



SCIE Highlights No 4 – July 2018

# Delivering integrated care: the role of the multidisciplinary team

Multidisciplinary teams (MDTs) are promoted as a means to enable practitioners and other professionals in health and social care to collaborate successfully. Research suggests that MDTs can be effective in meeting the needs of some populations. They are identified in SCIE's [Integration Logic Model](#) as a core desire of what good integrated care looks like. Sufficient diversity of professions and disciplines, suitable leadership and team dynamics, and supportive organisations are important enablers.

Integrated care requires professionals and practitioners from across different sectors to work together around the needs of people, their families and their communities. Not working together results in a poor experience of care, a waste of resources and in some cases people suffering harm.

Teams which bring together the relevant professionals and practitioners are seen as an effective means to encourage better coordination of their work. Often these are labelled as 'MDTs' but are in fact often seeking to enable 'inter' or 'trans' working between different 'professionals' and 'practitioners'. MDTs are encouraged (and in some cases mandated) by policy-makers in relation to different populations and needs. Examples include:

- young people who have offended
- people with mental health issues
- children and young people who are at risk of abuse or neglect

- older people with multiple long-term conditions.

Common elements of MDTs include:

- an identified manager and/or practice leader who oversees and facilitates the work of the whole team
- a single process to access the workers in the team, with joint meetings to share insights and concerns
- electronic records of all contacts, assessments and interventions of team members with an individual and their family
- a 'key worker' system through which care for those with complex support packages is coordinated by a named team member.

Some professionals work mainly within a single MDT in co-located premises. Others may be members of multiple MDTs and not located with other team members.

## Key messages

- Multidisciplinary teams (MDTs) have been shown to be an effective tool to facilitate collaboration between professionals and hence improve care outcomes.
- Successful working requires at minimum an identified manager or coordinator, regular joint meetings and the effective sharing of electronic records.
- Teams do not necessarily have to be located in the same premises to work successfully.
- Multidisciplinary working can be approached in more than one way as the case studies in this briefing demonstrate.
- The success of the MDT approach is not guaranteed: without strong organisation the impact may be negative rather than positive.
- Ongoing integrated care developments should provide further evidence to enable us to understand how MDTs should be used in the future.

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## Definitions

**Discipline:** a specialist field of practice or study within a profession and/or in academia.

**Integrated care:** services working together to ensure people can plan their care to achieve the outcomes that are important to them.

**Practitioner:** an individual who has the training and experience to undertake roles within health and social care.

**Professional:** an individual for whom qualification and registration are necessary to undertake a particular role.

**Team:** a group of identified individuals with a shared purpose for which they are mutually accountable and which requires interaction between team members.

## What do we hope MDTs will achieve?

There are a common set of aspirations about what MDTs will achieve no matter what the population or need concerned.

- MDTs will enable professionals and practitioners from different backgrounds to communicate better about each other's roles and responsibilities.
- MDTs will provide a shared identity and purpose that encourages team members to trust each other.
- MDTs will lead to better communication and trust between team members and more holistic and person-centred practice.
- MDTs will prevent unnecessary errors and avoidance of related harm to individuals and their families.
- MDTs will result in resources being used more efficiently through reduced duplication, greater productivity and preventative care approaches.
- MDTs will mean professionals and practitioners are less isolated and so will improve morale and reduce stress.

## What is the evidence on MDTs?

- A systematic review of MDTs in cancer services found that all studies reported improved outcomes. These included increased rates of survival, improved patient satisfaction and better treatment planning.
- Better team working in mental health services increases job satisfaction. This is positively associated with the level of choice experienced by individuals accessing support and their satisfaction with these choices.
- MDTs can encourage better care coordination and quality by fostering collaboration between professionals.
- MDT meetings in cancer services last up to five hours and involve up to 27 professionals. On average, only three professionals contributed to the discussion of each individual's needs.
- Primary care MDTs have not decreased admissions to hospital for people in high-risk populations. If anything, admissions to hospital have increased slightly.

(Huxley et al 2011, Prades et al 2015, Cancer UK 2016, EU 2017)

The evidence from research is that MDTs can in some circumstances result in positive outcomes for people and their families, and improved job satisfaction for professionals and practitioners. However, this is not guaranteed, and if not well organised, MDTs can have no impact or in some cases a negative impact. The following case studies highlight different approaches taken by three local areas to encourage collaborative working between professionals and practitioners.

## Case study: neighbourhood teams in Manchester

Increasing numbers of people in Manchester have to cope with multiple health conditions and the difficulties of living on lower incomes. To support people and communities with such challenges, the city council and the clinical commissioning groups (CCGs) have developed primary care-based MDTs. These were initially tested out by different pilots in north, central and south Manchester.

Central Manchester developed practice integrated care teams (PICTs). These included general practitioners, social workers, practice and community health practitioners such as district nurses, and case managers. Specialist teams were called upon as necessary, depending on the needs of the individuals and families concerned. The PICTs had clear principles to guide their work – people would feel more in control of their lives; they would be seen as a whole person; health and social care would work together; and care would be planned ahead. To aid coordination of care, a key worker was identified and electronic care plans were accessible to all team members.

PICTs met monthly to ensure they had the opportunity to share learning as well as to seek advice and support regarding the care of the people for whom they were key workers. A multiprofessional group led the initial design of PICTs. The group maintained its involvement to constructively challenge and further improve the work of PICTs. Achieving the core principles required professionals to collaborate more closely with one other and also adopt a more outcomes-orientated approach with the individuals concerned. This element of practice was challenging for some team members.

Developing the PICTs and the other MDT pilots provided important lessons for Manchester

on MDT working. In particular, it was recognised that engagement of people and communities was not as strong as they had hoped and there could have been a better connection with the voluntary sector. These lessons have been taken forward in the creation of integrated neighbourhood teams within the local care organisation. These have adopted an ‘asset-based’ approach, which focuses on communities’ skills and capacities, and will work with the voluntary sector to help people to improve their resilience, independence and wellbeing. By including all relevant professionals in a single patient-centred approach to care, the aim is to deliver high-quality care, improve the patient experience and ultimately avoid unnecessary hospital admissions.

One example of the impact that the neighbourhood teams can have is Eileen. She is 89 and had lost her confidence after a fall while out shopping. She was only able to get out of the house if assisted in a wheelchair and experienced long days by herself. Reducing Eileen’s social isolation was a key priority for the MDT. The care navigator took the lead and began visiting Eileen to build rapport and find out more about her individual situation and interests. Eileen was helped with day-to-day chores by friends and family but did not have any opportunities to take part in different and stimulating social activities or interactions. Volunteers from Didsbury Good Neighbours arranged for Eileen to attend a regular local coffee morning and also engaged a local befriender who now visits once a month for a cup of tea and a chat.

For more details see Beacon, A. (2015) ‘[Practice-integrated care teams – learning for a better future](#)’, *Journal of Integrated Care*, vol. 23, no. 2, pp 74–87.

See also [Our healthier Manchester](#)



## Case study: Stockport family model

The Stockport family model bases its multidisciplinary working on the principles of restorative practice. Developed initially in relation to those who had experienced crime, this approach seeks to help families to deal with challenges and build relationships. Mainstream services such as social care, health visiting, school nursing, early years and early help are organised into three localities within their traditional disciplinary teams, with specialist teams such as youth offending and 'Mosaic' (drug and alcohol) working across the borough and being 'called in' as required to reduce 'hand-offs' for families.

Collaboration is encouraged through all professionals and teams signing up to the common principles of restorative practice. The principles are introduced through a three-day interprofessional training programme. Champions from different services then encourage colleagues to embed these principles in their work through informal support and mentoring. They themselves meet regularly to share experiences and develop further opportunities to implement the principles.

There has been a strong emphasis on openness and engagement in the service, with regular communication with colleagues, partners and families. This includes weekly sharing of good practice via email, informal coffee sessions with senior managers and serious success reviews that examine why support for a given family went well. Social media provides further opportunities for networking across organisations, roles and layers of management. Various routes are open to those with lived experience to share their perspectives. These include formal forums for people leaving care and foster carers, as well comment and complaints processes.

Innovation is encouraged through a 'design by doing' methodology. Small- and large-scale changes that can demonstrate 'minimal viability' undergo trials. The impact and process of trials are reviewed through multi-stakeholder workshops to identify learning for further implementation. The use of language has been an important element in developing a positive culture in which professionals and practitioners are able to speak up and indeed constructively challenge others.

A grant from the Department for Education's Innovation Programme has helped to launch the Stockport family model. A multiagency innovation board brought together agencies to provide a strategic overview, with an evaluation published in 2017. Due to the early stages of implementation, the evaluation could not provide a clear judgement on the overall success of local developments. It did however report that short-term outcomes which supported the underlying thinking behind the model were starting to be observed. Stockport was graded as 'Good with outstanding features' at the Ofsted inspection in July 2017.

For more information see [Stockport family services project](#)



## Case study: Lincolnshire community learning disability team

Specialist health and social work professionals who support people with a learning disability in Lincolnshire functioned separately for many years. Formal referrals were required for one professional to request the involvement of another, which could lead to delays before the individual and their family received support. To address this fragmentation, the learning disability health professionals now work within a locality based MDT. Each locality has a physical hub from which the team members work on a regular or occasional basis depending on the geographic size of the locality. Social workers remain within the local authority and are not managed through the locality teams.

A weekly MDT meeting provides an opportunity for all professionals to contribute to discussions of individuals in need. There is always representation from social workers

at these meetings. Minutes are circulated to ensure that if a team member is absent then they can still be aware of what was discussed. A lead professional coordinates care for people with more complex packages of support. This is decided in part by discipline but also by matching the interests and background of the professional with the person concerned.

The service has employed five experts by experience. They will provide training to mainstream health services, be involved in all recruitment to the MDTs and help to connect with community groups. MDTs can in principle be managed by any profession, although currently the team managers all have a nursing background. Team members can select who provides them with clinical supervision – this could be someone of the same or a different profession.

The introduction of MDTs followed a turbulent time in which a number of learning disability services were closed. All members participated in an initial week-long event in which there was open discussion about the purpose of the team and how it should operate in the future. The values on which the MDTs would operate were clearly articulated. Every six months, development days are held which present organisational and policy updates and an opportunity for team members to share examples of good practice. They also provide a safe space for team members to express concerns about current arrangements and future direction.

For more details see [National evaluation of the Building the Right Support programme](#)



The case studies show that there are different ways to support groups of professionals and practitioners to collaborate successfully. Lincolnshire and Manchester have brought together those working within an identified locality into an MDT. Stockport has instead maintained single-discipline teams but enabled collaboration through shared principles, joint training and an emphasis on innovation and improvement.

Research has revealed that for MDTs to work successfully there are a set of enablers that should be in place.

**Clear purpose:** MDTs need a defined role that requires team members to interact across professional and disciplinary boundaries.

**Institutional support:** the organisations which employ staff and (if in place) the partnership bodies overseeing this area of collaboration must provide support. This should include public endorsement (and so legitimacy), ensuring that the MDT has the necessary resources, and developing integrated performance systems.

**Team leadership:** leaders should generally be facilitative in their approach to encourage different contributions, but be directional when necessary. An awareness of team dynamics and a willingness to challenge poor collaborative practice are important competences for a team leader.

**Collaborative opportunities:** teams must have physical space and time for their members to engage across professions and disciplines. This enables them to improve communication and better understand each other's roles and resources.

**Person-centric:** there is a danger that teams can become too inwardly focused on their own functioning. This can lead to people and their families feeling more, rather than less, excluded from discussions about their care.

**Role diversity:** there is no magic formula for MDTs. Rather, the mix of professions and practitioners must respond to the needs of the population concerned while still being small enough to allow members to know each other.

**Evidence focused:** teams require timely and accurate evidence of their shared impact. Structured opportunities for teams to reflect on this evidence is one of the most impactful means to strengthen their work.

## Conclusion

MDTs are likely to remain an important component of health and social care. It is important that those who create, lead and work in them are aware of both the pitfalls and opportunities of MDTs. The current integrated care developments in England and internationally should provide considerable evidence about their deployment within different populations. Learning from this evidence will enable us to understand when and how MDTs should be used in the future.

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# Further information

## About SCIE

The Social Care Institute for Excellence improves the lives of people of all ages by co-producing, sharing, and supporting the use of the best available knowledge and evidence about what works in practice. Last year, the Department of Health funded SCIE to produce an Integration Logic Model to help local areas to plan and monitor performance towards an integrated system and deliver the national Better Care Support Programme. We are currently evaluating the Integration Accelerator Sites, which are piloting a single assessment and care planning approach. We offer:

- ✓ rapid reviews of evidence and tools to support implementation
- ✓ co-production of integrated strategies and plans
- ✓ diagnostics and analysis
- ✓ whole system facilitation and action planning.

## About the Health Services Management Centre

The Health Services Management Centre (HSMC) at the University of Birmingham is one of the UK's foremost centres for research, evaluation, teaching and professional development for health and social care organisations.

Find out [more](#)

## About the author

Dr Robin Miller is an applied health and social care academic with an interest in the development and leadership of new models of integrated and primary care. Robin is the current joint editor-in-chief of the International Journal of Integrated Care, an advisory group member of the European Primary Care Network and a fellow of the School for Social Care Research. The International Journal of Integrated Care is an open access journal available at:

[www.ijic.org](http://www.ijic.org)

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## Further reading

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[International Journal of Integrated Care](#) is an open access journal on latest research and case studies.

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