Evidence Summary: Enablers and Barriers for Multidisciplinary Teams in Primary Care and the Community

About this summary

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Ovid MEDLINE, EBSCO CINAHL and Google were searched, Search limits were last 5 years, UK only and primary and community care. Search history is available on request.

ChatGPT was used to assist with some paraphrasing and summarising tasks. All outputs were thoroughly checked and edited as necessary.

The knowledge service aims to use the best, most appropriate and most recent sources of information available, but can make no warranty, express or implied as to the accuracy of any information or advice supplied. It is the responsibility of the requester to determine the accuracy, validity and interpretation of the search results.

Contents

Headlines

Planning and Design There is no blueprint for MDTs in primary care and the community, but the following are likely to be beneficial:

- Take a bottom-up approach, giving relevant organisations ownership of the process.
- Ensure clarity of purpose, shared goals and clearly defined roles among the team
- Skill mix aligned to population needs. GP engagement is key.
- Include patient and community views
- Embed monitoring and evaluation processes at the outset
- Ensure wider system support and consider contextual factors

More information

Leadership Facilitative and collective leadership are beneficial, enabling the team to innovate and make decisions More information

Culture It is important to foster a collaborative culture, Joint working, training and engagement activities and ensuring team members understand each other's roles and responsibilities support this. More information

Training and Development Training in collaborative working and OD processes can be beneficial. Allow time for training and reflection More information

Workforce and Capacity Heavy workloads and high staff turnover can be a barrier to MDT working More information

Communication and MDT Meetings Effective communication is key. MDT meetings are a key aspect of MDT working, and require competent chairing to ensure usefulness More information

Co-location Co-location has many benefits, such as enabling joint working, informal communication and learning, but it is not always effective, and not essential for MDT working. More information

IT, facilities and shared data Adequate IT resources and access to shared patient data are vital. More information

HEE Multidisciplinary Toolkit

Health Education England's Multidisciplinary Team Toolkit includes a diagram of success factors of MDTs, based on their research. This is available at: https://www.hee.nhs.uk/our-work/workforce-transformation/multidisciplinary-team-mdt-toolkit

Planning and Design

There is no blueprint for successful MDTs. 2, However, several articles and reviews make suggestions, based on the research, that are likely to support success.

Suggestions from the literature for planning and design of MDTs for integrated working

- Consider MDTs as core rather than additions to existing services 2
- Keep it simple and small scale initially 13
- Take a bottom-up approach. Organisations need to have ownership of the service 13
- Clarity of purpose is key 13
- Prioritise workforce and workflow planning 2
- Consider necessary structural change including accountability, governance, shared management lines, information and data sharing, formal inter-agency committees/teams and processes for shared decision-making 1, 2, 8
- Consider how budget allocation relates to accountability 13
- Clearly define roles and responsibilities, including a clear leader 2
- Securing team support for changes in ways of working is essential 1
- The MDT members must have shared, clear, realistic and achievable goals 7 for the service and it is important to ensure these are understood and accepted by all partners, patients, families and carers 1
- Allow sufficient time and resources for planning 13
- Consider the significant time and effort it takes to build relationships, foster a collaborative culture, develop the team and implement vital IT and data-sharing processes 1
- Incentivise outcomes, not activity 13

Patient-centred approach

- Consider patient journey and experience in the design of the service 13
- Clearly define the role of citizen involvement 13
- Prioritise what patients value: timeliness, flexibility and responsiveness, rather than focus on organisational structures and processes 1
- Co-production of services with patients and communities will help to ensure the service meets local population needs 1, and patients and patient representatives share the vision of the service 1. Ongoing co-production is beneficial 2

- To enable co-production to take place, ICSs should ensure teams have required support and skills to facilitate this 3
- Ensure co-production processes address the power imbalances between professionals and people with lived experience and that participation reflects communities 3

Planning and Design Barriers to MDT working

- Translating the principles of the service into operational detail was challenging. Staff felt there was a lack of detailed planning and communication 9
- Overambitious aims, and expectations of significant improvements too early on 13
- Confusion from some participants over which team they were now in, and who else was a member of their team 5
- Organisational structures too complex. Difficult to understand roles and responsibilities 13
- Governance structures not embedded enough in organisations, with some not taking ownership or contributing 13

Monitoring and Evaluation of MDT Impact

Several articles emphasised the importance of including monitoring and evaluation in the planning and design process.

- Embed ongoing evaluation from the beginning and respond to lessons learned. 2,13
- Involve integrated neighbourhood teams in developing measures for the service. In one study, where the team did not have input, the measures included reduced A&E attendances and length of hospital stay. These measures also perceived to be misaligned with the aims of integration and fed a perception that acute care was prioritised over community/social care. 9
- A structured approach to evaluation will support regular reviews and collective reflection on areas for improvement. 3
- Establish a framework for tracking progress achieved through MDT working, showcasing impact, and taking into account potential drawbacks.1
- It may take several years for MDTs to realise impacts such as reduced hospital admissions, and initially it may even increase.2
- Ensure sufficient space (physical or virtual) and time for team reflection on MDT working. This can improve communication, facilitate constructive discussion and improve team effectiveness 3

The Health Foundation recommends an evaluation process:

1. “Create a clear logic model that explains how service changes will lead to better care, identifying the necessary support and setting meaningful goals.

2. Gather data on key components of the logic model during MDT implementation, covering resources, activities, and timely outcomes.
3. Monitor inputs, activities, and short- to mid-term outcomes to assess MDT effectiveness and find opportunities for improvement.
4. Conduct thorough evaluations to determine what works, for whom, and in what contexts. Impact measures should go beyond emergency hospital use and consider outcomes important to patients. High-quality evaluation demands careful planning, reliable data, and support from local and national decision-makers". 2

Skill Mix

Several papers considered which professionals should be included.

- It is unclear what the optimal professional membership of MDTs is, but aligning this with local context and population needs 1,2,3, along with flexibility and responsiveness likely to be beneficial 6
- GP involvement seen as absolutely key for integrated working 9
- Engaging with additional specialists, e.g. in substance misuse, housing, learning disabilities etc.as appropriate will support holistic working 3, 6
- Care navigators or care coordinators acted as a conduit between health and social care professionals on the team 2, 7
- Ensure adequate administrative support e.g., to formulate treatment plans 6

Wider Contextual Factors

It is important to consider the wider context in planning and design of MDTs.

- The wider organisations and system need to have a culture that supports MDT working 1
- Consider the wider context e.g. local authority and community resources and include contingency planning. Reduced local authority budgets and the impact on community services have been a challenge to integration with the community sector 2, 13
- MDTs should explore how to engage with other local teams to support patients with complex needs and improve understanding of the MDT's role 3
- Public endorsement from local community leaders provides legitimacy and increased visibility within the system 3
- Institutional support for MDTs from their organisations and wider partnerships is vital for long-term effectiveness 3
- MDTs benefit in areas where organisations have collaborated previously and relationships between local leaders are established 2
- Conflicting national policies can be a barrier 2

Leadership

- A facilitative leadership style is beneficial 3

- It is important for the team to embrace collective leadership 2, 10
- Courage is needed to foster a non-hierarchical, permissive, innovative non-blaming culture, where the team is empowered to act autonomously, make decisions and take managed risks 8, 9, 10
- Willingness to take risks and develop new ways of working 9
- Ability to take a more directional approach when necessary. Knowledge of inter-professional relationships and willingness to challenge poor collaborative practice 3
- Devolved leadership model needs to be flexible to accommodate differences in local areas, and in teams, levels of integration, skills and knowledge 9

One paper asked MDT members what leadership behaviours and character traits they most valued:

- Enables team building and supports wellbeing.
- Define clear boundaries.
- Sets team direction, decisive, and organised. Takes responsibility.
- Supporting access to training
- Represents the team externally, builds networks, entrepreneurial, gains resources for the team, breaks down barriers.
- Advises the team on navigating health and social care systems.10
- Inspiring and positive
- Commitment, enthusiasm, high standards, confident in own decision-making
- Valuing and developing the team, and the service. Gives constructive feedback.
- Allows team members to express their views
- Calm, flexible and empathic
- Approachable and non-judgmental 10

Barriers to effective MDT leadership

- Although managers supported an innovative, learning culture in principle, aiming to empower staff to make decisions, take managed risks, free from blame, this failed because the approach to learning, communication and knowledge sharing was too top-down. 8
- Leaders tended to revert to usual ways of working with colleagues they knew and trusted 9
- Devolved leadership was restricted by failure to communicate this aim, or staff not empowered to make decisions locally 9
- Disconnect between leadership and operational delivery team 13
- Clash between management and clinical leadership models 13
- Leaders prioritised patient safety, and ensuring they were not lost in the system as it changed, but some staff felt this was excessive and hindered the development of new ways of working. 9

Who should lead MDTs?

- There was no clear verdict on which professions were most suited to leading MDTs 10, although some felt strong clinical leadership was important 13. A high level of professional expertise was seen as an advantage, although it was recognised that leadership involves a different skillset to being a health or social care professional 10
- Preferably a member of one of the professions making up the team, but experience in an integrated teams setting is crucial. 10
- Someone who is able to understand roles of the team 10
- Primary care clinical leadership, including on programme boards had a real benefit. 13

Culture

A positive, collaborative, learning culture is important for MDT working. Recommendations were made on how to foster this:

- Strong relationships and mutual respect and trust are a key factor 2
- "Put interests of patients/service users before professional norms; be open minded and curious." 1
- Recognise the value of relationships and dedicating time and effort to their development 2
- Equality between members and supporting constructive challenge 3
- Building trust is key, so team members trust each other's assessments and judgement. Finding common ground between professional values can help. 11
- Dedication to developing common beliefs, values, and philosophy within the team 2
- Readiness to acknowledge, articulate, and address cultural differences among employees from diverse organisations and professions 2
- All team members need to have the skills and confidence to engage constructively with other professionals 3
- Joint training, networking and social activities can help build relationships 8
- Foster a culture of innovation 13
- Make health and wellbeing support available. Consider risk of burnout and change fatigue 1
- Ensure team members feel psychologically safe and free to share ideas,1 and are not penalised for mistakes 2
- Staff suggested rotations between sectors to build relationships and foster understanding 8
- Create a collaborative team identity 11 *See Fig. 1 on page 733 and Fig. 2 on page 735 for diagram showing intersection of professional and team identities*
- Defining roles and boundaries is complex. MDTs require trust and flexibility 11
- Consider a system-wide OD strategy to foster collaboration 1
- Celebrate successful initiatives by frontline staff and share as best practice across services. 8

Barriers to a positive culture

- Initial hostility between different sectors can occur in MDTs. e.g. in one case primary care were wary of a takeover and felt general practice not understood. This did change over time and a collaborative culture was formed 13
- Hierarchical structures, risk aversion and lack of understanding of other sectors and roles prevented staff from taking a learning approach and developing collaborative working. They did not feel they were empowered to make decisions or try new ways of working. 8
- Limited understanding of other sectors, e.g. social workers believing lack of understanding of the Care Act and local authority procedures led to community nurses suggesting care plans that were not workable for the local authority 7 creating conflict and a culture of blame 8
- Staff engagement events mainly attended by managers, and rarely led by frontline staff. Perception that they were being used for managers to showcase achievements rather than learning or fostering relationships. 8

Understanding Roles

- Understanding the roles and expectations of own and other's roles in the team was key to creating a collaborative culture 1
- Joint working e.g. home visits, was transformative for understanding other roles and services. 5, 9, 11
- Training and joint activities helped the team to understand other roles and build confidence in articulating one's own role. 11
- Staff suggested rotations between sectors to build relationships and foster understanding 8

Barriers to understanding other roles

- Difference in budgets, management structures, professional bodies, policies and procedures and training needs were seen as challenges to integration 9
- Joint patient visits rarely took place due to differences in procedures and standards. 8
- Differences in perceptions of key concepts, e.g. role of care navigators, care co-ordination (a role, a skill, or the model of care?) 5
- Variations in terminology e.g. patients vs citizens was an obstacle to communication 9
- Perceived differences in approach between health and social care staff. Some social workers perceived healthcare staff as unwilling to try new things. This created conflict between aims to offer holistic or more task-oriented care 8
- Lack of parity in perceptions and approach to patients with risky behaviours. Social care staff felt health care staff were more risk averse. 9

- Differences in professional responsibility made trust difficult: healthcare staff (nurses) felt that their duty of care could lead to taking on extra work to social care staff. While social care staff felt that their statutory responsibilities were not understood. 9

Professional Identity

One study examined how professional identities impacted on MDT working.

- A flexible sense of professional identity is key to integrated working i.e. the ability to move between individual professional identity and collaborative team identity. 11
- Open-mindedness and the ability to see the wider aims of the team, and when to defer to other team members in the best interests of the patient and the service more widely is key to MDT working 11
- The blurring of boundaries between roles should be balanced with enabling team members to maintain a professional identity by supporting them to identify their unique skills and contributions 11
- Appreciating and strengthening existing professional identities can support team building and trust. New roles may not be necessary 5

Profession Identity as a barrier

- Blurred boundaries between professional roles, scope of practice and identities can create conflict e.g., being asked to undertake tasks that fall outside professional training 11
- A rigid sense of professional identity is not conducive to integrated working 11

Training and Development

Training and development was identified that could benefit MDTs

- Foster a culture of learning from each other within the team 2
- Training on collaborative working can help foster a team culture, improve understanding of MDT members' own and other roles within the team, improve confidence to contribute in MDT meetings, confidence in the use of clinical tools for assessment and care planning, autonomy, resilience and support for MDT working. 4, 9
- Put in place time and resources for training, mentorship, peer-to-peer reflection, sharing of best practice, and support to ensure all team members are able to fulfil their roles and value all members of the team.1
- Holistic approach to care led team members to be more aware of patients' wider needs especially mental health. Some staff lacked confidence and skills to support patients with mental health needs. Mental health training a likely benefit 5
- OD process involving Myers-Briggs personality assessment, individual coaching for managers and frontline leaders, and team coaching, was transformative. It

encouraged staff to move beyond traditional top-down thinking, improved leadership skills, and supported MDTs through behaviour and culture change. 5

- Training Needs Analysis was proposed but decided against due to early stages in development for some teams and staff difficulty in articulating what their training needs might be 5
- Provide training to support wider use of telehealth systems 5
- Access to high quality clinical supervision is important 2
- Incorporate team goals into appraisals and give MDT members opportunity for feedback 2

Barriers to Training and Development

- Lack of protected time and staffing cover for learning, development and reflection time. Staff had to complete work they had missed while in training as there was no cover 8

Communication and MDT Meetings

Communication

- MDTs delivery of safe, high quality care hinges on effective communication 1
- MDTs should constantly review and improve communication methods 2
- Bottom-up efforts towards MDT learning were effective e.g discharge forum led by frontline staff and service managers and centred on the patients. 8
- Sharing patient information was seen as important for staff safety, as information on home circumstances could help with risk assessments about home visits and lone working. 9
- Determine communication frequency, timing, and methods within the MDT at the outset 1 Agree use of digital communication systems 2

MDT Meetings

MDT meetings are a key aspect of MDT working and several studies looked at the benefits and best practice.

- MDT meetings provided numerous benefits including: the opportunity to share information on patients and other services, collaborative planning for patients that did not engage with services, risk management and mutual support in managing challenging and upsetting cases.6
- MDT meetings enabled the sharing of soft intelligence from different perspectives. e.g. a social worker understanding a patient's ability to undertake a plan suggested by a GP 12
- In one study, MDT meetings were thought to be most important factor for integrated working, although their potential wasn't always realised 13
- Clear leadership and competent chairing is required to ensure decisions are made, actions are determined and tasks allocated 6

- Allowing time for reflection, learning and celebration during MDT meetings is likely to be beneficial for teambuilding 1
- Aside from formal MDT meetings, huddles or other forms of brief, frequent opportunities for the team to check in are useful 2

Barriers to effective MDT meetings

- Some perceived MDT meetings as additional workload and were concerned about the lack of capacity to address unmet needs identified through integrated working. Lack of capacity could lead to MDT meetings being viewed as a tick-box exercise 5
- Some members, particularly community and voluntary services staff may feel less able to participate in meetings 6
- Too much emphasis placed on following instruction from higher up, leaving original intentions unfulfilled, led to MDTs being perceived as not useful. 13

Co-location

Several studies found many benefits to co-location of MDTs, although this was not found to be essential.

- Co-location facilitated communication, especially informal 'corridor conversations', decision-making, mutual understanding and relationships, knowledge and skills, joint working. It is recommended to consider co-location where possible 1, 5, 7
- Discussions and referrals between co-located team members was much easier. It reduced bureaucracy and improved efficiency. 7
- If co-locating, provide equity in the work environment to all team members. 7
- Co-location is not a silver bullet for partnership working, additional support and investment also required 7, 9
- Inter-professional respect, balance of power between sectors, shared records, understanding of roles and responsibilities and staff turnover are more important factors in the success of partnership working than co-location. 7
- Co-location is not crucial to successful MDT working. But it is important to enable team members to engage in person as well as online to build relationships 3 e.g. OD and team building activities, joint training and networking opportunities 1
- If co-location is not possible, establish a virtual space for MDTs 1

Co-location-related barriers to MDT working

- Even where they were co-located, the nature of integrated working meant team members often worked elsewhere e.g. in GP practices or on home visits This could feel isolating for some staff, and limited the benefits of co-location. 5, 7
- Where MDT teams were co-located, this could lead to separation from other services e.g. where team members were moved out of GP practices to the MDT co-located space, opportunities for discussion with GPs were reduced 7

- In some cases where teams were co-located, this did not include social workers on a full-time basis. This limited information sharing to formal meetings. 7
- Building of positive relationships is context-dependant and not entirely down to co-location. Continuity of leadership and staff, autonomy and flat hierarchies also enabled this. Professional identities, hierarchical structures and perception that social care seen as the 'inferior' sector were barriers to partnership working even when the team was co-located 7

Workforce and Capacity

MDTs were affected by wider workforce and capacity issues facing health and social care

- Staff reported integrated care was hard to deliver in context of understaffing, high staff turnover, high caseload, constant service reorganisation and lack of clarity on new services. 8
- Staff were concerned about the lack of capacity to address unmet needs identified through integrated working. 6
- Staff feeling overworked and concerned for their mental health. Lack of acknowledgement from managers of frontline pressures 8
- Frequent turnover of staff especially social workers, and reliance on agency staff made relationship building a challenge 7
- It takes time for staff to build the relationships and develop the skills needed to initiate service change for improved integrated care. Staff retention is important to the success of MDTs in integrated care. 8

Person-centred care

- Patient-centred approach is key to success of MDT working and has been argued it should be the foundational organising principle of integrated care 1,13
- MDTs should be proactive in involving patients and families to ensure decision-making is centred on their views and concerns. 3
- Some staff felt patients should have the opportunity to attend MDT meetings 12
- There is a risk MDTs focus too much on their own processes, and unintentionally exclude patients and families from discussions about their care, MDTs should establish regular communication with individuals and provide real opportunities for their involvement in decision-making 3
- Use of patient activation measures (PAMs) may support MDTs to have a more co-productive relationship with patients who are willing and able to engage 5
- Greater integration of informal carers into professional services seen as key to integrated care 5

Barriers to person-centred MDT working

- Patient input can enhance the function of MDTs but is often lacking 2
- Lack of time to contact patients for their views before MDT meetings 12

- Logistical challenges of including patients and carers in MDT meetings where several people are due to be discussed 5
- Common concern that patients do not really want to be more involved in planning their care 5
- Consider how MDTs can combine macro, system-wide view of integrated care and the micro, individual view of person-centred care 12
- MDTs could even shift focus away from the patient, as professionals discuss issues with other MDT members rather than with the patient 5

IT, facilities and shared data

IT facilities, sufficient space, and particularly access to shared patient data is crucial for successful MDT working

- Adequate IT facilities and the ability to share data especially patient information in real time was seen as absolutely crucial for MDT working 1, 6
- Practical support from organisations including digital infrastructure, shared records and integrated performance systems are important enablers for MDTs 3
- Shared 'read only' records were seen as a success, although implementation took several years and benefits took time to realise 13
- Adequate space and facilities: e.g. a meeting room are required 6
- Establish a virtual space for MDTs where co-location is not possible 1
- Ensure physical spaces provided are suitable for collaboration 2

IT and shared data-related barriers to MDT working

- Inadequate IT, incompatible systems inability to share data, plus slow progress in developing information governance protocols were a major inhibitor of MDT working., leading to much valuable MDT meeting time taken up with collating information 5, 6, 7
- Some staff shared patient information informally with other team members but were concerned this was not always allowed 5
- Data protection concerns and a lack of trust between services inhibited information sharing 9
- Sometimes important details missed form shared care records, even when these were available 12

Reviews

1.	**Multidisciplinary Team (MDT) Toolkit** **Item Type:** Report **Authors:** Dodkin, L.

	Publication Date: no date HEE: Health Education England **Abstract:** As part of its 2021-22 Business Plan for Recovery and Delivery, Health Education England (HEE) has a strategic goal to transform today's workforce to work in a co-operative, flexible, multi-professional, digitally enabled system. This includes an objective to support the expansion and development of multi-disciplinary teams to achieve a diverse, sustainable skills mix in primary care. To help build capacity and capability within Integrated Care Systems (ICSs) for workforce redesign, HEE has developed a suite of resources including a new Multidisciplinary Team (MDT) toolkit. This toolkit is a step-by-step guide to help progress a one workforce approach across health and care organisations and Integrated Care Systems (ICSs). By one workforce we mean people coming together as part of multidisciplinary teams (MDTs) to deliver a shared objective – whether that be a project to introduce a new role, redesign of a patient pathway or providing care in a different way. Whilst there is lots of evidence already published, this is often sector or setting specific. This toolkit is intended to collate the current evidence base into a single, whole system guide and so complements existing frameworks. It is aimed at those who are driving greater collaboration across boundaries and is relevant to MDTs regardless of composition, setting or organisation/ system. The toolkit is framed around six enablers of MDT working and presents evidence, supporting resources and success factors within each chapter. The six enablers are: Planning and design Skill mix and learning Culture Shared goals and objectives Working across boundaries Communication There is also a development plan on a page to help teams self-assess their current position and identify areas for development to become an effective MDT. **URL:** https://www.hee.nhs.uk/our-work/workforce-transformation/multidisciplinary-team-mdt-toolkit
2.	**Briefing: Realising the potential of community-based multidisciplinary teams. Insights from evidence**

	Item Type: Report **Authors:** Lloyd, T., Beech, J., Wolters, A. and Tallack, C. **Publication Date:** 2023 **Publication Details:** London: The Health Foundation **Abstract:** Key points Key points • Better integration between health and social care services is a longstanding policy objective in England and other countries. Recent reforms to the NHS in England established 42 area-based integrated care systems (ICSs) to lead local efforts to develop more integrated models of care. A common approach is the development of community-based multidisciplinary teams (MDTs), in which a mix of health and care professionals come together to plan and coordinate people's care. Many MDTs are based around general practices and typically focus on care for adults with complex health and care needs. This briefing brings together evidence from Improvement Analytics Unit (IAU) evaluations of three MDTs and wider evidence to inform current efforts to develop integrated care in England. Despite widespread policy support, evidence on the impact of community-based MDTs is mixed. Our three IAU evaluations found that MDTs did not reduce emergency hospital use – and may even have led to increases – at least in the short term. Our longer term evaluations of the broader programmes in which these teams were implemented found some evidence of reductions in emergency hospital use, but this took between 3 and 6 years. Wider evidence on the impact of community-based MDTs was limited and mixed – though some studies suggest broader integrated care interventions can improve patient satisfaction, perceived quality of care and access. MDTs are not new and are widely thought to be needed to deliver high-quality care for people with chronic conditions. There could be several explanations for lack of clear evidence on impact – including unrealistic assumptions about MDTs and challenges in evaluating impact. The effect of MDTs also depends on many factors, including team resources and skills, staff engagement, IT resources, access to data, population characteristics and the broader context, such as local community services and overall levels of investment. **URL:** https://www.health.org.uk/sites/default/files/upload/publications/2023/MTD%20briefing_WEB.pdf
3.	**Multidisciplinary teams: Integrating care in places and neighbourhoods** **Item Type:** Report

	Authors: Miller, R. **Publication Date:** 2022 **Publication Details:** Egham: SCIE: Social Care Institute of Excellence **Abstract:** Multidisciplinary teams (MDTs) are central to achieving the vision of Integrated Care Systems (ICSs) as they are a structured forum in which practitioners from across health and social care can come together around the needs of individuals and communities. MDTs need to have a clear role and purpose, be well led and organised, have sufficient diversity of professions and disciplines, and be supported by an enabling infrastructure. MDTs must be pro-active in how they engage individuals and families in their discussions and decision making. MDTs should also connect with other services and teams in their neighbourhoods and place. **URL:** https://www.scie.org.uk/integrated-care/workforce/role-multidisciplinary-team

Studies

4.	**Improving Multidisciplinary Team Working to Support Integrated Care for People with Frailty Amidst the COVID-19 Pandemic** **Item Type:** Journal Article **Authors:** Barber, Susan;Otis, Michaela;Greenfield, Geva;Razzaq, Nasrin;Solanki, Deepa;Norton, John;Richardson, Sonia and and Hayhoe, Benedict W. J. **Publication Date:** 2023 **Journal:** International Journal of Integrated Care (IJIC) 23(2), pp. 1-13 **Abstract:** Multidisciplinary team (MDT) working is essential to optimise and integrate services for people who are frail. MDTs require collaboration. Many health and social care professionals have not received formal training in collaborative working. This study investigated MDT training designed to help participants deliver integrated care for frail individuals during the Covid-19 pandemic. Researchers utilised a semi-structured analytical framework to support observations of the training sessions and analyse the results of two surveys designed to assess the training process and its impact on participants knowledge and skills. 115 participants from 5 Primary Care Networks in London attended the training. Trainers utilised a video of a patient pathway, encouraged discussion of it, and demonstrated the use of evidence-based tools for patient needs assessment and care planning. Participants were

	encouraged to critique the patient pathway, reflect on their own experiences of planning and providing patient care. 38% of participants completed a pre-training survey, 47% a post-training survey. Significant improvement in knowledge and skills were reported including understanding roles in contributing to MDT working, confidence to speak in MDT meetings, using a range of evidence-based clinical tools for comprehensive assessment and care planning. Greater levels of autonomy, resilience, and support for MDT working were reported. Training proved effective; it could be scaled up and adopted to other settings. **Access or request full text:** https://libkey.io/10.5334/ijic.7022 **URL:** https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=169856642&custid=ns128641
5.	**Making a difference: workforce skills and capacity for integrated care** **Item Type:** Journal Article **Authors:** Akehurst, Joy;Stronge, Paul;Giles, Karen and Ling, Jonathon **Publication Date:** 2022 **Journal:** Journal of Integrated Care 30(5), pp. 93-107 **Abstract:** Purpose: The aim of this action research was to explore, from a workforce and a patient/carer perspective, the skills and the capacity required to deliver integrated care and to inform future workforce development and planning in a new integrated care system in England. Design/methodology/approach: Semi-structured interviews and focus groups with primary, community, acute care, social care and voluntary care, frontline and managerial staff and with patients and carers receiving these services were undertaken. Data were explored using framework analysis. Findings: Analysis revealed three overarching themes: achieving teamwork and integration, managing demands on capacity and capability and delivering holistic and user-centred care. An organisational development (OD) process was developed as part of the action research process to facilitate the large-scale workforce changes taking place. Research limitations/implications: This study did not consider workforce development and planning challenges for nursing and care staff in residential, nursing care homes or domiciliary services. This part of the workforce is integral to the care pathways for many patients, and in line with the current emerging national focus on this sector, these groups require further examination. Further, data explore service users' and carers' perspectives on workforce skills. It proved challenging to recruit patient and carer respondents for the research due to the nature of their illnesses. Practical implications: Many of the required skills already existed within the workforce. The OD process facilitated collaborative learning to enhance skills; however, workforce planning across a whole system has challenges in relation to data gathering and management. Ensuring a focus on

	workforce development and planning is an important part of integrated care development. Social implications: This study has implications for social and voluntary sector organisations in respect of inter-agency working practices, as well as the identification of workforce development needs and potential for informing subsequent cross-sector workforce planning arrangements and communication. Originality/value: This paper helps to identify the issues and benefits of implementing person-centred, integrated teamworking and the implications for workforce planning and OD approaches. **Access or request full text:** https://libkey.io/10.1108/JICA-05-2020-0030 **URL:** https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=160709361&custid=ns128641
6.	**Observations of community-based multidisciplinary team meetings in health and social care for older people with long term conditions in England** **Item Type:** Journal Article **Authors:** Douglas, Nick;Mays, Nicholas;Al-Haboubi, Mustafa;Manacorda, Tommaso;Thana, Lavanya;Wistow, Gerald and Durand, Mary Alison **Publication Date:** 2022 **Journal:** BMC Health Services Research 22(1), pp. 1-12 **Abstract:** Background: Community-based multi-disciplinary teams (MDTs) are the most common means to encourage health and social care service integration in England yet are rarely studied or directly observed. This paper reports on two rounds of non-participant observations of community-based multi-disciplinary team (MDT) meetings in two localities, as part of an evaluation of the Integrated Care and Support Pioneers Programme. We sought to understand how MDT meetings coordinate care and identify their 'added value' over bilateral discussions.Methods: Two rounds of structured non-participant observations of 11 MDTs (28 meetings) in an inner city and mixed urban-rural area in England (June 2019-February 2020), using a group analysis approach.Results: Despite diverse settings, attendance and caseloads, MDTs adopted similar processes of case management: presentation; information seeking/sharing; narrative construction; solution seeking; decision-making and task allocation. Patient-centredness was evident but scope to strengthen 'patient-voice' exists. MDTs were hampered by information governance rules and lack of interoperability between patient databases. Meetings were characterised by mutual respect and collegiality with little challenge. Decision-making appeared non-hierarchical, often involving dyads or triads of professionals. 'Added value' lay in: rapid patient information sharing; better understanding of contributing agencies' services; planning strategies for patients that providers had struggled to find the right way to engage satisfactorily; and managing risk and providing mutual support

	in stressful cases.Conclusions: More attention needs to be given to removing barriers to information sharing, creating scope for constructive challenge between staff and deciding when to remove cases from the caseload. **Access or request full text:** https://libkey.io/10.1186/s12913-022-07971-x **URL:** https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=157318811&custid=ns128641
7.	**Co-location, an enabler for service integration? Lessons from an evaluation of integrated community care teams in East London** **Item Type:** Journal Article **Authors:** Lalani, Mirza and Marshall, Martin **Publication Date:** 2022 **Journal:** Health & Social Care in the Community 30(2), pp. e388-e396 **Abstract:** In an attempt to support care integration that promotes joined up service provision and patient-centred care across care boundaries, local health and social care organisations have embarked on several initiatives and approaches. A key component of service integration is the co-location of different professional groups. In this study, we consider the extent to which co-location is an enabler for service integration by examining multi-professional community care teams. The study presents findings from a qualitative evaluation of integrated care initiatives in a borough of East London, England, undertaken between 2017 and 2018. The evaluation employed a participatory approach, the Researcher-in-Residence model. Participant observation (n = 80 hr) and both semi-structured individual (n = 16) and group interviews (six groups, n = 17 participants) were carried out. Thematic analysis of the data was undertaken. The findings show that co-location can be an effective enabler for service integration providing a basis for joint working, fostering improved communication and information sharing if conditions such as shared information systems and professional cultures (shared beliefs and values) are met. Organisations must consider the potential barriers to service integration such as differing professional identity, limited understanding of roles and responsibilities and a lack of continuity in personnel. Co-location remains an important facet in the development of multi-professional teams and local service integration arrangements, but as yet, has not been widely acknowledged as a priority in care practice. Organisations that are committed to greying care boundaries and providing joined up patient care must ensure that sufficient focus is provided at the service delivery level and not assume that decades of silo working in health and social care and strong professional cultures will be resolved by co-location. **Access or request full text:** https://libkey.io/10.1111/hsc.13211

	URL: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=155057680&custid=ns128641
8.	**Understanding integrated care at the frontline using organisational learning theory: A participatory evaluation of multi-professional teams in East London** **Item Type:** Journal Article **Authors:** Lalani, Mirza;Bussu, Sonia and Marshall, Martin **Publication Date:** 2020 **Journal:** Social Science & Medicine 262, pp. N.PAG **Abstract:** Integrated care has been proposed as an organising principle to address the challenges of the rising demand for care services and limited resources. There is limited understanding of the role of learning in integrated care systems. Organisational Learning (OL) theory in the guise of 'Learning Practice' can offer a lens to study service integration and reflect on some of the challenges faced by multi-professional teams in developing a learning culture. The study presents findings from two qualitative evaluations of integrated care initiatives in three East London boroughs, England, undertaken between 2017 and 2018. The evaluations employed a participatory approach, the researcher-in-residence model, to coproduce findings with frontline staff working in multi-professional teams in community care. Thematic analysis was undertaken using an adapted version of the 'Learning Practice' framework. The majority of learning in the teams was single loop i.e. learning was mainly reactive to issues that arise. Developing a learning culture in the three boroughs was hindered by the differences in the professional and organisational cultures of health and social care and challenges in developing effective structures for learning. Individual organisational priorities and pressures inhibited both the embedding of learning and effective integration of care services at the frontline. Currently, learning is not inherent in integrated care planning. The adoption of the principles of OL optimising learning opportunities, support of innovation, managed risk taking and capitalising on the will of staff to work in multidisciplinary teams might positively contribute to the development of service integration. • Organisational learning can foster the development of service integration. • Learning bridges the gap between the rhetoric of integrated care and service outcomes. • Frontline staff have demonstrated the potential for change and innovation. • Relational aspects of integrated care are integral in enabling the success of initiatives. **Access or request full text:** https://libkey.io/10.1016/j.socscimed.2020.113254 **URL:** https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=145681286&custid=ns128641

9.	**More that unites us than divides us? A qualitative study of integration of community health and social care services** **Item Type:** Journal Article **Authors:** Mitchell, Claire;Tazzyman, Abigail;Howard, Susan J. and Hodgson, Damian **Publication Date:** 2020 **Journal:** BMC Family Practice 21(1), pp. 1-10 **Abstract:** Background: The integration of community health and social care services has been widely promoted nationally as a vital step to improve patient centred care, reduce costs, reduce admissions to hospital and facilitate timely and effective discharge from hospital. The complexities of integration raise questions about the practical challenges of integrating health and care given embedded professional and organisational boundaries in both sectors. We describe how an English city created a single, integrated care partnership, to integrate community health and social care services. This led to the development of 12 integrated neighbourhood teams, combining and co-locating professionals across three separate localities. The aim of this research is to identify the context and the factors enabling and hindering integration from a qualitative process evaluation. Methods: Twenty-four semi-structured interviews were conducted with equal numbers of health and social care staff at strategic and operational level. The data was subjected to thematic analysis. Results: We describe three key themes: 1) shared vision and leadership; 2) organisational factors; 3) professional workforce factors. We found a clarity of vision and purpose of integration throughout the partnership, but there were challenges related to the introduction of devolved leadership. There were widespread concerns that the specified outcome measures did not capture the complexities of integration. Organisational challenges included a lack of detail around clinical and service delivery planning, tensions around variable human resource practices and barriers to data sharing. A lack of understanding and trust meant professional workforce integration remained a key challenge, although integration was also seen as a potential solution to engender relationship building. Conclusions: Given the long-term national policy focus on integration this ambitious approach to integrate community health and social care has highlighted implications for leadership, organisational design and inter-professional working. Given the ethos of valuing the local assets of individuals and networks within the new partnership we found the integrated neighbourhood teams could all learn from each other. Many of the challenges of integration could benefit from embracing the inherent capabilities across the integrated neighbourhood teams and localities of this city. **Access or request full text:** https://libkey.io/10.1186/s12875-020-01168-z **URL:** https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db

	=cin20&AN=143491876&custid=ns128641
10.	**Towards a theoretical framework for Integrated Team Leadership (IgTL)** **Item Type:** Journal Article **Authors:** Smith, Tony;Fowler Davis, Sally;Nancarrow, Susan;Ariss, Steven and Enderby, Pam **Publication Date:** 2020 **Journal:** Journal of Interprofessional Care 34(6), pp. 726-736 **Abstract:** This study presents a framework for the leadership of integrated, interprofessional health, and social-care teams (IgTs) based on a previous literature review and a qualitative study. The theoretical framework for Integrated Team Leadership (IgTL) is based on contributions from 15 professional and nonprofessional staff, in 8 community teams in the United Kingdom. Participants shared their perceptions of IgT's good practice in relation to patient outcomes. There were two clear elements, Person-focused and Task-focused leadership behaviors with particular emphasis on the facilitation of shared professional practices. Person-focused leadership skills include: inspiring and motivating; walking the talk; change and innovation; consideration; empowerment, teambuilding and team maintenance; and emotional intelligence. Task-focused leadership behaviors included: setting team direction; managing performance; and managing external relationships. Team members felt that the IgTL should be: a Health or Social Care (HSC) professional; engaged in professional practice; and have worked in an IgT before leading one. Technical and cultural issues were identified that differentiate IgTL from usual leadership practice; in particular the ability to facilitate or create barriers to effective integrated teamworking within the organizational context. In common with other OECD countries, there are policy imperatives in England for further integration of health and social care, needed to improve the quality and effectiveness of care for older people with multiple conditions. Further attention is needed to support the development of effective IgTs and leadership will be a pre-requisite to achieve this vision. The research advances the understanding of the need for skilled interprofessional leadership practice. **Access or request full text:** https://libkey.io/10.1080/13561820.2019.1676209 **URL:** https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=147339139&custid=ns128641
11.	**Integrated care: mobilising professional identity** **Item Type:** Journal Article

	Authors: Best, Stephanie and Williams, Sharon **Publication Date:** 2018 **Journal:** Journal of Health Organization & Management 32(5), pp. 726-740 **Abstract:** Purpose Integrated care has been identified as essential to delivering the reforms required in health and social care across the UK and other healthcare systems. Given this suggests new ways of working for health and social care professionals, little research has considered how different professions manage and mobilise their professional identity (PI) whilst working in an integrated team. The paper aims to discuss these issues. Design/methodology/approach A qualitative cross-sectional study was designed using eight focus groups with community-based health and social care practitioners from across Wales in the UK during 2017. Findings Participants reported key factors influencing practice were communication, goal congruence and training. The key characteristics of PI for that enabled integrated working were open mindedness, professional trust, scope of practice and uniqueness. Blurring of boundaries was found to enable and hinder integrated working. Research limitations/implications This research was conducted in the UK which limits the geographic coverage of the study. Nevertheless, the insight provided on PI and integrated teams is relevant to other healthcare systems. Practical implications This study codifies for health and social care practitioners the enabling and inhibiting factors that influence PI when working in integrated teams. Originality/value Recommendations in terms of how healthcare professionals manage and mobilise their PI when working in integrated teams are somewhat scarce. This paper identifies the key factors that influence PI which could impact the performance of integrated teams and ultimately, patient care. **Access or request full text:** https://libkey.io/10.1108/JHOM-01-2018-0008 **URL:** https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=131574747&custid=ns128641
12.	**Enacting person-centredness in integrated care: A qualitative study of practice and perspectives within multidisciplinary groups in the care of older people** **Item Type:** Journal Article **Authors:** Riste, Lisa K.;Coventry, Peter A.;Reilly, Siobhan T.;Bower, Peter and Sanders, Caroline **Publication Date:** 2018 **Journal:** Health Expectations : An International Journal of Public Participation in Health Care and Health Policy 21(6), pp. 1066-1074

	Abstract: BACKGROUND: Person-centredness is important in delivering care for long-term conditions. New models of care aim to co-ordinate care through integration of health and social care which require new ways of working, often remotely from the patient., OBJECTIVE: To describe how person-centred care is enacted within multidisciplinary groups (MDGs) created as part of a new service, integrating health and social care for older people., METHODS: We followed the implementation of eight neighbourhood MDGs, observing and interviewing staff from three MDGs at different phases of programme implementation using semi-structured topic guides., RESULTS: Thirty-four MDG meetings were observed and 32 staff interviewed. Three core themes were identified which impacted on enactment of person-centred care: the structural context of MDGs enabling person-centred care; interaction of staff and knowledge sharing during the MDG meetings; and direct staff involvement of the person outside the MDG discussion., CONCLUSIONS: This study provides new insights into attempts to enact person-centred care within a new model of service delivery. Teams did what they could to enact person-centred care in the absence of the "real" patient within MDG meetings. They were successful in delivering and co-ordinating some aspects of care (eg prompting medication reviews, referring to social worker, health improvement and arranging further multidisciplinary team meetings for complex cases). This "absence of patients" and time pressures within the MDGs led to reliance on the "virtual" record, enhanced by additional "soft" knowledge provided by staff, rather than ensuring the patient's voice was included. Copyright © 2018 The Authors Health Expectations published by John Wiley & Sons Ltd. **Access or request full text:** https://libkey.io/10.1111/hex.12803
13.	**An integrated care programme in London: qualitative evaluation** **Item Type:** Journal Article **Authors:** Round, Thomas;Ashworth, Mark;Crilly, Tessa;Ferlie, Ewan and Wolfe, Charles **Publication Date:** 2018 **Journal:** Journal of Integrated Care 26(4), pp. 296-308 **Abstract:** Purpose A well-funded, four-year integrated care programme was implemented in south London. The programme attempted to integrate care across primary, acute, community, mental health and social care. The purpose of this paper is to reduce hospital admissions and nursing home placements. Programme evaluation aimed to identify what worked well and what did not; lessons learnt; the value of integrated care investment.Design/methodology/approach Qualitative data were obtained from documentary analysis, stakeholder interviews, focus groups and observational data from programme meetings. Framework analysis was applied to stakeholder interview and focus group data in order to generate themes.Findings The integrated care project had not delivered expected radical reductions in hospital or nursing home utilisation. In response, the

	scheme was reformulated to focus on feasible service integration. Other benefits emerged, particularly system transformation. Nine themes emerged: shared vision/case for change; interventions; leadership; relationships; organisational structures and governance; citizens and patients; evaluation and monitoring; macro level. Each theme was interpreted in terms of "successes", "challenges" and "lessons learnt".Research limitations/implications Evaluation was hampered by lack of a clear evaluation strategy from programme inception to conclusion, and of the evidence required to corroborate claims of benefit.Practical implications Key lessons learnt included: importance of strong clinical leadership, shared ownership and inbuilt evaluation.Originality/value Primary care was a key player in the integrated care programme. Initial resistance delayed implementation and related to concerns about vertical integration and scepticism about unrealistic goals. A focus on clinical care and shared ownership contributed to eventual system transformation. **Access or request full text:** https://libkey.io/10.1108/JICA-02-2018-0020 **URL:** https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=132161992&custid=ns128641

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