Developing recommendations to improve the effectiveness of multidisciplinary team meetings for patients with chronic diseases

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Aim
To develop a set of feasible recommendations for improving multidisciplinary team meetings (MDMs) for patients with chronic diseases.

Using Consensus Methods
- Formal consensus methods are structured facilitation techniques that explore levels of consensus among a group of experts by synthesising opinions (Campbell et al., 2003). They are designed to minimise some of the limitations associated with group decision making.
- Their main purpose is to define levels of agreement, particularly where there is an insufficient or contradictory evidence base (Jones and Hunter, 1995).
- This is particularly important in the field of health care, where clinical practice varies widely, and clinicians are often faced with uncertainty about the value of different options (Murphy et al., 1998).
- Three main approaches have been used in health research since the 1950s.
  - the Delphi Method
  - the Nominal Group Technique
  - the RAND appropriateness method
- In practice, formal consensus studies often adopt elements from each of these methods to optimally address specific research objectives (Murphy et al., 1998). We adopted such an approach to develop a set of recommendations that are both desirable and feasible.

Phase 1: Examining current MDM practice
Phase 1 involved the collection and analysis of qualitative and quantitative data sources to identify areas for improvement in MDMs. This process is illustrated in Figure 1.

Phase 2: Developing recommendations for improvement
- The steps of Phase 2 are illustrated in Figure 3.
- Drawing on the Phase 1 findings and a review of the relevant research and policy literature, we developed a list of 68 potential recommendations.
- We established a panel of 16 expert stakeholders including patient representatives, clinicians and policymakers.
- A questionnaire pack was sent to the panellists, containing a summary of research and policy and the recommendations relevant to each of the 16 themes.
- Panellists privately rated the feasibility and desirability of each recommendation on a scale of 1 to 9, where 1 indicated strong disagreement with the recommendation and 9 indicated strong agreement (Round 1 ratings, see Figure 2a).
- A meeting was then convened to discuss the ratings, focusing on areas of low consensus among panellists. The discussion was chaired by the principal investigator, and was designed to ascertain whether discrepant ratings were due to real clinical disagreement or to misunderstandings.
- At the meeting, each panellist received a second, personalised version of the questionnaire pack showing the distribution of all panellists’ first round ratings, together with his/her own ratings (see Figure 2b).
- Having discussed each theme as a group, panellists individually rated each recommendation a second time (Round 2 ratings).
- The extent to which each respondent agrees with each statement (i.e. 7-9 on the Likert scale), and the extent to which respondents agree with each other will be used to generate a final list of recommendations.

Conclusions
- MDMs are widespread across the NHS. This study, the largest of its kind, compared MDMs in a range of clinical specialties, allowing us to develop recommendations that are generalisable to a broad range of disease types.
- The study developed recommendations both from empirical evidence and the experience of a diverse group of expert stakeholders.
- This process allowed us to identify recommendations that are both desirable and feasible, making it more likely that they can be practically implemented.

Further information
- Email: c.bhaird@ucl.ac.uk
- Follow the Dept of Applied Health Research on Twitter @UCL_AHR
- Visit targeted evidence rapidly to use the QR code on the right

References

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Figure 1. Phase 1: Examining current MDM practice
Figure 2. Rating response scales for Round 1 (a) and Round 2 (b)
Figure 3. Phase 2: Developing recommendations

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