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Multidisciplinary teams: Integrating care in places and neighbourhoods

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.

MDTs and integrated care

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 wasting of resources, and can lead to individuals suffering harm or being exposed to abuse.

Teams which bring together the relevant professionals and practitioners can be an effective means to encourage better co-ordination of their work. MDTs have long been deployed within services for individuals with complex needs such as young people who have offended; people diagnosed with cancer; people with severe mental health issues; and people who are at risk of abuse or neglect. In more recent times, they are also being deployed for more diverse populations, such as those within a community at high risk of poor health and social outcomes, people being discharged from hospital, and older people living in residential care homes.

Common elements of MDTs include:

- An identified manager and/or practice leader who facilitates the work of the whole team.
- A single process to access the team with joint meetings to share insights and concerns.
- Shared electronic record 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.
- Diversity of professions and disciplines, including those from the Voluntary & Community Sector (VCS).

“Integrated care requires professionals and practitioners from across different sectors to work together around the needs of people, their families and their communities.”

Definitions

Individual: Someone who is accessing social or health care services or support due to their own or a family member's needs.

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

Professional: An individual who has the qualification and experience to undertake the role of a licensed profession.

Practitioner: An individual who has training and experience to undertake other direct care and support roles.

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

Neighbourhoods: Local areas of often 30,000-50,000 people supported by primary care and their community partners.

Place: A larger geographic area which often includes 250,000-500,000 people such as a borough or county.

System: Usually larger geographies of about one million people which often cover multiple places.

Integrated care: Services working together to ensure people can plan their care to achieve the outcomes important to them.

What is hoped to be achieved by MDTs?

Based on practice and policy guidelines, there are a common set of objectives for what MDTs will achieve across different populations and circumstances:

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

"Not working together results in a poor experience of care, a wasting of resources, and can lead to individuals suffering harm or being exposed to abuse."

What is the evidence on MDTs?

- Better team working in mental health services increases job satisfaction (Huxley et al., 2011).
- Professionals with skills of working with adults being members of child safeguarding MDTs reduces the number of children taken into care and/or placed on child protection plans (Rodger et al., 2020).
- MDTs within cancer care have been shown to significantly increase survival rates for those suffering common types of cancer (Koco et al., 2021).
- National integrated care pilots in England including MDTs led to gradual reductions in the growth of people experiencing unplanned admissions to hospital but this impact took over five years to achieve (Lewis et al., 2021).
- MDTs in mental health in-patient settings which directly involved individuals within meetings did not enable them to influence major decisions. The individuals concerned did appreciate the opportunity to meet the wider care team and share their requests (Haines et al., 2018).
- There is limited research on how community-based MDTs involve individuals in their discussions. Professionals try to be person centred through sharing their insights, but this would be strengthened with more direct discussions with an individual before and after the MDT (Riste et al., 2018).
- MDTs within cancer services can last up to five hours and involve up to 27 professionals. However, on average only three professionals contributed discussions of an individual (Cancer UK, 2016).

MDTs were the most common approach used by **Integrated Care and Support Pioneers**.[1] This national programme looked for the most ambitious and visionary local areas to drive forward health and social care integration at scale and pace.

An **in-depth study of two Pioneer areas**[2] observed that added value of MDTs included the sharing of real-time information, professionals learning about the services, processes and decision making of other agencies, developing strategies to support people facing complex situations and risks, and providing peer support.

Issues that MDTs faced included arranging of suitable meeting spaces, accessing input from wider services such as substance misuse and housing, and overcoming challenges related to separate and unconnected electronic record systems. The research found that no one profession dominated discussions but did note that the VCS representatives were less able to engage (Douglas et al., 2022).

1 https://www.england.nhs.uk/new-care-models/integrated-care-pioneers/.
2 https://piru.ac.uk/projects/current-projects/integrated-care-pioneers-evaluation.html.

Case examples

Alongside evidence from formal research studies, it is helpful to consider examples of best practice to understand how MDTs are being developed and coordinated within the current health and social care context. The following case examples were identified through SCIE's direct engagement with local systems and through national health and social care networks.

Torbay

Background
Torbay was one of the first areas in England to develop a Care Trust to bring together community health and social care professionals and resources. In 2015 this was extended further when the Care Trust merged with the local acute NHS Foundation Trust to create an Integrated Care Organisation (ICO). Integrated care has been supported by MDTs within each of the five localities to support older people and people with long-term conditions. These include social workers, community matrons, occupational and physiotherapists, mental health liaison workers and health and social care co-ordinators.

Type of team
To strengthen care co-ordination and person-centred approach, the ICO subsequently introduced Enhanced Intermediate Care. This extended the MDTs to include a wider range of professionals including community pharmacists, GPs, and wellbeing coordinators (WBC). WBC are employed by the VCS to help connect people with VCS resources. They also develop plans with individuals to improve their independence and wellbeing over a 12-week period through coaching, practical and emotional support.

How it works
MDT members meet daily to consider the needs of people who are deemed to be at high-risk of hospital admission and/or who were recently discharged from hospital. They are based in a community hub with a joint management arrangement. Community health professionals all use the same electronic patient record and laptops which connect remotely to support mobile working. This allows the latest information to be shared with primary care. Social care professionals use different recording systems but MDT coordinators have access to this and can update/share information between services as required.

Ongoing engagement/quality monitoring
Healthwatch facilitated engagement of local communities in the overall reshaping of community services, including the design of the hub. MDTs undertake peer reviews to identify best practice and teams reflect on feedback from people accessing the service through satisfaction surveys and complaints or compliments. Induction processes inform new members from across health, social care and VCS into how the MDTs work. There is also on-going engagement with hospital-based professionals to increase their awareness of the role of the MDTs.

Impact
Developments in Torbay have been supported by an innovative researcher-in-residence model. This has embedded two researchers from the University of Plymouth to support local improvements through existing evidence and building in thorough evaluation approaches. Research of the extended model suggests that in comparison with the existing MDTs people accessing their support had a shorter average length of admission to hospital and overall reduced activity across the health and social care system. WBCs had a positive impact on the wellbeing of individuals, their motivation to improve their wellbeing and their overall independence. The researchers note that alongside the extended model, the locality which was studied had contextual factors which support more integrated care. This includes its smaller size, a history of collaboration, a well-developed VCS, and clinical leadership by a GP who worked across the key organisations.

For more information see: Impact of 'Enhanced' Intermediate Care Integrating Acute, Primary and Community Care and the Voluntary Sector in Torbay and South Devon, UK.[3]

3 https://www.ijic.org/articles/10.5334/ijic.5665/.

Rutland

Overview
Rise is the Integrated Neighbourhood Team in Rutland jointly funded by the Primary Care Network (PCN), Rutland County Council, and the Better Care Fund. The aim of Rise is to promote health and wellbeing for the local population through taking a holistic approach, encouraging people to have an active role in their own care and wellbeing, and building on local community assets. The team has been in existence since 2018 with core team roles including Integrated Care Coordinator, Community Mental Health Care Manager, Domiciliary Care Lead, Social Prescriber Link Worker, and Clinical Care Home Coordinator.

Management
The MDT is led by the Head of Service in the Local Authority who meets weekly with each team member and arranges monthly team meetings. Staff with a clinical role also receive professional supervision with a suitable health colleague and the team engages in wider networks such as neighbourhood forums. The team leader meets regularly with the PCN manager to discuss new opportunities and shared challenges. The MDT has used the Office for National Statistics wellbeing survey (ONS4) to understand what difference its support has made to people - 94% reported improvement in their life satisfaction, feeling of life being worthwhile, happiness, and/or levels of anxiety.

Digital platform
Integrated care has been supported through the development of a new digital platform. This allows GPs to refer someone through their electronic patient record system and the MDT to then provide updates back to the GP. The platform also connects the MDT with VCS resources. This enables interactive discussions, confirmation of what support is being provided, and if there are any delays. The public can access it so that they can explore what options are available and directly contact a VCS resource. The platform provides useful data for commissioners and voluntary organisations on referral trends and activity, if there has been any change in their use of GP services, support that people would like to access but is not available, and on the impacts that people report in relation to their wellbeing.

System working
Developments in Rutland have been facilitated through similar geographic boundaries of the Local Authority and the PCN. Monthly neighbourhood forums are held to bring together wider networks of health and social care professionals and the VCS to discuss challenges facing the local population and develop responses to health and social inequalities. In COVID this enabled RISE to coordinate vaccinations for those seen as clinically vulnerable and respond to environmental challenges such as a loss of utilities. Other enablers included positive long-term relationships and a high degree of trust between the lead individuals in health and social care; sharing of capacity and skills between RISE and the other teams in the locality to respond to demand; and, training and development opportunities being offered across teams to support them to become familiar with each other and their roles.

City & Hackney

Neighbourhoods
Locality working in City and Hackney has been based around eight neighbourhoods of between 30,000 and 50,000 population since 2018. This is being led by a transformation team employed by Homerton Healthcare NHS Foundation Trust who work closely with Hackney Council and the Primary Care Network. Core adult health and social care services have been reconfigured to align with neighbourhoods and in future this will include commissioned homecare agencies and children services. Community Navigation within neighbourhoods incorporates a range of VCS services including social prescribing, health and wellbeing coaches, tenancy support, and debt advice. Neighbourhood Forums organised by Hackney Council of Voluntary Services / Healthwatch provide an opportunity for teams to come together with residents. Neighbourhoods have adopted an anticipatory care approach which will focus on those with 'rising need'. This includes funding being delegated to forums to support local initiatives. Population profiles have been provided by public health to support planning in neighbourhoods.

Care coordination
Care coordination for individuals with complex needs is undertaken through monthly multi-disciplinary meetings (MDMs). A core group of health and social care professionals including social work, community pharmacists, general practices and community navigators discuss each person's situation. They also invite (with the individual's permission) other colleagues from the extended neighbourhood team of statutory and voluntary sector services to attend as relevant. It is expected that before the MDM there will have been discussion with the individual on what matters to them. Different professions take on the role of chair of the MDMs and are supported by an administrator.

Development programme
The Workforce Enabler Board are responsible for strengthening the collaborative culture between agencies and professions. They are introducing a range of developmental offers including joint neighbourhood induction programmes, coaching, buddying, action learning sets and reflective seminars. Shared co-production training is provided with members of the local resident panel and across programmes will be an emphasis on recognising and responding to structural racism. A theory of change and associated outcomes framework has been devised with the assistance of an external consultancy. These will be used to commission a contribution analysis of the neighbourhoods from an independent evaluator.

For more information see: Neighbourhoods: City & Hackney Living Better Together.[4]

4 https://cityandhackneyneighbourhoods.org.uk/.

Bracknell Forest

Background
Berkshire Healthcare NHS Foundation Trust (BHFT) is a Community and Mental Health Trust providing care for communities across East and West Berkshire, covering six Unitary Authorities. East Berkshire is part of the newly formed Frimley Integrated Care Board which also covers parts of Surrey and Hampshire. Within East Berkshire there are three Unitary Authorities including Bracknell Forest Council (BFC).

Mental Health MDT
The Community Mental Health Team (CMHT) for Adults in Bracknell is jointly funded by BHFT and BFC. The team includes social workers, mental and physical health nurses, psychiatrists, psychologists, psychotherapists and employment specialists. Staff from both organisations work within the same building with joint management arrangements. All MDT members use the same electronic recording system resulting in a record that is fully inclusive of an individual's health and social care needs. There is a weekly MDT meeting chaired by the joint service manager to discuss the needs of individuals and coordinate care and support. Individuals do not attend the MDT but are given the opportunity to discuss their needs with their care coordinator.

Community Hub
The local community network has developed a hub to facilitate collaboration between VCS and statutory mental health professionals to help individuals in their recovery. Community network members attend the MDT on a rota basis. This enables the MDT to identify people who may require a step down into the hub or step up into the more specialist service provided by CMHT.

Zoning
The MDT is currently working to introduce 'Zoning' in which daily mini-MDTs will be held to discuss individuals who are thought to be at high risk. It is hoped that this will lead to good communication within the team and targeted case management to individuals most in need, and an opportunity for peer support.

Improvement
BHFT have also recently introduced a new system called 'I want great care' to obtain feedback from individuals about the care they receive. This is accessed via a link which is detailed on appointment letter or they can complete a form when they attend the CMHT for appointments. The format of the MDT is regularly reviewed by the Service Manager and the Team Leads. For example, the need to balance business items with case discussion resulted in a recent decision to hold a business MDT monthly. This gives the Service Manager the opportunity to discuss wider topics of relevance to service development. The Trust also have a Quality Improvement Programme with a monthly meeting to discuss progress in improving care and achievement against set metrics. Many of these are determined organisationally but the MDT will also be setting its own local metric. MDT members are able to attend a monthly group facilitated by Psychology which gives an opportunity for open reflection with peers.

What enables MDTs to work effectively?

The case studies demonstrate that local areas have been able to use MDTs to overcome many of the ongoing challenges to integrated care through adopting innovative and flexible approaches. Building on their experience, and insights from wider research, the following factors can be identified as increasing the effectiveness of MDTs.

Clear purpose: MDTs need a defined role which is supported by team members. Their responsibilities must require interaction across professional and disciplinary boundaries.

Institutional support: MDTs benefit from public endorsement from local leaders of their place and neighbourhoods to provide legitimacy and wider recognition within the system. Practical support with digital infrastructure, shared records and integrated performance systems are also important enablers.

Team leadership: Leaders should generally be facilitative in their approach to encourage different contributions within the team but be ready to be more directional when necessary. An awareness of inter-professional dynamics and a willingness to challenge poor collaborative practice are important competences for team leaders.

Collaborative spaces: MDTs need supportive physical and/or virtual environments and dedicated time for their members to reflect on how the team is operating. These improve communication and strengthen constructive discussion between team members.

Person centred: There is a danger that teams become too inwardly focused on their own functioning. This can lead to people and their families feeling more, not less excluded, from discussions about their care. MDTs therefore need to ensure good communication with individuals about what is being discussed and genuine opportunities for them to contribute to decision-making.

Role diversity: The blend of professions and practitioners must reflect the needs of the population concerned. Processes to engage other specialist practitioners in MDT discussions when relevant will support more holistic working.

Outward-looking: MDTs need to engage with other teams and services in their local neighbourhood and place. This will enable more coordinated care and help the wider system to better understand the role and skills of the MDTs.

Evidence focused: Teams require timely and accurate evidence of their shared impact. Structured opportunities for teams to reflect on this evidence will strengthen their effectiveness.

"MDTs need a defined role which is supported by team members. Their responsibilities must require interaction across professional and disciplinary boundaries."

Conclusion

Integrated care systems will rely on MDTs to encourage better collaboration between professions, disciplines and sectors within neighbourhoods and places. Such collaboration is central to both more coordinated and person-centred care and addressing health and social inequalities. Effective MDTS are dependent on a supportive environment and infrastructure, well-constructed and led teams, and members with the skills and confidence to engage constructively with other professionals.

Whilst some good examples of co-production exist in the development and improvement of MDT working, there is considerable opportunity to strengthen this aspect of how teams are planned and delivered. This will require ICSs to embed the four principles of co-production, ensure that MDTs have the necessary knowledge and support, and develop sufficient local capacity of expert facilitation. Co-production opportunities must also address potential power imbalances between people with lived experience and professionals and ensure that participation reflects local diversity of communities.

Further reading and resources

Analysis of recent developments of integrated care In England: Miller, R., Glasby, J., & Dickinson, H. (2021). Integrated Health and Social Care in England: Ten Years On. *International Journal of Integrated Care*.

Practical toolkit to support the developments of MDTs: Health Education England (2021) Working differently together: Progressing a one workforce approach.

Guide to how integrated care systems can strengthen co-production: Kings Fund (2021) Understanding integration: how to listen to and learn from people and communities.

Guidance to undertaking an MDT review: NHS England (2022) Multidisciplinary Team Review.

Briefing which outlines strengths-based approaches to leadership including within teams: SCIE (2022) Leadership in strengths-based social care.

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- identifying and sharing knowledge about what works and what's new
- supporting people who plan, commission, deliver and use services to put that knowledge into practice
- informing, influencing and inspiring the direction of future practice and policy.

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First published in Great Britain December 2022
by the Social Care Institute for Excellence

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