NHS
Health Education England

Working differently together:
Progressing a one workforce approach

Multidisciplinary Team Toolkit

Contents

www.hee.nhs.uk

We work with partners to plan, recruit, educate and train the health workforce

Introduction

This toolkit is a step-by-step guide to help progress a one workforce approach across health and care organisations and ICSs. In this context, 'one workforce' is intended to be indicative of a workforce drawn from a range of health and social care disciplines, working seamlessly as a productive, multi-functional team across clinical pathways, for the benefit of patients/service users.

Whilst there is lots of evidence around multidisciplinary teams (MDTs) 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 driving greater collaboration across boundaries and is relevant to MDTs regardless of composition, setting or organisation/ system.

Although many teams are already working in this way, recent healthcare policy is driving the need for greater MDT working: the Long Term Plan set out an ambition to break down traditional barriers between teams and organisations in order to better support the increasing number of people with long-term health conditions, and this became a key commitment in We are the NHS: People Plan 2020/21. [1]

The concept for this toolkit evolved during discussions with providers from all sectors, building on work from across health and care, including Think Tanks, to develop some practical guidance on effective implementation of MDTs.

This toolkit is part of a suite of resources and support offered by HEE to support workforce redesign, including:

- HEE Star, a methodology for planning workforce redesign which is proven to be more efficient and effective than more traditional methods. [2]

- HEE Roles Explorer, guidance to help when introducing new roles, or innovative adaptations to existing roles already being deployed within a service or system. [3]

Context

In a system as multi-faceted as the NHS, the increasing complexity around care pathways, lack of coordination and cohesion between organisations and teams, and duplication of effort and resources can all impact on the way patient care is delivered.

Changing health needs, a complex health and social care system, a growth in multiple co-morbidities and staff shortages mean the NHS must think differently about how it supports new ways of working across teams. Multi-disciplinary team (MDT) working offers an opportunity to not only bridge the workforce gap but to improve quality by drawing on a broader range of skills and competencies. [4]

MDT working is not a new concept and has a lengthy history in the NHS. Over the past decade, policy initiatives, pilots and incentive schemes have consistently promoted MDT working including NHS England's New Care Models programme, and many teams are already working in this way.

Building on progress already made, recent healthcare policy is now driving the need for greater MDT working: the Long Term Plan set out an ambition to break down traditional barriers between teams and organisations in order to better support the increasing number of people with long-term health conditions, and this became a key commitment in We are the NHS: People Plan 2020/21. [1] MDT working also supports the generalism agenda as part of HEE's Future Doctor and Future Nurse programmes, also signalled in the NHS People Plan. Furthermore, the changes in health and care infrastructure and establishment of ICSs across England provides a platform to support and enable MDT working like never before.

Defining an MDT

Multidisciplinary teams or MDTs are teams consisting of individuals drawn from different disciplines who come together to achieve a common goal, whether that be a project to introduce a new role, redesign of a patient pathway or providing care in a different way.

They may also be described as interdisciplinary teams or multi-professional teams.

Importantly, there is no one set form of MDT; they can and often do, include a wide range of disciplines beyond a particular service setting and beyond direct care roles; service users and carers can also sometimes play a part where appropriate. Implementation requires a flexible approach, and so measures of success will differ. [4]

Social Care Institute for Excellence (SCIE) identify a common set of aspirations for MDTs regardless of the common goal concerned:

- Bring together team members from diverse backgrounds to better understand each other's roles and responsibilities as part of a shared identity

- Enable better communication and greater trust between team members

- Lead to more holistic and personalised care, preventing unnecessary errors and avoidance of related harm

- Result in resources being used more efficiently through reduced duplication, greater productivity and preventative care approaches. [5]

Defining an MDT

Research undertaken by Professor Michael West identifies three principles to ensure effective team working. [6]

Clear shared objectives

The team needs to understand the objectives they collectively need to achieve together.

Working interdependently

The team has to work closely together, communicating and coordinating with each other in order to deliver effective, efficient and continually improving high quality and compassionate care.

Meet regularly

The team needs to meet regularly to review their performance and consider any areas of improvement required. The King's Fund suggests that this could be done in the form of team time-outs, away days or regular huddles, covering both technical aspects of work, and how people are feeling. However, it is important to create a safe environment to allow people to feel able to contribute freely. [7]

The research shows that when these three principles are met, teams are more effective and more innovative, as well as enhancing the wellbeing and flourishing of team members, including lower levels of stress, absenteeism and staff turnover.

Challenges

Implementing MDT working isn't easy with practical challenges including:

- ## Establishing the rationale for change

As set out in the NHS Change Model, [8] establishing a shared purpose is a critical driver of success; improvement efforts work best if there is an explicit connection between the change and people's values. In establishing an MDT, diverse groups of professionals are brought together and so there needs to be a shared commitment across the team. A shared commitment helps to transcend any conflicting views and priorities which can impact on progress. Finding commonalities and reaching a shared understanding and aspiration can overcome these barriers and unite diverse groups of stakeholders behind a common cause. Furthermore, the case for change should fit with the organisation or system strategy; it needs to be of relevance to the local population, to help teams understand the motivation for implementing new ways of working. If changes are primarily driven by cost rather than improvements to patient care, team members may be less receptive to the proposed change.

- ## Time

Any transformational change requires sufficient time; time for implementation and time for benefits to be realised. Building effective relationships, developing a culture of collaboration, team development and implementing the necessary information systems and data sharing procedures for effective MDTs, all require significant time investments. Too often projects are abandoned for not delivering immediate, tangible benefits and agreement on review points should be reached at the outset. [9]

Challenges

Implementing MDT working isn't easy with practical challenges including:

- ## Resources

  Lack of funding and capacity are challenges in day-to-day delivery within the NHS, but are also often barriers to successful change. It is often difficult to make commitments across financial years and without longer term assurances about sustainability, MDT members may feel the organisation isn't committed to the new way of working in the medium to longer term, and instability in the team can also impact on progress. Working as an ICS provides greater opportunity to target resources where they are most required to benefit the wider system and the population. Funding improvements can also help to build momentum and improve morale. Short-term external support can inject energy, pace and expertise, and internal improvement teams can help build capability within the workforce.

- ## Adoption and spread

  Scaling and spreading innovation is a well-recognised and long-standing challenge across the NHS. HEE's Framework for spread and adoption of workforce innovation identifies five steps to successfully and sustainably embedding change. [10] However, it is not just about adoption, but also adaption, recognising that what works in one place might not easily be transferred elsewhere, and so an understanding of the context is vital. [4] Evaluation should also be embedded into any initiative to ensure formative learning and continuous improvement remains central to team development. [9] There are lots of case studies (including Fab NHS Stuff) showcasing effective MDT working; and NHS knowledge and library services can help in searching and making sense of evidence. [11][12]

8

Benefits

Despite the challenges, MDT working offers huge benefits: [4] [13]

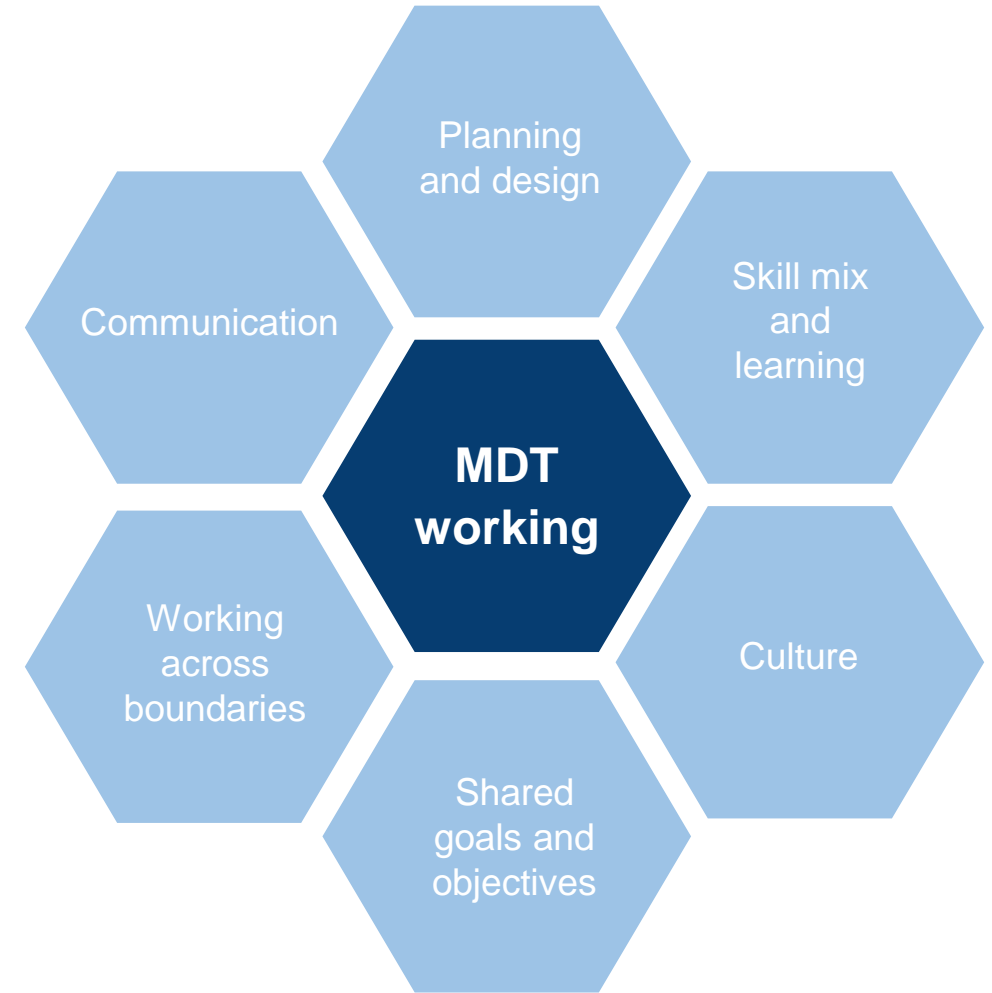|	
Patients/ service users	There is evidence that suggests MDTs can result in improved outcomes for people and their families, and higher quality, personalised care.
Staff	Evidence suggests that MDT working can lead to improved job satisfaction for professionals and practitioners as a result of greater autonomy, skill enhancement and knowledge sharing. In addition, shared projects, a focus on the patient/ service user and being able to celebrate together can all help to improve morale. Teams must be supported to meaningfully embed and integrate new roles, as well as allowing space to design new ways of working and the ability to successfully implement and sustain them.
Organisations	Greater job satisfaction inevitably leads to improved retention within organisations which could also have a significant economic value. Furthermore, evidence suggests MDT working has the potential to use resources more efficiently whilst maintaining or improving quality.
Systems	Benefits of MDTs have a much wider reach across systems. Through managing patients/service users much more proactively, early identification of health needs can, in the longer term, outweigh the impact of potential short-term indicators across a health and care system, such as an increase in unplanned admissions.

How to use this toolkit

Successful workforce redesign at an organisational level requires: a culture of innovation, a strong communication and change management strategy, a detailed understanding of staff skills and patient needs, and sufficient time and investment to support implementation. [4] [14]

A review of the literature has identified six enablers to effective MDT working as shown on the right.

The following sections describe each enabler and include success factors, useful resources and further reading, to spread the learning of what works, helping to accelerate successful MDT working.

In addition, there is also a development plan for MDT working and a self-assessment tool available.

It is recognised that many teams are already working as MDTs and this toolkit enables them to recognise their good practice, identify areas requiring development and show progress, building on what they have done so far.

Planning and design

Skill mix and learning

Communication

MDT working

Working across boundaries

Culture

Shared goals and objectives

1 Planning and design

The NHS Long Term Plan set out radical changes to service models to meet changing health needs, join up care for patients, and take advantage of technological and scientific advances.

This includes dissolving the historic divide between primary and community health services, redesigning urgent and emergency care services, giving people more control over their own health and care, introducing digitally enabled primary care and outpatient care, and taking more ambitious action to prevent ill-health and reduce health inequalities. All this requires fundamental changes in how health and care professionals work and how they develop their skills to work differently.

Put simply, workforce planning is a case of getting the right people, with the right skills and competencies, in the right place at the right time, and the bringing together of any team or service must be based on population needs, and shaped by patients/ service users and communities being served. [9] [15]

Listening to communities

Picker and The King's Fund have been working with NHS England and NHS Improvement on how ICSs can listen to and learn from people and communities and have produced this practical guide for partners working in these systems, with ideas on how to go about this. [16]

11

1 Planning and design

Methodologies such as the six step approach to workforce planning places emphasis on the desired outcomes and assessing demand before then considering workforce numbers available now and in the future. [17] When it comes to assessing demand, the approach includes four key stages:

- **Services for particular care pathways** - What services will be needed to meet the patients' needs and how are they likely to change?
- **Tasks** - What tasks are needed to deliver these specific services?
- **Requirements** - How do these workforce tasks translate into skills, roles and numbers?
- **Demand options** - What options exist for changing workforce demand through new service models or ways of working?

Workforce planning

- This e-learning programme can be used as a tool to support the six step approach to workforce planning. It is aimed at anyone engaged in service redesign, restructures and reorganisations but can be scaled dependent on the size of the change. [17]

- The Recipe for Workforce Planning to help organise the workforce most effectively across a system. [18]

1 Planning and design

The HEE Star is a methodology for developing comprehensive plans for workforce redesign. Based on the principle that improvement happens project by project, the HEE Star identifies five key enablers of workforce change (Supply, Up-skilling, New roles, New ways of working and Leadership), and brings structure and focus to diverse conversations; the result being a shared consensus of workforce priorities. The methodology is proven to be more efficient in planning workforce change than other more traditional methods, helping to realise benefits faster.

✏️ HEE Star

Access the HEE Star and associated resources. [2]

1 Planning and design

Perhaps the most important common guiding principle for all MDTs, regardless of setting, is having a shared commitment to the delivery of personalised coordinated care from the perspective of the individual. [19]

Personalised care means people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths, needs and preferences. This represents a new relationship between people, professionals and the health and care system. It provides a positive change in power and decision making that enables people to feel informed, have a voice, be heard and be connected to each other and their communities. [20]

The evidence base for personalised care demonstrates a positive impact on people, professionals and the system. Shared decision making about tests, treatments and support options leads to more realistic expectations, a better match between individuals' values and treatment choices, and fewer unnecessary interventions. [20]

1 Planning and design

Key actions to realising personalised care include identifying the patients/ service users that are most likely to benefit from integrated care and proactive support, and preventative support - also known as risk stratification - and developing personalised care plans together with the people using services, their family and carers. [21]

Personalised care

- The Comprehensive Model for Personalised Care presents six evidence-based and inter-linked components, each of which is defined by a standard, replicable delivery model. [20]

- The Person Centred Approaches Framework aims to distil best practice and to set out core, transferable behaviours, knowledge and skills. It is applicable across services and sectors and across different types of organisations. [22]

1 Planning and design

Success factors

- Organisations and interventions that fail to place the patient or service user at the centre of their MDT efforts are unlikely to succeed. [9]

- Design of the team should be based on population need. Models such as Six Steps or the HEE Star can support with workforce planning and redesign.

- As well as getting feedback from users, involving the communities served in the design of services will ensure that service provision adequately reflects the population.

- Timeliness, flexibility, responsiveness and suitability of services are likely to matter more to patients than structures and processes adopted by organisations. [9]

2 Skill mix and learning

In their characteristics of a good team, Nancarrow et al define skill mix as: *"the mix and breadth of staff, personalities, individual attributes, professions and experience. Teams value diversity and clearly need input from a range of staff who bring complementary experience and attributes to the team."* [23]

Carefully articulated roles and task definition are essential for effective implementation of workforce changes. This helps to build shared expectations but also build awareness of new roles and responsibilities for specific activities. There is the potential for MDTs to blur boundaries between roles which could cause anxiety if team members feel their professional identity is threatened. All roles in the MDT must be valued in terms of their contribution. Consideration may need to be given in terms of fairness between roles as inequities may impact the success of the MDT. [4]

MDTs and changes to skill mix can also impact on job satisfaction if they fundamentally alter the core aspects of the role that drew them to the job in the first place. For example, redistributing work around a team will mean that advanced practitioners oversee more complex caseloads. This may lead to stress and burnout if they are not adequately upskilled and supported. As clinicians' workloads change, the increasing intensity of caseload means that working practices will need to adapt to allow for the time need to manage increased complexity. [4]

17

2 Skill mix and learning

Effective implementation of MDTs and skill mix changes requires significant training, mentorship and supervision, and so adequate time and resources should be made available to maintain job satisfaction and avoid increasing workloads. [4] Training is required to ensure team members understand and value each other's roles and develop an ethos of working as a member of a team, particularly focusing on providing the best possible outcomes for patients/service users.

In particular, a frequent recommendation of workforce research and integrated care programme evaluations is the need for cross-professional and cross-organisational training. [7] Team members work across organisational and professional boundaries, so they need to acquire new skills, adapt their ways of working and facilitate communication. Joint training facilitates a shared culture and practice.

People who learn together, work better together; through shared understanding of each other roles and an appreciation for the expertise which others bring to the MDT. Interprofessional learning helps to build relationships across professions and contribute to an understanding of shared responsibilities.

Interprofessional learning

The Interprofessional Education Handbook from The Centre for the Advancement of Interprofessional Education (CAIPE) includes a good account of how interprofessional education helped integrated working. [24]

2 Skill mix and learning

Skills and roles

HEE has produced a range of guidance and supporting resources to support considerations around skills, capabilities and roles, including:

- The Advanced Practice toolkit is a repository for consistent, credible and helpful resources relating to Advanced Practice. [25]

- The HEE Roles Explorer includes details of how different roles are deployed within different services. [3]

- This guide brings together a suite of resources to support developing and implementing new workforce roles (also available as a PDF). [26]

- The HEE Star also acts as an online repository for good practice and includes a range of offers in relation to Up-skilling and New roles. [2]

2 Skill mix and learning

Top tips for MDT working

- Don't be afraid to ask other team members about their roles and professional backgrounds – it's harder to work well together if people don't understand each other.

- Encourage the team to share insights into how the other services work – and make sure someone finds out any details no one is sure of.

- Don't assume that others will have been kept up to speed with changes within the organisation – be proactive in checking that they understand new initiatives and structures.

- Incorporate some 'socialising' into multi-disciplinary team meetings. This helps to develop that vital personal connection. It will improve the effectiveness of working relationships.

Adapted from Royal College of General Practitioners' MDT Toolkit [27]

2 Skill mix and learning

Success factors

- Ensure roles are clearly defined and that all team members understand what is expected.

- Gain buy-in from team members for any changes in ways of working.

- Provide time and resources for adequate training, mentorship and support to ensure team members are adequately skilled to deliver their roles as well as value each other.

3 Culture

Cultural barriers have been shown to be one of the key challenges to MDT working. Staff must be able to put the interests of patients/service users before professional cultural norms and be prepared to work in different ways. [9]

Organisations and systems need to provide the right culture to allow MDTs to flourish. ICSs require people to work across organisational and professional boundaries to achieve success. This requires significant culture change and a system-wide organisational development strategy that fosters collaboration at all levels. [21]

Setting up MDTs should not be underestimated in terms of the amount of support required; not everyone embraces or responds well to change and the approach may well need to be constantly evaluated to ensure it remains effective and optimises team members' time.

Culture change

The time taken to shift culture should not be underestimated and there are models and resources available to support with practical interventions.

- Do OD is the expert resource on Organisation Development (OD) for health and care, delivered by NHS Employers in partnership with NHS England and NHS Improvement. A range of resources and support is available. [28]

- The COM-B model is a behaviour change model used to identify what needs to change in order for a behaviour change intervention to be successful; the three key factors being Capability, Opportunity and Motivation. [29]

3 Culture

Supporting our NHS people was one of the key themes in the NHS People Plan, and is more important than ever following the response to Covid-19. [1] NHS staff are 50% more likely to experience high levels of work-related stress compared with the general working population, which not only impacts their health but also affects quality of care as well as patient satisfaction, financial performance, absenteeism and organisational performance. [30] Evidence shows that MDT working delivers more effective and satisfying work for clinicians, depending on how they are implemented. However, team members may be suffering from burn out and change fatigue and so health and wellbeing must be a key consideration through any change in ways of working.

Shared leadership is a product of the culture of an organisation. Where an organisation is knowledge dominated and involves teams of individuals who collectively work towards a shared goal (such as the NHS) then shared leadership will flourish.

Effective MDTs develop over time and with experience. Collaborative cultures, trusting relationships and reflective team learning are at the heart of team working. [19] A key driver of behaviour is trust. [31] High-performing teams have high levels of trust and there is much evidence which illustrates that building trust between staff is more important than structures when it comes to delivering care.

Supporting our NHS people

This Health and Wellbeing Hub pulls together a suite of resources and support offers for staff to manage their own health and wellbeing while looking after others. [32]

23

3 Culture

In its work on effective teams, The King's Fund share Google's two-year research project into teams, which found that the highest-performing teams had one thing in common: psychological safety – the belief that you can speak up or make mistakes without retribution. [7] [33] People become more creative, resilient and motivated when they feel safe. This can build over time if leaders work with their teams to encourage and develop this type of communication but needs to be nourished and respected as it can also be easily lost. [7]

Within healthcare, psychological safety is seen as a key ingredient for patient safety and is created by compassionate leadership encouraging team members to pay attention to each other; to develop mutual understanding; to empathise and support each other. Feeling part of a team protects individuals against the demands of the organisation they work for and if they have clarity about their role in the team, they are less likely to burn out and more likely to operate in a safe way. [34]

How to foster team psychological safety

In her TEDx talk, Amy Edmondson, Novartis Professor of Leadership and Management at the Harvard Business School, offers three simple things that individuals can do to foster team psychological safety:

1. Frame the work as a learning problem, not an execution problem.
2. Acknowledge your own fallibility.
3. Model curiosity and ask lots of questions. [35]

Google's guide on Team Effectiveness provides practical advice, including questions on how to measure and foster psychological safety in the team. [36]

3 Culture

Success factors

- Put interests of patients/service users before professional norms; be open minded and curious.

- Ensure the organisation or system has the right culture to foster MDT working and support this new way of working.

- Provide appropriate health and wellbeing support to team members, particularly where there is risk of burnout or change fatigue following Covid-19.

- Create psychological safety to allow team members to share ideas without fear.

- Consider a system-wide OD strategy to help foster collaboration and use tools and support where required.

- Ensure sufficient time is provided for MDTs to share best practice, undertake supported learning and skill development, including opportunities for peer-peer reflection.

- Build time for reflection, learning and celebration into MDT meetings.

4 Shared goals and objectives

Successful joint working requires clear, realistic and achievable aims and objectives, understood and accepted by all partners, including patients/service users, families and carers. [9] MDTs need a defined role that requires team members to interact across professional and disciplinary boundaries. [5]

A clear, shared vision and common goals bring teams together, and help and support the necessary behavioural changes for achieving better health and wellbeing outcomes. [21] It is important that appropriate structures are in place to uphold the vision of the service with the best interests of communities and service users at heart. [23] Patients/ service users should be involved in co-design from the outset and through delivery, implementation and evaluation. Furthermore, any commissioning should be underpinned by shared agreements on how resources will be allocated in relation to outcomes.

4 Shared goals and objectives

Building a shared purpose

The NHS Change Model suggests three steps – with links to useful supporting tools – to build a shared purpose:

1. Create a safe space – it is important to create a space in which genuine two-way conversations can take place.

2. Look for commonalities – this helps to move beyond conflicting agendas and priorities to a common understanding and ambition.

3. Design together – agree how to translate the shared understanding into an action plan including medium and long-term milestones, ensuring vision and goals are tangible, well-defined and measurable. [8]

| Create a space | Look for commonalities | Design together |

4 Shared goals and objectives

It is crucial to be able to monitor progress when implementing new ways of working; demonstrating the difference being made to patients/service users, staff, organisations and systems. [9] Transformational change can take time and agreeing and defining timescales for measuring outcomes should be agreed with all stakeholders at the outset. Through continuous learning, teams should also be empowered in order to be flexible and brave enough to adapt approaches when things aren't working.

Key indicators of progress should be agreed with buy in from all partners, recognising that there may be unintended consequences of introducing MDT working, for example more preventative and personalised care may lead to a rise in unplanned admissions, however benefits of earlier diagnosis and proactive management will improve population outcomes and have wider benefits across a health and care system.

In addition, MDTs need to have agreed shared decision making, governance and accountability processes, including an understanding of roles and responsibilities. This should be considered when agreeing how to evaluate the effectiveness of the MDT and will contribute towards any required business planning for the future of the team.

4 Shared goals and objectives

Planning an evaluation

There are many frameworks available to help with evaluation. Here's five top tips from the Evaluation works toolkit for planning an evaluation:

1. Involve all key stakeholders and ensure appropriate patient and public involvement. This helps stimulate buy-in and can ensure the evaluation is successful. It is also an opportunity to identify local evaluation experts who can help to design the right evaluation.

2. Identify the purpose of the evaluation and set clear, appropriate aims and objectives. Have a clear understanding from all stakeholders as to the purpose for undertaking the evaluation. This in turn will help to identify the right methodology, measures and data collection tools.

3. Understand the evidence base and how the service was designed to achieve its desired outcomes. This helps inform the type and level of evaluation required.

4. Plan the evaluation early with key stakeholders. It is good practice to plan the evaluation when deciding priorities and designing services. This will help ensure that the methodology is appropriate, adequate resources are allocated and realistic timescales are set.

5. Share the findings and act on them. Make sure that they have an impact on patient care. [37]

4 Shared goals and objectives

Learning from staff experiences of Covid-19: let the light come streaming in

In their blog on learning from staff experiences during the COVID-19 pandemic, Prof Michael West and Suzie Bailey discuss the impact of teams having a shared sense of purpose:

"Multidisciplinary teams have had a clear and common sense of purpose, which has built cohesion and a sense of team compassion and support.

Improved teamwork is just one outcome of the blurring of hierarchical and professional boundaries. Even organisational identities have been relinquished, for example as staff have transferred from different settings to work in other parts of local health and care services. And cross-boundary working has become the new normal for some staff, with examples of increased collaboration between primary care, secondary care, social care and whole range of volunteer and community groups. Ways of working have been transformed in days and in ways that were unimaginable just three months ago." [38]

4 Shared goals and objectives

Success factors

- Successful joint working requires clear, realistic and achievable aims and objectives, understood and accepted by all partners, including patients/service users, families and carers.

- Agree a framework to monitor progress being made by MDT working to demonstrate the impact, including consideration of any disbenefits that may occur.

- Ensure there is a clear leader and agreed shared decision making, governance and accountability processes.

- Support co-production with patients/service users (and representatives) from the outset and throughout delivery and evaluation. Ensure resources are produced, grounded in practical experience, to support diffusion of the shared vision amongst patients/service users.

5 Working across boundaries

Working across boundaries relies on new systems and processes for sharing information, as well as establishing new networks, all of which is time consuming and requires significant support. Often these tasks are filled by enlarging existing roles to fill gaps in service, which can result in staff absorbing extra activities on top of existing workloads. [4]

Roles that are specifically established to bridge care and carry out tasks across organisations (like liaison or coordinator roles) face a number of distinct challenges, as they typically involve working across multiple contexts, and feature tasks that are never easily captured in job descriptions or task definitions, like daily negotiation with different stakeholders. [4]

Cross-boundary working also involves a high degree of cultural change, and some teams have found co-location of staff across MDTs – particularly those that span boundaries of health and care – helpful for building and cementing relationships, breaking down barriers and improving communication. [4] Co-location encourages informal contact, increased mutual understanding, quicker and easier communication, expedited problem-solving and facilitating learning across professional boundaries, helping to support the development of trust more quickly given the increased opportunity for personal as well as professional interaction. [9] [39] Regular team meetings and team building activities can also achieve this where co-location is not possible, although at a slower rate.

5 Working across boundaries

Working across boundaries

The King's Fund has looked in detail at the issue of working across organisational and professional boundaries within health and care, finding that having a culture that transcended professional and organisational identities is fundamental, especially when established roles are being reconfigured. [7] Embracing the principles of collective leadership helps to deal with the emotional transition and being clear about the shared vision across the organisations and continually identifying, communicating and valuing progress towards achieving improved care aspirations. [40] [41] This helps everyone to take responsibility for the success of the team, rather than just their own job or work area.

5 Working across boundaries

Considerations for re-designing physical space

Changing the physical working environment can help support new teams to function. Evidence suggests teams sharing the same working space brings many benefits: improving integration and team cohesion, enabling real-time communication in huddles, and facilitating information sharing between team members. Team members are more likely to be sensitive to one another's problems and appreciate each other's roles when they have this sort of contact with each other. For professionals who work remotely or between practices, co-locating on a regular basis in a shared space can really help to improve team cohesion.

Creating shared space isn't always straightforward and co-location isn't always possible, but focusing on creating lots of opportunities for informal communication through team meetings, team-building activities and technology can help to achieve some of the same benefits of trust and a strong team identity.

Even when co-location is possible, re-designing physical spaces can be met with resistance, even when the current spaces are not optimal, because people are accustomed to particular ways of working. To support individuals who might feel a lack of ownership with shared space or feel they will have less privacy, it's important to talk about any concerns and explain the benefits of co-location. Ideally, this will be done well in advance of trying to implement any changes, so that team members can be involved in creating new spaces and ways of working, and there is time to work through any potential implications for their satisfaction and wellbeing.

Adapted from How to build effective teams in general practice, The King's Fund (2020). [7]

5 Working across boundaries

Technology is a key enabler to supporting MDT working. Implementing new ways of working often relies on data sharing across team members working in different parts of the system. Sharing data is critical for informing joint care decisions and supporting strategic planning around patient needs, however it can also be time-consuming, complex and costly. [4] [9]

A common implementation challenge is getting different IT systems to communicate with one another, and more generally the fragmented and incomplete nature of data at different points along a care pathway. Teams should be supported to carefully work through these challenges at the start of implementing new team-based approaches, and reach agreements on which data to capture. Appropriate training should also be made available to teams. [4]

It is crucial to build realistic timescales for putting new data agreements in place. It is easy to underestimate the complexity of designing and implementing new technological solutions, particularly the time and range of skills required. [4] Where possible, data should also be accessible in real time, and in order to facilitate more agile working, investment will also be required in mobile technology allowing more rapid responses. [9]

5 Working across boundaries

Shared records: How to achieve it

Access to shared care records is an important enabler of MDT working; a focus on eliminating the barriers to data access and data sharing will help to accelerate progress.

To do this well, requires:

- committed leadership, supporting culture change, openness and collaboration – beyond just introducing new technology – to reimagine work processes, professional interactions and the engagement of service users
- strong information governance, including formal information-sharing agreements and partnerships – acknowledging that users of services generally assume information is already shared
- interoperability and standardisation, ensuring IT systems are able to communicate across settings and organisations
- a focus on the relevance and quality of data
- staff skills development and clear guidance to ensure consistent compliance with data protection laws and the wider regulatory framework
- processes in place to ensure customisable sharing, tailored to the person's consent and service needs
- user-centred design, developing the facility for people to have access to their own records
- analytic capacity and capability to extract insights and monitor outcomes.

Adapted from Achieving integrated care: 15 best practice actions, Local Government Association and Social Care Institute for Excellence (2019) [21]

5 Working across boundaries

Data sharing

Information governance is all about how to manage and share information appropriately. This NHSX portal brings together national guidance on information governance for patients/service users, health and care organisations and information governance professionals. [42]

Specifically for MDTs, the following guidance for healthcare workers is provided:

All health and care professionals have a duty of care to their patients or service users. This includes sharing information to support patient and service user care. Those working within an MDT which is providing individual care to a patient or service user must share information that is relevant and necessary for care with the MDT. [43]

Seek advice if unsure about sharing or accessing information within the MDT, or if a patient or service user objects. This advice could be sought from the Caldicott Guardian of your organisation, IG or senior staff (e.g. in the case of a small care home where there may not be a Caldicott Guardian). If challenged at a later date, be prepared to justify why information was, or was not, shared with the MDT. [43]

5 Working across boundaries

Success factors

- Consider ways to co-locate teams where possible, particularly when working across organisational boundaries.

- Optimise the use of technology where possible in order to create a virtual space for MDTs if co-location isn't possible.

- Find ways to make data accessible in real time to team members.

6 Communication

Communication is important for any team, but especially so in health and care. The World Health Organization (WHO) describes ineffective communication as a leading cause of inadvertent patient harm, especially common at the interface between primary and secondary care. They can culminate in adverse events, including an increase in preventable hospital admissions. [44]

Effective communication also improves job satisfaction, increases staff retention and facilitates a culture of support and trust. When individuals have confidence that their opinions will be heard, they are more likely to speak up. This maximises use of the team's internal resource to solve issues and improve performance. [44]

Practical implementation of MDTs requires planning and effective communication throughout, and frequency, timings and methods of how the team will communicate need to be agreed, so the team can function and make decisions effectively. [45]

It is also important to raise awareness of the MDT, explain this way of working to other teams, organisations and patients/service users where required; use of patient stories and proven outcomes will help patients/service users to understand any changes in service provision. [45]

The importance of communication within teams cannot be overstated. With new team members, changing roles, restructured teams and re-designed physical spaces, thinking about how teams communicate will be the most important element for leaders to consider.

6 Communication

Building common purpose: Learning on engagement and communications in Integrated Care Systems

In this report published by the NHS Confederation, it is suggested that systems which have achieved success in their integration journey were found to have:

- embedded a strategic approach to engagement and communications
- adopted a systematic approach to continuous relationship building
- developed a shared vision and narrative that is continuously implemented and reinforced
- embedded open, transparent and two-way engagement approaches that build trust
- developed engagement and communications leadership, capacity and expertise. [46]

6 **Communication**

Team communication

In this report published by the Royal College of Physicians, a number of barriers to effective communication in healthcare were identified:

- Interprofessional communication
- Fear of failure
- Human factors, stress and fatigue
- Team instability
- Inconsistent technology
- Hierarchy [44]

How to achieve effective communication – some simple steps to consider for all interactions:

- Introduce yourself and clarify your role
- Listen attentively and allow people to complete their thoughts
- Ask questions for clarification
- Check for understanding of what has been said
- Invite opinions from those who have not spoken
- Be aware of communication barriers e.g. hierarchy
- Use objective not subjective language
- Show mutual respect
- Consider setting: right place, adequate time, no distractions
- Be aware of body language, both given and received: facial expressions, eye contact, posture.

TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety) is one example of a strategy employed by healthcare organisations to improve communication. Developed jointly by the US Department of Defence and the Agency of Healthcare Research and Quality, it has demonstrated improvements in institutional communication relating to patient safety. [47]

6 Communication

Success factors

- Effective communication is key to delivering safe, high quality care.

- Agree frequency, timing and methods of communications within the MDT up front.

- Raise awareness of the MDT to other teams, the organisation and system, and most importantly to patients/service users.

Summary

The review of the evidence identified six enablers to MDT working, and a number of success factors:

Planning and design

- Organisations and interventions that fail to place the patient or service user at the centre of their MDT efforts are unlikely to succeed. [9]
- Design of the team should be based on population need. Models such as Six Steps or the HEE Star can support with workforce planning and redesign.
- As well as getting feedback from users, involving the communities served in the design of services will ensure that service provision adequately reflects the population.
- Timeliness, flexibility, responsiveness and suitability of services are likely to matter more to patients than structures and processes adopted by organisations. [9]

Skill mix and learning

- Ensure roles are clearly defined and that all team members understand what is expected.
- Gain buy-in from team members for any changes in ways of working.
- Provide time and resources for adequate training, mentorship and support to ensure team members are adequately skilled to deliver their roles as well as value each other.

Summary

The review of the evidence identified six enablers to MDT working, and a number of success factors:

Culture

- Put interests of patients/service users before professional norms; be open minded and curious. [9]
- Ensure the organisation or system has the right culture to foster MDT working and support this new way of working.
- Provide appropriate health and wellbeing support to team members, particularly where there is risk of burnout or change fatigue following Covid-19.
- Create psychological safety to allow team members to share ideas without fear.
- Consider a system-wide OD strategy to help foster collaboration and use tools and support where required.
- Ensure sufficient time is provided for MDTs to share best practice, undertake supported learning and skill development, including opportunities for peer-peer reflection.
- Build time for reflection, learning and celebration into MDT meetings.

Summary

The review of the evidence identified six enablers to MDT working, and a number of success factors:

Shared goals and objectives

- Successful joint working requires clear, realistic and achievable aims and objectives, understood and accepted by all partners, including patients/service users, families and carers.
- Agree a framework to monitor progress being made by MDT working to demonstrate the impact, including consideration of any disbenefits that may occur.
- Ensure there is a clear leader and agreed shared decision making, governance and accountability processes.
- Support co-production with patients/service users (and representatives) from the outset and throughout delivery and evaluation. Ensure resources are produced, grounded in practical experience, to support diffusion of the shared vision amongst patients/service users.

Summary

The review of the evidence identified six enablers to MDT working, and a number of success factors:

Working across boundaries

- Consider ways to co-locate teams where possible, particularly when working across organisational boundaries.
- Optimise the use of technology where possible in order to create a virtual space for MDTs if co-location isn't possible.
- Find ways to make data accessible in real time to team members.

Communication

- Effective communication is key to delivering safe, high quality care.
- Agree frequency, timing and methods of communications within the MDT up front.
- Raise awareness of the MDT to other teams, the organisation and system, and most importantly to patients/service users.

References

- [1] NHS. *We are the NHS: People plan for 2020/21- action for us all.* 2020. https://www.england.nhs.uk/ournhspeople/ [Accessed 2nd September 2021].

- [2] Health Education England. *HEE Star: accelerating workforce redesign.* n.d. https://www.hee.nhs.uk/our-work/hee-star [Accessed 2nd September 2021].

- [3] Health Education England. *Roles Explorer.* n.d. https://www.hee.nhs.uk/our-work/workforce-transformation/hee-roles-explorer [Accessed 16th September 2021].

- [4] The Health Foundation. *Improvement snapshot: multi-disciplinary team working.*

- [5] Social Care Institute for Excellence (SCIE). *Delivering integrated care: the role of the multidisciplinary team.* No 4 July 2018. https://www.scie.org.uk/integrated-care/workforce/role-multidisciplinary-team [Accessed 7th July 2021].

- [6] AOD. *Professor Michael West: what is the difference between a real team and a pseudo team [video file].* September 2019. Available from: https://www.youtube.com/watch?v=bqipJlb1oMM [Accessed 2nd September 2021].

- [7] Baird B, Boyle, T, Chauhan, K, Heller A, and Price C. *How to build effective teams in general practice.* The King's Fund. January 2020. https://www.kingsfund.org.uk/publications/effective-teams-general-practice [Accessed 7th July 2021].

- [8] NHS England. *Change Model.* 2012. https://www.england.nhs.uk/sustainableimprovement/change-model/ [Accessed 7th July 2021].

- [9] CordisBright. *What are the key factors for successful multidisciplinary team working?* September 2018. https://www.cordisbright.co.uk/admin/resources/05-hsc-evidence-reviews-multidisciplinary-team-working.pdf [Accessed 7th July 2021].

- [10] Health Education England. *Framework for spread and adoption of workforce innovation.* November 2019. https://www.hee.nhs.uk/our-work/workforce-transformation/spread-adoption [Accessed 7th July 2021].

- [11] The Academy of Fabulous Stuff. *Fab stuff.* 2021. https://fabnhsstuff.net/fab-stuff [Accessed 2nd September 2021].

- [12] Health Library & Information Services Directory (HLISD). *A comprehensive directory of health libraries and information services across the United Kingdom and the Republic of Ireland.* 2021. https://www.hlisd.org/ [Accessed 2nd September 2021].

References

- [13] Shen, J, and Lloyd T. Statistical analysis protocol for pooled analysis of three evaluations of community-based multidisciplinary teams in England. The Health Foundation. August 2020. https://www.health.org.uk/sites/default/files/2020-11/statistical_analysis_protocol_for_pooled_analysis_of_three_evaluations_of_mdts_in_england.pdf [Accessed 2nd September 2021].

- [14] Imison C, Castle-Clark S, and Watson R. *Reshaping the workforce to deliver the care patients need.* Nuffield Trust. May 2016. https://www.nuffieldtrust.org.uk/files/2017-01/reshaping-the-workforce-web-final.pdf [Accessed 2nd September 2021].

- [15] Suter E, Oelke N, Adair C, and Armitage G. Ten key principles for successful health systems integration. Healthcare quarterly. 2009; 13 Spec No(Spec No): 16-23. https://pubmed.ncbi.nlm.nih.gov/20057244/ [Accessed 2nd September 2021].

- [16] Thorstensen-Woll C, Wellings D, Crump H, and Graham C. *Understanding integration: how to listen and learn from people and communities.* The King's Fund. July 2021. https://www.kingsfund.org.uk/publications/understanding-integration-listen-people-communities [Accessed 2nd September 2021].

- [17] Health Education England. *Six step approach to workforce planning.* e-Learning for Healthcare. n.d. https://www.e-lfh.org.uk/programmes/six-steps-approach-to-workforce-planning/ [Accessed 2nd September 2021].

- [18] Chamberlain S. *Workforce planning within a system.* Health Education England. n.d. https://recipeforworkforceplanning.hee.nhs.uk/Portals/0/HEWM_Cookbooks/Workforce%20Planning%20within%20a%20System%20Guidance%20Document.pdf?ver=2017-02-24-143230-873 [Accessed 2nd September 2021].

- [19] NHS England. *MDT development – working toward an effective multidisciplinary/ multiagency team.* January 2014. https://www.england.nhs.uk/wp-content/uploads/2015/01/mdt-dev-guid-flat-fin.pdf [Accessed 7th July 2021].

- [20] NHS England. *Universal personal care: implementing the comprehensive model.* January 2019. https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf [Accessed 7th July 2021].

- [21] Local Government Association and Social Care Institute for Excellence. *Achieving integrated care: 15 best practice actions.* November 2019. https://www.local.gov.uk/publications/achieving-integrated-care-15-best-practice-actions [Accessed 7th July 2021].

References

- [22] Skills for Health, Skills for Care and Health Education England. *Person-centred approaches: empowering people in their lives and communities to enable an upgrade in prevention, wellbeing, health, care and support: a core skills education and training framework.* 2017. https://skillsforhealth.org.uk/wp-content/uploads/2021/01/Person-Centred-Approaches-Framework.pdf [Accessed 2nd September 2021].

- [23] Nancarrow SA, Booth A, Ariss S, Smith T, Enderby P, Roots A. Ten principles of good interdisciplinary team work. *Human resources for health.* 2013; 11(1):19. Available from: https://human-resources-health.biomedcentral.com/articles/10.1186/1478-4491-11-19#Tab3 [Accessed 7th July 2021].

- [24] Ford J, and Gray R. *Interprofessional education handbook.* Centre for the Advancement of Interprofessional Education (CAIPE). 2021. https://www.caipe.org/resources/publications/caipe-publications/caipe-2021-a-new-caipe-interprofessional-education-handbook-2021-ipe-incorporating-values-based-practice-ford-j-gray-r [Accessed 2nd September 2021].

- [25] Health Education England, NHS Improvement and NHS Employers. *Advanced practice: an online toolkit which provides a repository for helpful resources relating to advanced practice.* e-Learning for Healthcare. n.d. https://www.e-lfh.org.uk/programmes/advanced-practice-toolkit/ [Accessed 2nd September 2021].

- [26] Health Education England. *Good practice in new workforce roles.* n.d. https://www.e-lfh.org.uk/wp-content/uploads/2020/06/Good-Practice-in-Developing-New-Workforce-Roles.pdf [Accessed 2nd September 2021].

- [27] Royal College of General Practitioners. *Multidisciplinary team working toolkit.* n.d. https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/multidisciplinary-team-working-toolkit.aspx [Accessed 7th July 2021].

- [28] NHS Employers. *Do OD.* 2021. https://www.nhsemployers.org/topics-networks/staff-experience-culture-and-change/do-od [Accessed 2nd September 2021].

- [29] West R, and Michie S. *A brief introduction to the COM-B model of behaviour and the PRIME theory of motivation.* Qeios. April 2020. https://www.qeios.com/read/WW04E6.2 [Accessed 2nd September 2021].

- [30] House of Commons Health and Social Care Committee. *Workforce burnout and resilience in the NHS and social care.* June 2021. Report number: HC 22. https://committees.parliament.uk/publications/6158/documents/68766/default/ [Accessed 7th July 2021].

- [31] Imison C. *Trust in transformation change.* Nuffield Trust. 12th September 2016. https://www.nuffieldtrust.org.uk/news-item/trust-in-transformational-change#better-team-working [Accessed 7th July 2021].

References

- [32] NHS. *Supporting our NHS people.* 2021. https://www.england.nhs.uk/supporting-our-nhs-people/ [Accessed 2nd September 2021].

- [33] Wisdom J. *Cultivating great teams: what health care can learn from Google: psychological safety is the key to teamwork.* NEJM Catalyst. February 2017. https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0518 [Accessed 2nd September 2021].

- [34] NHS England and NHS Improvement. *The NHS patient safety strategy: safer culture, safer systems, safer patients*. July 2019. https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf [Accessed 7th July 2021].

- [35] TEDx. *Building a psychologically safe workplace | Amy Edmondson [video file].* May 2014. Available from: https://www.youtube.com/watch?v=LhoLuui9gX8 [Accessed 3rd September 2021].

- [36] re:Work. *Tool: foster psychological safety.* n.d. https://rework.withgoogle.com/guides/understanding-team-effectiveness/steps/foster-psychological-safety/ [Accessed 2nd September 2021].

- [37] Evaluation Works. *Welcome to your evaluation works toolkit.* n.d. https://nhsevaluationtoolkit.net/ [Accessed 2nd September 2021].

- [38] Bailey S, and West M. *Learning from staff experiences of Covid-19: let the light come streaming in.* The King's Fund. June 2020. https://www.kingsfund.org.uk/blog/2020/06/learning-staff-experiences-covid-19 [Accessed 2nd September 2021].

- [39] Ling T, Bardsley M, Adams J, Lewis R, and Roland M. Evaluation of UK integrated care pilots: research protocol. *International journal of integrated care.* 2010; 10:e056. Available from: doi: 10.5334/ijic.513 [Accessed 2nd September 2021].

- [40] West M, Eckert R, and Pasmore B. *Developing collective leadership for health care.* The King's Fund. May 2014. https://www.kingsfund.org.uk/publications/developing-collective-leadership-health-care [Accessed 2nd September 2021].

- [41] The King's Fund. *The challenge of culture change: sharing system-wide learning to deliver the NHS long-term plan.* October 2019. https://www.kingsfund.org.uk/events/challenge-culture-change [Accessed 2nd September 2021].

- [42] NHSx. *Information Governance.* n.d. https://www.nhsx.nhs.uk/information-governance/ [Accessed 2nd September 2021].

References

- [43] NHSx. *Information sharing in multidisciplinary teams (MDTs).* May 2021. https://www.nhsx.nhs.uk/information-governance/guidance/information-governance-guidance-support-multidisciplinary-teams-mdts/ [Accessed 2nd September 2021].

- [44] Royal College of Physicians. *Improving teams in healthcare – resource 3: team communication.* 2017. https://www.rcem.ac.uk//docs/External%20Guidance/ITIH%20R3%20Final.pdf [Accessed 7th July 2021].

- [45] Royal Pharmaceutical Society and Royal College of General Practitioners. *Multidisciplinary team working in a general practice setting: the practicalities of making it work.* n.d. https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Wales/00215%202001-Welsh-MDT-English-AWD.pdf?ver=2020-02-07-140429-840 [Accessed 7th July 2021].

- [46] NHS Confederation. *Building common purpose: engagement and communications in ICS.* 2020. https://www.nhsconfed.org/resources/2020/12/building-common-purpose-engagement-communications-ICS [Accessed 7th July 2021].

- [47] Agency for Healthcare Research and Quality. *TeamSTEPPS.* n.d. https://www.ahrq.gov/teamstepps/index.html [Accessed 2nd September 2021].

Bibliography

- Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement. *Shared leaderships: underpinning of the MLCF.* 2012. https://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/10/776bc9c27b6e8741d0ff42e593ba44cf.pdf [Accessed 7th July 2021].

- Brock D, Abu-Rish E, Chiu C, et al. Republished: Interprofessional education in team communication: working together to improve patient safety. *Postgraduate Medical Journal.* 2013;89:642-651. Available from: https://pmj.bmj.com/content/89/1057/642 [Accessed 2nd September 2021].

- Cameron A, Lart R, Bostock L and Coomber C. *Factors that promote and hinder joint and integrated working between health and social care services.* Social Care Institute for Excellence. May 2012. https://www.scie.org.uk/publications/briefings/files/briefing41.pdf [Accessed 2nd September 2021].

- Ehrlich C, Chester P, Kendall E, Crompton D. Implementing new models of integrated mental health care: what impacts effective performance? *International journal of integrated care.* 2017;17(3):A77. Available from: doi: http://doi.org/10.5334/ijic.3189 [Accessed 2nd September 2021].

- The Health Foundation. *Transformational change in NHS providers.* 2015. https://www.health.org.uk/sites/default/files/TransofrmationalChangeInNHSProviders_CCsupplement.pdf [Accessed 7th July 2021].

- National Cancer Action Team. *The Characteristics of an Effective Multidisciplinary Team (MDT).* February 2010. http://www.ncin.org.uk/view?rid=136 [Accessed 7th July 2021].

- Neuro Network. *The Neuro Network Vanguard (new care model programme: Cheshire and Merseyside Acute Care Collaboration): final evaluation report.* 2018. https://www.thewaltoncentre.nhs.uk/uploadedfiles/documents/Neuro%20Network%20Final%20Evaluation%20Report%20November%202018.pdf [Accessed 7th July 2021].

- NHS England. *Multidisciplinary team working – lessons from the vanguards and beyond.*

- NHS England and NHS Improvement. *Streamlining multi-disciplinary team meetings: guidance for cancer alliances.* 2020. https://www.england.nhs.uk/wp-content/uploads/2020/01/multi-disciplinary-team-streamlining-guidance.pdf [Accessed 2nd September 2021]

- NHS England and NHS Improvement. *Enhanced health in care Homes: vanguard learning guide - multi-disciplinary team (MDT) working with care homes.*

- Social Care Institute for Excellence (SCIE). *Multidisciplinary teams: what are MDTs and why are they important to integration?* June 2018. https://www.scie.org.uk/integrated-care/research-practice/activities/multidisciplinary-teams [Accessed 2nd September 2021]

- Soukup T, Lamb BW, Green J, and Sevdalis N on behalf of the Consortium for MDT Improvement. *Overview of MDT assessment tools and literature.*

Acknowledgements

HEE would like to thank a number of people who provided helpful materials at the outset of this project and comments in the production of this toolkit. These include:

- Dr Nav Chana, GP and Clinical Director, National Association of Primary Care
- Emily Henderson, Deputy Director Primary Care Workforce, NHS England
- William Palmer, Senior Fellow, Nuffield Trust
- Sarah Reed, Senior Fellow, Nuffield Trust (formerly Health Foundation)
- Rachel Souter, Deputy Director, Primary Care Workforce, NHS England
- Faye Simms, Head of Primary Care Workforce, NHS England
- Susie Srivastava, Blackpool Teaching Hospitals NHS Foundation Trust
- Ian Vousden, Programme Director - Kent & Medway Cancer Alliance, NHS England and NHS Improvement – South East

Author: Lucy Dodkin, Development Manager, Health Education England.

This toolkit was first published in October 2021.

Please contact transformation@hee.nhs.uk should you have any comments on this toolkit