

Multidisciplinary team meetings in community mental health care:

a mixed-methods investigation of their functions and organisation

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Thesis submitted for the degree of Doctor of Philosophy

University College London

2015

Declaration

I, Caoimhe Nic a Bháird, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Caoimhe Nic a Bháird

To my parents,

Mary Shorten and Domhnall Mac a' Bháird,

with love and thanks

Abstract

Background

Community mental health teams are a central means of delivering specialist mental health care in England. Weekly multidisciplinary team (MDT) meetings are assumed to improve the quality of care by incorporating diverse professional perspectives into care planning. However, these meetings are resource-intensive and there has been little investigation of their operational procedures or their impact.

Aim

The aim of this PhD is to examine the functions and organisation of MDT meetings in community mental health care, and to identify current challenges to effectiveness and opportunities for improvement.

Method

A mixed-methods investigation was conducted to examine current practice and stakeholder views in six community-based mental health teams: three general community mental health teams, two memory clinics and one early intervention psychosis service. This involved non-participant observation of 109 MDT meetings; quantitative data on 3,213 MDT case discussions from 181 MDT meetings; and semi-structured interviews with 35 practitioners and patients.

Results

MDT meetings were perceived to serve a wide variety of functions, ranging from care planning to peer support. However, many practitioners believed that their meetings were poorly managed and lacked clarity of purpose. Teams varied in terms of which patients were discussed, the time dedicated to each

discussion, multidisciplinary representation, and operational procedures. Several challenges made it difficult for teams to capitalise on their multidisciplinary diversity, including conflicting models of care, ambiguous leadership, and a struggle to balance profession-specific and generic keyworker roles. Practitioners' ability to implement agreed MDT care plans was limited by a lack of patient involvement, inadequate resources, administrative requirements, and organisational instability.

Conclusions

A wide range of factors mediate the potential for MDT meetings to benefit patients. The findings highlight the importance of critical reflection on the purpose and organisation of MDT meetings to ensure that they are a valuable use of practitioner time.

Acknowledgements

This research would not have been possible without the generosity and openness of those who gave up their time to participate. It was a privilege to be welcomed into their homes and workplaces to hear their stories.

I have learned a great deal from my PhD supervisors: Professor Rosalind Raine, Professor Susan Michie, Dr Nora Pashayan and Dr Georgia Black. I am most grateful for their guidance and encouragement. Professor Gill Livingston and Professor Michael Crawford also provided invaluable insights from a psychiatric perspective.

I had the privilege of spending three months at Yale University while writing this thesis. Professor Jacob Kraemer Tebes was a superb advisor during my stay. His wisdom and clarity of thought have improved this work. I am also indebted to Dr Vinod Srihari and Dr Jessica Pollard at the Connecticut Mental Health Centre for sharing their ideas with me.

I couldn't have asked for more thoughtful or generous colleagues than Isla Wallace and Penny Xanthopoulou. I have benefited hugely from their friendship and intellectual insights. Mr Dave Ardron, Dr Julie Barber, Ms Rowan Calloway, Dr Alex Clarke, Ms Miriam Harris, Dr Anne Lanceley, Professor Gill Livingston, Dr Manonmani Manoharan, Dr William O'Driscoll and Dr Archie Prentice also contributed to the larger NIHR Project from which my PhD arose. They are referred to by their initials in the following chapters.

A number of friends devoted time to reviewing various aspects of this thesis; I am grateful to Alexandra Hands, Lochlann Mac a Bháird, Cliódhna O'Connor, and Aoife O'Connell for their guidance. Particular thanks are due to my mother, Mary Shorten, and my aunt, Anna Shorten, who never complain when I exploit their unconditional love with proofreading requests. Paul Deane kept me smiling and well fed throughout this endeavour; his love and support make everything easier.

This work was generously supported by Research Capability Funding from the National Institute for Health Research, and the Yale-UCL Collaborative Exchange Programme.

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List of Abbreviations

AHP	Allied Health Professional
AMHP	Approved Mental Health Professional
AOT	Assertive Outreach Team
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CMHT	Community Mental Health Team (usually refers to general or “generic” rather than specialist community mental health teams)
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CQC	Care Quality Commission
CRT	Crisis Resolution Team
CTO	Community Treatment Order
DLA	Disability Living Allowance
EIS	Early Intervention Service (for young people experiencing their first episode of psychosis)
HMIC	Health Management Information Consortium
HTT	Home Treatment Team
MDT	Multidisciplinary Team
NHS	National Health Service
NICE	National Institute for Health and Care Excellence (formerly known as the National Institute for Health and Clinical Excellence)
NIGB	National Information Governance Board for Health and Social Care
NIHR	National Institute for Health Research
NSF	National Service Framework
StR	Specialty Registrar grade doctor
UCL	University College London

1 Introduction

Community mental health practitioners face a formidable challenge. They are tasked with providing holistic, integrated care, involving multiple professions and a range of agencies, while ensuring that patients experience continuity in their therapeutic relationships^{i,1} They are expected to provide care in a recovery-focused, patient-centred and minimally restrictive manner, while maintaining public safety and confidence.² In this context, multidisciplinary teams (MDTs) are assumed to improve quality of care by incorporating diverse professional perspectives to produce comprehensive and coherent care plans.³⁻⁷

An MDT can be defined as a group of people from at least two different professions combining their expertise in pursuit of a common purpose.⁸ MDTs in the form of Community Mental Health Teams (CMHTs) have been a central organisational model for the delivery of mental health care since the widespread closure of large psychiatric institutions.^{9, 10} However, they evolved in an unsystematic and gradual manner, leading to local variation in their organisation and functions.^{11, 12} Despite a sustained emphasis on multidisciplinary care in mental health policy,¹³⁻¹⁸ there has been little empirical investigation of MDT meetings, the formal mechanism for achieving multidisciplinary collaboration.

MDT meetings are resource-intensive, often occupying whole teams for several hours each week;¹⁹ yet there is little national guidance on their specific format, content or administration.^{6, 17} Their operational procedures are largely locally determined and, consequently, the extent of multidisciplinary input that patients receive may vary geographically. A clearer understanding of how MDT meetings function is crucial to ensuring that teams make the best possible use of

ⁱ Please see Appendix 1 for a note on the use of the term *patient*.

available skills and resources to provide equitable, high-quality multidisciplinary care to all patients. This thesis begins to address this issue by examining the functions and organisational features of MDT meetings in six community-based mental health teams in the south of England, with a view to identifying current challenges to effectiveness and opportunities for improvement.

In this introductory chapter, I begin by describing the research context in which this study was developed and explaining how it relates to a broader programme of work. This is followed by a brief history of community-based mental health teams, which frames the study in light of relevant policy developments. I then review a number of previously identified challenges to multidisciplinary collaboration and summarise the available literature on MDT effectiveness in community mental health care. The final section provides an overview of the research and outlines the structure of the thesis.

1.1 Background to the study

The research conducted for this PhD arose from a larger programme of work funded by the National Institute for Health Research (NIHR), which compared MDT meetings in mental health, heart failure and cancer care.¹⁹⁻²² I was one of three full-time Research Associates on this broader project, which was led by my primary supervisor Professor Rosalind Raine. A summary of the NIHR Project is provided in Box 1.1.

Improving the effectiveness of multidisciplinary team meetings for patients with chronic diseases: a brief summary

We conducted a large mixed-methods prospective observational study of 12 MDTs in cancer, heart failure, and mental health care (NIHR Project reference HS&DR 09/2001/04). Data were collected through non-participant observation of 370 MDT meetings, 161 staff questionnaires, interviews with 53 MDT members and 20 patients, and reviewing the medical records of 2654 patients. We used random-effects logistic regression to investigate the impact of MDT features (team climate and skill mix) and patient-related features (illness, age, gender, deprivation status) on the implementation of MDT treatment plans. We used the qualitative data to explore possible explanations for the quantitative findings and to identify areas of diversity across specialties. We then used an expert consensus development method to derive a set of high-level generalisable recommendations for improving decision-making in diverse healthcare contexts. A list of publications from this project is provided in Appendix 2.

Box 1.1 Summary of the NIHR Project

A primary finding of the NIHR Project was that the mental health teams made fewer care planning decisions in their MDT meetings than the other teams, and they were less likely to implement the decisions they did make (with the biggest differences between mental health and cancer teams).¹⁹ These findings suggested that further investigation was warranted to gain a clearer understanding of the functions mental health MDT meetings serve and the factors that shape whether or not agreed actions are subsequently implemented. This provided the starting point for my doctoral research.

Though the larger project focused on high-level factors that were comparable across healthcare settings, it provided a wealth of rich data on the mental health teams which allowed for more in-depth analyses to explore issues specific to the mental-health context. In order to refine my research objectives, I reviewed the literature on multidisciplinary teamwork mental health care and traced the development of community-based mental health teams in policy. I then performed independent analyses on the mental health data to address these objectives. I describe my role in the NIHR Project in greater detail and explain exactly how the data were used for this PhD in Section 1.7.4.

1.2 A brief history of MDTs in community mental health care

When the NHS was founded in 1948, more than half of inpatient beds were dedicated to psychiatry.²³ The following years saw the widespread closure of large residential psychiatric institutions, and the number of psychiatric beds in England dropped from around 150,000 in 1955²⁴ to less than 22,000 in 2014.²⁵ This decline has been attributed to a range of factors, including increased public concern for the rights of the mentally ill,²⁶ advances in psychopharmacology,²⁷ changes in the professional interests of psychiatrists, and overcrowding and short-staffing in residential facilities.²⁸

The need for alternative provision led to a proliferation of community-based teams that has been described as “pragmatic, largely atheoretical and relatively unresearched”.^{12 (p.311)} These teams were local initiatives that varied in their organisation and funding arrangements, but had a common focus on moving care from institutional settings to community centres.²⁹

The 1960’s and 1970’s saw the growth of political and social movements which were highly critical of psychiatry and emphasised social causes of mental distress.³⁰⁻³² The 1971 white paper *Better Services for the Mentally Ill* sought to

extend the role of social services caring for people suffering from mental illness, and to improve coordination between agencies. Community Mental Health Centres (CMHCs) staffed by both health and social service practitioners began to emerge,^{2, 33} and in 1976, a system of joint financing between health and local authorities was developed to promote integrated planning in community care.³⁴ In practice, this collaboration proved challenging and was beset by differences in priorities, a shortfall of investment in services for people leaving hospital, and dramatic variation in mental health expenditure between local authorities.^{34, 35}

Concerns about a lack of clear service objectives,³³ fragmented community care, and poor coordination between health and social services³⁶ throughout the 1980s led to several further government initiatives to improve services. The *Care Programme Approach (CPA)*, introduced in 1990, stipulated that every patient referred to specialist psychiatric services should be allocated a named practitioner who would be responsible for designing a bespoke care package and coordinating its delivery.^{37, 38} This initially took the form of *care management* in social services and *key-work* in mental health services.³⁹ For some years there was confusion as to how these two roles related to each other,² and they were gradually combined, with a 1994 policy stating that mental health assessments and social care assessments should to be coordinated to produce a single care plan,⁴⁰ and a 1995 white paper stating that the roles were “in essence” the same.¹⁷ Full integration came in 1999 when they were explicitly merged into the *care-coordinator* role.⁴¹ The precise arrangements for the CPA were to be determined locally by individual health authorities “in discussion with relevant social services authorities”.³⁸ (Paragraph 5)

The term *Community Mental Health Team* was not formalised in policy until the mid-1990s, with the government documents *Building Bridges*¹⁷ and *The Spectrum of Care*.⁴² The latter states:

“The professional groups will have skills specific to their particular profession, and will have other skills in common with others. They are expected to use skills in a flexible way so that they can work together as teams to meet the [needs of the] full range of the people referred to them.”
(p 5)

Policy was not prescriptive regarding the organisation, staffing or service objectives of the teams, emphasising that these should be determined locally.^{17, 43, 44} Consequently, there remained wide variation in their composition, reporting structures and clinical focus.⁴⁵

The *National Service Framework for Mental Health*,³ introduced in 1999, promoted the establishment of more specialised community teams catering to specific populations, such as Assertive Outreach Teams (AOTs), Crisis Resolution Teams (CRTs), Home Treatment Teams (HTTs) and Early Intervention Psychosis Services (EIS).³ Further specialist teams such as Substance Misuse Teams, Forensic Teams and Older Adults Teams were formalised in the following years.^{6, 46} In 2001, the *National Service Framework for Older People* recommended that all specialist mental health services for older people include *Memory Clinics* dedicated to the assessment and diagnosis of memory disorders.⁴⁷⁻⁴⁹ Subsequent guidance clarified that these memory services could be provided either by stand-alone teams or within the structure of more general CMHTs.⁵⁰ As of 2013, 66% were provided within Older Adult CMHTs.⁴⁷

The 2001 Mental Health Policy Implementation Guide emphasised that generic CMHTs were to remain the “mainstay” of the system, continuing to care for the majority of mentally ill people in the community and functioning as a key source of referrals to the more specialised teams.¹⁵ However, critics have argued that the creation of the newer forms of CMHT has stripped the general teams of experienced staff, leaving them overwhelmed and prone to high levels of burnout, job dissatisfaction, and high staff turnover.^{9, 11} Oakley⁵¹ noted that so-

called “generic” or general CMHTs are “sometimes treated as little more than the handmaidens to specialist services” (p. 45).

A recent wave of further changes has led some trusts to abolish general CMHTs completely as they reconfigure their services in accordance with *Service Line Management*, a business model strongly encouraged by Monitor (the body responsible for authorising and regulating NHS foundation trusts).⁵² This model involves dividing trusts into specialist clinical areas (known as *service lines*) which are managed by clinicians as distinct operational units.⁵³ Consequently, many trusts are restructuring their current MDTs into “functionalised” MDTs catering to particular types of illness (e.g. Psychosis, Common Mental Health Problems, and Severe and Complex Non-Psychotic service lines). Again, this reform has not been without its challenges. There is evidence that some board members have been reluctant to relinquish managerial control to clinicians, and clinicians have expressed frustration with what they see as increased accountability without corresponding autonomy.⁵⁴

Despite this frequent organisational restructuring, MDTs in various forms have remained the central organisational model for community mental health services, and key-work (or care-coordination) has remained the central approach to delivering care. Within this framework, multidisciplinary care planning is dependent on keyworkers making effective use of both their own specialist knowledge and that of their diverse colleagues. Yet there has been little investigation of MDT meetings, the formal mechanism for achieving this multidisciplinary collaboration. One possible explanation for this lack of research is that the specific purpose of MDT meetings has not been well-defined in mental health policy, making it difficult to measure their effectiveness.

1.3 MDT meetings: policy and practice

1.3.1 What should be discussed?

The question of which cases should be discussed at MDT meetings has been complicated by inconsistencies in policy. The 1995 document *Building Bridges* stated, “The CPA only involves the whole multi-disciplinary team for **complex** assessments” (emphasis added).¹⁷ (p.47) Similarly, a 1999 policy document on effective care-coordination stated, “Reviews, by means of a multi-disciplinary team meeting, only take place where plans are complex, clearly not working or in imminent danger of breakdown”.⁴¹ (p.10)

In contrast, the 2002 *Policy Implementation Guide for Community Mental Health Teams* stated that “assessments and reviews [are] to be **routinely** discussed by the whole team in a time-tabled weekly meeting ... where actions are agreed and changes in treatment discussed by the whole team” (emphasis added).⁵⁵ (p.9)

A more recent policy on responsibility and accountability⁵⁶ also implied that all care-coordination decisions should be subject to team review:

“Care coordination decisions concerning an individual user ... for example, who should be working together and how, what the objectives of different inputs to care are, whether a new or different approach should be used, and whether other resources can be brought to bear to improve the situation ... **should be very visible and subject to regular review by the team as a whole**” (p. 25, emphasis added).

However, the same policy later suggested that only the more ‘*significant*’ or ‘*important*’ decisions should be discussed by the whole team:

“Decisions will be made by practitioners with the service user, but the model encourages team discussion of **the more significant decisions**, where more views on the issue will contribute to the safety and

robustness of the ensuing plan ... The team has collective responsibility to come to a consensus on **important decisions**” (p. 25, emphasis added).

It is therefore unclear whether MDT meetings are to be used to regularly review all patients or whether they should be reserved for discussing decisions that are considered special in some way. Consequently, teams may differ in how they select patients for discussion, resulting in variation in the level of multidisciplinary consideration patients are granted.

1.3.2 Who should be present?

The extent of multidisciplinary input a patient receives depends not only on their case being raised at MDT meetings, but also on the mix of professionals in attendance. Currently the composition of CMHTs varies widely.⁹ Guidance for general CMHTs advocates local flexibility, providing a “guide to the likely level of resources required”^{55 (p.19)} rather than mandating minimum requirements. It states that patients need input from nursing, social work, psychology and medicine, but also makes reference to occupational therapists, support workers and administrators.

Guidance documents for the newer forms of CMHT (e.g. AOTs, CRTs, HTTs and EIS) vary in their prescriptiveness regarding team composition.⁵⁷ For example, the *Mental Health Policy Implementation Guide* suggests that an EIS team with 120-150 patients should have a part-time adult consultant psychiatrist, a non-career grade psychiatrist, a part-time child and adolescent consultant psychiatrist, and 10 care-coordinators comprising an “appropriate mix” of nurses, social workers, psychologists and occupational therapists.¹⁵ Service specification for memory clinics simply states that providers should draft a care plan “in consultation with other relevant disciplines”.^{58 (p.25)} Several authors have reported that, in practice, the professional composition of CMHTs is largely based on supply rather than on a strategic rationale reflecting local

need,^{12, 59, 60} and severe shortages of psychiatrists, psychologists, occupational therapists⁵⁹ and social workers⁵⁷ have been reported.

1.3.3 MDTs in other healthcare contexts

The lack of prescriptive policy on MDT meetings in mental health care is striking when compared with policy in other healthcare contexts. This may, in part, explain the relatively low rates of decision-making and implementation in mental health teams relative to other MDTs.¹⁹ In cancer care, for example, MDT meetings are nationally audited against a list of indicators specifying which patients should be discussed, which staff members should be in attendance, what administrative support should be available and how decisions should be documented.⁶¹ The introduction of these standards has facilitated benchmarking and inter-team learning.⁶²

In contrast to the gradual and localised development of CMHTs, cancer MDTs were formally introduced through an explicit policy designed to ensure a uniform standard of care nationally.⁶³ The *National Cancer Plan*⁶⁴ (2000) mandated the nationwide establishment of MDTs “to help ensure that all patients have the benefit of the range of expert advice needed for high quality care” (p.58). Crucially, these changes were backed by significant financial investment to enable teams to meet the specified minimum standards.

In parallel with these policy developments, there has been a growing body of research focusing on cancer MDT meeting effectiveness. An explicit objective of cancer MDT meetings, specified in policy, is to agree treatment plans for all newly diagnosed cancer patients.⁶¹ Several studies have therefore measured the effectiveness of these teams in terms of both their ability to reach a decision,⁶⁵ and whether these decisions are subsequently implemented.⁶⁶⁻⁶⁸ A range of tools have been developed for monitoring the quality of cancer MDT meetings and facilitating improvement, including a decision-aid called MDT MATE,⁶⁹

observational tools such as MDT-OARS⁷⁰ and MDT-MODE,⁷¹ a discussion checklist called MDT-QuIC,⁷² and a self-assessment questionnaire called TEAM.⁷³ The latter has been endorsed in the National Cancer Strategy as part of a toolkit for improving MDT working.⁷⁴

MDT meetings in mental health care have not received the same attention. Because mental health policy is less explicit regarding the desired outcomes of MDT meetings, it is less clear how their effectiveness should be monitored. A recent report on quality in community care by the King's Fund concluded that providers are "severely hampered by a lack of robust, comparable national indicators that would enable them to benchmark their performance".^{75 (p.2)}

Despite being the single largest cause of disability in the UK,⁷⁶ mental illness has historically received a disproportionately low portion of public spending, both in terms of research spending⁷⁷ and health service commissioning.⁷⁸⁻⁸⁰ Mental health accounts for 23% of the total disease burden (including premature death) in the UK, and yet it receives only 13% of NHS expenditure.⁷⁹ There has been increased recognition of this disparity in recent years and mental health is becoming more of a political priority.⁸¹ The government has recently launched a Mental Health Intelligence Network (based on the National Cancer Intelligence Network) to monitor variation in provision,⁸² and, in recognition of the need for more clearly defined service objectives, the Care Quality Commission (CQC) has committed to developing "definitions of what good looks like" (p.8) in mental health care.⁸³ However, these recent efforts to achieve "parity of esteem"^{82, 84} with physical illness have arrived at a time of economic austerity, and alongside government directives to make large efficiency savings in the NHS.⁸⁵ In this difficult financial context, it is crucial that services make the best possible use of the available resources.

1.4 Challenges to collaborative multidisciplinary teamwork

Bringing diverse professionals together and calling them a team does not guarantee productive collaboration. A number of challenges to effective multidisciplinary teamwork in healthcare have been identified. Members of different professional groups differ not only in their skills and expertise, but also in the culture, identity, lexicon, values and goals instilled by their training.⁸⁶⁻⁸⁹ Conflict can arise as professional groups struggle to assert the primacy of their own theories of illness^{90, 91} and to defend their professional territory.⁹²⁻⁹⁴ Differences in social status and earning power can also cause tension⁹⁵ and lead to reluctance among lower-status members to contribute their expertise, even where they have valuable contributions to make.⁹⁶

Research on teamwork in mental health services has highlighted the importance of team members having a shared understanding of their roles and responsibilities, how these roles relate to each other, and how they contribute towards a shared team objective.⁹⁷⁻¹⁰² There is evidence, however, that achieving such role clarity is difficult in the context of generic key-working, which sees team members with diverse disciplinary backgrounds performing the same tasks (e.g. monitoring medication, conducting risk assessments, and advising on social benefits and housing).^{103, 104}

Several studies have reported that the introduction of key-working fostered resentment and frustration among staff, who resented being obliged to take on new duties while losing exclusive responsibility for others.^{101, 105, 106} For example, nurses expressed frustration at having to address social care needs which had traditionally been the domain of social workers.^{107, 108} Some social workers reported that their specialist approach was “under siege” from what they saw as a more paternalistic medical perspective.¹⁰¹ Similar concerns about multidisciplinary teamwork resulting in a loss of professional identity, isolation

from disciplinary colleagues, and the underuse of specialist skills have been expressed by psychiatrists,¹⁰⁵ psychologists,¹⁰⁶ and occupational therapists.¹⁰¹

Most of the research on the impact of multidisciplinary working and role blurring in community mental health was conducted in the 1990s, when the CPA was still in its early stages. Few studies have explored these issues in recent years and it is unclear whether problems relating to role clarity have been resolved over time. Though key-work has become standard practice, further policy and legal changes have led to new forms of role overlap. For example, in 2005, specially trained nurses were granted the power to prescribe and monitor any licenced medicine independently of doctors.¹⁰⁹ Legal changes in 2007 meant that Mental Health Act assessments, previously only undertaken by Approved Social Workers, could also be conducted by appropriately qualified psychiatric nurses, occupational therapists or clinical psychologists. The introduction of new non-professionally-affiliated roles, such as support workers, time workers, recovery workers and graduate mental health workers^{9, 16} has also raised concerns due to uncertainty regarding their remit.¹¹⁰

In the midst of these challenges, some have argued that the promotion of multidisciplinary working has been largely based on an intuitive sense that it *should* improve care rather than on robust evidence that it does.^{111, 112}

1.5 MDT effectiveness

Effectiveness is defined as the degree to which something is successful in producing a desired result.¹¹³ The desired result of an organisational system or process may be conceptualised in terms *purpose* or *function*, two overlapping but distinct concepts. The *purpose* of a system refers to the *intention* for which it exists (i.e. its reason for being, according to whoever designed or instigated it), while the *function* of a system refers to its *action* (i.e. what it actually does or achieves in practice).¹¹⁴ Though the original purpose of an established

organisational system may be nebulous or unknown, its current functions can be observed and described. A system or process may serve multiple functions, and different stakeholders may have different views as to what they are and their relative importance. Effectiveness is therefore a multifaceted concept tied to the expectations of different interested parties. The effectiveness of healthcare teams has been conceptualised and measured according to a range of functions, from organisational expenditure to individual patient outcomes (Table 1.1).^{115, 116}

Table 1.1 Outcome measures of effective teamwork (adapted from Mickan, 2005)

Collective benefits		Individual benefits	
Organisational	Team	Patient	Team member
Reduced administrative costs	Coordination of care	Engagement	Job satisfaction
Reduced admissions	Enhanced communication	Adherence	Role clarity
Meeting external requirements	Efficient use of services	Health outcomes	Wellbeing

The evaluation of CMHTs has also been complicated by a lack of alternatives with which to compare them and variation in practices from team to team. Nonetheless, there have been a number of attempts to assess their impact on care. A Cochrane review to evaluate the effectiveness of CMHTs was conducted in 2001¹¹⁷ and updated in 2007.¹¹⁸ The reviewers collated studies comparing CMHTs with ‘standard non-team community care’ (usually outpatient hospital care) on a range of quantitative outcomes, including rates of patient mortality, hospital admission and police contact. The study found less dissatisfaction with care, fewer hospital admission rates, and fewer people losing contact with services in the CMHT group, but no gains in clinical symptoms or social functioning. The authors concluded that evidence for CMHT-delivered care compared with standard non-team care was “insubstantial considering the massive impact the drive toward community care has on patients, carers, clinicians and the community at large” (p.2). This somewhat damning

conclusion must be considered in light of some substantial methodological limitations. The review was based on only three studies, all of which were conducted in the 1990s, by which time all NHS mental health services care were moving towards a multidisciplinary format. The difference between the CMHT condition and the “standard care” control was somewhat unclear, with the control teams described as having *less* of an emphasis on multidisciplinary working and *usually* assessing patients in outpatient clinics rather than in the community.

Given that CMHTs and their variants have now become ubiquitous in the NHS, there is little prospect of a more tightly controlled trial. Instead, more recent efforts have focused on developing scales to assess the quality of care provided by CMHTs on various dimensions, with a view to informing practice and facilitating comparisons between teams. These scales measure factors such as patient well-being, carer engagement, inter-team working, ability to meet external requirements, creative problem-solving, respect between professionals and continuity of care.^{6, 119-121} Yet despite the policy emphasis on multidisciplinary care planning, none of these tools directly address the MDT meeting, the central forum for multidisciplinary collaboration.

Though numerous challenges to multidisciplinary teamwork have been identified, the effectiveness of these meetings has been largely taken for granted. In order to explore these issues, it is worth considering the process through which MDT meetings may lead to benefits for patients.

1.6 From MDT meeting to patient benefit: a conceptual model

MDT meetings are particularly important in the context of key-working, where each patient has regular contact with only one member of the team. The

potential for a patient to benefit from MDT meetings therefore largely depends on their keyworker raising their case for discussion, sharing the relevant information, and eliciting the expertise of their colleagues. It depends on other team members actively engaging in these discussions — even for the cases they don't manage directly — and generating ideas to improve care. Finally, it depends on team-members having the capacity to act on these ideas, which will be shaped by contextual factors such as personal resources, organisational resources and patient engagement. Figure 1.1 illustrates this process in the form of a basic conceptual model. Though such models are inevitably simplistic, they can serve as useful “tools for thinking” about complex processes.¹²²

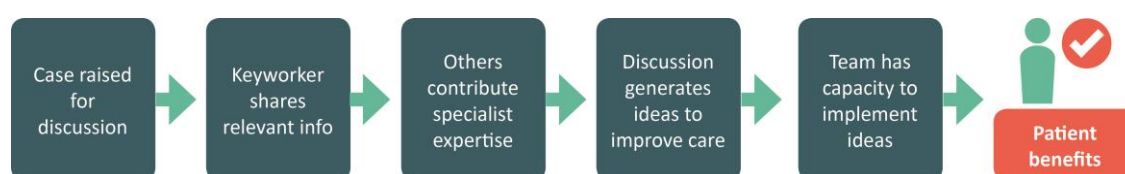


Figure 1.1 Conceptual model: Steps from MDT meeting to patient benefit

In light of the known challenges to multidisciplinary collaboration, the lack of prescriptive policy regarding which patients should be discussed, and the under-resourcing of mental health services, there is the potential for problems to arise at various points in this process. In the final chapter I will return to a modified version of this model to show how the study findings elucidate these intervening factors.

1.7 Overview of the research

1.7.1 Summary of rationale: why study MDT meetings?

The importance of multidisciplinary care has long been emphasised in mental health policy. MDT meetings are the formal mechanism for achieving this multidisciplinary collaboration, yet there is little research evidence^{12, 46} or specific policy to guide teams in ensuring their effectiveness. Furthermore, MDT meetings are resource-intensive and a number of challenges to effective multidisciplinary collaboration have been identified which may hinder their potential to optimally benefit patients.

1.7.2 Aim and objectives

The overarching aim of this research was to explore the functions and organisation of multidisciplinary team meetings in community mental health care, with a view to identifying current challenges to effectiveness and opportunities for improvement. This exploratory aim was supported by the following specific objectives:

- i. To identify the functions served by MDT meetings.
- ii. To examine how MDT meetings are organised and managed, and the extent to which this varies between teams.
- iii. To explore practitioner views on MDT meetings and multidisciplinary care planning.
- iv. To explore patient views of MDT meetings and multidisciplinary care planning.
- v. To identify factors that have an impact on the potential for patients to benefit from MDT meetings and multidisciplinary care planning.

1.7.3 Research design

The research is presented in two parts. The first is a **systematic review and thematic synthesis** which was conducted to identify and collate the functions of community mental health MDT meetings identified in previous literature (the precise methods are detailed in Chapter 2).

The second is a **mixed-methods investigation** of the functions and organisation of MDT meetings in six community-based mental health teams in southern England. Qualitative data were collected through:

- non-participant observation of MDT meetings;
- interviews with MDT staff members;
- interviews with patients and carers.

Quantitative data were collected through:

- non-participant observation (details recorded on structured proformas);
- review of patient medical records;
- staff questionnaires.

The data from this mixed-methods investigation were analysed and integrated to produce five global themes. A detailed description of the methods is provided in Chapter 3.

Table 1.2 shows how each data source contributed to addressing each study objective.

Table 1.2 Research objectives and the relevant data sources

Objective	Data source				
	Systematic review	Qualitative observation	Quantitative data	Staff interviews	Patient interviews
i. Identify meeting functions	✓	✓	✓	✓	
ii. Organisation and management		✓	✓	✓	
iii. Staff views			✓	✓	
iv. Patient and carer views					✓
v. Factors that impact on potential for patients to benefit		✓	✓	✓	✓

1.7.4 How data from the NIHR Project were used in this PhD

As described in Section 1.1, the fieldwork conducted for this PhD was undertaken as part of a larger programme of research on which I was employed as one of three full-time Research Associates. This project involved data from mental health, heart failure and cancer teams. I collected the majority of the data from the mental health teams: observational data from 109 of 181 MDT meetings, 20 of 32 interviews with staff and patients, and 24 of 59 staff questionnaires. However, because some of teams held their meetings simultaneously, it was not possible for me to attend them all. Some of the mental health data were therefore collected by the other Research Associates (PX and IW, see acknowledgements on p.6) and by three students trained as part of the NIHR Project (MM, WO and RC).

For the independent analyses presented in this thesis, I included the interview data and quantitative data from all six of the mental health teams, and qualitative observational data (field notes and audio recordings) from only the meetings I observed in person. Table 1.3 shows the portions of the NIHR Project

data used in this PhD research. The footnotes specify where the data were collected by my colleagues.

Table 1.3 Outline of NIHR Project data showing which data were used in this PhD

Team name	Type of data		
	Qualitative observational data	Quantitative data	Interview data
CMHT 1	✓	✓*	✓
CMHT 2	✓	✓**	✓
CMHT 3	✓	✓	✓
EIS	✓	✓	✓
Mem 1	✓	✓†	✓†
Mem 2	×	✓‡	✓‡
Cancer 1	×	×	×
Cancer 2	×	×	×
Cancer 3	×	×	×
Cancer 4	×	×	×
Heart Failure 1	×	×	×
Heart Failure 2	×	×	×

* For CMHT 1, I collected the quantitative data for 14/15 meetings. IW covered the one meeting I could not attend.

** For CMHT 2, I collected the quantitative data for 31/55 meetings and IW collected the rest. I collected all of the data from the medical records.

† For Mem 1, I collected the quantitative data for 21/43 meetings and PX collected the rest. Interviews were conducted by PX, WO, and RC.

‡ For Mem 2, the qualitative observation was conducted by PX and is therefore excluded. Quantitative data were collected by PX. Interview data were collected by PX, WO and MM.

A number of aspects of my PhD were shaped by decisions made about the NIHR Project, namely, the choice of teams recruited, the number of interviews conducted, the length of the observation period, and the design of the data collection tools (e.g. the interview topic guides). I co-designed the data collection instruments, in collaboration with my colleagues, to focus on high-level issues of relevance across a range of chronic diseases. However, the

flexible format of the semi-structured interviews and the inductive nature of the non-participant observation made it possible to pursue a fine-grained analysis of issues that emerged as particularly important in the mental health context.

1.8 Thesis structure

This first chapter has provided a brief history of community-based mental health teams, outlined the rationale for investigating MDT meetings and provided an overview of the research.

Chapter 2 presents a systematic review of the functions of mental health MDT meetings identified in previous literature.

Chapter 3 describes the methods used in the primary research. It provides a rationale for the use of a mixed-methods approach and describes the recruitment, data collection and analysis procedures. It then explains how the data from each of the methods were integrated to produce an overarching thematic framework.

Chapter 4 provides an introduction to the findings, describing the organisational setting and the participating teams and individuals. It also presents the integrated thematic framework, around which the following results chapters are structured.

Chapters 5 to 9 present the results of the primary research. Each results chapter relates to one of five global themes, presenting the relevant data, followed by an interim discussion.

Chapter 10 summarises the research findings, relating them to the conceptual model presented in Section 1.6. Strengths and limitations of the work are considered, and implications for practice, research and policy are discussed.

2 Systematic review: what functions do MDT meetings serve in community mental health care?

2.1 Chapter overview

This chapter presents a systematic review and thematic synthesis of the functions of community mental health MDT meetings that have been reported in previous academic literature. Papers relating to CMHTs for adults in the UK and published between September 1999 and February 2014 were reviewed. Eligible studies were appraised using NICE quality checklists. Of the 4046 papers identified, none explicitly investigated the functions of MDT meetings; however, 49 mentioned functions in passing. These were categorised into four thematic domains: discussing the care of individual patients; enacting teamwork; team management; and learning and development. In most cases, the functions related to outcomes for individual patients (e.g. agreeing care plans); however, five papers mentioned only process-related functions such as team management and peer support. The one study that investigated team meetings in detail reported that their purpose was usually left implicit and varied from team to team. The findings highlight a need for empirical research to clearly establish how MDT meetings are being used so that their functions can be understood, monitored and evaluated.

2.2 Method

Systematic reviews in health research have traditionally focused on measurable, quantifiable variables.¹²³ In recent years systematic reviews of qualitative and mixed-methods studies have become increasingly common, due to growing recognition of the need for different forms of evidence in explaining complex

social phenomena.¹²⁴ Reviews of quantitative studies typically address questions about *what works*, while reviews of qualitative evidence tend to address questions about *what matters* to relevant stakeholders,¹²⁵ and can be thought of as '*reviews of views*'.^{126, 127}

This review set out to investigate the perceived functions of MDT meetings. It was possible that both qualitative papers (e.g. interview studies) and quantitative papers (e.g. surveys) would report relevant data; therefore, the type of study to be included was not restricted *a priori*.

Numerous methods have been proposed for synthesizing evidence from diverse studies to develop a more comprehensive understanding of an issue. Several authors have advocated distinguishing between *integrative* and *interpretive* approaches to evidence synthesis.^{128, 129} Integrative approaches aim to pool and summarise data, typically through statistical techniques. Such methods are usually applied to quantitative studies, and include various forms of meta-analysis,¹³⁰ meta-regression,¹³¹ content analysis,¹³² and case surveys.¹³³ In contrast, interpretive approaches aim to develop conceptual understandings or specifications by synthesising concepts identified in relevant primary studies to produce a higher-order theoretical structure. The product of this kind of synthesis is a framework of concepts or a theory rather than an aggregation of data.¹³⁴ Interpretive approaches are typically applied to qualitative studies, and include narrative summary,¹³⁵ meta-ethnography,^{128, 136} critical interpretive synthesis,¹³⁴ realist synthesis,¹³⁷ framework synthesis,¹³⁸ and thematic synthesis.¹³⁹ ii

ii The literature on evidence synthesis is complicated by ambiguous terminology. Different authors use the terms *integrative versus interpretive*;^{123, 128} *aggregative versus configurative*;¹³⁶ and *aggregative versus interpretive*¹³⁴ to refer to roughly the same dichotomy. Furthermore, in these conceptualisations, "aggregation" refers to the pooling of quantitative data, while others have used it to mean developing themes from qualitative data.¹²⁷

Each method of synthesis has advantages and disadvantages. The suitability of a given approach depends on the context and the question being addressed.¹²⁹ In this review I elected to use thematic synthesis as a means of collating and structuring the perceived functions of MDT meetings. This approach is helpful in configurative reviews, as it uses techniques from thematic analysis to identify themes by looking across multiple primary studies.¹⁴⁰ The result is a thematic framework which distinguishes different facets of the issue under study. In health research, such frameworks can provide an orienting structure for further investigations and clinical efforts to improve care quality.¹⁴¹ The goal in this review was to produce a thematic framework which makes explicit the often taken-for-granted functions of MDT meetings. I followed the three stage procedure for thematic synthesis outlined by Thomas and Harden, which is described in detail in Section 2.2.7.¹³⁹

The review was conducted in accordance with ENTREQ (ENhancing Transparency in Reporting the synthesis of Qualitative research)¹⁴² guidance and PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidance¹⁴³ where applicable.

2.2.1 Study eligibility criteria

For the purposes of the review, *Community Mental Health Team* was defined broadly to include Assertive Outreach Teams (AOTs), Early Intervention Services (EIS), Home Treatment Teams (HTTs), Crisis Resolution Teams (CRTs), specialist teams catering to Older Adults, and Memory Clinics, as well as general CMHTs. As the research focuses on NHS teams, only papers relating to services in the UK were included.

A number of inclusion and exclusion criteria were defined in order to determine the relevance of the papers to the review question (Table 2.1). Papers were included only if they mentioned at least one function of team meetings.

Unlike a traditional systematic review, this study did not aim to pool quantitative data or assess the effectiveness of an intervention. Rather, it aimed to develop a rich conceptualisation of the full range of views regarding the functions of MDT meetings. It was therefore informative to review a diverse range of publication types, including *primary sources* which report original research and *secondary sources* such as editorials and books. Because secondary sources are not amenable to formal methodological quality assessment, they were treated as distinct in the analysis. Author comments from primary studies that were not derived directly from the data (e.g. commentary in the introduction sections of papers) were also reviewed in this way.

Table 2.1 Inclusion and exclusion criteria for systematic review papers

Parameter	Inclusion criteria	Exclusion criteria
Location	United Kingdom	Outside of United Kingdom
Language	English	Non-English
Time Frame	1999 – 2014	Studies published prior to 1999
Population	Studies of mental health teams caring for adults in the community	Studies of inpatient care Studies of children’s services Studies of illness populations other than mental health
Content	Mentions one or more functions of MDT meetings	
Study design	Qualitative and quantitative studies investigating MDT meetings	Drug trials Disease prevalence studies
Publication type	Primary sources: Peer-reviewed journal articles Published comprehensive research reports (e.g. Sainsbury Centre for Mental Health) Secondary sources: Editorials Books	Conference abstracts Letters to the editor Policy documents Book reviews Newsletters Magazines Study protocols Obituaries

The search was restricted to articles published between the 1st of September 1999 and the 17th of February 2014. In 1999 the Department of Health published the National Service Framework for Mental Health, which set out an agenda for improving mental health care in England.³ This initiated substantial change in how care was planned and delivered; therefore, studies published after this date are likely to be of most relevance to current practice.

My colleague PX collaborated on the review as a second reviewer, and together we piloted and refined the eligibility criteria by applying them to a subset of 20 studies.

2.2.2 Sources

Electronic databases

The following databases were searched to identify relevant published academic papers: Medline, PsychINFO, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Embase, and Health Management Information Consortium (HMIC). The returned references were downloaded to the bibliographic referencing software EndnoteX7 (Thomson Reuters, Philadelphia, USA). Duplicate references were deleted.

Expert correspondence

Five expert clinical academics who have published in the field were contacted in an effort to identify any additional relevant studies. They were supplied with a summary of the review protocol, the inclusion and exclusion criteria, and a list of the eligible primary studies that had been identified in the electronic search. They were asked to identify any further relevant studies of which they were aware.

Citation searching

The reference lists of all studies identified as eligible were reviewed to identify additional relevant studies.

2.2.3 Search Strategy

A scoping review was initially performed to identify the most relevant databases and the terminology to be used in the search strategy. I then devised a formal systematic search strategy in consultation with a clinical information scientist at University College London (UCL) Library. Word clusters consisting of synonyms representing the concepts *multidisciplinary*, *team meeting*, *community*, and *mental health* were developed (Figure 2.1). Terms within clusters were combined using the operator 'or', and clusters were combined using the operator 'and'.

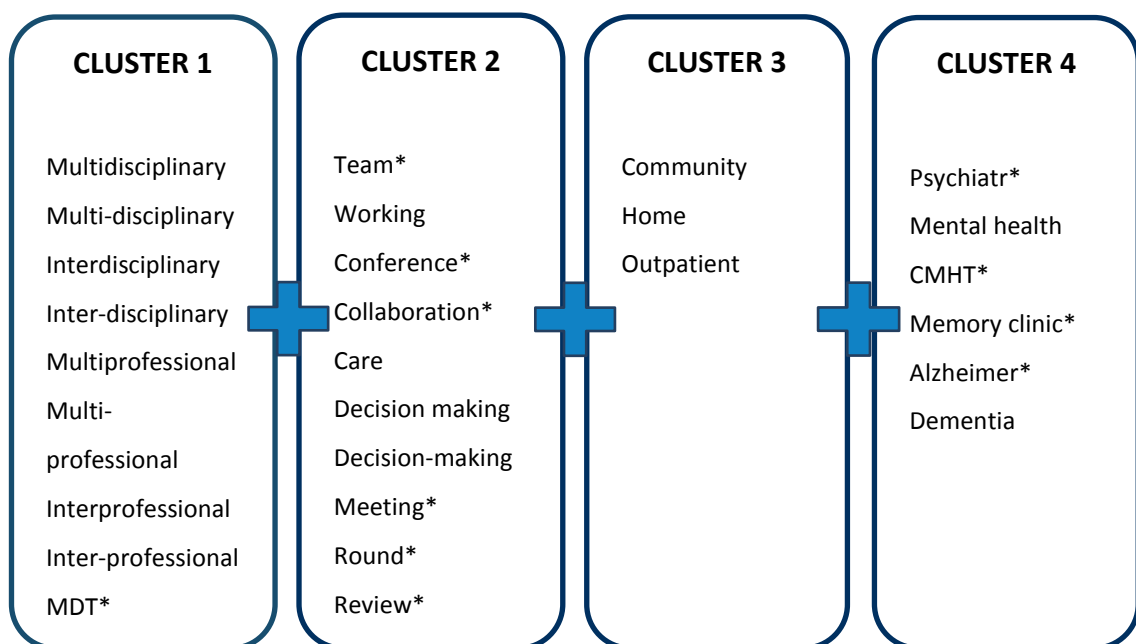


Figure 2.1 Word clusters included in the systematic review

2.2.4 Screening

The review involved two stages of screening to exclude papers which did not meet the inclusion criteria:

- (i) title and abstract screening;
- (ii) full-text screening.

At each screening stage, 10% of the references were independently screened by PX for quality assurance. In keeping with PRISMA guidance, the reasons for excluding any ineligible papers at the full text screening stage were recorded. Papers meeting all of the criteria were fully reviewed.

2.2.5 Quality assessment

Following the full-text screen, primary sources were evaluated using quality appraisal checklists developed by the National Institute for Health and Clinical Excellence.¹⁴⁴ The checklists used are provided in Appendix 3.

Based on these checklists, the studies were classified in the following manner:

- ++ indicates that all or most of the checklist criteria have been fulfilled, and where they have not been fulfilled the conclusions are very unlikely to alter;
- + indicates that some of the checklist criteria have been fulfilled, and where they have not been fulfilled or adequately described, the conclusions are unlikely to alter;
- indicates that few or none of the checklist criteria have been fulfilled and the conclusions are likely or very likely to alter.

These checklists are particularly useful in reviews which incorporate a range of study designs because they maintain the comprehensiveness and thoroughness of design-specific evaluations, yet their outputs are in a commensurable format.

Where studies involved multiple methods, they were assessed on the method that provided the data used in the review.

PX independently assessed 50% of the eligible studies.

2.2.6 Data extraction

Study characteristics were recorded in a data extraction database. The details extracted are listed in Box 2.1. Though the primary aim of the review was to identify the perceived functions of MDT meetings, other findings and comments relating to the team meeting were also recorded; for example, any barriers to effectiveness identified.

- | | |
|--------------------------|---|
| 1. Author | 8. MDT Meeting functions identified by participants |
| 2. Year | 9. MDT Meeting functions identified by authors |
| 3. Title | 10. Barriers to effectiveness identified |
| 4. Design | 11. Facilitators of effectiveness identified |
| 5. Participants | 12. Effectiveness measures identified |
| 6. Team type | 13. Comments about team meetings |
| 7. Aim/research question | 14. Summary of other relevant findings |
| | 15. Recommendations for improving MDT meetings |

Box 2.1 Data extracted from reviewed sources

2.2.7 Analysis

I conducted a thematic synthesis^{139, 140} to develop a thematic framework of stakeholder views on the functions of MDT meetings. This involved line-by-line coding of the relevant sections of the primary studies, organising these

inductive codes into descriptive themes, and inferring higher-order analytic themes based on the data as a whole (Box 2.2).

Stage 1. Coding text

The relevant sections of included studies are entered verbatim into a database. Each sentence of text is inductively coded to capture its meaning and content.

Stage 2. Developing descriptive themes

Codes are grouped into a hierarchical tree structure based on similarities and differences. These groups of codes are labelled with a descriptive theme to capture the meaning of the grouping.

Stage 3. Generating global analytical themes

More abstract themes are inferred from the descriptive themes to address the review question.

Box 2.2 Stages of thematic synthesis (adapted from Thomas & Harden, 2008)

Coding was performed with the aid of the qualitative data management software NVivo10 (QSR International, Warrington, UK).

2.3 Results

The review process is illustrated in Figure 2.2.

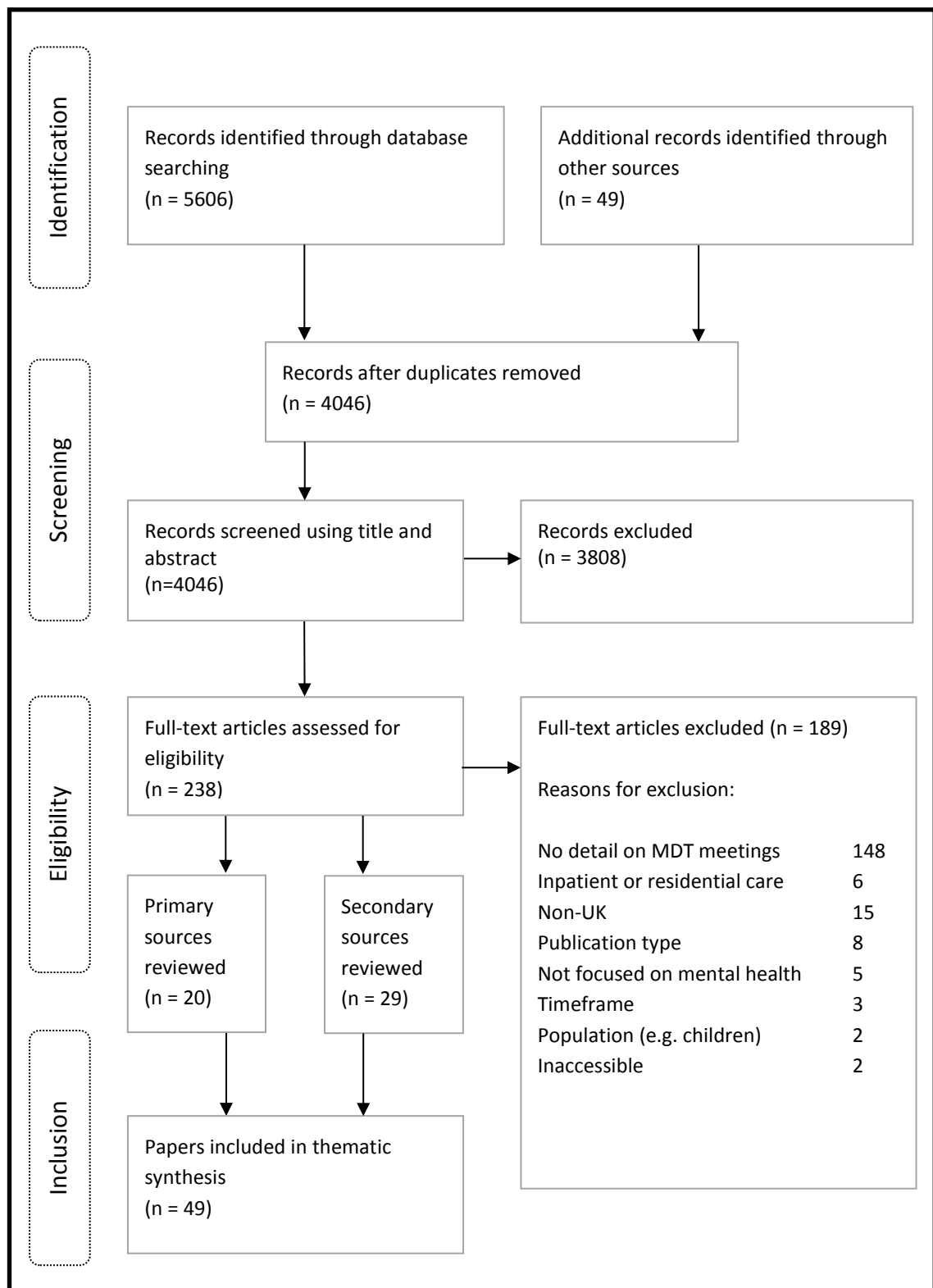


Figure 2.2 PRISMA diagram of the review process

The database search retrieved 5606 results. Citation searching identified an additional 48 papers. After removing duplicates, 4046 papers remained. Of the five experts contacted, four replied that they had no further papers to add. One suggested an additional paper which was found to be ineligible at the full-text screening stage.

On screening the titles and abstracts, 3808 papers were excluded, leaving 238 for full-text screening. On screening the full-texts, 189 papers were excluded. The reasons for exclusion are given in Figure 2.2. Two papers could not be accessed at the British Library or through contacting the journal's online editor. In seven papers, MDT meetings were mentioned only as part of the study methods; for example, where team meetings were used to distribute a research questionnaire or to introduce an upcoming study to a team. These were excluded (within the 'content' category) as they did not provide any detail about the usual functions or processes of the meeting.

Having excluded ineligible papers based on the full-text screen, 20 primary sources and 29 secondary sources remained.

2.3.1 Agreement between reviewers

At the title and abstract screening stage, PX independently screened 400 (10%) of the titles and abstracts. We reached the same conclusion in 97% of cases, giving us confidence that the inclusion and exclusion criteria were robustly defined. The discrepancies related to 12 references and were due to a lack of clarity regarding whether certain specialist teams were within the remit of the review. Following discussion, we decided to include forensic teams and dementia home treatment teams, but to exclude teams focusing on intellectual disability due to their distinct policy and organisational context.^{145, 146}

At the full text screening stage, PX independently screened 10% of the papers. We reached discrepant conclusions regarding the inclusion of two papers. In

the first, the MDT meeting was mentioned, but no detail was provided on its function. In the second, the meeting mentioned was in fact an assessment meeting held to discuss a specific patient rather than a weekly team meeting. Following discussion, both of these papers were excluded.

2.3.2 Quality assessment

All primary sources were of adequate quality for inclusion. Eleven were rated as “++” and nine were rated as “+”, indicating that, even where checklist criteria were not fulfilled, it was unlikely to have influenced the study conclusions. The quality rating of each paper is given in Table 2.2.

PX independently assessed the quality of 50% of the included studies. There was only one discrepancy, where one of us rated a paper (Barlow, 2006)¹⁴⁷ “-” and the other rated it “+”. Following discussion we agreed that the findings that were pertinent to the review were unlikely to have been altered by the methodological limitations, and it was therefore included.

2.3.3 Overview of included primary sources

Twenty primary sources were included in the review. Study characteristics are provided in Table 2.2. Nine were qualitative interview studies, three were surveys (with some open-ended questions) and seven used multiple methods. Eleven related to general CMHTs, two to HTTs, one to forensic teams, one to AOTs, and four reported on several kinds of team.

Table 2.2 Overview of primary sources included in the systematic review

Author	Year	Aim	Team type	Location	Methods and participants	Qual. Rating	Functions mentioned (basic codes)
West et al. ⁶	2012	To identify the principal factors that ensure multiprofessional team work is effective in delivering and improving mental health care for service users	Multiple types of team	England	<ul style="list-style-type: none"> • 10 workshops attended by 157 service providers, users and carers from 13 mental health trusts • Survey of 1500 staff members from 135 teams in 11 trusts • 158 interviews with staff members, service users and carers • Non-participant observation of a total of 20 team meetings in 19 teams 	++	<ul style="list-style-type: none"> • Deciding or approving care plans • Discussing care of individual patients • Discussing problems or difficulties • Discussing recent assessments • Providing updates on ongoing work • Discussing new referrals or inquiries • Planning contact • Reflecting on team tasks or processes • Assessing risks
Christofides et al. ¹⁴⁸	2012	To investigate clinical psychologists' accounts of their use of psychological case formulation in multidisciplinary teamwork	Multiple types of team	Not given*	Interviews with 10 psychologists from a range of inpatient and community teams in one trust	+	<ul style="list-style-type: none"> • Sharing discipline-specific knowledge
Rhodes et al. ¹⁴⁹	2010	l) To assess staff knowledge and use (a) of the NICE guidelines [for depression] and (b) of Cognitive Behavioural Therapy	CMHT	England	Survey (mix of open and closed questions) of 26 staff members from 4 teams	++	<ul style="list-style-type: none"> • Learning about guidance or evidence

		ii) To identify factors involved in staff decision-making about referrals					
Donnison et al. ¹⁵⁰	2009	To explore conceptual models employed by CMHT staff in the care of their clients and how CMHT clinicians communicated with one another, particularly in relation to complex clinical work	CMHT	UK	7 interviews with staff from 2 teams	++	<ul style="list-style-type: none"> • Discussing managerial or business matters
Brown et al. ¹⁰⁸	2000	To interrogate the implications of multidisciplinary teamwork for professional identities and occupational boundaries for those working in community mental health	CMHT	England	29 interviews with staff from 3 teams	++	<ul style="list-style-type: none"> • Discussing care of individual patients • Discussing managerial or business matters
McCrae et al. ¹¹⁰	2008	To evaluate the introduction of support workers from the perspectives of role incumbents and professional practitioners in the CMHTs	CMHT	England	<ul style="list-style-type: none"> • Interviews with a mix of 27 staff members from 4 teams • Survey of work group satisfaction completed by 28 staff members from 4 teams 	++	<ul style="list-style-type: none"> • Allocating cases to keyworkers
Thompson et al. ¹⁵¹	2008	To explore CMHT members' experiences of receiving an innovative introductory level training in Cognitive Analytic Therapy	CMHT	England	12 structured open-ended interviews with social workers and nurses from 1 team	++	<ul style="list-style-type: none"> • Discussing problems or difficulties

McEvoy & Richards ¹⁵²	2007	To develop a better understanding of the contextual influences that impact upon the outcome of gatekeeping decisions	CMHT	England	29 interviews with team members (number of teams not specified)	++	<ul style="list-style-type: none"> • Deciding or approving care plans • Discussing new referrals or inquiries
Simpson ¹⁵³	2007	To enhance understanding of the structures and interactions within CMHTs that facilitate or impede effective teamwork and case management	CMHT	UK	<p>Multiple case study of 7 CMHTs involving:</p> <ul style="list-style-type: none"> • Non-participant observation of over 70 meetings and in team offices, CPA review meetings and service user consultations • Repeated semi-structured interviews with 15 service users, 6 carers and 25 team members (“over 200” interviews in total) • Review of nursing files, care plans, local policies and audit reports 	++	<ul style="list-style-type: none"> • Discussing care of individual patients • Discussing managerial or business matters • Reviewing minutes of previous meetings • Allocating cases to keyworkers • Discharge planning • Discussing problems or difficulties • Discussing recent assessments • Sharing discipline-specific knowledge • Discussing new referrals or inquiries
Barlow ¹⁴⁷	2006	To explore the perceived differences between the contributions of community psychiatric nurses and other members of a multidisciplinary community mental health team for older people	Older Adults	Scotland	Free-text questionnaire completed by 9 team members from 1 team	+	<ul style="list-style-type: none"> • Providing updates on ongoing work

Chisholm & Ford ¹⁵⁴	2004	Describes the implementation of two service models for people with severe and enduring mental health problems	Multiple types of team	England	Interviews with CRT and AOT staff, managers and service users across 10 NHS trusts (does not specify number of interviews or provide a breakdown across groups)	+	<ul style="list-style-type: none"> • Discussing managerial or business matters • Training • Discussing new referrals or inquiries • Sharing discipline-specific knowledge
Mohan et al. ¹⁵⁵	2004	To establish clear definitions of the so-called <i>integrated</i> and <i>parallel</i> models of specialised forensic community mental health services	Forensic	England	<ul style="list-style-type: none"> • Focus group with a mix of 10 professionals affiliated with forensic teams • Modified Delphi process with a mix of 32 mental health professionals 	+	<ul style="list-style-type: none"> • Discussing new referrals or inquiries
Brown & Crawford ¹⁵⁶	2003	To show how management is accomplished amongst a diverse set of mental health professionals who work in a community setting in the Midlands	CMHT	England	29 interviews with a mix of professional groups from 3 teams	++	<ul style="list-style-type: none"> • Discussing care of individual patients • Discussing managerial or business matters • Reviewing minutes of previous meetings • Discussing service improvement • Providing updates on ongoing work • Hosting presentations from external speakers
Lankshear ¹⁵⁷	2003	To explore how the members of six multidisciplinary mental teams learned to cope with the problems that arose when nurses, social workers and	CMHT	England	55 semi-structured interviews a mix of professionals from 6 CMHTs	++	<ul style="list-style-type: none"> • Allocating cases to keyworkers

		occupational therapists were brought together to form teams, and describes the tensions created by political and organizational imperatives					
Burns et al. ¹⁵⁸	2001	To identify the components for home-based services that experts considered most important in enabling people with mental health problems to be treated outside hospital	Home Treatment	UK	Systematic review and Delphi survey involving 12 consultant psychiatrists	+	<ul style="list-style-type: none"> • Sharing discipline-specific knowledge
Cunningham & McCollam ¹⁵⁹	2001	To explore the challenges that arise when moving a pilot assertive outreach model to mainstream practice	Assertive Outreach	Scotland	<ul style="list-style-type: none"> • Interviews with 25 service professionals, 5 clients and four family carers • Health of the Nation Outcome Scales for 44 clients • Referral information for 37 clients • Care diaries relating to 5 clients • Staff activity diaries completed by 7 professionals • 'Written documentation' from a new pilot assertive outreach service and an existing outreach service 	+	<ul style="list-style-type: none"> • Discussing care of individual patients • Reaching shared decisions
King ¹⁶⁰	2001	To investigate the processes through which one CMHT interpreted and implemented	CMHT	Not given*	5 semi-structured interviews with a mix of professionals from 1 team	++	<ul style="list-style-type: none"> • Discussing new referrals or inquiries

		prioritisation criteria aimed at focusing services on people with severe mental health problems					
Orme ¹⁶¹	2001	To survey the provision of crisis home treatment and other emergency mental health services	Home treatment	UK	Survey of the operational policies of 152 mental health services	+	<ul style="list-style-type: none"> • Providing supervision
Freeman et al. ¹⁶²	2000	To explore the factors that inhibited or supported collaborative practice and the ways in which organisational structures and processes impacted on team function	Multiple types of team	England	<ul style="list-style-type: none"> • 600 hours of observation of 6 healthcare teams, including 2 CMHTs • Repeated interviews with a mix of staff (145 in total) 	+	<ul style="list-style-type: none"> • Discussing care of individual patients
Peck & Norman ¹⁶³	1999	Reports on a series of facilitated workshops to enhance the role relations of CMHT staff within which clinical mental health staff were enabled to explore their perceptions of their own and the other professions with whom they work	CMHT	England	Series of workshops involving 61 service professionals	+	<ul style="list-style-type: none"> • Sharing discipline-specific knowledge

*These papers did not specify the location of the research but it was possible to infer that they were based in the UK from their content.

2.3.4 Overview of included secondary sources

Thirty-one papers referred to the functions of MDT meetings without reporting on any relevant primary data and were therefore analysed separately. Characteristics of the secondary sources are presented in Table 2.3. They included 12 service descriptions, nine editorials, three books, one book chapter, one report from the Social Services Inspectorate and one systematic review. Five studies reporting primary data were also included in this section because, although they mentioned MDT meeting functions, this came from author commentary rather than from the primary data collected.

The secondary sources discussed a more diverse range of teams than the primary sources. Nine related to CMHTs, six to AOTs, three to memory teams, three to Older Adults teams, two to EIS teams, one to a 'focused intervention team', one to a CRT and one to a combined Crisis Resolution and Home Treatment team.

Table 2.3 Overview of secondary sources included in the systematic review

Author	Year	Aim	Team type	Location	Publication type	Functions mentioned (basic codes)
Firn et al. ¹⁶⁴	2013	To test the effectiveness of integrating the AO function from two AO teams into six standard community mental health teams (CMHT)	CMHT	England	Primary research	<ul style="list-style-type: none"> • Deciding or approving care plans • Allocating resources • Monitoring performance • Sharing burden or peer support
Page et al. ¹⁶⁵	2012	To compare initial diagnostic hypotheses made by Allied Health Professionals (AHPs; mental health nurses, occupational therapists and social workers) with subsequent formal multidisciplinary formulation based upon full investigations, neuropsychological tests and brain imaging	Memory	England	Primary research	<ul style="list-style-type: none"> • Assigning or approving diagnoses
Abendstern et al. ⁴⁶	2012	To collate existing evidence regarding the structures and processes of CMHTs for older people and to evaluate evidence linking approaches to effectiveness (systematic review)	Older Adults	UK	Secondary data/author opinion	<ul style="list-style-type: none"> • Discussing care of individual patients
Whicher & Abou-Saleh ¹⁶⁶	2009	Describes the development and implementation of a new service for people with dual diagnosis	CMHT	England	Service description	<ul style="list-style-type: none"> • Liaising with members from other teams
Mitchell & Patience ¹⁶⁷	2008	To study the introduction of a system of conjoint multidisciplinary assessment in a Scottish CMHT	CMHT	Scotland	Primary research	<ul style="list-style-type: none"> • Deciding or approving care plans • Discussing recent assessments • Assigning or approving diagnoses • Discussing new referrals or inquiries

Huxley et al. ¹⁶⁸	2008	To study the characteristics of clients in contact with community mental health workers in 8 English locations	CMHT	England	Primary research	<ul style="list-style-type: none"> • Deciding or approving care plans
Page et al. ¹⁶⁹	2008	To examine the accuracy of nurses' initial diagnoses compared to subsequent multidisciplinary assessments	Memory	England	Primary research	<ul style="list-style-type: none"> • Assigning or approving diagnoses
Molodynski & Burns ¹⁷⁰	2008	To describe how community psychiatric services have developed in different nations and to highlight some key issues in service organisation	Multiple	Undefined	Editorial	<ul style="list-style-type: none"> • Discussing care of individual patients • Discussing recent assessments • Reflecting on team tasks or processes
Poole & Higgs ¹⁷¹	2008	To outline ideas and ways of thinking that assist in the development of clinical skills and the effective use of treatment technologies in the real world	Multiple	Undefined	Book	<ul style="list-style-type: none"> • Resolving differences between members • Sharing discipline-specific knowledge
Burns ¹⁷²	2007	Describes the development of CMHTs in the UK and internationally and describes their functions and organisational characteristics	CMHT	UK	Editorial	<ul style="list-style-type: none"> • Discussing care of individual patients • Sharing discipline-specific knowledge
Agius et al. ¹⁷³	2007	Describes the development of a new EIS service in Bedfordshire	EIS	England	Service description	<ul style="list-style-type: none"> • Discussing recent assessments
Gregory & MacPherson ¹⁷⁴	2006	Describes the fidelity characteristics of an established ACT team service Gloucester City and describes user demographic and illness data, comparing these findings to other studies from the United Kingdom	Assertive Outreach	England	Service description	<ul style="list-style-type: none"> • Discussing care of individual patients

Shajahan et al. ¹⁷⁵	2006	Describes the redesign of a CMHT in Lanarkshire	Focused Intervention Team	England	Service description	<ul style="list-style-type: none"> • Allocating cases to keyworkers
Uddin ¹⁷⁶	2006	Describes the development and implementation of the Leicestershire County CRHT operational model, its main functions and infrastructure	Crisis Resolution and Home Treatment	England	Service description	<ul style="list-style-type: none"> • Deciding or approving care plans
Burns ¹⁷⁷	2006	Describes the functions of CMHTs and how they serve patients with personality disorder	CMHT	UK	Book chapter	<ul style="list-style-type: none"> • Allocating cases to keyworkers • Discharge planning • Sharing discipline-specific knowledge
Kent & Burns ¹⁷⁸	2005	Describes the history of the assertive community treatment model, the processes required to run an effective team, and the current status of the model as a mental health service intervention in the UK	Assertive Outreach	UK	Editorial	<ul style="list-style-type: none"> • Discussing care of individual patients • Assessing risks
Lawley et al. ¹⁷⁹	2005	Describes an adapted model of working adopted by two consultants in old age psychiatry in the Hull and East Riding Community Health NHS trust	Older Adults	England	Service description	<ul style="list-style-type: none"> • Discussing recent assessments • Developing through discussion • Arranging cross-cover • Discussing new referrals or inquiries • Sharing burden or peer support • Assessing risks
Ingram & Tacchi ¹⁸⁰	2004	Discusses the changing role of psychiatrist in crisis resolution teams	Crisis resolution	England	Editorial	<ul style="list-style-type: none"> • Allocating cases to keyworkers • Sharing burden or peer support • Sharing discipline-specific knowledge • Providing supervision

Singh et al. ¹⁸¹	2004	Describes development and functioning of new service	EIS	England	Service description	<ul style="list-style-type: none"> • Sharing discipline-specific knowledge
Burns ¹⁸²	2004	Describes the development and functions of both 'sector' and 'functional' CMHTs and outlines core clinical and administrative procedures to assist with implementation	Multiple	Undefined	Book	<ul style="list-style-type: none"> • Discussing care of individual patients
Simpson & de Silva ¹⁸³	2003	Describes two different approaches to MDT assessments in old age mental health services	Older Adults	England	Service description	<ul style="list-style-type: none"> • Deciding or approving care plans • Discussing recent assessments • Discussing new referrals or inquiries
Jones ¹⁸⁴	2002	Describes an approach to developing Assertive Community Treatment in the UK	Assertive Outreach	UK	Service description	<ul style="list-style-type: none"> • Monitoring performance • Sharing burden or peer support
Kennedy & Griffiths ¹⁸⁵	2001	Editorial reporting on solutions to coping with large workloads identified by general psychiatrists (draws on an interview study)	CMHT	UK	Editorial	<ul style="list-style-type: none"> • Allocating resources
Lieberman et al. ¹⁸⁶	2001	Describes the properties and functions of the multidisciplinary team and key attributes of effective teams	Multiple	Undefined	Editorial	<ul style="list-style-type: none"> • Training • Empowerment through discussion • Allocating resources • Reflecting on team tasks or processes • Discussing service improvement
Social Services Inspectorate ¹⁸⁷	2001	Describes how Hounslow Social Services implemented national and local objectives relating to the social care needs of adults with mental health difficulties and the quality of outcomes for service users and their carers	Multiple	England	Inspection report	<ul style="list-style-type: none"> • Allocating cases to keyworkers

O'Brien & Burns ¹⁸⁸	2000	Describes approaches to psychiatric care in the community in the UK, including CMHTs and Assertive Community Treatment	Multiple	UK	Editorial	<ul style="list-style-type: none"> • Discussing problems or difficulties • Discussing new referrals or inquiries
Singh ⁹¹	2000	Discusses the attributes of effective CMHTs, enumerates barriers and challenges to team-working and suggests strategies for improving team effectiveness	CMHT	Undefined	Editorial	<ul style="list-style-type: none"> • Developing through discussion • Sharing discipline-specific knowledge
Lowe ¹⁸⁹	1999	Describes the introduction of a new assertive outreach service	Assertive Outreach	England	Service description	<ul style="list-style-type: none"> • Discussing care of individual patients • Sharing burden or peer support
Burns & Guest ¹⁹⁰	1999	Describes an assertive community treatment service	Assertive Outreach	England	Service description	<ul style="list-style-type: none"> • Discussing care of individual patients • Discharge planning • Discussing problems or difficulties • Professional development activities • Discussing managerial or business matters • Discussing service improvement • Providing supervision • Monitoring performance

2.3.5 Thematic synthesis: reported MDT functions

None of the source articles directly investigated the functions of MDT meetings. They had other aims and, for the most part, only mentioned MDT meetings in passing. Inductive coding of the relevant sections of text from the source articles produced 28 basic codes. These were grouped into eight descriptive themes, which in turn were clustered into global themes representing four broad domains:

1. Discussing the care of individual patients
2. Enacting teamwork
3. Team management
4. Learning and development

The thematic framework constructed from these themes is presented in Table 2.4, showing the basic codes and the number of papers in which each function was mentioned. Quotations illustrating each code are provided in Appendix 4.

Table 2.4 Thematic framework of reported functions

Global themes	Descriptive themes	Basic codes	No. of primary sources	No. of secondary sources	
Discussing care of individual patients	Transition periods	Discussing new referrals or inquiries	6	5	
		Allocating cases to keyworkers	3	4	
		Providing feedback on recent assessments	2	5	
		Discharge planning	1	2	
	On-going care	Providing updates on ongoing work	3	0	
		Assessing risks	1	2	
		Planning contact	1	0	
		Discussing problems or difficulties	3	2	
		Deciding or approving care plans	2	5	
		Assigning or approving diagnoses	0	3	
Enacting teamwork	Specialist input	Sharing discipline-specific knowledge	5	6	
		Liaising with staff from other teams	0	1	
	Generic input	Reaching shared decisions	1	0	
		Sharing burden or peer support	0	5	
		Arranging cross-cover	0	1	
Team management	Managing service	Allocating resources	0	3	
		Service improvement	1	2	
		Reviewing previous minutes	2	0	
		Discussing managerial or business matters	5	1	
	Managing staff	Monitoring performance	0	3	
		Providing supervision	1	3	
Learning and development	Informal learning	Reflecting on team tasks or processes	1	2	
		Learning about guidance or evidence	1	0	
		Developing through discussion	0	3	
		Empowerment through participation	0	1	
	Formal learning	Professional development activities	0	1	
		Training	1	1	
		Hosting presentations from external speakers	1	0	

The functions listed are not mutually exclusive; rather, they overlap, reflecting the different ways they have been conceptualised in the literature. For example, functions within the domain of 'teamwork' (e.g. sharing discipline-specific knowledge) can facilitate functions within the domain of 'discussing care of

individual patients' (e.g. allocation to keyworker). In the following sections, each of the global themes is considered in turn.

2.3.6 Theme 1. Discussing the care of individual patients

Discussing the care of individual patients was the dominant theme. Where papers were more specific about the nature of these discussions, the functions could be categorised into two subthemes: discussions relating to transition periods and discussions relating to on-going care.

Discussing patients at transition periods

Many sources described teams using MDT meetings to discuss patients experiencing transitions in their care. These included their initial referral to the team, allocation to a keyworker, and discharge. Discussing new referrals was among the most frequently cited functions.^{6, 152-155, 160, 167, 179, 183, 188} Several papers referred to the weekly MDT meeting as the *referral meeting* or the *allocation meeting*.^{155, 160, 167, 183} This referred to teams discussing recent referrals with a view to deciding whether or not each case was suitable for assessment by the team. This decision was ostensibly based on whether or not the case was within the remit of the team; however, two studies reported that team members sought out ways to decline or redirect referrals due to resource constraints: "*The team described how a considerable amount of time and effort was continuously spent, especially during referral meetings, on the process of finding ways of 'sharing unwanted cases' with other agencies.*"^{160 (p.82)} A participant in a study on "gatekeeping" access to CMHTs stated that team members who personally found it hard to reject referrals would strategically present them at the meeting "*so that other people may say, 'no that's primary health care' or 'no, you shouldn't be getting involved'*".^{152 (p.389)}

Seven papers mentioned teams having discussions about which practitioner would be most suitable to work with a given patient.^{110, 153, 157, 175, 177, 180, 187} In

theory, this decision was to be made by finding the most suitable match between a specific case and the expertise of a particular professional. In practice, however, Lankshear¹⁵⁷ found that this thoughtful matching process was often bypassed, and it was assumed that whoever had conducted the assessment would take the patient on to their caseload. In the words of one participant, *"At one point if you were allocated [to do the initial assessment] it was generally accepted that you took that one on [to your caseload]. So people who were full up were saying 'No I'm not even going to assess it because, I can't, I haven't got the time to take it on'"* (p.460).

The final transition period identified as a focus of discussion was the discharge of the patient, either from hospital back to community care, or from the CMHT to another healthcare service.^{153, 177, 190}

Discussing on-going care

Meetings were described as an opportunity to share information such as feedback on recent work^{6, 147, 156}, day-to-day difficulties and risks^{6, 151, 153, 188, 190}. Some papers described meetings being used as a forum for making group decisions about care plans or diagnoses.^{165, 167, 169, 176} Others described meetings being used to approve or confirm care plans and diagnoses that had already been made by individual team members.^{6, 152, 167, 183}

2.3.7 Theme 2: Enacting teamwork

Meetings were reported to facilitate teamwork, both in terms of sharing specialist knowledge and providing peer support. They were described as an opportunity for *"multidisciplinary review,"*^{158, 172} though few papers commented on how multidisciplinary input was achieved in practice. In one study, a participant stated *"I do get concerned at times when I come into team meetings and the discussion is all about what medication people are on. That's talked about a lot, and*

that disappoints me a bit" (p. 29).¹⁵⁴ Another paper emphasised that psychological ideas were shared with the team informally rather than systematically, with psychologists "*chipping in*" during team meetings.¹⁴⁸

Other teamwork functions were unrelated to discipline-specific expertise; rather they related to general benefits of working in a team, such as sharing responsibility for decisions¹⁷⁹ and facilitating cross-cover when a patient's keyworker was unavailable.¹⁵⁹ Peer support was a recurring theme among secondary sources, which highlighted the importance of creating a supportive environment¹⁸⁰ and sharing the burden of care:¹⁸⁴ "*Through sharing and processing their thoughts and feelings, the team can progress the therapeutic work*".¹⁸⁹ (p.18)

2.3.8 Theme 3: Team management

Several papers mentioned that the team meeting was used for "*business matters*" or "*team business*."^{150, 153, 154, 156, 190, 191} 'Business' was not explicitly defined, but service improvement functions such as audit and quality improvement were also mentioned.^{156, 186, 190}

The meeting was also reported to facilitate staff supervision^{154, 180, 190} and performance monitoring:^{164, 184, 190} "*Meetings enabled far greater scrutiny of what keyworkers were doing with the clients*".¹⁸⁴ (p.263) Two primary sources stated that teams reviewed the minutes from their previous meetings,^{153, 156} presumably to assess progress on agreed actions.

2.3.9 Theme 4: Learning and development

MDT meetings were reported to facilitate both formal and informal learning, and to provide opportunities for reflection on team functioning.^{6, 170, 186} Participating in meetings was reported to facilitate staff development and empowerment,^{91, 154, 179, 186} and several papers mentioned formal professional

development activities such as training sessions and presentations from external speakers taking place during the meeting^{154, 156, 186, 190}

2.3.10 Other relevant findings

In most sources, MDT meetings were only mentioned in passing. Where they were discussed in more detail, it usually pertained to perceived challenges or barriers to their effectiveness. One large mixed-methods study by West and colleagues explicitly examined MDT meeting effectiveness.⁶ Part of this work was an ethnographic study designed to “*identify the fine grained team processes, and contextual, professional and institutional incentives and barriers to effective multi-professional team work in CMHTs*” (p.74). This study involved non-participant observation of 20 team meetings from 19 teams, and interviews with 158 service providers, patients and carers. The authors found that the MDT meetings varied in their purpose, frequency, duration and chairing arrangements, and noted that it was not always clear if, or when, a decision had been reached.

Other papers reported that effective team working was hindered by ambiguity about the purpose of meetings¹⁵⁶ and several highlighted a need for explicit discussion of the team goals and the aims of team meetings.^{6, 154, 156} There was also some confusion about the roles of different team members.^{110, 162} For example, a lack of clarity regarding the duties of support workers was reported to hamper the effective allocation of tasks.¹⁶² Two studies reported problems caused by a perceived disconnect between ‘official’ rhetoric and the clinical experiences of staff. For example, King¹⁶⁰ reported that the definition of ‘severe mental illness’ in official documentation differed from how staff members understood it in practice, leading to difficulties in deciding which referrals to accept and which to decline. Similarly, Lankshear¹⁵⁷ identified a disparity between the stated remit of teams and the needs of the patients who were being referred.

Finally, several procedural issues were reported to hinder productivity, such as inconsistent documentation systems,¹⁵³ the lack of a permanent chairperson,¹⁹¹ and the lack of agreed policies regarding the allocation of work.¹⁵³

2.4 Summary and discussion

This was the first systematic review to collate views on the perceived functions of MDT meetings in UK community mental health services. No studies were identified which explicitly investigated this issue, suggesting a need for primary research. However, papers investigating other issues mentioned a wide range of meeting functions in passing. These fell into four broad domains: discussing the care of individual patients; enacting teamwork; team management; and learning and development. Within these domains, the functions ranged from concrete tasks such as distributing assignments, to more abstract concepts such as sharing the emotional burden of the work.

The thematic framework illustrates how meetings were perceived to be beneficial to both patients and staff. They served to benefit patients by allowing team members to elicit both specialist and generic input by discuss their cases with their colleagues. They served to benefit staff through functions such as peer support, learning and development. They also facilitated team processes such as management and supervision, which may be seen as benefiting patients indirectly by promoting the smooth running of the service.

None of the papers examined the effectiveness of teams in achieving the different functions identified or assessed whether participants considered these functions a valuable use of time. On the contrary, there was evidence that the purpose of meetings was largely left implicit and several authors called for teams to explicitly discuss meeting functions so as to ensure a shared understanding.

There were some differences between the primary and secondary sources in the kinds of functions that were mentioned. Functions relating to the development and empowerment of staff, sharing the burden of the work, and peer support were mentioned only in secondary sources. This may be due to the more reflective nature of publications such as editorials compared with primary research papers. The primary sources tended to focus on more directly observable, practical tasks such as the discussion of new referrals.

The review also collated a number of findings relating to the effectiveness of meetings, with previous authors concluding that productivity was hindered by ambiguity of purpose and procedural problems relating to chairing and documentation.

The findings of the review must be considered in light of a number of limitations. It is likely that some teams use MDT meetings for purposes other than those mentioned in the literature. None of the reviewed papers directly asked participants what they perceived the functions of MDT meetings to be, and the list of functions identified cannot be considered exhaustive. Rather, it has collated and synthesised those functions that have been reported in the published UK research literature since the introduction of the National Service Framework for Mental Health.

The search may not have identified all of the relevant papers, though an inclusive search strategy was employed, and experts with relevant clinical and research experience were contacted to mitigate this. Some of the teams described in the sources reviewed may have been atypical in terms of how they conducted their meetings, therefore, the extent to which these functions are “representative” of all teams is not clear.

The review identified a number of gaps in the research literature to date. Most strikingly, it highlights a dearth of primary research investigating MDT meetings in community mental health. The extent to which meeting functioning

varies across teams is unclear. Though a wide range of functions have been mentioned in the literature, it is not known which of these are perceived to be most valuable by staff and how they should be prioritised with respect to time. None of the papers reviewed involved patients as participants, thus what they expect from MDT meetings has not been established.

2.5 Conclusions

This review found that there has been little direct investigation of MDT meetings in community mental health care. Though a wide variety of functions for MDT meetings were mentioned in the literature, these varied across papers, and several authors highlighted challenges to effectiveness such as ambiguity of purpose and procedural inefficiencies. None of the studies attempted to establish how well the various functions were achieved or the extent to which stakeholders perceived them to be beneficial.

A clearer understanding of MDT functioning is necessary to ensure that time and resources are used effectively to enhance the quality of care. The empirical research presented in the following chapters was undertaken to contribute to this understanding by investigating how MDT meetings were organised and perceived by staff and patients in six teams. The next chapter describes the different methods employed and how they were integrated.

3 Methods for the primary research

3.1 Overview

This chapter explains the rationale and philosophy behind the methods employed in the primary research study. It describes the recruitment, data collection and analytic procedures in detail, and shows how data from different sources were integrated to provide a nuanced understanding of the issues under investigation. The issue of quality assurance in qualitative and mixed-methods research is discussed and the strategies employed to ensure methodological rigour are described. Finally, the ethical considerations that arose during the course of the research are considered.

3.2 Rationale for the methods

3.2.1 *Philosophical approach*

This research is underpinned by a *critical realist* philosophy, as described by Maxwell.^{192, 193} *Realism* is a philosophical approach defined as “the view that entities exist independently of being perceived, or independently of our theories about them.”^{194 (p.205)} *Critical realism* integrates this realist ontology (theory of reality) with a constructivist epistemology (theory of knowledge). Though there are several variants of critical realism (e.g. experiential realism,¹⁹⁵ pragmatic realism,¹⁹⁶ fallibilist realism,¹⁹⁷ subtle realism¹⁹⁸), they share the premise that although an independent reality exists (an ontological assertion) one’s knowledge of that world is inevitably constructed from a particular subjective standpoint (an epistemological assertion).^{192, 199} Accordingly, scientific knowledge is considered a fallible representation of reality, inevitably limited by our capacities to perceive and understand.¹⁹⁴ The adequacy of scientific theories is therefore judged according to their explanatory value – the extent to

which they work as tools for understanding and influencing the world by solving problems or leading to useful action.¹⁹³

Critical realism provides a solid foundation for mixed-methods research because it posits a relationship between subjective world-views (typically assessed through qualitative methods) and objective reality (typically investigated through quantitative means).¹⁹³ It recognises the explanatory value of social constructs (motivations, social institutions) by virtue of their impact on the real world, and supports the investigation of both observable associations (e.g. different rates of decision-making between teams) and unobservable processes which account for them (e.g. varied staff views on the purpose of their teams).

3.2.2 The value of mixed-methods research

Mixed-methods research combines different data sources and analytic strategies to achieve a common overarching research goal.²⁰⁰ The aim is to develop a better understanding of the phenomenon of interest than could be achieved by using any one method alone.²⁰¹ The precise definition remains contested, with different interpretations of what exactly is “mixed” (e.g. forms of data or philosophical approaches) and when the mixing takes place (e.g. during analysis or during interpretation).²⁰² Some define mixed-methods research as that which combines qualitative and quantitative data, while others include the use of multiple methods within the same paradigm (e.g. two qualitative approaches).²⁰³ Still others reject the idea of a clear distinction between qualitative and quantitative approaches.²⁰⁴⁻²⁰⁶ Despite these ongoing debates, most agree that the use of multiple research methods can help shed light on different aspects of complex phenomena.¹⁴⁰

In this research, non-participant observation was used to generate both quantitative and qualitative data describing the structure and organisation of

MDT meetings, and the behaviour of participants during those meetings. Interviews and questionnaires were used to generate data on the unobservable phenomena underlying this behaviour, namely the opinions, motivations and subjective experiences of the people involved.

The term *triangulation* is often used in mixed-methods research, though it has several different interpretations. One common use is to describe *corroboration* between two sets of findings, ostensibly increasing confidence in the robustness or validity of the results. This has also been termed the “increased validity” model of triangulation.²⁰⁷ Though widely employed, this interpretation is problematic in that it assumes that weaknesses in each method are somehow offset by the other methods, potentially obscuring bias where methods have similar weaknesses.²⁰⁸ A second use of the term triangulation is to describe the process of using different methods to gain a more comprehensive, multidimensional understanding of a complex issue.²⁰⁹ This has been termed the *complementarity* model of triangulation.²¹⁰ This is the approach adopted in this work, with ethnographic observation, interview and questionnaire data employed to address different aspects of the research problem.

3.2.3 The value of ethnographic methods in health research

Ethnographic observation is a method designed to produce a detailed or ‘thick’ description of events²¹¹ and to conceptualise institutional practices in terms of their social meanings, functions and consequences.²¹² It typically involves the sustained observation of everyday practices within a group or organisation of interest in its natural setting.²¹³ Observation has historically been the primary method for creating ethnographic accounts, but it is often combined with the collection of other forms of data from interviews, documents or quantitative measures (for example, surveys or psychometric tools).^{212, 214, 215}

Ethnographic methods provide a means of examining how contextual, social, and political factors shape the success or failure of interventions,^{216, 217} and several authors have called for their greater use in health research.^{214, 216, 218-221} Ethnography has evolved substantially from its anthropological roots as an immersive means of documenting other cultures. In his seminal work on asylums, Goffman argued that, in order to understand a social group, one should “submit oneself in the company of the members to the daily round of petty contingencies to which they are subject.”^{30 (p. ix)} In modern health research, long-term, round-the-clock participant observation is not always feasible or appropriate given issues of privacy and constraints on time and funding.²²¹ The degree to which the researcher participates in the social group under study varies with the aims and practical limitations of the research.^{215, 222} Non-participant observation, the approach adopted in this study, is commonly used in health service contexts, especially when the researcher is not a clinician.²²³⁻²²⁵ It is less immersive than participant observation but is conducive to establishing a more critical outsider perspective because it affords the researcher a degree of independence from local social structures and hierarchies.

Though fully-immersive ethnographic investigation is not always appropriate, the core features of ethnography can be retained, namely a holistic, systems-oriented approach which:

- explores the influence of social and cultural context;
- elicits participants’ understandings of their world;
- takes a *reflexive* stance by examining the role of the researcher in the co-production of knowledge;
- achieves *critical distance* by exploiting the outsider perspective to question socially constructed categories.²¹⁴

Observational methods can shed light on the gap between theoretical models of healthcare practice and the ‘messy reality’ on the ground.^{216 226} This makes it particularly useful in understanding why technically sophisticated interventions often fail to live up to expectations when applied in real-world uncontrolled environments²²⁷ or when transferred from one setting to another.^{228, 229} They can provide insights into the discretion routinely employed by staff in response to the everyday trade-offs, ‘backstage politics’ and energy-saving ‘workarounds’ that often characterise healthcare provision in real life.²¹⁴

Observational accounts have the potential to ‘make the familiar strange’, revealing aspects of work that may not be visible to participants in the ‘thick of things’ in their everyday practice.²³⁰ They are particularly valuable therefore, in examining long-established, taken-for-granted aspects of care such as MDT meetings, which are assumed to be beneficial though their functions are rarely made explicit.⁶

3.3 Recruitment, data collection and analysis

This section explains the recruitment, data collection and analytic procedures employed for the observation, interview and quantitative data sets respectively. It then describes how the findings from these distinct data sets were integrated.

3.3.1 Non-participant observation

Recruitment of teams

The clinical co-investigators on the NIHR Project identified potential MDTs for recruitment in the North Thames area. Teams were purposively selected to include a diverse range of services for different chronic conditions which varied in terms of their organisational context and professional composition. The co-investigators aimed to include both semi-urban and metropolitan teams. The Principal Investigator (Professor Rosalind Raine) wrote to each team inviting

them to take part. This was followed by a discussion to clarify any issues or concerns.

Three general CMHTs, two Memory Clinics and one EIS team were recruited, along with four cancer teams and two heart failure teams. Further details on the recruited teams are provided in Chapter 4.

As explained in Section 1.7.4, the fieldwork was divided between the three Research Associates on the NIHR Project. I was predominantly responsible for the three CMHTs, the EIS team and Mem 1 (plus a Heart Failure team). PX was responsible for Mem 2 (plus a second Heart Failure Team)ⁱⁱⁱ. The sections below explain the procedures I followed for introducing the study to mental health participants and collecting the data. PX followed the same procedures for Mem 2.

Introducing the study

I visited each MDT meeting to introduce myself and the study, and to distribute participant information sheets and consent forms (Appendix 5). Teams were given at least a week to read and consider the information. All teams agreed to participate and I returned within a fortnight to collect the signed consent forms and begin the pilot observation period.

Because additional practitioners occasionally attend MDT meetings on an *ad hoc* basis, I displayed a printed notice at the entrance to the meeting room during every meeting I recorded. The notice explained the research and provided my contact details.

I explained that if individuals did not wish to take part in the study I would delete their contributions from all transcripts. Nobody requested this.

ⁱⁱⁱ IW was responsible for the four cancer teams.

Data collection

I undertook two weeks of pilot observations with each team to minimise any observer effects by allowing participants to grow accustomed to my presence. I then conducted non-participant observation of 109 MDT meetings (approximately 170 hours) across five teams (CMHT 1, CMHT 2, CMHT 3, EIS & Mem 1) between December 2010 and April 2012.

I took freehand observational field notes at each meeting. Field notes are necessarily selective and involve a trade-off between depth of description and breadth of focus. The challenge for the researcher is to reduce unstructured naturalistic data into a format that is usable and appropriate to addressing the research aims.²³¹ It is neither possible nor desirable to indiscriminately record every discursive feature, facial expression, gesture and concurrent event that occurs in the setting; rather, what is recorded depends on the researcher's sense of what is relevant to the foreshadowed research problem, and on their background expectations.²³² I was sensitised to certain aspects of the meeting by the focus of the NIHR Project, which was structured around a model conceptualising MDT meetings in terms of inputs, processes and outputs (the IPO model; Appendix 6).²³³⁻²³⁵ This model was designed for the NIHR Project by the co-investigators. It included inputs, such as policies and resources; processes, such as communication and leadership; and outputs, such as decisions and documentation.

Throughout the study, the focus of my field notes developed as issues of specific relevance to mental health became apparent. This process of clarifying the focus of the investigation as analytic categories are formulated has been described as "progressive focussing".²¹² Within 24 hours of each meeting I typed my field notes and organised them according to a structured field note form (Appendix 7) based on the IPO model. Organising field notes on the form made it easier to manage the large volume of data produced. I also listened to the audio recording of each meeting within the 24-hour time period, to ensure

the accuracy of my field notes and to note the point in each recording at which the specified events occurred. This made it easier to find these sections later for transcription.

Analysis

The data were analysed using thematic analysis, a method of identifying, organising and reporting patterns in data. Thematic analysis has advantages over other common approaches to qualitative analysis because it is theoretically flexible, making it particularly useful in the multidisciplinary field of Health Services Research.²³⁶ Unlike theoretically-driven methods such as Grounded Theory,^{237, 238} Discourse Analysis,²³⁹ and Interpretive Phenomenological Analysis,²⁴⁰ it is not bound to any particular theory or philosophical position. Rather, it is defined by its analytic process, making it methodologically accessible and transparent. It provides a structure for identifying and organising themes and subthemes and is well suited to large datasets.^{236, 241} In this study, I followed the six stage procedure for Thematic Network Analysis outlined by Attride-Stirling (Box 3.1).²⁴²

Step 1. Code Material

The data are segmented according to basic descriptive codes, dividing the text into meaningful fragments and categorising each fragment. Recurring, salient categories or *codes* form a coding framework which is continually refined throughout the analysis.

Step 2. Identify and Refine Themes

Codes are clustered into *organising themes* according to the theoretical and semantic characteristics.

Step 3. Construct Thematic Networks

Through further revision and the examination of relationships between the organising themes, *global themes* are abstracted.

Step 4. Describe and Explore Thematic Networks

Data are re-examined in light of this network of themes.

Step 5. Detail Thematic Networks

Patterns characterising the main themes are described.

Step 6. Interpret Patterns

Themes are interpreted in light of the research aims and existing theoretical understandings.

Box 3.1 Stages of thematic network analysis (based on Attride-Stirling, 2001)

I imported my field notes into NVivo 10 data management software. Verbatim transcription of the full meetings was not practical given the volume of data collected. Instead, portions of the audio recordings were selectively transcribed²⁴³ using the following procedure:

- (i) All field notes were coded.
- (ii) Case discussions illustrating each code were transcribed.
- (iii) Transcripts were coded in greater detail.

First, I inductively coded the field notes by labelling each observation with a basic descriptive code. I compiled recurring and salient issues into an initial coding framework.

Second, I used this coding framework to identify and transcribe case discussions illustrating each code. I initially transcribed two case discussions from each team for each code. These examples were selected based on their succinctness and how well they represented the meaning of the code. As I became more familiar with the data through the transcription process, I developed further code subcategories. This led to the ongoing revision and expansion of the coding framework and further transcription.

Third, I imported the transcribed discussions into the NVivo database alongside the field notes and coded them in greater detail. Throughout the analysis, I added, merged and split codes as patterns in the data became clearer.

Each time I finished the initial coding and transcription for a particular team, I discussed my code definitions with the other NIHR Project field researchers (IW and PX) and senior clinical members of the research team (AC, AL and RR) in what we termed “analytic conferences”. Obtaining input from multiple researchers in qualitative analysis is recognised to have a number of benefits, increasing rigour by providing an opportunity to challenge and clarify conflicting understandings and encouraging a richer conceptual analysis.²⁴⁴ In these discussions my colleagues sometimes made me aware of possible alternative interpretations of codes or events which helped me to refine the analysis. For example, following discussion, an early code called *deception* was broken down into two separate codes, with one reserved for whenever a practitioner reported that a patient had deliberately deceived them (*questioning patient truthfulness*) and another for when they reported a patient saying something untrue without explicitly suggesting that the patient had been deliberately deceptive (*contradictory information*).

Once all transcripts had been coded, I grouped the codes into organising themes, representing clusters of similar issues. These organising themes were, in turn, grouped into higher-order global themes. The resulting codes and themes are provided in Appendix 8. This interim thematic framework was combined with a second interim framework from the interview analysis at the integration stage, which is described below in Section 3.3.4.

3.3.2 Semi-structured interviews

Developing the interview topic guides

In collaboration with my colleagues, I drafted separate interview topic guides for the practitioner and patient interviews based on the aims of the NIHR Project. These were designed as flexible guides to allow participants to expand on issues they felt were important while ensuring that a number of basic topics were covered.

The practitioner topic guide focused on the purpose of MDT meetings, decision-making processes, how professional groups interact, and external influences on MDT functioning (Appendix 9). This was piloted with a clinical co-investigator on the NIHR study (AP) and amended on the basis of his feedback.

The patient topic guide focused on their knowledge of MDT meetings and the issues they believed should be considered when teams discussed their care (Appendix 10). This topic guide was piloted with two patient representatives who were co-investigators on the NIHR Project (DA and MH), to ensure that questions were comprehensible and appropriately worded.

Recruitment of interviewees

Practitioner interviewees were recruited from the participating teams after I had completed the non-participant observation at each site. I purposively selected interviewees to obtain a diversity of professional groups, seniority and levels of

participation in MDT meetings (based on the observation) within each team. I also aimed for diversity of age, sex and ethnicity. This was with a view to obtaining as wide a range of views as possible, and to allow for comparison between different subgroups. I contacted potential interviewees by email and provided them with an information sheet and consent form.

Patient interviewees were also recruited from the teams under observation. The terms of the ethical approval stipulated that patients be contacted via their keyworkers (known as *care-coordinators* in the CMHTs and EIS, and *Memory Service Practitioners* in Mem 1 and Mem 2). For each team, I listed the 30 patients that had most recently been discussed in the MDT meetings at the end of the observation period. I assessed their eligibility for inclusion based on the criteria listed in Box 3.2. From this group I created a shortlist, purposively selecting potential participants with the aim of achieving diversity of age, sex and mental health condition. I discussed this shortlist with the lead clinician or team manager at each team to identify each patient's keyworker. I then asked each patient's keyworker whether they thought the interview would pose a risk to either the patient or to the interviewer. If not, I asked them to contact the selected patients, provide them with a study information sheet and consent form, and seek permission for me to contact them directly to discuss the study further. When this permission had been granted, I telephoned patients to confirm participation, address any questions they had, and arrange the interview.

Inclusion criterion:

- Under the care of a participating team.

Exclusion criteria:

- Non-English speaker.
- Clinician deems a risk to interviewer.
- Clinician deems too vulnerable for interview.
- Not living in England.

Box 3.2 Inclusion and exclusion criteria for recruiting patients to interview

As outlined in Section 1.7.4, interviews with memory clinic patients were conducted by my colleagues on the NIHR study. They followed the same procedure.

Challenges to recruitment

Challenges to recruiting participants from vulnerable groups have been well documented in the literature.²⁴⁵ In this study, recruitment of patients for interviews proved very difficult for a number of reasons, particularly the need to rely on keyworkers to make the initial contact with potential patient interviewees. The teams were undergoing organisational restructuring (discussed in detail in subsequent chapters) and many staff members were concerned about losing their jobs, thus, the research was not a high priority for them. Keyworkers were very busy and did not always have time to speak to the patients they had agreed to contact. Several did not respond to my email and voicemail reminders. Similar problems with research recruitment during service restructuring have been reported by other mental health researchers.⁶

Even when keyworkers did get in touch with the shortlisted patients as agreed, they often did so several weeks after agreeing to, by which time many patients

had experienced deterioration in their health, left the service or changed their contact details.

When I did get to the stage of discussing the research directly with patients, several agreed to be interviewed during our initial conversation but were subsequently unreachable by phone. One patient agreed to participate but then rescheduled the date of the interview and subsequently changed her mind and declined. One patient did not attend two appointments that we had agreed and so I decided not to pursue her for a third appointment. Both of the CMHT patients I did interview had rescheduled at least once.

Recruitment of staff members was less challenging. All but two of those invited to take part agreed. The first exception was a locum psychologist from CMHT 1 who had originally agreed, but then left the service due to the team being disbanded. The second was the consultant psychiatrist from CMHT 3, who said he was too busy when I first asked but suggested I contact him the following month. When I did so he did not reply to my messages.

Data collection

Interviews with practitioners were conducted in private, in meeting rooms or offices at their places of work. Interviews with patients took place either in their health care centres or at their homes, according to their preferences. I recorded the interviews on an encrypted audio recorder and wrote field notes after each interview to help me to reflect on any new insights and learning points.

At the beginning of each interview I reiterated the aims of the research and asked participants if they had any remaining questions. I explained that there were no right or wrong answers and that they were welcome to say as much or as little as they liked in response to each question. When they were happy to proceed, I asked them to sign two copies of the consent form, which I counter-signed. I gave them one of these to keep for their records. I then switched on the

recorder and conducted the interview in a semi-structured manner based on the topic guide. The same procedure was followed by my colleagues who conducted the Memory Clinic interviews.

All interviews were fully transcribed by a professional transcription service which conformed to NHS standards and was bound by a confidentiality agreement. I checked the transcripts against the audio recordings to ensure that they were accurate and that any names of individuals, teams or trusts were removed.

Analysis

I imported the interview transcripts into NVivo for coding and conducted an inductive thematic analysis using the procedure outlined in Box 3.1 (p.78). Staff and patient interviews were analysed within the same NVivo file to allow me to compare their views on common issues. NVivo enabled me to classify each transcript according to participant attributes (male/female and nurse/doctor/patient etc.) which allowed me to run data retrieval queries comparing the coding profiles of different participant subgroups (e.g. comparing those in different teams or professions). This was useful in identifying differences between participant subgroups that warranted closer investigation (Figure 3.1).

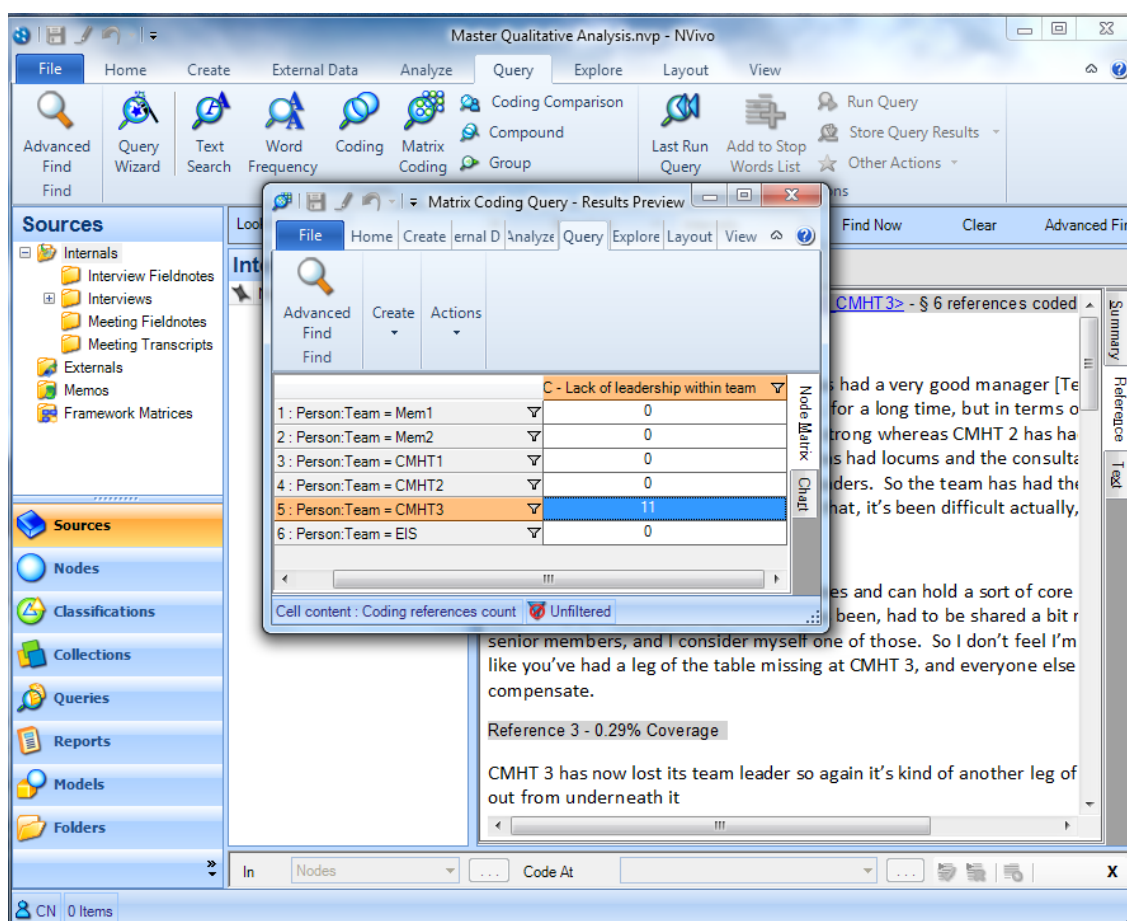


Figure 3.1 Comparative matrix query showing number of excerpts coded *lack of leadership*

The interim thematic framework for the interview analysis is provided in Appendix 11. Section 3.3.4 below explains how the interview data were integrated with the other datasets.

3.3.3 Quantitative data collection

Quantitative observational data

As part of the NIHR Project, my colleagues (IW, PX) and I collected quantitative data on 3213 case discussions from 181 MDT meetings in six mental health teams (Section 1.7.4 details who collected which data). We co-designed a structured proforma for recording data on patient characteristics and discussion features (e.g. whether a decision was made) (Appendix 12). A 'decision' was defined as a resolution about patient management made in the meeting. We

listened to the recording of each meeting to check that the information had been recorded accurately and typed it into an SPSS file.

We also collected quantitative data on the number of attendees and their professions according to the categories presented in Table 3.1. Both regular and visiting members were included. Observers such as students and administrators were excluded.

Table 3.1 Inclusion criteria for each professional category

Professional category	Inclusion criteria
Allied Health Professional	Includes occupational therapist, support workers and Age Concern representatives
Nurse	Includes clinical nurse specialists, community psychiatric nurses, palliative care nurses and visiting crisis team nurses
Doctor	Includes junior doctors, consultant and staff grade doctors (medical students were excluded)
Psychologist	Includes assistant psychologists and clinical psychologists
Social Worker	Includes junior and senior social workers

We reviewed the medical records of each patient discussed to record their socio-demographic information, to ascertain whether each MDT decision had been implemented, and, where applicable, to document reasons for non-implementation (see Table 3.2). These data were recorded directly into an SPSS database. Levels of deprivation were estimated by linking patients' postcodes to the 2010 English Index of Multiple Deprivation (IMD) database.²⁴⁶ This measure was chosen by the NIHR study co-investigators as it is a well-established area-based index that combines seven domains into a single deprivation score. Each score relates to a *lower layer super output area*, a small geographic area covering approximately 1500 people. The domains are income, employment, health and disability, education, skills and training, barriers to housing and services, and crime and living environment. The IMD scores were grouped into to quintiles,

where *Quintile 1* encompassed the least deprived areas and *Quintile 5* encompassed the most deprived areas.

As discussed in Chapter 1, there is no consensus regarding the best way to measure MDT meeting effectiveness. Measuring health outcomes is problematic because they are influenced by a large number of other causal factors, they may not be known for years, and they are difficult to compare across diagnostic categories. Decision implementation was chosen by the NIHR study co-investigators as a useful proxy measure because it focuses on process rather than outcomes and is comparable across conditions. It has been used and recommended by other researchers investigating MDT performance.^{247, 248}

Decision-implementation was assessed a minimum of three months after each MDT decision was made. This timeframe was chosen by the NIHR study co-investigators because, based on cancer waiting times policy, it was deemed a reasonable time for decisions to have been implemented, even when accounting for unavoidable delays.^{iv} Where it was explicit that a decision would not be implemented within three months (e.g. “*see in four months*”) we assessed implementation after the specified time-period.

^{iv} The government has recently committed to establishing clear waiting time limits for mental health services for the first time.⁸¹

Table 3.2 Information gathered from medical records

Patient details	
	Date of birth
	Ethnicity
	Postcode (used to derive indicator of deprivation)
	Recorded diagnosis
Decision details	Response options
Decision implementation	Implemented
	Partially implemented*
	Not implemented
	Not documented
	Patient not identifiable
	Records not available
Reasons for non-implementation recorded in notes	Patient choice
	Carer/family choice
	Patient and family/carer choice
	Comorbidity present but not mentioned at MDT meeting
	Comorbidity deteriorated post-MDT meeting
	New comorbidity arose post-MDT meeting
	No reason recorded
	Clinician notes decision not implemented
	Patient died
	Other
	Patient did not attend (DNA)
	Change in circumstances
	Condition not met
Was implementation rescheduled?	Rescheduled by patient
	Rescheduled by staff

* Partially implemented decisions included those that were implemented later than agreed, those that were implemented by a different individual than agreed, and when a patient was due to be seen by two members of staff together but was actually only seen by one.

As a quality assurance measure, a Consultant Psychiatrist (GL) independently reviewed a random selection of the decisions (approximately 20 decisions from each team) and assessed decision implementation using the medical records. Discrepancies between her ratings and mine were rare, giving us confidence in the accuracy of data collection. Where discrepancies occurred they were usually due to ambiguous variable definitions (e.g. partially implemented) rather than clinical issues, and were resolved when the variable definitions were clarified.

Questionnaire data

During the final month of observation, practitioners were invited to complete a questionnaire composed of the Team Climate Inventory (TCI) ²⁴⁹ and an additional item. This item asked respondents to rate their agreement with the statement “*I believe that the [team name] MDT meetings are an effective use of my time,*” on a scale of one to five. Data from the TCI (a 44-item questionnaire²⁵⁰⁻²⁵² which assesses perceptions team vision, participative safety, task orientation and support for innovation) are not included in this thesis, but responses to the additional item are discussed in Chapter 5.

Analysis

Descriptive statistics were performed to characterise and compare the different teams in terms of the content of their MDT meetings (e.g. numbers of patients discussed, characteristics of patients discussed, and frequency of decision-making) and their responses to the questionnaire.

Chi-Square (χ^2) Tests of Independence were used to examine whether teams differed significantly in:

- the proportion of discussions resulting in a decision;
- the proportion of decisions implemented;
- the proportion of decisions recorded in writing;
- the proportion of decisions where implementation status was recorded in writing.

These analyses were conducted using IBM SPSS Statistics Version 22.

3.3.4 Integration of findings

Four sets of data were collected as part of this study: interview data, qualitative observational data, quantitative observational data and quantitative questionnaire data. Rather than reporting the observational, interview and questionnaire analyses as individual sub-studies, their findings are integrated

and reported thematically. Figure 3.2 illustrates how the different datasets were integrated.

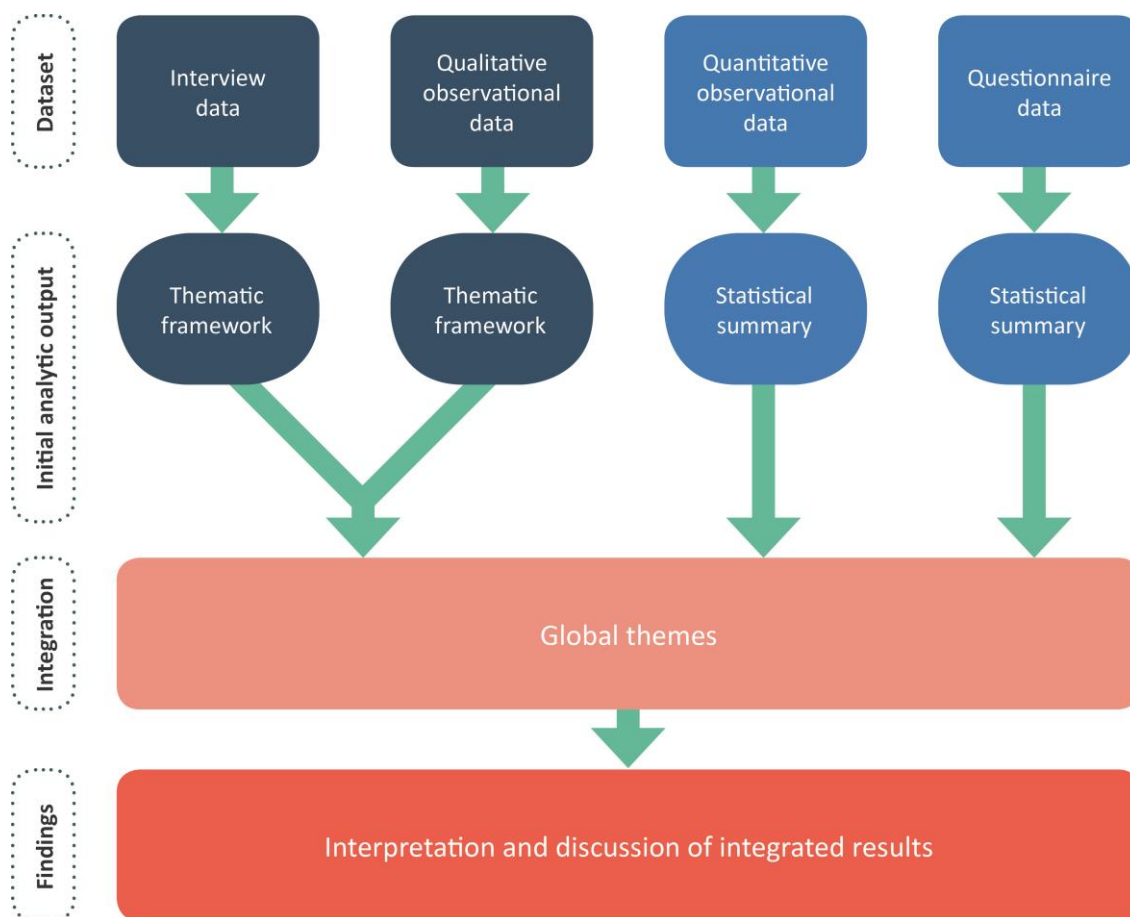


Figure 3.2 Diagram of mixed-methods integration

As described in the preceding sections, the interview data and qualitative observational data were initially analysed separately, producing two thematic frameworks (see Appendix 8 and Appendix 11). This approach was adopted to help ensure that the inductive detail specific to each dataset was identified. Such detail would potentially have been obscured had a higher level cross-method analysis been attempted from the outset. Given the large volume of data collected, keeping the qualitative datasets separate at first also made the organisation and coding of the material more manageable. These frameworks

were then synthesised by identifying patterns in their content and organising them into overarching conceptual domains known as *global themes* or *meta-themes*.²⁵³ Combining the data in this way allowed me to examine how the data from the two sources converged, diverged and related to each other. Codes were iteratively refined throughout the process to capture these interfaces. Where differences between subgroups of participants were apparent (e.g. between different teams or professional groups) these are discussed in the results.

The quantitative observational data and questionnaire data were also analysed independently to produce descriptive summaries. In keeping with the complementarity approach to triangulation, the quantitative and qualitative data were used to examine different aspects of the same phenomena. For example, quantitative data showing different rates of MDT decision-making in different teams is illuminated by qualitative data showing that practitioners in different teams have different views on the functions of MDT meetings. In this way, juxtaposing data from different sources provided a more detailed understanding than would have been possible by looking at any one of the datasets alone. Accordingly, the quantitative data are reported thematically alongside the qualitative results.

3.4 Methodological rigour and quality

There is a lack of consensus as to how the quality of qualitative research should be appraised. Years of debate have led to more than 100 proposed quality criteria.²⁵⁴ This debate has grown from the understanding that long-established quality criteria for assessing quantitative research, the 'holy trinity' of reliability, validity and objectivity, are not directly applicable to qualitative research, at least not without some reconceptualisation.²⁵⁵

The concept of quality has been defined in various ways. Some use the term to indicate the extent to which a study is free from common methodological biases (such as selection bias, response bias, observer bias and attrition bias) while others take a much broader approach, to include transparency of reporting, suitability of methods, ethical research conduct, impact, and auditability.^{125, 255, 256} Suggestions for quality criteria in qualitative research have included persuasiveness, accessibility, plausibility, trustworthiness, authenticity, fidelity, understanding, confidence, relevance, transparency, procedural clarity, reflexivity, public accountability, credibility, confirmability, transferability and dependability.²⁵⁷⁻²⁶¹ Amid this proliferation of concepts and terms, several attempts have been made to collate the varied aspects of quality into usable frameworks for quality assessment, including the NICE quality checklist used in the systematic review reported in Chapter 2.^{144, 255, 260}

The use of quality criteria has been criticised on the basis that adherence to a list of methodological rules does not guarantee quality, and that a focus on tick-box exercises can detract from the use of critical reflection and common sense.^{262, 263} Some have cautioned against “methodolatry” – an over-emphasis on methods at the expense of other considerations such as epistemological clarity.^{264, 265} Notwithstanding these caveats, such frameworks can provide useful aid to (rather than replacement for) informed judgement, by prompting researchers to consider diverse aspects of quality and providing a common language and strategic basis for critical inquiry.

A detailed quality framework for mixed-methods research has been developed by O’Cathain²⁶⁶ based on a critical review of the relevant literature in a range of academic disciplines. This framework brings together conceptualizations of quality from the work of six groups of mixed-methods researchers. It consists of eight quality domains and is structured according to the chronology of a research study, from the planning stage through to data collection, analysis, interpretation and application. Table 3.3 presents this framework and describes

how I have addressed each element in an effort to maximise the quality of the study.

Qualitative data management software

The use of data management software such as NVivo can help improve rigour in a number of ways. Because it facilitates systematic coding and data retrieval, the analysis is less reliant on the researcher's memory. This helps to ensure the thoroughness of the analysis. For example, by using the software to systematically collate all quotes labelled with a particular code, the research can examine the consistency of the quotes without relying on their ability to remember and find each use of the code amid hundreds of pages of quotes. This increases their capacity to meticulously examine the detail and consistency of the findings.²⁶⁷ The software's data visualisation tools can help the researcher to see the data in new ways, prompting analytic reflection and building understanding.²⁰⁰ Software can also be useful in creating an audit trail, allowing the researcher to save progressive iterations of their coding framework to create a historical record of the analytic process as it evolves.²⁶⁸

Table 3.3 Quality framework for mixed-methods research (O’Cathain, 2010)

Stage of study	Domains of quality	Items within Domain	Steps taken by the research team to ensure quality
Planning	Planning quality	Foundational element	The research questions and choice of analytic methods arose from a critical review of the literature on multidisciplinary teamwork in health care and from the findings of the NIHR Project.
		Rationale transparency	A rationale for the use of a mixed-methods approach is provided in Section 3.2.
		Planning transparency	Details of the philosophical approach, design, data collection and analysis are reported according to Creswell’s <i>Checklist for Designing a Mixed Methods Procedure</i> . ²⁶⁹ (Appendix 13)
		Feasibility	The study was completed well within the allotted timeframe (usually five years for a part-time PhD).
Undertaking	Design quality	Design transparency	The design of each method is described, and the process of integrating of the findings is explained.
		Design suitability	The design is appropriate to the research objectives and the underlying philosophical approach.
		Design strength	The methods employed assessed different aspects of the phenomena

under study, generating complementary insights to provide a richer understanding than would be possible using any one method alone. The interviews provided insights into the attitudes and perspectives of staff members, which could not be accessed through observation. Conversely, the observation allowed me to document precisely what occurred in meetings, rather than relying only on what participants reported. The quantitative data facilitated clear comparisons between teams and provided a numerical overview and summary of meeting attendance and content, as well as information on whether or not decisions made in the meeting were subsequently implemented.

Design rigour

Each data source was analysed in accordance with the overall design of the research and the process through which the different components were integrated is explicitly described and illustrated in Figure 3.2.

Data quality

Data transparency

Each data collection method is described in detail.

Data rigour/design fidelity

The following steps were taken to ensure rigorous data collection: listening to the audio of each meeting several times to check that the quantitative data and field notes were accurately recorded; analytic conferences with colleagues to debate the qualitative coding strategy; and “clinician validation” of the quantitative follow-up data to guard against any misunderstandings that might occur due to my not having a clinical

background (Section 3.3.3). In addition, three of my supervisors have clinical backgrounds (two in Medicine and one in Psychology) and have been involved throughout and available to respond to any queries regarding clinical terminology or procedures.

Sampling
adequacy

The procedure for recruiting teams and participants is described in detail and implications for the generalisability or ‘transferability’ of the findings are discussed in Chapter 10.

Analytic
integration rigour

Data were integrated in a systematic manner with the aid of NVivo data management software. The interim thematic frameworks for the interview and observational data are provided in appendices to serve as an “audit trail” for the purposes of transparency.

Interpreting

**Interpretive
rigour**

Interpretive
transparency

Themes are supported by multiple quotations to show how the interpretation is derived from the data. The data source is provided for each quotation, allowing the reader to make links between the rigour of the method and the inferences drawn. Furthermore, the interim thematic frameworks from the observation and interview analyses are provided as appendices so that the process from data to final interpretation can be traced.

Interpretive
consistency

Inferences are supported by illustrative quotes to show how the findings led to the conclusions. The interpretations provided are consistent with the

data and mutually compatible.

Theoretical
consistency

The findings are consistent with existing knowledge and build on the previous literature.

Interpretive
agreement

Analytic conferences were convened to examine the meanings of the codes and to seek alternative explanations for the findings. Supervision meetings were also used to consider possible alternative interpretations. Presenting the work at conferences and invited talks (Appendix 2) also allowed me to assess the face validity of the findings according to other researchers and clinicians.

Interpretive
distinctiveness

This refers to whether the conclusions drawn are more credible than any other conclusions. The credibility of the findings was discussed with other researchers and clinical academics. Throughout the analysis I was careful to attend to 'negative' or 'deviant' cases (i.e. unusual events and opinions which did not conform to the majority view). I endeavoured to preserve complexity in the analysis so as to avoid reaching overly simplistic conclusions or making inappropriate generalisations.

Interpretive
efficacy

This refers to the extent to which meta-inferences (overarching findings) are consistent with the findings from the different methods. I have endeavoured to make this clear by being explicit about the process of integration (Section 3.3.4) and how the overarching inferences and

implications for practice discussed in the final chapter are derived from the data.

Interpretive bias reduction

This criterion applies where there are inconsistencies between the findings derived from different data sources which could indicate bias. Such inconsistencies were very rare in this data. This in part reflects a number of design features which reduced the likelihood of social desirability bias in the interviews and questionnaire (e.g. the fact that I observed the meetings over a number of months allowed me to gain the confidence of participants and made it unlikely that they would give inaccurate descriptions of the meetings in interviews.)

Interpretive correspondence

The findings correspond to the goals of the study.

Inference transferability (applying conclusions to other settings)

Ecological, population, temporal, and theoretical transferability

I have endeavoured to provide sufficient information on sampling and on the participating teams to allow the relevance of the findings to other settings to be assessed. This is discussed further in Section 10.3 in the final chapter.

Disseminating Reporting Quality

Report availability

This thesis provides a comprehensive report of the study.

		Reporting transparency	The study is reported in accordance with the <i>Good Reporting of A Mixed Methods Study (GRAMMS)</i> guidance (Appendix 13). ²⁰⁹
		Yield	The use of mixed-methods has provided a more comprehensive understanding than would have been possible using any of the individual methods alone.
Application in the real world	Synthesizability	Of sufficient quality for inclusion in systematic reviews	As recommended in the guidance for this framework, the study conformed to all applicable criteria from Pluye and colleagues' scoring system for mixed-methods research and mixed studies reviews (Appendix 13). ²⁷⁰
	Utility	Utility quality	This refers to the extent to which study findings can be used to inform positive change. The findings of this study have a number of implications for policy and practice which may be useful in improving services. These are explicitly discussed in Chapter 10.

3.5 Ethical considerations and research governance

The Principal Investigator of the NIHR Project (RR) applied for ethical approval for the study. This was granted by the East London Research Ethics Committee (10/H0704/68) and the National Information Governance Board for Health and Social Care (NIGB; ECC 6-05 (h)/2010).

To avoid selection bias it was necessary to obtain data on all patients discussed within the observation period. It was not known in advance which patients would be raised for discussion at each meeting, therefore it was not feasible to gain the explicit consent of all patients discussed. Even if all existing patients were contacted about the research, there would not have been time to identify and contact newly referred patients prior to each weekly meeting, or to allow them adequate time to consider their participation. Because of this, the NIGB Ethics and Confidentiality Committee granted special permission under Section 251 of the NHS Act 2006 to process patient identifiable information without consent. The Research and Development departments at each participating NHS trust granted permission to collect data from each healthcare team following submission of Site Specific Information forms using the Integrated Research Application System (IRAS). The study was also registered with the Data Protection Officer at the Joint UCL/UCLH Biomedical Research Unit (Registration Number: Z6364106/ 2010/06/08).

I was granted an NHS Research Passport following the requisite Occupational Health Assessment and enhanced Criminal Records Bureau check. I underwent both Research Governance Training and Information Governance training at UCL. I also followed the local security procedures at each site to gain access to the medical records, and underwent local training as required.

All participants and teams were given pseudonyms. Recordings were made and transported using encrypted digital audio recorders. The laptop I used to collect

data from medical records was also encrypted. All data were deleted from portable equipment as soon as they were transferred to the institutional servers at UCL. Electronic data files were only accessible to members of the NIHR study research team. At the end of the NIHR study, all data were transferred to the UCL Data Safe Haven. This is a technological solution for storing, handling and analysing sensitive data in accordance with ISO27001 information security standards and the requirements of the NHS Information Governance Toolkit. All data in paper-form, such as the observational field notes and questionnaires, were kept in a locked cabinet in a locked office in the UCL Department of Applied Health Research.

While the practical precautions required by ethics committees are important safeguards against breaches of confidentiality, research involving face-to-face interactions with participants gives rise to more complex ethical issues which are not so easily measured or monitored. Qualitative interviews are characterised by a power imbalance where interviewees are often asked to share personal aspects of their lives in detail while interviewers divulge relatively little about themselves.²⁷¹ Interviewers are trained to deliberately convey empathy and authenticity to encourage disclosure. Participating in research often makes people aware of and alert to things they do not normally think about, which may be unpleasant or uncomfortable.²⁷² Duncombe and Jessop²⁷³ highlighted the ethical tension inherent in 'doing rapport' and 'faking friendship' when discussing sensitive issues. With this in mind, ethical research involves not only confidentiality and consent, but also respect, compassion, openness and attentiveness.²⁷⁴ This is particularly important when interacting with 'doubly vulnerable' populations such as people with mental health difficulties.²⁴⁵

Mindful of these issues, I made it clear to participants that they were free to say as much or as little as they liked in response to each question. I also endeavoured to be constantly attentive, sensitive and appreciative during

interviews. I kept interviewees informed as to our progress through the topic guide and I let them know when we were approaching the final section, checking that they were happy to continue. At the end of each interview I asked whether they had anything else to add, and whether they felt there were any related issues which were important to them but had been missing from my line of inquiry.

As previous authors have noted, the issue of informed consent is not simply 'dealt with' once the consent forms are signed, rather sustained vigilance and careful judgement are required throughout the research process.^{275, 276} Ethical issues requiring discretion and flexibility arose several times during the course of this project. For example, I needed to decide how proactively I should pursue patients who initially agreed to participate but subsequently did not reply to my messages or attend our agreed appointments. This could be attributed to forgetfulness or a 'chaotic lifestyle' (many of the patients under the care of these teams changed their contact details regularly), but it may also have indicated a reluctance or refusal to participate. I dealt with these incidents on a case-by-case basis in consultation with each patient's keyworker, who could inform me if any changes of circumstance might have accounted for the communication breakdown.

My role as an observer also gave rise to some ethical considerations. When collecting patient data from medical records I was usually stationed at a computer in an office shared with staff from the teams under study. My interactions with them during these periods were not part of formal data collection; however, my understanding of their work and their day-to-day struggles was inevitably shaped by what I heard and observed during the many hours I spent sitting and working among them.

Being involved in research, even anonymously, can have unexpected consequences for participants. An unanticipated finding of this research is that

most of the patients interviewed did not know that they were being discussed in MDT meetings (Chapter 8). The interview was the first time they were made aware of these meetings, and several expressed surprise and discomfort at the idea that, unbeknown to them, intimate aspects of their lives were being discussed with a room full of strangers. This realisation could potentially have an impact on their relationships with their keyworkers, and ultimately on the quality of their care. On the other hand, participating in research can also be experienced as a positive and empowering experience, and several participants explicitly indicated that they had enjoyed the experience. I return to these issues in the final chapter when I reflect on my role as the researcher and on interpersonal aspects of the work (Section 10.5).

There are also subtle ethical issues inherent in the process of reporting qualitative research, in terms of which groups or individuals are given a 'voice'. This pertains both to the selection of participants and to the selection of quotes provided in research reports. Even where data are pseudonymised, there is a danger of reinforcing negative stereotypes or publishing information that can be used against particular groups.²⁷⁷ I have aimed to be as transparent as possible regarding the recruitment process and to give an account of the range of views on each issue rather than just the 'average' or dominant view, which could give rise to inappropriate generalisations.

3.6 Summary

This chapter has provided a detailed description of the methods employed. It describes the steps taken to ensure the credibility of the research, drawing on O'Cathain's quality framework for mixed-methods studies. It has also discussed some of the ethical issues encountered and emphasised how ethical conduct in research extends beyond simply adhering to the stipulations of institutional ethics committees. The next chapter provides an introduction to

the findings. It outlines the characteristics of the participants and teams studied, describes the context in which they operate, and introduces the integrated thematic framework. It is followed by five chapters which present each of the global themes in turn.

4 Introduction to the findings: study context, participants, and thematic framework

4.1 Chapter overview

This chapter introduces the participating teams and individuals, and sets out the context for the substantive findings presented in the following chapters. It first outlines key features of each team and the organisational setting. It then provides details of the interview participants and discusses challenges to recruitment. Finally, it introduces the integrated thematic framework which serves as the starting point for the following results chapters.

4.2 Participating teams

Three CMHTs, one EIS team and two Memory Clinics (Mem 1 and Mem 2) participated. CMHTs typically care for patients with time-limited disorders that are too complex to be treated in primary care and those with severe and enduring needs. Most patients are referred back to their GPs within weeks or months of their initial contact, but a significant minority remain with their team for several years.⁵⁵ EIS teams cater specifically to patients under the age of 35 experiencing their first episode of psychosis, or who are in their first three years of psychotic illness. They usually provide care for three years, though this varies according to severity of illness.¹⁵ Memory Clinics assess adults of all ages with symptoms of dementia who have not been previously diagnosed. Where a diagnosis of dementia is confirmed, they typically provide and monitor treatment for up to three months, before discharging the patient back to their GP for continued management.⁵⁸ Patients are usually referred to these teams by general practitioners when they believe that specialist input is required. Table 4.1 presents an overview of the participating teams.

Table 4.1. Overview of participating teams

Team name	NHS Trust	Setting*	Weeks of qualitative observation	Weeks of quantitative data collection
CMHT 1	Trust A	Urban	14	15
CMHT 2	Trust B	Urban	31	55
CMHT 3	Trust B	Urban	20	20
EIS	Trust B	Urban	23	23
Mem 1	Trust B	Urban	21	43
Mem 2	Trust C	Rural Town and Fringe	NA	25

* Classified according to the Office of National Statistics Rural Urban Classification, available at <http://www.neighbourhood.statistics.gov.uk/HTMLDocs/urbanrural.html>

4.2.1 Organisational context

The six participating teams came from three different NHS mental health trusts, all of which were undergoing major organisational restructuring. During the observation period, CMHT 1 disbanded and CMHTs 2 and 3 were preparing for major changes. These general CMHTs were being abolished in favour of specialist teams dealing with different categories of mental illness (e.g. psychosis, personality disorders, and common mental health problems such as depression and anxiety). As part of the restructuring, many staff members had to re-interview for their jobs and redundancies and redeployments were expected. This context had a major influence on the attitudes and morale of staff, and many reported that it was negatively impacting on the quality of care (this is discussed in greater detail in Chapter 9, which explores external influences on team functioning).

Compared to acute services and physical health services, community mental health services have historically had fewer nationally comparable quality indicators with which to monitor their performance.^{75, 82} There have been recent attempts to address this, however, and a number of trust-level data sources are available, including:

- CQC National Community Mental Health Survey of patient experiences;²⁷⁸
- Mental Health Trust Quality Profiles developed by Quality Intelligence East (QIE) and the North East Quality Observatory System;²⁷⁹
- CQC Intelligent Monitoring Reports for assessing risks.²⁸⁰

Tables 4.2-4.4 show how the participating trusts scored on a selection of relevant quality indicators from these sources. Though these trust-level indicators may not be representative of the specific teams recruited, they nonetheless give a sense of the organisational contexts in which the teams were operating.

Table 4.2 Trust results on relevant indicators from the CQC patient experience survey

Indicator	Trust A	Trust B	Trust C
Organising care	Average	Average	Average
Planning care	Average	Average	Average
Reviewing care	Average	Average	Average
Changes in whom people see	Average	Average	Average
Health and social care workers	Average	Average	Average
Crisis care	Average	Average	Above average
Treatments	Average	Average	Average
Other areas of life	Average	Above average	Average
Overall views and experiences	Average	Average	Average

Table 4.3 Trust results on relevant indicators from the Mental Health Trust Quality Profiles

Indicator	Trust A	Trust B	Trust C
Safe, high-quality coordinated care	Average	Average	Average
Care plan patient participation	Average	Average	Average
Staff recommending trust	Below average	Average	Average

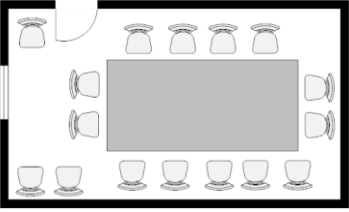
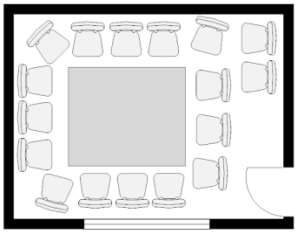
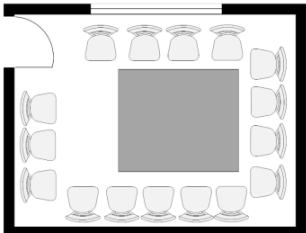
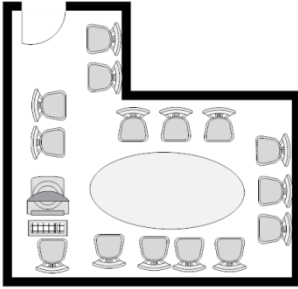
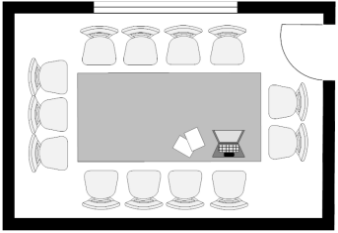
Table 4.4 Trust results on relevant indicators from the CQC Intelligent Monitoring Reports

Indicator	Trust A	Trust B	Trust C
Safe?	Risk identified	No evidence of risk	Risk identified
Effective?	No evidence of risk	No evidence of risk	No evidence of risk
Caring?	Risk identified	No evidence of risk	Risk identified
Responsive?	No evidence of risk	No evidence of risk	No evidence of risk
Well led?	Risk identified	No evidence of risk	No evidence of risk

4.2.2 Characteristics of each team meeting

Table 4.5 details the typical meeting format and attendance profile at each site. Minor changes to team composition occurred throughout the observation period due to retirement, maternity leave, sabbaticals and scheduled training rotations. The team compositions presented here reflect each team as it was at the end of the observation period (when the questionnaires were distributed). Meeting formats were followed only loosely, particularly in teams with a rotating chairperson (CMHT 2 and CMHT 3), where the style of chairing varied from week to week. The table also shows the typical room layout at each team (these diagrams are for illustrative purposes and are not to scale). Brief notes are provided on each team below, and their organisational arrangements are discussed in greater detail in Chapter 6.

Table 4.5 Characteristics of team meetings at each site

CMHT 1 (Trust A)	CMHT 2 (Trust B)	CMHT 3 (Trust B)	EIS (Trust B)	Mem 1 (Trust B)
Team composition*				
<ul style="list-style-type: none"> • 1 Consultant Psychiatrist • 1 Specialty Registrar (StR) • 4 Community Psychiatric Nurses (CPNs) • 3 Social Workers • 1 Psychologist Visitors: <ul style="list-style-type: none"> • Inpatient/HTT Psychiatrist (weekly) • Students (occasional) 	<ul style="list-style-type: none"> • 1 Consultant Psychiatrist • 1 StR • 6 CPNs • 6 Social Workers • 1 Psychologist • 1 Administrator (occasional) Visitors: <ul style="list-style-type: none"> • Visiting CRT member (weekly) 	<ul style="list-style-type: none"> • 1 Consultant Psychiatrist • 1 StR • 4 CPNs • 6 Social Workers • 1 Psychologist • 1 Administrator (occasional) Visitors: <ul style="list-style-type: none"> • Visiting CRT member (weekly) • Students (occasional) 	<ul style="list-style-type: none"> • 1 Consultant Psychiatrist • 1 StR • 4 CPNs • 2 Social Workers • 2 Occupational Therapists • 1 Support Worker Visitors: <ul style="list-style-type: none"> • Forensic Psychiatrist & Nurse (monthly) • Students (occasional) 	<ul style="list-style-type: none"> • 2 Consultant Psychiatrists • 2 StRs • 3 Specialist Nurses • 1 Social Worker • 1 Occupational Therapist • 1 Psychologist • 1 Assistant Psychologist • 2 Support Workers
Typical meeting format				
<ul style="list-style-type: none"> • New referrals • Recent assessments • Updates from inpatient ward/HTT (if representative present) • Ongoing work 	<ul style="list-style-type: none"> • Apologies and absences • Matters arising from the previous minutes • Recent or planned Mental Health Act assessments • Recent assessments • Updates from crisis team (if representative present) • Clinical liaison (ongoing work) • Any other business 	<ul style="list-style-type: none"> • Apologies and absences • Matters arising from the previous minutes • Recent or planned Mental Health Act assessments • Updates from crisis team (if representative present) • Feedback from recent assessments • Clinical liaison (ongoing work) • Any other business 	<ul style="list-style-type: none"> • Inpatients • Recent assessments • Clients of concern 	<ul style="list-style-type: none"> • New referrals • Recent assessment • Ongoing work
Room layout				
				

Additional notes on CMHT 1

CMHT 1 was the only participating team from Trust A, and was managed by a social worker. The weekly MDT meeting lasted 2.5 hours and was chaired by the team manager. The team discussed a mean of 29 patients per week. After each meeting the team shared lunch. The food was brought by a different team member each week on a rotational basis. Most weeks, the consultant from the Home Treatment Team at the trust attended for part of the meeting to discuss shared patients. A locum psychologist joined the team for the final six weeks of observation before the team disbanded.

Additional notes on CMHT 2

CMHT 2 was part of Trust B, and was managed by a social worker. The weekly MDT meeting lasted one hour and the team discussed a mean of 15 patients per week. Team members took turns to chair the meeting on a rotating basis. Most weeks, a member of the Crisis Team at the trust attended for part of the meeting to discuss shared patients. The team also held daily morning *handover meetings* in an open-plan office. These were shorter and less formal than the weekly team meetings and were not attended by the doctors. They were an opportunity for the care coordinators and the manager to briefly discuss new assessments and any urgent concerns. The whole team also attended a weekly business meeting where they discussed general issues such as workplace facilities, trust policies and organisational restructuring.

Additional notes on CMHT 3

CMHT 3 was part of Trust B, and was managed by a social worker. The weekly MDT meeting lasted one hour and the team discussed a mean of 14 patients per week. Team members took turns to chair the meeting on a rotating basis. Most weeks, a member of the Crisis Team at the trust attended for part of the meeting to discuss shared patients. Like CMHT 2, the team held daily morning handover meetings and a weekly business meeting.

Additional notes on EIS

This was the only participating EIS team. The weekly MDT meeting lasted two hours and 20 minutes and the team discussed a mean of 49 patients per week. The deputy team manager, a social worker, usually chaired the meeting. The team manager, also a social worker, did so when present; however, she was also in charge of another team and rarely came to team meetings. Team members took turns to provide breakfast, which was usually laid out on a coffee table in the middle of the room for team members to share during the meeting. A forensic psychiatrist and a forensic nurse attended on a monthly basis to consult on relevant cases. The team meeting took place in a small L-shaped room, and some team members could not be clearly seen by others. Like CMHTs 1 and 2, the team also held daily morning handover meetings and a weekly business meeting.

Additional notes on Mem 1

Mem 1 was part of Trust B. The weekly MDT meeting lasted one hour and 15 minutes. A mean of 11 patients were discussed per week. The team manager, a specialist dementia nurse, chaired the meetings. The whole team also attended a monthly business meeting.

Additional notes on Mem 2

Mem 2 was part of Trust C. It was the only participating team based in a rural town. Their MDT meetings lasted an hour and a half and the team discussed four patients on average per week. As explained in Section 1.7.4, only interview and quantitative data were included from this team.

4.3 Interview participants

Interviews were conducted with 28 staff members (13 male, 15 female) and seven patients (4 male, 3 female). For three of the patient interviews, spousal

carers were present and made occasional contributions^v. Table 4.6 presents the number of interviewees from each participant group and team.

Table 4.6 Number of interviewees from each participant group and team

Role	CMHT 1	CMHT 2	CMHT 3	EIS	Mem 1	Mem 2	Total
Psychiatrist	1	1	0	1	2	1	6
Nurse	0	2	1	2	1	0	6
Social Worker	4	1	2	1	0	N/A*	8
Occupational Therapist	N/A	N/A	N/A	2	1	N/A	3
Psychologist	0	1	0	N/A	2	2	5
Patient	0	0	1	1	2	3	7
Total	5	4	5	7	8	6	35

*N/A indicates that the team did not include a member of the specified professional group

4.4 Questionnaire respondents

The questionnaire was distributed to 82 team members and the overall response rate was 72%. This varied from 50% in CMHT 1 (which had disbanded unexpectedly) to 93% in CMHT 2 (Table 4.7).

Table 4.7 Questionnaire distribution and response rates

Team	No. of questionnaires issued	No. of questionnaires returned	Response rate
CMHT 1*	12	6	50%
CMHT 2**	14	13	93%
CMHT 3*	12	7	58%
CMHT 4	16	11	69%
Mem 1	15	12	80%
Mem 2	13	10	77%
Total	82	59	72%

*These teams disbanded around the time the questionnaire was distributed, which contributed to the relatively low response rate.

** The questionnaire was not issued to one team member who was on long-term sick leave.

^v Where quotes are provided in the results chapters, I usually specify both the team and the profession of the speaker. Very occasionally I specify only one or the other, where specifying both would potentially make the participant identifiable to other team members.

4.5 Quantitative patient data

Quantitative data were collected on 3213 separate case discussions relating to 1048 individual patients. Table 4.8 provides details of the patients discussed in each team. With the exception of those attending Mem 2, most patients had IMD scores in the fourth and fifth quintiles, indicating high levels of deprivation.

Table 4.8 Summary of patient details taken from observation and medical records

Team	No. of meetings	No. of patients discussed	Mean (SD) age*	% male	Modal IMD Quintile**	% in IMD Quintiles 4 & 5
CMHT 1	15	231	38 (11)	52	4	88
CMHT 2	55	314	42 (12)	50	5	84
CMHT 3	20	134	43 (13)	51	5	80
EIS	23	169	26 (6)	69	5	89
Mem 1	43	95	81 (9)	42	4	56
Mem 2	25	105	67 (12)	59	4	41
Total	181	1048	45 (19)	54	5	78

* 4% missing where medical records unavailable or incomplete

**7.5% missing due to unavailable postcodes

4.6 The integrated thematic framework

The thematic integration resulted in five overarching themes, which progressively broaden in focus from examining what happens *within* team meetings (e.g. meeting functions and organisation) to the impact of external influences such as patient involvement and contextual factors. The global themes are presented in Box 4.1.

- I. The value and functions of MDT meetings
- II. The organisation of MDT meetings
- III. Patient involvement in multidisciplinary care planning
- IV. Multidisciplinary teamwork: professional roles and participation
- V. External influences on multidisciplinary care planning

Box 4.1 Global themes from the primary research study

Appendix 13 presents the integrated thematic framework in detail, specifying the subthemes, codes, and sub-codes where applicable. The global themes are discussed in detail in Chapters 5-9.

4.7 Summary

This chapter has provided an introduction to the findings by describing the participating teams and individuals and introducing the thematic framework. The following chapters report on each of the five overarching themes in turn, providing illustrative quotes from interviews and meeting transcripts throughout.

5 Theme I. The value and functions of MDT meetings

5.1 Chapter overview

This chapter examines practitioner views on the value of MDT meetings and the functions they serve. It begins by examining questionnaire and interview data to establish whether MDT meetings are considered a constructive use of time. The findings show that, while most practitioners found the meetings valuable, many believed they were inefficiently managed and lacked clarity of purpose. The remainder of the chapter illustrates the wide range of functions served by the meetings, as reported by interviewees and supported by observational data. These functions were grouped into six categories: a central forum for teamwork, feedback on recent assessments, updates on ongoing work, team decision-making, sharing the emotional burden of the work, team management, and learning and development.

In discussing these issues, this chapter addresses the following research objectives (p.32):

- i. to identify the functions served by MDT meetings;
- iii. to explore practitioner views on MDT meetings and multidisciplinary care planning.

5.2 The value of MDT meetings: are they a good use of time?

Practitioner views on the value of MDT meetings were assessed using both questionnaire and interview data. Almost all questionnaire respondents agreed

with the statement “I believe that the [team name] MDT meetings are an effective use of my time” (Figure 5.1; median score 4 out of 5, interquartile range 4-5)^{vi}.

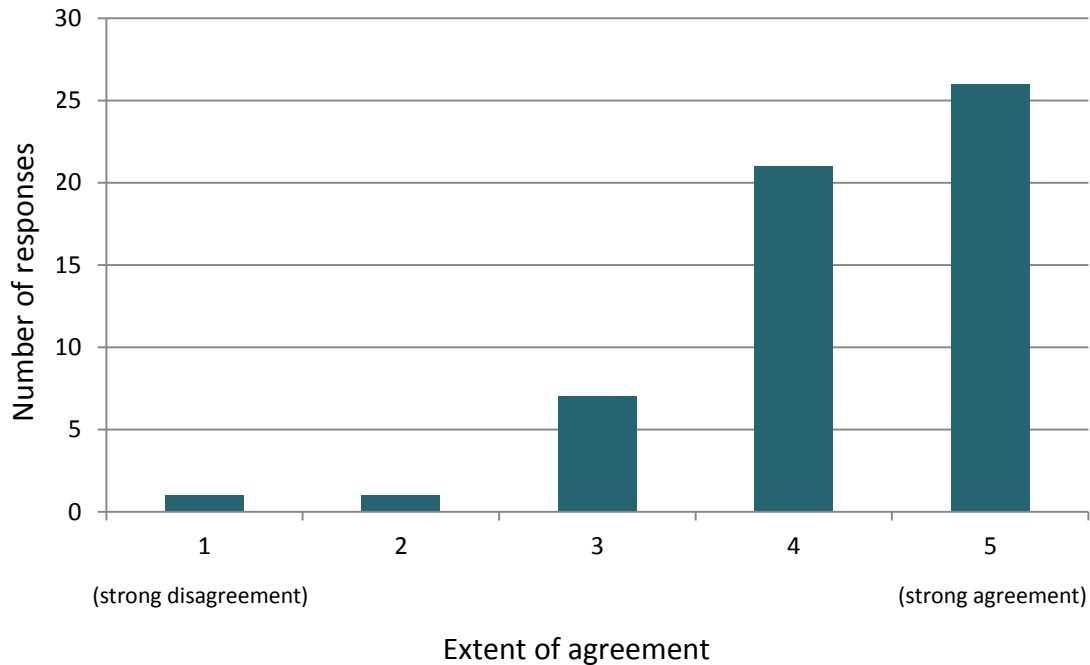


Figure 5.1 Responses to statement ‘I believe that MDT meetings are an effective use of my time’

The qualitative data revealed a more complex picture. Though most interviewees reported that they saw some value or potential value in the meetings, many argued that meetings were not managed efficiently, leading to boredom, inattention and loss of productivity:

“One inevitably wonders whether the sort of relatively long and dreary kind of team meetings, where you go over the same thing week by week, is the sort of very best way to do things.” (Psychiatrist, EIS; interview).

One participant highlighted the opportunity costs of occupying the entire team for several hours a week:

^{vi} It was not possible to compare responses from each team using inferential statistics due to the low numbers in each group.

“People are sitting doing nothing because other peoples’ patients are being discussed, you’re actually using up about 14 personnel in one of those [2.5 hour] meetings. That’s the equivalent of having another worker on the team.” (StR, Mem 1; interview)^{vii}

A patient made a similar point, arguing that it would be more beneficial for staff to spend their time seeing patients rather than discussing them with colleagues:

“If they’re not working with you directly it just seems like a waste of time and resources ... These are people who you’re potentially never going to meet, don’t even know the names of, are like just an invisible team in the background ... They could be using those hours actually going out and working with people and providing [laughs] the care that people need.” (Patient, CMHT 3; interview)

Though none of the practitioners went so far as to suggest that MDT meetings should be abolished, many said that they found the meetings boring and struggled to pay attention, particularly if they were not directly involved in the case under discussion: *“They get very samey and I think people switch off” (Occupational Therapist, Mem 1; interview).*

One nurse regularly brought along other work that he could attend to during the meeting: *“It’s tedious ... What I do is I take a pen and write my to-do lists and stuff, because I have a very low threshold for dropping off” (Nurse, CMHT 3; interview).*

One possible explanation for this lack of focus is that some practitioners were unsure of the purpose of MDT meetings and their roles within them.

^{vii} This participant was describing the MDT meeting at a team he had previously worked with (not Mem 1).

5.3 Clarity of purpose

Participants reported that the purpose of meetings was rarely, if ever, explicitly discussed within their teams; rather, they relied on a “*tacit understanding*” or an “*unwritten rule*” about the remit of discussions. While some believed that their team had developed a good mutual understanding of what the meeting was for, several CMHT practitioners believed there was a problematic lack of clarity.

“I am never quite sure what the purpose of the meetings are ... It was the thing that was done and therefore I did not have any say in whether it was done or not.” (Nurse, CMHT 3; interview)

“We have to revisit the purpose of the meetings and what the aims of the meetings are ... I wasn’t around when the meetings started so I don’t know the ground rules.” (Nurse, CMHT 2; interview)

Several argued that there was a need to explicitly review the purpose of meetings and what was expected of individual team members:

“I’d have some sort of discussion more explicitly; I don’t know why I haven’t done this, I hadn’t thought of it before, about what the team meeting is for and how people consider their roles in it.” (Psychologist, CMHT 3; interview)

One psychiatrist suggested that the gradual manner in which MDT meetings had been developed meant that there had been little scrutiny of their purpose and performance:

“The organisation hasn’t always sort of ‘overviewed’ to ensure some sort of consistency of standards ... I think with things that evolve organically we probably don’t step back and think as readily as we should about ‘What’s the purpose that it solves?’ ‘Has it served its purpose as well as it should?’ And ‘What’s everyone’s understanding of it?’ ... We probably haven’t actually talked about the function of the team meeting for about three years at least” (Psychiatrist, CMHT 2; interview)

As this quote suggests, the lack of an organisational “overview” regarding the purpose of meetings has implications for the quality and consistency of care. In the absence of a shared understanding of the purpose of meetings, deciding

which patients to discuss was largely at the discretion of individual staff members: *“As far as I know, there is not a set criteria or protocol for that. It more of an ad hoc sort of thing”* (Psychologist, Mem 2; interview)

“The sort of bulk of the team meeting, where we’re discussing our existing caseloads, that’s very much left up to the individual professional’s decision about who they’re going to bring that week” (Psychiatrist, CMHT 1; interview)

This led to some concern that certain patients would be left without regular multidisciplinary review and would therefore be at a disadvantage. These concerns are discussed further in the following chapter (Section 6.4).

Despite this lack of clarity about what meetings were *supposed* to achieve (their purpose), practitioners reported that, in practice, meetings were used in a variety of ways to serve a broad range of functions.

5.4 Functions served by MDT meetings

Meetings were perceived to serve as a central forum for teamwork and were used to discuss recent assessments, provide feedback on ongoing work, facilitate team decision-making, share the emotional burden of the work, achieve managerial tasks, and promote professional learning and development (Figure 5.2). The following sections discuss each of these broad functions in turn.



Figure 5.2 Functions served by MDT meetings

5.4.1 A central forum for teamwork

The team meeting was considered integral to teamwork. On a practical level it was a central forum for communication, coordination of tasks, and seeking specialist input from diverse colleagues. In a broader sense, it was seen as essential in cultivating a sense of cohesion and shared responsibility among team members. In some cases, it was the only regular opportunity for the team to meet as a whole, making it crucial to their sense of team identity: *“It’s quite important in terms of making us feel like a team, rather than just a group of people working in the same office”* (StR, Mem 1; interview).

The meeting provided a “focal point” for the week, where the work being undertaken was consolidated and reviewed: “It just feels like a place where everything gets pulled together once a week” (StR, Mem 2; interview). Because of this, it served as an implicit deadline for people to work towards: “You kind of feel like, well actually I have to get this done because I need to discuss it in the team meeting” (Occupational Therapist, EIS; interview).

Several interviewees reported that the prospect of the meeting prompted team members to address issues that might otherwise be left “bubbling under” or unresolved: “You know, often when things go wrong in mental health care it’s because no-one has really decided, because a problem has been left hanging, and I guess [the meeting] guards against that ” (Psychiatrist, EIS; interview). In this way the meeting was perceived to protect against inaction by forcing people to articulate and communicate their ongoing work.

MDT meetings facilitated teamwork by allowing practitioners to share information, seek specialist input from their colleagues and promote multidisciplinary thinking.

Sharing information

Sharing information was a core function of the meeting. Practitioners used the forum to provide both detailed descriptions of recent assessments and more informal brief updates on recent events:

“The primary role [of the meeting] would have to be the, sort of, clinical sharing of significant information.” (Psychiatrist, CMHT 1; interview)

“It’s information sharing ... for people to give updates of what’s going on.” (Psychiatrist, CMHT 2; interview)

Recurring weekly discussions granted all team members a broad awareness of the work being undertaken with different patients. Establishing this shared knowledge of patients had the practical advantage of making it easier to arrange appropriate cross-cover when someone was unavailable:

“The good thing about that meeting was ... everybody knew who you were working with and it felt quite nice and contained ... When you went off on your holidays or whatever, there wasn’t such a big handover ... You’d say, ‘Oh you know that lady?’, and they’d say, ‘Oh yeah, yeah, you’ve spoken about her.’ It wasn’t just, ‘They’re your clients.’” (Social Worker, CMHT 1; interview)

Beyond the practical advantages, practitioners emphasised the sense of psychological safety they gained by sharing their concerns about patients: *“You’re handing the responsibility to the team”* (Psychologist, CMHT 2; interview). This sense of collective responsibility was considered important in developing a sense of team identity and ensuring that individual team members did not feel isolated in their work.

Seeking specialist input

Practitioners used meetings to seek specialist input from particular colleagues as well as drawing on the team as a whole:

“Adam^{viii} [Social Worker], he’s got quite a specialist knowledge on children’s services and child protection and things like that, so I might turn to him when I’m dealing with that. Or when I’m dealing with safeguarding issues I might think about Nicola [Occupational Therapist] ... Me and Joan tend to take a lot of the female group that have been sexually abused, so it’s quite useful to have a chat with her about how to manage some of that.” (Nurse, EIS; interview)

This was occasionally evident in the observational data, with practitioners directing queries to specific colleagues rather than to the group at large:

Social worker: I said I’d discuss it here and see if the doctors have any suggestions regarding the medication (CMHT 2; observation)

Staff valued having this dedicated space to consult colleagues who were not always readily available. One nurse reported that it was difficult to have a

^{viii} Names mentioned in quotes are pseudonyms.

thorough discussion with the doctors outside of the meeting because he felt that he was encroaching on their time and space. He argued that the meeting gave him the chance to make a stronger case in relation to issues that might otherwise only get a superficial hearing:

“You feel like if you are invading a little bit, like you are disturbing something, because that’s his time and he’s typing something ... so you skip things out, you try to make it as brief as possible and then you mightn’t win the argument ... you are coming on their ground, on their territory ... Whereas in the meeting we have a lot of time ... you have that time to go back and forth, and go back and forth, and go back and forth.” (Nurse, CMHT 2; interview)

Promoting multidisciplinary thinking

Several team members argued that the meeting provided an opportunity to counter what they saw as a dominant “medical model” of illness, and to promote other ways of thinking:

“That’s the joy of multidisciplinary [working], you look at the whole person not just the medical part of it and I do think that the multi-disciplinary team has, has enabled certainly the social work profession to shine, because I don’t like the medical model.” (Social Worker, CMHT 1; interview)

“The team discussion gives a bigger chance for more psychological thinking to enter into the discussion. Which I think, otherwise it lacks that. I think it becomes over-medicalised.” (Psychologist, Mem 1; interview)

The perceived dominance of the medical approach and its implications for multidisciplinary working are discussed further in Chapter 7.

5.4.2 Feedback on recent assessments

In all teams, staff used the meetings to provide feedback on their recent assessments (see Table 4.5 for an overview of the structure of meetings in each team). Teams varied in how structured these case presentations were. In Mem 1, team members took turns to formally present all patients they had assessed that week, feeding back test scores (e.g. the Mini Mental State Examination) with a view to deciding or confirming a care plan. In the EIS team, the team

manager or deputy team manager, following a printed list, read out the name of each patient that had been recently assessed in turn, and the relevant team member responded with an update from memory. In contrast, in the CMHTs, the chairperson usually simply said “*recent assessments?*” and individual team members raised patients for discussion at their discretion.

Though discussing assessments sometimes resulted in new diagnostic or care planning decisions (team decision-making is discussed in Section 5.4.4), often the assessor had already decided on a plan for the patient, and was using the meeting to check that they had identified all the appropriate options: “*Sometimes it’s just about, ‘Have I thought about everything?’ You know, ‘Have I crossed the t’s and dotted the i’s?’*” (Occupational Therapist, Mem 1; interview).

Sharing feedback from assessments gave colleagues the opportunity to chip in with suggestions:

Manager: Is there any group we could set him up with?

Psychiatrist: Is there any church? They can be quite good

Nurse: How about [mental health charity]?

Manager: I was thinking more mainstream, although his self-care will be a problem

Nurse: Cinema groups? (EIS; observation)

Once recent assessments had been discussed, team members had the opportunity to discuss their ongoing work.

5.4.3 Updates on ongoing work: challenging and risky cases

Memory Clinics spent most of their meetings discussing recent assessments. In contrast, the CMHT and EIS teams dedicated the greater part of their meeting to discussing ongoing work with patients on their established caseload. Interviewees reported that they raised ongoing work for discussion when they were struggling with a challenging case or sensed an imminent risk:

“It’s, you know, clients of concern; if there’s someone that you’re concerned about. I suppose that’s just reached purely by your own sort of level of anxiety

really ... you're either concerned or feel that there needs to be input from another professional." (Occupational Therapist, EIS; interview)

"The more complex the situation, the more likely you are to actually use the team to make the decision." (Psychiatrist, CMHT 1; interview)

The qualitative observational data allowed for an in-depth analysis of the kinds of difficulties raised for discussion, to delineate factors that made certain cases particularly challenging for practitioners. Recurring struggles included managing challenging behaviour, ethical dilemmas, and a lack of clear treatment options (Box 5.1; supplementary illustrative quotes are provided in Appendix 15).

Recurring challenges raised during discussions of individual patients

Challenging behaviour

- Violence and aggression
- Opportunistic or inappropriate service use
- Suspected deception
- Obstructive carer influence (e.g. collusion in harmful beliefs or behaviours, interference with treatment)
- Distinguishing between 'illness', 'behaviour' and 'personality'

Ethical dilemmas

- Conflicting responsibilities towards patient and staff
- Conflicting responsibilities towards patient and family
- Conflicting responsibilities towards patient and wider society
- Unclear responsibilities towards other state agencies

Lack of clear options

- Required services unavailable
- Complex diagnosis
- Complex social circumstances
- Patient disputes illness
- Patient does not wish to engage

Box 5.1 Challenges to care provision commonly discussed in team meetings

Managing challenging behaviour

Managing “difficult” patient behaviour was a frequent topic of discussion. This often related to behaviour that posed a risk of harm to the patient, their family members, or the public at large.

- Social Worker:* Every time I see her she tells me in detail that she wants to burn down the flat and that she wants to be in prison ...
- Team Manager:* I mean she’s served time for making threats like that ... She has got a history of arson ...
- Social Worker 2:* Well she knows how to step it up ... she knows she’s always got the trump card doesn’t she? She thinks she can choose whether to play it or not ...
- Social Worker 1:* After the discharge meeting she said ‘Well I’m fine, you discharged me, I’m going to burn down the flat’ ... I think there’s a real possibility that she will do it, absolutely. She’s done it before ... I’ve asked her, ‘What would you do about the neighbours underneath you?’ ‘I don’t care, I’m being driven to it. I don’t care about anybody else’ (CMHT 2, observation)

Other behaviours seen as “difficult” were those that were perceived to waste time and resources.

- StR:* Now he’s driving me a little bit mad ... He says, ‘Oh, I’m really sorry I’ve missed so many appointments. I know it looks like I’m messing you around, I really want an appointment, I’m going to be here Monday to Wednesday’ ... So I phone him first thing yesterday morning saying, ‘Come in any time today’ and he says, ‘Oh, that’s a bit short notice, I’m feeling quite hung-over’ ... Eventually we agreed tomorrow at four, but I have no confidence that he’s going to come in (EIS; observation)

Team members often raised cases for discussion when they felt services were being used in an inappropriate or opportunistic manner, or where they believed they were being deliberately deceived by patients:

- Manager:* They’re not an easy family from my memory ... they sort of identify as slightly outside the system ... they’re always spotting ways that they can get things. That’s a terrible thing to say, but they seem to, they seem to manipulate the trust ... Don’t throw all your energy into it ...

Occupational Therapist: There's nothing they won't stop at. It's 'get me a bigger flat or I'll eat my goldfish!' [laughter] (EIS; observation)

Social Worker: It's business as usual with him ... It's benefits really. He'll play us for all we're worth ... He uses all the buzzwords. He told the GP to put him down as a paedophile ... The only time he'll come to me is when he's run out of money ... He's got that exquisitely honed ability to press the right buttons again, and again, and again (CMHT 3, observation)

As these examples illustrate, team discussions did not always lead to a conclusive management plan; rather meetings were often used to clarify what was happening in a particular case by teasing out underlying risks, motives and needs. The excerpts also hint at the emotional burden of the work, with practitioners often expressing fears and venting frustration at the behaviour of some of their patients. Emotional expression and peer support were considered to be important functions of the meeting and are discussed further in Section 5.4.5.

Coping with ethical dilemmas

Ethical dilemmas were a frequent topic of discussion. They often arose when team members believed they had conflicting responsibilities towards the patient and others, such as family members, the public, or other statutory agencies.

Though there were risk assessment procedures and policies in place, it was ultimately up to the practitioners involved to judge the likelihood that a potential risk would be realised, whether to intervene, and how best to do so. Team discussions involved weighing the risks of harm against the risk of damaging their therapeutic relationship by intervening:

Social worker: There's not, sort of, acute, gross concern about the son's welfare ... [but] it's far from optimum really ... Whilst Children in Need probably don't have a duty - it's probably not meeting the threshold for them - he probably is meeting the threshold for referral to the Education Welfare Officer. But the question for me is would the benefits outweigh the risks? ... We don't want to put a spanner in it (CMHT 3; observation)

Care provision in such circumstances was rarely a matter of simply making rational choices and following protocols; rather, it had important moral and emotional dimensions. The following extract shows how staff members were guided by their 'gut feelings', as well as factual information, in their care planning:

Occupational Therapist: It's just the kids, you know? ... I've got plenty of clients where I'd wait for an incident, but he's got these little children. It just doesn't feel comfortable (EIS; observation)

They evoked not only their legal obligations, but also what they saw as their moral and ethical obligations:

StR: The GP thinks he's beating his mother. She says it's not true

Nurse: He wouldn't be detainable at the moment

StR: Don't you think? ...

Psychiatrist: It wouldn't be right to leave him untreated if we could (EIS; observation)

Where patients had a history of committing harm or thoughts of doing so (e.g. violence or inappropriate sexual conduct), team members had to constantly balance the need for preventative intervention with the danger of unnecessarily restricting a patient's liberty. Meetings allowed practitioners to pool information and share responsibility in such risky scenarios.

Forensic Psychiatrist: He did come across to me as someone who was struggling in relation to sexual images of children but he was not fully disclosing it. But it's a bit hard to write that in a report because he kind of gives information, then withholds it and then goes back on it ...

Nurse: He's a bit reticent now. He's very guarded about what he tells me. Because he's on to it now you see ... I say, 'well have you seen your siblings?' and he's sort of clever enough to say no ... He's not allowed have unsupervised contact with the siblings (EIS; observation)

Another frequently discussed challenge was how to balance the need to maintain the safety of staff with the need to provide support to potentially aggressive patients.

[Discussion of patient with a history of extreme violence towards staff]

StR: Our policy is not to see him unless it's a pre-arranged appointment ...

Forensic Psychiatrist: I suppose you've got a slight issue there because if he comes seeking help and we don't see him, it's not going to look great

Manager: I was just thinking that ...

Nurse: I mean, he comes to get money, he doesn't come to get help ... and if he doesn't get his needs met he's going to get violent and beat one of us up ...

Forensic Psychiatrist: [But] he is still under your service and so there's kind of a need to see him somewhere I guess. But as you say you've got to put safety first. And maybe the way to do that is for two people to see him and if it's all about that then you terminate it quickly, and if he gets funny call the police I guess (EIS; observation)

By posing questions in meetings, practitioners helped each other think through the risks in a given scenario:

Nurse: He recently said his voices were telling him to rape women in their houses ...

Social Worker: That's kind of scary ... in terms of you working with him, being a female ... how safe is it for you?

Nurse: Maybe I'm being naive, [but] I wonder is it positive in terms of him learning about women. I mean he's never had a relationship (EIS; observation)

Dilemmas also arose when practitioners were uncertain about their obligations towards other state services. Numerous queries arose regarding whether they were required to break confidentiality and inform authorities when they discovered that patients had committed crimes such as violence or fraud, or when they disclosed thoughts of doing so:

Psychologist: I'm not suggesting we do this, but if someone's got their [immigration] status here on

Social Worker: False grounds?

Deputy Manager: We did wonder what to do when someone tells us they've murdered someone (CMHT 3; observation)

Teams were constantly dealing highly unique and complex scenarios for which there were no protocols to follow.

Nurse: I don't know where I stand legally ... I don't know whether, one, the rape has happened; two, she's dissociated and believes she has been raped; or three, she is lying ...

Psychiatrist: It's tricky because in some ways if you flag this up with the police they may never take her seriously again (EIS, observation)

In contrast to the memory clinics, the kinds of problems discussed in the CMHTs and EIS meetings could rarely be addressed using rule-based formulae (e.g. diagnostic protocols, NICE guidance) because they were linked to highly unique social circumstances. In the absence of such decision-making aids, the team meeting appeared to be an important support to making clinical judgements in situations of high uncertainty.

Lack of clear options

Interviewees reported that they used the meetings to draw on the expertise of the team when they felt "stuck" and out of options: *"I guess it's about generating ideas"* (Psychologist, Mem 1; interview). Often practitioners believed a patient was in need of support but simply did not know how to help them:

"Sometimes you get a bit stuck with patients ... because you've probably done so many different things ... You might just be offered a solution that was staring you in the face, but because you're just tearing your hair out about it you can't see it. Or it could just be that somebody further around the table is having a similar kind of thing and they are saying 'oh well I tried this,' and I'd think 'oh yeah!'" (Social worker, CMHT 1; interview)

The observational data revealed that this situation often arose when the required services were unavailable (see Section 9.2 on diminishing resources), when a patient had a complex diagnosis or a challenging social situation, and when a patient simply did not want to engage in services:

- Deputy Team Manager:* So, what to do with Sarah [sighs]. What to do with Sarah ... there seems to be a bit of an impasse ...
- Nurse:* She's a tough nut to crack
- Team Manager:* A tough nut, very much ...
- Psychologist:* This isn't working at all ...
- Nurse:* She likes to be unwell, because when she is well she thinks about the things that are happening in her life and gets a clarity which she doesn't like ...
- Deputy Team Manager:* Ok. Have we agreed that we don't know what to do with her? [laughter]
- Social Worker:* We could just do what she wants and discharge her
- Deputy Team Manager:* The risks are too high (CMHT 3; observation)

Many of the above examples demonstrate how meetings were often used to keep people informed of what was happening and to help people think through challenges, often generating ideas and communicating risks rather than agreeing new actions. The next section focuses on the use of meetings to make concrete care planning decisions.

5.4.4 Team decision-making

Some teams used the meetings mainly to share information while others were much more focused on decision-making. Interviewees from Mem 2 consistently reported that the primary function of meetings was "to make a diagnosis and propose a care plan" (*Psychologist, Mem 2; interview*). Interviewees from the other teams reported a much broader range of functions, usually placing more importance on providing feedback from assessments and raising awareness about risks: "It's just about good communication and everybody being aware" (*Social Worker, CMHT 1; interview*). This was corroborated by the quantitative data, which showed that the proportion of case discussions resulting in a decision varied significantly between teams, ranging from 100% in Mem 2 to 31% in EIS (Table 5.1); χ^2 (df=5, n=3213) = 575.59, $p < .001$.

Table 5.1 Proportion of case discussions resulting in a decision

Team	No. of case discussions	% of discussions where at least one decision was made
CMHT 1	437	47.1
CMHT 2	764	58.6
CMHT 3	290	35.2
EIS	1132	31.3
MEM 1	483	86.7
MEM 2	107	100.0
Total	3213	50.9

CMHT and EIS meetings were largely used to provide updates on individual patients and to report decisions that had already been made: *“A lot of the time ... you’ve already made your decision, it’s more you’re informing [the team]”* (Social Worker, CMHT 1; interview).

Team Manager: *Ok [reads patient name from list]*

Social Worker: *I just need to sort out housing for him. I’ll probably take him to [housing project] this week or next week. He’s on the housing waiting list anyway*

Team Manager: *Ok. And he’s improving and all?*

Social Worker: *Very, very much. He’s a different man completely (EIS; observation)*

Interviewees from these teams reported that the majority of their decision-making happened outside of the meetings, but that the discussions they had during meetings *“fed in”* to their day-to-day care planning. They used the fact that a plan had been discussed or endorsed at a team meeting to lend weight to their decisions when communicating with outsiders:

“You’ve got the power of the meeting, you understand? So if you write a letter to the GP you’ve got the power to say, ‘We assessed this client and the team decided’ ... If the GP comes back to you and wants to argue, the team decided, you know? And that’s it.” (Nurse, CMHT 2; interview)

“You can say, ‘It’s not just my decision; this has come from the team’” (Social Worker, CMHT 1; interview).

They also alluded to a sense that discussing decisions as a team fostered a sense of “*shared ownership*” and gave them a sense of protection if any adverse consequences or legal actions arose.

Decision implementation

Memory clinics were not only more likely to make decisions during meetings, but were also more likely to implement the decisions they did make. Rates of decision implementation varied from 83% in CMHT 1 to 98% in Mem 2 (Table 5.2); χ^2 (df=5, n=1994) = 56.68, $p < .001$.

Table 5.2 Rates of decision implementation in each team

Team	Number of decisions*	% of decisions fully/partially implemented
CMHT 1	206	83.0
CMHT 2	541	83.9
CMHT 3	117	84.6
EIS	371	86.3
MEM 1	507	93.3
MEM 2	252	98.4
Total	1994	88.5

*Excludes 15% of decisions for which there was no documentation of whether or not the decision had been implemented. Completeness of documentation varied between teams and is discussed further in Section 6.6.

In part, this reflects the nature of the decisions that were being made in the different teams. Memory clinics largely focused on providing a diagnosis and protocol-based treatment plan to patients: “*To be honest, most of the decisions in this team are so easy and so laid out for us by the protocol that there’s very little room to get things wrong.*” (StR, Mem 1; interview). In Mem 2 the decision often involved agreeing a diagnosis and referring the patient back to the GP for treatment rather than providing treatment themselves. This was inherently easier to implement than the decisions typically made in the EIS team and the CMHTs, which were usually less concrete, for example, “*Go and find out if he started the fire*” and “*Get a sense if he will keep off alcohol and drugs*”.

Reasons for non-implementation were provided in 84% of cases, and ranged from patient choice to changes of circumstance that rendered the decision inappropriate or unnecessary (Table 5.3).

Table 5.3 Documented reasons for non-implementation of decisions

Reason for non-implementation	%
Change in circumstances*	29.0
Patient did not attend	20.2
Patient/carer/family choice	14.5
Decision was conditional and condition was not met	7.3
Other**	29.0

* This included changes in the patient's illness presentation or personal circumstances that rendered it inappropriate or unnecessary to implement the decision (e.g. new comorbidity, patient died)

** This category included diverse reasons that did not fit into the pre-specified categories e.g. where the decision had been based on inaccurate information or the patient had left the care of the team.

Interviews revealed another possible explanation for variation in decision implementation; staff members had different views as to whether or not team decisions were binding. Some reported that, while they valued their colleagues' advice, they ultimately felt that the decision was up to them as the patient's keyworker and the person who knew them best: *"I have had discussions in there and done the exact opposite when I've gone out ... sometimes I used to think 'too many cooks.' You could have too many opinions"* (Social Worker, CMHT 1; interview).

Sometimes a practitioner agreed with a decision during the meeting but changed their mind upon further consideration: *"Like anything in life, people can make the wrong decision ... Sometimes plans are changed, you know, if you reflect on things afterwards or take further advice"* (Nurse, EIS; interview). Not all changes were the result of careful reflection, however; sometimes the practitioner simply couldn't remember the rationale for the decision made: *"Occasionally I am slightly at loss why we made the decision we made ... If they are my patient and I am*

giving the feedback, I have to say ... I just change the diagnosis if I disagree.”
(Psychiatrist, Mem 2; interview).

Others reported that they felt it was inappropriate to change the course of action decided at the team meeting, though they acknowledged that it did occasionally happen: *“It would be dangerous to do that ... I don’t think you should change what’s discussed in the meeting ... It’s all minuted ... People do it actually ... people who don’t want to listen”* (Nurse, CMHT 2; interview). This was a matter of concern for several senior CMHT practitioners:

“Sometimes it’s individual error, it’s forgotten or whatever. Sometimes, it’s individual resistance or anxiety, it’s a task that they’re quite not sure how to go about and rather than ask for support and so on, they just defer it or don’t do it.”(Psychiatrist, CMHT 2; interview)

“Sometimes I worry that actions agreed in the team are then not followed up by individuals, and no, it’s not okay. If you didn’t agree, bring it back the next week, but don’t just be quiet and not do it.” (Psychologist, CMHT 3; interview)

Despite these concerns, none of the teams had a systematic process for reviewing whether or not MDT decisions had been implemented. Though CMHTs 2 and 3 took time to review the minutes of the previous meeting each week, they usually only mentioned matters they considered pressing rather than all action points, and this was hampered by inconsistent documentation (discussed further in Chapter 6).

5.4.5 Sharing the emotional burden of the work

Most interviewees from the CMHTs and EIS team emphasised that discussing their emotions was a paramount function of meetings. They saw the meeting as a crucial forum for peer support which helped them cope with what was often a highly stressful job:

“That’s another function of the MDT, holding that anxiety ... You may have a member of staff who is worried about their service user and they may feel like,

'What am I going to do with this person?' So in the MDT, they can air that anxiety and they can get support from their colleagues." (Team Manager, CMHT 2; interview)

The following example illustrates how meetings were used to help practitioners to process and understand their own emotional reactions to patients and their circumstances. The social worker says she feels hopeless, frustrated and angry that her patient is not getting better, and her colleagues respond with empathy and suggest strategies that she might use to protect herself emotionally:

- Team Manager: I think you should talk to the team though, about the way that's, you know, making you feel ...*
- Social Worker: He [patient] has completely lost hope, and his wife has completely lost hope, and I've completely lost hope that this man will ever get better ... I just don't know how to work with him in any effective way ... you know, I'm very aware of it, and angry about it as well. What's the point? This work's all been futile, you're in exactly the same place as you were 15 months ago, what are we doing with you?*
- Psychologist: He gets rid of all his crap into everyone else around him*
- Social Worker: Yeah but he still has it as well*
- Team Manager: So how can we support [Social Worker] with this?*
- Psychologist: I'd say that's the only thing you can work with, feelings he generates. You know, your role is to try and help him, and that's the problem. You've got to try and stop helping him [laughter]. Because if you take it in then you just get completely crushed and feel rubbish yourself ... It's something about **how you protect yourself from getting caught up in it** ... It's giving him the chance to think about what he's doing and how he feels and what he does to other people. That's it ... Otherwise you're just going to feel crap the whole time. And that you're somehow responsible for keeping this man alive, and you're not ... **If he kills himself then he knows what he's doing ... it's not your fault** (CMHT 2; observation)*

Venting and offloading

Participants argued that, even where no clear solutions were forthcoming, the act of expressing their emotions (“offloading” or “venting”) was helpful in and of itself:

“Just to offload and say, ‘It’s absolutely shit and I can’t, don’t want to work with this person, or I don’t want to do this’ ... at least you went away feeling that you weren’t alone...I think it is important for professionals to have a venue to, as I’ve said, vent or moan ... I think what it did is it allowed you to be weak. It allowed you to feel confident enough to say ‘I don’t know what to do’, or ‘I don’t want to do this’, and ‘I’m tearing my hair out.’” (Social Worker, CMHT 1; interview)

In CMHT 1, the meeting was moved from midweek to Friday specifically to help team members resolve work-related stress and “re-charge” before the weekend.

In the observed meetings these discussions often involved practitioners expressing annoyance at patients who seemed to be avoiding contact, engaging in risky behaviour, or exploiting services:

Social Worker: Charlie is really irritating me. I want to say a stronger word [laughter] ... We supported him through thin and thick to get his Indefinite Leave to Remain and now he’s taking the absolute - I’m really not happy about it ...

Nurse: I mean, let’s not mess about. We’re not going to be manipulated by him

Team Manager: He’s done pretty well by us, hasn’t he really?

Social Worker: That’s what I pretty much told him. I said, “Stop taking the micky man” ...

Occupational Therapist: Yeah, I just, this, this culture of entitlement, you know? We work hard for people to get them their dues, and that’s absolutely right, but it’s always wanting that little bit more

Social Worker: This is more than wanting more, it’s someone taking the micky. I mean, he had nothing, he was going to be sent to [country] where there’s a war. We supported him, gave him more extra money, and he’s just chucking it in our face (EIS; observation)

On other occasions they expressed frustration at being unable to provide a satisfactory level of care due to organisational barriers or inadequate resources:

- Team Manager:* In other times she would be in some sort of residential nursing home
- Psychologist:* Expensive
- Team Manager:* Expensive, but, you know ...
- Psychologist:* In the meantime we're drifting back into the 1960s aren't we really? It's scary stuff ...
- Social Worker:* As we've accepted, she's contained as cheaply as possible at the moment and that's probably what matters most. [Residential home] would have been perfect. But who listens to me Claire?
- Psychologist:* Well clearly no one Ben [laughter] (CMHT 3; observation)

It was also common for practitioners to express a sense of resignation in meetings when they recognised that their care was not having the desired impact on patients:

- Psychologist:* That idea that she's going to change is a bit naive isn't it?
- Social Worker:* Yeah, right. Yeah, I mean we've tried so many things
- Psychologist:* Over years (CMHT 2; observation)
- Occupational Therapist:* It's a bit of a heart sink ... I don't think we're going to have any major shifts" (EIS; observation)

Several interviewees mentioned that they thought this cathartic aspect of meetings was its primary function: "The most important part of it really is that you can air your feelings" (Social Worker, CMHT 3; interview). There was one interviewee, however, who believed this aspect of meetings was a waste of time: "It's just a moaning session so what's the point?" (Nurse, CMHT 3; interview).

Reflecting on therapeutic relationships

Emotionally-charged conversations in meetings also prompted practitioners to reflect on their therapeutic relationships:

- Nurse:* She said I have as much empathy as a brick wall

Psychiatrist: Well she's right in a way [laughter]. Not about your empathy but that you're like a brick wall

Nurse: No!

Psychiatrist: I mean it in a good way, in that she's kicking against it and you're containing and keeping the boundaries. I mean she won't like it but I think you should just keep doing what you're doing (CMHT 2; observation)

Social Worker: His poor wife; it's just so awful, awful

Team Manager: You're like another wife to him aren't you?

Social Worker: No! Absolutely not! [laughter]

Team Manager: Not in the same way that his wife is his wife but [laughs]. That got a reaction from you! But you know, like, you're part of that caring network aren't you? And there's the family therapist as well, you know, he's surrounded by these females (CMHT 2; observation)

If one team member was feeling too emotionally drained to engage with a patient effectively, a colleague occasionally offered to stand in, using the meeting to report back:

Manager: We saw [patient name] yesterday

Nurse: Oh did you? Lucky you. What did he have to say? Get his needs met was it?

[Laughter]

Manager: That's what they come for! He didn't want much

Nurse: Was he alright? Did he swear at you or threaten to kill any of your children or anything?

Manager: No, he wasn't as bad as all that, but he wasn't very forthcoming ...

Nurse: So what are we doing with him then?

Manager: Discharging him

Nurse: Oh great ... Thanks for doing it, thank you for standing in there

Manager: Not at all

Nurse: I couldn't quite face him to be honest (EIS; observation)

By providing an outlet for practitioners to express their emotions and receive peer support, meetings were believed to improve care indirectly by increasing the resilience of care providers.

5.4.6 Team management and administration

Meetings served a number of managerial and administrative functions (Box 5.2). Some of these, such as processing new referrals, featured only in some teams; others, such as performance monitoring and general administration, were common across all teams.

Managerial functions
<p>Processing new referrals</p> <ul style="list-style-type: none"> • Deciding if case is appropriate for the team • Allocating case to a team member for assessment
<p>Performance monitoring</p> <ul style="list-style-type: none"> • Overseeing the quality of the work • Monitoring completion of paperwork requirements (e.g. Risk Assessment forms)
<p>General administration</p> <ul style="list-style-type: none"> • Allocation of tasks • Monitoring achievement of targets (e.g. number of Carer's Assessments per month) • Issuing deadlines for paperwork • Planning team-building events, training or annual leave • Updates on organisational issues • Data collection (Mem 1 only)

Box 5.2 Examples of managerial functions achieved in MDT meetings

Processing new referrals

CMHT 1 and Mem 1 used part of each meeting (up to a third of the allocated time) to process new referrals. Team members took turns to read aloud the referral letters that had been received during the preceding week. They then

discussed the case, ostensibly to decide whether it was appropriate for the team to assess the patient in question and, if so, which practitioner should conduct the assessment. Usually, however, these decisions were made by the manager or the consultant and were rarely challenged. Nonetheless, other team members saw the process as a valuable way of ensuring that everybody was familiar with the work being undertaken by the team as a whole: *“For me it’s essential that the whole team knows what referrals are coming in and I think that’s one of the functions ... so everybody knows who’s doing what”* (Social Worker, CMHT 1; interview).

In the other teams, decisions on new referrals were made outside of team meetings by senior team members (usually the team manager or consultant psychiatrist). The CMHT 2 consultant explained that his team used to allocate assessments within the meeting, but found it to be a poor use of time:

“In those days you also discussed new referrals within the meeting which was a laborious process in a way. It was discussing the referral, who should see this, should this be in the clinic, should this be a joint doctor/coordinator assessment, and so on. And actually, it was a very inefficient and time consuming way of [doing it] ... You could spend an hour discussing five to ten referrals, well more than that, and that’s just one part of the meeting. So we actually stopped this and developed a separate thing where I and the team leader and another senior person would do referrals separately.” (Psychiatrist, CMHT 2; interview)

These teams, therefore, did not share information on new patients until after their initial assessments, when the assessing practitioner shared detailed feedback with the team.

Performance monitoring

Managers said that they used the meeting to monitor individual team members and to maintain an overview of the work being undertaken by the team:

“One of the other important functions that the meeting plays is about checking out peoples practice, and checking out their understanding of what they’re actually managing. If there wasn’t that central place, it would be left to the individuals to do what they felt should be done and no real, sort of, checking out that they are actually on the right road.” (Team Manager, CMHT 1; interview)

In the observed meetings, this usually manifested as senior members subtly questioning more junior staff and providing gentle suggestions rather than open criticism:

Senior Nurse: *When was his last review Harry?*
Nurse 2: *That is actually due to be booked as well*
Senior Nurse: *Maybe you can do that*
Consultant Psychiatrist: *Maybe a CPA meeting where we can talk about some of those things as well*
Psychologist: *Yeah*
Consultant Psychiatrist: *Invite everybody to the CPA meeting*
Nurse 2: *Yeah (CMHT 3; observation)*

General administration

General managerial tasks such as ensuring compliance with reporting requirements and targets were also addressed in meetings. Team managers often reminded practitioners of administrative requirements in response to case presentations:

“There’s targets the team has got to achieve so the management use [the meeting] as a way of reminding individual clinicians about it ... When someone does a presentation there is then a sort of checklist of things: have we done a carer’s assessment or a risk assessment and a CPA? You know. It’s a kind of place to ask those.” (Team Manager, EIS; interview)

Managers were also observed to use the meeting to make requests and issue deadlines relating to general management issues such as annual leave or new documentation procedures. Occasionally, managers would provide updates on organisational issues such as service restructuring, or provide feedback from meetings they had attended (e.g. service users forums, senior management meetings).

5.4.7 Learning and development

The meeting was seen as an important forum for learning and development. Explicit teaching and professional development activities were occasionally observed (e.g. presentations from external speakers); however, interviewees placed greater emphasis on the informal, passive learning that occurred by listening to colleagues discuss their work:

“I joined that team when I was newly qualified and I think that meeting was one of my biggest sources of learning really, just listening to all the other cases and what people were doing with them and I think I just picked up so much” (Social Worker, CMHT 1; interview).

Sharing knowledge of services and patients

Participation in meetings improved practitioners’ knowledge of local services and individual patients. This sharing of information on services and organisational procedures appeared to be particularly beneficial for new and temporary members of staff:

Locum Psychiatrist: A lot of the time with patients it’s signposting and trying to find out what’s available and that’s why these meetings are so good
StR: Absolutely, I’m learning a lot (CMHT 1; observation)

Social Worker 1: I’m a bit concerned that Julie is leaving her gas on. A couple of times recently there was a smell and it’s a bit worrying ...

Social Worker 2: You know the tele-care devices that they’ve got in Adult Social Care? They can detect gas smells and it sends an alarm to the service

Social Worker 1: Oh really? Oh!

Social Worker 2: Yeah ... It’s kind of like big brother ... but cheaper than a care home! (CMHT 2; observation)

Team members also shared knowledge of specific patients. This was particularly relevant where a new keyworker was trying to assess whether certain symptoms or behaviours were typical for a particular patient or indicative of a relapse:

- Nurse 1: *She says "Well I phoned to tell you," but there are no records of the calls being made*
- Team Manager: *Is this unusual behaviour for her?*
- Nurse 1: *I don't know because I've only just started working with her*
- Team Manager: *Lucy, you worked with her for quite a while*
- Nurse 2: *Yeah, she often said she rang me and there was no record (CMHT 3; observation)*

Learning about each other's roles

Memory clinic interviewees stressed the value of meetings in learning about each other's roles and professional disciplines. Several mentioned that it took some time for other team members to understand what their professional discipline did and did not offer to patients:

"Learning about the role and contribution other people might have to make. For example ... people learn what the psychologist actually does behind the closed doors [laughs]. That's one example. Another example might be, you know, the contribution the occupational therapist might make ... So we learn about, you know, skills that that person has." (Team Manager, Mem 1; interview)

This was considered an important by-product of the meeting because misunderstandings about the roles of different professional groups sometimes led to inappropriate referrals between team members, wasting time and resources (challenges relating to role clarity are discussed further in Chapter 7).

5.5 Summary and discussion

The analysis presented in this chapter has made explicit the range of functions served by MDT meetings and examined participant views on these functions. Most participants perceived MDT meetings to be a valuable use of their time, allowing them to achieve practical tasks such as decision-making and team management, as well as enabling peer support and learning. Despite the wide range of functions identified, however, some CMHT practitioners reported that meetings lacked clarity of purpose and were poorly managed with respect to

time. They called for explicit discussion of the purpose of meetings to ensure a shared understanding and a consistent approach. Without a clearly agreed purpose, meetings risk becoming a “catch-all” forum used to address any issues that are not resolved elsewhere. This can result in unfocused discussions and precludes the possibility of monitoring whether these functions are being served well and the extent to which they actually benefit patients.

There were notable differences in MDT functioning between teams. Memory clinics were more focused on making concrete decisions, while the other teams spent more time discussing challenging cases and sharing the emotional burden of the work. This may be because memory clinics tend to focus on initial diagnosis and treatment, usually seeing patients on a relatively short-term basis (typically less than three months),⁵⁸ whereas CMHTs and EIS services often care for patients over the course of several years^{15, 55} and face highly complex interpersonal, ethical, and legal challenges. The other major difference between teams was that some spent substantial portions of their meetings processing new referrals while others did not. Processing new referrals was one of the most frequently cited functions in the literature reviewed in Chapter 2, yet it only occurred in two of the five teams observed. Some participants argued that this was an important way of making everyone aware of the work being undertaken by the team as a whole, while others dismissed it as a waste of time, arguing that they soon learned about all of the patients anyway. Given these opposing views and the amount of time that some teams dedicate to collectively reviewing new referrals, further investigation is warranted to investigate how this practice impacts on care and whether it is a worthwhile use of resources.

This chapter has expanded on the findings of the systematic review (Chapter 2) by presenting an in-depth analysis of the content of discussions, providing insights as to what it is about certain cases that makes them particularly challenging for staff. Practitioners were particularly likely to raise their ongoing work for discussion when faced with challenging behaviour, ethical dilemmas,

or a lack of clear options. The data corroborate the finding from the review that meetings were seen as beneficial to staff as well as to patients, serving as a crucial space to process work-related emotions and to avail of peer support. In this sense, patients may benefit indirectly from MDT meetings, even when their case is not discussed, because the meetings increase the knowledge and emotional resilience of practitioners (see Figure 5.3).

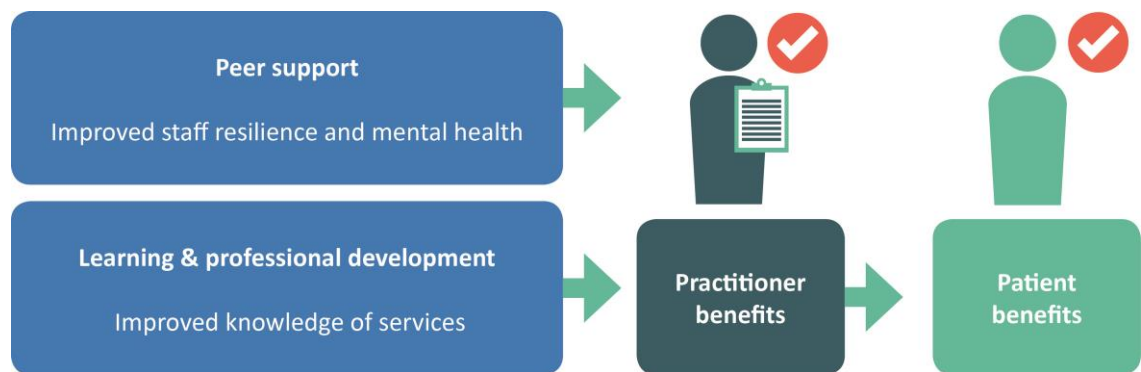


Figure 5.3 Indirect patient benefits of MDT meetings through staff support and learning

The findings presented in this chapter also help to explain some of the differences between mental health MDTs and cancer MDTs found in the NIHR Project^{19, 20} (Section 1.1). The relatively low rates of decision-making in mental health teams may be partially explained by the fact that they considered information sharing and peer support to be central functions of the team meeting. There is a much more explicit emphasis on MDT decision-making in cancer care,¹⁹ with cancer policy stating that teams should clearly agree and record a treatment plan for each patient discussed in the team meeting, and that the record should specify when this will be communicated to the patient and by whom.^{61, 281} The finding that some mental health practitioners do not perceive MDT decisions to be binding, as well as the complex and socially-contingent nature of the kinds of decisions being made, may explain why mental health MDTs are also less likely to implement the team decisions they make.

5.6 Conclusions

MDT meetings were valued by the majority of staff, and served a wide range of functions which were perceived to benefit both staff and patients. However, the findings indicate a need for greater clarity regarding the objectives of meetings, and more effective time-management so as to make the best possible use of resources. The next chapter takes up these threads by examining how meetings were organised and managed in the different teams, and by investigating participants' thoughts on these processes.

6 Theme II. The organisation of MDT meetings

6.1 Chapter overview

This chapter describes and compares the organisation of MDT meetings in the participating teams and explores participants' views of these procedures, showing how operational and managerial factors shaped the extent of multidisciplinary input patients received (Research Objectives ii and iii; p.32). It examines how the teams differed with respect to meeting size, duration, and structure. It then describes four organisational issues which appeared to substantially hinder the effectiveness of their meetings: inconsistent attendance and punctuality; unsystematic selection of patients for discussion; poor time management; and inconsistent documentation.

Figure 6.1 illustrates the issues discussed in this chapter.

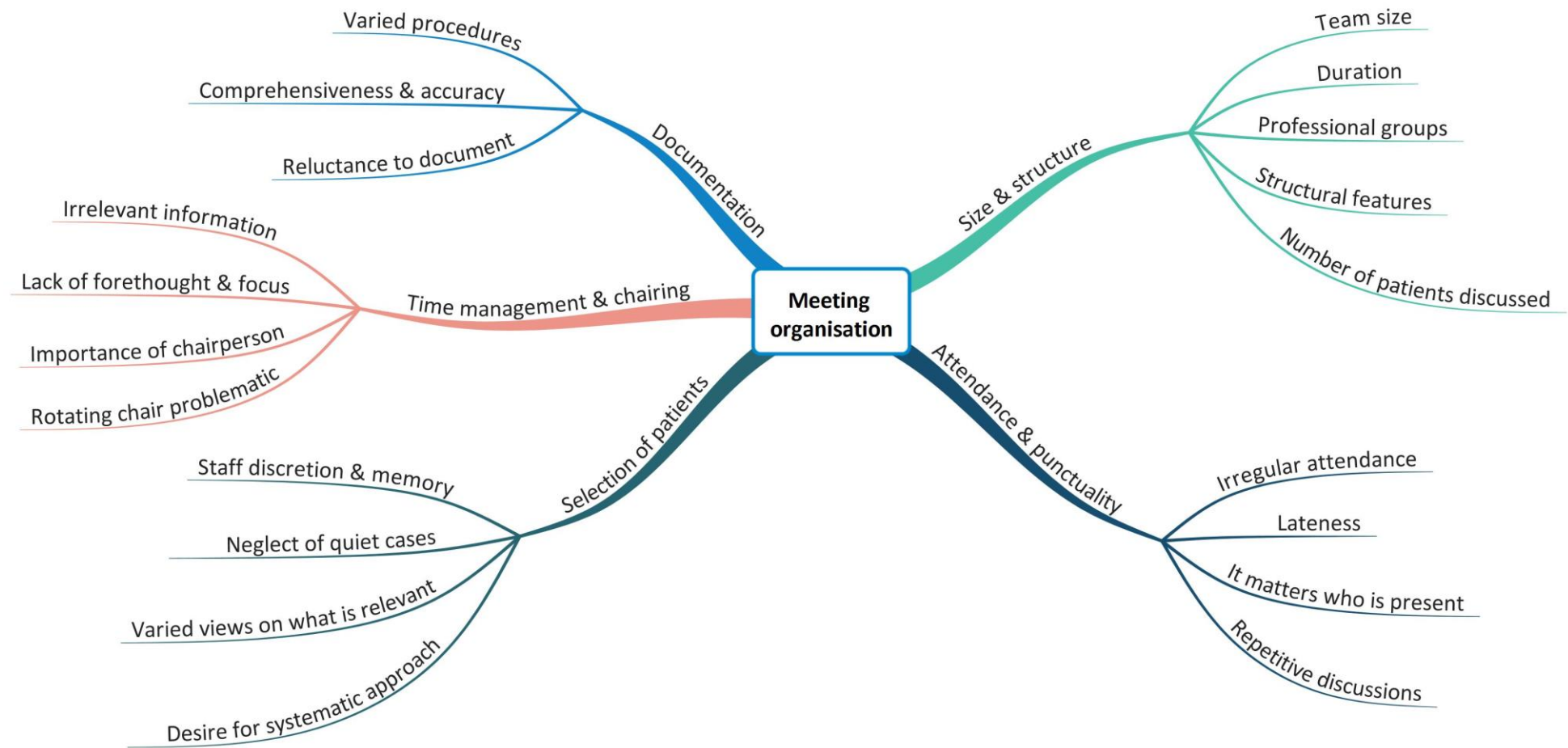


Figure 6.1 The organisation of MDT meetings: organising themes and subthemes

6.2 Meeting size and structure

The profile of attendees, the number of patients discussed, and the length of meetings varied from team to team (Table 6.1).

Table 6.1 Size and duration of MDT meetings in the participating teams

Team	N*	Meeting duration in minutes Mean (SD)	No. patients discussed Mean (SD)	No. patients discussed per hour	No. team members in attendance Mean (SD)	No. prof. groups Median (Interquartile range)
CMHT 1	15	139 (33)	29 (12)	13	8 (3)	3 (3-4)
CMHT 2	20	64 (19)	15 (4)	14	8 (2)	4 (3-4)
CMHT 3	55	65 (14)	14 (5)	13	9 (2)	4 (3-4)
EIS	23	138 (17)	49 (12)	21	10 (2)	4 (4-4)
Mem 1	43	75 (19)	11 (5)	9	9 (2)	5 (5-6)
Mem 2	25	88 (9)	4 (1)	3	7 (2)	3 (2-3)

*Number of meetings observed

The mean number of attendees at each meeting ranged from seven to ten across the teams. The degree of multidisciplinary representation (or “skill mix”) varied more widely, even within team type, with up to six professions represented in Mem 1, and as few as two professions represented in Mem 2. This suggests that the extent of multidisciplinary input patients receive varies widely depending on where they are referred.

The average duration of the meetings ranged from just over one hour in CMHT 2, to more than two and a half hours in CMHT 1. There was also wide disparity in the numbers of patients discussed each week. For example, Mem 1 discussed a mean of nine patients per hour while Mem 2 discussed only three. In two and a half hours, CMHT 1 typically discussed 30 patients, while EIS discussed 50

(their whole caseload) (see Section 6.4. on the selection of patients for discussion).

Table 6.2 shows differences in how the meetings were structured and managed. Some had a permanent chairperson while others rotated the role. In some teams, meetings were attended by administrators and visiting associates from other teams as well as local team members, such as specialist consultants or crisis team representatives. Only two teams used computers during their meetings.

Table 6.2 Organisational features of the observed teams

Team	Meeting chairperson	Administrator attends	Patient list used	Regular visiting associate(s)	Use of IT
CMHT 1	Manager* or consultant	No	✗	Inpatient consultant	✗
CMHT 2	Rotates	Yes	✗	Crisis team representative	✗
CMHT 3	Rotates	Yes	✗	Crisis team representative	✗
EIS	Manager*	No	✓	Forensic psychiatrist & nurse (monthly)	✓
Mem 1	Manager†	No	✗	✗	✓

* Manager is a Social Worker

† Manager is a Nurse

6.3 Inconsistent attendance and punctuality

Though all team members were supposed to be present at the meeting each week, poor attendance and punctuality were common, which limited the potential for multidisciplinary discussion. With the exception of Mem 1, where people usually arrived on time, latecomers regularly delayed meetings by 10 to 20 minutes, causing substantial disruption when they arrived because of the need to retrieve and rearrange chairs. As the following examples illustrate, this led to frustration and resentment among those who had arrived punctually:

Psychiatrist: The busy people arrive on time, and the people who aren't busy pretend they're busy and come late (CMHT 1; observation).

Support Worker: Come on people. Let's get this over and done with. This meeting does get on my nerves I have to say (EIS; observation)

Psychologist: We're waiting for [lists names]. Graham is quite busy, too busy to come and spend time with us. Philip and Jessica say that if the meeting is long they'll have to leave early. Come on people (CMHT 2; observation)

Occasionally someone was sent back to the offices to "round up" the rest of the team:

*Social Worker: Is this us? Four people? It's pathetic!
[They discuss which team members had been seen in the office earlier.]*

Psychologist: Did they look like they were moving?

Social worker: I don't know, shall I go and?

Psychologist: Yes, give them a hard poke. You know the sooner we start the sooner it's over (CMHT 2; observation)

One manager commented that poor attendance in part reflected how busy people were, but believed that the meeting should be prioritised nonetheless because it was central to their functioning as a team:

Manager: I'm going to send out an e-mail [about attendance] because I think we're going to lose the sense of a team meeting if we don't. I know it's hard and everyone's flat out, but it's just the only opportunity to think about, you know, the difficulties we have with work that we do, and if we don't come together and really prioritise that time

Psychiatrist: That will make it worse

Manager: Yeah (EIS; observation)

Irregular attendance was not confined to any particular group of practitioners, but it was considered particularly disruptive when senior people were absent. In CMHT 3, for example, the consultant psychiatrist attended only 60% of the observed meetings and arrived late or left early for half of those he did attend. Another senior team member reported that this significantly altered the dynamic of the meeting: "I feel really strongly that people should attend and

prioritise it. If you don't have at least two senior people in the team meeting it's very difficult to manage it" (Psychologist, CMHT 3; interview).

Attendance was also important because the profile of the group each week had a bearing on which patients were raised for discussion. Input from certain individuals was valued more highly than input from others: *"I must say I do think about who is in the room when I think about who to discuss, about how helpful I think, who might offer me something helpful" (Psychologist, CMHT 3; interview).*

Quite often in the observed meetings people withheld their case discussions in the hope that the consultant or the team manager would arrive late:

Social Worker: Do you want to do yours or do you want to wait?

Nurse: Well I was kind of hoping [consultant] would be here really (CMHT 2; observation)

The absence and lateness of senior members also led to repetition in what was discussed. Stories were often told week after week or multiple times in the same meeting if relevant parties arrived late:

Social Worker: Can I do a postscript, just for [consultant]'s benefit, as you weren't here, [repeats update] (CMHT 3; observation)

Poor punctuality and attendance were therefore doubly disruptive in that they caused delays and disruption at the start of the meeting and led to the repetition of information, which prolonged the meetings further.

6.4 Unsystematic selection of patients for discussion

None of the teams constructed a written agenda or specified patients for discussion in advance of meetings. Rather, they relied on individual team members remembering relevant information and choosing to share it. Though all teams followed some sort of meeting format (e.g. allocation of new referrals, recent assessments etc.; see Table 4.5, p.109) EIS was the only team to distribute

a printed list of all patients, which served as a prompt for team members. In Mem 1, participants occasionally brought paper copies of neuropsychological assessments to aid team discussions. In all other teams, the results of assessments and ongoing work were reported entirely from memory.

Because of this “*ad hoc*” approach to discussing patients, the degree of whole-team consideration a patient received was almost entirely at the discretion of their keyworker. Team members varied in how much information they volunteered and had different views on what should be discussed. For example, one social worker felt there should be a system in place to ensure that all recent assessments were routinely discussed so that everyone was aware of all ongoing work. In contrast, two nurses from different MDTs felt that providing feedback on straightforward assessments was a waste of time and undermined their professional autonomy:

“Some of the cases already could easily be decided by that person ... You’ve got enough room based on your experience and expertise to say, ‘Well this person doesn’t need CMHT input’ ... You can close that case as a professional in your own right and a case like that doesn’t need to come to the meeting to be regurgitated.” (Nurse, CMHT 2; interview)

In part this reflects the different interpretations of the purpose of meetings discussed in Chapter 5. However, there was some concern that not everyone could be “*relied on*” to raise concerning issues: *“I don’t know if it’s because work gets generated if you do present a client of concern ... or whether it’s that they don’t find it a supportive thing” (Nurse, EIS; interview).*

There was also evidence from the observational data that, in the absence of a written prompt, people sometimes forgot which patients they had seen over the course of the preceding week or details of the assessments:

Psychiatrist: I’m trying to remember ... They all merge into one after a while (Mem 1; observation)

Social Worker: There was one last week that I completely forgot to mention (CMHT 3; observation)

Some feared that the tendency to focus on salient risks and crises in meetings might lead to the neglect of “quiet clients” who could be better served:

“Where maybe not much is happening but something needs to ... the ones who are managed on the whole by the care coordinator on their own, they’re not causing too much fuss, but maybe things aren’t moving on ... [they’re] not being very tightly looked after.” (Psychologist, CMHT 3; interview)

Though individual staff supervision could serve as a safety net for such clients, several participants reported that supervision sessions did not take place as regularly as they were supposed to due to high workloads and time constraints. The deputy manager of EIS explained that they had initially intended to go through one practitioner’s case load in detail at the meeting each week, but that this had fallen by the wayside as the workload increased. It did not happen during the five months of data collection at that site.

Several interviewees argued that there was a need for a more systematic approach to selecting patients for discussion, for example, by collating a list of patients or topics for discussion in advance. They felt this would encourage team members to plan case discussions more carefully so as to improve the use of time in the meeting:

“I think that would maybe cut away a bit from some of the pointless conversations we have sometimes ... if you actually book people in or make a list of people that you wish to discuss, you may have a bit more thought behind those discussions rather than just mentioning people for the sake of it.” (Occupational Therapist, EIS; interview)

Many participants reported that MDT discussions were often directionless or redundant. They attributed it to both a lack of critical reflection on which patients should be discussed, and the failure to steer discussions and manage time effectively.

6.5 Dissatisfaction with time management and chairing

A recurring complaint during interviews was the inefficient use of time during meetings. Discussions were described as unfocused, circular, and repetitive:

"I'm not always convinced that we make use of time in absolutely the most effective way ... I think we sometimes are in danger of repeating ourselves excessively." (Psychiatrist, EIS; interview)

Interviewees argued that their colleagues often gave long-winded case presentations which failed to prioritise the relevant information: *"Sometimes they go into unbelievable detail into incredibly irrelevant things. It is just not relevant for somebody aged 75 if they had a normal delivery. It is truly, nobody cares"* (Psychiatrist, Mem 2; interview).

"It's quite annoying ... the things that they are saying are largely irrelevant, and by the time they get to the interesting bit, where we could have an input, you've completely lost the will to live ... Three hours later you're sitting there ... It's actually agony, you know, physically and mentally [laughs]." (Social Worker, CMHT 1; interview)

Presentations were rarely framed in terms of a specific query and it was often unclear to listeners why certain information was being shared. This caused frustration which was sometimes evident during the meetings:

Psychiatrist: *Thanks for sharing that story. Why did we hear it? [laughter]*
(CMHT 1; observation)

Several interviewees commented that people should put more forethought into what they said at meetings: *"It can get a bit self-indulgent ... They just think, 'Oh I want to talk,' and actually they need to think more about what they're saying"* (Social Worker, CMHT 1; interview).

"You can find yourself just saying things for the sake of saying it rather than actually thinking about, 'actually is this a point of concern? Is this something that's going to be helpful for myself or the client or for the team to actually discuss?'" (Occupational Therapist, EIS; interview)

Some suggested that it would be valuable to have a time-limit for each case discussion to encourage brevity and focus. There was evidence from the observational data that discussions of cases raised towards the end of meetings were often rushed:

Manager: It will have to be brief I'm afraid ... [interrupting case presentation] Very quickly I'm afraid Ben (Mem 1; observation)

Social Worker: Luke, have you got any concerning clients, very briefly? (CMHT 3; observation)

Some participants felt that, because so much time was spent on mundane and unnecessary details, complex issues were not afforded the attention they deserved and consequently teams sometimes failed to get to the crux of the relevant issue. They argued that there wasn't enough time for "*thrashing out the actual bare bones of what's going on in particular cases*" (Manager, CMHT 1; interview).

"We're there to talk about things in depth, but what can happen is you talk about more people in a similar lack of depth." (Deputy Manager, EIS; interview).

Most interviewees believed that the chair had a responsibility to keep the discussions on point, and to seek out the relevance of the information presented:

" ... to say to the presenting staff, 'You mentioned about this, what was the significance of this? ... You spent 10 minutes talking about his trip to China, but you never said how you think that's affected his outlook' ... I think it's the role of the chair." (Nurse, CMHT 3; interview)

The importance of strong chairing was raised by interviewees in all teams: "*I think we really lack a chairman. And that is why the meetings are a little bit unstructured and too free flowing*" (Psychiatrist, Mem 2; interview).

A strong chair was characterised as someone who would ensure that discussions focused on relevant details, seek out an action plan, and cut

discussions short where necessary. Chairing was seen as a difficult skill which required legitimate authority and the rotating chairperson system adopted by some teams was largely considered well-intentioned but inefficient: *“Although it’s a way of making people feel included, sometimes it’s a bit like tokenism. In fact, you need somebody chairing it who can drive the agenda forward so it doesn’t take all day”* (Psychiatrist, Mem 1; interview).

“I think one of the weaknesses is everyone chairing and therefore everyone being lumbered two or three times a year ... Seniors chairing the meeting, that makes little a bit more sense because then that person can deliver their control of the group a bit more ... The idea was having everyone as equals, but not everyone was as equals.” (Nurse, CMHT 3; interview)

Furthermore, in teams with a rotating chairperson, meetings were often delayed due to confusion about who was supposed to be chairing or the nominated person being absent.

6.6 Inconsistent documentation

Teams varied in their administrative arrangements (Table 6.3) and in the comprehensiveness and accuracy of meeting minutes.

Table 6.3 Record-keeping arrangements in the observed teams

Team	Recorded electronically	Recorded manually	Documented in patient’s medical records	Recorded by
CMHT 1	×	✓	×	Manager
CMHT 2	×	✓	×	Administrator
CMHT 3	×	✓	×	Administrator
EIS	✓	×	×	Deputy manager/Nurse
Mem 1	✓	×	✓	Manager

Only Mem 1 accessed the electronic patient records system during their meetings. The manager documented meeting outcomes in the patient’s electronic notes in real-time using a laptop. This meant they were instantly

accessible to all practitioners involved in the patient's care throughout the trust, something participants found to be an invaluable memory aid:

"[It's] really useful because you might discuss 15 patients and you go out and think 'Oh God, what did we say about it?' You know you can go and look it up straight away and it's there ... Having access to it there is absolutely essential."
(StR, Mem 1; interview)

EIS also used a computer during their meetings, but not to access medical records. Rather, the deputy manager or a nurse usually typed meeting minutes into a Microsoft Word document during the meeting using a desktop computer situated in the corner of the room (see Table 4.5, p109). These were not reviewed in subsequent meetings but were saved on a server accessible to the whole team. In previous years, an administrator used to transfer the relevant portions of these minutes into each patient's medical records, but that this had stopped as the team no longer had an administrator.

In CMHT 2 and CMHT 3, minutes were handwritten during the meeting by a team member or an administrator (when available). These notes were subsequently typed and saved as a Microsoft Word document on a server accessible to the whole team. A printed copy was brought to the meeting the following week and relevant updates were briefly discussed.

In CMHT 1, the manager made handwritten minutes in a notebook. These were not transcribed electronically or reviewed in subsequent meetings.

6.6.1 Quality of documentation

Minutes in some teams were far less comprehensive than in others. For example, in EIS only 33% of the decisions agreed were recorded in meeting minutes or in the patient's medical record, in comparison to 100% in Mem 2 (Table 6.4); χ^2 (df=5, n=2368) = 523.91, $p < .001$. This may reflect the different views regarding the centrality of decision-making to the purpose of meetings discussed in Chapter 5.

Table 6.4 Documentation of MDT decisions

Team	N*	% decisions recorded in minutes or medical records
CMHT 1	242	50
CMHT 2	670	55
CMHT 3	127	57
EIS	456	33
Mem 1	606	87
Mem 2	267	100
Total	2368	64

*Number of decisions (excludes 2% of decisions for which the relevant records were unavailable).

The accuracy of records was also variable. In CMHTs 1, 2 and 3 (where minutes were written by hand) patient names were often misspelled or omitted from the minutes, making it difficult or impossible to link action points to specific patients or to assess whether or not they had been implemented. Several team members highlighted the importance of comprehensive documentation, noting that when a discussion wasn't documented *"it's almost as if it didn't happen"* (Nurse, EIS; interview).

Because meetings were not comprehensively documented, teams could not systematically keep track of whether or not team decisions were being implemented, which patients had been discussed previously, or the extent to which patients were receiving equitable levels of multidisciplinary input.

One participant argued that inconsistent documentation was, in part, a strategic response to feeling overburdened, observing that staff were disinclined to agree definitive decisions and make written commitments which they may struggle to fulfil:

"We're very loose on decision-making ... We're not very good at recording or identifying when it is we've made a decision and why ... it's this culture of just drifting ... once you start writing minutes and having actions and timescales, those things have to be done ... so you can see how you drift into this position of, 'Let's not write too much down. Let's not have too many action points, because we're busy enough'." (Deputy Team Manager, EIS; interview)

In this sense, patchy documentation was seen as a sort of coping mechanism in the face of overwhelming work demands and limited time.

The observational data suggested another possible reason for unsystematic documentation. On several occasions staff commented that they were reluctant to document discussions due to concerns that the records would subsequently be made available to patients and carers. They worried that patients would react negatively if they saw what was written about them:

StR: This is complex because we should be putting all the discussions on [the electronic record system], but what if she turns around and says 'I want to see my notes'?

Deputy Manager: We just need to clearly justify everything (EIS; observation)

This also appeared to influence what was documented in correspondence to other practitioners:

Psychiatrist: Do we still send out the [clinic] letters to the patient as well? ... I think that's dangerous in some ways

Manager: It's their information and as the professionals we should be transparent with the information we're recording ...

Psychiatrist: But you can't say someone is charming to their face and then tell them they're a psychopath in the letter

Manager: Exactly. So the assumption is all letters are automatically copied to the patient ...

Psychiatrist: Well that's good to know. [To StR] were you aware of that?

StR: No, I wasn't. I'm just thinking 'what have I written?' ... It's quite difficult with mental states, especially when someone's presenting as unkempt and overweight, you can't always put that in a letter because they'd be quite insulted [laughs]

Manager: But that's what's recorded also because we're health and social care professionals and if people do have a weight problem we should be discussing that with them ...

Psychiatrist: I'm going to keep my letters very brief [laughter]

Social Worker: 'Dear Doctor. Saw patient. All well. Love, Doctor Smith' [laughter] (CMHT 1; observation)

There was also variation in the extent to which teams subsequently documented whether or not agreed MDT actions had been implemented (Table 6.5). Implementation status was not documented for 20% of MDT decisions in

EIS, while this was only true of 5% of decisions in Mem 2 and 10% of decisions in CMHT 3; χ^2 (df=5, n=2352)=36.76, $p<.001$.

Table 6.5 Proportion of decisions where implementation status not documented

Team	N*	% decisions where implementation status not documented
CMHT 1	237	13
CMHT 2	657	18
CMHT 3	130	10
EIS	461	20
Mem 1	603	16
Mem 2	264	5
Total	2352	15

*Total number of decisions (excludes 2% of decisions where the patient wasn't identifiable or the records were unavailable)

6.7 Summary and discussion

Given the costs of occupying whole teams for several hours each week, it is important that MDT meetings make the best possible use of the time and expertise available. This chapter has identified substantial variation in who attends MDT meetings, which patients are discussed, and the content and depth of those discussions. Considering the localised development of MDTs and the lack of best practice guidance on the functioning of MDT meetings, such variation is perhaps to be expected. However, there has been little previous investigation of how such variation impacts on the quality of care. In the words of W. Edwards Deming, "Uncontrolled variation is the enemy of quality".^{282 (p.19)} Though variation can signify appropriate responsiveness to local needs, it can also reflect an uncritical acceptance of the status quo and the failure of teams to learn from each other. The study identified many aspects of meeting organisation and management that practitioners believed wasted precious time and resources.

The lack of a systematic approach to deciding and monitoring which cases are discussed has substantial implications for patients. There is a risk that, left entirely the discretion of individual keyworkers, only the most anxiety-provoking cases will be raised for discussion while the remaining patients are left without potentially beneficial multidisciplinary input. Conversely, some keyworkers may omit their most troubling cases for fear that their work will be criticised. Where keyworkers forget or deliberately neglect to raise particular patients for discussion, care may be compromised or delayed, resulting in unnecessary deterioration in their health and increased waiting times for other patients. While UK policy is somewhat unclear regarding which patients should be discussed (see Section 1.3), recent guidance from the European Psychiatric Association⁷ states that “regular team reviews” (p104) for all patients are an essential component of effective community mental health treatment. The findings presented in this chapter suggest that improved documentation and monitoring systems may be necessary to ensure that such reviews take place.

Despite the belief among practitioners that MDT meetings were valuable on the whole (Chapter 5), poor punctuality and irregular attendance suggest that there was some reluctance to attend and prioritise them. This is in keeping with the finding that some team members were unsure of the point of meetings and found them boring and repetitive (Chapter 5). Practitioners offered a number of suggestions for improving the efficiency of meetings, such as having a designated chairperson with legitimate power and authority. This is consistent with other studies which have found having a rotating (or “rolling”) chairperson to be problematic.^{6, 108} Other suggestions for keeping discussions focused included collating an agenda prior to each meeting which lists the patients to be discussed, and imposing a time limit on each case discussion. It was argued that this would prompt practitioners to think in advance about why they were raising each issue, encourage focused discussions, and minimise

repetition. Ensuring that an adequate record of each case discussion is available those who were absent could also reduce the need for repeated discussions.

West and colleagues⁶ reached similar conclusions in the only other study to examine mental health MDT meetings in depth. They recommended that meetings be structured around a clear agenda focused on team objectives, that the start and end time of the meeting should be determined in advance, and that discussions should be moderated by a trained, skilled chairperson. Liberman and colleagues¹⁸⁶ argued that the role of an effective chairperson is to focus team meetings on the extent to which the service is addressing the needs and goals of patients, to set an expectation that case presentations will be “specific and cogent” (p.1335), to involve staff in prioritising topics for discussion, and to ensure that decisions are documented. While there is no specific UK guidance on how MDT discussions should be documented, general guidance on responsibility and accountability in the NHS states that decisions resulting from multidisciplinary assessments should be documented, along with the names of those involved in the discussion.⁵⁶

6.8 Conclusions

Inconsistent attendance, varied views on which patients should be discussed and wide variation between teams in the time spent discussing each patient suggest that the degree of multidisciplinary input a patient receives may vary widely according to where they are referred and which keyworker they are assigned. Practitioners identified a number of challenges to the effective management of meetings and proposed a range of improvements, such as having a strong authoritative chairperson and planning case discussions in advance. The next chapter moves from examining procedural and structural aspects of the meetings to exploring how participants viewed multidisciplinary teamwork and the roles of different professional groups.

7 Theme III. Multidisciplinary teamwork: professional roles and participation

7.1.1 Chapter overview

Multidisciplinary working is based on the premise that different professional groups offer varied but complementary skills and perspectives which can be integrated to form a coherent and comprehensive programme of care. For a patient to benefit from this pool of knowledge, their keyworker must elicit specialist input from their colleagues and incorporate it into care provision. It is therefore important to understand how team members view multidisciplinary working and the roles of the different professional groups. This theme reveals a number of challenges to productive multidisciplinary teamwork, including conflicting models of care, difficulty balancing professional and generic roles, ambiguous leadership and power struggles.

In exploring these issues, this chapter addresses the following research objectives:

- iii. to explore practitioner views on MDT meetings and multidisciplinary care planning;
- v. to identify factors that impact on the potential for patients to benefit from meetings and multidisciplinary care planning.

Figure 7.1 summarises the themes and topics discussed in this chapter.

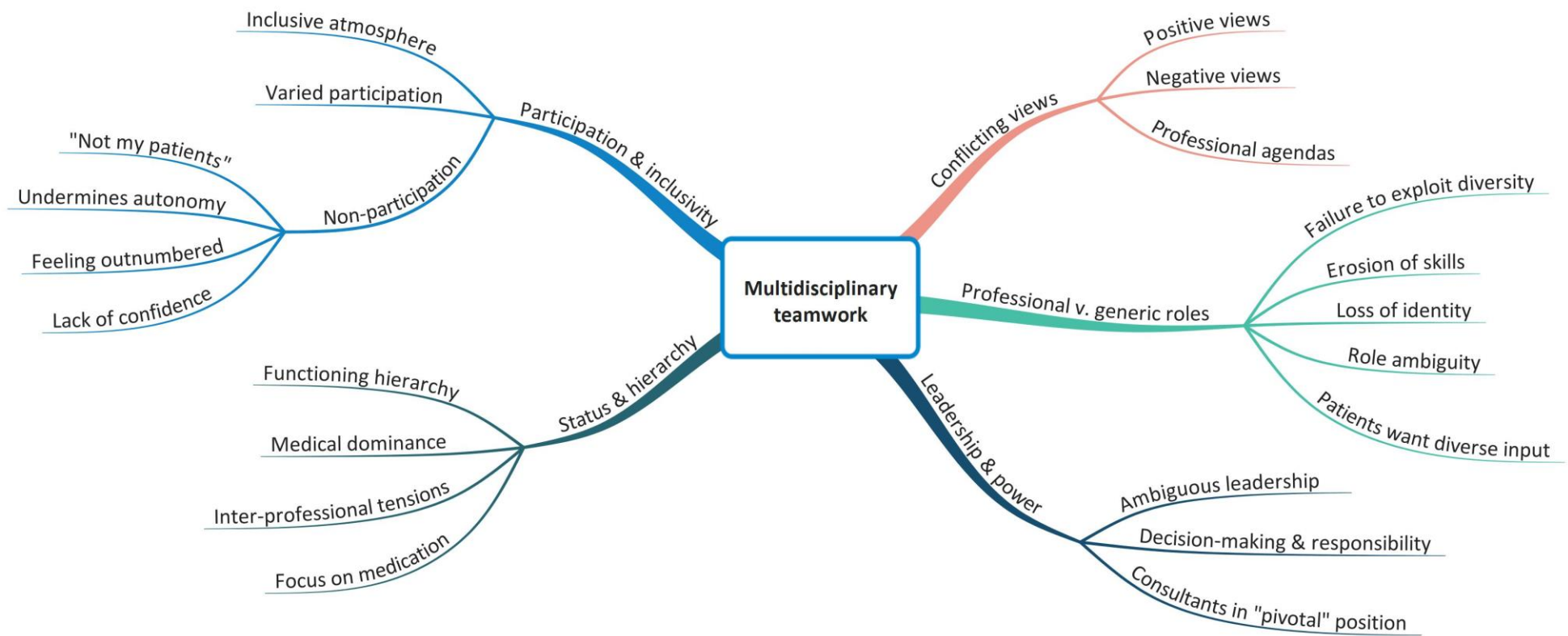


Figure 7.1 Multidisciplinary working: organising themes and subthemes

7.2 Multidisciplinary working: conflicting views and agendas

Team members had varied views on the value of multidisciplinary working. Many enjoyed being able to learn from other disciplines and reported that hearing different perspectives gave them a greater range of ideas for managing complex situations:

“I learn a lot, I learn a lot all the time from psychiatrists and different perspectives from nurses, from social workers, managers ... It is so sort of nourishing to have input from different professionals, the different disciplines. I find it much more stimulating.” (Psychologist, CMHT 3; interview)

Yet, not everyone believed that multidisciplinary working was beneficial. A minority of interviewees argued that bringing together different disciplines added little value and could even be detrimental to care:

“I personally think you could replace most of the people in the team with nurses. You know, it’s a biased personal view being a nurse [laughs]. I mean the only thing with social workers is they are free labour, in the way the council pays for them and they don’t come out of the NHS budget ... I think it might improve the service.” (Nurse, CMHT 3; interview)

I think people stick to their kind [laughs] ... I think the social workers stick together and I think the nurses stick together, and I think the doctors stick together amidst their own ... It’s probably not a good thing to mix professionals up ... I see them bunching together but they see us bunching together too. (Nurse, CMHT 2; interview)

The different professional groups were seen as having distinct agendas and models of care. Social workers argued that nurses and doctors tended to have a more paternalistic approach which was more narrowly focused on the patient’s symptoms and medication. In contrast, social workers were seen as emphasising broader issues such as the patient’s housing situation and family circumstances.

“From the social worker background, we’ve always worked with value systems such as self-recovery and self-determination and empowerment ... Whereas I think it’s slightly different for nurses, because it was very much around, ‘Ok you’ve got a disorder, I need to monitor you and your medication to make sure that you’re symptom free.’ So there’s lots of responsibilities as a nurse to ‘do for’ the individual, whereas now what we’re trying to do is to ‘do with’ the individual.” (Social Worker, CMHT 1; interview)

MDT working is based on the idea that different professional groups will offer complementary approaches, but some participants argued that in practice they sometimes had conflicting priorities:

“Different people have different agendas and different understandings of what the team is there to do ... There’s a strong affinity with some people with the medical model, then some people with their more functional model ... Some people will be more focused on getting medication involved and other people won’t. Some people much more interested in psychological interventions. And then there’s, well, there’s a myriad of different agendas ... I think that’s one of the major problems of MDTs ... And there’s certainly not the openness within the team to recognising all those different agendas.” (Social Worker, EIS; interview)

Some of these differences were based on different fundamental values and were therefore difficult to resolve. Beliefs relating to the coercion of patients were a particular source of conflict:

“There’s a different idea of human rights ... Social workers very much do try to defend a person’s right to be mad. I mean the nurse view is, ‘You’re not well, so we need to get you on the path and let’s make the decisions you would make’. Because part of nursing is do for others what they would do for themselves if they were well ... Well social workers, they come from a different point of view. They are usually the ones that argue for the least restrictive [treatment option] ... and as long as you don’t disturb the peace and you’re not causing trouble you can carry on being as crazy as you want to.” (Nurse, CMHT 3 interview)

Evidence of such contrasting underlying care priorities occasionally manifested in meetings. One source of several heated disagreements was the use of Community Treatment Orders (CTOs) to recall patients back to hospital if they violated the terms of their discharge. In these discussions, the different professional groups tended to behave in a manner consistent with the role

stereotypes described earlier. For example, in the following extract the nurse and psychiatrist advocate for a more paternalistic approach (*“as indeed one might have with children”*) to alleviate the patient’s condition, while the social worker and the psychologist emphasise the patient’s personal liberty and sense of control:

Nurse: *I’d have just recalled him rather than having him see a doctor*
Psychologist: *Mmm no*
Social Worker: *I don’t think that’s in the spirit of the CTO, to recall without even giving him an arena to discuss his concern i.e. the medication ... He should have that space*
Nurse: *Well, the condition of the CTO is to take the meds*
Psychologist: *But our job is ultimately about engagement isn’t it? ...*
Social Worker: *It’s like treating people like children, isn’t it? Saying, ‘You will do as we say and blah, blah, blah,’ and that’s just the road to disaster*
Psychologist: *Yeah*
Psychiatrist: *I think equally firm boundaries are important, as indeed one might have with children, because otherwise someone like him just goes round, and round, and round*
Social Worker: *Yes, firm boundaries, but with him having some control of*
Psychiatrist: *Yeah, yeah, obviously we see him (CMHT 3; observation)*

Some participants argued that differences in the philosophies underlying the different professions were ignored rather than openly addressed. A related concern was that differences in the practical aspects of the work were also minimised due to the generic keyworker model. Many believed that these factors undermined the potential for MDTs to benefit from their diversity.

7.3 Balancing professional and generic roles

Despite their distinct training and theoretical perspectives, most team members performed a generic keyworker role, leading some to question the value of bringing different professional groups together in the first place.

7.3.1 Failure to capitalise on diversity

Several interviewees argued that the generic key-work model made little use of their specialist knowledge and meant that teams failed to capitalise on their diversity:

“We all do the same job. I mean there’s an argument for saying that people from different professions might approach it in a slightly different way. I’m not sure about that to be honest ... The way I present in the MDT meeting is reflective of the kind of work that I do day-to-day, and that is generic work. I do very little OT-specific work because I don’t have time to do it really.”(Occupational Therapist, EIS; interview)

They reported that the only remaining difference between the duties of social workers and nurses was that nurses could give depot injections.

Several participants argued that the keyworker model was based on an erroneous implicit assumption that practitioners’ different disciplinary backgrounds would somehow add value even if their distinct skills and knowledge were never explicitly used:

“EIS, unusually, has these OTs in the team, community OTs, and brilliant, brilliant. But what do we actually get from them that’s OT based? I think we fail to do that. Maybe it’s this expectation that it’s going to be in a seeping way. You know, somehow we all come together and without being explicit about it, we’ll all learn from each other. Well, that’s never going to happen unless you’ve got very strong focused individuals with great support outside the team.”(Deputy Manager, interview)

Frustration at the lack of opportunities to use their specialist skills was compounded by resentment at having to perform tasks that were outside their areas of interest and expertise (e.g. social workers having to monitor medication and nurses having to complete Housing Benefit applications). They reported that the skills they had developed through years of training were being eroded through lack of use.

“You find there is a bit of role blurring, so I end up doing things that I think I shouldn’t be doing as a nurse, and I guess maybe that a social worker might feel

that way or a psychologist might feel that way ... I think when we became integrated, mixed with health and social care, a lot of our skills I think got eroded ... it became social services top-heavy and so nurses kind of lost out ... Our clinical expertise became just a small percentage of the work that we do." (Nurse, CMHT 2; interview)

7.3.2 Loss of professional identity

Team members from nursing, social work, and occupational therapy all expressed concerns that working in a generic capacity was leading to a loss of their sense of professional identity:

"I think there is a danger of that disappearing ... the whole social work thing could get a bit lost in the team ... There's a real danger of it getting lost ... You become a care-coordinator and your other title kind of goes a bit." (Social Worker, CMHT 1; interview)

"OTs have struggled to define what their role is in this kind of a team ... is it something that's just an add-on that the health care staff could do, or is it a role in itself? ... In multidisciplinary teams, we've got these disciplines; what are they? How do you define what they are? Very easy in some cases and not so easy in other cases." (Deputy Manager, EIS; interview)

Social workers reported a particular sense of insecurity about their role within teams: *"I personally worry about our future in the organisation as a sort of social work profession, and a social work voice."* (Social Worker, CMHT 3; interview). Despite the fact that social workers have been employed in mental health teams for decades, some believed that they were still seen as outsiders:

"Doctors, psychologists and nurses do seem to band quite happily together. Social workers, I think, have always been seen as the poor relation." (Social Worker, CMHT 1; interview)

"There hasn't been the interest in social work ... I think social workers are seen as quite awkward customers, difficult characters, tend to be a bit stubborn ... There's been talk recently of social workers being pulled out because the local authority targets weren't being met and for me that seems crazy ... It's been a time of sort of a lot of soul searching for social workers anyway, thinking do we have a role in mental health? Maybe we don't." (Social Worker, EIS; interview)

One social worker from CMHT 3 reported that her fellow social workers were increasingly using medical terminology and eschewing social work concepts as a strategy to gain professional recognition in the face of a dominant medical culture. She argued that care was consequently becoming more narrowly focused on medically-defined symptoms at the expense of a more holistic person-centred approach.

A potential solution to the challenge of maintaining one's professional identity and practice was expressed by a member of Mem 1, who explicitly divided his time between his Occupational Therapy role and his keyworker role:

"I have like a hybrid job, so I do 50% of OT and 50% Memory Service Practitioner, which is medication reviews and things like that ... I do it because it is part of my job. It's not my passion, it's not the thing, you know, my training was for, so yeah I think if it wasn't for the OT [referrals] ... I wouldn't be here, I'd probably leave." (Occupational Therapist, Mem 1; interview)

For most interviewees, however, there was little distinction between professional and generic roles; *"You become a generic worker rather than a specifically trained member of staff"* (Nurse, EIS; interview).

7.3.3 Unclear remit of the keyworker role

Patients also perceived their care as generic rather than multidisciplinary, and there was uncertainty among both patients and staff about the duties associated with the keyworker role.

Proponents of multidisciplinary working noted that having multidisciplinary teams made the service easier to navigate for patients, who would otherwise have to undergo multiple assessments with different professionals: *"I think one of the benefits is that service users and their families are not subjected to so many assessment processes"* (Manager, CMHT 2; interview). Yet many patients wanted

more explicit input from different disciplines and did not perceive their care to be multidisciplinary:

"It's probably limited by funding and cuts and there aren't really, like I've never had a CPN [Community Psychiatric Nurse] or a social worker or anything like that. It's just been sort of like a psychologist once a week, whereas I know other people with the same diagnosis have had like CPN's and social workers, and like a little bit of extra support to help them out which I think would be quite helpful." (Patient, CMHT 3; interview)

"You might benefit from someone else's wisdom than seeing the same person doing the same, like it's like robotic. I know what he's going to ask me before he does." (Patient, EIS; interview)

The following patient argued that he needed help with the social consequences of his illness, but that such support seemed to be beyond the remit of his nurse keyworker:

"The things I've asked him to do it seems like it's not the mental health nurse's job to do ... I think for most people it would be like a big thing to get help with their benefits, you know, like filling the forms out for instance. I mean they're daunting at the best of times, so when you're medicated up and you are not in the right frame of mind, I think his job ... should be like checking you're on the right benefits, you're getting the right thing." (Patient, EIS; interview)

The observational data revealed that nurses were also at times uncertain as to whether helping with social service applications was part of their job:

Nurse: I've got a nice big DLA [Disability Living Allowance] form that the mother dumped on me three weeks ago and her expectation is that I do that. She keeps saying 'You don't do anything' ... So I don't know, I mean, should I be filling it in or?

Psychiatrist: Well I think we said that we or [legal advice charity] would do it (EIS; observation)

One team manager commented that nurses faced a "hard learning curve" when they became keyworkers, because they were unaccustomed to dealing with social aspects of mental health: "None of them even knew what a Housing Benefit Form was, and they didn't know about accommodation and stuff like that" (Manager, CMHT 2; interview).

This uncertainty about the remit of the keyworker role, combined with concerns about the underuse of specialist skills, contributed to a sense of disillusionment among both staff and patients about the extent to which teams truly delivered multidisciplinary care.

7.4 Leadership and power

There was also some confusion about leadership roles within the teams, specifically regarding how authority and responsibility were shared between the team manager and the consultant psychiatrist.

One manager described an ongoing “*political battle*” over who should have the power to direct the work of the team, arguing that the role of the manager remains unclear in a context where doctors have traditionally defined the strategic direction of the work:

“What is the relationship between doctors and managers? That’s a constant thing, a struggle, a reflection of mine ... What is the manager’s role? Is it just to be the admin person who produces the minutes and sort of chairs the meeting meekly on behalf of the psychiatrists so they don’t have to? Or is it to say no, this is where we’re going with this team?” (Team Manager; interview)

Consultant psychiatrists and managers were both seen as having veto privileges when there was disagreement or multiple options (“*Where the team is struggling to make a decision, then it will be left to the senior consultant or the manager,*” *Manager, CMHT 1; interview*), but it was unclear who had the final say. Participants, including managers and consultants themselves, expressed conflicting views as to where legal responsibility for MDT decisions lay.

“Ultimately the team consultant is responsible” (Nurse, CMHT 2; interview)

“It would be Jack as the CMHT manager legally more than me as the consultant” (Psychiatrist, CMHT 1; interview)

Several psychiatrists acknowledged this ambiguity, attributing it to a gradual political shift that has moved power and responsibility from doctors to managers:

"I mean I think the whole sort of medical role has become somewhat ambiguous ... I do sometimes worry just that it's all a bit fuzzy and that sometimes I don't feel very clear where my responsibilities end for people whom I may not have seen but who have been discussed with me in team meetings. So I think there's sort of a considerable grey area." (Psychiatrist, EIS; interview)

Despite this apparent shift in power, consultants were still considered to hold a "pivotal position" and the degree to which they adopted a positive leadership role was seen as having substantial consequences for the rest of the team. In most teams, the consultant was considered an excellent source of expertise and support: "the team consultant is fantastic" (Nurse, CMHT 2; interview). In CMHT 3 however, several participants described the consultant as remote and lacking in commitment and reported that this had a negative impact on decision-making, team morale and staff retention:

"The consultant in this team doesn't seem to take up much authority in those meetings and I sort of sometimes feel that his contributions are certainly superficial, they're not necessarily engaging with the detail of what's going on. I find that quite frustrating ... [he] doesn't seem very engaged, I mean that's quite, this is quite damning, nor is he confident or generous enough to give away his authority ... Sort of serving his time is the sort of slight sense." (Social Worker, CMHT 3; interview)

The consultant's failure to fulfil the expected leadership role was seen as increasing the burden on other senior staff members, giving rise to a sense of instability and insecurity.

"The consultants we've had have not been team players, have not been leaders ... It's been difficult ... It's like you've had a leg of the table missing at CMHT 3 and everyone else has had to step in and compensate ... [He's] a nice guy but ... he doesn't consider himself a member of the team, doesn't want to sit with the team, doesn't like to come to the team meeting, has to be asked to come to the team meeting. Doesn't want to take responsibility for decisions." (Psychologist, CMHT 3; interview)

There appeared to be substantial variation in how consultants interpreted their roles, even among those that were highly-respected by their colleagues. One manifestation of this was the degree of assertiveness they adopted in team meetings. For example, one consultant described his approach as first allowing team members to “ventilate,” and then helping them to reach their own conclusions:

“Facilitating the individual professional really to make any decisions that they’re capable of basically. So, the process might be that the individual is almost sort of ventilating as it were, saying what they want to say about the patient, and then hopefully one is just assisting them to sort of clarify what the issues are and then to discover their own answers to them.” (Psychiatrist, CMHT 1; interview)

In contrast, another consultant saw his role as steering the team to make decisions quickly and concisely:

“It’s having the ability I suppose from hearing ... a presentation, being able to quickly identify the gaps, questions that haven’t been asked and so on ... being able to help the team reach a decision fairly quickly without it dragging on ... being able to reach decisions and to be clear and not sort of dither and waiver and being sure is a containing thing in itself.” (Psychiatrist, CMHT 2; interview)

Though most consultants were held in high esteem by their colleagues, there was some discomfort among other participants about their *de facto* status as team leader. Where participants described the characteristics of good leaders, the features they raised were not specific to any particular professional discipline. Good leaders were characterised as being:

- easily accessible for advice;
- willing to engage in team discussions;
- willing to make decisions and settle disagreements;
- capable of “holding” or “containing” the anxiety of other team members.

Some questioned the legitimacy of automatically granting doctors a commanding role over other professional groups and of privileging their specialist knowledge over that of others. This related to a broader theme of differences in the status and power of the different professional groups.

7.5 Status and hierarchy

Differences in social status between the professions were widely acknowledged by participants, but there were varied views about the extent to which they were problematic. Some team members felt that everyone had a fair say and was granted respect regardless of their professional background:

“I definitely think there’s a hierarchy ... [but] even though there is hierarchy, because people respect each other, I think we can agree to disagree.” (Psychologist, Mem 1; interview)

“I think all the opinions are valid and I think it’s helpful to have that ... I’ve never had a sense of being inhibited in any way.” (Occupational Therapist, EIS; interview)

Several commented that they felt community teams tended to be more professionally inclusive than hospital-based teams.

Others felt that, in keeping with “*traditional medical hierarchies*”, doctors had a disproportionate amount of power which limited the potential for patients to benefit from the expertise of other professional groups:

“In terms of some archetypes, some things were being played out [in the meeting] which were quite classically what you might expect ... doctors not liking other professionals second guessing them, or sort of, disagreeing with them, or suggesting that something was different.” (Social Worker, CMHT 3; interview)

The perception that doctors were granted special privileges and a disproportionate degree of influence fostered resentment among other team members:

"[Psychiatrists] have a traditional power. They get paid much, much more than anyone else and they're often called the clinical lead, but they're not, they're kind of informally the clinical lead ... There needs to be an MDT approach across the organisation ... Well, you know, it's never going to change so I don't know why I keep battling it. It might change a little bit, but those are sort of long traditions of power ... strange differences in power, the unexplained differences in the hierarchy, unwarranted maybe." (Manager; interview)

When interviewees were asked what happens when people disagree in meetings, their responses suggested that professional affiliation played a substantial role, above and beyond the merits of the arguments being put forward:

"It depends on who is disagreeing, doesn't it? It depends on the hierarchies and the powers ... the usual, you know, managers and psychiatrists win generally." (Social Worker, EIS; interview)

"It very much depends on who disagrees ... It depends where you are in the hierarchy. What generally happens is that arguments are paid lip service to and overruled." (Assistant Psychologist, Mem 1; interview)

In this sense, the social hierarchy had a tangible impact on the decisions made in team meetings and consequently on the care patients ultimately received. Both staff and patients expressed concerns about an over-reliance on medication in care planning, which may, in part, reflect the apparent priority given to the medical perspective:

"Sometimes I think that some of our core service users are like guinea pigs. They've been on maybe, I don't know, half a dozen anti-depressant meds, five anti-psychotic meds and I just think, if that was me, would I want to do that? I wouldn't." (CMHT 2; interview)

Patients expressed frustration at what they saw as an over-emphasis on medication at the expense of other forms of care such as counselling:

"If you have a problem, it's a tablet, that's the answer ... They want to just up more and more medication ... I don't need more medication, I need help to deal

with my psychological issues ... All I hear is, 'You're not taking enough medication, if you take more medication it will stop you being scared' ... but I don't agree with that." (Patient, Mem 2; interview)

"I think they're happy drugging people up and thinking that's the best thing for them. You just medicate, they think that's the answer ... I think I could have done with counselling, someone talking to you on the level, rather than someone like just telling you 'Oh just take the drugs or we're going to get a team up here with security guards to hold you down and force it on you.'" (Patient, EIS; interview)

Though it was very rare for other team members to overtly challenge the doctors, these concerns occasionally surfaced in team meetings:

StR: *The plan was ... to increase the Risperidone ...*

Social Worker: *Well, to tell you the truth, I've had enough of this increase. It's been ongoing since January, increase, increase, and the psychosis doesn't seem to be going anywhere (CMHT 2; observation)*

Many of the doctors also saw medical dominance as a problem. They reported that the professional hierarchy sometimes hindered participation in meetings and that they wished other professionals would contribute more proactively to discussions:

"I think sometimes they should disagree more ... When I say something, they all accept it, when I think it would be more helpful to hear their opinion." (Psychiatrist, Mem 2; interview)

"One of the potential drawbacks, which I try to keep aware of, is that if you, you know, provide leadership, containment and direction ... people end up passively sort of receiving that and not giving views and giving back." (Psychiatrist, CMHT 2; interview)

Several reported that they sometimes found themselves being more directive than they would like, particularly when under time-pressure: *"Depending on how busy I am, the more medically-led [the meetings] become"* (Psychiatrist, Mem 1; interview). There were occasions in the observed meetings where consultant

psychiatrists explicitly sought other people's opinions, but this was relatively infrequent:

Psychiatrist: I'd really value people's ideas on this chap (Mem 1; observation)

Psychiatrist: I wanted to get the team's view on it, what do you think? (CMHT 2; observation)

Psychiatrist: I hope I did the right thing by discharging him. Anyone got any thoughts on whether we should be doing more for him perhaps? (CMHT 1; observation)

The only team where none of the interviewees considered medical dominance to be a problem was CMHT 1. On the contrary, this team occasionally made good-natured jokes about the stereotype of the domineering doctor:

Social Worker 1: The mum started talking about, 'No I'm not listening to what you're saying. My God has just told me that he is well'

Psychiatrist: But the consultant is above God, no? [laughter]

Social Worker 2: Is that a delusion you have?

Manager: I think so. Here's my Section papers (CMHT 1; observation)

Participants in this team attributed their flat social structure to the fact that their consultant psychiatrist had been with the team since he was a trainee, and they considered him particularly progressive: "We were just really fortunate ... He's more forward-thinking and willing, I think, to relinquish some of that old medical model" (Social Worker, CMHT 1; interview).

The idea that medical professionals held more power and status than their colleagues from other disciplines was reflected in their pay, their dominance in team discussions, and possibly in the privileging of medication over other forms of care. However, status was not the only factor which influenced levels of participation. The next section describes a number of other factors that influenced the degree to which team members engaged in team discussions.

7.6 Participation and inclusivity

Team meetings can only result in multidisciplinary collaboration if members of the different professional groups actively participate in discussions. Interviewees reported that having the confidence to speak freely was a crucial factor in the productivity of their team meetings. Most described an inclusive atmosphere and reported feeling safe and comfortable in voicing their opinions and asking questions. Though case discussions were usually dominated by that patient's keyworker, the manager and a psychiatrist, there were frequent examples of wider team discussions involving a range of disciplines:

Social Worker: Is he someone who would benefit from talking?
StR: Well, he developed delusions about the last therapist
Social Worker: It's difficult. You don't want to rule him out of the system
StR: He has no insight
Social Worker: Does he like music?
Nurse: He has no obvious interests at the moment
Social Worker: What about something like an OT assessment? We do get people to engage in practical things despite being psychotic ...
StR: I wasn't sure we should take him on
Nurse: I don't think we should preclude him. I mean he needs help. He needs assistance and he would benefit from it. He certainly needs housing (EIS; observation)

However, it was clear from the observational data that individuals varied widely in how much they contributed to discussions, and interviewees revealed several factors that shaped the degree of participation.

There was evidence that some team members didn't see it as part of their role to comment on other people's patients: *"We are talking about people that I haven't got a clue what they look like, who they are, you know? I just felt most of the time, these aren't my patients"* (Nurse, CMHT 3; interview). This resonates with the finding reported in Chapter 5 that participants had different understandings of the purpose of the meeting. It appeared that some saw the meeting as a forum for

individual care coordinators to report to and consult more senior clinicians, rather than for the team to plan patient care collectively.

Others felt that discussing their work in detail with the team undermined their professional autonomy and wasted time. They argued that they had sufficient training and experience to make decisions on their own: *"I'm not presenting no case because I already decided what I'm going to do ... It is my professional registration on the line ... If I wasn't clear, if I think there is a risk, then I would reserve judgement."* (Nurse, CMHT 2; interview)

It was also considered difficult to convey a particular professional perspective when one was vastly outnumbered by colleagues from other professional groups: *"Doing it on your own is very hard. I think MDTs don't work where you've got overwhelming numbers of one set of professionals and just one of another"* (Social Worker, EIS; interview).

Finally, several senior team members commented that they thought some colleagues lacked the confidence to contribute spontaneously, highlighting how presenting their work can make people feel *"vulnerable"* and *"exposed"* because others might point out weaknesses or gaps in their assessments.

7.7 Summary and discussion

This chapter has explored staff views of multidisciplinary working and professional roles. The findings highlight a number of challenges to collaborative teamwork which appear to hinder the potential for teams to provide holistic multidisciplinary care. These include a lack of role clarity, ambiguous leadership, inter-professional tensions and barriers to participation in meetings.

Not all participants were convinced of the value of multidisciplinary working, with some reporting that the different professional perspectives were

occasionally incompatible rather than complementary, particularly in relation to patient coercion.

A prevailing concern was that teams failed to capitalise on their diversity due to the generic keyworker model. Keyworkers reported that they almost exclusively performed generic tasks and both practitioners and patients expressed confusion as to the remit of the keyworker role. Generic working also led to frustration among staff, who felt that it led to the erosion of their specialist skills and sense of professional identity.

The findings suggest a need for clearer demarcation between generic and specialist aspects of the work so that teams can make optimal use of their diverse skills to deliver truly multidisciplinary care. In the words of Ovretveit,²⁸³ "A multidisciplinary team without differences is a contradiction in terms" (p.41). It appears that many of the concerns about "creeping genericism"¹⁰⁸ and role blurring first expressed 15 to 20 years ago (see section 1.4) have not yet been fully resolved.^{46, 108, 284}

Managers and consultant psychiatrists also faced some role ambiguity. Both were seen by others as holding important leadership positions, but there was confusion as to how these roles related to each other and who had ultimate responsibility for team decisions. When team managers were first introduced in the 1990s, several authors described reluctance among consultants to relinquish managerial control, and confusion among managers about how to steer the team without having authority over all team members.^{153, 285} While overt conflict was rarely observed in this study, there was evidence that this underlying confusion regarding the division of labour between consultants and managers remains problematic. Previous research has found that a lack of role clarity^{2, 147} and unclear leadership^{6, 89, 101} can both be highly detrimental to team performance, suggesting that the relationship between managers and consultants warrants clarification.

The majority of interviewees reported that there was a respectful atmosphere in meetings and that they felt comfortable voicing their opinions. However, they also reported that psychiatrists' views were sometimes given disproportionate weight, and questioned their *de facto* status as "*clinical leads*", arguing that this reflected an outdated hierarchical culture rather than legitimately earned authority. Conversely, doctors sometimes found it frustrating that others did not engage more fully in discussions. Similar concerns about medical dominance have long been discussed in the mental health literature,^{286, 287} and other studies have reported concerns that MDT discussions are sometimes overly focused on medication at the expense of other issues.^{101, 154}

Providing genuinely multidisciplinary care depends on effective communication between team members. In theory, the generic keyworker model means that one team member serves as a gateway to the expertise of the other team members. However, this assumes that keyworkers are willing and able to seek out the expertise of their colleagues as required. For some team members, participation in discussions was limited by a fear of criticism and the sense that it was not their role to comment on other people's patients. Where practitioners feel unable or unwilling to contribute their expertise unless directly involved in a case, the whole basis for MDT meetings may be undermined. This highlights the importance of clarifying what is expected of the different team members and of fostering an open and supportive atmosphere. Where team meetings are not considered a safe environment in which to disclose uncertainty and risk, team members may withhold important information, with potentially serious consequences for patients.¹⁵³

7.8 Conclusions

A team's capacity to provide multidisciplinary care depends on team members making use of both their own specialist skills and those of others. Yet a number

of factors threaten to undermine the potential for productive multidisciplinary collaboration, including conflicting models of care, generic roles, ambiguous leadership, and power struggles. The findings suggest a need for improved role clarity with respect to both leadership and generic working.

The first three global themes (Chapters 5, 6 and 7) have largely focused on staff views of MDT working. The next theme shifts the focus to the perspectives of patients and carers, exploring their views of MDTs and care planning.

8 Theme IV. Patient involvement in multidisciplinary care planning

8.1 Chapter overview

This chapter examines patient involvement in multidisciplinary care planning. It first explores patient views of multidisciplinary team meetings, showing that most patients were unaware of the meetings and that some had concerns about how they would be portrayed by their keyworkers. It then discusses the degree to which patients are involved in care planning more broadly, revealing mixed views among both staff and patients about whether patient preferences are given adequate consideration. Finally, it describes how some patients were reluctant to make requests or voice concerns about their care and illuminates a number of factors that limit their sense of agency and involvement. Participants made practical suggestions for improving patient involvement and service transparency, such as introducing patients to all team members and providing feedback after MDT meetings.

The findings reported in this chapter address the following research objectives:

- iv. to explore patient views on MDT meetings and multidisciplinary care planning;
- v. to identify factors that impact on the potential for patients to benefit from MDT meetings and multidisciplinary care planning.

Figure 8.1 illustrates the subthemes and issues discussed in this chapter.

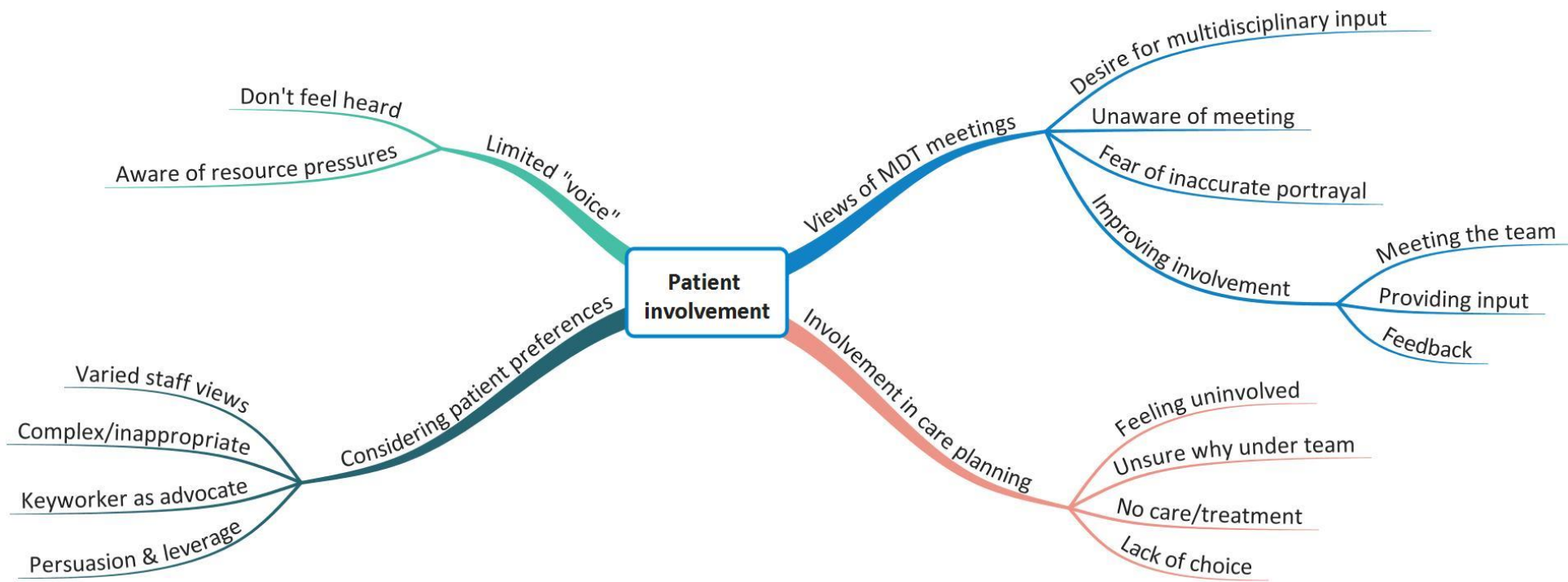


Figure 8.1 Patient involvement: organising themes and subthemes

8.2 Lack of patient involvement in MDT meetings

Almost all of the patients and carers interviewed were unaware of the team meetings and had little knowledge of how the teams operated. They were surprised to learn that their care was being discussed with a team and wanted to learn more about who was part of the team and what their roles were:

“There isn’t information about what the set-up is, what happens behind the scenes ... I have no idea who I’m discussed with. I’d quite like to know ... and have some kind of sense of who they are, what their roles are, if they’re people that I can contact if I ever needed to ... I just assumed that psychologist would have supervision with one supervisor ... it didn’t occur to me there might be a whole team discussion somewhere.” (Patient, CMHT 3; interview)

The only exception was a patient from Mem 2: *“My understanding is it’s a team. They report back to the team and they make the decision from there” (Patient, Mem 2; interview).*

Some patients were uncomfortable with the idea that intimate aspects of their lives were being discussed by a room full of *“invisible”* strangers without their knowledge. A particular concern was that their keyworkers would not convey them accurately to the rest of the team. They noted that patients did not always have a good rapport with their keyworkers, and worried that they would be misrepresented in meetings:

“You’ve got the nurse who you’re seeing discussing you with strangers ... [They’re] hearing it from just one person. You might not get on well with that certain particular person and then they’re going to portray you across to the rest of the team as you might come across to them ... It’s second-hand information based on his assumptions of you.” (Patient, EIS; interview)

They also had experience of their keyworkers being forgetful and making factual errors, which made them wary of how their case would be presented to other members of the team: *“I’m concerned as to what’s being fed back ... I personally wouldn’t trust an individual, after my experiences, to represent me on their*

own. I would have to know that what's being said is the truth." (Patient, Mem 2; interview)

The lack of confidence some patients had in their keyworkers was compounded by a perceived lack of transparency: *"I think they want you to know as little about them as possible" (Patient, CMHT 3; interview).*

Though some rejected the idea of MDT meetings completely (*"I just think it should be personal and private between you and the physician;" Patient, Mem 2; interview*), others offered suggestions for making the meetings more inclusive for patients. Both patients and carers said they would like to attend the meetings, but they acknowledged that this might be too disruptive:

"I would love to attend the meeting but I could see that it's probably very inhibiting for them ... The thing is, when you go to a meeting like that, you actually hear the truth, as opposed to the edited truth being told to that patient and their partner. On the other hand, it might inhibit the meeting to a point where they felt they couldn't do it properly. Because they might say, 'He's married to that old bat who's always interfering' ... I imagine they would much rather not have the patient involved there, I can see that." (Carer, Mem 1; interview)

Given that practitioners often used meetings to discuss the emotional burden of the work and to reflect on their therapeutic relationships (Chapter 5), the nature and content of discussions would be likely to change substantially if patients were to attend. Team meetings often involved dark humour, which staff said helped them to cope with the seriousness of their work on a day-to-day basis. One social worker commented that she felt that having this private forum was essential in enabling staff to do their jobs well:

"I think it is important for professionals to have a venue to, as I've said, vent or moan ... I wouldn't want a service user to be present when I was, when those types of discussions were going on ... I think service user involvement is of course essential, but I do believe that there has to be a space which is not available to everybody and actually just available for the staff to do their jobs efficiently and properly." (Social Worker, CMHT 1; interview)

Nonetheless, patients and carers argued that “some sort of compromise” could be reached to grant patients greater involvement in the meetings, even if this did not mean attending. They believed that patients should be informed about the meetings and have the opportunity to provide their opinions and pose questions in advance. They also felt that they should receive explicit feedback afterwards on what had been discussed: “A phone call before and after would suit me fine but I would like to know the options considered” (Carer, Mem 1; interview).

One patient suggested that he would be more comfortable about his care being discussed if he had at least met the different team members once:

“I think if they’re going to discuss you in a team meeting you should come in and meet the team ... They might all not like you but at least they have seen you for themselves and seen what kind of a person you are.” (Patient, EIS; interview)

8.3 Lack of patient involvement in general care planning

The fact that patients were unaware that they were being discussed in MDT meetings appeared to be symptomatic of a broader problem; patients and carers generally felt uninvolved in how their care was planned. Several patients reported that they were not sure why they were being seen by the team and believed that they were not receiving any care:

“I haven’t had any care really. All I do is come along and see people and then they write me a letter to suggest that I come again ... We just sort of feel a bit in limbo ... We’re quite happy to come along here but it does, you do sort of reach the point where you think to yourself, ‘Are we wasting our time going along?’” (Patient, Mem 2; interview)

Several patients explained that they attended appointments because they had been asked to, rather than because they found them a valuable use of their time:

“I come here because he gives me appointments. To be quite, what I gain out of it, I don’t see any benefit from it ... I don’t know what the purpose of it is ... I don’t know like what I should be getting from this and what they should be

giving or offering ... I think it's a waste of time coming here to be honest ... I don't think I've got a care package, as in any help with like housing, you know things like that, anything basically, helping with my benefits. They just basically ask you, 'Are you okay? Are you taking the medication?' ... I'm out of here normally within five minutes ... I just feel like I'm an entry in the diary and once I've been in, it's ticked off." (Patient, EIS; interview)

Even where patients were receiving a clearly defined treatment (e.g. medication or weekly psychotherapy) they often felt uninvolved in the decisions leading up to it:

"I think until they actually got a piece of paper saying that patients must see their care plan, like I only saw my care plan for the first time maybe a month ago ... I had a sense that I was supposed to have seen the care plan but I never had ... so I don't think I really had any involvement in writing my care plan or what went down on it." (Patient, CMHT 3; interview)

Patients emphasised that they were happy with how they were treated on a personal level by individual team members, but reported that they hadn't been offered any choices regarding their care:

"It's so mixed up ... I know that I'm extremely lucky to have weekly therapy and to have had it like quite long term like I have. And it's been like, like I do get on with my psychologist. I like her. I think she's really good at what she does. So like its positive in that sense, but I don't feel like I ever had any choice. I was just like, I wasn't given any treatment choices or any choices of people to work with or anything. It was just luck. And it feels like a lot of this is down to luck, like you're either lucky and you get someone good or you're unlucky and you don't." (Patient, CMHT 3; interview)

"I feel like we know nothing about it [the medication]. Totally ignorant. All we've been told is that it's a good thing. You can't question it ... We weren't offered any choices. You could either have it or not have it, that's it." (Carer, Mem 1; interview)

Though treatment options were often restricted due to a shortage of resources (discussed further in Chapter 9), there were also times where options raised during MDT meetings were not offered to patients because their keyworker assumed that they would refuse them. For example, it was common for keyworkers to respond to ideas suggested by their colleague with statements

such as, *“No, he wouldn’t go for that” (Nurse, EIS; observation)*. Such assumptions may often have been accurate, informed by the keyworker’s longstanding personal knowledge of the patients. However, by bypassing the opportunity to offer a choice, such assumptions deprive patients of a chance to change their position and deny them an opportunity to establish a sense of control over their care.

8.4 Considering the patient’s perspective in MDT meetings

Many keyworkers saw themselves as the patient’s representative and advocate in the meeting (though evidently they did not all discuss this with their patients). They reported that they aimed to convey the patients’ perspective to the rest of the team: *“You should, sort of, represent the patients and their preferences” (Nurse, CMHT 3; interview)*.

Some reported that patient preferences were discussed as a matter of course: *“We always ask ... the person who has presented, ‘What does the client want? ... What do they expect from coming here? ... A lot hinges on that ... That’s a basic thing you should be checking” (Nurse, CMHT 3; interview)*. However, the quantitative data revealed that patient or carer preferences were only mentioned in 29% of patient discussions overall. This varied significantly between teams, ranging from 23% of discussions in CMHT 1 to 37.4% of discussions in Mem 2 (Table 8.1); χ^2 (df=5, n=3213) 22.75, $p < .001$. To some extent, this reflects differences in the depth of discussion across teams, with Mem 2 discussing only three patients per hour while CMHT 1 discussed 13 (Chapter 6).

Table 8.1 Proportion of case discussions where patient or carer preferences were mentioned

Team	No. of case discussions*	% of discussions where patient or carer preferences were mentioned
CMHT 1	437	23.1
CMHT 2	764	25.1
CMHT 3	290	33.1
EIS	1132	31.3
MEM 1	483	31.1
MEM 2	107	37.4
Total	3213	29.0

*A *case discussion* is defined as a discussion relating to a particular patient at a particular MDT meeting on a given date.

Many staff members believed that patient preferences were not given due consideration, and argued that they should be discussed more routinely and given greater priority:

“We do talk about patient preference sometimes, but it quite often feels like lip service is being paid to it ... It is part of the standard assessment [form] and quite often it is not even filled in.” (Assistant Psychologist, Mem 1; interview)

“Patients’ preferences aren’t systematically sort of brought into decision-making enough.” (Social Worker, CMHT 3; interview)

Two psychiatrists said that mental health services generally lagged behind physical health services in terms of giving patients choices. They cited the fact that, unlike people with physical health problems, those with mental health problems were not given options about which service or hospital they would like to attend: *“I think mental health is going to be one of the last services to really apply any decent choice agenda ... and it’s not fair on our patients” (Psychiatrist, CMHT 1; interview)*^{ix}.

^{ix} As part of a broader drive for parity of esteem between mental and physical health services, the government has recently introduced legislation granting patients the right to choose their mental health care provider and team.²⁹¹

Several practitioners argued that patients were the ultimate decision-makers because they were free to decline any treatment offered to them, excluding the minority of patients who were being treated on an involuntary basis. However the reality appeared to be somewhat more complex. As described in the following section, staff sometimes employed informal strategies such as bargaining and leverage to pressure patients to comply with treatment, even when there was no legal compulsion in place.

8.4.1 Complexity in incorporating patients' perspectives

What patients wanted often differed from what staff perceived to be in their best interests: *"It's the classic debate between needs and wants"* (Manager, EIS; interview). Consequently, many MDT discussions concerned the validity of patients' preferences regarding whether or not they should receive treatment and the kind of treatment they should receive. For example, it was common for patients not to want any involvement with mental health services, particularly in the CMHTs and EIS: *"She has absolutely no desire to see services ... zero motivation to work with us"* (Nurse, CMHT 2; observation). Sometimes this wish was respected and the patient was simply discharged. Often, however, practitioners believed there were risks to the patient or to others that they should not ignore (see Section 5.4.3 on challenging cases). While it was relatively rare to instigate formal proceedings enforcing treatment (e.g. CTOs and Mental Health Act Assessments), practitioners often discussed more subtle strategies to ensure compliance. They used meetings to share ideas on how to persuade, negotiate with or even threaten patients who did not want to attend appointments or take medication:

"It's a delicate balance with her ... When she gets stressed she just wants to go [to hospital], so we can't threaten her with hospital. You can threaten her a bit with her conditions of her stay there and so on." (Psychiatrist, CMHT 2; observation)

"We could write to her and say, 'If you don't turn up, I'm not sure you're fit to work as a nurse'." (StR, EIS; observation)

These quotes demonstrate a grey area between voluntary and involuntary treatment, showing that it can be difficult or impossible for patients to opt out of treatment even when they are not under any legal obligation to comply.

The use of informal strategies to manipulate or "push" patients to comply with treatment was often discussed as a way of diverting official involuntary treatment proceedings, which were considered a last resort. However, as a result, patients sometimes felt they were being coerced even where there were no legal orders in place. For example, the following patient (who was not on a CTO) expressed that the only reason he attended his appointments was that he was afraid that he would be *"dragged down by the police to the hospital [again]"*.

"I'm only coming here for the simple fact that if I ever have any problems in the future ... my worker can say 'Yeah, he came to all the meetings.' That's the only reason I'm coming to be honest. Because other than that I don't see any benefit in coming here ... I haven't took the meds for weeks and I've been alright ... but I haven't told [keyworker] that, because I think he might say, 'Oh you better go back to the hospital then.' I just don't trust him anymore to be honest." (Patient, interview)

Usually, where patient preferences were mentioned, it was in the context of tensions arising from practitioners trying to impose a treatment that the patient didn't want. Occasionally, however, tensions arose from a patient wanting something that the team was not willing to provide. For example, teams sometimes discussed withholding services that patients desired when they were not convinced it would be a good use of resources:

Social Worker: He wanted a blitz clean because his flat is actually waist-high in beer cans ... I've checked with the boss, and the boss says 'the computer says no' ...

Psychologist: What's he after, Ben?

- StR: *Permanent care. He says he can't cope by himself. I think he wants to live in supported accommodation*
- Social Worker: *And then he'll change his mind you see ...*
- Psychologist: *He can't really use the support can he? That's the thing (CMHT 3; observation)*

Navigating patients' "needs" and "wants" was complicated by the perception that some patients "*just don't have a straight-forward desire to get well and progress*" (Psychiatrist, CMHT 1; interview).

- Social Worker: *She is quite a well-known saboteur ... Whether she'll accept this ongoing support or not, or whether she'll try and scupper it again, another work in progress (CMHT 3; observation)*

There were several discussions about patients who wanted to maintain their hallucinations because they enjoyed them or found them helpful in their creative endeavours. This raised difficult questions about the ethics of "allowing" patients to remain untreated where they were not causing obvious harm, an issue that sometimes provoked disagreement among practitioners (see Section 7.2 on different models of care).

Staff also faced a dilemma when patients expressed preferences that appeared to be based on prejudiced views, for example, preferences regarding the gender, race or sexuality of their care providers. One patient interviewee expressed that he wasn't comfortable taking instructions from a woman:

"I've had a lot of women in my time and I've been very naughty, but, I find that they irritate me. Perhaps it's because my wife took me back to court too many times ... so therefore ... I wouldn't like a woman nurse to come in here and start dictating to me. I would feel that a man I could cope with, a woman, I couldn't." (Patient, Mem 1; interview)

Team members used meetings to discuss how to balance their desire to respect patients' preferences with the risk of reinforcing damaging prejudices:

"Sometimes there are the kind of difficult ones like, 'I don't want a black worker' ... 'I don't want a man giving me a depot', 'I don't want a Japanese woman giving me a depot' ... Obviously there are really difficult things around

sexual orientation, 'I don't want him to give it', that kind of thing. So I think we talk about it in a team and we try and separate, we try and look at what's underneath it, is it just racism? You know we try and think about that and not just hold a really rigid line, but that's tricky, obviously." (Psychologist, CMHT 3; interview)

Given the complexities described above, it was often deemed justifiable to reject patients' choices or to restrict their freedom through formal or informal strategies.

One psychiatrist emphasised that, even if they were being treated involuntarily, it was possible to offer patients choice about some aspects of their care. He believed this wasn't given enough consideration:

"If they're being treated under the Mental Health Act, it can be a struggle for everybody in the service to remember that that doesn't necessarily mean that they can't have a choice about anything. One can still offer them a choice of different treatments for instance, or, you know, times of appointment." (Psychiatrist, CMHT 1; interview)

Some participants noted that part of the reason patient preferences were not always prioritised was that patients were often unforthcoming or unassertive about what their preferences were.

8.5 Limited patient "voice"

A patient's preferences can only be considered in MDT care planning if they are made known to the team. Despite their clear dissatisfaction with aspects of their care, there was evidence that patients were reluctant to voice these concerns to their keyworkers.

Some felt that they had not been listened to and had been labelled as *"difficult," "awkward"* or *"non-compliant"* when they had raised issues or concerns in the past:

"When I've tried to raise stuff ... it's like you're seen as being, 'Oh that's just part of your condition that you want more services,' or 'You're being difficult' ... so now I just don't raise it because I just feel like I don't want them to think that I'm asking for too much." (Patient, CMHT 3; interview)

Several commented that they were aware of the resource pressures within mental health services and didn't want cause a further burden on staff:

"I don't like getting involved and I don't want to trouble them ... I suppose I feel a bit guilty at times about having to use them quite a lot ... It's making me feel really quite guilty ... It's really slightly, I say slightly embarrassing only because you know it causes trouble in a way." (Patient, Mem 1; interview)

One participant suggested that part of the reason mental health services were under-resourced was that patients internalised the stigma associated with their illness and lacked the confidence to demand high quality care:

"Unfortunately, some of our patients have lower expectations than we do about these things ... They can be unassertive ... They sometimes have a low expectation about what service they would get from services. They sometimes share societies stigmatisation of the disorder so they're not about to stand up and say, 'I've got schizophrenia and I want to be treated in the best schizophrenia service.' They can be very downtrodden and accepting of poor services. Maybe our services would be better funded if they complained more." (Psychiatrist, CMHT 1; interview)

A range of factors therefore made some patients reluctant to make requests or place demands upon staff. Consequently, it was unlikely that their preferences would be considered in MDT meetings unless their keyworkers deliberately and explicitly sought them out.

8.6 Summary and discussion

Patient involvement in care planning and service design is widely considered to improve the accessibility, acceptability and quality of services, and is strongly endorsed in government policy.^{76, 288-291} However, no previous studies have

investigated patient views of MDT meetings, a central forum for planning care. This chapter has explored patient and carer views of MDT care planning and examined the degree to which patient preferences were incorporated into team discussions.

The 2011 cross-government strategy *No Health Without Mental Health*⁷⁸ states that services must ensure “that people with mental health problems are able to plan their own route to recovery, supported by professional staff” (p.16). More recent policy documents have emphasised that patients should have choice and control over the services they receive,^{76, 291} and have highlighted the importance of openness, transparency and candour in practitioner-patient interactions.²⁹² Yet, all but one of the patients interviewed in this study were unaware that their care was being discussed in an MDT meeting, and many believed that there was a need for greater transparency about how their care was managed “*behind the scenes*”.

The findings indicate a failure of communication, whereby patients want more input from different professional groups (Section 7.3.3), but they are not made aware that their care is reviewed by multiple professionals in MDT meetings. It may be that staff are reluctant to inform patients about MDT meetings due to concerns that it would generate feelings of suspicion and lead to disengagement. Yet there was evidence that a lack of openness exacerbated feelings of mistrust and resentment. This suggests that there is a need to provide patients with a clearer explanation of the multidisciplinary expertise available to them, and to involve them more actively in MDT care planning. A growing body of research suggests that patient satisfaction and quality of communication are improved when a patient knows the different members of

their treating team^{x, 293, 294} One possible means of improving patients' familiarity with team members is to provide them with a leaflet that clearly introduces the team members, outlines their roles, and explains how they all work together. Appendix 16 presents an example of such a leaflet from an EIS team in the USA (the *Specialized Treatment Early in Psychosis* team at the Connecticut Mental Health Centre/Yale School of Medicine).^{xi} This team also invites patients and carers to an annual *Open House* event at which they give a presentation explaining the service and answering frequently asked questions (see Appendix 17 for sample slides). They personally introduce each team member and provide refreshments and food in order to create a welcoming and friendly atmosphere (J. Pollard, STEP Programme Clinical Director; personal communication, April 13, 2015).

Another source of dissatisfaction among the patients interviewed was that they felt they had not been offered any choices in relation to their care. Patient preferences were mentioned in only one third of MDT case discussions and many staff reported that they were considered only superficially. There was evidence that some patients felt under duress to comply with the team's requests even when they were not under any legal obligation to, and some felt that their contact was more about being monitored for compliance than about receiving care. It was not uncommon in meetings for teams to consider "threatening" patients with hospitalisation, regardless of whether or not they were on CTOs. The use of informal practices such as persuasion and leverage to pressure patients into adhering to treatment raises important ethical issues regarding patient choice and autonomy.^{295, 296} Despite limited evidence for its

^x This is the basis for the "Hello my name is" campaign founded by Kate Granger, a doctor and cancer patient who was struck by how her treating clinicians often failed to introduce themselves, and how this impacted on her experience of care (<http://hellomynameis.org.uk/>).

^{xi} Materials reproduced with permission.

effectiveness,²⁹⁷ there has been a rise in coercive treatment in the UK and other parts of the world.^{298, 299} Increases in involuntary hospitalisation may be linked to the under-resourcing of community services, such that they cannot adequately provide for patients in the community. It may also reflect an increasing organisational concern with managing risk and protection from litigation. Both of these issues are discussed in the next chapter.

The majority of both staff and patients believed that having patients attend MDT meetings would be both undesirable and logistically problematic. This assessment is supported by a small survey of inpatient MDTs in Northern Ireland, which found that 48% of patients who attended MDT meetings found the experience threatening and anxiety provoking.³⁰⁰ Nonetheless, this study has generated several other suggestions for improving care planning, including informing patients that their care is being discussed by a team. Patients would like to know who discusses their care and they would value feedback after their care has been discussed. They would also appreciate having an opportunity to provide some input into MDT discussions. In other contexts (for example, in some cancer and cardiology MDTs), minutes from each team discussion are routinely sent to the patient in question and added to their medical records.¹⁹ While this may require greater administrative support than is currently available to mental health teams, taking the time to provide verbal feedback in person or on the phone may be a worthwhile investment in terms of fostering an open and trusting therapeutic relationship and making the patient feel like part of the team.³⁰¹ Another potential mechanism for improving dialogue between staff and patients might be to have a general patient representative attend meetings. There are several examples in the USA of Peer Specialists and Carer Representatives being employed as permanent members of community mental health MDTs and being actively involved in case reviews.³⁰²⁻³⁰⁴

Despite the growing prominence of the patient choice agenda,^{305, 306} the findings suggest that some patients do not feel empowered to voice their concerns or to

ask questions about their care for fear that they will be labelled as uncooperative or excessively demanding. Recent guidance from the World Psychiatric Association has identified a need for a “system shift” to ensure that the goals of patients and carers are taken seriously and that shared decision-making becomes the norm.⁷ The suggestions provided by patients in this study for increasing patient involvement in care planning may be helpful in opening these lines of communication.

8.7 Conclusions

The findings presented in this chapter suggest that many patients have a limited understanding of MDT processes and that they feel largely uninvolved in multidisciplinary care planning. There appears to be an urgent need to improve how MDT processes are communicated to patients, and for practitioners to become more proficient in eliciting and considering patients’ preferences when planning care. Several suggestions for achieving this have been outlined in this chapter, including introducing patients to the whole team, informing them that they are going to be discussed in team meetings, and providing them with feedback from these discussions. The next chapter moves the analytic focus further outside the team to examine how their work is influenced by external factors such as organisational and political processes.

9 Theme V. External influences on multidisciplinary care planning

9.1 Chapter overview

Multidisciplinary care planning can only benefit patients if teams have the means to implement the ideas generated in team discussions. This final theme explores how a number of external factors shaped both the range of treatment options that teams could consider in MDT meetings, and their ability to deliver them. It first describes how a shortage of resources and personnel sometimes made it impossible for teams to offer the care they believed was most appropriate for a patient. It then reports on the perceived impact of ongoing organisational restructuring, which staff believed had been poorly managed, resulting in low morale and a short-term focus in care planning. Discussions of how to cope with these external factors often pervaded team meetings and overshadowed care planning. The final section describes how externally-imposed managerial targets were perceived by staff to detract from care-provision by imposing an unwarranted administrative burden.

In describing these challenges, the chapter addresses Research Objective v: to identify factors that impact on the potential for patients to benefit from MDT meetings and multidisciplinary care planning. Figure 9.1 provides an overview of the subthemes and issues discussed in the following sections.

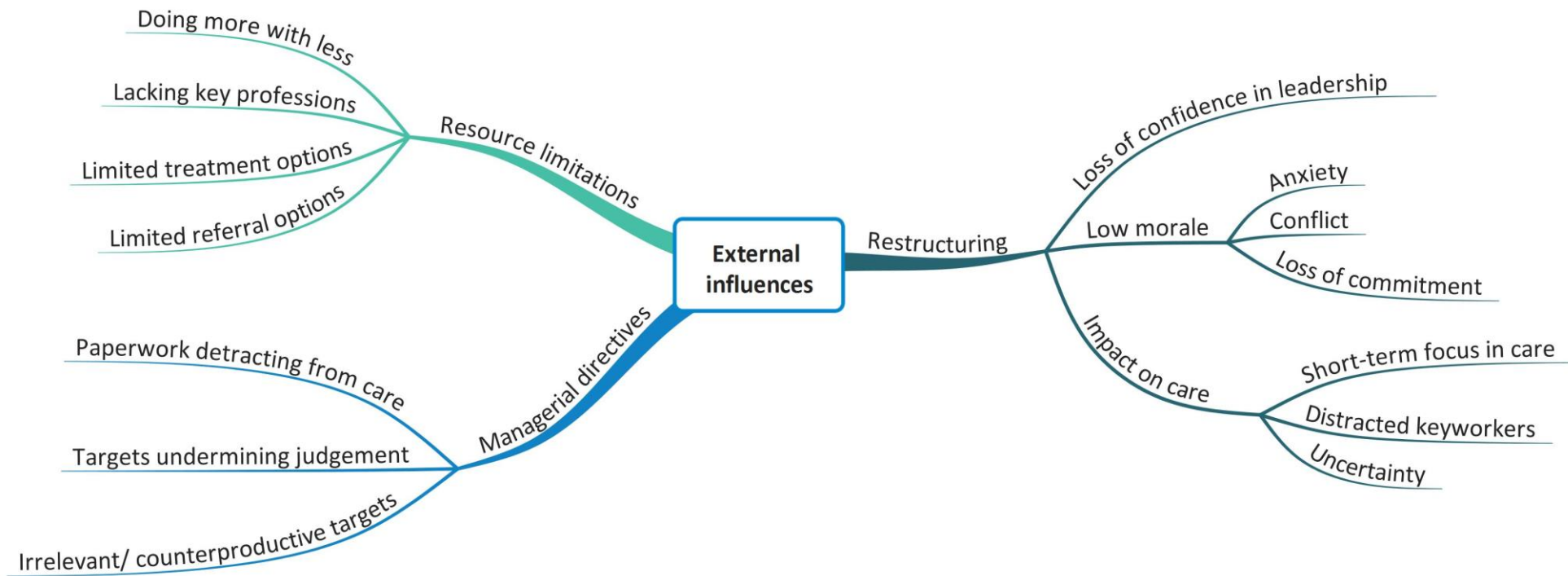


Figure 9.1 External influences: organising themes and subthemes

9.2 Diminishing resources

Team members reported that the range of treatment options they could offer to patients was severely limited by a lack of resources. There was evidence from both the observation and the interviews that they often lacked both the time and the specialist personnel required to offer the care they believed would most benefit their patients. Many of the observed teams had become less multidisciplinary over time, with the loss of key professional groups such as occupational therapists and psychologists.

Psychiatrist: If we had a psychologist and if we had a family therapist we would be offering him that ... [Later] Again, she's somebody who I'd definitely refer to a psychologist if we had one (EIS; observation)

The EIS team did not have a psychologist, CMHT 1 had a temporary locum psychologist for less than half of the observation period, and CMHT 2 and CMHT 3 both had half-time psychologists. Even where there was a psychologist on the team, demand for their services exceeded the time available:

"You are not able to offer someone what we would have done ... I can't commit to therapy with people." (Psychologist, CMHT 3; interview)

Team members argued that they were under increasing pressure to do more work with fewer resources: *"There are more patients and we have less time"* (Psychiatrist, Mem 2; interview). This was sometimes evident in meetings, with teams struggling to distribute the work among their members:

Psychiatrist: [Pointing to a stack of files] Are those all new referrals?

Manager: Yes, there's 20

Psychiatrist: How can that be? It's ridiculous! ... 15 is really bad news because we haven't got the people here to see them ... As we're in complete crisis I'll take four. Joanne [nurse]? All hands on deck! (Mem 1; observation)

Many believed that the quality of care they were providing was being negatively affected by an excessive workload:

“There’s a certain feeling of hopelessness about some of those [long-term] issues because we’re rather stripped bare of resources currently ... We don’t have time to work with people very intensively ... There’s a bit of a fire-fighting feel about the whole thing ... I feel at the moment we’re aspiring to decency rather than excellence in care ... I would like to shift back to aspiring to be excellent really.”
(Psychiatrist, EIS; interview)

This shortage of resources shaped team decision-making about which patients to treat and the duration of treatment, with teams raising their thresholds so as to only provide care in the most severe cases: *“You just have to prioritise more and more and discharge early someone that you might have kept on longer”* (Psychiatrist, CMHT 2; interview).

Psychologist: He’d like some long-term support but I told him that doesn’t exist in the new NHS (CMHT 3; observation)

A recurring concern was that the level of administrative support available to practitioners had been reduced. Practitioners reported that tasks which had previously been undertaken by administrators (e.g. uploading documents to the electronic medical records, sending out letters) increasingly fell to the healthcare providers themselves, reducing the time available to interact with patients:

“Our time, more and more, is spent on [the computer system] ... You spend hours on end on administrative functions rather than seeing the people, so of course that’s going to affect the quality of your work with people.” (Social Worker, CMHT 3; interview)

Nurse 1: We’re ending up doing more and more of our own admin which would be far better off done by a member of admin staff (CMHT 3; observation)

External agencies which had once provided alternative or additional support to patients were closing down, restricting the options available for onward

referrals: *“Previously there would have been places, really good places we could have referred people, and [now] we can’t. And so we have to think differently about who we refer and where we refer them” (Psychologist, Mem 1; interview).*

The closure of day centres, supported housing, and offender programmes was commonly discussed in meetings as team members struggled to identify safe placements for their patients:

Social Worker: [Her housing] really needs tying up as soon as possible, but as far as I’m aware there are no possibilities ... There’s no Plan B, because resource-wise there are very few Plan Bs these days (CMHT 3; observation)

As resources grew scarcer, teams were less well equipped to proactively manage risks:

Forensic Psychiatrist: [His mental] images did feel more in the paedophilia spectrum than anything else ... We did have a [sex offenders] service which we don’t have any more because it was too expensive ... But the potential [for him to offend] is there so, I don’t know, we just have to monitor it probably for now (EIS; observation)

Several participants commented that they were reaching a breaking point at which they would not be able to meet the basic requirements of their jobs: *“I’m running out of runway really” (Occupational Therapist, EIS; observation).*

“I might be getting quite close to actually feeling that I can’t, I’m under too much pressure to actually do the job.” (Psychologist, CMHT 3; interview)

The shortage of resources was reported to impact not only on the number of patients practitioners could see, but also on the quality of their interactions with those they did see:

“The team is in its half capacity here. So the quality of work is just, we’re not satisfied. I’m not satisfied with the work that I do with my clients I don’t think. It’s just harrying, I feel I’m harrying them all the time.” (Social Worker 2, CMHT 3; interview)

Some trusts were being restructured in an attempt to reduce the impact of resource shortages, but the way in which these changes were being managed was perceived to be causing further problems.

9.3 Coping with organisational restructuring

Trusts A and B were undergoing substantial organisational changes involving redundancies, redeployments and team relocations. There were plans for new teams (or “Service Lines”) specialising in particular types of illness (e.g. psychosis) to replace the existing CMHTs, though team members were unsure when these changes were going to take place, leading to a looming sense of uncertainty in care planning. Intense discussions about the impact of the reorganisation on staff and patients often took place in team meetings, sometimes taking up 20 or 30 minutes of meeting time. These discussions were overwhelmingly negative, with staff expressing serious concerns about how the change was being managed and its impact on staff morale and quality of care.^{xii}

9.3.1 Change management and a loss of confidence in leadership

Staff acknowledged that changes needed to be made in response to national policies and resource constraints, but they were frustrated and demoralised by how the changes had been managed. They felt that there had been a lack of transparency about the motivation behind the changes, which were described as “cuts ... dressed up as efficiency” (*Psychiatrist, CMHT 2; interview*). This resulted in a widespread loss of confidence in organisational leaders, who were seen as

^{xii} Only two interviewees, both from CMHT 1 (Trust A), mentioned any potential benefits from the reorganisation: “In the short term it’s quite chaotic whilst things change, but in the longer term there should be lots of benefits for service users” (*Manager, CMHT 1; interview*).

“slightly manic” in their promotion of the reorganisation and dismissive of the views of front-line practitioners:

“I think it’s a panic leadership, I think there is no articulation about actually what we do ... There’s a sort of failure right at the top ... The layer down is even worse ... they’re incapable of doing anything other than panicking about the next set of performance indicators.” (Social Worker, CMHT 3; interview)

“We’ve felt a bit under siege in recent times from the wider organisation and indeed the wider NHS ... I mean the whole trust has felt a bit catastrophic really over the last year or so ... I do think that they have made some somewhat disastrous decisions.” (Psychiatrist, EIS; interview)

High-level managers were seen as remote and out-of-touch with the reality of care-provision. Though there had been official “staff consultations” regarding the reorganisation in both trusts, these were perceived to be superficial and insincere. The following discussion illustrates the pervading sense of helplessness among team members regarding the decisions being made:

- Social Worker: Can we feedback here from the [consultation] meeting ... or is there any point? I wasn’t there I’m afraid*
- Psychologist: Well you missed a treat*
- Social Worker: I was doing some AMHP [Allied Mental Health Professional] work*
- Psychologist: Basically there was a brief, standard presentation which [Associate Director 1] was a bit embarrassed about having to make*
- Social Worker: Yeah, well ... he seems to be really uncomfortable with the whole process ...*
- Manager: He’s still got a conscience I think*
- Social Worker: A what? [laughter]*
- Psychologist: As opposed to [Associate Director 2]?*
- Social Worker: Oh yeah, Mister Smiley*
- Psychologist: I thought it was a really depressing meeting because, not only were questions not answered, but people’s feelings weren’t acknowledged either*
- Nurse: There was a touch of arrogance, I’m sorry I have to say, with [Associate Director 2]. A touch of arrogance which is not really nice*

- Social Worker:* Well he is just so removed from everyday life ... He's on such a different level and he just looks down thinking 'They're just sort of virtual pawns, aren't they?'
- Psychologist:* Well I think that's how we're made to feel isn't it? I don't know. I didn't feel it was worth going to any more [consultations] ...
- Social Worker:* I mean the whole process is designed to wear people down, scare people. It's just absolutely petrifying isn't it? Really
- Manager:* Yeah
- Psychologist:* It didn't make us feel like valued members of staff, did it?
- Social Worker:* Because you're probably not ... You're just a pawn on the celestial chess board (CMHT 3; observation)

Staff reported that any attempts to voice dissenting opinions or discuss alternatives with trust leaders were dismissed:

"We have been told verbally that 'If you don't like it, you know where the door is.' So that's the mentality ... It's like going back to the dark ages." (Social Worker, CMHT 1; interview)

"If you try to engage them [trust management] in a conversation about, you know, what the purpose of a mental health service is, it's like trying to punch jelly." (Social Worker, CMHT 3; interview)

9.3.2 Impact on staff morale

The threat of unemployment and demotion caused high levels of anxiety among staff. Several interviewees mentioned that this "battering of morale" had led to conflict and irritability within the team. This was occasionally evident in meetings, for example in the following excerpt, where a nurse has just expressed annoyance at being asked to chair the meeting:

- Manager:* Don't be defensive! It's only chairing the meeting
- Nurse 1:* This trust makes me defensive
- Nurse 2:* Don't let them get you down (CMHT 2; observation)

Interviewees reported that the reorganisation was causing particular tension between those professional groups which had been forced to re-interview for their jobs (social workers, nurses and psychologists) and those that had not

(doctors). They noted that psychiatrists had been granted greater involvement in the consultation processes, despite being the group least affected by the changes:

"[Psychiatrist]'s involved with the consultation...Well, she is and she isn't...Her job is not on the line, whereas everyone else's is...I suppose that's brought a bit of resentment, a little bit of questioning about, 'Well we have to go for interviews, why don't you?'" (Assistant Psychologist, Mem 1; interview)

The service restructuring therefore appeared to add to the existing sense that doctors were granted special privileges which were not necessarily warranted (Section 7.5):

Psychologist: Do you know, Steven [Consultant Psychiatrist] has not attended for three weeks ... He's gone AWOL. To be honest I think they're doing the "new plan" aren't they?

Social Worker: Oh of course. He's arranging our futures

Psychologist: Yeah (CMHT 2; observation)

A widespread sense of disillusionment among staff appeared to pervade all aspects of their work and most believed that it would inevitably impact on the quality of care the team provided.

9.3.3 Impact on patient care

Most participants felt that the reorganisation was having a palpable negative impact on patient care. They argued that when practitioners were feeling extremely stressed and demoralised, their ability to provide high-quality care and support was severely compromised:

"People are far less able to engage and reflect on the way that they're making decisions and empathise with people ... if they're in a state of fear. I am absolutely sure it has a direct influence." (Social Worker, CMHT 3; interview)

They described how feeling undervalued made them less willing to go beyond the call of duty in their work:

"I think that the whole process that we're going through is having a massive impact on basically what we give. Even though I think we give an awful lot over here, I mean we would never, we try our best to give patients what they need but, yeah I think motivation is sort of gone ... You don't feel respected so you know, it's bit like 'working to rule' ... We're coming in at nine and I go more often between five and quarter past these days, whereas before I was quite happy to stay a bit longer. Not now." (Occupational Therapist, Mem 1; interview)

Participants believed that the way the change and been managed had led to a loss of commitment and loyalty to the organisation, an increase in sickness absence and the loss of "highly skilled, motivated staff," either through early retirement or by their seeking employment elsewhere:

"I've made a clear decision to leave this organisation ... because I don't think there is proper leadership ... It's all about strategy rather than values and I think that's a hopeless way to try and engage people." (Social Worker, CMHT 3; interview)

They also described a direct impact on practical aspects of care. Ongoing uncertainty and confusion about how services would ultimately be organised and what resources would be available meant that practitioners couldn't make long-term plans for their patients:

"One I saw with the StR, we would like to offer a minimum of six months therapy. Can't do that ... We'll review in three months to see if then we are in a position to offer something." (Psychologist, CMHT 3; interview)

The practical upheaval of reassigning patients to new teams and new keyworkers was also seen as having a serious impact, with patients "struggling to find their way around the new system" (Manager, CMHT 1; interview). Practitioners reported that, because there was so little information available about the planned changes, they were unable to adequately prepare their patients:

- Manager:* Service users are feeling rejected, panicking. And they're having all those emotions of feeling rejected
- Social Worker:* Yeah, but I think that's what staff are having. So it's like a knock-on because the staff have been rejected (CMHT 1; observation)

This was tragically illustrated in CMHT 1, where a patient took his own life when his keyworker was changed as a result of the reorganisation:

"He came in here about two weeks before he killed himself ... He was in reception in tears, 'If you change my care co-ordinator I will kill myself ... The service user at the moment is not central to our way of working ... It's about saving money, not looking at people's needs.'" (Social Worker, CMHT 1; interview)

Staff believed that several things could have been done differently to minimise the negative impact of the changes on staff and patients. These are summarised in Box 9.1.

Staff believed the negative consequences of the organisational restructuring could have been ameliorated by:

- genuine staff and patient consultation early in the planning process;
- greater transparency about the planned changes;
- greater transparency about the motivation for the changes;
- timely and sensitive feedback from staff interviews relating to their continued employment;
- offering choice to staff about voluntary redundancy and redeployment;
- the availability of information and guidance to prepare patients for upcoming changes.

Box 9.1 Staff suggestions for improving the management of organisational restructuring

The extent to which concerns about the detrimental impact of the restructuring pervaded MDT meetings and interviews highlights the fact that careful

multidisciplinary care planning is somewhat futile if staff do not have the mental or physical resources to carry out the agreed actions. Another factor which was perceived to impinge upon practitioners' ability to deliver high-quality care as planned was the administrative burden imposed by managerial targets.

9.4 Managerial pressures: targets and tick-boxes

MDT care planning and delivery were shaped by a number of external managerial pressures and targets, for example, reaching specified quotas for particular services. Staff saw many of these managerial directives targets as redundant or even counter-productive.

- Occupational Therapist:* His mum's quite involved
Manager: Carer's Assessment?
Occupational Therapist: Well ... she's had carer's assessments because of her husband ... she's had input but feels a bit let down by it
Manager: Ok, it's just that we need more Carer's Assessments, I've been told at yesterday's meeting, about 20
Occupational Therapist: Oh she'll have to have one then, whether she wants one or not [laughter]. Okay we're going to do the CPA [review meeting] ... so I can bring it up then
Manager: Yeah, I mean there is a pot of money ...
 [Later, discussing another patient]
Manager: Is it worth trying mum for a carer's assessment again?
Nurse: Well I think she's had two already and she doesn't want another one, I did ask her ...
Psychiatrist: Are we allowed to meet these requirements by repeatedly assessing the same people?
Manager: Yes [laughter] (EIS; observation)

Such managerial pressures were sometimes seen as increasing the burden on patients and carers rather than improving their experiences of care. In the following example, team members discuss a new managerial directive requiring

keyworkers to assign a diagnosis to each patient on the electronic medical records system.

- Deputy Manager:* It seems a bit uncomfortable us making the diagnosis quite frankly. If they haven't been seen by a psychiatrist recently and probably, possibly don't need to ...
- Nurse:* They're saying that they can accept a nurse or social worker's or OT's kind of impression of what the concerns are, rather than a formalised diagnosis done by a qualified doctor, which seems, you know, inappropriate
- Manager:* And you wonder what the benefit of this is, why are we doing this? It's the clusters isn't it?
- Nurse:* It ignores the inherent problem that if a patient doesn't have a clear diagnosis we're going to start throwing labels at people, condemning them to various things and it's going to impact on their lives for the sake of our financial system
- Psychiatrist:* Yeah, I know
- Nurse:* It's completely not patient-centred care
- Manager:* It's the wrong way around
- Nurse:* Exactly
- Manager:* And it's not the first example Andy [laughter]. It's always startling when we're made to do this stuff
- Nurse:* It's the business model (CMHT 3; interview)

Financial resources were often contingent on achieving managerial targets, thus staff members felt they had to comply with them even when they were considered irrelevant or detrimental to care. This caused frustration which regularly surfaced in interviews: *"It is all money. It has absolutely nothing to do with a sensible way of looking after patients. It is all to do with purchasers and providers"* (Psychiatrist, Mem 2; interview).

Practitioners were frustrated at the amount of time they were obliged to spend completing paperwork at the expense of spending time with patients.

"Thinking about some of the targets is rather frustrating because that once again draws us away from individuals ... and just puts us behind our computers and ticking boxes which is very frustrating ... We tend to be spending ever-increasing periods of our time more focused on things which I don't think get down to the bottom line of someone's mental health." (Manager, EIS; interview)

The perceived increase in bureaucratic procedures was attributed to an organisational culture which prioritised protecting the trust from litigation over ensuring high-quality care. Some argued that this was highly counter-productive because the administrative burden was so detrimental to care quality that it ultimately increased the likelihood of serious adverse incidents.

"I said, 'I trained to be a Social Worker, not a Data Inputter.' And the stock response was, 'If you do your computer work well then you won't have anything to worry about' ... Another trust that has re-organised exactly along the same lines as this trust has gone completely pear shaped. High incident of homicides, high incidence of suicides ... and the coroner and the trust couldn't fault the workers because the [electronic record] was completed and the boxes were ticked ... I think you could just be so busy doing [electronic records] that the patient's dead. The patient killed himself. Why did the patient kill himself? Well it doesn't matter because you ticked all the right boxes. To me that's not patient care." (Social Worker, CMHT 1; interview)

Several interviewees argued that many of the managerial directives they were expected to enact had become ends-in-themselves rather than indicators of high quality care. Many were sceptical of the privileging of simplistic quantitative targets over professional judgement, and some believed that the emphasis on targets was tokenistic and reduced the potential for personalised care.

"The saddest thing is that we're going into business ... The quality of your work is judged by your targets, how many assessments that you've done, how many smoking discussions you have with your client ... how many accommodation thingies you've recorded. That's not what we emphasised before ... The computer tells me what I haven't done right really. You know I think I've lost the sort of spirit I had of trusting myself and my judgments as a professional ... It's mechanical and procedural and it loses its spirit in a way, you know, what you came into this profession for really, to support and help people and work with people." (Social Worker, CMHT 3; interview)

One psychiatrist noted that it might be more useful to have targets stipulating how regularly practitioners should attend MDT meetings and how frequently

patients should be discussed (a suggestion which closely resembles how cancer MDTs are assessed, see Section 1.3.3).

9.5 Summary and discussion

The findings presented in this chapter highlight the fact that multidisciplinary care planning can only benefit patients if practitioners have the means to implement the ideas generated. Teams struggled to design and implement comprehensive multidisciplinary care packages in a highly unstable organisational and political context. MDT discussions were dominated by concerns about powerful and unpredictable external pressures such as resource shortages, organisational restructuring and bureaucratic requirements.

A dearth of treatment options (e.g. family therapy), key professional colleagues (e.g. psychologists), and onward referral options (e.g. day centres) meant that teams were often unable to offer patients the care they believed would best meet their needs. Participants' claims that the teams were dramatically under-resourced are corroborated by national and international staffing recommendations.^{7, 57} Boardman and Parsonage⁵⁷ calculated the staffing levels that would be required to deliver the government's mental health policies for a CMHT in a typical English catchment area. They reported that, in addition to doctors, nurses, social workers and occupational therapists, each CMHT would require two employment specialists, a learning difficulties worker, a dual-diagnosis worker, a support worker, a black and minority ethnicity support worker, an assistant psychologist, a part-time pharmacist and a part-time pharmacy technician. This reveals the stark mismatch between the demands placed on services and the resources at their disposal.⁷⁹ In recent years the government has recognised this funding gap and has announced plans for increased investment which may alleviate these problems.^{76, 81-83, 307} However,

given the high demand for services and the broader economic context, it is unlikely that these challenges will be resolved in the near future.

Practitioners reported that a lack of transparency and clear communication about ongoing organisational restructuring was having a seriously detrimental impact on their ability to plan and deliver high-quality care. Uncertainty about the future of the service made it impossible to make long-term plans for patients, and uncertainty about the security of their own positions made it difficult for staff to engage with patients in an empathetic and reassuring manner. Resentment among practitioners appeared to be compounded by the perception that reductions in funding and workforce were being promoted as improvements, while negative consequences went unacknowledged. These findings are in keeping with an extensive literature on “change management”, which has established that staff commonly resist change when there is uncertainty, fear of personal loss and when changes are not perceived to be beneficial to the organisation.^{308, 309} Some conflict may be inevitable when the priorities of high-level managers (defined by available funds and Department of Health agendas) differ from those of front-line practitioners (e.g. the patients under their direct care).³¹⁰ However, this study suggests that the manner in which changes are managed and communicated has a significant impact on morale and care quality, independent of the changes themselves. Organisational leaders were seen as being out-of-touch with the reality of care provision, a finding supported by a recent national survey which found that NHS executive directors consistently expressed more positive views of the working environment and culture within their organisation than did clinicians.³¹¹

A prevailing concern among participants was that managerial targets primarily served financial and legal ends and often undermined, rather than enhanced, the quality of care. Staff argued that they were spending increasing amounts of time completing administrative work on their computers at the expense of

spending time with patients. Similar findings were reported in a study of CMHT practitioners in Northern Ireland³¹² which reported that secondary tasks such as completing forms and meeting external targets were given precedence over the primary task of providing good care. The authors argued that there is a risk that such “bureaucratic defence procedures” (p.303) become a substitute for critical reflection, to the detriment of patient care. Dixon-Woods and colleagues³¹³ located the source of the problem upstream, arguing that NHS organisations revert to a highly bureaucratised style of management when faced with a proliferation of varied and complex external demands. They note that the enforcement of rules and procedures often results in “displays of compliance” (p.5) rather than genuine efforts to improve quality and safety. When forced to focus their energy on de-contextualised, externally-imposed regulations, teams risk ‘hitting the target but missing the point’.³¹⁴

9.6 Conclusions

This final results chapter has illuminated how the political, economic and organisational contexts in which teams operate impact on care provision, and has highlighted how practitioners struggle to cope with externally-imposed demands and a changing landscape of service providers. The findings suggest that there is a need for improved communication between front-line workers and organisational leaders to ensure that negative consequences of organisational changes are thoroughly considered and minimised, and that managerial targets are in keeping with patients’ needs and the realities of care provision.

The next chapter brings together the findings presented in all five of the results chapters to consider their overarching implications for practice.

10 Overarching discussion

This thesis has identified a broad range of challenges that hinder the potential for mental health MDTs to capitalise on their diverse skills, both within team meetings and in their broader practice. In this final chapter, I summarise the findings as they relate to each of the research objectives and discuss their implications for practice. I then consider strengths and limitations of the work and highlight remaining questions for research and policy. I conclude by offering some critical reflections on the research process. Box 10.1 summarises the main findings.

- Team meetings are perceived to serve a wide range of functions, from care planning to peer support.
- Teams vary in the number of patients discussed, how these patients are selected for discussion and the disciplines represented at MDT meetings.
- Many patients are unaware that they are being discussed in MDT meetings and would value more information on team processes and feedback from team discussions.
- Many practitioners believe their meetings are poorly managed and lack clarity of purpose.
- Meetings are often hindered by inconsistent attendance, chairing and documentation procedures.
- Multidisciplinary collaboration is sometimes undermined by conflicting models of care, ambiguous leadership and difficulties in balancing profession-specific and generic keyworker roles.
- Practitioners' capability to implement the care plans agreed in team meetings is mediated by external factors such as a lack of resources, organisational instability and administrative requirements.

Box 10.1 Summary of key findings

10.1 Summary of findings and implications for practice

The first objective of this study was to identify the functions served by MDT meetings in community mental health services. The systematic review presented in **Chapter 2** found that, despite substantial literature on CMHTs, there has been little direct investigation of MDT meetings and their functions. Where meeting functions were mentioned in the published academic literature, they fell into four thematic domains: discussing the care of individual patients, enacting teamwork, team management, and learning and development.

Chapter 5 expanded on the findings of the systematic review by offering a more detailed analysis of MDT meeting functions based on interview, observational and quantitative data. This in-depth analysis identified seven main functions served by MDT meetings:

- providing a central forum for teamwork;
- providing feedback on recent assessments;
- providing updates on ongoing work;
- facilitating team decision-making;
- sharing the emotional burden of the work;
- team management and administration;
- learning and development.

Chapter 5 also explored the extent to which the meetings were valued by practitioners. Although most participants perceived MDT meetings to be a valuable use of time overall, many found them tedious and lacking in clarity of purpose. Some practitioners viewed MDT decisions as binding while others did not. The findings strongly suggest that teams would benefit from reflecting on the functions their team meetings currently serve, how well these functions are achieved, and how they should be prioritised with respect to time. Without a clearly agreed purpose, there is a risk that team meetings become a 'catch-all' forum where a wide range of issues are discussed, but in an inefficient,

unfocused manner. Once a clear purpose has been agreed, it becomes possible to evaluate and monitor a team's effectiveness in fulfilling this specified purpose using appropriate outcome measures (e.g. the proportion of patients reviewed, staff wellbeing surveys, the proportion of discussions resulting in an agreed decision, or the rate of decision implementation).

The second objective of the study was to examine how MDT meetings are organised and managed, and the extent to which this varies between teams. **Chapter 6** revealed wide variation in the structure and operational processes of meetings in the different teams, with variation in who attended, which patients were discussed and the amount of time spent on each patient. The lack of a systematic approach to deciding which patients were discussed meant that the degree to which a patient benefited from the expertise of the wider team was largely at the discretion of their keyworker. Some keyworkers raised more patients for discussion than others. These findings imply that the extent of multidisciplinary input a patient receives may largely depend on where they are referred and which keyworker they are allocated.

Chapter 6 also described how inconsistent attendance, poor time management and inconsistent documentation often led to discussions which were circular and repetitive. These findings indicate a need for teams to establish efficient organisational systems for managing time and achieving their agreed purpose. Specific suggestions for improving efficiency included having a permanent senior chairperson, advance planning of which patients are to be discussed, and ensuring that documentation is accurate and accessible to the whole team.

The third objective of the study was to explore practitioner views on MDT meetings and multidisciplinary care planning. **Chapter 7** illustrated how conflicting priorities, a lack of role clarity and power imbalances threatened to undermine multidisciplinary collaboration. It highlighted a need to revisit the balance between generic and specialist work so as to capitalise on the diverse

skills of team members from different professional groups. The evidence highlights the importance of ensuring that medical contributions, though crucial in the care of many patients, do not “drown out” the voices other practitioners. This is particularly pertinent given that the more social aspects of care appear to be highly valued by patients.

The fourth objective of the study was to explore patient views of MDT meetings and multidisciplinary care planning. **Chapter 8** established that many patients were unaware of MDT meetings and had a limited understanding of MDT processes. They commonly expressed that they had not been offered any choices in relation to their care and that they felt largely uninvolved in care planning. Patients’ experiences of care may be improved by greater transparency about how teams operate and what expertise is available to them. They would like to know who is discussing their care and would value feedback on what has been discussed. While it may not always be possible or appropriate to share every detail with patients and carers, fostering a culture of transparency and open communication may benefit the quality of therapeutic relationships and encourage patient engagement more broadly.

The final objective of the research was to identify factors that have an impact on the potential for patients to benefit from MDT meetings and multidisciplinary care planning. All of the themes addressed this objective. As described above, the potential for teams to capitalise on their diverse expertise to deliver effective multidisciplinary care was shaped by clarity regarding meeting purpose and professional roles, efficient meeting organisation, and patient involvement. In addition, **Chapter 9** showed how a number of external influences played a pivotal role in the pathway from MDT meetings to patient benefit. These external factors determined both the range of care options that could be considered by the team, and whether they had the means to deliver them. Staff argued that their practice was increasingly dominated by externally imposed targets and an abundance of paperwork, which reduced the time available to

spend with patients. This suggests a need for improved communication between front-line workers and organisational leaders, to help ensure that such managerial requirements are meaningful to front-line workers and patients, and appropriate to local needs. There was also evidence that poor communication regarding ongoing organisational changes threatened the quality of care by leading to a short-term focus in care planning and undermining staff morale.

10.1.1 *Revisiting the conceptual model*

In the introductory chapter, I considered the basic steps that need to occur for a patient to directly benefit from an MDT meeting (Figure 1.1, p.31):

- their case must be selected for discussion;
- their keyworker must share the relevant information;
- the other team members must be present and willing to share their specialist expertise;
- together they must generate ideas for improving the patient's care;
- they must have the capacity to implement these improvements.

As the previous chapters have shown, achieving these conditions is not straightforward; rather, it relies on team members sharing an understanding of the purpose of the meeting, effective organisational and administrative procedures, clear roles and role relations, patient engagement, and favourable external conditions.

Figure 10.1 illustrates how the factors discussed shape the potential for MDT meetings to benefit patients by mapping the study findings onto the original diagram.

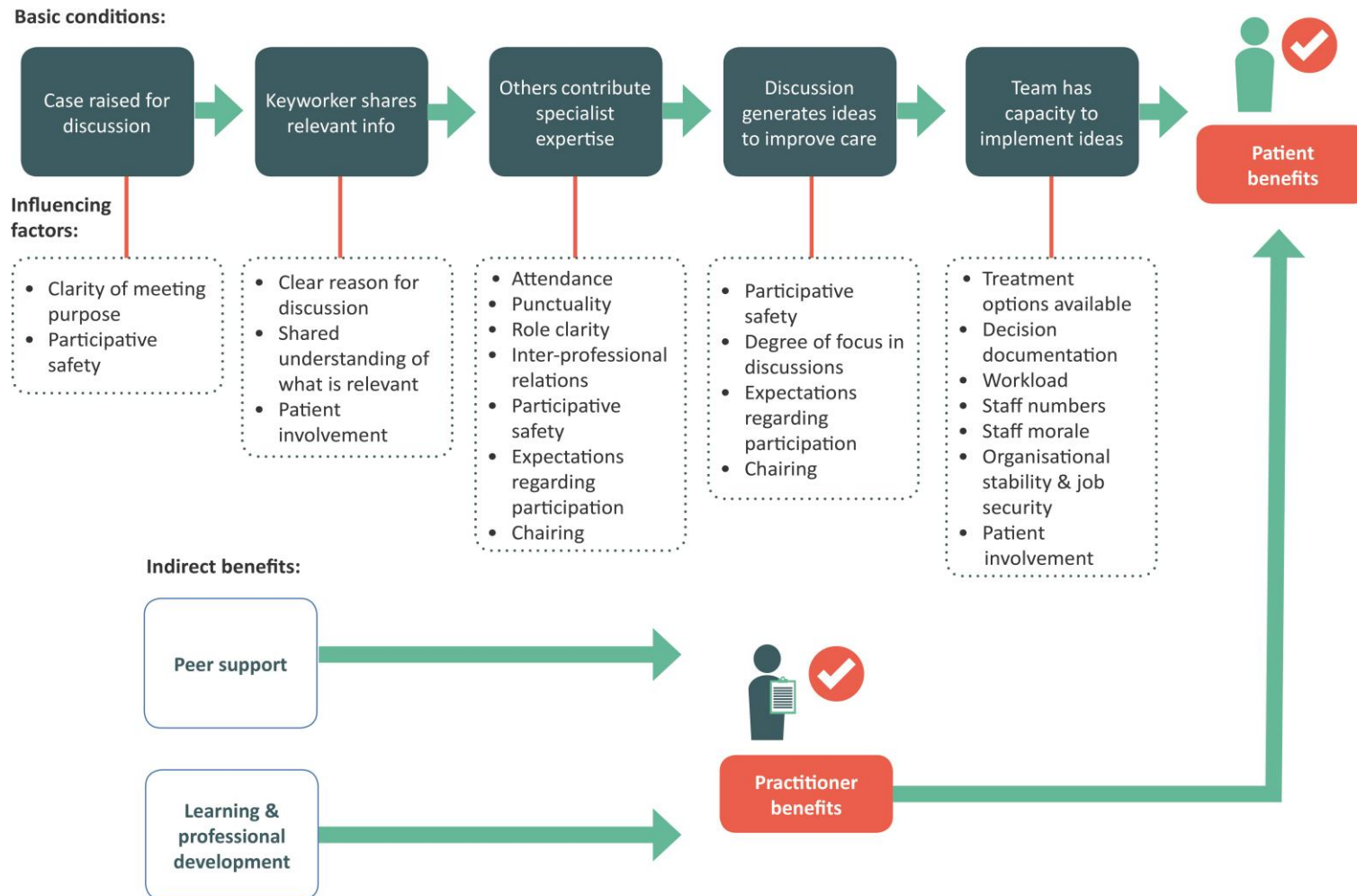


Figure 10.1 Steps from MDT meeting to patient benefit and influencing factors

10.1.2 *Making the most of MDT meetings: current challenges and opportunities for improvement*

The overarching aim of this research was to explore MDT functioning with a view to identifying challenges to effectiveness and opportunities for improvement. Table 10.1 summarises the challenges that arose within each theme and highlights practices and adaptations which, the findings suggest, have the potential to improve functioning.

Table 10.1 Challenges and opportunities for improvement identified by the study

Challenges	Suggestions for practice
i. Meeting functions	
Diversity of functions but unclear purpose Inefficient use of time within meetings (perceived as boring and repetitive)	Explicitly agree the purpose of meetings & prioritise discussions accordingly Reflect on whether any current functions might be better served in another forum (e.g. business meetings, individual supervision)
ii. Meeting organisation	
Wide variation between teams in: <ul style="list-style-type: none"> – numbers of patients discussed – choice of patients discussed – length of discussions – number of professions represented Inconsistent attendance and punctuality lead to tension and repeated discussions <i>Ad hoc</i> selection of patients leads to unfocused discussions and possible neglect of “quiet clients” Poor time management Lack of administrative support Inaccurate recording of patient names, meaning discussions cannot be linked to patient notes Inconsistent documentation of decisions No system to monitor decision implementation	Agree which patients should be discussed in MDT meetings Collate agenda in advance of meeting which lists each patient for discussion and the reason for their discussion to encourage forethought Frame each case presentation in terms of specific query or rationale for discussion Designate a permanent senior chairperson to manage time and ensure focused discussions Limit time spent on each discussion Document agreed action points Ensure documentation associated with correct patients Use IT to access electronic records in meeting Ensure meeting minutes accessible to whole team Monitor implementation of decisions Monitor which patients are discussed

iii. Multidisciplinary teamwork	
<p>Conflicting professional agendas</p> <p>Lack of role clarity</p> <ul style="list-style-type: none"> – Generic roles undermine specialist contributions and professional identity – Relationship between managers and consultants unclear <p>Medical dominance may limit potential for patients to benefit from the expertise of other professional groups</p> <p>Some don't see it as their role to comment on cases they don't manage directly</p> <p>Difficult to express professional view when one's profession is vastly outnumbered</p>	<p>Team reflection to establish how best to exploit the distinct skills of different team members e.g. protected time for specialist work</p> <p>Clarify how the roles of manager and consultant psychiatrist relate to each other and where responsibility for decisions lies</p> <p>Clarify expectations regarding participation in meeting</p>
iv. Patient involvement	
<p>Patients unaware of meeting</p> <p>Patients don't trust keyworkers to represent them accurately at meetings</p> <p>Patients would like some involvement in meetings</p> <p>Some practitioners feel patients' preferences are not given due consideration</p>	<p>Inform patients about MDT meetings</p> <p>Introduce patients to the different team members (see Appendix 16 and Appendix 17)</p> <p>Provide patients with an opportunity to contribute a statement or pose questions for the whole team</p> <p>Provide patients with feedback from discussions</p>
v. External influences	
<p>Lack of resources</p> <ul style="list-style-type: none"> – High workloads – Absence of key roles (e.g. psychology) – Limited treatment and onward referral options <p>Managerial targets and paperwork detracting from face-to face care</p> <p>Organisational instability resulting in:</p> <ul style="list-style-type: none"> – job insecurity, low morale and tension between professional groups – short-term focus in care planning – confusion among patients <p>Discussions about organisational change taking up large portions of meeting at the expense of time for discussion of patients</p>	<p>Instigate recommended minimum staffing standards (cf. National Cancer Peer Review Programme)</p> <p>Ensure managerial targets and paperwork requirements are relevant and worthwhile</p> <p>Minimise negative impact of organisational change through:</p> <ul style="list-style-type: none"> – genuine consultation with staff early in organisational change process – offering staff choices where possible (e.g. voluntary redundancy) – transparency about plans and timely feedback from staff interviews <p>Reserve discussion of organisational matters for a designated time slot in the meeting or a separate business meeting</p>

These suggested modifications are derived from a relatively small number of teams and may not all be appropriate or feasible in every context. As described in Chapter 10 and elsewhere,^{312, 313} the imposition of externally derived standards can stifle rather than enhance team effectiveness. Nonetheless, the suggestions could be constructively used as points of reflection and as a means of sharing learning across teams. Many of the suggested improvements do not require additional financial resources; rather, they require practitioners to critically reflect on their goals, procedures and performance as a team.

Team reflexivity, the extent to which a team explicitly discusses their objectives and processes and adapts them to changing circumstances,³¹⁵ has been associated with improved team effectiveness, creativity and innovation, both in healthcare settings^{6, 316} and elsewhere.³¹⁷⁻³¹⁹ In this study, interviewees highlighted numerous aspects of team meetings that they perceived to be inefficient and frustrating, and offered many ideas for improvement. Yet it appeared that such issues were rarely if ever discussed within the teams. Regular team reflection could facilitate the development of these ideas, promote consideration of how best to organise meetings, and encourage a focus on service improvement.

Many of these suggested improvements could be initiated by the teams without external intervention. Others would depend on collaboration with outsiders, such as organisational leaders and policy makers. For example, reducing the administrative burden on practitioners is likely to require improved communication between practitioners and trust leaders. Ensuring that teams have the necessary staffing levels, administrative support and financial resources to deliver high quality multidisciplinary care will depend on wider commissioning bodies and policy directives.

10.2 Contributions

This is the largest study of community mental health MDT meetings in the UK to date, with data from 181 MDT meetings and 3213 separate case discussions. It is, to my knowledge, the first study to explicitly investigate the functions of MDT meetings, to elicit patient views of MDT meetings, and to quantitatively assess rates of decision-making and implementation in this context. Exploring patient views is particularly important given the growing acceptance of the need to improve patient involvement in the design of health services,²⁹⁰ as well as in their own care planning.^{82, 291}

The findings of this study begin to address a number of weaknesses in the existing literature on community mental health services, such as a paucity of recent research on the challenges associated with role blurring and the need to balance specialist and generic roles.³²⁰ Concerns about these issues were prominent in the literature in the early years of the CPA, but have received little research attention in recent times. The findings have demonstrated that these challenges have not been fully resolved; many practitioners still believe that their teams fail to effectively use their diverse skills, and there remains confusion about how leadership and authority are distributed between the roles of managers and consultant psychiatrists.

This study also addresses calls for research on the impact of contextual organisational factors on collaborative working,^{46, 321} and, more specifically, the influence of ongoing and anticipated service restructuring on day-to-day working and quality of care.^{6, 46} Resource shortages appeared to have an extensive impact on the range of treatment options that the teams could consider, while burdensome administrative tasks and organisational instability were perceived to limit their capacity to deliver agreed care plans.

Finally, the study has offered a practical contribution by generating suggestions for improvement in light of the challenges identified. These range from

recommendations about organisational processes, such as planning and managing discussions, to higher-level issues such as clearly agreeing the purpose of meetings and reflecting on performance as a means to improving it.

10.3 Limitations

Conducting this PhD as part of a broader programme of research (the NIHR Project) had both advantages and disadvantages. It provided an opportunity to investigate a highly policy-relevant topic with practical implications for service development, and granted access to the wealth of expertise held by the other researchers and advisory group members affiliated with the NIHR Project. However, it also meant that the design and process of data-collection were shaped and constrained by considerations broader than this thesis. For example, the sampling of teams and participants was dictated by the NIHR Project protocol. As described in Chapter 3, teams were purposively selected to achieve diversity within the constraints of the study. Several common types of mental health team were not represented (e.g. AOT, CRT, HTT); thus, the relevance of the findings to such teams is not clear. Nonetheless, few of the findings appeared to be linked to team type. Most were consistent across the memory clinics, general CMHT and EIS, and it is therefore likely that they are of broad relevance.^{xiii} Ongoing service changes may mean that the team types studied (e.g. general CMHTs) are gradually replaced by others (e.g. psychosis service lines), but it is unlikely that multidisciplinary teamwork or the keyworker approach will be abandoned. Many of the implications for practice will therefore continue to be relevant.

^{xiii} Where there were clear differences between the team types studied (e.g. memory clinic teams having a more focused purpose than the other teams) these were expressly described.

A related limitation is that all the participating teams were based in South-East England, and only one was based outside of London. It is possible that these teams were somehow unusual or unrepresentative of mental health teams generally. There was also a risk of selection bias; for example, particularly effective teams may have been more (or less) likely to participate. The fact that all the teams that were approached agreed to participate provides some reassurance in this regard. Furthermore, the NHS trusts in which the teams were based had average scores on most of the relevant quality indicators presented in Chapter 4, suggesting that they were reasonably typical. I have provided details of the context and operation of these teams to allow the relevance of the findings to other contexts to be assessed (also known as the “generalisability”, “transferability” or “external validity” of findings).^{257, 266 322}

The research was conducted during major organisational restructuring, which may have resulted in attitudes that did not represent “business as usual”. This would be more of a concern if the data represented a brief ‘snapshot’ in time rather than consistent observation over 17 months. Given the frequency of service reorganisation in mental health care,³²³ the struggle to deliver continuous care in the midst of major organisational change is likely to be a relatively common experience. The data are limited in that they present the experience of reorganisation only from the perspectives of front-line practitioners. A more comprehensive picture could be gained by interviewing employees at every level of the organisations, including organisational leaders and mid-level managers, so as to understand their interpretations of events and gain more information on how future changes could be better implemented.

The number of interviews conducted was limited by the resources available for the NIHR Project and unforeseen circumstances (such as the disbandment of CMHT 1). It was not possible to interview members from every professional group (e.g. support workers), and fewer patients were recruited than planned (for the reasons described in Section 3.3.2). It is possible that patients who were

less satisfied with services were more likely to agree to participate, resulting in an overly-negative representation of services. Nonetheless, some of the issues raised are important even if they are only true of a subset of service users because of their ethical implications (e.g. patients not being aware of MDT meetings, not being aware of the purpose of their contact with teams, and feeling unable to voice concerns). Further research with a larger sample would help to establish the prevalence of the negative experiences identified, illuminate positive experiences of care, and identify what works well.

It is possible that practitioners behaved differently while under observation. Two weeks of pilot observation were conducted to allow participants to become accustomed to my presence and mitigate this risk. Nonetheless, in the early stages of the observation, team members made occasional reference to the fact that they were being recorded (*"We're learning sign language. Then we're moving to telepathic communication!"* [laughter]; *Manager, CMHT 3; observation*). These references were usually jokes in reaction to someone using profane language or casually complaining about other practitioners. Reassuringly, the tone of the discussions did not noticeably change after such comments and several interviewees remarked to me that they didn't think my presence had any effect on the meeting.

10.4 Remaining questions for research and policy

This research has highlighted several issues that are in need of clarification through further research and policy.

10.4.1 *Research implications*

A central issue that warrants further investigation is the question of whether teams are really providing a multidisciplinary service if most team members are performing generic roles. Possible mechanisms for reintroducing specialist

work include arranging protected time for such work during each week (e.g. a weekly Occupational Therapy clinic), or explicitly considering what each discipline can offer each patient when they are discussed in team meetings.

This research has generated a range of ideas for overcoming the challenges identified (Table 10.1). These suggestions remain tentative, as their effects have not been empirically tested. Further research is required to investigate the impact of interventions such as collating agendas in advance of each meeting, changing from a rotating to a permanent chairperson, and initiating regular team review of processes and performance.

A larger study of patients is required to elicit a wider range of views and provide a more detailed understanding of how they experience multidisciplinary care. Such an investigation would be valuable in generating further ideas for improvement.

The generalisability of the findings should be investigated by studying MDT meetings in a broader range of contexts, for example, in rural settings or in different kinds of teams such as AOTs and CRTs.

10.4.2 Policy implications

Though current policy advocates the use of MDT meetings and multidisciplinary team review, it has been somewhat inconsistent as to what should be discussed (Section 1.3) and offers little detailed guidance on operational procedures. The wide variation in MDT practices identified in this study (even within teams of the same type) may be indicative of a need for more detailed best practice guidance to ensure a uniform standard of high-quality multidisciplinary care nationally.

Standards specifying how regularly patients should be reviewed by the whole team, and how reviews should be documented and monitored, could guard

against the neglect of “quiet cases” which may otherwise be overshadowed (Section 6.4). Policy specifying minimum staffing levels would help to ensure that patients receive the relevant multidisciplinary input regardless of where they reside. It would also clarify whether the roles of the psychologist or occupational therapist are to be considered fundamental to a high-quality service or (in the words of one participant) a “luxury” that only some teams can afford.

Minimum standards and operational guidance can reduce uncertainty, disorganisation and unwarranted variation in care provision (that is, variation which is not consistent with underlying levels of patient illness or patient preferences).^{182, 324, 325} However, over-prescriptive policy can hamper the ability to respond flexibly to local needs. As described in Chapter 9, the imposition of targets, without the provision of the necessary support to implement them, can hinder rather than enhance quality care provision. Cancer teams are supported in maintaining their standards by dedicated *MDT Co-ordinators* who are responsible for tasks such as: distributing lists of patients for discussion; monitoring review periods; recording attendance; and ensuring that the relevant medical records are available at meetings.¹⁹ Similar standards in mental health will be effective only if the necessary funds and administrative support are provided to enable implementation.

10.5 Critical reflections

Research is a social endeavour, shaped by the personal characteristics and interests of the people involved. Ethnographic fieldwork involves developing relationships with participants over time and balancing being both an insider and an outsider. The researcher must become adept at “managing marginality”, gaining the trust of participants while maintaining a critical distance.²¹² In this context, it is particularly important to reflect on the role of the researcher in the

co-production of knowledge.^{212, 214} In this section, I offer some brief reflections on personal and interpersonal aspects of the research process.

Others have written about challenges faced by junior researchers when their research participants are older experienced professionals, outlining difficulties in gaining respect and trust when “interviewing up”.³²⁶⁻³²⁸ This was not my experience with the mental health practitioners. I was struck by how open and honest interviewees were in sharing information about their relationships with colleagues, difficulties they were experiencing, and the emotional burden of their work. The months I spent observing team meetings before the interviews allowed me to gain team members’ confidence, and my affiliation with a larger NIHR-funded project may have lent credibility to the work.

Though participation in interviews was entirely voluntary, I was conscious that the research imposed an additional burden on staff during an extremely busy and stressful time. However, a number of interviewees made affirmative comments on the value of the research given the time and resources tied up in MDT meetings:

“Whether the MDT is a useful use of everybody’s time and resources, whether things could be done more efficiently in a way which wouldn’t take so much time out of the working day ... It’s actually quite useful for you to do a piece of research on it.” (Psychiatrist, Mem 2; interview)

Some appeared to find it useful to reflect on team processes and areas for improvement during their interviews:

*“In a way I feel like **these** kinds of conversations would be good conversations to be having within the team and within the management structure. Instead I feel like that just doesn’t happen.” (Deputy Manager, EIS; interview)*

Several commented that they found cathartic to discuss the challenges of their work:

“It’s lovely venting my frustration [laughs]!” (Social Worker, CMHT 1; interview)

“Am I talking and talking? I’ve almost enjoyed myself!” (Social Worker, EIS; interview)

Similarly, several patients and carers emphasised that they appreciated someone taking an interest in their experiences and that they valued having the opportunity to contribute:

Patient: Hopefully it will be useful for patients in the future

Carer (wife): It’s good you listen. It’s good for him to talk about it (EIS; interview)

Interviewer: I don’t want to take too much of your time

Patient: One of the things that’s nice about being old is that we have lots of time ... It’s very kind of you to take so much trouble (Mem 1; interview)

While writing this report I have been conscious of the negative tone of many of the findings. My intention has not been to present practitioners in a negative light. On the contrary, my impression throughout the 17 months of observation was that they were extremely hard-working, generous professionals, struggling to provide high-quality care in difficult circumstances. I have focused on the challenges they faced both because they dominated team discussions, and because understanding such challenges is an important first step towards implementing positive change.

10.6 Conclusion

This thesis has offered a detailed exploration of the functions and organisation of MDT meetings, illustrating how the potential for these meetings to benefit patients is mediated by a range of factors both internal and external to the team. The findings suggest that the effectiveness of MDT meetings should not be taken for granted. They highlight the importance of critical reflection on organisational and operational processes to enable teams to capitalise on their diverse skills and provide the best possible multidisciplinary care to patients.

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Appendix 1 A note on terminology

Various terms are used to refer to people who use mental health services, including *service user*, *client*, *survivor*, *consumer*, *recipient*, *attende*e and *patient*.^{1, 2} Opinions differ on which is the least stigmatising term. There have been objections to the term *patient* on the basis that it is perceived to promote a passive rather than an agentic role, to encourage an objectifying medical ‘gaze’ and to reinforcing perceived power asymmetries between the recipients and providers of care.^{6, 7} In contrast, others have argued that the term grants legitimacy to those suffering with mental illness and encourages parity of esteem with physical illnesses.¹⁸ Policy documents are inconsistent in their terminology. For example, *New Horizons*, the government’s 10-year plan for mental health,⁴ mentions *service user* 23 times, *patient* 12 times and *client* 5 times. Surveys of people who use mental health services in the UK have found *patient* to be the preferred term overall.^{1, 2} Based on this, I have used the term *patient* throughout this work.

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Appendix 2 Related papers and presentations

Nic a Bháird C, Xanthopoulou P, Black G, Michie S, Pashayan N, Raine R. Multidisciplinary team meetings in community mental health: a systematic review of their functions. *Mental Health Review Journal*. Forthcoming.

Nic a Bháird C. Making the most of multidisciplinary team meetings in community mental health care. *Yale Department of Psychiatry*. New Haven, CT, 2015.

Nic a Bháird C. Multidisciplinary team meetings in community mental health: what can we learn from other specialties? Paper presented at the *5th Qualitative Research on Mental Health Conference*. Crete, 2014.

Nic a Bháird C. Challenges to providing high-quality multidisciplinary care in community mental health. Paper presented at the *5th Qualitative Research on Mental Health Conference*. Crete, 2014.

Nic a Bháird C, Xanthopoulou P, Wallace I, Raine R. Improving the effectiveness of multidisciplinary team meetings: assessing the predictors of decision implementation. Paper presented at the *National Cancer Intelligence Network Cancer Outcomes Conference*. Birmingham, 2014.

Nic a Bháird C, Wallace I, Xanthopoulou P & Kononovas K. Managing large qualitative datasets: experiences from the MDT Study. Paper presented at the *UCL Qualitative Health Research Meeting*. London, 2013

Nic a Bháird C, Wallace I, Xanthopoulou P. Improving the effectiveness of multidisciplinary team meetings for patients with chronic diseases. London Chest Hospital Training Day for Specialist Registrars in Geriatric Medicine. London, 2013

Related papers from the NIHR Project

Raine R, Nic a Bhaírd C, Xanthopoulou P, Wallace I, Ardron D, Harris M, Barber J, Prentice A, Gibbs S, King M, Blazeby J, Michie S, Lanceley A, Clarke A, Livingston G. Use of a formal consensus development technique to produce recommendations for improving the effectiveness of mental health multidisciplinary team meetings. *BMC Psychiatry*. 2015; 15(143).

Raine R, Wallace I, Nic a Bháird C, Xanthopoulou P, Barber J, Lanceley A, Clarke A, Prentice A, Ardron D, Harris M, Gibbs S, Ferlie E, King M, Blazeby J, Michie S, Livingston G, Barber J. Improving the effectiveness of multidisciplinary team meetings for patients with chronic diseases: a prospective observational study. *Health Services and Delivery Research*. 2014; 2(37).

O'Driscoll W, Livingston G, Lanceley A, Nic a Bháird C, Xanthopoulou P, Wallace I, Manoharan M, Raine R. Patient experience of MDT care and decision-making. *Mental Health Review Journal*. 2014; 19(4):265-278.

Raine R, Xanthopoulou P, Wallace I, Nic a Bháird C, Lanceley A, Clarke A, Livingston G, Prentice A, Ardron D, Harris M, King M, Michie S, Blazeby J, Austin-Parsons N, Gibbs S, Barber J. Determinants of treatment plan implementation in multidisciplinary team meetings for patients with chronic diseases: a mixed-methods study. *BMJ Quality & Safety*. 2014; 23:867-76.

Appendix 3 NICE Quality Checklists used in the systematic review

NICE quality appraisal checklist for qualitative studies^{xiv}

Study identification: Include author, title, reference, year of publication		
Guidance topic:	Key research question/aim:	
Checklist completed by:		
Theoretical approach		
1. Is a qualitative approach appropriate? For example: <ul style="list-style-type: none"> Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings? Could a quantitative approach better have addressed the research question? 	Appropriate Inappropriate Not sure	Comments:
2. Is the study clear in what it seeks to do? For example: <ul style="list-style-type: none"> Is the purpose of the study discussed – aims/objectives/research question/s? Is there adequate/appropriate reference to the literature? Are underpinning values/assumptions/theory discussed? 	Clear Unclear Mixed	Comments:
Study design		
3. How defensible/rigorous is the research design/ methodology? For example: <ul style="list-style-type: none"> Is the design appropriate to the research question? Is a rationale given for using a qualitative approach? Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used? Is the selection of cases/sampling strategy theoretically justified? 	Appropriately Inappropriately Not sure/ inadequately reported	Comments:
Data collection		

^{xiv} Available from : <http://www.nice.org.uk/article/pmg4/chapter/Appendix-H-Quality-appraisal-checklist-qualitative-studies>

<p>4. How well was the data collection carried out?</p> <p>For example:</p> <ul style="list-style-type: none"> • Are the data collection methods clearly described? • Were the appropriate data collected to address the research question? • Was the data collection and record keeping systematic? 	<p>Appropriately</p> <p>Inappropriately</p> <p>Not sure/ inadequately reported</p>	<p>Comments:</p>
Trustworthiness		
<p>5. Is the role of the researcher clearly described?</p> <p>For example:</p> <ul style="list-style-type: none"> • Has the relationship between the researcher and the participants been adequately considered? • Does the paper describe how the research was explained and presented to the participants? 	<p>Clearly described</p> <p>Unclear</p> <p>Not described</p>	<p>Comments:</p>
<p>6. Is the context clearly described?</p> <p>For example:</p> <ul style="list-style-type: none"> • Are the characteristics of the participants and settings clearly defined? • Were observations made in a sufficient variety of circumstances? • Was context bias considered? 	<p>Clear</p> <p>Unclear</p> <p>Not sure</p>	<p>Comments:</p>
<p>7. Were the methods reliable?</p> <p>For example:</p> <ul style="list-style-type: none"> • Was data collected by more than 1 method? • Is there justification for triangulation, or for not triangulating? • Do the methods investigate what they claim to? 	<p>Reliable</p> <p>Unreliable</p> <p>Not sure</p>	<p>Comments:</p>
Analysis		
<p>8. Is the data analysis sufficiently rigorous?</p> <p>For example:</p> <ul style="list-style-type: none"> • Is the procedure explicit – i.e. is it clear how the data was analysed to arrive at the results? • How systematic is the analysis, is the procedure reliable/dependable? • Is it clear how the themes and concepts were derived from the data? 	<p>Rigorous</p> <p>Not rigorous</p> <p>Not sure/not reported</p>	<p>Comments:</p>
<p>9. Is the data 'rich'?</p> <p>For example:</p> <ul style="list-style-type: none"> • How well are the contexts of the data described? • Has the diversity of perspective and content been explored? • How well has the detail and depth been demonstrated? • Are responses compared and contrasted across groups/sites? 	<p>Rich</p> <p>Poor</p> <p>Not sure/not reported</p>	<p>Comments:</p>
<p>10. Is the analysis reliable?</p>	<p>Reliable</p>	<p>Comments:</p>

<p>For example:</p> <ul style="list-style-type: none"> • Did more than 1 researcher theme and code transcripts/data? • If so, how were differences resolved? • Did participants feedback on the transcripts/data if possible and relevant? • Were negative/discrepant results addressed or ignored? 	<p>Unreliable Not sure/not reported</p>	
<p>11. Are the findings convincing?</p> <p>For example:</p> <ul style="list-style-type: none"> • Are the findings clearly presented? • Are the findings internally coherent? • Are extracts from the original data included? • Are the data appropriately referenced? • Is the reporting clear and coherent? 	<p>Convincing Not convincing Not sure</p>	<p>Comments:</p>
<p>12. Are the findings relevant to the aims of the study?</p>	<p>Relevant Irrelevant Partially relevant</p>	<p>Comments:</p>
<p>13. Conclusions</p> <p>For example:</p> <ul style="list-style-type: none"> • How clear are the links between data, interpretation and conclusions? • Are the conclusions plausible and coherent? • Have alternative explanations been explored and discounted? • Does this enhance understanding of the research topic? • Are the implications of the research clearly defined? <p>Is there adequate discussion of any limitations encountered?</p>	<p>Adequate Inadequate Not sure</p>	<p>Comments:</p>
<p>Ethics</p>		
<p>14. How clear and coherent is the reporting of ethics?</p> <p>For example:</p> <ul style="list-style-type: none"> • Have ethical issues been taken into consideration? • Are they adequately discussed e.g. do they address consent and anonymity? • Have the consequences of the research been considered i.e. raising expectations, changing behaviour? • Was the study approved by an ethics committee? 	<p>Appropriate Inappropriate Not sure/not reported</p>	<p>Comments:</p>
<p>Overall assessment</p>		
<p>As far as can be ascertained from the paper, how well was the study conducted?</p>	<p>++ + -</p>	<p>Comments:</p>

NICE quality appraisal checklist for quantitative studies reporting correlations and associations^{xv}

Study identification: Include full citation details		
Study design:		
Guidance topic:		
Assessed by:		
Section 1: Population		
1.1 Is the source population or source area well described? <ul style="list-style-type: none"> Was the country (e.g. developed or non-developed, type of health care system), setting (primary schools, community centres etc), location (urban, rural), population demographics etc adequately described? 	++ + - NR* NA	Comments:
1.2 Is the eligible population or area representative of the source population or area? <ul style="list-style-type: none"> Was the recruitment of individuals, clusters or areas well defined (e.g. advertisement, birth register)? Was the eligible population representative of the source? Were important groups underrepresented? 	++ + - NR NA	Comments:
1.3 Do the selected participants or areas represent the eligible population or area? <ul style="list-style-type: none"> Was the method of selection of participants from the eligible population well described? What % of selected individuals or clusters agreed to participate? Were there any sources of bias? Were the inclusion or exclusion criteria explicit and appropriate? 	++ + - NR NA	Comments:
Section 2: Method of selection of exposure (or comparison) group		
2.1 Selection of exposure (and comparison) group. <ul style="list-style-type: none"> How was selection bias minimised? 	++ + - NR NA	Comments:

^{xv} Available from: <http://www.nice.org.uk/article/PMG4/chapter/Appendix-G-Quality-appraisal-checklist-quantitative-studies-reporting-correlations-and-associations>

<p>2.2 Was the selection of explanatory variables based on a sound theoretical basis?</p> <ul style="list-style-type: none"> • How sound was the theoretical basis for selecting the explanatory variables? 	++ + - NR NA	Comments:
<p>2.3 Was the contamination acceptably low?</p> <ul style="list-style-type: none"> • Did any in the comparison group receive the exposure? • If so, was it sufficient to cause important bias? 	++ + - NR NA	Comments:
<p>2.4 How well were likely confounding factors identified and controlled?</p> <ul style="list-style-type: none"> • Were there likely to be other confounding factors not considered or appropriately adjusted for? • Was this sufficient to cause important bias? 	++ + - NR NA	Comments:
<p>2.5 Is the setting applicable to the UK?</p> <ul style="list-style-type: none"> • Did the setting differ significantly from the UK? 	++ + - NR NA	Comments:
<p>Section 3: Outcomes</p>		
<p>3.1 Were the outcome measures and procedures reliable?</p> <ul style="list-style-type: none"> • Were outcome measures subjective or objective (e.g. biochemically validated nicotine levels ++ vs self-reported smoking -)? • How reliable were outcome measures (e.g. inter- or intra-rater reliability scores)? • Was there any indication that measures had been validated (e.g. validated against a gold standard measure or assessed for content validity)? 	++ + - NR NA	Comments:
<p>3.2 Were the outcome measurements complete?</p> <ul style="list-style-type: none"> • Were all or most of the study participants who met the defined study outcome definitions likely to have been identified? 	++ + - NR NA	Comments:
<p>3.3 Were all the important outcomes assessed?</p> <ul style="list-style-type: none"> • Were all the important benefits and harms assessed? • Was it possible to determine the overall balance of benefits and harms of the intervention versus comparison? 	++ + -	Comments:

	NR NA	
3.4 Was there a similar follow-up time in exposure and comparison groups? <ul style="list-style-type: none"> If groups are followed for different lengths of time, then more events are likely to occur in the group followed-up for longer distorting the comparison. Analyses can be adjusted to allow for differences in length of follow-up (e.g. using person-years). 	++ + - NR NA	Comments:
3.5 Was follow-up time meaningful? <ul style="list-style-type: none"> Was follow-up long enough to assess long-term benefits and harms? Was it too long, e.g. participants lost to follow-up? 	++ + - NR NA	Comments:
Section 4: Analyses		
4.1 Was the study sufficiently powered to detect an intervention effect (if one exists)? <ul style="list-style-type: none"> A power of 0.8 (i.e. it is likely to see an effect of a given size if one exists, 80% of the time) is the conventionally accepted standard. Is a power calculation presented? If not, what is the expected effect size? Is the sample size adequate? 	++ + - NR NA	Comments:
4.2 Were multiple explanatory variables considered in the analyses? <ul style="list-style-type: none"> Were there sufficient explanatory variables considered in the analysis? 	++ + - NR NA	Comments:
4.3 Were the analytical methods appropriate? <ul style="list-style-type: none"> Were important differences in follow-up time and likely confounders adjusted for? 	++ + - NR NA	Comments:
4.6 Was the precision of association given or calculable? Is association meaningful? <ul style="list-style-type: none"> Were confidence intervals or p values for effect estimates given or possible to calculate? Were CIs wide or were they sufficiently precise to aid decision-making? If precision is lacking, is this because the study is under-powered? 	++ + - NR NA	Comments:
Section 5: Summary		
5.1 Are the study results internally valid (i.e. unbiased)? <ul style="list-style-type: none"> How well did the study minimise sources of bias (i.e. adjusting for potential confounders)? Were there significant flaws in the study design? 	++ + - NR NA	Comments:

<p>5.2 Are the findings generalisable to the source population (i.e. externally valid)?</p> <ul style="list-style-type: none"> • Are there sufficient details given about the study to determine if the findings are generalisable to the source population? • Consider: participants, interventions and comparisons, outcomes, resource and policy implications. 	<p>++ + -</p>	<p>Comments:</p>

*NR= Not reported; NA= Not applicable

Appendix 4 *Quotes illustrating the thematic synthesis codes*

Global themes	Descriptive themes	Basic codes	Quotes
Discussing care of individual patients	Transition periods	Discussing new referrals	"All non-urgent referrals were directed through the CMHT, debated at a weekly meeting, allocated to individual workers and rediscussed following assessment at the following meeting." (Lawley et al., 2005; p.101)
		Allocating cases to keyworker	"Communication within CMHTs mostly took place in weekly team meetings, which included discussions on referrals ... allocation of care co-ordinator responsibilities" (Simpson, 2007; p.411)
		Discussing recent assessments	"Most meetings focussed on service-users' care and 'case management' issues e.g. reporting/communicating developments ... giving feedback on assessments" (West et al. 2012; p.74)
		Discharge planning	"...included discussions on referrals, assessments, discharging patients" (Simpson, 2007; p.411)
On-going care		Providing updates on ongoing work	"It's talking about what, what I do, what other people are doing, that's the most important thing. (CMHN)" (Brown & Crawford, 2003; p. 75)
		Assessing risk	"Weekly review meetings are an opportunity for a more in-depth review of cases ... reviews should be systematic and include a summary by the case manager and risk and needs assessments." (Kent & Burns, 2005; p. 392)
		Planning contact	"Most meetings focussed on service-users' care and 'case management' issues ... planning contact..."(West et al. 2012; p.74)
		Discussing problems or difficulties	" ... to analyse difficult cases that people are struggling with" (Thompson et al., 2008; p. 134)
		Deciding or approving care plans	"The completed assessment is discussed at the weekly team meeting to formalise the outcome of the assessment, provide a provisional diagnosis ... and agree on an initial care plan." (Mitchell & Patience., 2008; p. 608)

		Assigning or approving diagnosis	“Appraisal of all collected evidence within a multidisciplinary meeting, led by a Consultant Old Age Psychiatrist, concludes with a formal diagnosis being assigned to each patient.” (Page et al., 2008; p. 28)
Teamwork	Specialist input	Sharing discipline-specific knowledge	“All cases are reviewed during team meetings on a regular basis, and both generic and specialist inputs are offered as appropriate.” (Singh et al., 2004; p. 943)
		Liaising with staff from other teams	“The role of the link worker is to act as a liaison expert ... assisting and enabling CMHT staff to deliver drug and/or alcohol interventions ... This is achieved by attending the CMHT team meeting or ward round every few weeks” (Whicher & Abou-Saleh, 2009; p. 229)
	Generic input	Reaching shared decisions	“to reach shared decisions about what had to be done” (Cunningham & McCollam, 2001; p.34)
		Sharing burden and peer support	"Community workers need to be able to share the burden of caring for this vulnerable and demanding group. Although more time is spent occupied in work-planning meetings, this results in care being delivered in a more responsive client-centred way." (Jones, 2002; p. 269)
		Arranging cross-cover	“Cross-cover arrangements for annual leave, training, sickness, etc. are straightforward. Patients might have been discussed within previous multidisciplinary team meetings, or during in-patient ward rounds when both consultants have been present, providing some insight into the plan of care, even if they have not been directly involved.” (Lawley et al., 2005; p. 102)
Team management	Managing service	Allocating resources	“ ... planning the delivery and allocation of resources” (Firn et al., 2013; p.1002)
		Discussing service improvement	“Weekly team meetings, which can be used to evaluate the program as a whole, task assignments, in-service training, quality improvement activities, and program renovation.” (Lieberman et al., 2001; p. 1335)
		Reviewing previous minutes	“A secretary took minutes at each ‘Yellow team’ meeting, which were referred to the following week.” (Simpson, 2007; p. 411)

	Managing staff	Monitoring performance	“Client-focussed meetings enabled far greater scrutiny of what key workers were doing with the clients.” (Jones, 2002; p. 263)
		Providing supervision	“More than one service stated that supervision was available during team meetings and at daily handovers.” (Orme, 2001)
Learning and development	Informal learning	Reflection on team tasks or processes	“A reflective approach to team task and processes was evident in most of the team meetings observed.” (West et al., 2012; p. 75)
		Learning about guidance or evidence	“The majority [of CMHT staff] had learned about [NICE guidelines for treating depression] from informal sources, such as team meetings.” (Rhodes et al., 2010; p., 150)
		Developing through discussion	“Multidisciplinary team colleagues report that debates on patient care ‘allow practitioners to express their views, are interesting and educational, enabling staff to develop professionally. Clinical isolation is no longer an issue for the psychiatrists.” (Lawley et al., 2005; p. 102)
		Empowerment through participation	" ... empowerment through participation in meetings." (Lieberman et al., 2001; p. 1332)
	Formal learning	Professional development activities	“One hour is allocated on rotation for business, audit, group supervision and professional development meetings.” (Burns & Guest, 1999; p. 350)
		Training	“The first hour is for the initial inquiry reviews. The second part alternates between team business one week and training the other week so there’s time for the training and development needs of the team" (Chisholm & Ford, 2004; p. 30)
		Hosting presentations from external speakers	“presentations may be given by outside experts” (Brown & Crawford, 2003; p.75)

Appendix 5 Participant information sheets and consent forms

This appendix contains the following study materials:

1. Practitioner Information Leaflet
2. Practitioner Consent Form for observations
3. Practitioner Consent Form for interviews
4. Patient Information Leaflet
5. Patient Consent Form for interviews

1. Practitioner Information Leaflet

[Trust logo]

Version 2 03/08/10

PARTICIPANT INFORMATION LEAFLET

Improving the effectiveness of Multidisciplinary Team Meetings (MDMs) for patients with chronic diseases

We would like to invite you to take part in a research study. Please read this leaflet which tells you about the study and what it involves and ask one of our team if there is anything that is not clear. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

Multi-Disciplinary Team Meetings (MDMs) are widely used across the NHS for managing chronic diseases. We want to find out more about the factors that influence clinical decision making at MDMs. The findings will be used to improve treatment decisions in your MDM and in other MDMs across the NHS by recommending possible improvements in the way that MDMs work.

Why have I been chosen?

We wish to examine a number of MDMs covering a wide range of clinical conditions affecting a diverse range of patients. All members of your multi-disciplinary team have been provided with this information sheet because we wish to observe your MDM and to invite some MDM members to participate in an interview. We will invite MDM members from each core professional group represented on the MDM, including both regular and infrequent attenders, to be interviewed.

What does the research involve?

If all multi-disciplinary team members consent, a researcher - Ms Caoimhe Nic a' Bháird - will attend and observe a number of consecutive MDMs. She will not be an active participant in these meetings, but will take notes, using a structured

form. She will collect information on the structure of the meeting (including the number of patients discussed, the professional mix of members attending); processes (including the roles of each of the members); patient related factors that are discussed and the clinical decision made. We expect to attend and observe between 22 and 41 meetings, depending on the number of patients discussed. The first eight meetings will be audiotaped. In this part of the study, you will not be required to do anything outside of, or in addition to your normal day to day activities.

Patients discussed at each MDM will be given the opportunity to 'opt out' of having their medical information included in the study. Your trust routinely asks new patients for permission to make their medical records available to researchers. We will respect the patient's response to this request.

In addition, the researcher will conduct face-to-face interviews with a selection of multi-disciplinary team members. The purpose of these interviews is to explore members' perceptions of MDM strengths and weaknesses; factors influencing MDM decisions; their professional role and value to the MDM. The questions will be flexible and open-ended, to allow you the chance to raise the issues that you feel are important. If you are approached to be interviewed, we will ask you to sign a further consent form. All information given during these interviews will be kept strictly confidential and no names will be attached to the information provided. The interview will be conducted at a convenient time and place of your choosing. The interview will last between 30 minutes and one hour and may be ended by you at any time. It will be tape-recorded, if you consent, but the tapes will be destroyed after analysis has been completed.

Do I have to take part?

It will be entirely up to you to decide whether or not to take part in the study and you can withdraw from the study at any time without having to give a reason. If you decide to participate, you will be asked to sign a consent form, and given a copy to keep. A decision not to take part or a decision to withdraw from the study will not affect your work in any way.

What are the possible disadvantages of being interviewed?

It is expected that this study does not have any disadvantages, but the interview will take between thirty and sixty minutes of your time.

What are the possible benefits of being interviewed?

The information we get from this study will improve the MDM decision-making process by highlighting areas of excellence and possible weaknesses. If you take part in an interview, your anonymised views will contribute to our findings and any resulting recommendations for change.

Will what I say be confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. If you are interviewed, this will take place in private, and the recording will not contain your name or any personal information, only a study identification number. Recordings will be encrypted and held in a computer in the Department of Epidemiology and Public Health, UCL. Only those members of the research team who are directly involved in analysing the information will have access to the recordings. In publications and reports, the identity of participating MDMs will not be revealed, only basic descriptive information on the conditions covered and regional location of the MDM will be given. Professor Rosalind Raine is the Chief Investigator and she has overall responsibility for confidentiality and data security.

What will happen to the results of the study?

Once the study has finished the results will be analysed and conclusions drawn about how treatment decisions are reached, and how this process might be improved. Findings will be published in scientific journals, but the MDM and all individuals will be referred to in anonymised form. Quotes from the interviews may be used, but again will be anonymised. Any quotes where the individual concerned could be identified by another team member, or anyone else, will not be used. We will also visit your MDM and provide a summary of our findings. Again, interview quotes will only be used as long as the speaker's anonymity can be preserved. MDM members will have the opportunity to discuss the findings and give their views on the recommendations.

Who is organising and funding the research

Professor Rosalind Raine is the Chief Investigator and the study is funded by the National Institute of Health Research. No payments are made to the researchers conducting this study.

Who has reviewed this study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by East London Research Ethics Committee.

What do I do if I wish to make a complaint about the research?

If you wish to complain about any aspect of the research, you should contact the Chief Investigator Professor Rosalind Raine or the researcher Ms. Caoimhe Nic a Bháird. If you feel you do not receive a satisfactory response and you wish to take the matter further you should contact the Complaints Manager (see below) giving the project title and the Chief Investigator's contact details.

Contact details

Please contact Caoimhe Nic a Bhaird if you are interested in participating, if you would like to ask questions about the study or for any other reason:

By telephone: 020 7679 1968

By email: c.bhaird@ucl.ac.uk

By post: Caoimhe Nic a Bhaird
Department of Epidemiology and Public Health
University College London
1-19 Torrington Place
London WC1E 6BT

You can also contact Professor Raine on 0207 679 1713 or by email (r.raine@ucl.ac.uk).

Contact details for the Complaints Manager are

[Local trust Complaints Manager contact details]

Thank you very much for taking the time to read this information about the study.

2. Practitioner Consent Form (observations)

[Trust logo]

UCL Project ID number: 10/071

Participant ID number for this study:

Title of study: Improving the effectiveness of Multidisciplinary Team Meetings (MDMs) for patients with chronic diseases: Non-participant observation

Chief investigator: Professor Rosalind Raine

Principal Investigator at [trust]: [Name]

Researchers: Caoimhe Nic a Bhairst, Dr Penny Xanthopoulou & Isla Wallace

INFORMED CONSENT FORM

Please initial box

1. I confirm that I have read and understand the participant information sheet dated 03/08/10 (Version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my medical care or legal rights being affected.

3. I understand that all the information I provide for the purposes of this study will be kept strictly confidential.

4. I consent to the multidisciplinary meetings being taped and understand that these recordings will be stored securely and destroyed after analysis is complete.

5. I agree to being quoted anonymously in the results.

6. I agree to take part in this study.

Name of Participant (PRINT)	Date	Signature
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Name of person taking consent	Date	Signature
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3. Practitioner Consent Form (interviews)

[Trust logo]

UCL Project ID number: 10/071

Participant ID number for this study:

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Title of study: Improving the effectiveness of Multi-Disciplinary Team Meetings (MDMs) for patients with chronic diseases: Interview

Chief investigator: Professor Rosalind Raine

Researcher: Ms Caoimhe Nic a Bhaird

INFORMED CONSENT FORM

1. I confirm that I have read and understand the participant information sheet dated 03/08/10 (Version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my medical care or legal rights being affected.

3. I understand that all the information I provide for the purposes of this study will be kept strictly confidential.

4. I consent to the interview being taped and understand that these recordings will be stored securely and destroyed after analysis is complete.

5. I agree to being quoted anonymously in the results.

6. I agree to take part in this study.

Name of Participant (PRINT)	Date	Signature
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Name of person taking consent	Date	Signature
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4. Patient Information Leaflet

[Trust logo]

Version 2 28/03/12

SERVICE USER INFORMATION LEAFLET

Improving the effectiveness of multidisciplinary team meetings in healthcare

We would like to invite you to take part in a research study. Please read this leaflet which tells you about the study and what it involves and ask one of our team if there is anything that is not clear. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

Multidisciplinary Team Meetings (MDMs) are widely used across the NHS for managing service users' care. We want to find out more about the factors that influence clinical decision making at MDMs. The findings will be used to improve care decisions in your MDM and in other MDMs across the NHS, by recommending possible improvements in the way that MDMs work.

Why have I been chosen?

As part of our research we wish to explore methods for taking service users' wishes about their care into account during MDM decision making. We are therefore inviting a diverse range of service users to be interviewed.

What does the study involve?

A researcher will contact you to see if you are willing to be interviewed. If you are, they will arrange a time and day that suits you. You will be interviewed in private at a place of your choice. This may be at your home or at this clinic, when you next have an appointment. During the interview, the researcher will ask you questions about your health care wishes and expectations and the

extent to which these were met by the decisions made about your care at the MDM. She will also be interested to hear any suggestions you may have to improve service users' involvement in health care decision making. The questions will be flexible and open-ended, to allow you the chance to raise any issues that you feel are important. The interview will last between 30 minutes and one hour and may be ended by you at any time. It will be tape-recorded, if you consent, but the tapes will be destroyed after analysis has been completed. You will also be asked to allow the researcher to collect medical information about your condition and care from your medical records.

Do I have to take part?

It will be entirely up to you to decide whether or not to take part in the study and you can withdraw from the study at any time without having to give a reason. A decision not to take part or a decision to withdraw from the study will not affect your care in any way.

If you are interested in taking part then the health care professional who has given you this sheet will give us your contact details. The researcher will then contact you by phone. If you prefer to be contacted by another method, then please tell the person who gave you this sheet and we will email or write to you instead. The researcher will then arrange to meet you. You can contact the researcher or other members of the research team at any other time using the contact details below.

If you decide to be interviewed, you will be asked to sign a consent form to say that you are happy to take part and that you agree to the researcher having access to your healthcare records. You will be given a copy of the consent form to keep. You will still be free to withdraw from the interview at any time, and without giving a reason.

What are the possible disadvantages of being interviewed?

It is expected that this study does not have any disadvantages, but the interview will take up your time.

What are the possible benefits of being interviewed?

The information we get from this study will improve the MDM decision-making process by highlighting areas of excellence and possible weaknesses. If you take part in an interview, your views will contribute to our findings and any resulting recommendations for change. However the identities of participants will not be revealed in any publication or report relating to this research.

Will what I say be confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. If you are interviewed, this will take place in private, and the recording will not contain your name or any personal information, only a study identification number. Recordings will be encrypted and held, together with information from your medical records in a password protected computer in the Department of Epidemiology and Public Health, UCL. Only those members of the research team who are directly involved in analysing the information will have access to the files on the computer. Professor Rosalind Raine is the Chief Investigator and she has overall responsibility for confidentiality and data security.

Involvement of your doctor

The health care professional in charge of your care here is aware that you have been invited to participate in this study. If you decide to participate, a copy of your signed consent form will be kept in your notes. However s/he will not see any study information with your name on it. In all publications and reports, the identity of participants will not be revealed.

What will happen to the results of the study?

Once the study has finished the results will be analysed and conclusions drawn about how care decisions are reached, and how this process might be improved. Findings will be published in a scientific journal, but it will not be possible to identify you or your healthcare team. Quotes from the interviews may be used, but again, these will be anonymised. We will also produce a summary of our findings which we will send to you.

Who is organising and funding the research

Professor Rosalind Raine is the Chief Investigator and the study is funded by the National Institute of Health Research. No payments are made to the researchers conducting this study.

Who has reviewed this study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by East London Research Ethics Committee.

What happens if I become upset by any aspect of the study?

In the unlikely event that you become distressed by any aspect of the study, the researcher will offer support and can contact a person suggested by you if that is your wish. This may be your partner or carer. If you ask, they will also provide feedback (the content of which will be agreed with you) to the healthcare professional who is primarily responsible for your care. In the event of illness the researcher will contact the healthcare professional most readily available to offer help.

What do I do if I wish to make a complaint about the research?

If you wish to complain about any aspect of the research, you should contact the [local collaborator], Professor Rosalind Raine or the researcher. If you feel you do not receive a satisfactory response and you wish to take the matter further you should contact the Complaints Manager (see below) giving the project title and the Chief Investigator's contact details.

Contact details

Please contact Caoimhe Nic a Bhaird, if you would like to ask questions about the study or for any other reason:

By telephone: 020 7679 1968

By email: c.bhaird@ucl.ac.uk

By post: Caoimhe Nic a Bhaire
Department of Epidemiology and Public Health
University College London
1-19 Torrington Place
London WC1E 6BT

You can also contact:

Professor Raine on 0207 679 1713 or by email (r.raine@ucl.ac.uk).

Contact details for the Complaints Manager are:

[local contact details]

More general information about taking part in medical research is available from the Patient Advice and Liaison Service (PALS), either online at www.pals.nhs.uk or via your local PALS office:

[contact details for local service]

Thank you very much for taking the time to read this information about the study.

5. Patient Consent Form (interviews)

[Trust Logo]

UCL Project ID number: 10/071

Service User ID number for this study:

Title of study: Improving the Effectiveness of Multidisciplinary Team Meetings in Healthcare

Chief investigator: Professor Rosalind Raine

Principal Investigator at [trust]: [name]

Researchers: Caoimhe Nic a Bhaird, Isla Wallace, Dr Penny Xanthopoulou, Dr William O'Driscoll & Dr Mano Manoharan

INFORMED CONSENT FORM

1. I confirm that I have read and understand the service user information sheet dated 28/03/12 (Version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my medical care or legal rights being affected.

 3. I understand that all the information I provide for the purposes of this study will be kept strictly confidential.

 4. I understand that the researchers will need to know my name, address and contact details. These will be used only to contact me about the study.
- I give permission for the researchers to have this information.

5. I understand that the researchers will have access to my medical records. The researchers will use these:

- to collect medical information about my condition and care
- to update my contact details if these change during the study

I give permission for these individuals to have access to my records

6. I consent to the interview being taped and understand that these tapes will be stored securely and destroyed after analysis is completed.

7. I agree to being quoted anonymously in the results.

8. I agree to take part in this study.

Name of Participant (PRINT)	Date	Signature
Name of person taking consent	Date	Signature

Appendix 6 *Inputs-Processes-Outputs model*

INPUTS

- System and organisational inputs:
- National policy/guidance
 - Local policy/guidance
 - Resources
 - External services

- Team and task inputs:
- Advance information
 - Meeting environment
 - Use of technology
 - Meeting structure
 - Patient information and preferences

PROCESSES

- Participation
- Communication
- Misunderstandings and ambiguity
- Leadership
- Social cohesion
- Decision mechanisms

OUTPUTS

- Decisions
- Documentation
- Responsibility for implementation

6. What information is shared in advance? How does this influence decision-making?

7. Meeting environment (e.g. size of room / seating arrangements / light / acoustics):

8. What use is made of technology? E.g. access to test results, patient notes, virtual team. How does this influence decision-making?

9. How structured is the meeting process? (e.g. following agenda, protocol):

10. Who presents cases? How? Use of structured proforma? Framing of decisions to be made:

11. Patient factors: who mentions patient preferences? Who, if anyone, mentions carer or family preferences? How do attendees react? Any variation by patient characteristics:

- Socio-demographic (e.g. age, gender)
- Socioeconomic (e.g. education, poverty)
- Social (e.g. marital status, employment, family)
- Health literacy (e.g. understanding about condition and navigation of healthcare services)

12. Mention of missing information (e.g. test results, attendees)? Impact on decision-making:

13. Other team, task and patient inputs influencing decision-making:

PROCESSES - Team processes, emergent states

14. Participation / communication: who dominates? Who has least involvement? Is there a hierarchical pattern of participation or a relatively even distribution?

15. Any misunderstandings/lack of clarity - between whom? Who asks questions? To whom? Is there dissent or conflict? Who disagrees? How is it dealt with?

16. Leadership style: Clear role or several competing leaders? Does the leader dominate discussion or decision-making, or take a back seat? Do they encourage involvement or limit contributions (e.g. because of time)? Do they check understanding or proceed at their own pace?

17. Cohesion: Any social conversation immediately pre/post meeting? Is everyone focused on the task - anyone chatting/disinterested? Mood/affect - Relaxed? Pressured? Formal? Focused on task?

18. Decision mechanisms: Is consensus sought? How (e.g. verbal, eye contact)? Are decisions made in the absence of consensus?

19. Other mediators, processes influencing decision-making:

OUTCOMES

20. OUTCOME: Clarity of recommendations. Who records the decision? Is there a verbal summary and rationale? Is responsibility for implementation discussed?

Other:

Appendix 8 Interim thematic framework from the observational analysis

Basic codes	Organising themes
Decision-making Sharing success Emotional expression and support Professional support, guidance and teaching Debating ethical dilemmas Feedback of assessments Updates on ongoing cases Liaison with other teams Legalities and professional safeguarding Sharing responsibility Documentation and audit Reflecting on therapeutic alliance Discussing research or evidence Seeking opinions or advice Validation of decisions made externally Meeting management Sharing knowledge of organisational systems Sharing knowledge of specific patients Team management Team building and cohesion Responding to errors Discussing service improvement Discussing patient experience of services	Multiple functions
Inconsistent documentation of meeting outcomes Attendance and punctuality Meeting disruption Problems with meeting room Missing information Delays while searching for information Resources: system capacity Resources: time Resources: funding Professionals adopting administrator role Selecting cases for discussion	Administrative challenges
High level management Organisational restructuring Relationships with other services Local policy and guidance National policy and guidance	External influences
Withholding information from patients Conflicting responsibilities: patient and carers/family Conflicting responsibilities: patient and society	Ethical dilemmas

<p>Conflicting responsibilities: Patient and staff safety Patient persuasion, negotiation and management Labels and stigma Deciding when to discharge Distinguishing 'illness' from 'bad behaviour' Resignation: knowing when to stop</p>	
<p>Complex diagnosis Questioning patient truthfulness Opportunistic or inappropriate service use "Challenging" behaviour Patient disputing/denying illness Lack of clear options for patient Contradictory information Obstructive carer collusion Obstructive carer interference</p>	<p>Challenging cases</p>
<p>Directives and requests Allocating implementation responsibility Consensus Multidisciplinary participation Clinical disagreements Non-clinical disagreements Hierarchy Challenging, questioning and clarifying</p>	<p>Communication features</p>
<p>Patient awareness of MDT meetings Need to seek collateral information Use of IT Awareness of researcher Patient treatment preferences Carer preferences Carer wellbeing Ownership of the case Positive carer influence Positive comments about patients Challenging an earlier decision Empathy towards patient Advocacy/patient-centred care Presenting clinical history Reference to decision-making outside of meeting Holistic discussion of patients and comorbidities Pathways of care</p>	<p>Miscellaneous codes*</p>

*The miscellaneous category was used to store codes that were used during the development of the framework but did not fit under any of the themes. Many of these were subsumed under the meta-themes in the integrated thematic framework, for example, "Use of IT" became part of the "Organisation of MDT meetings" meta-theme.

Appendix 9 Practitioner interview topic guide



MDT Study Participant Interview Topic Guide

INTRODUCTION

- Explain purpose of interview
- Explain that the questions are flexible and open-ended to allow them the chance to raise the issues that they feel are important.
- Explain that their responses will be confidential and anonymous in any findings we publish
- Explain that findings will not be shared with their team
- Explain that there are no 'right' or 'wrong' answers
- Invite questions and check if happy to proceed

WARM UP

This interview is about your experience of the MDT meeting, in general, how do you find working in this way?

- What do you think works well about your MDT meeting?
- Is there anything you would change about your MDT meeting?
- If there was no MDT meeting, what difference would it make?
- Is the MDT a good use of your time? What is most/least valuable?
- What would you describe as the primary role of the MDM? Does it have any other functions?

What factors are most important to the success of an MDT meeting?

TEAM PROCESSES

What is the atmosphere like in the team meetings? What do you think creates this atmosphere?

- Is there anything that would make it better?
- Do you think people are able to speak freely during the meetings? Why?
- How do the different professional groups interact?
- Are some professions more or less relevant to the meeting than others?

- What do you see as your role in the meeting?
- What kind of issues do you bring to the meeting? Do you think the MDM is the best way to do this?

What happens when people disagree?

- Can you give example of time you disagreed?

DECISION-MAKING

How does the team come to a decision about a case/patient?

- What information do you need to make a decision?
- Probe re barriers to accessing information?
- Are there times when the team doesn't come to a decision? Why is this?

Can you tell me about how patient preferences factor in decision-making?

- How much do you tend to know about patient's preferences? To what extent do they influence decision-making?
- How can patient preferences be incorporated into decision-making?
- What about other factors, for example, other illnesses or conditions: how do these influence decision-making?

Is there anything you think doesn't get discussed enough during the meeting?

- Is there anything you think less time should be spent on?
- Are there any changes that could realistically be made to improve it? How could this happen?

How do MDT meetings affect the quality of clinical decisions?

- Can you describe a time when an MDT meeting led to a better clinical decision for a patient?
- Are there times when poor or sub-optimal decisions are made? Why do you think this happens?
- Prompt for a specific example

Can you describe a time when a decision made at the meeting was changed? Why did this happen?

How much of decision-making happens outside of the meeting? How does the quality of these decisions compare?

To conclude this section, could you reflect on anything that could be improved about the way decisions are made?

EXTERNAL INFLUENCES

How is decision-making influenced by resource issues?

- E.g. time-constraints, funding, staff shortages)

Thinking about the physical environment, are there any aspects of the room or layout that influence the way the team interacts?

At the moment, there are a lot of changes going on in the NHS...

- How would you describe the impact of this on your organisation?
- Do you think this has impacted on your team? In what way?

Finally, is there anything else you think is relevant?

Appendix 10 Patient interview topic guide



MDT Study Patient interview Topic Guide

INTRODUCTION

- Explain purpose of interview
- Explain structure of topic guide (care so far, experience of decision-making, preferences about involvement in decision making)
- Explain that questions are flexible and open-ended to allow them the chance to raise issues that they feel are important.
- Explain that responses will be confidential and that quotes may be used in publications, but that it will not be possible to identify them or their team from these
- Explain that the study is being conducted by UCL and that the researchers are not employed by the NHS or affiliated with the trust
- Explain that their responses will not be shared with their team
- Explain that there are no 'right' or 'wrong' answers, that they do not have to answer any question they are uncomfortable with, and that they can stop the interview at any time, without it affecting their care
- Invite questions and check if happy to proceed

I'd like to start by asking you about your condition and your care.

Could you briefly tell me about your [condition] and the most important ways that it affects you?

What types of care do you currently have for your [condition]?

Can you describe how decisions were/ are made about your care?

- Who are the main people involved in making decisions about your care?
- What involvement do you have in making decisions / planning care?
- What are your preferences/wishes regarding your care?
- Can you describe any times when you were invited to discuss or make choices about any aspects of your care?
- Did you want to make choices? Does it depend on the type of decision?

I'd like for us to talk in more detail about any particularly important decision that was made about your care. This may include a treatment, diagnostic procedure, something about the timing, setting, or anything else.

Can you describe how you made your decision to / not to receive this care?

- What factors influenced your decision? Why
- Any perceived concerns / benefits (e.g. side effects, time in hospital, convalescence time, enormity of procedure, quality of life, etc.)
- Where they received information from (e.g. family, friends, reading, clinical staff)
- Extent to which their decision was influenced by personal characteristics (e.g. belief systems, desire to retain personal control, delegation of decisions)
- Extent to which personal characteristics were mediated by context (e.g. relationship with key health professionals / the importance of the decision / uncertainty surrounding management options etc.)

Is there anything about your care that you know now, that you would like to have known before?

- How might this information have changed your care preferences / decision?

Increasingly in the NHS, patient care is managed by a team of professionals with different skills, rather than one person. For example, social workers, doctors, nurses and psychologists may meet together once a week to discuss different cases. Patient care decisions are often made in these in 'multidisciplinary team meetings' by the whole team.

What do you know about these meetings?

- What do you think about this way of working?
- Have any decisions been fed back to you from these meetings?
- How do you feel about your care being discussed in these meetings?

What were / are the important things about *you* that you would want the multidisciplinary team to consider when they meet to discuss your care/ management?

What were / are the important things about *your care* that you would want the multidisciplinary team to consider when they meet to discuss your care/ management?

When is the most appropriate time to discuss this information with you?

- How should it be done? How often? E.g. before or after the MDT?
- Who would you want to represent your views at a multidisciplinary meeting? E.g. key health professional, patient advocate, patient/carer

Are there issues that you would wish to remain confidential (not to be shared) when the team is discussing management options for you?

In this final section, I'd like to talk more generally about how you think multidisciplinary teams should work.

Do you think it is important for multidisciplinary teams to always consider patients' views when making a decision about care?

As appropriate, probe the influence of:

- Context e.g. major decisions (to have a major intervention or not etc.) vs. decisions about process (scheduling, setting etc.);
- Intervention-specific issues (e.g. where there is clinical uncertainty about options, quality of life etc.)

What information should be fed back to patients about the multidisciplinary team meeting decision-making process about their care?

Do you have any suggestions of ways for patients' views to be represented at the multidisciplinary team meeting?

As appropriate, probe:

- Some suggestions include: staff known to patient attend, patient advocate attends, preparatory meeting with patient, patient preferences written down in advance, patient submits a written statement, patient/carer attends meeting, formalised feedback after the meeting, decision options discussed with patient after meeting etc.
- How would this work in practice?
- What about for patients who feel unable to express their view / ask questions?

Finally, is there anything else that you would like to add?

Appendix 11 Interim thematic framework from the interview analysis

Basic codes	Organising themes
Administrative problems Attendance and punctuality Challenges specific to new models of teams Communication with other agencies Dangers of democracy Diff views on whether or not decisions are binding Drive to discharge Lack of clear decision-making Lack of depth Lack of focus & irrelevant info Lack of leadership within team Need more reflection on mode of working Needs better structure Participation (lack of) People not open to suggestions Perceived as boring Poor chairing Poor time management Pressure to discharge Remit too narrow Role relations Too much time on new referrals or assessments Unclear purpose Unclear who is responsible Undermining professional autonomy Unsystematic approach to deciding who is discussed Venue and facilities	Perceived challenges and areas for improvement
Administrator attends Data collection Morning handovers Processing referrals Protocol type decisions Separate business meetings Whether attendance mandatory or voluntary Comments on how teams developed	Differences between teams
Keyworkers How is it decided who is in a team Manager Psychiatry Psychology	Different professional roles

<p>Higher management & organisational restructuring Research Resources</p>	<p>External influences</p>
<p>Allocation of work Communication and sharing information Cross-cover Data collection Decision-making Dedicated space to debate Discussing individual patients Discussing the wider service Discussing wider service Documentation of meeting outcomes Education Emotional support and expression Endorsement of plans Focal point or focus for week Generating ideas and seeking advice Getting new perspectives Liaising with other team members Management and leadership Only time when whole team meets, bonding Power of the team - legitimising - you can say 'the team decided' Processing new referrals Promote psychological thinking Provides nourishment and stimulation Reflecting on therapeutic relationships Risk awareness Seeking specialist views Sharing responsibility or passing it on</p>	<p>Functions</p>
<p>Cohesion Deciding which patients are discussed Handling disagreements It matters who is present Leadership Morning handover Negotiation within the team Personalities Role of different personalities Supervision Who has responsibility Withholding info from team</p>	<p>Group processes</p>
<p>Patient awareness of meetings Care coordinator as patient advocate Patients not confident they'll be portrayed accurately at meetings Preferences sometimes inappropriate Preferences considered enough Preferences not considered enough</p>	<p>Patient involvement</p>

<p>Good management Not considered enough Patient ultimately decides (with exception of MHA and CTO) Unassertive patients with little 'voice' Patients unsure why referred Patients don't feel they've had care/decisions Patients not feeling heard Patients happy with aspects of care Patients aware of resource pressures Ideas to increase patient involvement</p>	
<p>Attendance Attendees from other teams Co-location Committed to the work Documentation Flat hierarchy Good leadership Having social worker as manager Sense that there are no stupid questions Presenters coming with a provisional plan Professionalism Respect Stable team membership Strong chair Structure Trust</p>	<p>What makes it work?</p>

Appendix 12 Observation proforma

Patient Data Proforma: Community Mental Health

Study ID					
Meeting Date					

A. PATIENT AND SOCIAL CHARACTERISTICS

Information shared explicitly during MDM (written/verbal):

1. Descriptors of age	<input type="checkbox"/> 1 Elderly	<input type="checkbox"/> 2 Young	<input type="checkbox"/> 0 No mention		
2. English proficiency	<input type="checkbox"/> 1 Poor	<input type="checkbox"/> 2 Good/native	<input type="checkbox"/> 0 No mention		
3. Ethnicity	<input type="checkbox"/> 1 White	<input type="checkbox"/> 2 Mixed	<input type="checkbox"/> 3 Black	<input type="checkbox"/> 4 Asian	<input type="checkbox"/> 0 No mention

Nationality _____

4. Marital Status:	<input type="checkbox"/> 1 Single	<input type="checkbox"/> 2 Widowed	<input type="checkbox"/> 3 Married/cohabiting	<input type="checkbox"/> 4 Divorced	<input type="checkbox"/> 5 Separated	<input type="checkbox"/> 6 No mention
5. Relationship with services	<input type="checkbox"/> 1 Obstructive	<input type="checkbox"/> 2 Non-adherent	<input type="checkbox"/> 3 Positive	<input type="checkbox"/> 0 No mention		
6. Caring roles	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 0 No mention			
7. In residential care	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 0 No mention			
8. Disability	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 0 No mention			
9. Difficult socioeconomic circumstances	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 0 No mention			

10a. Social support	<input type="checkbox"/> 1 Good	<input type="checkbox"/> 2 Ambiguous	<input type="checkbox"/> 3 Poor	<input type="checkbox"/> 0 No mention
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10b. Free text detailing social needs discussed:

Health behaviours

11. Smoking	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 Prev. history	<input type="checkbox"/> 0 No mention
12. Heavy drinking	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 Prev. history	<input type="checkbox"/> 0 No mention
13. Physical activity	<input type="checkbox"/> 1 Inactive	<input type="checkbox"/> 2 Regular exercise	<input type="checkbox"/> 0 No mention	
14. Patient knowledge of managing condition	<input type="checkbox"/> 1 Poor	<input type="checkbox"/> 2 Good	<input type="checkbox"/> 0 No mention	
15. Patient/carer prefs mentioned	<input type="checkbox"/> 1 Patient	<input type="checkbox"/> 2 Carer	<input type="checkbox"/> 3 Both	<input type="checkbox"/> 0 No mention

B. Information shared explicitly during MDT (written or verbal): Diagnosis, severity^{xvi}

Diagnosis	Confirmed	Suspected	Ruled out		
1. Schizophrenia	1	2	3	0	No mention
2. Other non-affective psychosis	1	2	3	0	No mention
3. Bipolar disorder	1	2	3	0	No mention
4. Depression	1	2	3	0	No mention
5. Psychotic depression	1	2	3	0	No mention
6. PTSD	1	2	3	0	No mention
7. Personality disorder	1	2	3	0	No mention
8. Substance misuse	1	2	3	0	No mention
9. Phobic	1	2	3	0	No mention
10. Anxiety/ anxiety disorders	1	2	3	0	No mention
11. OCD	1	2	3	0	No mention
12. Dissociative	1	2	3	0	No mention
13. Somatoform	1	2	3	0	No mention
14. Eating	1	2	3	0	No mention
15. Sleep	1	2	3	0	No mention
16. Sexual	1	2	3	0	No mention
17. Psychotic symptoms	1	2	3	0	
Mania	1	2	3	0	No mention
Behaviour					
18. Overactive/ aggressive/disruptive	1	2	3	0	No mention
19. Non-accidental self-injury	1	2	3	0	No mention
20. Problems with relationships	1	2	3	0	No mention
21. Probs with activities of daily living	1	2	3	0	No mention
22. Probs with occupation and activities	1	2	3	0	No mention
C. Comorbidities					
	Yes	No	Suspected		
1. Sexual dysfunction	1	2	3	0	No mention
2. Obesity	1	2	3	0	No mention
3. Diabetes	1	2	3	0	No mention
4. Cardiovascular disease	1	2	3	0	No mention
5. Hypertension	1	2	3	0	No mention
6. COPD	1	2	3	0	No mention
7. Substance misuse	1	2	3	0	No mention

OTHER

^{xvi} This section was adapted to each disease type; thus, the memory clinic form listed diagnoses relevant to memory problems.

D. ACTIONS AND DECISIONS

Information shared explicitly during MDM (written/verbal):

1. Rational for patient being discussed

a	Protocol
b	Feedback
c	Specific query
d	Unclear

2. Missing info

1 Yes 2 No

3. Presenter questioned before decision made?

1 Yes 2 No 0 No mention

4. Is the intent curative or palliative?

1 Curative 2 Palliative 0 No mention

5. Actions discussed

6. Decision 1

6a. How is decision recorded?

1 Written 2 Verbal 3 Both 0 Unclear to researcher

6b. Named decision owner?

1 Yes 2 No

6c. Is decision conditional?

1 Yes 2 No 0 No mention

7. Decision 2

7a. How is decision recorded?

1 Written 2 Verbal 3 Both 0 Unclear to researcher

7b. Named decision owner?

1 Yes 2 No

7c. Is decision conditional?

1 Yes 2 No 0 No mention

8. Factors impacting on team ability to make a decision (free text)

9. Any disagreements/challenges? 1 Yes 2 No

9a. Cause/content of disagreement

Free notes

Appendix 13 Supplementary quality assurance checklists and guides

The following guides were used in combination with O’Cathain’s (2010) Quality framework for Mixed Methods Research.

1. Creswell’s Checklist of Questions for Designing a Mixed Methods Procedure (Creswell, 2003)

- Is a basic definition of mixed methods research provided?
- Are the reasons given for using both quantitative and qualitative data?
- Does the reader have a sense for the potential use of mixed methods research?
- Are the criteria identified for choosing a mixed methods design?
- Is the mixed methods design identified?
- Is a visual model presented that illustrates the research strategy?
- Is the proper notation used in presenting the visual model?
- Are procedures of data collection and analysis mentioned as they relate to the chosen design?
- Are the sampling strategies for both quantitative and qualitative data collection mentioned for the design?
- Are specific data analysis procedures indicated for the design?
- Are the procedures for validation mentioned for the design and for the quantitative and qualitative research?
- Is the narrative structure of the final dissertation or thesis mentioned, and does it relate to the type of mixed methods design being used?

2. Good Reporting of a Mixed Methods Study (GRAMMS) (O’Cathain, Murphy & Nicholl, 2008)

- Describe the justification for using a mixed methods approach to the research question
- Describe the design in terms of the purpose, priority and sequence of methods
- Describe each method in terms of sampling, data collection and analysis
- Describe where integration has occurred, how it has occurred and who has participated in it
- Describe any limitation of one method associated with the presence of the other method
- Describe any insights gained from mixing or integrating methods

3. A scoring system for mixed methods research and mixed studies reviews

(Pluye, Gagnon, Griffiths & Johnson-Lafleur, 2009).

Study component	Methodological quality criteria
1. Qualitative	<ul style="list-style-type: none"> • Qualitative objective or question • Appropriate qualitative approach or design or method • Description of the context • Description of participants and justification of sampling • Description of qualitative data collection and analysis • Discussion of researchers' reflexivity
2. Quantitative experimental	<ul style="list-style-type: none"> • Appropriate sequence generation and/or randomization • Allocation concealment and/or blinding • Complete outcome data and/or low withdrawal/drop-out
3. Quantitative observational	<ul style="list-style-type: none"> • Appropriate sampling and sample • Justification of measurements (validity and standards) • Control of confounding variables
4. Mixed methods	<ul style="list-style-type: none"> • Justification of the mixed methods design • Combination of qualitative and quantitative data collection-analysis techniques or procedures • Integration of qualitative and quantitative data or results

Appendix 14 Integrated thematic framework

Theme I: The value and functions of team meetings

Organising themes	Codes	Sub-codes (where applicable)
Value of meetings	Good use of time Poor use of time Tedious or boring	
Clarity of purpose	Lack of clear purpose Purpose implicit Purpose not explained to new members	
Central forum for teamwork	Only opportunity to meet as whole team Meeting provides a focus for work Sharing information Seeking specialist input Promoting multidisciplinary thinking	Team building and bonding Cross-cover and coordination Sharing responsibility Fewer assessments for patients Countering the “medical model” Promoting psychological thinking
Feedback on recent assessments	Checking if they thought of everything Generating new ideas / seeking advice	
Updates on ongoing work	Challenging behaviour Ethical dilemmas Lack of clear options	Violence or aggression Opportunistic or inappropriate service use Suspected deception Distinguishing between ‘illness,’ ‘behaviour,’ and personality Obstructive carer influence Conflicting responsibilities towards patient and staff Conflicting responsibilities towards patient and family Conflicting responsibilities towards patient and wider society Unclear responsibilities towards other state agencies Required services unavailable Complex diagnoses Patient disputes illness Patient does not wish to engage Seeking help when “feeling stuck” Complex circumstances
Team decision-making	Care planning and formulating diagnoses	

	<p>Endorsement or validation of plans Reporting earlier decisions Sharing responsibility and ownership Shared risk and protection from consequences Legitimising power of the team Views on implementation</p>	<p>Team decisions seen as binding Team decisions not seen as binding</p>
<p>Sharing the emotional burden of the work</p>	<p>Venting and offloading</p> <p>Sharing successes and positive emotions Peer support and guidance Reflecting on therapeutic alliance</p>	<p>Emotional expression Managing anxiety Frustration with opportunistic or inappropriate service use Frustration with lack of clear options Sense of resignation or failure</p>
<p>Team management</p>	<p>Processing new referrals</p> <p>Performance monitoring</p> <p>General administration</p>	<p>Deciding if case is appropriate for team Allocating case to a team member for assessment Overseeing the quality of the work Monitoring completion of paperwork requirements Allocation of tasks Issuing deadlines for paperwork Monitoring achievement of targets Planning Planning team-building events, training or annual leave Data collection (Mem 1 only) Updates on organisational issues</p>
<p>Learning and development</p>	<p>Learning about each other's roles Sharing knowledge of services and organisational systems Sharing knowledge of specific patients Teaching</p>	

Theme II: The organisation of MDT meetings

Organising themes	Codes	Sub-codes (where applicable)
Documentation and administration	Quality of documentation Need for greater admin support	Desire for better documentation Paperwork
Attendance and punctuality	Attendance Punctuality Repeated discussions	It matters who is present "Rounding up" attendees
Selection of patients for discussion	Neglect of quiet cases Need for a more systematic approach Reluctance to share Issues that don't need discussion Reliance on memory problematic Suggestions for improvement	Patient list/agenda in advance Time limit for each discussion booking discussions into slots
Time management and chairing	Lack of focus and irrelevant information Lack of forethought Need for stronger chairing Lack of depth Rotating chair problematic	

Theme III: Multidisciplinary teamwork

Organising themes	Codes	Sub-codes (where applicable)
Varied views on multidisciplinary working	Positive views Negative views Different professional agendas Different models of care	
Balancing professional and generic roles	Different professions perform the same role	Failing to use the different skills available Erosion of skills and changing roles Struggles with professional identity Unclear remit of keyworker role Patients want more discipline-specific input
Leadership and power	Role ambiguity for consultants and managers Consultants and managers as ultimate decision-makers Unclear who is ultimately responsible Consultant in “pivotal” position Characteristics of good leaders	Consequences when consultant does not fulfil expected role
Status and hierarchy	Functioning hierarchy Medical dominance	Sense that there are no stupid questions Power struggles Psychiatrists wanting more participation Psychiatrists more directive when under pressure Perceived over-reliance on medication in care planning
Participation and inclusivity	Multidisciplinary participation Reasons for non-participation	Not seeing it as one’s role to comment on other people’s patients Maintaining autonomy Being outnumbered Lack of confidence and fear of criticism

Theme IV: Patient involvement in MDT meetings

Organising themes	Codes	Sub-codes (where applicable)
Patient and carer views	<p>Lack of patient involvement in meetings</p> <p>Lack of patient involvement in care planning generally</p> <p>Suggestions for improved patient involvement</p> <p>Desire for greater multidisciplinary input</p>	<p>Unaware of meeting</p> <p>Fear they will be portrayed inaccurately</p> <p>Patients don't feel they are receiving care</p> <p>Unsure why they are involved with team</p> <p>Patients feel they have not been offered choices</p> <p>Staff assumptions regarding patient preferences</p> <p>Feeling like they have not received care</p> <p>Happy with staff on a personal level</p> <p>Unreliable contact</p> <p>Patient attending meeting</p> <p>Attendance disruptive</p> <p>Patient providing input</p> <p>Explicit feedback to patient after meeting</p>
Consideration of patient preferences	<p>Varied views on whether considered enough</p> <p>Preferences can be complex or inappropriate</p> <p>Limited patient "voice"</p>	<p>Patient preferences considered enough</p> <p>Patient preferences not considered enough</p> <p>Keyworker as advocate</p> <p>Patient ultimately makes decisions</p> <p>Patients not wanting to get well</p> <p>Patients not wanting treatment</p> <p>Preferences based on perceived prejudice</p> <p>Persuasion, negotiation and leverage</p> <p>Many patients unassertive</p> <p>Patients feeling ignored</p> <p>Patients don't want to trouble overburdened staff</p>

Theme V: External influences on multidisciplinary care planning

Organising themes	Codes	Sub-codes (where applicable)
Resource limitations	Doing more with less Lacking key roles Earlier discharge Diminishing care options Diminishing onward referral options Working beyond capacity	Reaching breaking point
Organisational restructuring	Change management Morale and anxiety Impact on patients	Lack of confidence in trust leadership What could have been done differently? Feeling helpless and voiceless Anxiety and tension in team Inter-professional conflict Absence and commitment Staff retention problems Short-term focus in care planning Distracted keyworkers Uncertainty
Targets and tick-boxes	Paperwork detracting from care Inappropriate or meaningless targets Targets and tick-boxes undermining professional judgement	











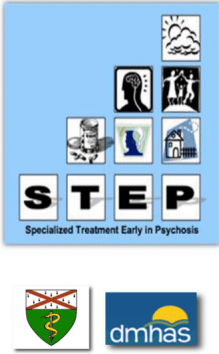


Appendix 15 Quotes illustrating the recurring challenges discussed

Challenging Behaviour	
Violence and aggression	<p>Social Worker: We went to see him with Brenda [StR], and he lunged at Brenda ... He lunged at Brenda because Brenda reduced the Clopixol. He's got it in for Brenda ...</p> <p>Team Manager: So has his medication been reviewed by Brenda? Increased, changed, whatever?</p> <p>Social Worker: No, no, no. We just legged it because he went for her (CMHT 2; observation)</p>
Opportunistic or inappropriate service use	<p>Consultant Psychiatrist: It was all bollocks as far as I was concerned, excuse my language ...</p> <p>Manager: The catalyst was this time last year, something happened to his benefits ...</p> <p>Consultant Psychiatrist: He's very convincing, you'd be fooled ... but shouldn't they be prosecuted for fraud? ... They're abusing our system ...</p> <p>Nurse: People want to be with the CMHT or secondary services because of benefits ...</p> <p>Consultant Psychiatrist: This guy is desperately devious ... What do we do with him? ... There was a lot of acting going on, very good quality acting (CMHT 1, observation)</p>
Suspected deception	<p>Nurse: He's acting out again ... Called the police at about eleven at night, he was saying he as suicidal ... He claimed to have taken 16 tablets of ecstasy ... which is like [laughs] he wouldn't have been moving. He's been doing this fairly regularly ... some of the drug use claims seem to be a bit high, a bit of bravado</p> <p>Consultant Psychiatrist: It sounds a bit unlikely doesn't it? ...</p> <p>Psychologist: Why do you think he's claiming overdoses when he's not taking them, if that is the case?</p> <p>Nurse: I cannot, it seems that he's then trying to attract attention, but when you try to talk to him about what's happening, he then says, "well I was only lying about that. I was telling lies, I was making it up" (CMHT 3, observation)</p>
Obstructive carer influence (e.g. collusion in harmful beliefs or behaviours, interference with treatment)	<p>Occupational Therapist: His wife says that he is [taking the medication] but she colludes with him at times (EIS, observation)</p> <p>Nurse: There's a strong element of helplessness reinforced by the mum over the years ... He knows that if he does help himself, then he gets less help from the mum ... she's over-involved. She always wants to adjust his medication (CMHT 3; observation)</p>
Distinguishing between 'illness', 'behaviour' and 'personality'	<p>Nurse: He's got a new male support worker because he's been disrespectful to women. He says he's going to take his Risperidone depot, he's been saying that for the last two weeks and those appointments have been made but he still hasn't materialised and had it. No obvious psychosis, it's just his behaviour really (EIS, observation)</p>
Ethical Dilemmas	
Conflicting responsibilities towards patient and staff	<p>Social Worker: He turned up on Friday with a loaded gun apparently ... I just wanted to raise that as well ...</p> <p>Nurse: A loaded gun can go off at any time!</p> <p>Manager: You're seeing him tomorrow with Dr Green? I mean maybe you need to check it out</p>

	Social worker: Yeah, I'll sit near the door (CMHT 2; observation)
Conflicting responsibilities towards patient and family	<p>Social Worker: He was expressing anger and intention to burn down a police station ... He's got a history of assault against his previous partner who had also accused him of rape ... He told us that he had previously killed someone in Morocco ... I mean to be honest the only, only warmth there was in relation to his two year old daughter. He was saying "my wife's not at risk because she knows to avoid me"</p> <p>Psychologist: You'd wonder how old that child has to get before that changes</p> <p>Social worker: Absolutely ... I mean, as you say, at what stage will that happen? It's not really clear that there's a role for CMHT to sort of help this man ... I suppose my thought is, not to [laughs], not to avoid contact with him, but</p> <p>Manager: Not to be in the same room with him for too long (CMHT 3; observation)</p>
Conflicting responsibilities towards patient and wider society	<p>Manager: You've got to hand it to her [laughs]</p> <p>Social Worker: She's a very stubborn lady</p> <p>Consultant Psychiatrist: I mean there is this. The worry simply is that when unwell she appears to be threatening to children. She has put her hands round the necks of children, so we can't just walk away from this one (CMHT 3; observation)</p>
Unclear responsibilities towards other state agencies	<p>Nurse: She's still claiming child benefits for a child that's been in care for years. If she's caught she'll have to</p> <p>Manager: - pay it all back</p> <p>Nurse: Or get prosecuted ... I told her she'd have to take responsibility for it. I said I won't document it but (observation)</p>
Lack of clear options	
Required services unavailable	<p>Manager: A small investment kept him alright</p> <p>Deputy Manager: But whether we can give him that small investment I don't know ...</p> <p>Manager: Well, we are a small team and resources are disappearing (CMHT 3; observation)</p>
Complex diagnosis	<p>Social Worker: Her diagnosis is changing, I've noticed, again. Paranoid PD [Personality Disorder] has now gone on to acute psychotic episodes, so this, there's no firm idea of what's happening with this woman (CMHT 2; observation)</p>
Complex social circumstances	<p>Consultant Psychiatrist: In some places they would confront him ... and get the wife involved and say 'listen you're colluding with this one'</p> <p>Manager: That has been done. I think there's a background of</p> <p>Consultant Psychiatrist: Domestic violence?</p> <p>Manager: Yeah, aggression. And so we concluded not to challenge too much because wifey's in the firing line ... They're a gang family and he's got lots of gang affiliations so it wasn't appropriate to</p> <p>Consultant Psychiatrist: - to rock the boat too much ... and I'm only finding that out now! (CMHT 1, observation)</p>
Patient disputes illness	<p>Social Worker: This is a fellow who persistently refuses to acknowledge that he's got a drug problem ... "I don't have a drug problem, I don't have drug-induced psychosis, I have spiritual experiences." So we're kind of dancing on the spot with him as well I'm afraid (CMHT 3, observation)</p>
Patient does not want to engage	<p>Social Worker: She's pathologically unable to keep appointments ... what kind of support can you give someone who won't engage? ... At the moment this is just going in absolute kangaroo jumps and circles ... There's nothing actively we can do (CMHT 3; observation)</p>

Appendix 16 Sample leaflet introducing team members to patients^{xvii}

You have taken an important first step in getting your life back on track! *Early intervention* makes a difference! Together we can help you achieve your goals!

			
<p>Jessica Pollard, Ph.D. Clinical Director (203) 974-7345, Rm. 219 Dr. Pollard oversees and provides STEP clinical services and conducts research and outreach.</p>	<p>Vinod Srihari, M.D. Attending Psychiatrist (203) 974-7816, Rm. 273A Dr. Srihari provides medication consultation, conducts research, and oversees STEP's psychiatric services.</p>	<p>John Cahill, M.D. Principal Psychiatrist (203) 974-7105, Rm. 2671 Dr. Cahill provides medication consultation, medical workup, and conducts research.</p>	<p>Tracey George, LCSW Social Worker (203) 974-7294, Rm. 222 Tracey provides clinical services, including individual therapy and helps coordinate services.</p>
			
<p>Lauren Utter, Psy.D. Postdoctoral Associate (203) 974-7244, Rm. 220 Dr. Utter is the STEP's Family Specialist, providing individual and family therapy.</p>	<p>Anna Fiskin, M.D. Psychiatry Resident (203) 974-7438, Rm. 2671 Dr. Fiskin provides medication consultation and psychotherapy.</p>	<p>Al Powers, M.D. Psychiatry Resident (203) 974-7329, Rm. 206 Dr. Powers provides medication consultation.</p>	<p>Nurse soon to come!</p>
			
<p>Barbara Walsh, Ph.D. (203) 974-7052, Rm. B38 Dr. Walsh provides comprehensive evaluations and community outreach.</p>	<p>Nina Levine, BA (203) 974-7043, Rm. B38 Nina is the Early Detection Campaign Coordinator and coordinates research visits.</p>	<p>Miranda Mast, BA Employment Specialist (203) 401-4227 x1224 Fellowship Place Miranda collaborates with clients to achieve their vocational goals.</p>	<p>STEP Specialized Treatment Early in Psychosis</p> <p>   </p>

Meet the STEP Team!

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***Appendix 17 Sample slides from Open House event
for patients and carers^{xviii}***

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