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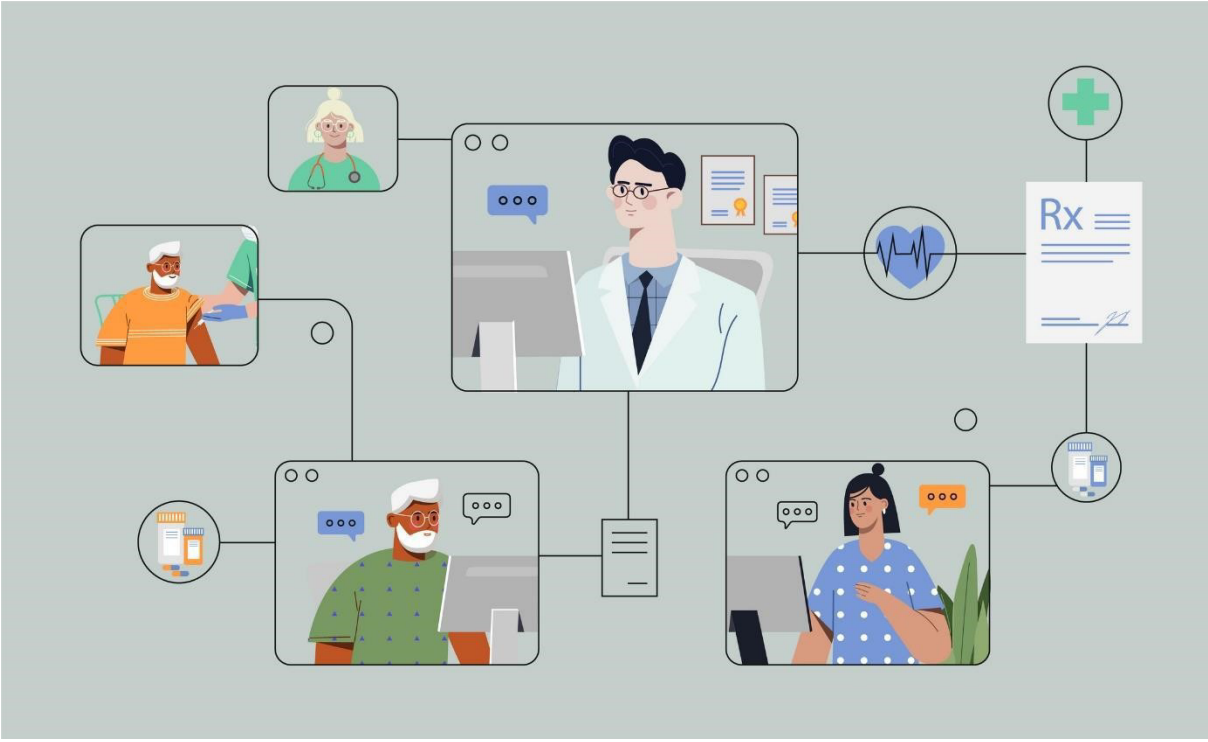
Best Practice Guide for Conducting Virtual Multi-Disciplinary Team Meetings within Diabetes Care



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Virtual Multi-disciplinary Team Meetings in Diabetes Care

Executive Summary

This Best Practice Guide details the opportunities and highlights some considerations about implementing virtual multi-disciplinary (MDT) meetings in diabetes care. Diabetes care had to rapidly evolve during the COVID-19 pandemic and beyond. Inevitably many people with diabetes (PwD) are presenting with more complex needs; the opportunities of bringing specialist MDTs together virtually in the generalist space for rapid referral and diagnostic decision making is apposite. Care around every PwD is an appropriate practice development engaging virtual and telemedicine opportunities to enhance informed decision making and prescribing. Evidence about virtual MDTs and feedback from Health Care Professionals (HCPs) and PwD to create a 360^0 perspective is detailed in the Best Practice Guide.

A multi-disciplinary team (MDT) is anyone who is involved with the care of a person with diabetes at any stage of the individuals experience and life with diabetes (Low et al, 2019). Within diabetes care MDTs are being encouraged to work more proactively to increase communication, share best practice and work in partnerships across both specialities and also for individuals, adopting a person centred approach (Nano et al, 2020). How virtual MDTs can be operationalised since 2020 and the Covid-19 pandemic complementing the birth of increasing uptake of remote consulting (Murphy et al, 2021) and digital reviews using telemedicine (Timpel el al, 2020).

A MDT consists of whichever specialist is required for an individual's care and should support and enable 'No decision about me without me' (Department of Health, (DH), 2012) as appropriate to the individual's circumstances and situation. Careful preparation of each individual and their circumstances is vital to ensure the use of virtual MDT consulting is both safe and enabling for the person concerned and the MDT members (Catapan et al, 2021). Virtual MDTs in diabetes care can be multi sized and have different clinicians involved at any one time (Nagi et al, 2021). Currently The Association of British Clinical Diabetologists (ABCD) along with Diabetes UK and The Primary Care Diabetes Society (PCDS) are all working collaboratively to make recommendations for future proofing diabetes care in the NHS for the future and introduction of virtual MDTs are fundamental in future proofing (Nagi et al, 2021).

Diabetes care MDTs can be multi sized and have a variety of specialist clinicians involved at any one time. Inequalities in access to health is seen across the spectrum of healthcare, including diabetes (Barnard-Kelly & Cherñavvsky, 2020). Health inequalities are defined as the 'preventable, unfair and unjust differences in health status between groups, populations or individuals' (NHS England, 2020).

The challenges of inequality and healthcare, particularly in the context of diabetes are undoubtedly complex, and there is no one-size-fits all solution (Barnard-Kelly & Cherñavvsky, 2020). This is an essential consideration of providing virtual MDTs and including PwD in these so they have a voice and say about what they want from their care reflecting on who this diabetes care approach might suit?

Undoubtedly since the pandemic appeared diabetes care is becoming more complex and MDT members are seeing PwD with more complex care needs and multi-morbidities (Stefan et al, 2021). These patients need a vibrant MDT to work alongside them to promote the best possible outcomes for them.

This best practice guide has been created by an MDT with all members delivering diabetes care through primary and secondary care services across England. People with diabetes (PwD) have also been included and have shared their perceptions and feedback about establishment of a virtual MDT approach across diabetes care services going forwards. This 360^0 approach offers unique perspectives to underpin this best practice guide.

Feedback from a group of MDT members (as below) all working in primary of secondary care has offered their guidance and feedback for this best practice guide.

Patrick Holmes – GP

Shafie Kamaruddin – Consultant Diabetologist

Anita Beckwith – Type 1 Specialist Dietitian

Paul Pipe-Thomas – Community Diabetes Dietitian

Charles Odiase – Consultant Pharmacist

Elizabeth Cooper – Diabetes Specialist Psychologist

Jane Diggle – Diabetes Specialist Practice Nurse

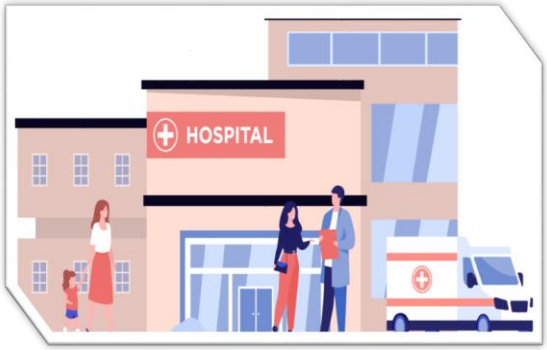
Jayne Robbie – Senior Podiatrist – Diabetes

Anne Phillips & Kate Walker – representative of people with type 1 and type 2 diabetes

Themes to consider:

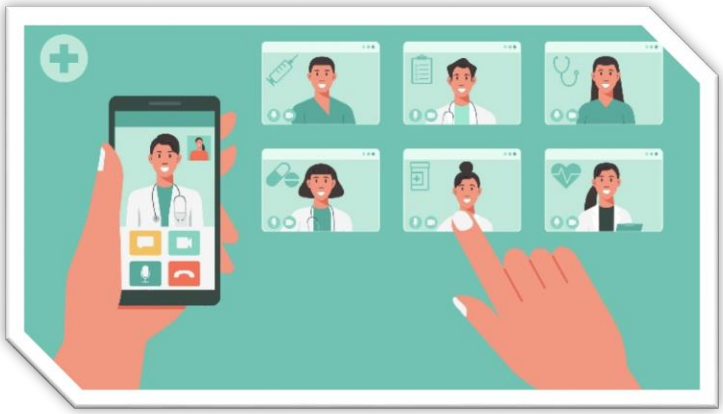
Environmental

Feedback from the MDT group have highlighted specials considerations for the provision of Virtual MDTs in diabetes care in terms of increased communication, referral delay avoided, facilitation, taking specialist MDT members into generalist arenas and the green impact on the environment. Some suggestions for consideration are details:



- Timings of meetings to enable all MDT members to attend easily encompassing cost / time effectiveness. No travel time wasted or parking difficulties.
- Greener as virtual leaving no carbon footprint.
- Easier remote connection using digital resources for MDT health care professional (HCPs) but considertation must be shown for PwD to be able to connect and join their appointment with ease.
- Maintains social distancing.
- Valuable connection between primary and specialist services with ease and little to no waiting times.
- Opportunity for increased meeting frequency to promote sharing of best practice.
- Reduces referrals as specific cases can be discussed in a shared MDT and quicker decision making is facilitated.
- Reduced demand on clinic space in primary or secondary care.
- System/One can share data easily.
- Better MDT meeting time management to promote group decision making.
- Improves access to care by being easier to get people in one place than in person.

Service delivery



In preparing diabetes care going forwards coordinating with the collaborative work of Diabetes UK, ABCD and PCDS (Nagi et al, 2021); the impact of service delivery been identified as fundamental for future proofing for adaptability. Enabling virtual MDTs across diabetes care is elementary to promote the most complex PwD being seen quickly to improve their outcomes. Considerations to enable adoption of virtual MDTs include the following aspects:

- Ground rules need to be agreed.
- Need a quiet area with good connectivity.
- Needs a dedicated timeslot everyone agrees too.
- Cameras need to be on and microphones off unless speaking.
- Ownership and permission to record sessions where PwD are included.
- Need access to blood or biochemical results if required.
- Dedicated time challenges in unpredictable service delivery i.e. primary care settings needs acknowledgement.
- Reduces long patient waiting times for reviews.
- There is a risk of being less productive with harder or hardest to reach patient groups.
- The Hawthorne effective can be difficult to manage virtually than face to face meetings.
- Requires high resolution images so potential diagnosis is accurate and safe.
- Risk of lack of MDT cohesion with more senior or vocal members tending to dominate and newer or junior team members lacking confidence to share their opinions.

Person with diabetes considerations

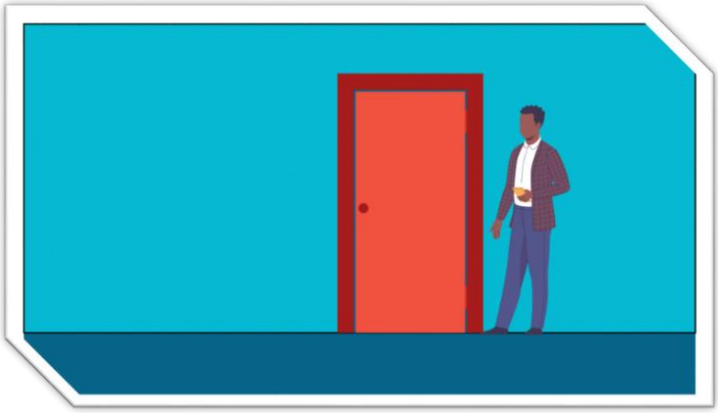
'No decision about me without me' (DoH, 2012) would promote inclusion of the PwD who the MDT concerns. However, there may be exceptions to this for specific reasons. Considerations to be taken into deliberation are detailed as follows:

- Reduced time to wait for referrals and consultations can be seen positively.
- No parking or travel required for any MDT or PwD team member.
- Potential to reach more house bound or socially vulnerable people if digital access can be enabled to reduce health inequalities.
- Ideal for individuals with highest medical needs in terms of complications or glycaemic management so these PwD should be the focus of virtual MDTs.

Concerns

- Individuals might be overwhelmed with amount of people in their MDT and feel intimidated.
  - PwD who are hard of hearing can be difficult to include unless subtitles can be easily enabled.

  People whose English is not their first language risk being intimidated in a virtual MDT.
- Needs a cohesive person first approach that centres around the individual being a partner and not a patient and listens to the PwD voice and what matters to them.
- May be a difficult and intimidating environment for people especially older adults, those with hearing impairments, those with mental health or learning disabilities and those with visual challenges.



- If too many clinicians involved, people can feel overwhelmed and lose confidence especially if dealing with difficult, dominating or arrogant characters in the MDT.
- Bad news should not be shared using a virtual MDT.
- Virtually it can be harder to read body language cues which could increase the risk of misinterpretations and miscommunications.
- Hardest to reach populations may not be engaged using a virtual MDT and 1:1 can provide a better experience.

HCP considerations

As the increasing use of virtual MDTs will feature within diabetes care, the MDT team has identified the following factors.

- Good for specialists to enter generalists' environments virtually.
- Good for social distancing as the team can come together virtually from a variety of locations.
- Good to share holistic management planning in a joined-up way.
- Governance and confidentiality, especially if recording the virtual MDT needs highlighting at the start of every MDT meeting.

Concerns

- Practicalities of busy clinicians committing to the time allocated.
- Needs a high degree of literacy in all members of the MDT and the PwD being included.
- Requires clarification of roles and introductions for every virtual MDT meeting.
- Requires a good facilitator to collate opinions and engage all MDT group members to ensure everyone is heard and the PwD has a safe place to express what they want also and for this to be respected by every MDT HCP present.
- There is less allowance for spontaneity which may mean a risk of missing out on generating specific ideas.
- Less community spirit is evident.

Conclusions

Virtual MDT meetings do have their place but careful consideration in the organisation, and group set ups needs careful thought and attention. The same considerations need to be applied in the PwD and respecting their voice and decision making in a virtual MDT meeting. As provision of virtual MDTs gain momentum a working group nationally would be a positive step forward to support the training and implementation of this diabetes service provision. This also will support individual Primary Care Networks advocating the introduction and use of virtual MDTs in diabetes care where appropriate.

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