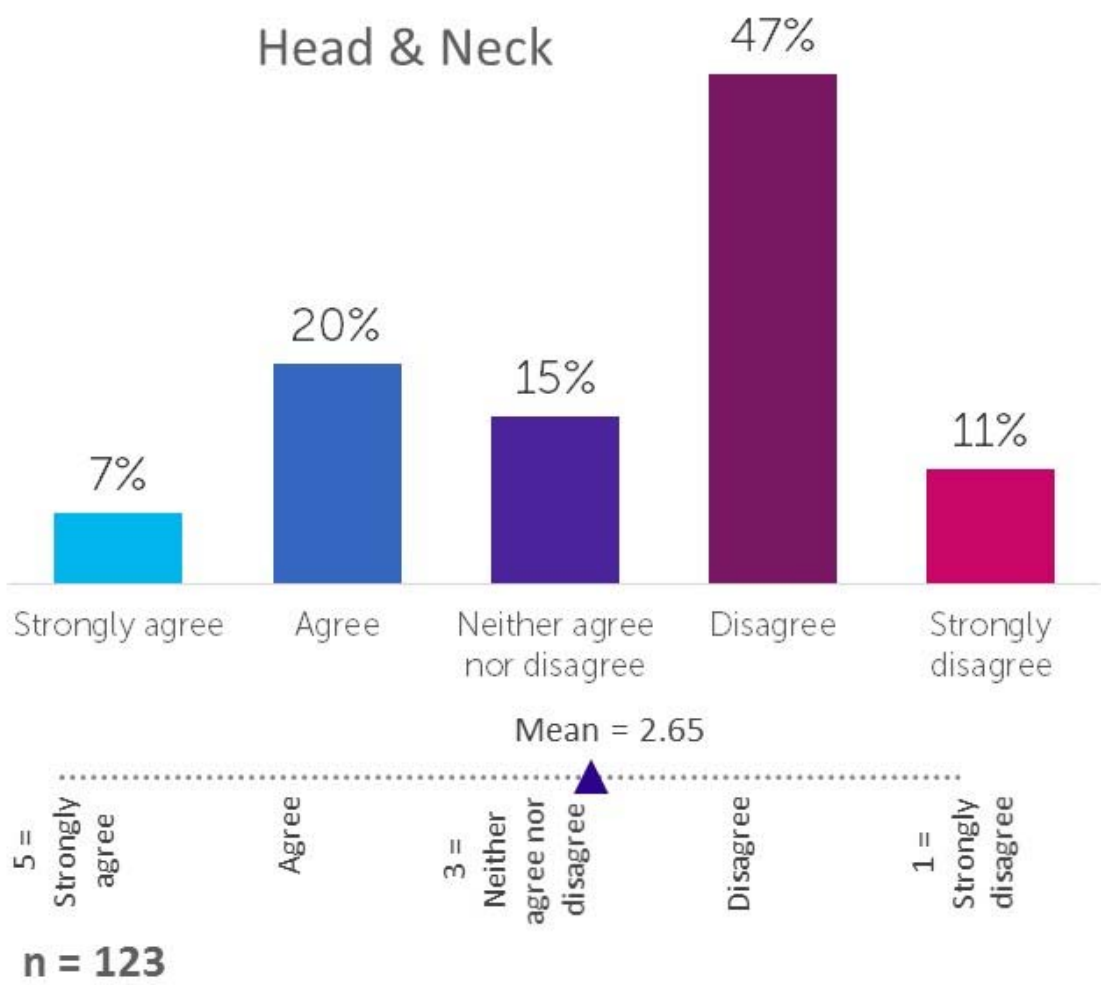
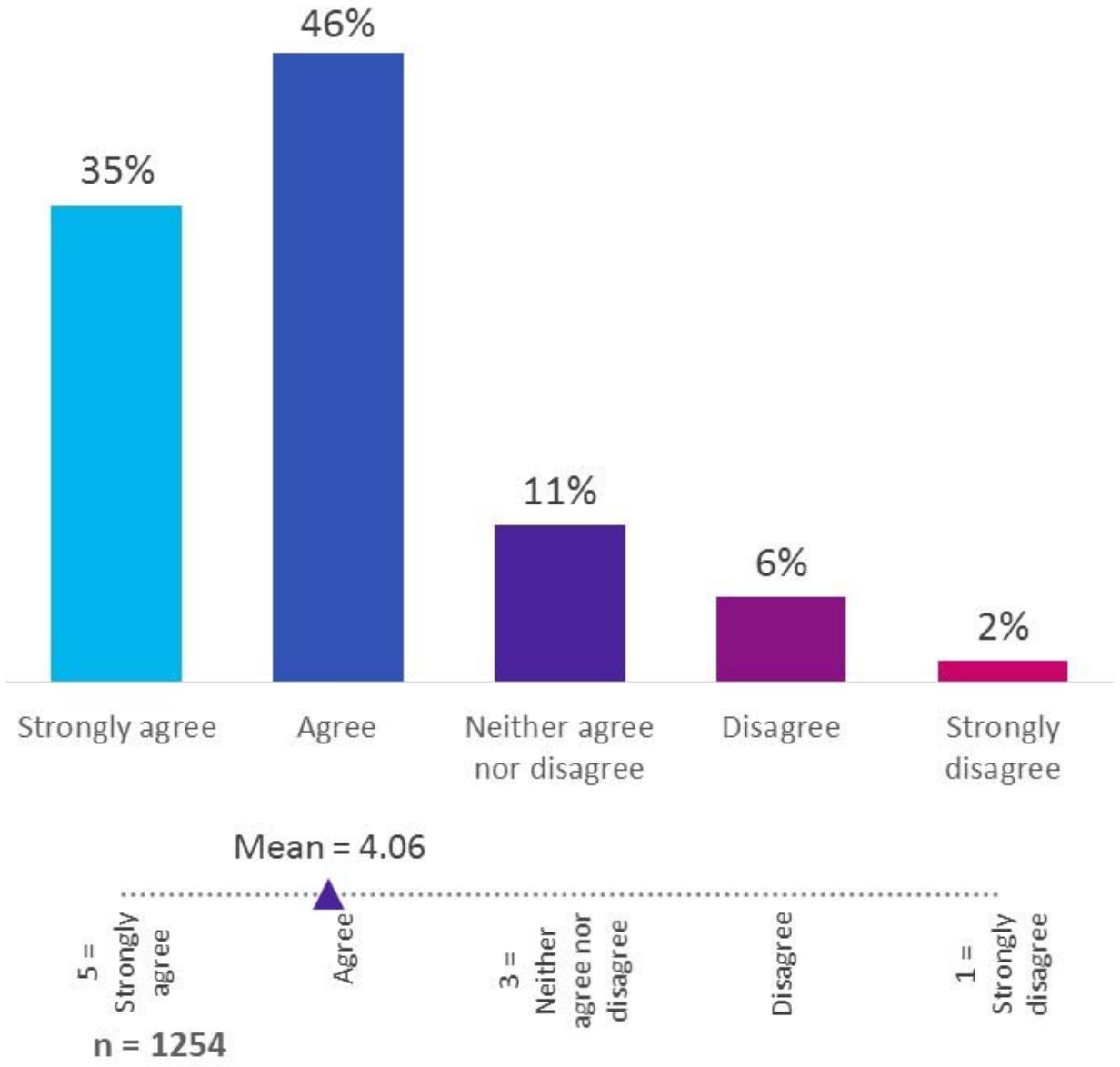


n = 123

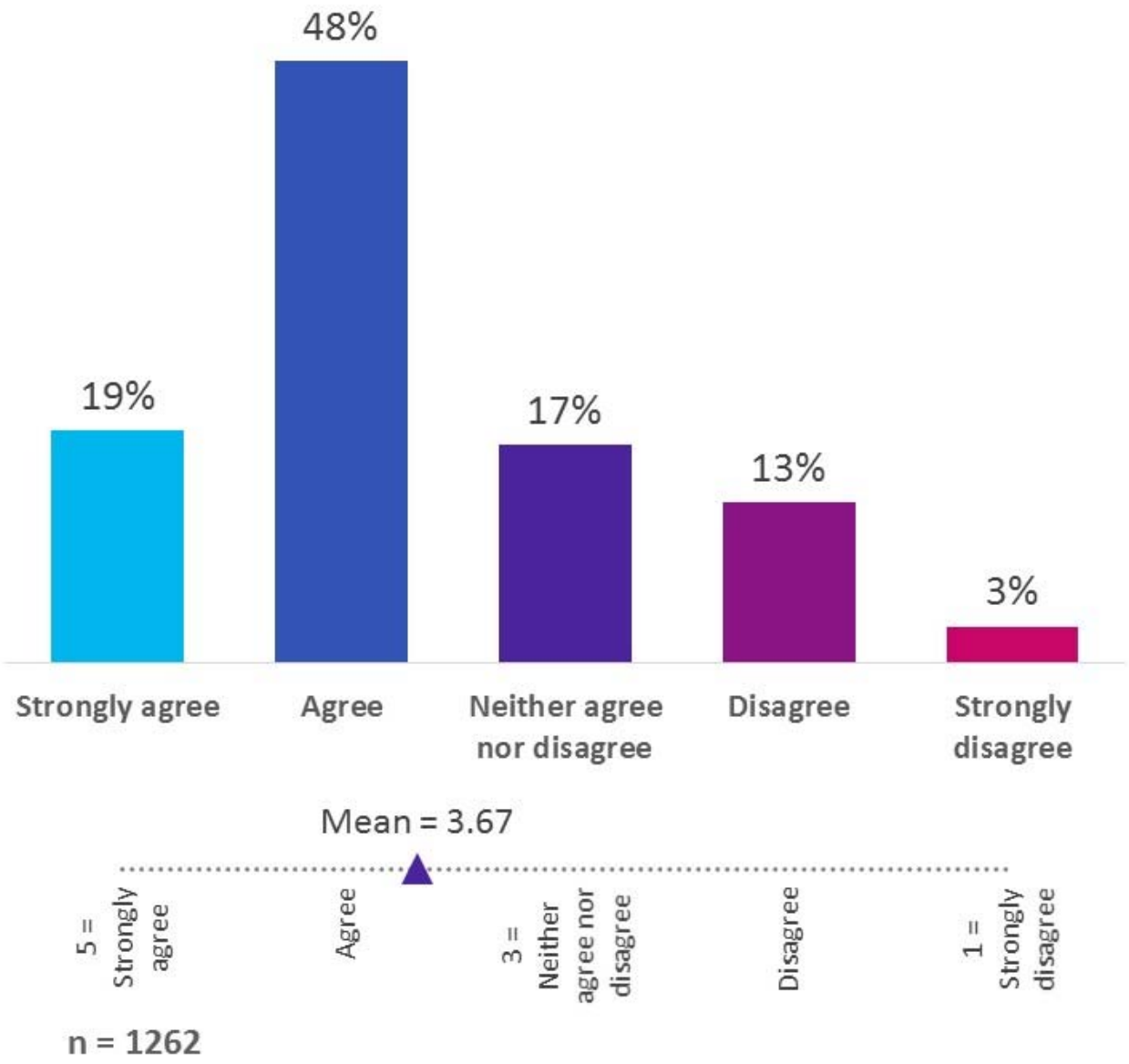
PROFORMAS

THE USE OF A PROFORMA TO ENSURE ALL NECESSARY INFORMATION IS AVAILABLE WOULD HAVE A BENEFICIAL IMPACT ON EFFICIENCY



NON-CASE DISCUSSION BENEFITS

QUARTERLY OPERTATIONAL MEETINGS TO REVIEW ELEMENTS OF THE MDT MEETING



WHAT’S NEXT?

THANK YOU

rose.gray@cancer.org.uk

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CANCER RESEARCH UK

Dudley Multi-specialty Community Provider

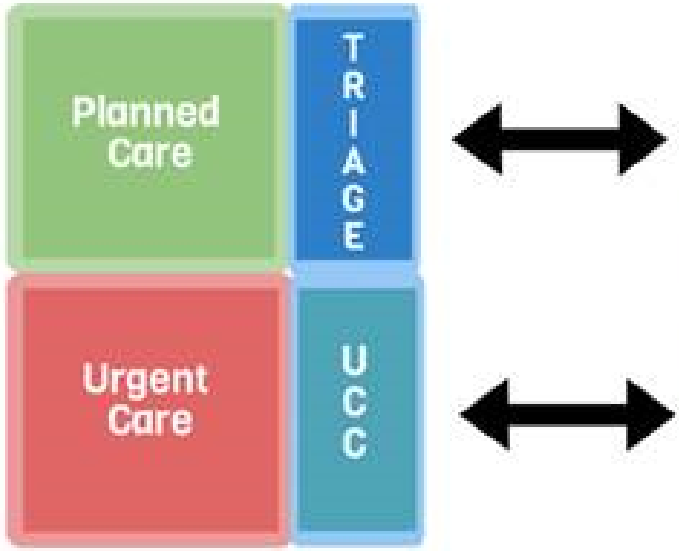
Our Multi Disciplinary Teams

Stephanie Cartwright
Director of Organisational Development & Human Resources
Dudley CCG

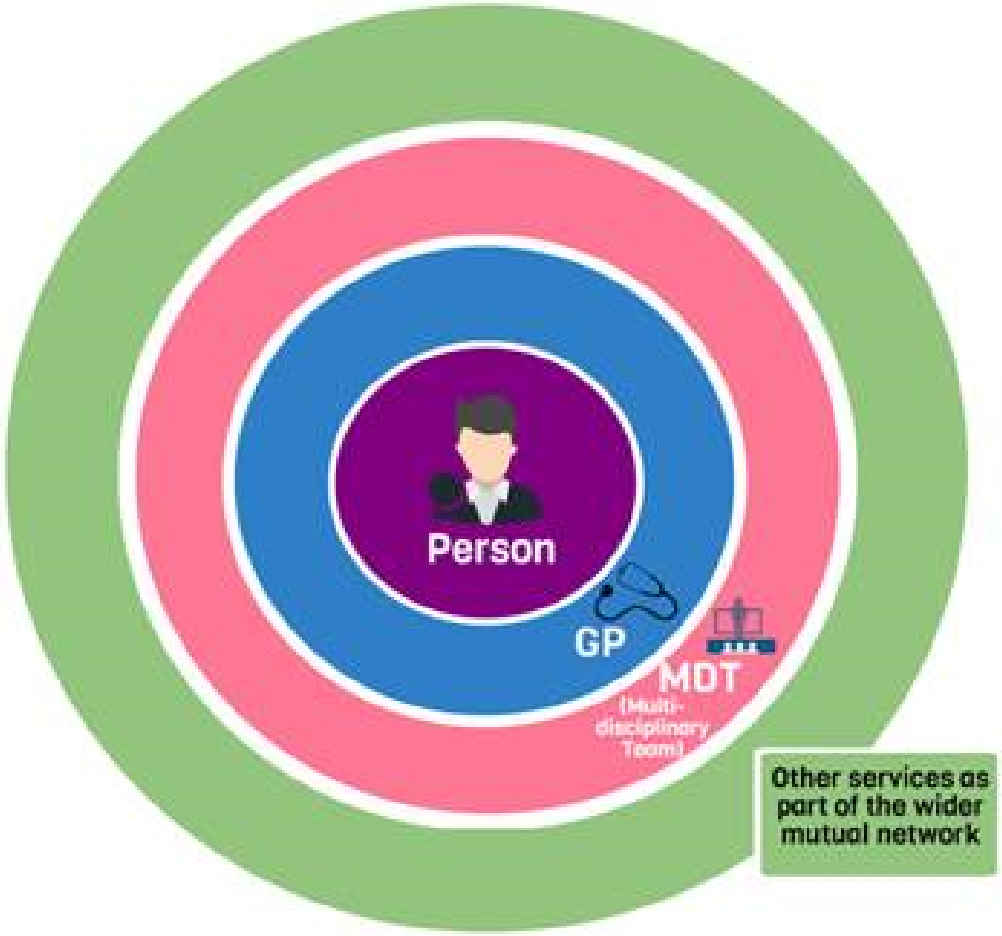
All Together Better

Our Model

Value added treatments : Commissioning best practice pathways



MCP (Multispecialty Community Provider) : Commissioning Shared Outcomes



GP - Led care

Our model is based on the following principles:

1. Shared ownership
2. Shared responsibility
3. Shared benefits

Maximising the potential of:

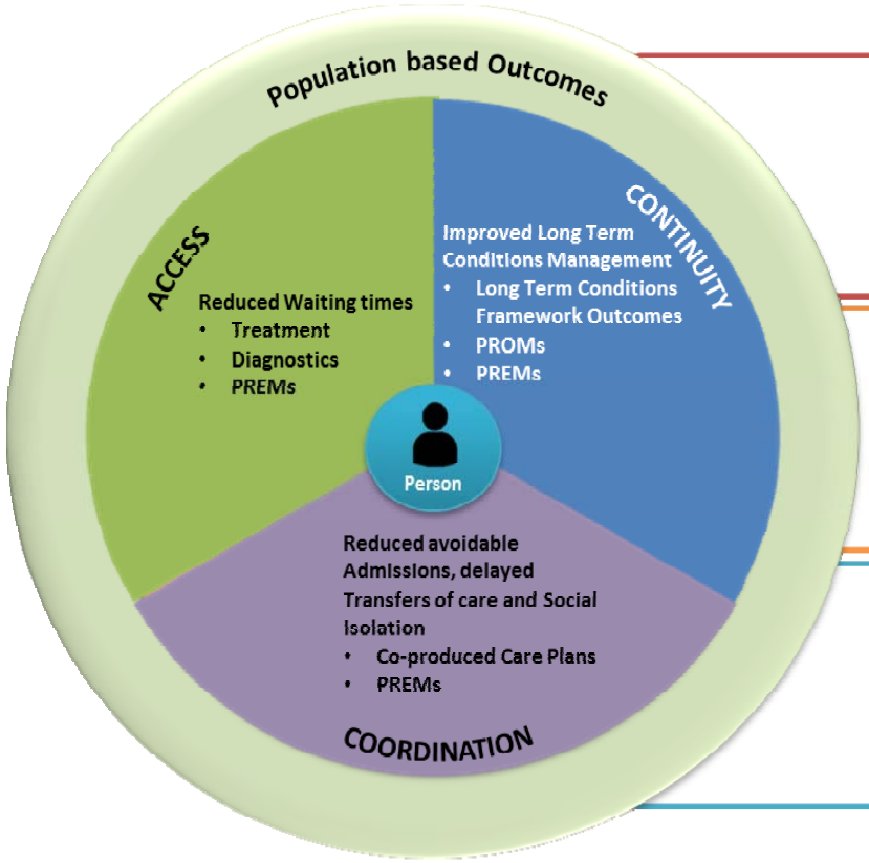
- The individual (in their community)
- Our staff in supporting the individual
- Our staff working effectively with each other

MCP connected to the community.

Locality approach provides resilience and a basis for services at appropriate scale.

Outcomes Framework

NHS Dudley Clinical Commissioning Group



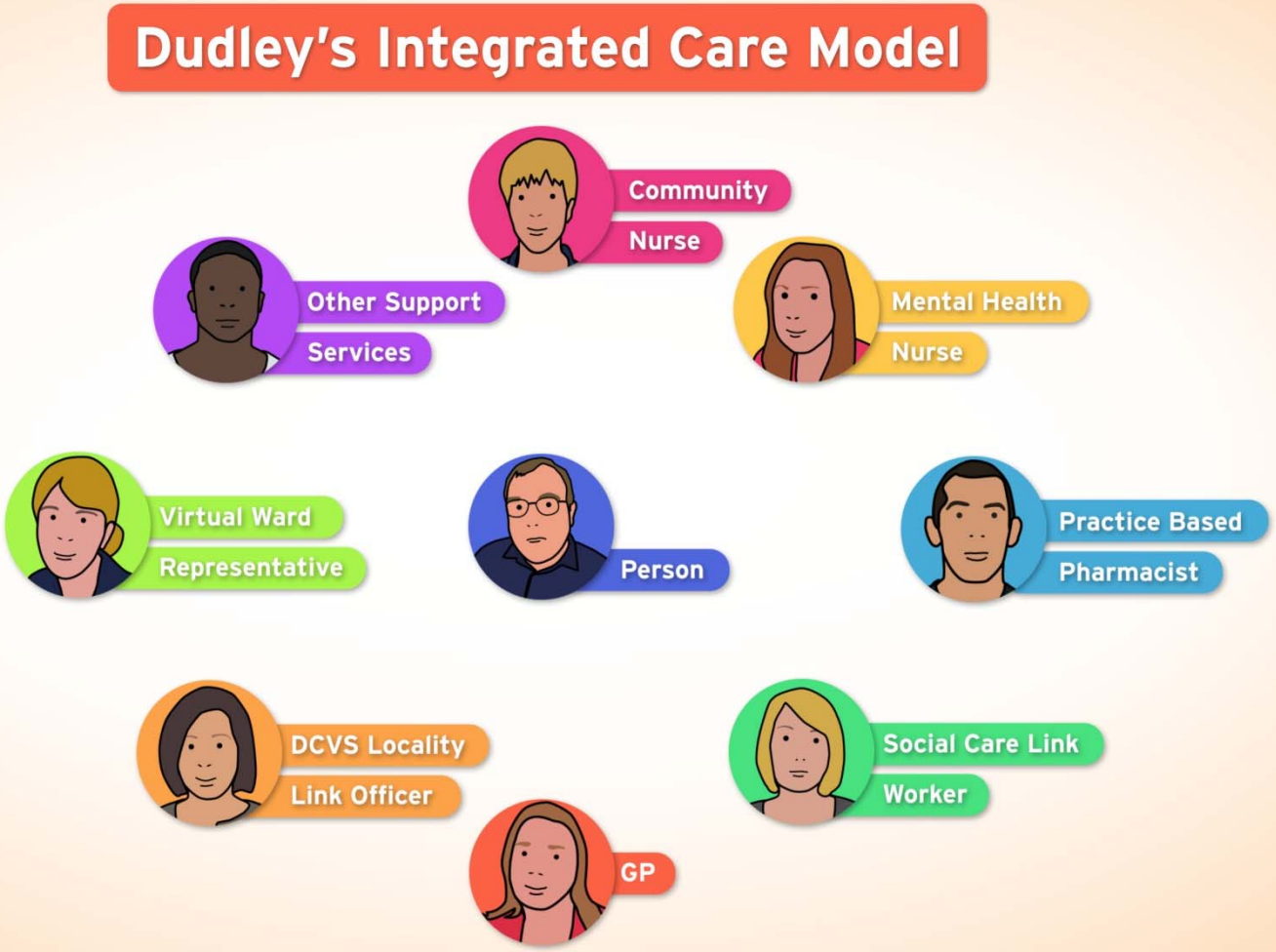
QUALITY & SAFETY

PATIENT BENEFITS

STAFF BENEFITS

All Together Better

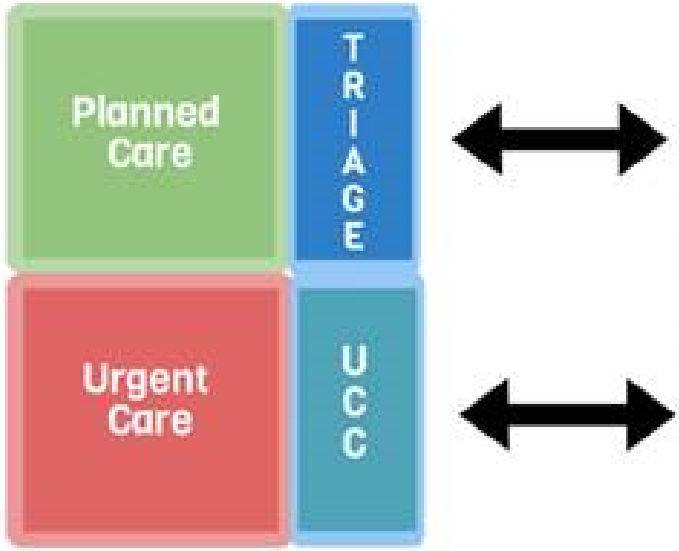
Teams without walls



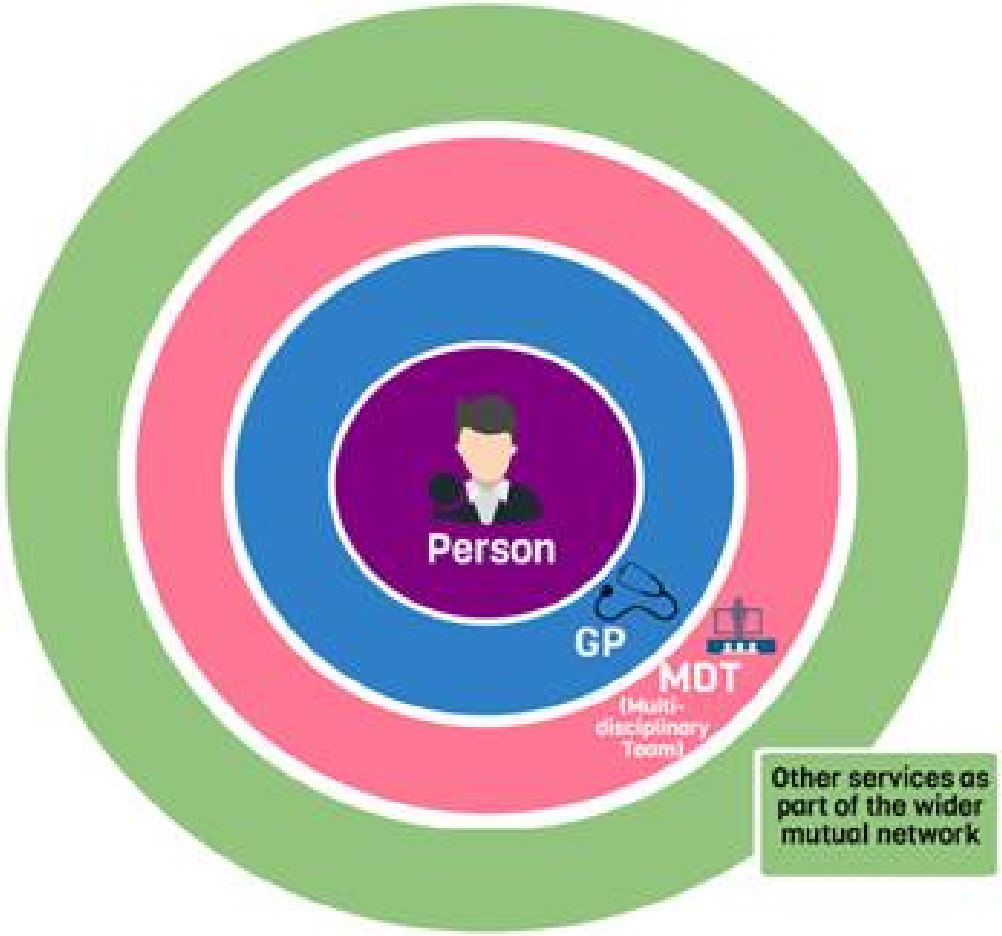
Maximising their potential to work efficiently and effectively together – to take a shared responsibility for achieving shared outcomes

Our Model

Value added treatments : Commissioning best practice pathways



MCP (Multispecialty Community Provider) : Commissioning Shared Outcomes



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- The individual (in their community)
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- Our staff working effectively with each other

Our Teams without Walls…

People make or break the difference……

- Shared purpose
- Shared accountability
- Shared outcomes
- Understanding and respecting different organisational cultures
- Taking responsibility
- Developing talent
- Managing change
- Empower and create autonomy
- Develop distributed leadership
- Give people permission
- Enable others
- Cross professional boundaries
- Manage and develop relationships

All Together Better

Our Approach

- **Team Development**

  Management of change (with particular focus on changing the culture by enabling "teams without walls")

  – *Practice MDTs*
  – *Locality MDTs*
  – *System Wide Teams*
  – *Talent Management (ambassadors of change)*
  – *System approach to staff engagement*

- **Leadership**

  MCP strategic system wide development

  – *Partnership Board*
  – *Clinical Strategy Board*
  – *Development of Locality MCP Integration GP lead roles*
  – *Consultants working out in the community setting*
  – *Relationship management*
  – *Negotiation and influencing skills*

- **Development of Professional Teams**

  – *Spreading the vision*
  – *Breaking down the walls*
  – *Effective use of skill mix*

All Together Better

- **Workforce Development**
  - *Integrated Plus*
  - *Recruitment of MDT Care Co-Ordinators*
  - *Extended role of Pharmacy*
  - *Community Paramedic Pilot*
  - *Chaplaincy Support*
  - *Place-based System Workforce Development Plan (particularly linked to STP)*
  - *EPIC - Enabling Practices to Improve and Change*
- **Patient Engagement**
  - *Real patient stories*
  - *Practice Patient Participation Groups*
  - *Task and Finish Groups for New Care Model*
  - *Listening events*
  - *Public consultation*
  - *Patient representation on Procurement Board*
- **Communications**
  - *Multi-organisational with consistent language and messages*
  - *Staff engagement*
  - *Statement of Intent*
  - *Use technology as an enabler (EMIS)*

All Together Better

Creating Capacity to Change

- Supported approach to establishment
- Resilience
- Communication
- Motivation
- Embrace challenge and difference
- New model of care becoming business as usual
- Be prepared to trouble shoot
- Working with multi organisational cultures and constraints (health, social care and voluntary sector)

All Together Better

Our Enablers

Transformation:

- Biggest change (particularly for primary care) that the NHS has ever seen
- Exhilaration and trepidation
- OD approach before a contracting approach
- Make the contract an enabler

Leadership:

- Organisational conflict
- The challenge of leaving your organisation at the door
- Leadership conflict
- Taking people with you

Staff engagement and workforce:

- Inherent since before day one
- New workforce solutions
- All organisations committed to joint messages and engagement

The reality:

- RAG rated system to freedom
- Intense level of support needs to be available
- Continually seek to improve “what is the next stage of development”
- Evaluation is key

All Together Better

Dudley MDTs

How does the model work?

- Practice integrated teams for all 46 practices in Dudley based around 5 localities. The MDTs consist of GP with pharmacist, MH nurse, community nurse, locality link officer (CVS) & social worker – there are 5 locality teams that lead the work in each locality from an organisational perspective including the locality leaders of all of the services in the MDT.
- They meet at least once a month chaired by a lead GP in each practice where they discuss their top 2% of patients (identified through risk stratification) & how to manage them - EMIS means practices can put notes straight on the system & can be reviewed by the MDT. The GP is the lead coordinator of care, the MDT is the locus of coordination – the MDT work with patients over the long term to support them
- The CCG coordinates the plan of all the respective meetings – they see this as their responsibility as system leaders.
- All members of the MDT have a flowchart of members of the MDT with contact details & who to contact in the MDT between meetings
- 5 GPs appointed as locality leads & chair a monthly meeting with community services to address operational issues with service managers. GPs are paid for 2 sessions a week to lead the development of the MDTs in their locality, engage GPs & attend other meetings.

Rationale/evidence for approach

- The MCP model is built from 3 key themes from local patient consultation & what is important to them – Access; Continuity; & Co-ordination. GP led & MDT care is central to delivering these and have been implemented to integrate health and social care.

How will/do they judge success?

Outcome measures are linked to improved patient experience and reducing demand on other services: reducing emergency admissions; reducing reliance on care & nursing homes; improving social isolation; reducing use of GP time; improving end of life care at home. An evaluation is currently underway.

Key success factors

- having all providers focused on delivery in the same geographical footprints
- The CCG has invested into OD support to ensure that teams work well together. The most successful teams are then back-filled to work with other struggling teams.
- Voluntary sector input – has been additionally commissioned by the CCG – providing holistic non-medical support for socially isolated & others that need to access different support (the gold of the model)
- The MDTS are not managed – self managed & determined with staff being given permission to do the right thing. There is real trust in the staff & GPs

Describing success: What staff are saying

It's more holistic and person centred. A good idea that could get much better.

The new integrated way of working has helped me: better integrate with teams, understand what services can offer... pulling this all together in a regular meeting has given me greater autonomy this has directly improved patient pathways of care and reduced unplanned admissions to hospital.

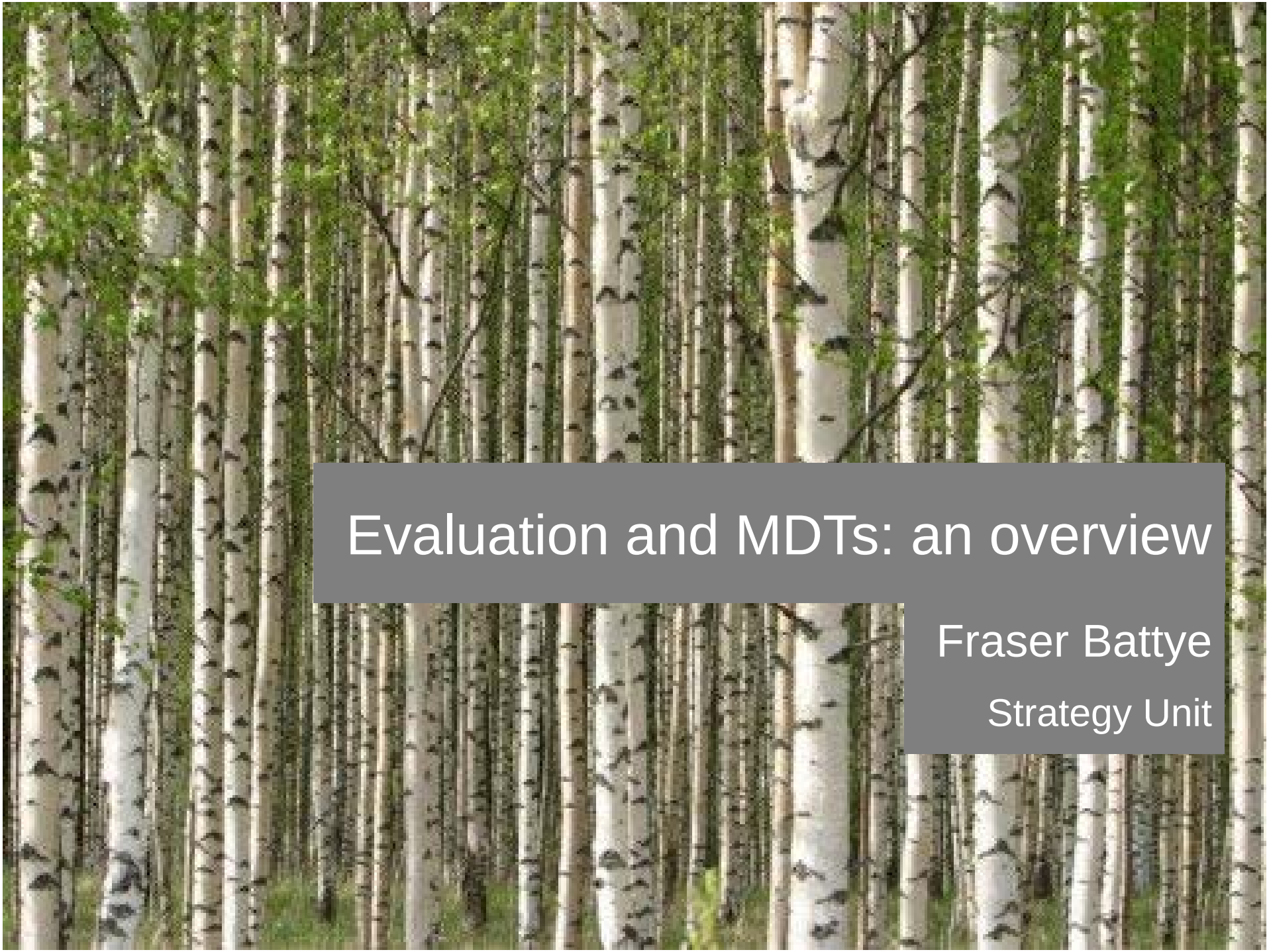
It is rewarding seeing how integration has re-energised team members and the enthusiasm of key professionals in the service has encouraged more staff to want to become involved...

In the past … it was often hard to access the services and the help you felt your patient would benefit from. It could be very time consuming finding out the appropriate service and then the appropriate person to refer to, however with the MDT meetings this has improved considerably. I now have a network of colleagues to whom I can refer or simply ask for advice. This has improved my efficiency greatly and lead to a service improvement for patients and their carers.

The response to this new way of working, through our patients has been that of thanks, praise and relief due to the easier access to a variety of professionals

escribing success:
hat patients are saying

Thank You



Evaluation and MDTs: an overview

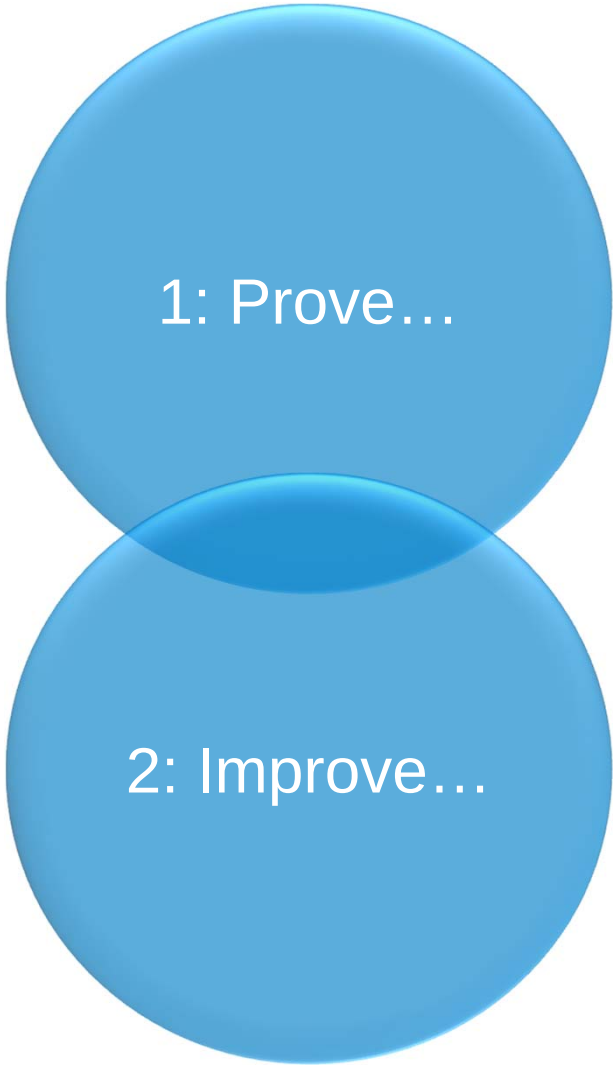
Fraser Battye

Strategy Unit

In this presentation I'll provide a broad structure for thinking about evaluation and MDTs, suggesting three stages in doing so:

1. Take several steps back (until you can see a wood):
    - What do you want an evaluation for? What do you need to know? What rests upon the results and what actions will follow?
    - Why was your MDT set up? What benefits do you expect from it? How do you expect these to be achieved?
2. Then get into the trees:
    - Methods and measures
3. Assuming you make it out again: how might measurement add most value in improving MDT functioning and so patient care?

Why might an evaluation be needed? What do you need to know and why? (and when!)



…that the MDTs have desired effects (if not, stop; if so, go?)

…that staff / patients / partner organisations are getting value from them

…that the service economics are right (etc.)

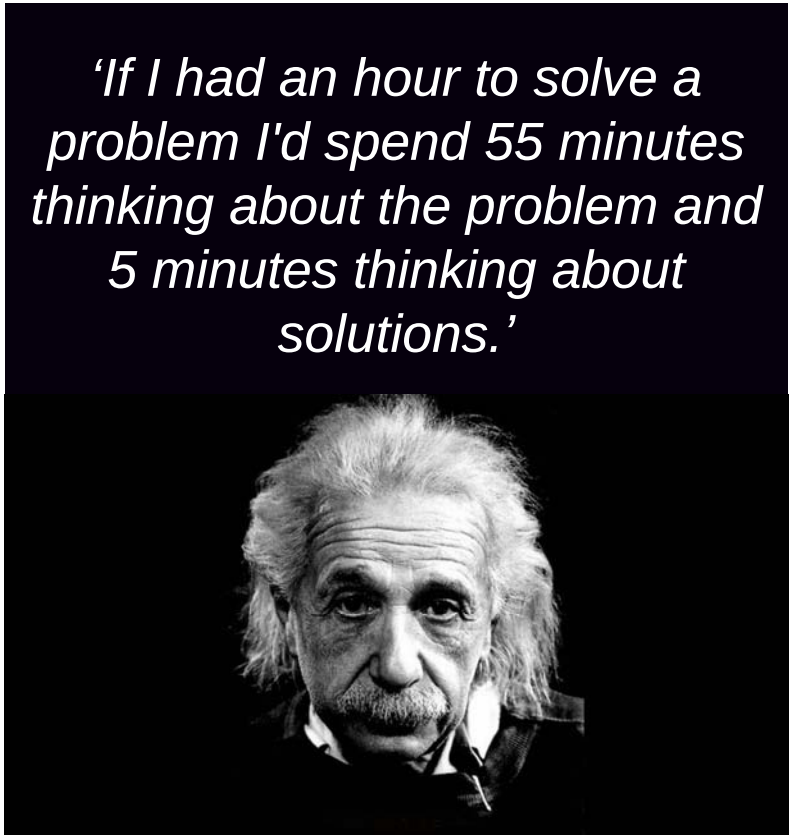
…the way the MDTs are functioning as teams

…the way they fit into broader pathways and systems

…their use given population need / system resources (etc.)

Answers to these questions should frame everything else

The next question should be: why do we have an MDT? What problem(s) led to this solution?



- So many definitions of 'MDT' that it's important to be clear on what we're looking at (don't assume)
- Discussing problems is a good place to start – it leads us to think about purpose, which can be evaluated against
- Think about problems for:
  - Specific groups of patients (experience / effectiveness?)
  - Staff (efficiency / experience?)
  - Services (economy / efficiency?)

What causes these problems, why and how do we think an MDT will help?

The next question is about expected results.
Start by thinking broadly: what effects might you see, and for whom?

	Patients / carers	Staff	Services
Improved experience	YY	Y	Y
Better outcomes	YY		
Better use of time / resources	Y	Y	YY

Triple Aim useful here

Logic models are an excellent tool for this (see Paul's presentation)

You might also think about *how* (by what mechanisms) you expect MDTs to work. For example:

That sharing knowledge / perspectives leads to…

…a clearer sense of the whole, not just component parts, which leads to…

…better decisions on care, which lead to…

…improved experience and outcomes for patients, gains in knowledge for staff

(etc)

MDTs and the ‘It’s an elephant!’ theory

Here's a possible framework for capturing that description

	Patients / carers	Staff	Services
Improved experience	*Coordinated inputs, not duplicated*	*Learning from / working with others*	*More joined up (e.g. with VCS)*
Better outcomes	*Better (shared) decisions on care*		
Better use of time / resources	*Less time spent waiting*	*Less time (overall) on individual cases*	*Less unplanned care*

Again, this works well as part of logic model development

Then you're ready to enter the wood to find what you need. The question now is about the methods you will use…

	Patients / carers	Staff	Services
Improved experience	*Interviews / PREMs*	*Observations*	*Referrals*
Better outcomes	*Decisions implemented / PROMs*		
Better use of time / resources	*Interviews*	*Case studies of resource use*	*Unplanned admission rates for target group*

Jo will say more about this later

Finally: how might measurement / evaluation add most value in improving MDT functioning and patient care?

Where measures (of things that matter) are demanded, supplied and used by MDTs – and an evaluative mindset is adopted by staff…

Where the primary use of measurement is for ongoing service improvement, not audits and occasional beatings…

Where the role of managers (and researchers?) is supporting comparison and improvement…

We would all need to change practice to achieve these things

Strategy Unit
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Logic Models in Evaluation

Dudley MDT Evaluation

17th November 2016

ICF, SU, HSMC
Learning from MDTs
BVSC

Paul Mason
paul.mason@icf.com

Understanding the theory behind a programme, intervention, or policy is key to effective evaluation

"Social programmes are… products of the human imagination: they are hypothesis about social betterment. Programmes chart out a perceived course whereby wrongs might be put to rights, deficiencies of behaviour corrected, inequalities of condition alleviated.

Programmes are thus shaped by a vision of change and they succeed or fail according to the veracity of that vision."

Ray Pawson and Nick Tilley 'Realist Evaluation' (2004)

At the most basic level, it is about the expectation of *'If we do X then we will achieve Y'*

If we deliver our training package, then we will improve the care planning skills of care homes staff…

If staff have better care planning skills, then they will be more able to cope in the event of a crisis…

If staff are more able to cope in a crisis, then there will be fewer unplanned admissions to hospital….

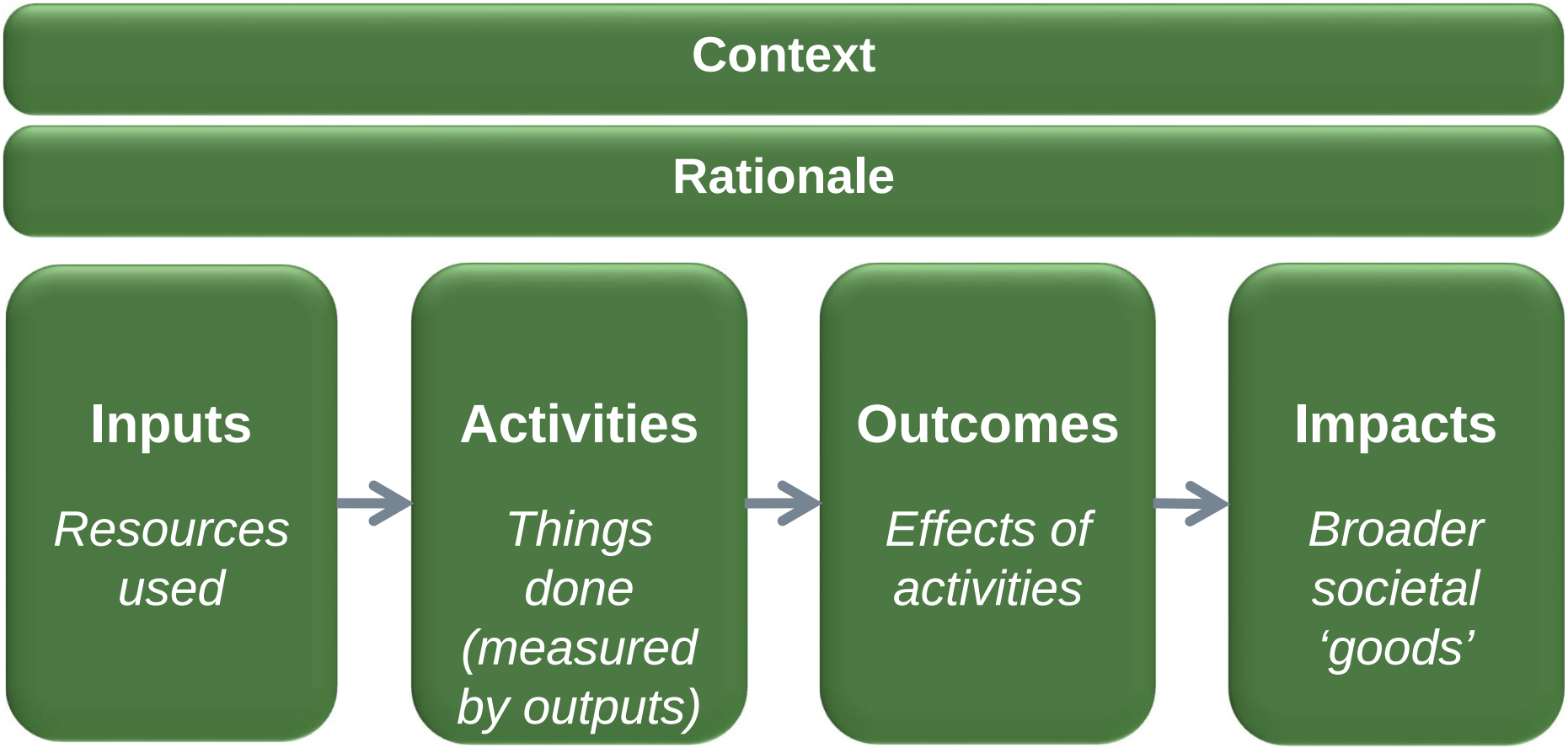
If there are fewer unplanned admissions, then more people will die in a setting of their choice."

This helps show the thinking that connects activity…

…to outcomes…

…and on to impacts

A logic model provides a structure for summarising your programme's theory



There are a wide range of approaches from this most basic version

- Links between inputs, activities, outputs, outcomes and impacts must be shown
- The rationale should be included at the programme or the activity level (or both)
- Developing the model is a good way of bringing stakeholders together or consulting on plans
- A narrative should accompany the model, which can only ever be a summary

Healthy Communities Work-stream Context

Stockport Together is an MCP site and is a partnership of Stockport CCG, Viaduct Health GP Federation including all 46 practices, Stockport NHS Foundation Trust which provides community services, Pennine Care Mental Health Foundation Trust, and Stockport MBC. The population is generally older than average and the proportion of older people is forecast to grow faster than average. Stockport has outcomes that are better than the North-West but challenging health inequalities. A&E performance has been poor for a significant time and the economy collectively forecasts a c£130m deficit unless care is delivered differently. The new model of delivery is based on eight neighbourhoods and this logic model describes one work-stream looking at how the neighbourhood will work more closely with the local population.

Rationale for Healthy Communities

Individual and community empowerment are key drivers of health, wellbeing and independence. We will work in partnership with voluntary and community organisations and individuals in a variety of settings. We will target resources to nurture individual and community assets, particularly in disadvantaged communities, and enable development of a social movement for health and wellbeing. This will facilitate co-design and delivery of care and support, including the development of voluntary activity.

Inputs	Activities	Short-term outcomes	Medium-term outcomes	Impacts
Organisation Public Sector leadership commitment to policy and training **Workforce**: Agreed development plan Skills for working with communities; Backfill for training **Policy & Communication** Standard, clear concise set of key messages	**Healthy Workplace** • Healthy Workplaces policy implementation (Public Sector and other local employers) • Healthy Hospital development • Public Sector workforce development and culture change programme including partnership skills	• More health and wellbeing promoting workplaces & hospital environments • Number of public sector staff trained to give brief intervention advice • Increased participation of individuals and user groups in the design and commissioning of services	• Improvement in health & wellbeing of public sector staff • Greater confidence among health & social care staff to champion healthier lifestyles • Reduced sickness rates among healthy workplace participating organisations	Fewer people will die early from causes that are preventable and amenable to healthcare
Resources: Increased resources to provide more capacity in targeted prevention **Organisation:** Encourage and free time for volunteering Neighbourhood leadership structure supports development of community asset approach **Estates** Neighbourhood estates review and investment in alignments **Informatics** IG protocols and frameworks in place to allow 3rd sector involvement Information available to help targeting of prevention activity	**Community Development & Targeted Prevention** • Increasing capacity for targeted prevention activity working with voluntary and community organisations • Redesign and integration of community capacity development support including for carers' organisations • Development and promotion of volunteering opportunities including the 'Champions for Health' project and time-banking • Engagement with other partners to develop joint working with disadvantaged groups • Realignment of delivery locations for multiple services' to establish healthy living centres in neighbourhoods	• Increased capacity in voluntary and community organisations • Increased number of people benefitting from voluntary & community groups • Increase in proportion of carers engaged in mutual support organisations • Activation and asset-based care planning embedded in services • Increasing co-location of service delivery • Stronger partnership and co-design/delivery of services between H&SC individuals and other public and voluntary organisations	• Greater take-up of screening and similar services by those in socially excluded groups • Fewer people experiencing social isolation & carers feel more resilient and supported • Reduction in inappropriate use of medical and urgent services for low level health and non-health needs • More people take action to improve their own health individually and collectively with fastest change among more deprived communities • Improvement in self-reported wellbeing and empowerment among people using services • Public sector staff volunteer more	People's healthy life expectancy will grow fastest in the most deprived areas of Stockport People will be more successful in managing their own health & wellbeing Working age adults will have fewer health & wellbeing barriers to being in work A smaller proportion of the population will utilise urgent and in-patient hospital services Costs will be contained within available Health &Social Care Resources

Logic Model: Paramedic Practitioners

Paramedic Practitioners will support home visiting and be aligned to Community Hub Operating Centres as part of a fully integrated health and social care team

Challenges:
- Ageing population profile
- Meeting complex needs of people living with LTCs
- Financial challenges faced by local health economy
- Traditional divide between primary, secondary and social care

Opportunities :
- Health professionals to work in a proactive and coordinated way
- Building multi-professional workforce capacity in the community to deliver optimum patient care in home setting
- Efficiencies and savings

Inputs

Financial:
- Unit cost of £45 per visit
- 2015/16: £100k
- 2016/17: £351k
- 2017/18: net saving will cover recurrent annual cost of £351k

Time/people:
- 5 paramedic practitioner teams covering
  - Faversham
  - Whitstable
  - Canterbury East
  - Canterbury West
  - Sandwich/Ash
- MCP core team monitoring, evaluating and managing contract

Activities

- Paramedic home visiting to support patients to be triaged at home in timely manner (<2 hrs), enabling correct treatment, referral and signposting as required (S3, S5/M5)
- Ambulance will have additional equipment (compared to GP) to enable enhanced treatment of patients (S5/M5)
- Paramedics attending 999 calls to have access to the patient's records, demonstrated to reduce conveyance (S1/M1, S2/M2, S6, S7)
- Paramedics will build relationships with both patients and GPs within hub areas, also reducing conveyance (S1/M1, S2/M2, S5/M5)

Short-term outcomes

S1) 10% reduction in conveyances to hospital for the areas supported by the PP teams

S2) 20% reduction in onward unscheduled admissions for this patient cohort

S3) Faster response to home visit requests

S4) GPs to have additional time to focus on patients requiring longer appt. slots, such as complex LTC and end of life patients

S5) High-levels of patient and staff satisfaction

S6) Improved access to patient records

S7) Improved patient safety

Medium-term outcomes

M1) 15% reduction in conveyances to hospital for the areas supported by PP teams

M2) 20% reduction in onward unscheduled admissions for this patient cohort

M8) Reduced pressure on acute services and long term care home placements

M9) Improved management of complex patients in primary care

M5) High-levels of patient and staff satisfaction

M10) Sustainability of scheme through efficiency and savings

M11) Stable, committed local workforce

Impacts

To deliver an integrated health and social care model of care that focuses on delivering high quality, outcome focused, person centred, coordinated care that is easy to access and that enables people to stay well and live independently for as long as possible in their home setting

To transform local services so that we deliver proactive care and support focused on promoting health and wellness, rather than care and support that is solely reactive to ill health

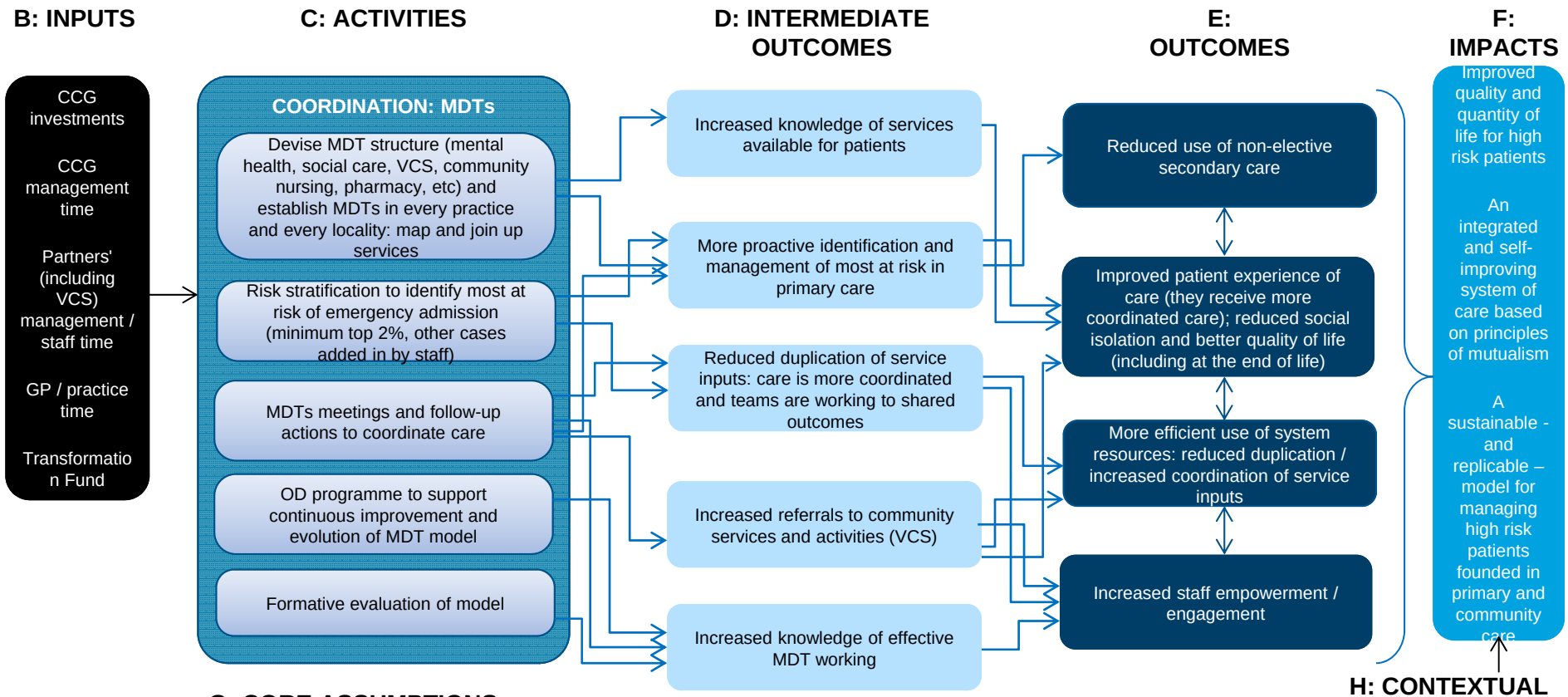
For the evaluation of Dudley MDTs we have developed a more complex model that shows more detailed links and includes assumptions.

It links to an overall model for the Dudley Vanguard MCP, not shown here.

Dudley MDTs logic model

A: RATIONALE

There is clear scope for improving the care of the highest risk patients in Dudley. Too often, current care is episodic and uncoordinated; it is also reactive. This does not provide a good experience for some of the most vulnerable in our population - nor does it represent a good use of resources. We have therefore devised Multi-Disciplinary Teams (MDTs) in primary care; they will operate as 'teams without walls', coordinating and drawing on specialist inputs from different services to focus on the needs of patients most at risk.



G: CORE ASSUMPTIONS

That partners function well as a team: the whole is greater than the sum of its parts
That the right patients can be identified
That effective, preventative interventions can be made once patients have been identified

H: CONTEXTUAL FACTORS

National policy / regulation; funding; patient / public expectation; support from local partners; supply of appropriate workforce

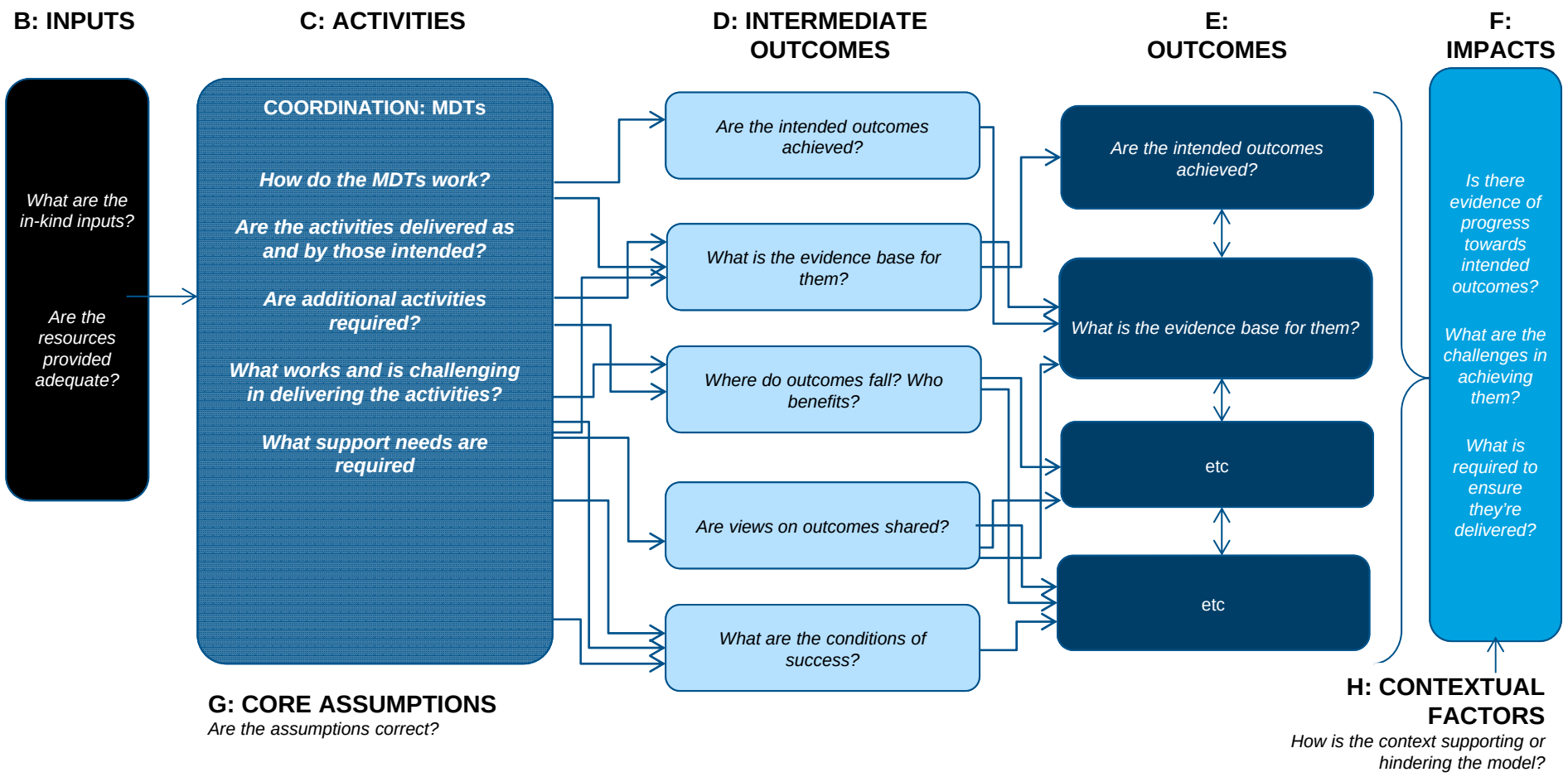
The evaluation takes a mixed methods approach to explore the theory and logic model

- Document review: materials relating to the model overall, resources provided to practices by CCG, materials used by MDTs
- Qualitative research: MDT observations; programme and stakeholder interviews; MDT interviews; patient interviews
- Quantitative research: MDT staff survey; outcome data review

How the methods explore the model: research Qs

A: RATIONALE

Do the MDTs operate as a 'team without walls' and work with the most at risk patients?



Now Jo Ellins will say more about understanding the patient perspective

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How can we evaluate patient and carers' experiences of MDTs?

Jo Ellins, Senior Managing Consultant

November 17 2016

Before we get started, some issues and challenges

- Core question: do MDTs improve experiences and outcomes for patients? Simple….
  - Patient outcomes
  - Patient-reported outcomes
  - Patient-valued outcomes
- When to evaluate? When will patients feel the benefits of MDTs?
- Do patients see MDTs or understand what they are? A conversation about ‘MDTs’ might be a short one
- Much of the language used is far from patient-friendly

Start with patients and families, what do they want from MDTs?

- Evaluation design should start with engagement: what would success look like to patients?
- Different groups may have different expectations and goals – don't treat 'patients' as one group (and remember carers/families may value different outcomes)
- Unpick key outcomes: eg. coordination – what does this mean in practice?

The literature suggest that there are three broad outcomes that are particularly important to patients:

1. **Better coordination of care**: care that feels joined up
2. **Person-centred and personalised care**: collaboration *with* the patient, not just *for* them; at least some patients want to be actively involved in decisions
3. **Holistic care**: MDTs providing access to a wider range of skills, services and resources to meet people's (diverse) needs

What does ‘coordinated care’ mean to patients?

think local act personal

National Voices
People shaping health and social care

A Narrative for Person-Centred Coordinated Care

www.nationalvoices.org.uk
www.thinklocalactpersonal.org.uk

@NVTweeting
@TLAP1

NHS England Publication Gateway Reference Number: 00076

1

cancer • campaigning • group

Patients’ experience of integrated care

A report from the Cancer Campaigning Group

November 2012

How to capture the patient perspective

Qualitative

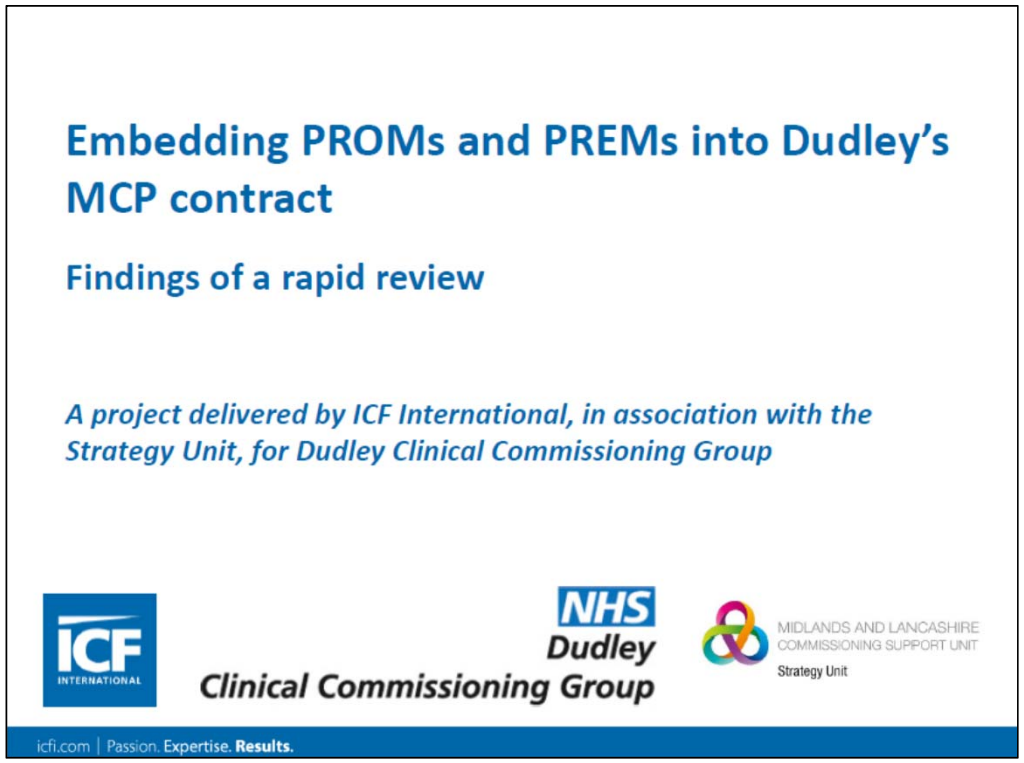
- Exploring complex issues that cannot be easily captured in a questionnaire
- Understanding why things work (or don't)
- For engaging 'seldom heard' groups
- Learning for implementation and improvement

Quantitative

- Capturing a breadth of views and experiences
- Comparing different groups
- Exploring how things change over time

Think about what evidence is most likely to convince people (eg. to adopt, sustain or roll out new ways of working)

There are a growing number of patient-reported outcome measures



- Hundreds of tools, most of which are flawed though
- Some more promising ones include:
  - IntegRATE (integration)
  - LTC-Q (long-term condition outcomes)
  - OPQOL (quality of life)
  - WEMWBS (social wellbeing)
  - Patient Activation Measure (empowerment)

Our work identified four key principles for choosing PROMs and PREMs

Link measurement to the delivery and improvement of care, don't measure just for the sake of it

Measure what is meaningful, accepting that some things will have to be measured imperfectly

Work with stakeholders at every stage, especially in defining what should be measured and how

Keep it as simple as possible, and see measurement as an ongoing process, not a one-off activity

Jo.Ellins@icf.com