MDT Development

- Working toward an effective multidisciplinary/multiagency team

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- *Advance equality of opportunity and foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it.*"

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Foreword

"As a patient with an array of long-term conditions including double above knee, arm muscles and finger amputations coupled with severe hearing loss; I have and continue to personally experience and benefit from an array of non-specialist and specialist health and social professions; and whilst these individual professions are distinctly different in the skills, knowledge and expertise that they possess and also the many varying services they provide, they are in my opinion inextricably linked in the common goal of all health and social professions, that being to keep the individual patient mobile, independent, dexterous and out of hospital wherever possible. So as an individual who will continue to need the many skills and expertise of the many caring health and social care professions' for the rest of my life, I feel privileged, that I am able to benefit from the mobility and independence afforded to me by the continuing innovative practices across health and social care".

Steve McNeice, Co-chair and patient representative

This Handbook is intended to give teams on the ground a practical, non judgemental set of tools to be able to assess their own teams against a set of benchmark descriptions of team working. In looking at the different descriptions of team working and examples, teams can come to an informed decision about how their team needs to function and what they might need to do to change to the desired state. There is no fixed solution or right answer to these questions, different solutions will be appropriate to different circumstances and different stages in team development. For the patient, being part of a multi disciplinary team which supports them with the right input at the right time can be the difference between being in control of their condition or not. Communication and information in a well functioning team are at their optimum. What's more, a well functioning team is much more fun to work in!

Peter Kohn, Director – Office of CCGs

1 Introduction

1.1 Background

May 2013 saw the publication of 'Integrated Care and Support: our shared commitment' which launched a shared vision for integrated care and support to become the norm in the next five years underpinned by a national collaborative programme to help organisations find local solutions to deliver this. In addition, a definition and narrative was published by National Voices. The latter has been fundamental in driving a sense of shared purpose and from the perspective of the individual through a series of 'I' statements.

Through the national collaborative for integration, a number of local integration pioneers were identified for the purpose of testing new models of commissioning and payment arrangements, developing and delivering new models of integrated care and support, and to accelerate learning and share this with others. This pioneer programme is managed and supported by NHSIQ.

Simultaneously with this, and as part of NHS England's work on integrated care, a national steering group for clinical integrated care and support (CICS) was established. The purpose of this group is to provide broader clinical leadership advice and guidance on integrated care, and support the development of an authoritative and collaborative position on the clinical interventions that will best deliver Integrated Care and Support.

Over the past several months, the CICS steering group has been working on three service components to support integrated care; risk stratification and case finding, care planning, and multi-disciplinary teams.

1.2 Service Component handbook for Multi-disciplinary teams.

This handbook is one of three service components designed to support commissioners, GP practices and community health and social care staff in planning personalised care and in providing services for people who are living with long term conditions.

They are intended to provide practical support on *how* this can be done in reality and arguably, the three most important areas to meet this challenge are:

- Risk stratification and case finding – *how to segment a population and provide person-centred care to those most in need recognising resource constraints*
- Multi-disciplinary team working – *how health and care professionals work together to support people with complex care needs that have been identified through risk stratification and case finding*
- Personalised care and support planning – *the key vehicle by which health and care professionals work together with patients and carers to meet their needs*

These resources were produced by a Task Group of service leads from Clinical Commissioning Groups (CCGs), GP practices and other stakeholder organisations, supported by NHS England. The resources contribute to the work of the 'Long term conditions, older people and end of life care' programme.

All three resources can be accessed through the web page for the 'House of Care' framework on the NHS England site (http://www.england.nhs.uk/house-of-care/) and through the House of Care webpages for NHS IQ's Long Term Conditions Improvement Programme.

This handbook brings together information about multi-disciplinary / integrated teams from a wide range of sources including publications, studies and operational examples for the purpose of providing a stimulus to the system to examine the type or types of teams that need to be in place to deliver integrated healthcare.

This handbook also offers a unique tool for consideration, the MDT Continuum that describes and sets out a journey from unidisciplinary to transdisciplinary team working.

1.3 Who is this handbook for?

THIS HANDBOOK WILL BENEFIT THE PATIENT BY:

- ✓ empowering patients to take the lead in managing their long term conditions outside acute services and in their own homes where appropriate

- ✓ improving health and well-being outcomes for patients by offering person centre co-ordinated care

- ✓ facilitating and enabling Patient Choice and Putting People First

- ✓ reducing any impact of post-code prescribing by equality of access to the highest quality services

THIS HANDBOOK WILL BENEFIT THE HEALTHCARE PROFESSIONAL & MULTI/INTER-DISCIPLINARY TEAM BY:

- ✓ supporting improved personalised care planning particularly for persons with complex often long term needs

- ✓ the implementation of the "Common Core Principles to Support Self-Care"

- ✓ improved career and professional opportunities within an innovative and dynamic working environment

- ✓ opportunities to directly influence service and equipment provision

THIS HANDBOOK WILL BENEFIT THE SERVICE / SERVICE PROVIDER BY:

- ✓ improved and best use of finite resources

- ✓ communicating and facilitating the delivery of NHS priorities

- ✓ the elimination of post-code prescribing by equality of access to the highest quality services

- ✓ underpinning Patient Choice by ensuring a competent workforce with the skills and knowledge to deliver specialised, high quality services to patients

- ✓ outlining a rationale for developing professionals teams from across the health, social care, private and voluntary sectors

THIS HANDBOOK WILL BENEFIT INTEGRATED HEALTH AND SOCIAL CARE COMMISSIONING BY:

- ✓ reducing emergency bed days through improved care in primary care and community settings

- ✓ close collaboration between Health and Social Care Services

✓ facilitates and environment of ever evolving service practices based on the changing needs of the patient

1.4 MDT and the NHS Five Year Forward View.

The NHS Five Year Forward View (FYFV) sets out in some detail a vision of what the future will look like in the context of new models of care and emphasises that over the next five years (and beyond) the NHS will need to dissolve the traditional boundaries that prevail between primary care, community services and hospitals, recognising that this traditional divide is increasingly a barrier to the personalised and coordinated health services people need.

In particular, the FYFV sets out that the NHS must increasingly manage systems as networks of care and not just organisations; and that services need to be integrated around the patient.

The Forward View also focuses services on health outcomes by putting a strong emphasis on secondary prevention and supporting patients to improve their own health and wellbeing through improved behaviours relating to tobacco, alcohol and healthy weight.

Inevitably, new models of care will lead to new types of MDT and the continuum approach described in this handbook sets out considerations for uni-disciplinary to trans-disciplinary working. http://bit.ly/1ok0qR7

1.4.1 FYFV MDT Opportunities

The FYFV offers many opportunities for MDTs, in particular their involvement in the implementation of new care models. Of particular reference are the models pertaining to Multispeciality Community Providers (MCPs) and Primary and Acute Care Services (PACS).

Some of the key opportunities include:
MCPs
Diverse & Specialist Workforce
Better Consultation
Manage Local Hospitals
Local Budgeting

PACS
Flexibility
Contractual Changes
Accountability for the whole

MDTs are advised to focus on these and the other care models in the FYFV to maximise the opportunities they present. Further detail can be found in Annex 1 and the FYFV (link above).

Annex One – Care model excerpt from Five Year Forward View

"These Multispecialty Community Providers (MCPs) would become the focal point for a far wider range of care needed by their registered patients.
• As larger group practices they could in future begin employing consultants or take them on as partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff.
• These practices would shift the majority of outpatient consultations and ambulatory care out of hospital settings.
• They could take over the running of local community hospitals which could substantially expand their diagnostic services as well as other services such as dialysis and chemotherapy.
• GPs and specialists in the group could be credentialed in some cases to directly admit their patients into acute hospitals, with out-of-hours inpatient care being supervised by a new cadre of resident 'hospitalists' – something that already happens in other countries.
• They could in time take on delegated responsibility for managing the health service budget for their registered patients. Where funding is pooled with local authorities, a combined health and social care budget could be delegated to Multispecialty Community Providers.
• These new models would also draw on the 'renewable energy' of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours."

"We will now permit a new variant of integrated care in some parts of England by allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services. The leadership to bring about these 'vertically' integrated Primary and Acute Care Systems (PACS) may be generated from different places in different local health economies.
• In some circumstances – such as in deprived urban communities where local general practice is under strain and GP recruitment is proving hard – hospitals will be permitted to open their own GP surgeries with registered lists. This would allow the accumulated surpluses and investment powers of NHS Foundation Trusts to kickstart the expansion of new style primary care in areas with high health inequalities. Safeguards will be needed to ensure that they do this in ways that reinforce out-of-hospital care, rather than general practice simply becoming a feeder for hospitals still providing care in the traditional ways.
• In other circumstances, the next stage in the development of a mature Multispecialty Community Provider (see section above) could be that it takes over the running of its main district general hospital.
• At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.

PACS models are complex. They take time and technical expertise to implement. As with any model there are also potential unintended side effects that need to be managed. We will work with a small number of areas to test these approaches with the aim of developing prototypes that Work."

1.5 Person Centred Care

The term 'person-centred care' is used to refer to many different approaches and activities, and there is no single agreed definition of the concept. This is partly because person-centred care is still an emerging and evolving area. It is also because, if care is to be person centred, then what it looks like will depend on the needs, circumstances and preferences of the individual receiving care. What is important to one person in their health care may be unnecessary, or even undesirable, to another. It may also change over time, as the individual's needs change.

National Voices, working with Think Local Act Personal and others, have also produced a [narrative for person-centred, co-ordinated care](#)[1] which helps define what 'integrated care' means to service users and demonstrates the pivotal role of effective, personalised care and support planning.

The narrative was co-produced with people using services, patients, carers and their organisations. From the perspective of the person using services, person-centred, coordinated care is defined as:

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

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[1] http://www.nationalvoices.org.uk/defining-integrated-care

2   What is a Multi-Disciplinary/Multi Agency Team?

2.1   Definition

A **multidisciplinary approach** involves drawing appropriately from multiple disciplines to explore problems outside of normal boundaries and reach solutions based on a new understanding of complex situations

Multidisciplinary and Multiagency working involves appropriately utilising knowledge, skills and best practice from multiple disciplines and across service provider boundaries, e.g. health, social care or voluntary and private sector providers to redefine, re scope and reframe health and social care delivery issues and reach solutions based on an improved collective understanding of complex patient need(s).

2.2   Core Development Elements of MDT Working

Continuum
The continuum sets out descriptions of different types of care delivery teams functioning and describes how these change as multidisciplinary team working deepens and extends throughout the team.

Common Principles
To be effective, every team needs core principles that to adhere their functions, practice and delivery together.

Commissioning
Focusing on innovative & effective use and distribution of funds to commission services for a multidisciplinary team.

3 Glossary of Terms

3.1 Health Terms

Commissioning - refers to the commissioning of whole services, organisations and clinical pathways

Stakeholders - refers to everyone who has a 'vested' interest in the service irrespective of their roles, responsibilities and contributions. . Patients, carers and communities must be included within any stakeholder analysis

Partners - refers to everyone who has a professional interest and is directly involved in the design, development and delivery of a service

Funders - refers to organisations who have provided any or all of the financial resources

Commissioners - refers to the organisations, agencies and / or departments who have provided the majority of financial resources to any programme, pilot or service

Outcomes – are the change in health status following an intervention eg reduced pain, and increased mobility post knee surgery

Outputs – are the products of health and social care intervention for example successful knee replacement

Packages of Care – same as Social Care

Transdisciplinary working means that one discipline may take on the traditional role of another by agreement.

Unidisciplinary is where the professional with continuing responsibility co-ordinates the care for the patient working with other professionals from their own organisation, as necessary.

3.2 Social Terms

Commission(s) - refers to any and / all financial resources that have been secured through open competition

Commissioning - refers to a process for and of awarding financial resources for a specific purpose

Grants - refers to any and / all financial resources that have been awarded outside of open competition or where selected organisations have been invited to present

Stakeholders - refers to everyone who has a 'vested' interest in the service irrespective of their roles, responsibilities and contributions.

Partners - refers to everyone who has a professional interest and is directly involved in the design, development and delivery of a service

Funders - refers to organisations who have provided any or all of the financial resources

Commissioners - refers to any organisation, agencies and / or departments who have provided the majority of financial resources to any programme, pilot or service

Local Partnerships - refers to two or more organisations coming together with or without a formal agreement to deliver a specific piece of work and / or service

Delivery consortium - refers to many organisations coming together with a formal agreement to deliver a specific piece of work and / or service. In these situation the consortium may or may not be formally constituted, if un-consitituted there will be a lead organisation

NB: LOCAL PARTNERSHIPS AND DELIVERY CONSORTIUM are pretty close to what is termed 'integration' in a health setting

Outcomes - sometimes there is confusion between outputs and outcomes. However the general rule is that outcomes are perceived as 'soft evidence' e.g changes in attitude, behaviour, practice and longer term targets.
The social care outcomes framework[2] has a strong emphasis on the client, patient or carer's perspective and a number of outcomes in common with the NHS outcomes framework.

Outputs - refer to 'hard evidence' e.g events held, patients accessing services and are usually short term targets

Care Package - refers to an organised schedule of support (inc direct care) that an individual has agreed with their GP, specialist and / or social worker

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[2]

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263783/adult_social_care_framework.pdf

3.3 Other Terms

Service User - a person with a long term condition(s) regularly receiving medical interventions (a person expert in their own care and can access and manage their way through the health and social care systems and processes)

Patient - a person receiving or registered to receive health intervention treatment.

Risk stratification and case finding - how to segment a population and provide person-centred care to those most in need recognising resource constraints

Multi-disciplinary team working - how health and care professionals work together to support people with complex care needs that have been identified through risk stratification and case finding

Care and support planning - the key vehicle by which health and care professionals work together with patients and carers to meet their needs

4 Care Coordinator Function

Research demonstrates that the most successful examples of integrated care and the facilitation of multi-disciplinary teams have been those that identified a designated care co-ordinator/ case manager.

In the case examples identified by the King's Fund in their research paper *Co-ordinated care for people with complex chronic conditions (2013)* Care Co-ordinators came from a range of professional backgrounds and included a diverse range of clinical experience. In some cases identified Care Co-ordinators were also directly involved in providing care, whilst in others the role was simply to facilitate multi-disciplinary care packages provided by other professionals.

The King's Fund identify the role of the Care Co-ordinator/ Case Manager as being fundamental to the successful delivery of integrated care and better long term outcomes for patients and users of services. It is less important as to who the Care Co-ordinator is, their clinical background or organisational base but vital that there is a commonality in terms of the role and the key skills needed to carry the role out effectively.

There is an argument that the underlying ethos of integrated care is to support and empower patients and users of services to become their own Care Co-ordinators with the ultimate aim of them becoming independent and resilient, taking responsibility for managing their own care and living well.

The commonality in terms of role and skills becomes more important when you consider that in some cases the identified Care Co-ordinator may change over time, being guided by the needs of the patient/ user of services at that point. The Care Co-ordinator/ Case Manager may not be the same person throughout a long period of care and support.

4.1 Roles and Functions of Care Co-ordinator

- Form a pro-active working relationship with an individual patient/ user of services
- Carry out a holistic, person centred assessment in partnership with the individual patient/ user of services
- Provide a central, continuous point of contact for the patient/ user of services and the range of professionals involved in the care package
- To act as the key advocate for the patient/ user of service as and when required
- To assist the patient/ user of services in the successful navigation of complex health and social care systems
- Demonstrate local knowledge of the range of local health and care services including the voluntary and community sector
- To take responsibility for care planning and ensuring that identified activities and interventions take place as agreed
- To hold other providers within the care plan to account

- To monitor and review care plans and agreed outcomes in partnership with the patient/ user of services and to evaluate outcomes. Additionally this would involve re-negotiating care plans as and when required
- To provide direct care where appropriate

5   Self Assessment

There is a wealth of information spanning many decades about teams both in terms of structure, function and development, and much more. We have included a section about team development in part 8 of this document.

In terms of self assessment, this relates to tools and frameworks for MDTs that can support the establishment, ongoing development and regular review of MDT effectiveness. In addition, and an important consideration, is the role of benchmarking for the purpose of ongoing quality improvement.

This section outlines three examples:

5.1   Bradford, Airedale, Wharfedale & Craven; Integrated Care for Adults Programme; Effective multi-disciplinary teams development tool

Developed by the Organisational Development Support team at Bradford, Airedale, Wharfedale and Craven, the purpose of the framework is to create a clear and consistent model of what good looks like for effective MDTs.

The development tool can be used to support the establishment, ongoing development and regular review of MDT effectiveness which over time could be used as a self-assessment tool by MDTs.

It includes the following indicators of effectiveness:
1. Execution of the task (clarity of purpose, outcomes, process)
2. MDT structure and membership
3. Meeting management
4. Roles and functions
5. Integrated Care Processes
6. Debate and discussion
7. Trust within the team
8. Individual/collective agreement
9. Acceptance of accountability
10. Attention to results.

The Development Tool is not intended as a monitoring or scrutiny mechanism and should not be used for this purpose.

Readiness Questionnaire - http://1drv.ms/1x5Tt6H
Effectiveness Framework - http://1drv.ms/1pl5HbL

5.2 QIPP national programme (upto 2013)

A Guide to the Implementation of the Long Term Conditions Model of Care Learning from the Long Term Conditions QIPP Workstream, is a key reference tool. Work done by the national QIPP LTC Programme, has embedded self assessment principles, which is an ideal starting point for most MDTs.

http://1drv.ms/1uuoHDC & http://1drv.ms/1HjiG3l

5.3 DiabetesE

This tool was established several years ago to enable the Diabetes Networks to self-assess themselves against the outcomes of the National Service Framework for Diabetes. It provided many benefits both in terms of identifying areas for improvement and generation of action plans, and benchmarking. It was **not** a tool for performance management but a tool for improvement.

DiabetesE was developed through considerable investment in the latest technology that ultimately enabled reporting and benchmarking in real time. It is not currently in use and yet offers considerable learning of what a successful self-assessment tool can offer and do in terms of generating scrutiny of form, function and effectiveness against a set of agreed criteria.

The national CICS steering group are currently considering the possibility of harnessing the investment and learning from DiabetesE and developing this platform for integration.

Information about this tool can be found **here: http://1drv.ms/1x5UsDX**

6 The Continuum

The *Continuum* model below sets out descriptions of different types of care team functioning and describes how these change as multidisciplinary team working deepens and extends through the team. While the model describes a general care team, it could be adapted to any type of multidisciplinary team by changing the disciplines involved. In line with NHS Constitution, the patient themself, is now an integral part of any multidisciplinary team.

The model describes four stages of the depth and extent of working within a Multidisciplinary Team (from left to right).

When looking at the continuum of different MDT models from unidisciplinary to transdisciplinary there is a temptation to read these from left to right and see transdisciplinary working as the ultimate goal. This is not necessarily the case, different models might be more appropriate to different circumstances.

For instance a child mental health team multidisciplinary referral meeting might be an obvious candidate for transdisciplinary working, whereas a team requiring immediate decision making may need one person to take charge. The challenge to any team is whether the type of working has been agreed consciously or is the product of history and personal preferences; and particularly how far the patient/carers are central to decision making.

6.1 Continuum Models

The original research which led to the description of the different models, from unidisciplinary to transdisciplinary was applied to Primary Care Teams; Once the basic concept was explained , teams found it easy to place themselves on the continuum. Applying the same concept to other types of teams necessitates identifying markers which would suggest progression from one model of MDT working to another. Once again, this is not to say that any model is right or that progression is required if the team has consciously decided the model of working for that particular team at that time. Working in a transdiciplinary way does, however, make the optimum use of the skills and abilities of MDT members and many teams find it desirable.

It is important to state that the models are a description, not a fixed state, and that they will differ between teams (even in the same organisation dealing with the same subject), geographies and over time. The description can be helpful for teams to fix on their characteristics and where they might prefer to develop to.

6.1.1 MODEL ONE

Unidisciplinary - This model is where the professional with continuing responsibility co-ordinates the care for the patient working with other professionals from their own organisation, as necessary. It might be characterised by meetings where other professionals input to care planning on an irregular basis or where they consult to the plan rather than develop the plan together. Records will tend to be separate for each member of the team and may be held separately. Team meetings may not be formalised and communication tends to be between team members and the patient rather than between each other. Where a particular profession dominates this model is common. Where decisions need to be made quickly this may be quite appropriate.

6.1.2 MODEL TWO

This model is common; the professionals working in an organisation work closely together as a team and include the patient to varying degrees. They may share records and have formalised meetings, to which other key professionals from other employers are attached. A shared plan is prepared within the organisation but may not be agreed by other organisations, particularly if there are resource implications or tasks to complete. Teamwork can be very high and communication good between team members.

6.1.3 MODEL THREE

The core team, i.e. all the key members needed to carry out the care, for that particular purpose from several organisations, work closely together. Assessments are carried out by each profession and patient plans worked up as a collaborative effort, including the patient/carers. Records are shared. The members of the core team are generally able to commit resources to the common effort. Teamwork and communication between team members is high and the lead role for co-ordinating the team may rest with any member. Many other disciplines can be called upon for specific purposes.

6.1.4 MODEL FOUR

Transdisciplinary working - This is a natural development from model 3 where the barriers between different disciplines break down and roles within the team are redesigned to make the optimum use of team skills and knowledge. Assessments may be carried out by different disciplines working together with insights from one discipline informing the assessments of another; the 'whole will be greater than the sum of the parts'. Patient plans will benefit from interdisciplinary insights, and a learning culture within the team will value all insights, especially those of the patient themselves. Transdisciplinary working means that one discipline may take on the traditional role of another by agreement. This is particularly true of care co-ordination and some teams have created specific roles to carry this out. This sort of working requires team members to sink part of their individual professional role into the team effort, and teams are non hierarchical and often self governing.

6.2 Good Practice Examples

The following are all examples of good practice in relation to MDT working, based on the **General Model of the Continuum**. There is a suggestion as to which stage of the continuum the examples appear to fit. Please note that these are indicative stages based on findings from the literature review of the models of care within each example. This is based on the team composition, how effective the MDT worked together, the level of involvement of patients in planning their own care and in being a core part of the team, as well as the resources available to the MDT from the wider community based services.

In addition to the general continuum model three other working examples have been formulated:

Children's Special Needs MDT – http://1drv.ms/10QSxYh
Diabetes MDT – http://1drv.ms/1uYrKGS
Primary Care MDT - http://1drv.ms/1uYrWG1

A set of primary care good practice examples can be found http://1drv.ms/1oUj4tj

"All the examples indicate positive outcomes for patients through effective MDT working, regardless of which stage of the continuum they are at."

6.2.1 Model 1

An introduction to the Gloucestershire Urological Cancer Multidisciplinary Team Service.

Description & Target Population

Consultant-led services based in Gloustershire Hospital. The MDT work together to plan and manage the care of patients diagnosed with cancer. The cases are discussed at the Urology Multidisciplinary Team meetings on a weekly basis and the plan is discussed with the patient and relatives afterwards. An MDT coordinator coordinates the meetings and the Clinical Nurse Specialist is the key worker who acts as a link between the MDT and wider community teams like the GP, social workers and other voluntary organisations including Macmillan Cancer Support services.

MDT Composition

Core - Urology Consultant, Clinical Oncologist, Physiotherapist, Radiographer, Clinical Nurse Specialist, MDT Coordinator, junior members of the medical team. Wider Team: GP, Macmillan Cancer service, social workers and community nurses as required.

Outcome of MDT Working

MDT meetings are coordinated by the MDT coordinator for smooth running and coordination of information about the patient.

The key worker function acts a as a link between the core MDT and wider community team to ensure continuity of care.

The patient's views and feedback about care are taken into consideration in agreeing their care plan although they are not part of the MDT discussions.

http://bit.ly/1m8emMP

6.2.2 Model 2

Midhurst Macmillan Palliative Care Service – King's Fund Review.

Description & Target Population

Consultant-led community-based palliative care provision by a specialist Palliative care team commissioned by Macmillan Cancer Support. The overall goal of the service is to enable people at the end of life to be cared at home in order to die in the place of their choosing and to prevent emergency admissions to hospital at the end of life. Referrals come from GPs, community nurses and other specialist services for patients with severe, intractable complex symptoms that have persisted after palliative care by generalists. The team work closely together with regular MDTs to manage the patient's care. The CNS holds overall responsibility for organising and co-ordinating care, while other team members retain responsibility for their aspect of the service. In addition, care is co-ordinated across the range of other partners including GPs, district and community nurses, social workers and others who are involved in the care of patients. A key feature of the service is its vision to provide personalised care responding to the changing needs of the patients. Care plans are the result of a mix of formal assessment and informal discussions with patients,

carers, nurses and GPs who are involved in the patient's care. The team regularly updates other partners on a patient's status, arrange visits and discuss care plans in regular meetings at GP practices

MDT Composition
Core: Consultants & Associate Specialists, Clinical Nurse Specialists (CNS), Team Leaders, Nurses, Counsellor, OT, Physio, Volunteers.

Additional Team: Social Workers, GPs, community nurses, Hospital, Hospice, Care Agencies.

Outcome of MDT working
Care coordination function of the CNS enables close working with GPs and community nurses; has reduced duplication and helped to build trust and respect between professionals.
Fostering a positive, supportive team culture creates an environment where staff can deliver high-quality holistic care to their patients. Overall, the service culture is marked by the team ethos that puts the patient first and has an holistic approach to patient care.
Positive patient experiences describe how the service has worked flexibly to provide patient centred care co-ordination.

http://bit.ly/1uAckGT

6.2.3 Model 3

Oxleas Advanced Dementia Engagement Service

Description & Target Population
This is a Consultant-led community based home care for patients with advanced dementia. The service is hosted by Oxleas NHS Foundation Trust, which provides community and mental health services across 125 sites in three boroughs. It is jointly funded by CCGs and the local authorities of Bexley, Greenwich and Bromley to provide health and social care services.
The service caters for people with a diagnosis of moderate to severe advanced dementia, complicated by complex mental and physical comorbidities requiring social care input, who are being supported to live at home (by family or paid carers). These patients tend to be in the last year of their lives with an average age of 75. The core team works with GPs, secondary care and social services to support carers in providing ongoing and palliative care. Staff respond to crises at home to prevent unnecessary hospital admissions where possible and reducing the likelihood that patients are placed in residential care. Care coordination is by the specialist nurse and care is tailored to each person based on their primary need and the range of services available locally

MDT Composition
Core: consultant in old-age psychiatry, several specialist nurses (CPNs and/or Community Matrons) Advanced Practice Nurse, dementia social worker, carer .

Additional Team: GPs, social workers, OTs, Physiotherapist, voluntary services.

Outcome of MDT working

There is a clear, shared aim among staff in the service to help people in the latter stages of advanced dementia to live well and die at home, with a focus on bringing together physical and mental health. Staff are strongly rooted in their local communities and feel supported by managers to work in an integrated way.
The strength of the service is the importance placed on the role of the carer as an essential element of the team.
Effective support to patients and carers, leading to improved quality of life.
70% of patients achieved their choice of place of death at home.

http://bit.ly/1s3od9w

6.2.4 Model 4

NHS at Home: Community Children's Nursing Services (CCNT)

Description & Target Population

The Islington model was developed as part of their status as Integration Pioneers and their approach is to improve care for children and young people through a range of initiatives including
1. Children's Hospital at Home
2. Children's Nurses in Primary Care
3. Children's Multi-disciplinary Team Teleconferences
Children's MDT Teleconferences model involves identifying children from hospital data using a Patient Identification Tool or the MDT core team itself, with the aim to improve health care for children with specific health needs through better co-ordination of care across primary, community and hospital services. Monthly MDT discussions then take place in GP localities via teleconferencing. Where children have special needs or other long term conditions, the involvement from the hospital team is greater.
The service links with the children's hospital at home service to manage acutely ill children in the community by the CCNT with support from acute (hospital based) team. This enables professionals to follow the children across the health system including when admitted to hospital, to maintain continuity of care. Community resources are fully utilised to support the parents and children.

MDT Composition

Core: Health Visitor/ or school nurse, Community Children's Nursing Team, a locality representative from Families First – (to address any barriers to support families who don't meet social care threshold), social worker if appropriate, a hospital pharmacist , a paediatrician, other specialist consultants and nurses and therapists required, and parents/carers.

Additional Team: Community resources as appropriate.

Outcomes of MDT working

The main feature of this model of seamless service is a multi-professional team with blurring of boundaries but with clear roles and responsibilities. Parents experience a co-ordinated seamless service that is centred on parental choice and decision-

making, personalised to the individual child and family, and promoting independence and quality of life; This is because they have reliable, simple and easy access to the resources required to provide optimal care for their child,.

Benefits: Improved information sharing, Health Care Plans based on goals established with parent/carer (or young people themselves if Gillick competent[3]), provides a learning opportunity to all present and use of 'Families First' to address barriers to support families who don't meet the social care threshold.

http://bit.ly/XoN7lX

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[3] http://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/

7   Common Principles

Perhaps the most important common guiding principle for all multi-disciplinary / integrated teams, regardless of organisational setting, is having a shared commitment to the delivery of person-centred coordinated care from the perspective of the individual

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me"

Many reports and publications have been considered in an attempt to identify and draw out the common principles / key traits to successful MDT working which could collectively be summarised around leadership, relationships, culture, clinical engagement, developing the workforce, information (data and intelligence), communication, and commissioning – more recently co-commissioning and outcomes based commissioning.

7.1 Challenging Principles

- Cultural boundaries across pathways – whether professional or sectorial

- System and bureaucratic boundaries to access joined up specialised and non-specialised services and equipment provision

- Funding and budgets

- Not looking beyond ones area of expertise; the disease focussed approach to managing care, whilst good at providing and generating clinical expertise, does not necessarily create a good experience for people with multiple conditions. The health professional workforce policies and professions themselves need to change as they deal with the increasing prevalence of people with multiple chronic conditions over the next few decades. Often professionals with specialisms are locked into fragmented, reductionist and dysfunctional health care provision, divided into numerous single condition professions and are often reluctant to co-ordinate care outside their areas of technical expertise

- Focus on professional intervention rather than promoting independence, focussing on health and wellbeing, building competencies, and self-care.

- Patient profile changing –and will continue to change in terms of demographics and need – the future patient is also well-informed and should work more collaboratively with the many caring healthcare professionals extending more choice over what, when and how…

7.2 Positive Principles

Changing Positive Principles to Opportunistic Principles (or the like) – should be seen as an opportunity…

- Transferable flexible guidelines, tools, techniques allowing the benefits of knowledge, skills and expertise to be shared and accessible across pathways – whether health, social care or public health for the benefit of all.

- Transferable across the many styles of team working – MDT/IDT/ Uni- & Trans-disciplinary etc.

- Focus on health, health outcomes and supporting the client or patient to maintain or improve their own health.

- Encourages leadership within a culture of collaboration, working with and across boundaries and along pathways based upon the need(s) of the patient

- Improved timely information and by definition understanding and recognition of service(s) and or equipment to be provided - for the service provider, healthcare professional and patient/carer

- Utilisation of Patient Outcome Measures (and others such as the I statements[4]) to facilitate the removal of boundaries whilst reducing / minimising unnecessary bureaucracy and systems which stifle much needed improvements in services

- Facilitating a culture of innovation and innovative practices whilst supporting research and development.

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[4] http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/TLAP/MakingItReal.pdf

8 Team Development

Team based working is more than team building. Team based working is a philosophy or attitude about the way in which organisations work – where key decisions are made by teams of people rather than by individuals and where those decisions are made at the closest possible point to the client or patient (Aston OD).

Teams go through stages of development. The most commonly used framework for a team's stages of development was developed in the mid-1960s by Bruce W. Tuckman, now a psychology professor at Ohio State University. Although many authors have written variations and enhancements to Tuckman's work, his descriptions of *Forming, Storming, Norming and Performing* provide a useful framework for looking at your own team.

Each stage of team development has its own recognizable feelings and behaviors; understanding *why* things are happening in certain ways on your team can be an important part of the self-evaluation process. The four stages are a helpful framework for recognizing a team's behavioral patterns; they are most useful as a basis for team conversation, rather than boxing the team into a "diagnosis."[5]
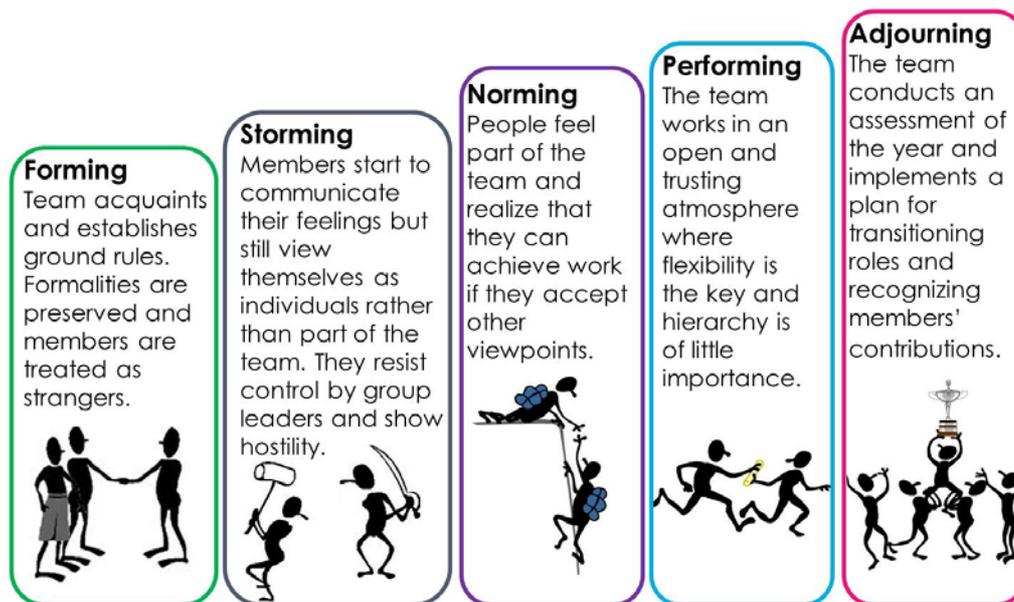
Bruce Tuckman's Model of Group Development ®

Some of the benefits of team development in health care include:
• Reduced hospitalisation and associated costs
• Improved service provision
• Improved levels of innovation in patient care
• Enhanced patient satisfaction
• Increased staff motivation and mental well-being
• Reduced error rates
• Reduced violence and aggression
• Lower patient mortality.

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[5] http://hrweb.mit.edu/learning-development/learning-topics/teams/articles/stages-development

However the fundamental benefits are relevant in teams that consist of clinical and non-clinical members:

- Opening communication across the team by having an objective, third-party assessment of the key issues affecting performance
- Leveraging true strengths and addressing fundamental challenges by better understanding the 'truth on the ground'—what people at all levels really think about their team's performance
- Building commitment by engaging all team members in a structured and inclusive process
- Resolving team conflicts and addressing sensitive issues constructively
- Moving forward by creating a concrete, realistic action plan to address immediate challenges and lay the foundation for long-term success
  http://www.diamond-insight.com

  www.1000livesplus.wales.nhs.uk/opendoc/179383

There are many different models of personal and team development; (Insight Discovery®, Myres & Briggs® and Aston®). All facilitate better knowledge of you and your team, in the pursuit of better integrated working. Read a summary of the processes involved here: http://1drv.ms/1rYcgjs (Source – Aston®)

Personal – Myres Briggs® - The Myers-Briggs Type Indicator® instrument has been extensively studied in various professions. When health care professionals understand personality type they have a constructive framework for better understanding what both the patient and family members need. http://www.myersbriggs.org/

Personal and team development – Aston ® - Aims to help organisations to build good team and inter-team working. Research-based tools are widely used by Service Improvement, OD and Learning Development practitioners who want to assess, develop and monitor the performance of teams but struggle with limited resources and constant change. http://www.astonod.com/

Personal, team and change - Insight Discovery ® - Gain a deep insight into yourself and your colleagues. Uncover meaning in preferences and behaviour. Learn to adapt and connect with others to create strong and effective relationships. http://bit.ly/1pq2yHN

9 Commissioning for Integration

The delivery of a model of health and social care which provides person centred seamless care necessitates system wide vision, co-ordination and collaboration. The role of commissioners is to facilitate, enable and support care providers to deliver a new model of care which improves health outcomes for the individual and the population.

9.1 Definitions of Commissioning for Integration

Commissioning of services that meet individual and population needs in a holistic manner, without the need for the patient or carer to navigate separate service providers is fundamental to realisation of quality service provision and shift in care to community settings. Whilst the NHS England Pioneer sites are developing models and exemplars of good practice, the key international example is the Buurtzorg[6], in the Netherlands.

The delivery of this approach will require commissioners to consider:

- Joint or co-commissioning approaches for integration– this approach requires consideration of joint financial commitment, lead commissioning organisation to be considered, arrangements for delegated responsibilities, utilisation of broker agencies such as Commissioning Support Unit.
- Commissioning from multiple providers for a seamless service.
- Commissioning from a single provider acting as the key contract holder with other organisations providing care.

9.2 Underpinning Principles

9.2.1 Development of a Shared Purpose

Development of a shared purpose across the health and social care economy enables the community, providers and stakeholders to focus and agree on the vision for care delivery.
An agreement of priority outcomes, vision and goals will facilitate the commitment to improved patient outcomes, better population health, and effective use of resources. Support for development of shared purpose is outlined on the NHS Change Model website www.**changemodel.nhs**.uk

9.2.2 Agreeing locally defined outcomes

The agreement and clarity of locally defined health outcomes are fundamental to supporting achievement of the shared purpose.
In developing your outcomes ensure they are:
- Meaningful to patients, providers and stakeholder
- Measure improvements in health and not outputs – utilising a SMART approach is helpful

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[6] http://www.kpmg.com/global/en/issuesandinsights/articlespublications/value-walks/pages/netherlands.aspx

- Contribute to the strategic health, social care and public health outcome framework

The development of these outcomes cannot be undertaken in isolation, they will emerge from the shared purpose agreement but must be developed, tested and agreed by all. Adoption of a collaborative leadership approach by all can facilitate the development of future collaborative working at the point of delivery.

Key Links:
NHS Outcome Frameworks - https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015
NHS Leadership Academy - http://www.leadershipacademy.nhs.uk/

9.2.3 Relationship Development

Health and Social care commissioning is broader than a transactional provider purchaser relationship - it is potentially transformational with commissioners engaging and communicating as partners throughout the whole process.
This level of commissioning requires commissioners to establish mature relationships with communities, patients, service users, carers, providers and stakeholders. Relationship development is not solely undertaken at the start of the commissioning process or within the contract monitoring process but is continuous, it takes time and commitment but is fundamental to the transformation of care delivery.

Within the context of delivery of an integrated model of care, effective and continuous relationship development is fundamental. Delivery of an integrated model of care necessitates organisations and clinicians to change practice, understanding and supporting this change is enabled through open and effective communication. Open communication will facilitate the sharing of best practice, learning from incidents, creative practitioner and patient led problem solving and the resolution of local issues in the interests of patient care.

As leaders in health and social care, commissioners must be brave and embrace their role in supporting on-going change.

9.2.4 Accountability & Governance

A potential challenge in commissioning for integration is the need for provider organisations to be clear of their accountability and governance arrangements. Clarity regarding these issues is important as it will underpin the viability of the organisation. The challenge of marrying clarity with an integrated model of delivery necessitates the blurring of traditional boundaries, and as such should not be dismissed; it is at this point that traditional commissioning approaches can limit delivery. In overcoming these challenges commissioners can consider adopting a different approach. Alternative approaches to commissioning include:

Lead Provider contracts/pathway commissioning
This approach enables the commissioner to commission the whole service from a single provider who will subsequently subcontract with other organisations and providers. This model provides greater emphasis on a single provider to facilitate delivery of care, although necessitates a maturity within organisations in the sub-contracting of elements of the pathway. This model may be attractive to providers who are recognising the need to collaborate across organisations in the delivery of care.

Multiple contracts
Commissioning of multiple contracts, all working with a shared service specification and key performance measures can facilitate integration. Within this approach the commissioner will act in a strategic co-ordinating function between and across organisations. The organisations must be committed to working collaboratively and sharing management of financial and service delivery risk and improvement targets. The development and agreement of a formal compact will facilitate this process.

9.2.5 Contracting

The contracting process whilst adopting a standardised approach does facilitate creative local solutions to integration. The CQUIN is an important tool in facilitating change in practice with measureable outcomes, and facilitate delivery.

NHS England CQUIN guidance - http://bit.ly/1zw4GRs

Further information on the 'Integration Pioneer' sites who have used some or all of these principles, can be found at:
http://www.nhsiq.nhs.uk/improvement-programmes/long-term-conditions-and-integrated-care/integrated-care.aspx

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