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Multidisciplinary team (MDT) review

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Purpose

The multidisciplinary team (MDT) review supports health and social care teams to:

1. Identify learning from multiple patient safety incidents (including incidents were multiple patients were harmed or where there are similar types of incidents)

2. Agree, through open discussion, the key contributory factors and system gaps in patient safety incidents for which it is more difficult to collect staff recollections of events either because of the passage of time or staff availability.

3. To explore a safety theme, pathway, or process. There will be many, but examples are:

    - delayed recognition of deteriorating patients
    - medication errors
    - admission or discharge-related safety events
    - safety issues relating to supported/therapeutic leave from a mental health unit
    - burns or other injuries sustained by residents in a care home.

4. To gain insight into ‘work as done’ in a health and social care system.

What is work as done?

By ‘work as done’ we mean how care is delivered in the real world, not how it is envisaged in policies and procedures (work as prescribed) or recounted in a walk through or a talk through (work as described). You can find more information on how to carry out walk throughs in the brief guide to walk through analysis.

This guidance sets out the steps to prepare for, carry out, and collate and use the findings from an MDT review.

Systems engineering initiative for patient safety (SEIPS)

We have used the SEIPS[1] framework (see SEIPS quick reference and work system explorer) to structure the MDT Review. There are other systems-based approaches and frameworks which you may use to frame an MDT Review, for example, the Human Factors Analysis Classification System and AcciMaps (amongst others).

How do I set up an MDT review?

MDT reviews are most useful when a wide range of stakeholders share their perspective on 'work as done' in the health or social care system being analysed.

To prepare for an MDT review you need to:

- Identify the stakeholders whose insights on 'work as done' need to be explored. Your list will depend on the incident or safety theme being explored. It should include clinical and non-clinical staff who work in the care setting or pathway to which you are applying the tool.
- Do some preparatory work to scope out the review. If the review is prompted by an incident, this may involve reviewing patient notes and carrying out some observations so you understand the context.
- Invite stakeholders to an MDT review workshop. Your invitation should clearly describe that the purpose of the workshop is to gain insight into the real world in which care is delivered and from this identify systems gaps and areas for improvement. Your invitation should also clearly identify what initiated the MDT review (eg an incident, a safety theme, a desire to understand work as done in the care setting or pathway).
- Be clear in the invitation that the outputs of the MDT review will be recorded and explain how you plan to capture the discussion (eg by having a notetaker present, audio recording the conversation or if using MS Teams using the transcription or recording facility (if available)).

[1] Holden, R.J., Carayon, P., Gurses, A.P., Hoonakker, P., Schoofs Hundt, A., Ozok, A.A. and Rivera-Rodriguez, A,J. (2013) SEIPS 2.0: a human factors framework for studying and improving the work of healthcare professionals and patients. Ergonomics, 56(11), 1669-1686.

How do I ensure participants feel safe to speak up and share their insights?

Creating a safe space at the outset of the MDT review

Step 1: Start the MDT review workshop by co-creating clear ground rules with participants. Say something like “We want to hear everyone’s insights in today’s workshop. How might we best work as a team to ensure everyone’s perspective is shared?”

Step 2: Be clear that your aim is to understand how care is delivered in the real world. This includes insights into systems gaps, barriers and enablers relating to the patient safety incident, pathway, process or safety theme being explored. Encourage participants to share any concerns they have around describing ‘work as done’ and answer any questions or concerns openly and honestly. For example, be open and honest about what prompted the MDT review and how its outputs will be used.

Step 3: Remind participants that you will be keeping a record the insights shared with you.

How do I set the scene and introduce the SEIPS framework to participants?

Introduce the SEIPS framework and relate it to the purpose of the MDT review

Step 4: Using the information in the SEIPS Quick reference and work system explorer, introduce participants to the SEIPS framework.

Step 5: Storytelling is a powerful way to explain the SEIPS framework because it helps clarify the dimensions of the work process and the outcomes. A good use of time at the start of the MDT review is to tell a patient or staff story through the lens of the SEIPS framework.

Step 6: Give participants time to ask questions about the SEIPS framework and answer their questions.

What is the SEIPS work system explorer and how do I use it in the MDT review?

Using the SEIPS work system explorer to gain insight into 'work as done'

The SEIPS quick reference guide and work system explorer contains prompt questions and statements for each of the six elements of the work system. Structuring the MDT review conversation around these will help you carry out a comprehensive systems analysis.

Step 7: Start a conversation about the desired outcomes by asking: "I am curious to learn how you would describe the desired outcomes in the SEIPS framework – please share your thoughts on the desired outcomes for system performance and human wellbeing in this care system?"

Step 8: There are various approaches to facilitating a conversation about 'work as done.' These options may be helpful:

> **Option 1:** ask questions that start a conversation about work as done. You may find these appreciative inquiry-based questions useful:
>
> - Question 1: Think back to the last shift you worked. Could you talk me through what happened on that shift? Please refer to the prompt questions/statements in the SEIPS work system explorer.
> - Question 2: I'm keen to hear about how care is delivered. Could you describe how you provide care on a day-to-day basis, including what barriers you face in providing safe patient care?
> - Question 3: I am curious to learn how a patient with [INSERT TYPE OF DIAGNOSIS] is cared for. Could you describe the steps in their patient journey? Please refer to the prompt questions/statements in the SEIPS work system explorer.
> - Question 4: I am interested to hear your initial reactions to the prompt questions and statements in the SEIPS work system explorer. Do any particularly resonate in this care setting?
>
> You do not have to ask all four questions – they are guiding questions that support you in shaping a conversation about work as done using the SEIPS work system explorer.

Option 2: You may prefer to structure the conversation about 'work as done' by systematically working through each of the prompt questions/statements in each element of the SEIPS work system explorer.

Ask participants about each element of the SEIPS framework in the context of the patient safety incident, safety theme, pathway or process being explored in the MDT review. You could choose to facilitate this conversation by working through each element of SEIPS or by leave participants to share their thoughts on the impact of any of the six elements.

Option 3: Facilitate the MDT review by splitting participants into pairs/groups and asking each pair/group to answer the prompt questions/statements in one of the six elements of the SEIPS work system explorer and share their responses with the rest of the group. This will generate further conversation and insight into work as done.

How do I wrap up the MDT review?

Wrap up, thank, and describe the next steps

Step 9: At the end of the MDT review, read back (ie summarise) your understanding of the key insights identified about work as done. Clearly outline what the next steps will be, including:

- how you plan to collate the outcomes of the MDT review
- how you will keep participants updated after the MDT review.

Remember to thank participants for their time.

What do I need to do after the MDT review?

Triangulating of information and collating insights about work as done from the MDT review

Step 10: You may or may not decide to gather further information relevant to the systems gaps and contributory factors identified in the MDT review. This may involve hosting another MDT review workshop with different participants or collecting further information relevant to the systems gaps and contributory factors identified.

Whether you choose to gather further information and the type of information you gather will depend on the patient safety incident, safety theme, pathway or process being

explored. For example, if this is the safety of mental health patients attending A&E, you may choose to triangulate the insights gained from the MDT review with data on the number of patients with mental ill health attending A&E over a period of time; information on how the psychiatric liaison team is resourced; referral pathways to mental health services; performance data on the timeliness with which mental health assessments are carried out; and insights from patient/carers' experiences.

Remember your aim is to build understanding of how patient care is delivered in the real world, and the systems gaps and contributory factors that impact on the safe delivery of care.

Step 11: Collate the insights from the MDT review: You can use the blank SEIPS quick reference guide and work system explorer to summarise the main findings.

How do I use the MDT review findings to support safety improvement work?

Ensuring what you have learnt about 'work as done' is fed back and integrated into your organisation's patient safety improvement work

Step 12: Share insights into systems gaps and contributory factors identified in the MDT review with those who have patient safety improvement roles. Who these stakeholders are will depend on the focus of the review and its findings. They may include:

- members of the MDT who can influence safety improvement work locally
- your organisation's patient safety improvement leads
- stakeholders in the ICS who have a role in resolving systems gaps relating to commissioning decisions and pan-organisational problems
- external bodies, including equipment manufacturers, regulators, NHS England, MHRA, HSIB and others who have a role in national safety improvement work.

Appendix: Worked example – carrying out an MDT review

Learning Response Lead A set up a multi-disciplinary team review to identify safety risks for mothers and their babies within the emergency maternity admissions pathway to Maternity Unit X. Stakeholders from across the healthcare system including ambulance trust managers, paramedics and call handlers, community midwives, antenatal team members, staff working in the obstetric emergency theatres, on postnatal wards and in the NICU were invited to attend the MDT workshop. Members of the Maternity Voices Partnership were invited to attend the workshop to share their experiences.

Learning Response Lead A chose to set up the multi-disciplinary team review after reading several national safety reports on maternity that were published in the first five months of 2022. These reports included:

- The Final report of the Ockenden review (March 2022)[2]
- The Healthcare Safety Investigation Branch's report, 'Maternity pre-arrival instructions by 999 Call handlers.'[3]
- The Birth rights report, Systemic Racism. Not Broken Bodies[4]
- Five X More report – The black maternity experiences survey: A nationwide study of black women's experiences of maternity services in the United Kingdom (24 May 2022)[5]

He was conscious that in the past, multiple action plans had been developed in response to each national report, often focusing on reminding staff to comply with safety policies and procedures, or providing further education and training on CTG interpretation, or putting in place additional safety checks for MDT members to carry out. Staff working in maternity and neonates had fed back that having multiple action plans which focused on telling staff to comply or added workload by doing more safety checks was not leading to improvements in maternity care because the action plans did not address the underlying systems issues.

Prior to the MDT review, Learning Response Lead A reviewed past incident investigation reports, incident reports and perinatal mortality review tool data. He reviewed progress with implementing safety improvements relating to controlled cooling for hypoxic ischemic encephalopathy (HIE). He also spent two afternoons observing in the obstetrics theatres.

[2] www.gov.uk/government/publications/final-report-of-the-ockenden-review
[3] www.hsib.org.uk/investigations-and-reports/maternity-pre-arrival-instructions-by-999-call-handlers/
[4] www.birthrights.org.uk/wp-content/uploads/2022/05/Birthrights-inquiry-systemic-racism_exec-summary_May-22-web.pdf
[5] https://www.fivexmore.com/blackmereport

The invitation to the MDT review explained its purpose clearly; setting out that he wanted help to identify how the emergency admissions pathway for obstetrics cases worked, what the pain points were, and to hear the perspectives of staff working along the pathway. The invitation also explained what was meant by the term 'work as done,' and how he would use the outputs of the MDT review.

On the day of the workshop, Learning Response Lead A set the scene for the MDT review and the participants co-created ways of working throughout the review which focused on:

- Being respectful & listening to colleague's experiences.
- Ensuring there was no hierarchy or blame in the workshop. It was an opportunity for reflection and walking in the shoes of other members of the multi-disciplinary team.
- Maintaining confidentiality.

Learning Response Lead A jointly introduced the SEIPS framework and the SEIPS work system explorer. He then shared his findings from the review of past incident investigation reports, incident reports and perinatal mortality review tool data, progress with implementing safety improvements and the observations he had carried out in the obstetrics theatres. The Maternity Voices Partnership representative shared the story of her emergency admission through the obstetrics pathway. Following this, participants split into break out groups and classified the safety issues raised in her story using the dimensions of the SEIPS framework.

Learning Response Lead A then asked participants to think back to the last shift they had worked and talk him through what happened on that shift referring to any of the prompt statements/questions in the SEIPS work system explorer that impacted on patient safety. This prompted a discussion which highlighted:

- Technology and Tools: Poor design of CTG machines making the CTG more difficult to read correctly, especially in dimly lit work environments like birthing suites.
- External influences: Different interpretations in the Advanced Medical Priority Dispatch System (AMPDS) and Royal College of Obstetricians and Gynaecologists (RCOG) guidelines for symptoms of bleeding and continuous abdominal pain.
- Person: Confusion amongst ambulance call handlers about the correct pre-arrival instructions to give women or their partners when they make a 999 call because of bleeding during pregnancy.
- Task and Work environment: High demand for emergency obstetrics theatres which meant there was a need for re-prioritisation. This in turn led to a need to

communicate the changes in list order to the MDT and time-pressure to complete emergency C-sections and episiotomies.

- Organisation of work: Brittleness in systems for ensuring a woman's ethnicity was recorded and available to all members of the MDT throughout her antenatal, maternity, and postnatal journey: This had on occasions led to black women's ethnicity being incorrectly recorded and sickle cell testing not being carried out.

The output of the MDT review was captured on the blank SEIPS work system explorer. He then summarised the findings of the MDT review in a thematic review report, presenting it alongside the findings from the analysis of past incident investigation reports, incident reports and perinatal mortality review tool data, progress with implementing safety improvements and the observations he had carried out in the obstetrics theatres. (You can find more information on carrying out thematic reviews in the guidance, Thinking Thematically: Top tips for completing a thematic review). The thematic review report was shared with stakeholders across the ICS including,

- The organisation's Patient Safety Improvement leads to inform the organisational maternity safety improvement plan.
- Stakeholders in the ICS whose roles in resolving systems gaps relating to commissioning decisions and pan-organisational problems.