Teamwork in a paediatric diabetes clinic

Emma Sands, Ashiya Ali

The importance of multi-professional teamwork to optimise care is highlighted in the Best Practice Tariff (BPT) for paediatric diabetes, but the BPT does not suggest a framework for how the professional groups should work together. This article considers the clinical utility of three models of collaborative care within a busy paediatric diabetes service: the multidisciplinary, interdisciplinary and transdisciplinary models. Examples of the key aspects of these frameworks in clinical practice are provided and a critique offered. A collaborative approach towards achieving optimal clinical effectiveness is supported.

Much has been written regarding teamwork across different fields of medicine, including mental health (Vinokur-Kaplan, 1995), rehabilitation (Mullins et al, 1999; Reilly, 2001), palliative care (Terashita-Tan, 2013) and paediatrics (Cushing et al, 2012). However, it is unclear which model defining the delivery of clinical services best improves patient care. Collaborative care, which encourages coordination between professional groups and avoids problems associated with fragmented services, is a helpful framework. Three models in which different professional groups form a team have been widely described in the literature, termed "multidisciplinary", "interdisciplinary" and "transdisciplinary" (Allen et al, 1997; Falk-Kessler et al, 2005; Mitchell, 2005). Although the models vary according to the mechanisms by which the teams coordinate and cooperate with each other, the terms have been used interchangeably in clinical practice (Falk-Kessler et al, 2005).

Models of team working

The *multidisciplinary* model comprises professionals from more than one discipline functioning according to their own practices and ideas (Allen et al, 1997). Roles are defined and discipline-specific goals developed for each patient. Formulations, goals and treatment plans are often devised separately. Key treatment decisions are ultimately made by the team leader. Often, if team members are working in parallel, there is not a clear team leader and multiple goals may result. The main criticism of this model is that it contributes to fragmented care and increases the demands on the patient and family by setting separate goals and treatment plans.

The *interdisciplinary* model blurs the boundaries between disciplines. Each professional works within their own area of expertise, but clinical decisions are often made by collaborative consensus, reflecting more coordinated decision-making and a less hierarchical structure (Allen et al, 1997). This approach is thought to be more family-oriented, by facilitating the team's responsiveness to the changing needs of the child and family. This in turn is suggested to be related to higher patient satisfaction and better treatment adherence, which is often a key outcome measure

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Article points

1. Collaboration, coordination and communication among professional team members are key elements for providing effective healthcare in paediatrics.
2. The Best Practice Tariff highlights the importance of multi-professional care for children and young people with diabetes but does not define how this should be delivered.
3. Frameworks of collaborative care highlight reflection and professional development of skills and acquisition of knowledge, within a supportive context.
4. A collaborative team approach may be an important step towards enhanced clinical effectiveness, patient satisfaction and improved health outcomes.

Key words

- Collaborative care
- Multi-professional teams
- Paediatric diabetes
- Teamwork

Authors

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Page points

1. In their paediatric service within London North West Healthcare NHS Trust, the authors have developed a collaborative model of care incorporating elements of the interdisciplinary and transdisciplinary approaches.
2. They offer collaborative clinics in which each child or young person can see the full team together.
3. This allows coordination of treatment planning and collaboration between team members, as well as reducing demands on families.

in this increasingly important climate of demonstrating effectiveness.

The *transdisciplinary* model requires professionals to cross the disciplinary boundaries further, sharing roles and responsibilities (Allen et al, 1997). All team members are involved in assessment, treatment planning and implementation. Children and families are part of this approach, contributing information and feedback. Role extension can take place, whereby each member understands their individual role and responsibilities and those of other members, and is achieved through team communication, coordination of care and collaboration. Team members educate each other, knowledge is shared and members teach each other to make judgements and decisions that transcend the boundaries of traditional roles. Support and feedback is provided within the team.

Application to a paediatric diabetes service

It is suggested that a collaborative team approach is most likely to create flexible, functional and developmentally appropriate treatment goals that are responsive to the changing needs of children and their families (Allen et al, 1997). In paediatric diabetes this seems particularly pertinent. The needs of the child and family differ according to the age at diagnosis. The demands and impact of the condition change with the child and family as they grow, and the challenges they face developmentally must evolve to incorporate their diabetes. Thus, their needs change.

In our busy paediatric diabetes service within a district general hospital, we have strived to improve patient care by developing a collaborative model that encompasses all skills of the clinicians and places the child and family at the centre of the approach. Our model is one that reflects the interdisciplinary approach, along with some elements of the transdisciplinary approach. The team comprises a consultant paediatrician, a paediatric diabetes nurse specialist, a dietitian and a clinical psychologist. We operate a collaborative clinic, whereby each child and family has an opportunity to see the full team together. This allows client-centred care and coordinated treatment planning, and aims to enhance the quality of collaboration between team members by working in close physical proximity with each other (Cushing et al, 2012). It also limits the demands on families by allowing them to meet with all the healthcare professionals in the same setting, rather than experiencing separate and perhaps discordant meetings with each. Targeted psychological, dietetic and nursing interventions can be provided within the clinic context alongside medical management. Of course, each professional can still offer additional time for individual input as needed (e.g. additional carbohydrate counting training with the dietitian, behavioural therapy to support variation in injection sites with the clinical psychologist and education to refine injection technique with the nurse specialist).

Healthcare services employing clinical psychologists often operate according to a referral system, which can be considered a reactive process for addressing acute problems that may be compromising the child's medical condition (Wagner and Smith, 2007). This model is thought to limit opportunities for providing preventative interventions aimed at promoting adjustment, which could also help to identify difficulties before they begin to impact significantly on daily functioning or disease-specific management (Guilfoyle et al, 2013). We suggest that integrating psychological provision directly into clinics goes some way towards addressing this.

In our own practice, we have become knowledgeable about each other's roles. We share knowledge and expertise, facilitating a clinic appointment that can be as responsive as possible to the families' immediate needs. The idea of psychosocial care for children and families affected by diabetes becomes part of every conversation, with every family and with every professional. We suggest that holistic care can therefore be better achieved.

Examples from clinical practice

Role expansion

It is helpful for the clinical psychologist to understand the impact that young people's behaviour may have on their blood glucose levels,

but without the responsibility to educate or advise about direct management, which remains the remit of the other team members who have the appropriate training. In a joint clinic, the clinical psychologist can explore experiences the child and family have had that may impact blood glucose control, and the nursing and medical team members are able to advise directly at that point, if necessary. This is educative for the other members of the team and enhances the advice that can be offered. Two separate appointments are not required and diabetes education can be delivered. Additional psychological questioning can enhance curiosity about the impact of behaviour or mood on blood glucose levels, and new information can be gleaned about the young person's current practices. The medical response can therefore be immediate and an intervention plan developed in a timely and responsive fashion that considers all aspects of care (medical, dietetic and psychological), including the young person's own personal goals. This is likely to result in increased adherence and enhanced patient satisfaction.

Enhanced collaboration and developing shared goals

Having shared goals, including the personal goals of the child and family, is a main feature of the transdisciplinary model. We suggest that this position is most easily achieved through joint conversations between all team members. Clinical interventions from all key areas are directed towards the shared goal. It is most helpful for the team to share a young person's goal (e.g. achieving fast times in competitive swimming) than it is to set specific goals around diet and blood glucose readings. A conversation with a child about this personal goal is likely to include talk about diet and blood glucose levels before exercise, in order to achieve the overall goal. Indeed, when such a goal is set by a young person, the route towards it will often involve maintaining good blood glucose levels, thus leading to improved diabetes care. When the full team is involved in this goal-setting conversation, the shared vision is enhanced even if additional intervention with one particular professional is subsequently provided.

Goal sharing can also help to avoid difficulties associated with separate goals being set with different professionals, which might feel overwhelming for the young person and risks the possibility that the goals will not be achieved.

Reflection and feedback

We have found it helpful to incorporate time for a brief team discussion following each clinic appointment. Team members can share their observations and consider their own thinking processes during a clinic consultation. This can contribute to a greater understanding, thereby informing future questioning or intervention. Indeed, the value of reflection is increasingly acknowledged and has become a key component of professional development programmes for paediatricians. It is suggested that reflection is "part of the art of medical practice" and needs to be grounded in an organisational context to achieve enhanced clinical performance (Murdoch-Eaton and Sandars, 2014). In our clinic, the clinical psychologist is well placed to act as facilitator and use this time to enquire with team members about their experience of a clinical interaction. This helps to make sense of complexity, enhance perception and gain new understanding. Reflective practice can be supportive and can also provide an opportunity for professional development. For example, the clinical psychologist may comment that team members had a tendency to direct advice towards the young child, mirroring parents' style. Clinically, if all team members have a shared belief that a parent should be giving less direct responsibility for diabetes management to the young child, this observation is likely to guide team members' interaction style and optimise clinical intervention towards the shared goal. To achieve this, it is helpful for an additional person outside of the direct interaction between child, family and professional, to observe and offer comment for further discussion.

Development of skills

A collaborative approach provides opportunities for learning and building on existing expertise, while facilitating conversations around the young person's shared goals. Providing feedback in a way that is helpful, informative, empowering and directed towards the teams' shared goals

Page points

1. Establishment of shared goals, including the personal goals of the child and family, is a main feature of the transdisciplinary model.
2. When the full team is involved in this goal-setting conversation, the shared vision is enhanced even if additional intervention with one particular professional is subsequently provided.
3. In their clinic, the authors and their team make time for a brief discussion for reflection and feedback after each appointment. This can not only improve care but also provide opportunities for professional development.

Page points

1. The team also value the increased practical and emotional support between professionals that this model of care provides.
2. There are some weaknesses to this approach that must be acknowledged, including potential conflicts between professionals concerning leadership and priorities.
3. Group meetings may also be uncomfortable for some families and even for new arrivals in the team.
4. However, despite these concerns, the authors argue that some of the aspects of the transdisciplinary approach are valuable.

will be most effectively provided when the team environment feels supportive. This, in turn, is developed through close team working, open communication and collaboration around the shared goals.

Support

Working directly with another colleague in clinic provides opportunity for reflection and can also provide practical support in the room and consistency in approach. The challenges of working with children with long-term or chronic conditions are often underestimated. As the problem of stress and burnout amongst healthcare professionals is increasingly being acknowledged, the provision of emotional support between team members can be invaluable. We have found that creating time for ourselves as clinicians to reflect on and process clinical experiences can be hugely helpful, as this minimises the processing that may occur outside of work, thereby enhancing a better work–life balance. Indeed, a study examining therapists' perceptions of team functioning in a rehabilitation context found that teams utilising the interdisciplinary or transdisciplinary approach were more closely associated with positive levels of team functioning (Mullins et al, 1997).

Critique

We do not assert that our team operates according to the true transdisciplinary model. Team members from other professional groups may be unable to make certain decisions and it may not be appropriate for clinical boundaries to be fully transcended. This is one of the main criticisms of the transdisciplinary model, as interprofessional conflict around leadership, professional boundary issues and priority of goals may be prevalent (Mullins et al, 1999). We are not necessarily advocating a purely transdisciplinary approach within paediatric diabetes care, but there do seem to be some aspects that are valuable.

We acknowledge that, for colleagues joining the team, this approach may feel daunting. Professionals early in their career gain confidence by sharing their knowledge with clients. In the joint setting, it may feel difficult to know when to contribute, how much time to spend on a particular topic or to feel that they can still be helpful even when not directly contributing. Indeed, there is little explicit training incorporated into academic and professional training courses around team approaches and collaborative working. A trainee's first clinical role may be their first experience of this. However, we have found our pre-clinic meetings, post-session reflective space and regular team meetings (incorporating teaching and continuing professional development) to be a valuable space for addressing these concerns and developing a collaborative approach that also facilitates a sense of professional growth.

We often discuss the impact on families of meeting with up to four team members simultaneously, and we acknowledge that this has the potential to feel uncomfortable for some. We have noticed, however, that the introduction of the team in this way helps children and families feel comfortable about discussing their concerns more openly, as each professional is viewed as integral to the team rather than a specialist to be referred to when there is a problem. By the very nature of paediatric diabetes care, we begin a long-standing relationship with our children with diabetes and their families from the time of diagnosis until their transition to adult services. As we continue to meet with them regularly, we develop a relationship that is supportive and holistic. The joint approach also makes it easier for separate time with a particular team member to be utilised more efficiently through familiarity. We often ask our families how they are experiencing the clinic and recognise the importance of exploring service user feedback. In addition to satisfaction, however, empirical studies assessing the team approach in terms of both clinical outcomes and cost-effectiveness are required. We are working towards the development of empirical outcome studies, which will also consider the full range of variables that may impact on outcomes in our own patient population.

Conclusion

From our experience, we would encourage paediatric teams working with people with long-term or chronic conditions to work collaboratively.

This is a helpful step towards achieving optimal clinical effectiveness; however, empirical studies are required to quantify and describe the most effective model of team working in clinical practice. While psychological input is a component of the Best Practice Tariff and a necessary starting point, we encourage teams to continue to develop and better describe the role. To hold in mind collaborative and coordinated team working is helpful in this regard. ■

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