

Evaluation of the Integrated Care and Support Pioneers Programme (2015-2020)

**Economic and impact evaluation of health and social care
integrated community-based Multi-Disciplinary Teams:
results from a survey of staff involved in MDTs**

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Summary

The Integrated Care and Support Pioneer programme, initiated by the Government to run over a five-year period (2013-18), aimed to improve the quality, effectiveness and cost-effectiveness of care for people whose needs are generally believed to be better met when the different parts of the health and social care system work in an integrated way. A first Wave (W1) of 14 Pioneers was announced in November 2013 and joined by 11 Wave 2 (W2) Pioneers in January 2015.

PIRU began a long-term evaluation in July 2015 to assess the extent to which the Pioneers were successful in providing coordinated care, including improved patient experience and outcomes, in a cost-effective way. [While the term 'patients' is used in this report, it refers to both 'patients and service users'.] The evaluation consists of a number of strands, conducted over a six year period, one of which is to carry out an economic evaluation of community-based multi-disciplinary teams (MDTs) in two (former) Pioneer areas.

Community-based MDTs are typically established to provide integrated care for patients and aim to encourage inter-professional collaboration and care coordination. For the purposes of our evaluation, we were specifically interested in those which included both health and social care professionals. MDTs are often, but not always, based around general practices, and encourage their members to exchange patient information and share ideas and make decisions on how best to intervene and deliver appropriate services. This should help prevent and reduce patients' health and care problems, unnecessary GP consultations, hospital and nursing home admissions, and even premature deaths. Evidence from earlier studies of MDTs are mixed, some showing improved service delivery and outcomes, while others show no effect or negative effects.

Our MDT evaluation is designed to assess the impact of MDT care on patients, aged 55 and over, who have multiple chronic conditions. It involves the use of mixed methods, including observations of MDT meetings, qualitative interviews with MDT staff and local strategic level managers, patients treated by MDTs and their informal carers, as well as surveys with these same groups (i.e. MDT staff, patients and carers). The evaluation also includes longitudinal analysis of administrative data pertaining to patients (e.g. hospital admissions and mortality) in these two areas. This report provides results on the MDT staff survey only. Future publications will bring together the different strands of the full MDT evaluation.

Our evaluation was undertaken in two (former) Pioneer areas covering four different MDT operating models and 11 MDTs. Pioneer 1 covers a dense inner city population, and includes eight MDTs all working to the same model, and is led by primary care. Pioneer 2 includes urban, suburban and rural locations, has 3 MDTs, two based around primary care, while the third is organised by an NHS acute hospital trust, which is also responsible for providing community health services.

Survey data collection

The MDT staff survey was carried out online and completed questionnaires were obtained from 70 respondents (Pioneer 1, n=26; Pioneer 2, n=44). About half the respondents were GPs (n=34), while the rest worked in other professions including nursing, social work, occupational/physio-therapy. Data collection was completed in the first quarter of 2020, before the first 'lockdown' was introduced by the Government on 23 March in response to the Covid-19 pandemic.

MDT membership and operation of meetings

In Pioneer 1, 92% of survey respondents said they considered themselves to be part of the MDT and 88% of them had attended MDT meetings in the last six months. The equivalent figures for Pioneer 2 were 66% and 55% respectively. MDT meetings in Pioneer 2 were reported to include individuals

from a wider range of professions/disciplines than did those in Pioneer 1 (e.g. hospital doctors and occupational-/physiotherapists were said to be regular attenders in Pioneer 2 but not in Pioneer 1).

Respondents in both areas held very similar, and overwhelmingly positive, views on the *operation* of MDT meetings. Of the 12 statements presented on how meetings operate, there were very low levels (and often no) disagreement. The highest levels of agreement were for allowing all those present at MDT meetings to participate fully, for consulting professionals on matters which pertain to them, and for meetings to facilitate the exchange of information between professionals, all of which are key objectives of MDTs. Somewhat lower levels of agreement, however, were found for meetings providing adequate time for discussion, for providing enough information for decisions to be made, and for being effective at reaching decisions.

Meeting attenders were also presented with nine statements on *how meetings affected their own work experience and satisfaction*. Again, views were highly positive, with over 90% of respondents in each area agreeing with nearly all nine statements (only two statements in Pioneer 1 and one statement in Pioneer 2 had rates of agreement below 90%, and they were all over 80%). The percentages selecting 'strongly agree' were slightly higher in Pioneer 1 than in Pioneer 2 for all but one statement. There were a couple notable differences by profession, with GPs more likely than other professions to strongly agree that the meetings increased their understanding both of the roles of other professionals and of local services available. Respondents in other professions were more likely than GPs to strongly agree that the meetings used their skills in a way that would be of greater benefit to patients.

Barriers affecting MDT

All respondents were asked about the extent to which eight potential barriers affected the working of their local MDT. In Pioneer 1, more than half of respondents identified five of the eight barriers as very or fairly significant, while in Pioneer 2, this applied to six of the eight barriers. In both areas, the barriers identified most often were financial constraints in social services and in the NHS, and insufficient local resources, followed by incompatible IT systems and a lack of appropriate local services. Respondents in Pioneer 2 were more likely than those in Pioneer 1 to identify eight of the barriers as very/fairly significant.

The differences between GPs and other professions were much larger than those between areas. GPs were more likely than other professions to mention financial constraints in social services and the NHS, insufficient local resources and lack of local services as barriers. Respondents in other professions were more likely than GPs to mention incompatible IT systems, information governance regulations and different professional cultures as barriers.

Impact of MDT on patient care

Respondents were shown 14 statements about the potential impact of MDTs on patients, and whether they provided *additional benefits* to patients aged 55 and over in comparison with patients who were not receiving MDT care. Respondents in Pioneer 1 were more likely than those in Pioneer 2 to agree with three of the statements on the potential benefits of the MDT, whereas respondents in Pioneer 2 were more likely than those in Pioneer 1 to strongly agree with 10 of the statements, including those more directly related to patient care (e.g. providing more patient-centred care, enabling more independent living, providing more timely care).

There were also some notable differences between GPs and other professions, with the latter more likely to strongly agree with 11 of the statements (although the differences were not always large). The greatest differences were for: increase voluntary, social, and community (VCS) involvement;

facilitate more innovative solutions; recognise unmet need; enable more patient-centred care; and reduce unplanned hospital admissions.

Conclusions

The MDTs in our study were overwhelmingly composed of NHS staff working in the NHS, with a majority in primary care. Some respondents expressed a desire for more diverse representation at meetings, in particular the inclusion of representatives from housing. Overall, MDT meetings were viewed in a favourable light, and they were thought to facilitate the exchange of information between professionals working in different fields, although some felt more time was needed to adequately discuss the patients referred. The biggest barriers to the successful working of the MDT were the lack of sufficient local services due to financial constraints within the health and care system. Despite these barriers, however, MDT meetings were seen to have a positive impact on staff work experience/satisfaction and to significantly benefit the care provided to patients on the MDT caseload.

1 Background

The lack of connectedness within and between the various elements of health and social care services throughout England is a common complaint, and leads to services that are judged to be inefficient and provide poor value for money, as well as leading to poorer patient experiences and outcomes (Goodwin et al 2012, Audit Commission 2011, Audit Commission 2009, Alltimes and Varnam 2012). There have been many attempts over the past several decades to integrate health and social care services, with one of the most common initiatives being community-based health and care Multi-Disciplinary Teams (MDTs). Recent national pilot programmes to integrate services include the Integrated Care Pilots in 2008, the Integrated Care Pioneers in 2013 (the subject of this report), and the New Care Model Vanguard in 2015. The twin pressures of an ageing population and financial austerity are widely seen to have increased this priority further, with the government undertaking more ambitious initiatives at a national scale including the launch in 2018 of Integrated Care Systems (ICSs) which are place—based and bring together partners in health, social care and public health to look after the health of a local community (NHS England 2019, House of Commons Committee of Public Accounts 2018, NHS England and Partners 2014, National Collaboration for Integrated Care and Support 2013). Integrated care is integral to the goal of meeting the ‘Triple Aim’ identified by the Institute for Healthcare Improvement (2014) of improved patient experiences and outcomes while delivering more cost-effective services.

The Government called for expressions of interest from the ‘most ambitious and visionary’ local areas to become Integrated Care Pioneers which would be capable of driving change ‘at scale and pace, from which the rest of the country can benefit’ (Department of Health May 2013). Each Pioneer was expected to: deliver improved patient experiences and outcomes; realise financial efficiencies; encompass whole system integration involving health, social care, public health and potentially other public services and the voluntary sector; and, importantly, make central to their plans the *Narrative on patient-centred care* developed by National Voices and Think Local Act Personal’s Making It Real (Department of Health May 2013).

Following recommendations from an expert panel, 14 Wave 1 Pioneer sites were announced in November 2013 (Department of Health November 2013). A second wave of 11 more Pioneers (the Wave 2 Pioneers) was announced in January 2015 (Department of Health 2015). The Pioneers were to be given access to expertise, support and constructive challenge from a range of national and international experts, but only very limited additional funding (£20,000 per site initially, later supplemented with a further £90,000).

Following an early evaluation of the Wave 1 Pioneers (January 2014 to July 2015) (Erens et al 2016), the longer-term evaluation aims to assess the extent to which all Pioneers are successful in providing ‘person-centred coordinated care’, including improved outcomes and quality of care, in a cost-effective way. The evaluation consists of a number of interdependent elements, one of which is an economic evaluation of health and social care integrated community-based MDTs, as MDTs are the most commonly reported initiative to integrate health and social care within Pioneers (Erens 2019). Community-based MDTs typically are established to undertake integrated needs assessment and care planning for patients, including developing new care pathways, and then to organise and deliver the resultant packages of care with the help of care navigators/coordinators. Teams may include new or extended roles for members, and may involve the voluntary and community sector (VCS) in addition to health and social care professionals. MDTs, which are often led by general practice, encourage their members to exchange patient information, community problems of service delivery, make shared decisions about how best to intervene, and engage in other processes, all of which should promote inter-professional collaboration and care coordination. That in turn could help prevent and reduce patients’ health and care problems, unnecessary general practitioner (GP)

consultations, hospital and nursing home admissions, and even premature deaths. Evidence from previous studies of MDTs are mixed, some showing improved service delivery and outcomes, while others show no effect or negative effects (O’Toole et al 2018, Seow et al 2014, Welch 2017, Smeltzer et al 2018, Anderson et al 2017, Rosenheck et al 2016, Fairhall et al 2014, Khan et al 2014, Spoorenberg et al 2018, Boulton et al 2013, Boland et al 2015, Bardsley et al 2013).

Consistent with the aims of the Pioneer programme, we defined a community-based MDT as one that: includes both health and social care, as well as allied healthcare, professionals, and in some instances, the voluntary and community sector (VCS); brings these professionals together in a shared process of care coordination; and has a caseload that includes people aged 55 and over with multiple long-term conditions, i.e. those whom evidence suggests often need complex care coordination and high levels of health and social care resources (Kasteridis et al. 2015, Martinez-Gonzalez et al. 2014). Our MDT evaluation was carried out in two of the former Pioneer areas, and examined four MDT models covering 11 different teams.

Pioneer 1, an entirely urban area within a large city, includes eight MDTs, all working to the same model. Each MDT is organised around a number of GP practices. Between them, the eight MDTs meet across a two-week cycle of 13 meetings. All eight MDTs in Pioneer 1 are administered by a dedicated team based in an NHS hospital trust.

Pioneer 2 is geographically large and includes urban, suburban and rural locations. It has three MDTs, with each MDT operating a different model. The first model (P2a) was initiated by a large local general practice and now has all but universal coverage of practices over a substantial urban and suburban area. It is managed from the original practice but has its own staff, meets every weekday and its meetings are chaired by its manager or specified GPs from several practices. The second model (P2b) was designed by GPs (from one local practice) in partnership with an adjacent care home for older people. The model is located in a small town and serves a highly rural area. The MDT includes a small number of beds in the care home contracted by the CCG and managed by the practice and care home manager. The team meets weekly, but the location and operation of the model facilitates more regular informal contacts. The third model (P2c) in Pioneer 2 was initiated by, and is led by, an NHS acute hospital trust covering the majority of the CCG’s territory. The MDT, itself, is based in a medium-sized town but also covers rural areas and commuter villages. The town contains a community unit. The team meets weekly to discuss both referrals from hospitals and from GPs. Key features of the MDT models are summarised in Table 1.1.

The MDT economic evaluation was designed to assess the impact of MDT care on patients/services users, aged 55 and over, who have multiple chronic conditions. It involved the use of mixed methods, including qualitative and quantitative components, and involved patients, informal carers and local strategic level managers working in CCGs and LAs as well as MDT operational and frontline staff. The evaluation includes longitudinal analysis of administrative data pertaining to patients (e.g. hospital admissions and mortality). This report provides results from one element of the MDT evaluation, that is, a survey carried out in the first three months of 2020 with (mainly) health and social care staff associated with the 11 MDTs (along with a several responses from MDT administrative staff).

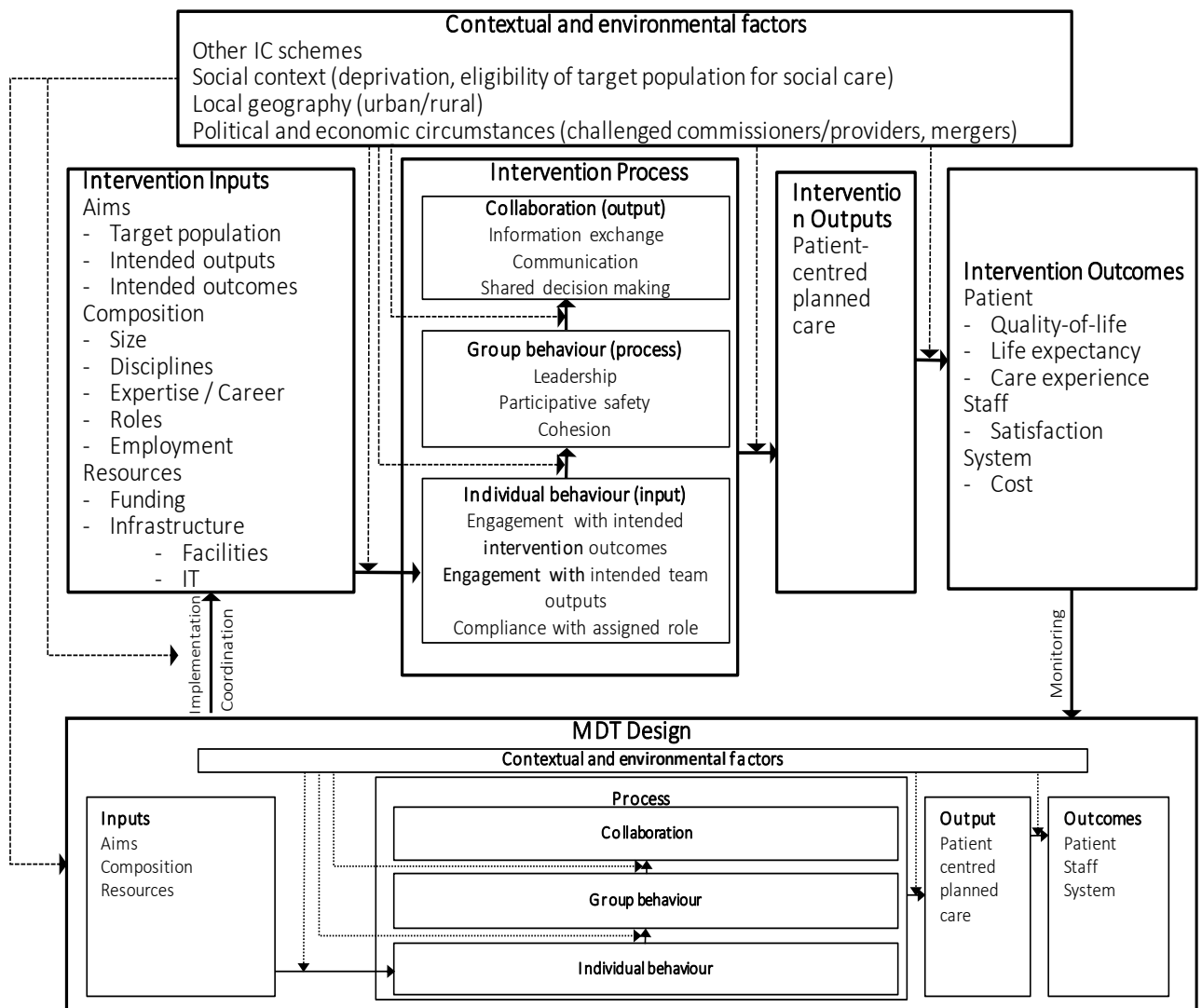
Table 1.1 Key features of MDTs within the two study areas

	Pioneer 1	Pioneer 2
Number of MDTs	8 MDTs	3 MDTs
Type of area	Dense urban area within a large city	Geographically large, covering urban, suburban and rural locations
Number of MDT models	1 model	3 models
How organised:	Each MDT organised around several GP practices	P2a and P2b organised around GP practices; P2c organised by a hospital trust serving a group of GP practices
Administration provided by:	A designated team in a hospital trust	P2a and P2b by practice staff; P2c self-administered by MDT staff
Meeting frequency	Weekly	P2a daily; P2b and P2c weekly
Chaired by	GP	P2a and P2b GP; P2c team manager
Caseload	Aged 18+; multiple long-term conditions; mental health conditions; physical or learning disabilities; social care needs	P2a and P2c Aged 18+; multiple long-term conditions; mental health conditions; social care needs; physical disabilities (P2c only) P2b Aged 65+, multiple long-term conditions; mental health conditions; physical or learning disabilities; social care needs

Based on the literature, we developed a conceptual model of MDT functioning (Figure 1.1.) This model guided all the components of the evaluation, including the development of the MDT staff survey questionnaire, the aim of which was to collect the views of (mainly) operational MDT staff on:

- whether the MDT meeting facilitates improved collaboration and coordination among different professions, especially across health and social care
- whether the MDT improves staff satisfaction and experience
- the extent to which the MDT provides additional benefits to patients
- barriers to the successful operation of the MDT.

Figure 1.1 Conceptual model of community-based MDT functioning



2 The survey design and procedures

We aimed to include in the survey a range of health and social care professionals, covering both managers and frontline staff, from all 11 MDTs in the two areas. In Pioneer 1, there was some overlap in membership between the eight MDTs; in Pioneer 2, the membership of the three MDTs was distinct, with no overlap.

MDT administrators were asked to provide names and email addresses for all staff who they considered to be members of their MDT(s). The number of staff names provided varied significantly by MDT model, as shown in Table 2.1. Each of the 150 staff members for whom we were provided with an email was sent an email invitation to take part in the survey.

An anonymous survey link was also provided to the administrator of MDT model 2a, who was asked to circulate the link to GPs and other health and social care staff who may be associated with the MDT but who are not directly part of the team. Similar anonymous links were provided to general practice managers for MDT models 1 and 2b, who were asked to circulate the link to all GPs within their practices.

The survey involved an online questionnaire, which included sections on: respondent characteristics; whether respondent attends MDT meetings; the operation of the MDT meetings; communication at MDT meetings; experience of MDT meetings; and benefits/outcomes of MDT meetings for staff and patients. The majority of the questions were pre-coded, with a few open-ended questions requiring respondents to type in their answers. The questionnaire was designed to take about 15 minutes on average to complete. A copy of the questionnaire is provided in the Appendix.

After an initial email invitation was sent to all 150 individuals on the sample frame, three further reminders were sent over the course of the fieldwork period. Overall, we obtained 49 completed questionnaires from those on the sample list, giving a response rate of 33%. A further 21 questionnaires were completed in response to the anonymous link.

Table 2.1: Issued and achieved samples by MDT model (N)

MDT model	Sample list: Issued	Sample list: Completed	Anonymous link: Completed	Total Completed
Pioneer 1	85	22	4	26
Pioneer 2a	27	15	14	29
Pioneer 2b	16	6	-	6
Pioneer 2c	22	6	3	9
Total	150	49	21	70

Given the very small sample sizes, especially for MDT models 2b and 2c, it is not possible to provide results by MDT model. This report will provide results for the overall sample (n=70) and for the former Pioneer area: Pioneer 1, n=26; Pioneer 2, n= 44. It should be noted that these are also small sample sizes, and the results need to be treated with caution. We also present results for Pioneer 2, which excludes Pioneer 2c; this is done because the Pioneer 2c MDT model is led by a hospital trust, whereas all the other MDT models are led by primary care. Presenting results for Pioneer 1 (n=26) and Pioneer 2 without model 2c included (n=35) enables a comparison between primary care-led MDT models in the two areas. Another comparison presented in this report is between respondents who are GPs (n=34) and those working in other professions (n=36).

The first email invitations were sent to staff for whom we were given emails in mid- to late-January 2020 (depending on the MDT). Email reminders were sent in late February and early March. The anonymous links were also sent to MDT administrators/Practice Managers in late February/early March 2020. All returned questionnaires were completed by mid-March (aside from one), before the Covid-19 pandemic led to the national “lockdown” in England on 23rd March. The month of completion for the achieved sample was:

Month of completion	N
January	47
February	4
March	18
April	1

3 Characteristics of the MDT staff sample

Respondents worked in the following organisations:

Table 3.1: Type of organisation by Pioneer (N)

Organisation	Pioneer 1	Pioneer 2	All
General practice/primary care provider	16	28	44
NHS acute trust	3	3	6
NHS mental health trust	1	1	2
NHS community health services trust	2	5	7
Local authority	1	4	5
Other (CCG, voluntary organisation, other)	2	2	4

Not answered = 2.

Nearly two in three respondents worked in primary care (65%), while one in five (22%) worked for an NHS provider (i.e. for an acute, mental health or community health services trust). Only 13% worked in a local authority or for another type of organisation.

Nearly half of respondents were GPs (49%), over one in four (29%) were nurses, and a further 7% were other NHS staff (including one hospital doctor and four physiotherapists/occupational therapists).

Table 3.2: Job title by Pioneer (N)

Job title	Pioneer 1	Pioneer 2	All
GP	16	18	34
Hospital doctor	-	1	1
Community nurse/matron	4	6	10
Other nurse	2	8	10
Physiotherapist/occupational therapist	-	4	4
Social work manager/social worker	1	3	4
Care coordinator	1	1	2
Other	2	3	5

Summarising Tables 3.1 and 3.2, it is clear that, in both MDT areas, the vast majority of respondents were health professionals and were working in primary care, for an NHS provider or for another NHS organisation (e.g. a CCG). Only six respondents worked in a non-NHS organisation (most often in a local authority). (For one respondent, it is unclear whether they worked in the NHS or elsewhere.)

Overall, three in five respondents (60%) had been working with their current employer for 10 years or more. By contrast, only 13% had been with their employer for less than 2 years: none in Pioneer 1, compared with 21% in Pioneer 2, had this short of a period with their employer (Table 3.6).

Table 3.6: Years worked for current organisation by Pioneer (N)

Years	Pioneer 1	Pioneer 2	All
Less than 1 year	-	3	3
1 to less than 2 years	-	6	6
2 to less than 5 years	8	4	12
5 to less than 10 years	1	5	6
10 to less than 15 years	5	7	12
15 years or more	11	18	29

Not answered = 2.

In terms of their personal characteristics, respondents were much more likely to be female than male (70% compared with 30%). Over two-thirds (69%) were aged 45 and over, 26% were aged 30-44, and 4% were aged under 30.

Given the different models of MDTs in the two Pioneer areas, and the different contexts in which they work, results for substantive findings are not shown for the total sample. Instead, three comparisons are provided:

- Pioneer 1 with Pioneer 2;
- Pioneer 1 with Pioneer 2 GP models only (P2a and P2b), to compare primary care-led MDTs operating in different contexts;
- GPs with other professions, since GPs are the main professional group within the MDTs examined, so may have different views from other professions who are less prevalent and more disparate within the MDTs. While it would be interesting to also compare results among other professional groups, the sample sizes for these groups are too small for this analysis.

4 Respondents' engagement with their local MDT

In order to assess how familiar respondents were with their local MDTs, they were asked a number of questions about their level of involvement with their MDT, including:

- Whether they consider themselves to be a part of the local MDT.
- Whether they have attended any of the regular meetings held by the local MDT in the last six months and, if so, how often they have attended. In Pioneer 1 only, whether they have attended meetings of more than one of the local MDTs in the last six months.
- Whether they have referred any patients/service users aged 55+ to the MDT in the last six months.
- Whether they have provided any care or treatment to patients aged 55+ referred to them by the MDT in the last six months.

Overall, 53 (76%) respondents said they considered themselves to be part of the MDT. Respondents in Pioneer 1 were more likely than those in Pioneer 2 to say they were part of the MDT (92% compared with 66%). Respondents who were GPs were less likely than those in other professions to consider themselves part of the MDT (68% and 83% respectively).

Twenty-three respondents (33%) said they had not attended any MDT meetings in the last 6 months, but the percentage saying this was much higher in Pioneer 2 than in Pioneer 1 (45% compared with 12%), which is no doubt a reflection of Pioneer 2 respondents saying they did not consider themselves to be part of their local MDT. Respondents who were GPs were less likely than those in other professions to have attended MDT meetings in the last six months (59% compared with 75%).

Among the 47 respondents who attended MDT meetings, the vast majority (n=33) attended meetings once a fortnight or more often (47% of all respondents, and 70% of those who attended any meetings in the last six months).

Table 4.1: Frequency of attending regular MDT meetings by Pioneer (N)

Frequency of meeting attendance	Pioneer 1	Pioneer 2	All
More than one MDT meeting/week	7	6	13
One MDT meeting/week	1	6	7
About one MDT meeting/fortnight	10	3	13
About one MDT meeting/month	1	2	3
Less than one MDT meeting/month	4	7	11
Have not attended any MDT meetings in last 6 months	3	20	23

In Pioneer 1 only, where we were aware that some professionals (e.g., social care managers) were attached to more than one of the eight local MDTs, respondents were asked whether they attended more than one local MDT meeting in the last six months: half (54%) attended meetings of only one MDT, while 35% attended meetings of more than one (and 12% attended no MDT meetings).

Table 4.2: Engagement with MDT in last 6 months by Pioneer (N)

Engagement with MDT	Pioneer 1	Pioneer 2	All
Attended MDT meeting	23	24	47
Referred patients to MDT	25	29	54
Provided care/treatment to patients referred by MDT ¹	21	26	47

¹Not answered = 6.

Just as respondents in Pioneer 1 were more likely than those in Pioneer 2 to attend MDT meetings in the last six months, they were also more likely to refer patients to the MDT during this period (96% in Pioneer 1 compared with 66% in Pioneer 2) and to provide care or treatment to patients referred by the MDT (84% compared with 67%). This is likely a reflection of the higher proportion of GP respondents in Pioneer 1, as 91% of GPs reported referring patients to the MDT and 76% said they provided care/ treatment to patients referred by the MDT.

Looking only at respondents who had not attended MDT meetings in the last six months, over 70% had either referred patients to the MDT or provided care to patients referred by the MDT (as had most of those who did attend the meetings). Thus, all but six respondents in our survey (one in Pioneer 1 and five in Pioneer 2) reported direct engagement with their MDT either by attending meetings, referring patients to the MDT, or treating patients referred by the MDT.

Respondents who said they had referred patients to the MDT were asked an open-ended question on what the most important considerations were in deciding to refer patients. A coding frame was developed by the researchers, and the coded responses are shown in Table 4.3 by Pioneer. The most common reasons for referral had to do with the patient's condition, either they had complex care needs (n=27) or were considered vulnerable (n=10). For example, one respondent said they referred *'complex patients who need a combination of medical (physical/mental) health issues as well as social care/housing'* (P1, respondent 33), while another would refer a *'patient [who] would usually have complex multi-layered problems not being served by the usual pathways'* (P1, respondent 39).

In Pioneer 2, however, the most common reason for referral to the MDT was to help avoid a hospital admission and enable the patient to continue living at home (n=14). One respondent said: *'I have also referred to the [MDT] to stop a patient having to be admitted to hospital to bridge the care gap until the care agency can start the care package'* (P2c, respondent 6). Other reasons for referral had to do with helping the GP/health professional, for example enabling them to access care for the patient, or to improve communication with other professionals (n=15). Examples of these types of referrals include: *'bridging communication holes'* (P1, respondent 30) and *'I can get support from the [MDT] regarding patient needs and advice'* (P1, respondent 43).

Table 4.3: Most important considerations when referring patients to MDT by Pioneer (N)

	Pioneer 1	Pioneer 2	All
Vulnerable/frail	4	6	10
Patient's past conditions/chronic conditions/complex care needs/multi-service needs	18	9	27
Patient has history of hospital admissions	2	4	6
In order to avoid hospital admission/help patient continue living at home	-	14	14
Facilitate discharge from hospital	1	-	1
Support GP/health professional: e.g. access help/care; improve communication; better coordinate care	7	8	15
Patient consent	2	-	2
Help patient navigate services	2	-	2
Professionalism/expertise of MDT	1	2	3
Repeat/multiple falls	-	2	2
Strain on carers	-	2	2
Lives in care home	-	1	1
Other/vague responses	1	2	3

Nearly all respondents who did not refer patients to the MDT most often said it was not their job to do referrals. However, other answers included that they did not know what the MDT offered and that the MDT was not convenient to access.

5 Views on the operation of MDT meetings

Respondents who had attended MDT meetings in the last six months were asked a number of questions about the operation of the meetings. First, they were asked to list which professions/disciplines regularly attend MDT meetings, and whether there any other professions/disciplines/organisations whose regular presence would benefit those attending the meeting or the patients discussed.

Table 5.1 shows the professions/disciplines identified by respondents as regular attenders at MDT meetings. Pioneer 2 had a wider range of professions/disciplines attending meetings, which is perhaps not surprising given that there are three different models of MDTs in Pioneer 2, compared with only one model in Pioneer 1.

Table 5.1: Health professionals/disciplines who regularly attend MDT meetings by Pioneer

Health professionals/disciplines	Pioneer 1	Pioneer 2	Pioneer 2 GP models only
GP	X	X	X
Hospital/specialist doctor		X	X
Practice nurse		X	X
District/community nurse/matron	X	X	X
Nurse practitioner	X	X	X
Other type of nurse	X	X	X
Occupational therapist		X	X
Physiotherapist		X	X
Mental health professional/worker	X	X	X
Social work manager/social worker	X	X	X
Care navigator/coordinator	X	X	X
Voluntary/community services representative	X	X	
MDT administrator/coordination	X	X	X
Other	x		

When asked if there were other professions/disciplines/organisations that do not regularly attend MDT meetings, but whose regular presence would benefit those attending or the patients they discuss, two-thirds (64%) said there were. The percentage suggesting the attendance of other professions/disciplines/organisations was higher in Pioneer 1 than in Pioneer 2 (78% compared with 50%). Respondents who thought other professions/disciplines/organisations should attend the meetings were asked to type in which ones, and it is clear from their responses that some of the professions/disciplines/organisations typed in were said by other respondents from that Pioneer to attend the meetings. With that proviso, Pioneer 1 respondents were most likely to mention having a representative from housing (mentioned by 10 respondents), followed by a social worker/social work manager (5); other mentions included secondary care support (2), mental health provider (2), community therapy (1); occupational therapy (1); learning disabilities team (1); and psychiatrist (1). In Pioneer 2, respondents mentioned mental health (3 respondents), community response team (3), district nurses (2), medical practitioner (1), pharmacist (1), representatives from all local general practices (1), community therapy (1), reablement provider (1), care of the elderly consultant (1), social worker (1), occupational therapist (1) and VCS representative (1).

Respondents were then asked if they agreed or disagreed with 12 statements about the operation of MDT meetings. The response scale was: strongly agree; somewhat agree; neither agree nor disagree; somewhat disagree; strongly disagree. The 12 statements were:

- MDT meeting rooms are able to comfortably accommodate everyone attending.
- MDT meetings are well planned and orderly.
- MDT meetings usually include the appropriate mix of skills and professions.
- MDT meetings facilitate the exchange of information among professionals.
- The atmosphere of the MDT meeting is comfortable and relaxed.
- Professionals attending MDT meetings are consulted on matters pertaining to them.
- MDT meetings provide opportunities to resolve differences in views and opinions on care options for patients/service users.
- MDT meetings are effective at reaching decisions.
- Everyone in MDT meetings can participate as fully as they need to.
- Enough information is provided at MDT meetings to enable appropriate decisions to be made about patients/service users.
- MDT meetings are chaired effectively.
- There is enough time at MDT meetings to adequately discuss all the patients referred to each meeting.

As Tables 5.2a and 5.2b show, in both Pioneers, there were very high levels of agreement with all 12 statements, and very little (and often no) disagreement (which is why somewhat and strongly disagree have been combined in the tables). (It should be noted that, in both Pioneers, there may be staff who choose not to attend meetings or otherwise engage with the MDT, and who may hold different, perhaps less positive, views.)

Focusing on the strongly agree response category, in Pioneer 1, the highest percentage was for the statement on MDT meetings facilitating the exchange of information between professionals (83%), followed by meetings having a relaxed atmosphere, having professionals consulted on matters relevant to them and allowing those present to participate fully (all 78% strongly agree). The lowest percentages were for having enough time to discuss all the patients (only 44% strongly agreeing with this), followed by the meetings being effective at reaching decisions (48%), and having enough information provided at the meetings to make decisions (52%).

Responses in Pioneer 2 were broadly similar to those in Pioneer 1 (also see Figure 5.1), although the percentages saying strongly agree tended to be very close to or a bit lower than in Pioneer 1. The three statements with the highest levels of strong agreement were allowing all those present at MDT meetings to participate fully (79%), meetings having a relaxed atmosphere (75%), and facilitating the exchange of information between professionals (71%). The lowest percentages were for the meetings being chaired effectively (only 33% strongly agreed with this), having enough time to discuss all the patients (42%), and having enough information provided at the meetings to make decisions (46%).

Figure 5.2 compares results to these questions for GPs and the other professions. While results are similar for eight of the 12 statements, GPs are much more likely than respondents in other professions to agree that: professionals are consulted appropriately; the meetings are chaired effectively; that meeting rooms are comfortable; and that there is enough time for discussion.

Table 5.2a: Views on the operation of MDT meetings: Pioneer 1 (row %)

MDT meetings:	Strongly agree	Somewhat agree	Neither	Strongly/somewhat disagree
Have comfortable rooms	57	22	9	13
Are well planned	70	30	-	-
Include appropriate mix of professions	70	13	4	13
Facilitate exchange of information	83	13	4	-
Have relaxed atmosphere	78	22	-	-
Enable professionals to be consulted on relevant matters	78	22	-	-
Provide opportunities to resolve differences of view about patients	65	26	9	-
Are effective at reaching decisions	48	44	4	4
Allow everyone to participate fully	78	22	-	-
Have access to enough information to take appropriate decisions	52	39	9	-
Are chaired effectively	65	35	-	-
Allow enough time to discuss all the patients referred	44	52	4	-

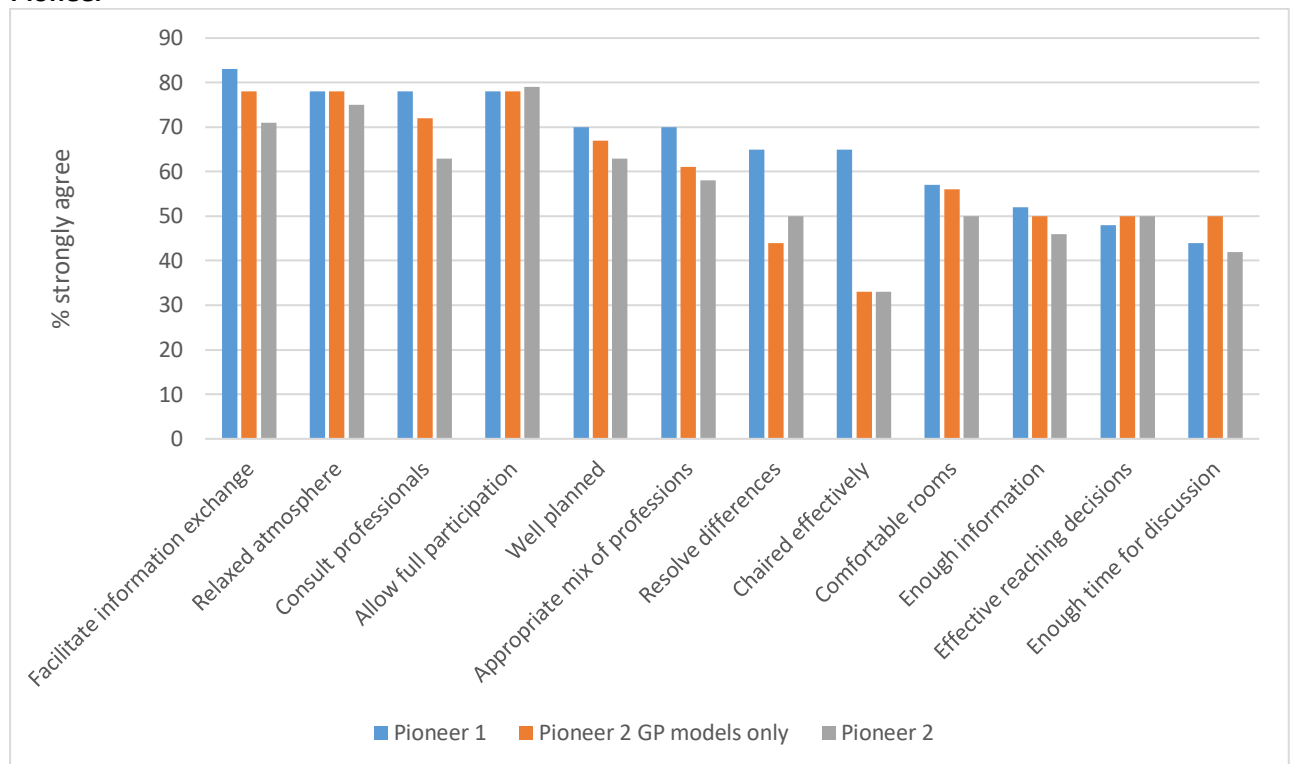
N=23

Table 5.2b: Views on the operation of MDT meetings: Pioneer 2 (row %)

MDT meetings:	Strongly agree	Somewhat agree	Neither	Strongly/somewhat disagree
Have comfortable rooms	50	37	4	8
Are well planned	63	33	4	-
Include appropriate mix of professions	58	29	4	8
Facilitate exchange of information	71	29	-	-
Have relaxed atmosphere	75	21	-	4
Enable professionals to be consulted on relevant matters	63	33	4	-
Provide opportunities to resolve differences of view about patients	50	46	4	-
Are effective at reaching decisions	50	50	-	-
Allow everyone to participate fully	79	21	-	-
Have access to enough information to take appropriate decisions	46	38	13	4
Are chaired effectively	33	63	4	-
Allow enough time to discuss all the patients referred	42	46	13	-

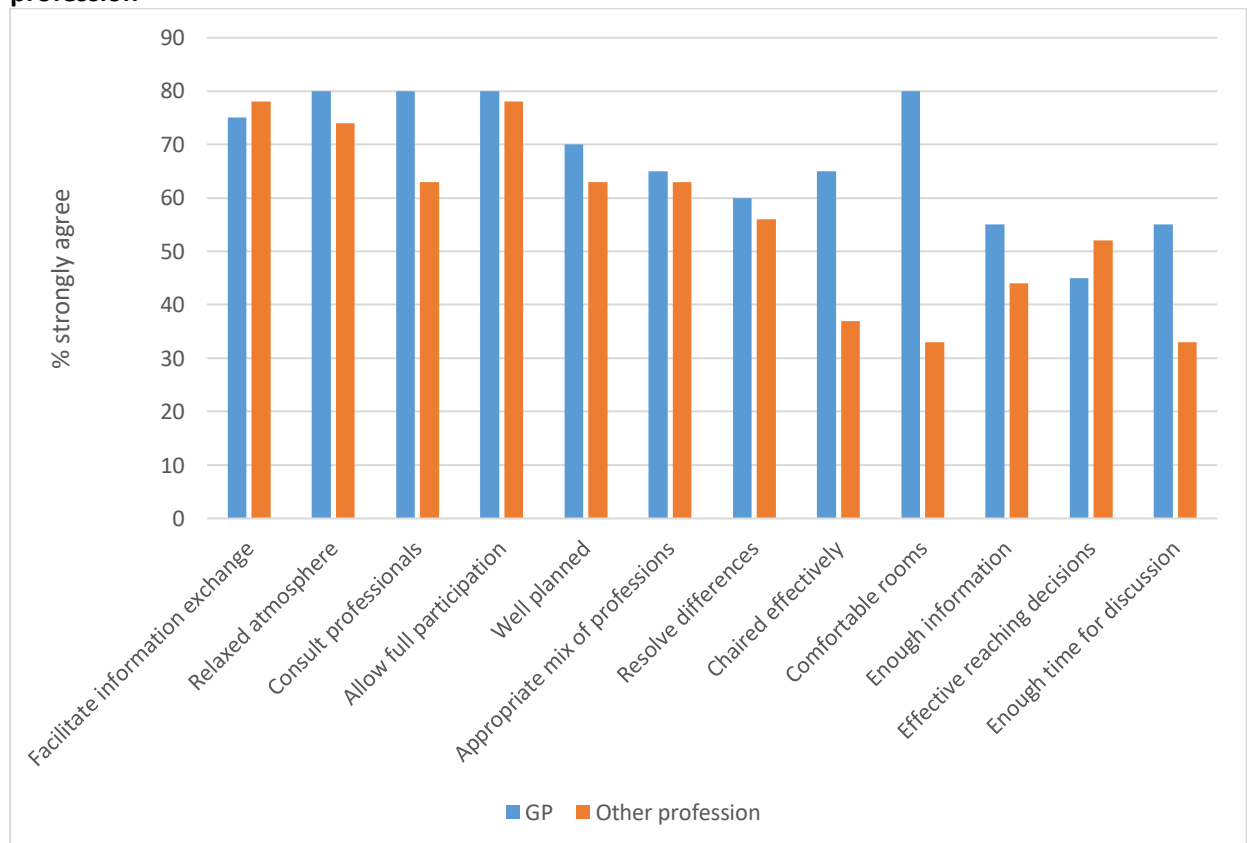
N=24

Figure 5.1: Views on the operation of MDT meetings: % strongly agree with each statement by Pioneer



Pioneer 1: N=23; Pioneer 2 GP models only: N=18; Pioneer 2: N=24.

Figure 5.2: Views on the operation of MDT meetings: % strongly agree with each statement by profession



GP: N=20; Other profession: N=27.

Nine respondents in Pioneer 1 said they attended more than one of the local MDTs in the last six months. When answering the attitude questions described above, they were asked to answer the questions in relation to one specific MDT (chosen at random from the MDTs they had attended). At the end of the section, these respondents were asked if they would give similar responses to the other MDTs they had attended: seven said they would (78%), and two of them said it depends/varies (22%).

Some comments were made about the meetings in the open-ended remarks at the end of the survey (which asked for any other comments on providing integrated care in their local area), both positive and negative. For example, one respondent said:

I really enjoy being part of the [MDT], it has enabled me to develop useful relationships with GPs and other professionals, I really appreciate the discussions we have and exchange of information and advice from different perspectives. I like being able to give direct feedback to the [MDT], giving updates and having a direct conversation if I need further support and guidance. I get a real sense that my input is appreciated and I really value the support I get from the team. You don't get this so much with organisations where the only contact is through email (P1, respondent 43).

We work hard as an integrated workforce to provide the correct support, at the right time in the right place (P2c, respondent 1).

On the other hand, several remarks were somewhat more critical of the MDT meetings:

Having only attended a few meetings, my observation is that when patients or service users are discussed they are considered in isolation and relatives and carers are often not taken into consideration and how their needs impact on the individual (P1, respondent 29).

I don't think the amount of time committed to this brings the appropriate benefit. A large amount of time wasted by professionals. GPs having to listen to other practices' patients is of minimal benefit and could be better spent seeing patients (P1, respondent 52).

I feel that it was a great shame that the social worker ... [was] removed from our team. When the service first started they were working as part of our team, physical[ly] sitting in the same office, but this was removed after 1-2 years (P2c, respondent 5).

Sometimes we discuss the unsolvable. I think this is so we can share the risk and support each other. Unfortunately we don't acknowledge this and keep trying to [do] the impossible and waste a lot of time (P1, respondent 52).

[The MDT is] responsive and motivated but could do with more team members in order to have the most impact. A lot of the work is reactive. It would be good if it could be proactive and identify and see frail elderly before they are admitted (P2a, respondent 13).

It works well when all support services are present, but we are quite limited when social services/mental health [are] not present (P1, respondent 44).

6 Barriers to the successful working of the MDT

All respondents were asked about barriers or challenges that may affect the working of their local MDT. This involved showing respondents eight statements, and asking them to select from the following response options: 'very significant barrier', 'fairly significant barrier'; 'not very significant barrier'; 'not a barrier at all'; 'don't know'.

The statements describing potential barriers to the successful working of their local MDT were:

- The different cultures of the professionals who participate in the MDT.
- Financial constraints in the NHS.
- Financial constraints in local social services.
- Lack of protected time to attend MDT meetings.
- Incompatible IT systems making it difficult to share patient/service user information/ records.
- Information governance regulations making it difficult to share patient/service user information/records.
- Lack of appropriate local services and support for the patients/service users to be referred to.
- Insufficient local health and social care resources to deal with the number of patients/service users referred on by the MDT.

Responses are shown in Table 6.1a for Pioneer 1 and Table 6.1b for Pioneer 2. (The 'don't know' response was not selected for any of the statements, so is not included in these tables.) Figure 6.1 compares the responses identifying each barrier as very or fairly significant by area.

While respondents in Pioneer 2 were somewhat more likely than those in Pioneer 1 to identify all of the eight barriers as being very or fairly significant (Table 6.1a, Table 6.1b, Figure 6.1), in general, the barriers identified in the two areas were very similar. The top two barriers in both areas were financial constraints in social services (79% in Pioneer 1 and 85% in Pioneer 2) and the lack of local health and social care resources (77% and 83% respectively). As one respondent wrote: *'Seems like a lot of talking but there are not the staff/services available to action tasks generated'* (P1, respondent 33). Two other barriers were also mentioned as very or fairly significant by around 70% of respondents in both areas: financial constraints in the NHS (Pioneer 1: 74%; Pioneer 2: 75%) and incompatible IT systems (Pioneer 1: 68%; Pioneer 2: 73%). In terms of IT, one remark was:

We also have no access to social services IT systems so are unable to see what input/contact patients have had with social services in the past....[Being] able to access this [would] help provide a more effective service and identify patients' needs more quickly (P2c, respondent 5).

In Pioneer 2, lack of appropriate local services was also mentioned by 74% of respondents (compared with 62% in Pioneer 1). The least significant barrier was the different working cultures between professionals: in Pioneer 1, 88% said this was not very significant or not a barrier at all, as did 85% in Pioneer 2.

As Figure 6.2 shows, there were some striking differences in views between GPs and respondents in other professions. GPs were more likely to identify as barriers: lack of appropriate local services/support; financial constraints in the NHS; and insufficient local resources. Other professions were more likely than GPs to identify as barriers: IG regulations making it difficult to share data; incompatible IT systems; and different cultures of professionals on the MDT.

Table 6.1a: Views on potential barriers to the successful working of MDT: Pioneer 1 (row %)

Barrier:	Very significant	Fairly significant	Not very significant	Not a barrier at all
Different professional cultures	8	4	38	50
Financial constraints: NHS	35	39	9	17
Financial constraints: social services	46	33	17	4
Lack of time to attend MDT	24	20	28	28
Incompatible IT systems	40	28	12	20
Information governance regulations	12	20	40	28
Lack of appropriate local services	15	46	31	8
Insufficient local resources	31	46	15	8

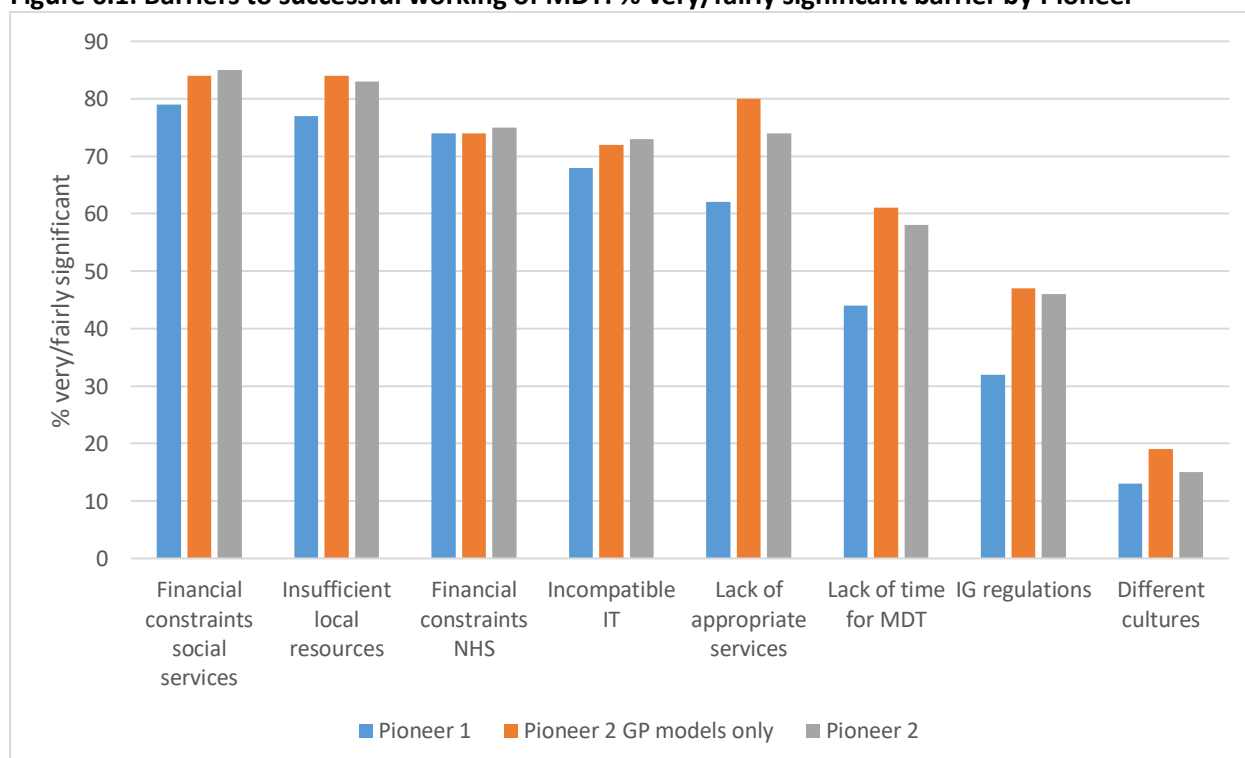
N=24 (bases vary slightly for each statement)

Table 6.1b: Views on potential barriers to the successful working of MDT: Pioneer 2 (row %)

Barrier:	Very significant	Fairly significant	Not very significant	Not a barrier at all
Different professional cultures	5	10	33	53
Financial constraints: NHS	25	50	23	3
Financial constraints: social services	39	46	12	2
Lack of time to attend MDT	19	39	14	28
Incompatible IT systems	34	39	22	5
Information governance regulations	10	37	41	12
Lack of appropriate local services	5	69	21	5
Insufficient local resources	40	43	18	-

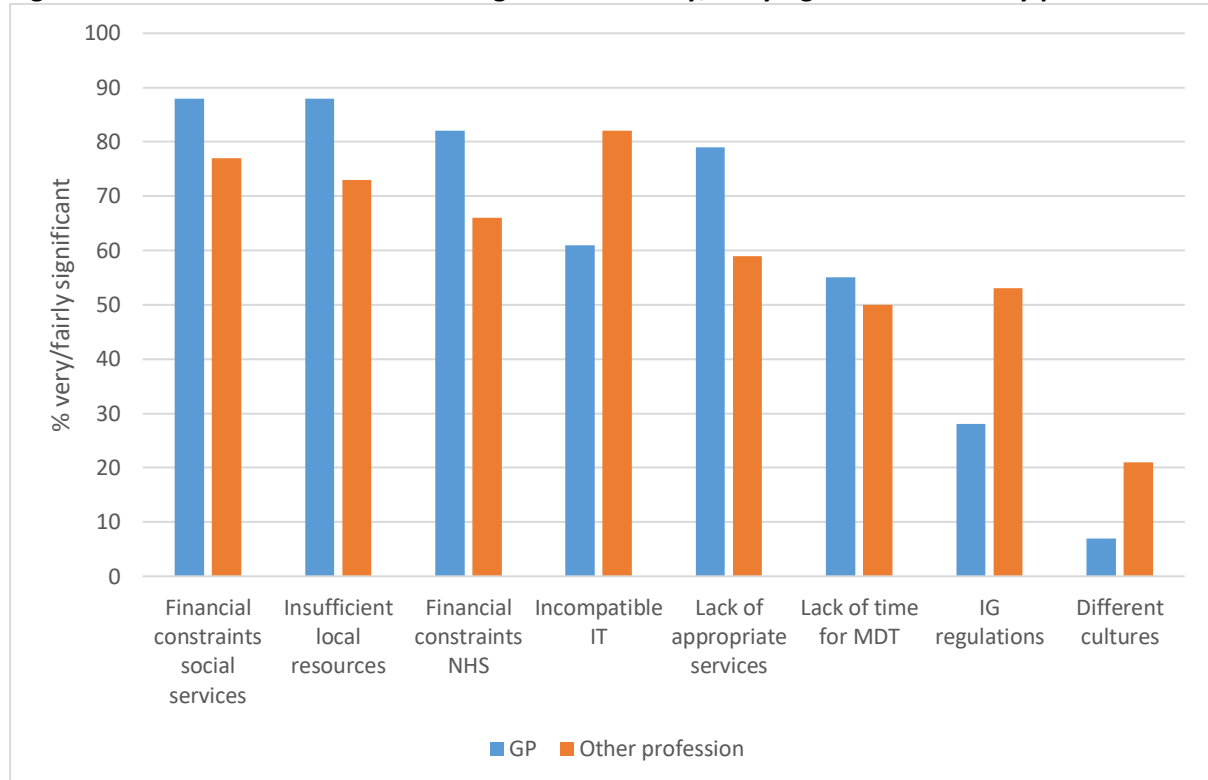
N=41 (bases vary slightly for each statement)

Figure 6.1: Barriers to successful working of MDT: % very/fairly significant barrier by Pioneer



Pioneer 1: N=25; Pioneer 2 GP models only: N=32; Pioneer 2: N=41 (bases vary slightly for each statement)

Figure 6.2: Barriers to successful working of MDT: % very/fairly significant barrier by profession



GP: N=33; Other profession N=33 (bases vary slightly for each statement)

Respondents were asked an open question whether they thought there were other services and support to which the MDT should have access to enable it to provide more comprehensive and integrated care. Responses to the code frame developed by researchers are shown in Table 6.2 for the 31 respondents who provided an answer. (Note that the numbers shown are N not %.) While a diversity of services/support was mentioned, those mentioned most often was social workers (n=8), other services like housing (n=6 all in Pioneer 1), other services like VCS, health promotion, respite beds, etc (n=6, mainly in Pioneer 2), and mental health/elderly specialists (n=5). One respondent said:

The team should be a true MDT with different MDT members actually sitting in the team on a daily working basis. The team currently comprises of a GP, 1 OT and multiple nurses. To be a true MDT requires social workers, physiotherapists, etc to sit directly in the team to be able to provide their specialist knowledge and skills to patients and other MDT members (P2a, respondent 14).

Another respondent pointed out the lack of engagement of local trusts:

...the Trusts involved do not necessarily value the work [of the MDT] as it does not fit into the usual boxes. Trusts are aware that new ways of working are important and part of the National Directive, however in day-to-day workings the Trusts do not appear to value the work or the MDT function as much as they should (P1, respondent 39).

Table 6.2: Other services and support MDT should have access to by Pioneer (N)

	Pioneer 1	Pioneer 2	All
Pharmacist	-	2	2
Social worker	4	4	8
Physiotherapist/exercise groups	-	1	1
Mental health/dementia/elderly specialists	3	2	5
Other specialists (e.g. occupational therapists, diabetes, learning disability)	2	1	3
Other services attending MDT (e.g. housing, benefits)	6	-	6
Other services available (e.g. VCS, respite beds, out-of-hours, social prescribing, support for non-English speakers, health promotion)	1	5	6
Improved IT (e.g. shared records, better internet, access to social work IT)	2	2	4
Better information (more up-to-date, better feedback to GP, earlier identification of patients, better promotion of MDT)	1	3	4
Other/vague responses	1	2	3

7 Impact of MDTs on staff work experience and on patient care

Respondents who had attended any MDT meetings in the last six months (see section 5) were asked how the meetings affected their work experience and satisfaction. Respondents were asked if they agreed or disagreed with nine statements:

The nine statements were:

The MDT meeting...

- Makes you feel part of a team in supporting and caring for patients.
- Increases your understanding of the role of others involved in planning and providing care.
- Increases your understanding about the services and resources that are available locally.
- Increases your trust in the other professionals/disciplines who attend the meetings.
- Helps you do your job better.
- Gives you the opportunity to go the extra mile in providing patients with the care they really need.
- Enables you to use your professional knowledge and skills in a way that is of greater benefit to patients.
- Increases your satisfaction in the role that you play in providing more person-centred care.
- Increases your satisfaction in the role that you play in providing more joined-up/coordinated care.

The response scale was: strongly agree; somewhat agree; neither agree nor disagree; somewhat disagree; strongly disagree.

Responses are shown in Table 7.1a for Pioneer 1 and Table 7.1b for Pioneer 2. Figure 7.1 compares the percentage of respondents selecting 'strongly agree' by Pioneer.

First, it is striking that very few respondents selected the disagree options; because of this, the somewhat and strongly disagree categories have been combined in these tables. In both areas, more than four in five respondents agreed with each of the statements on the positive impact of the MDT on their work experience/satisfaction. In Pioneer 1, at least two in three respondents said they strongly agree with all of the statements. In Pioneer 2, the percentage of respondents selecting strongly agree was lower than in Pioneer 1 for all the statements except for 'feel part of a team' where it was slightly higher (70% in Pioneer 1 compared with 79% in Pioneer 2). The largest differences between areas were for 'increase understanding of available local services' (83% strongly agree in Pioneer 1 compared with 67% in Pioneer 2) and 'helps me do my job better' (65% in Pioneer 1 compared with 50% in Pioneer 2).

As Figure 7.2 shows, the views of GPs and other professions were generally quite similar in terms of how the MDT meeting affected their work experience and satisfaction. GPs were more likely to strongly agree that the meeting increased their understanding of local services available and of the role of others involved in care provision. Other professions were more likely than GPs to strongly agree that their skills are used in a way to greater benefit patients.

Table 7.1a: Perceived impact of MDT meeting attendance on work experience: Pioneer 1 (row %)

MDT impact on work experience:	Strongly agree	Somewhat agree	Neither	Somewhat or strongly disagree
Feel part of a team	70	30	-	-
Increase understanding of others' roles	83	17	-	-
Increase understanding of available local services/resources	83	17	-	-
Increase trust in others	78	22	-	-
Helps do my job better	65	26	9	-
Allows me to go extra mile	65	17	17	-
My skills can be of greater benefit	65	26	4	4
Increased satisfaction due to more person-centred care	65	17	13	4
Increased satisfaction due to more coordinated care	74	13	4	9

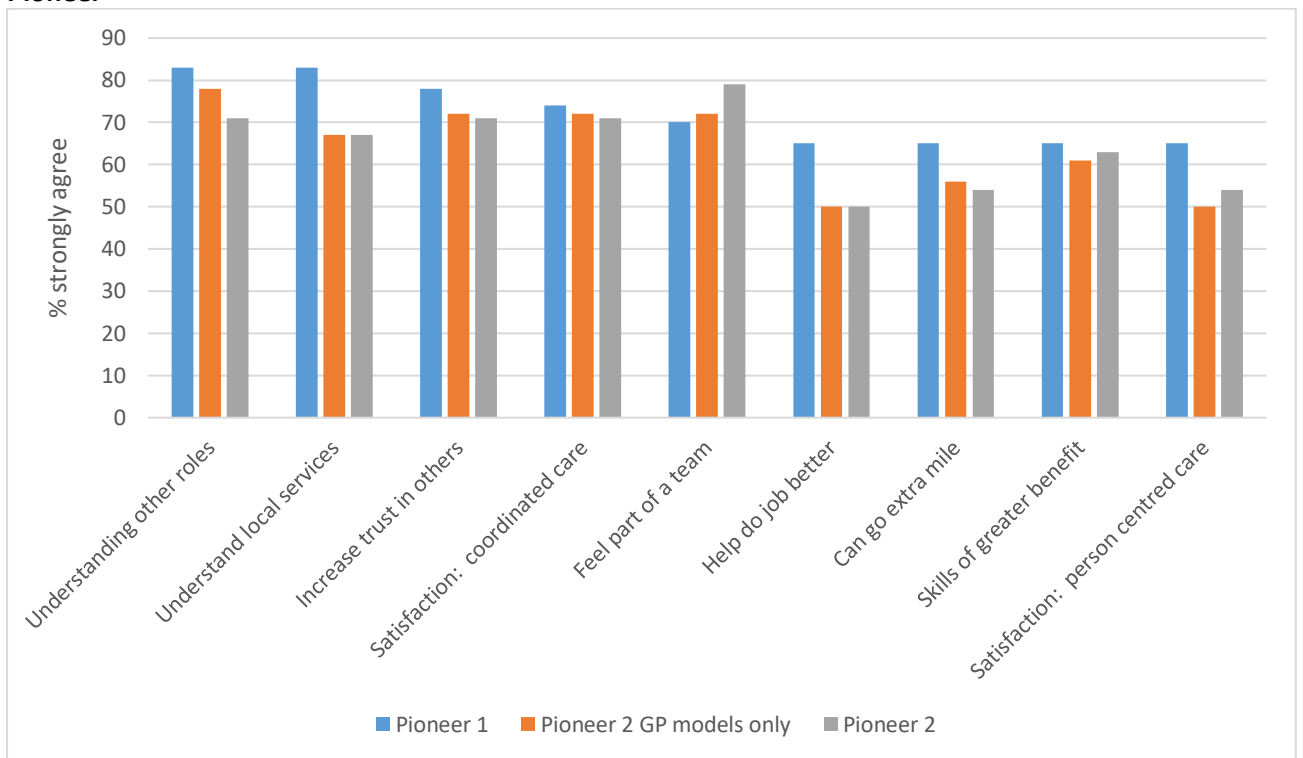
N=23

Table 7.1b: Perceived impact of MDT meeting attendance on work experience: Pioneer 2 (row %)

MDT impact on work experience:	Strongly agree	Somewhat agree	Neither	Somewhat or strongly disagree
Feel part of a team	79	17	4	-
Increase understanding of others' roles	71	29	-	-
Increase understanding of available local services/resources	67	29	4	-
Increase trust in others	71	29	-	-
Helps do my job better	50	33	8	8
Allows me to go extra mile	54	33	8	4
My skills can be of greater benefit	63	33	4	-
Increased satisfaction due to more person-centred care	54	38	8	-
Increased satisfaction due to more coordinated care	71	29	-	-

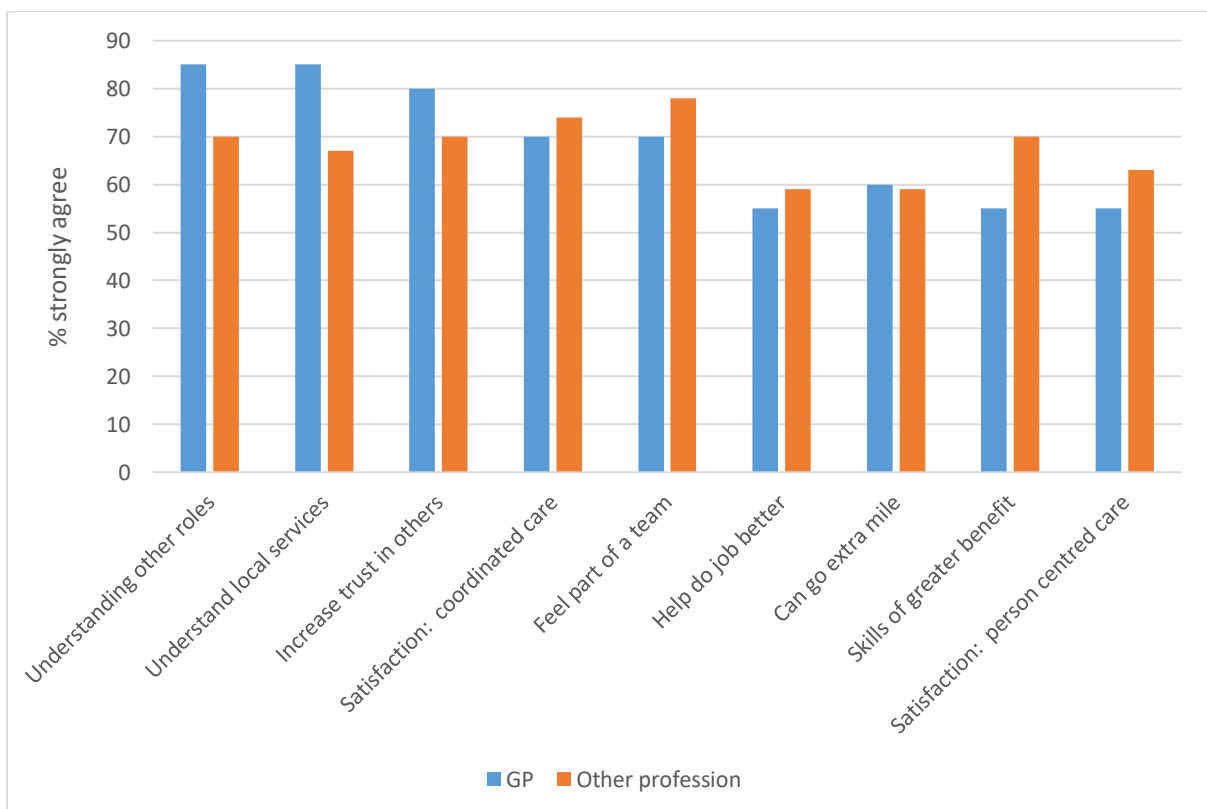
N=24

Figure 7.1: Perceived impact of MDT meeting attendance on work experience: % strongly agree by Pioneer



Pioneer 1: N=23; Pioneer 2 GP models only: N=18; Pioneer 2: N=24

Figure 7.2: Perceived impact of MDT meeting attendance on work experience: % strongly agree by profession



GP: N=20; Other profession N=27

Respondents were also asked how the MDT affected patient care and treatment. They were asked to think about whether there were **additional benefits** to patients aged 55+ who received care and support from the MDT in comparison with similar patients who were not receiving MDT care.

Respondents were asked whether they agreed or disagreed with 14 statements which asked:

Compared with similar patients who are **not** in the care of the MDT, does the MDT...

- Facilitate more innovative or creative solutions in caring for patients
- Increase the involvement of local voluntary or community organisations in the care of patients
- Facilitate data sharing about patients with other participating MDT professionals/ disciplines/ organisations
- Reduce duplication of assessments of patients
- Increase awareness among MDT participants of the different options available for providing care to patients
- Enable more patient-centred care and support to patients
- Make it more likely that patients will receive services that are joined-up and without gaps
- Make it more likely that patients will receive services that meet their needs
- Make it more likely patients receive services at the time they need them
- Better enable patients to live independently
- Make it more likely that unmet need among its patients is recognised and addressed
- Result in fewer unplanned hospital admissions among patients
- Result in fewer delayed discharges among patients
- Result in more efficient use of health and social care resources

The response options were: strongly agree; somewhat agree; neither agree nor disagree; somewhat disagree; strongly disagree.

Responses are shown in Table 7.2a for Pioneer 1 and Table 7.2b for Pioneer 2. Figure 7.3 compares the percentage of respondents selecting strongly agree by Pioneer.

Aside from one statement where responses were similar in the two areas (facilitate innovative solutions), there were often very large divergences of views between the areas. For three statements, Pioneer 1 was more likely than Pioneer 2 to strongly agree: increase VCS involvement; facilitate data sharing; and increase awareness of options. Pioneer 2 was more likely than Pioneer 1 to strongly agree on 10 of the statements, with very large differences between them on four statements: enable patients to live independently; provide more timely care; reduce delayed discharges; and reduce unplanned hospital admissions. Looking at the top four statements which respondents in each area were the most likely to strongly agree with, only one is shared by both areas (enable more patient-centred care). By contrast, the two statements with the highest levels of strongly agree in Pioneer 1 are ranked quite near the bottom by Pioneer 2 respondents: increase VCS involvement (72% strongly agree in Pioneer 1 compared with only 49% in Pioneer 2); facilitate data sharing (72% and 47% respectively). The statement with the second highest level of strongly agree in Pioneer 2 - reduce unplanned admissions - had the lowest level of strongly agree in Pioneer 1 (65% and 17% respectively).

Respondents in other professions were more likely than GPs to strongly agree with 11 of the 14 statements, although the differences were sometimes marginal (Figure 7.4). The largest differences were for: increase VCS involvement; facilitate more innovative solutions; recognise unmet need; enable more patient-centred care; and reduce unplanned hospital admissions.

Table 7.2a: Impact of MDT on patient care or treatment: Pioneer 1 (row %)

MDT impact on patient care:	Strongly agree	Somewhat agree	Neither	Somewhat or strongly disagree
Facilitate innovative solutions	52	28	16	4
Increase VCS involvement	72	20	8	-
Facilitate data sharing	72	20	8	-
Reduce duplicate assessments	36	28	28	8
Increase awareness of care options	64	32	4	-
Enable more patient-centred care	56	32	8	4
Provide more joined-up services	48	48	4	-
Better meet patient needs	56	36	8	-
Provide more timely care	28	60	12	-
Enable patients to live independently	28	60	12	-
Recognise unmet need	52	40	8	-
Reduce unplanned hospital admissions	17	54	25	4
Reduce delayed discharges	20	40	32	8
More efficient use of resources	44	24	24	8

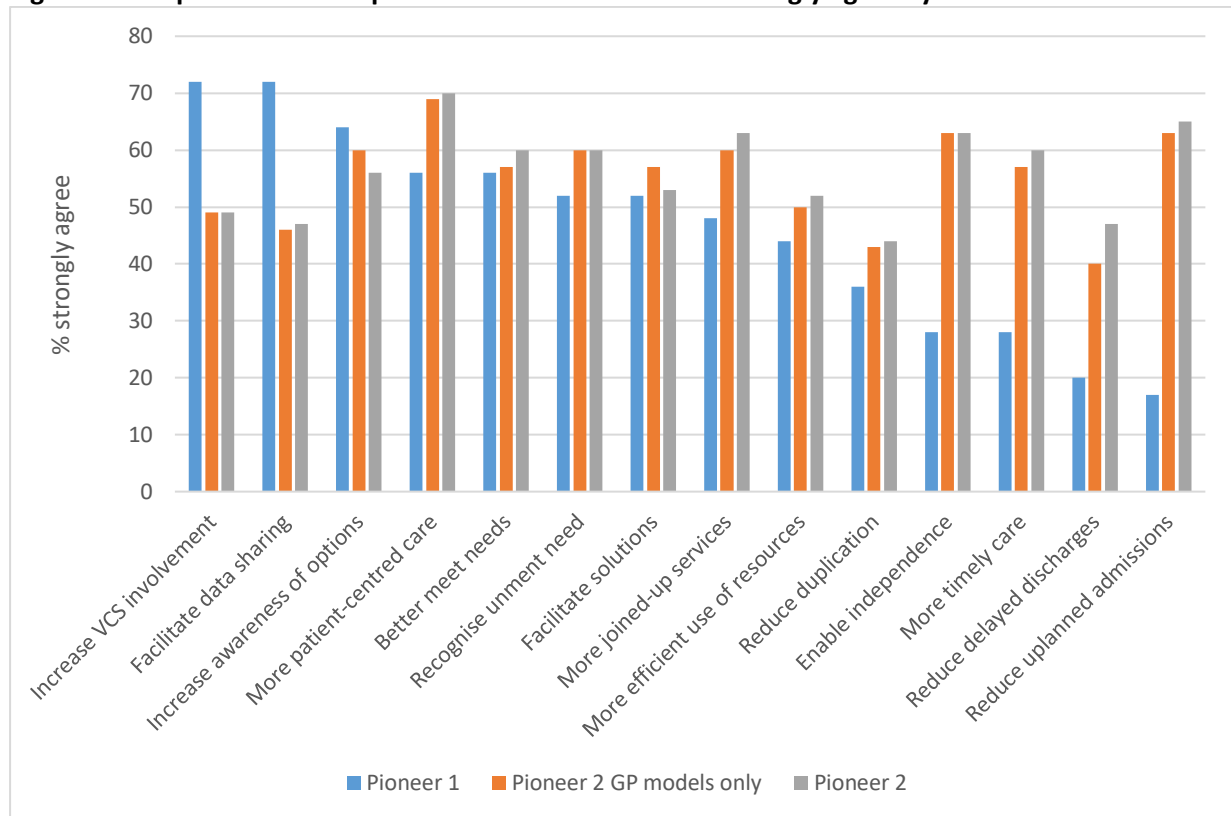
N=25

Table 7.2b: Impact of MDT on patient care or treatment: Pioneer 2 (row %)

MDT impact on patient care:	Strongly agree	Somewhat agree	Neither	Somewhat or strongly disagree
Facilitate innovative solutions	53	26	19	2
Increase VCS involvement	49	21	28	2
Facilitate data sharing	47	37	9	7
Reduce duplicate assessments	44	26	12	19
Increase awareness of care options	56	23	14	7
Enable more patient-centred care	70	19	9	2
Provide more joined-up services	63	28	5	5
Better meet patient needs	60	28	2	9
Provide more timely care	60	26	7	7
Enable patients to live independently	63	26	7	5
Recognise unmet need	60	33	2	5
Reduce unplanned hospital admissions	65	21	7	7
Reduce delayed discharges	47	30	14	9
More efficient use of resources	52	33	5	10

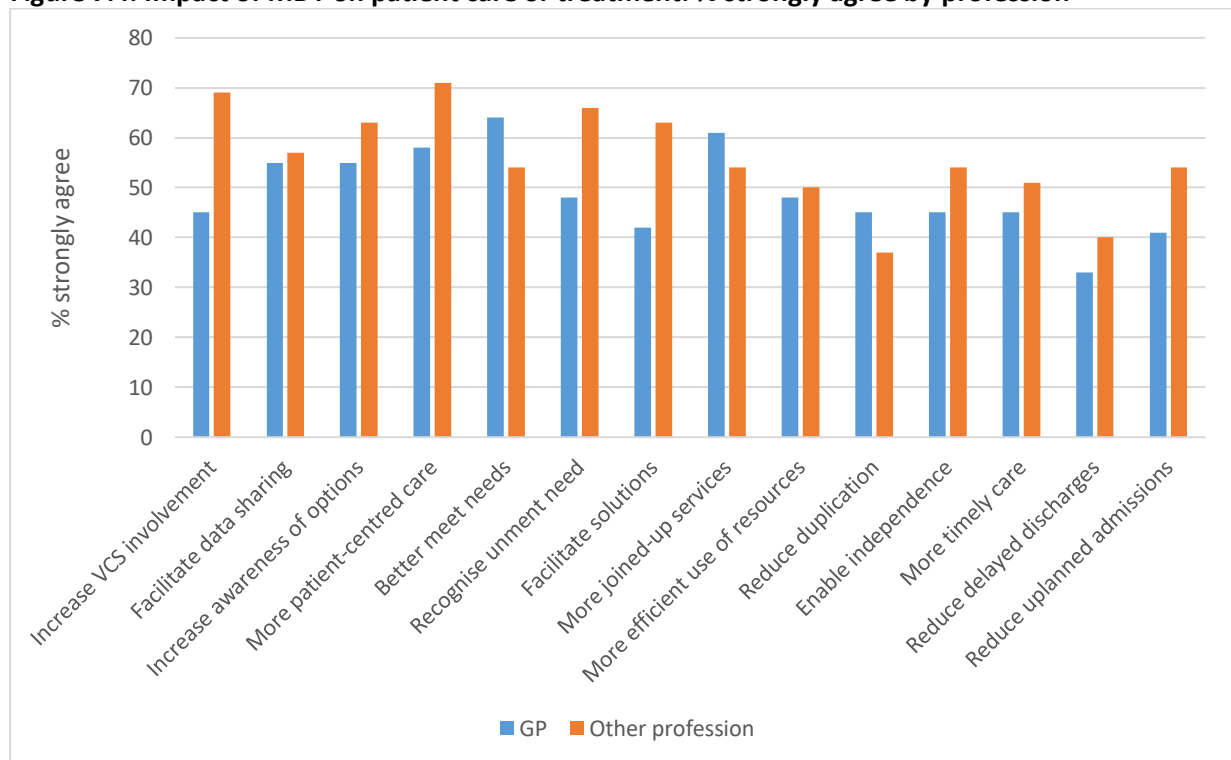
N=43

Figure 7.3: Impact of MDT on patient care or treatment: % strongly agree by Pioneer



Pioneer 1: N=25; Pioneer 2 GP models only: N=35; Pioneer 2: N=43 (bases vary slightly for each statement)

Figure 7.4: Impact of MDT on patient care or treatment: % strongly agree by profession



GP: N=33; Other profession N=35 (bases vary slightly for each statement)

Respondents were also asked to give a more general assessment of the impact of the MDT, with a question asking whether the MDT appropriately meets the care needs of: all of its patients; most of its patients; some of its patients; only a few of its patients; or very few or none of its patients (with a don't know option also provided).

The overwhelming majority in both areas felt their MDT met the care needs of all or most of its patients: 84% in Pioneer 1 and 91% in Pioneer 2. Respondents in Pioneer 2 were more likely to say the MDT met the needs of *all* of its patients (19% compared with 4% in Pioneer 1). In Pioneer 1, 12% of respondents said the MDT met the needs of only some/a few/none of its patients, as did 7% in Pioneer 2.

Table 7.3: Whether MDT meets care needs of its patients by Pioneer (%)

MDT meets care needs of...	Pioneer 1	Pioneer 2
All of its patients	4	19
Most of its patients	80	72
Some of its patients	8	5
Only a few of its patients	-	2
Very few or none of its patients	4	-
Don't know	4	2

Pioneer 1: N=25; Pioneer 2: N=43

Respondents who were GPs or in other professions were similarly likely to say that the MDT met the needs of all or most of its patients (GPs: 85%; other professions: 91%) (Table 7.4).

Table 7.4: Whether MDT meets care needs of its patients by profession (%)

MDT meets care needs of...	GP	Other profession
All of its patients	15	11
Most of its patients	70	80
Some of its patients	6	6
Only a few of its patients	-	3
Very few or none of its patients	3	-
Don't know	6	-

GP: N=33; Other profession N=35

Respondents were also asked whether they thought there were any types of patients not currently discussed by or referred to the MDT who they thought should be. In Pioneer 1, 13% of respondents thought there were, as did 8% of those in Pioneer 2. Those respondents were asked what other types of patients should be discussed by or referred to the MDT. Responses included younger adults, children, palliative care patients, and people who are not registered with a GP/ who do not typically engage with health and care services.

8 Discussion

Overall results

Community-based MDTs aim to provide better coordinated, integrated health and social care by improving information sharing, care coordination and professional collaboration across disciplines. As part of a wider evaluation of MDTs in two geographical areas in England, we carried out a staff survey covering 11 MDTs operating under four different MDT models. Nearly all of the 70 staff members who participated in our survey were closely engaged with the MDT in their area, either by attending meetings, referring patients to the MDT or treating patients referred by the MDT. Although our survey may therefore comprise a somewhat biased sample (since staff members who have less positive views of their local MDT may not be engaged with it and perhaps would be less likely to respond to our survey request), our respondents' views of their local MDTs were, overall, very positive. Respondents not only reported the MDT as improving their own work experience and satisfaction, but also that the MDT provided important benefits to patients, such as enabling more patient-centred care, better meeting patient needs, providing more timely care and enabling patients to live more independently.

Our respondents reported that the individuals attending their local MDT meetings were from a diverse range of professions. It is interesting to note that our survey respondents were overwhelmingly from the NHS (84%), with the majority from primary care. Although we cannot say how representative our sample is of MDTs in general, our sample appears to suggest that MDTs are likely to be dominated by health, rather than social, care professionals. This is perhaps not surprising given the range of health care professionals who attend these meetings, including GPs, hospital/specialist doctors, district/community/primary care nurses, mental health professionals, and occupational/physio-therapists. By contrast, representatives from non-NHS organisations are largely confined to social workers or social care managers and representatives from VCSs. This "imbalance" was reflected in the wish expressed by a significant minority of respondents in one of the areas to have representatives from LA housing attend their meetings.

The operation of MDT meetings themselves were viewed in a very positive light by respondents, who felt they facilitated the exchange of information, allowed the consultation and participation of all professionals in attendance, helped to resolve differences, etc. Many (but still only a minority of) respondents felt that the meetings could be improved by assembling more information in advance of the meeting and providing more time during the meeting to adequately discuss the patients referred. These findings align with those from another component of our MDT evaluation, namely, the research team's structured observations of the 11 MDTs' meetings (findings submitted for publication, September 2021), where we observed extensive information-sharing about patients, services and other local resources, collegiality, non-hierarchical shared decision-making about patient care, and, on occasion, the impact of time pressure on discussions towards the end of meetings.

Respondents also felt that MDTs were hampered by factors outside their control, most notably the financial resources available for social services and the NHS, which is also reflected in their view about the insufficiency of locally available services. Moreover, despite years of promising to improve IT infrastructure by national policy-makers, incompatible IT systems are still perceived as a barrier to more integrated working by MDTs.

On the other hand, it is encouraging that different professional cultures was not perceived to be a significant barrier by the majority of MDT attendees. This may provide an indication that perhaps some of the worst cultural divides between professions are being overcome, a view which may also be reflected in the largely positive opinions respondents expressed with regard to the comfortable

and relaxed atmosphere of the meetings, the fact that everyone who attended was given a chance to speak and for all the professions to participate as fully as they need to. Further evidence with respect to the possible erosion of cultural barriers between the professions is provided by a key informant survey undertaken as part of our wider evaluation of the Integrated Care Pioneers. This has involved a series of annual surveys over five years among senior (mainly strategic rather than operational) managers involved in integrating health and care services. When asked whether the different cultures of partner organisations is a barrier to integrating health and social care services, the percentages saying it was a very significant barrier has decreased over the past few years, from 28% in 2017 to 13% in 2020.

Differences between Pioneers/MDT models

Pioneer 2, which had two different models of MDTs – one based around general practice, the other around an acute hospital trust - had a wider range of professions attend their meetings than in Pioneer 1, which had only one model based around GPs. Even when looking only at the GP model MDTs in Pioneer 2, meeting attenders were still more diverse than those in Pioneer 1. While respondents in both areas generally held positive views about the operation and impacts of their MDTs, there were some differences in emphasis. Some of the differences between areas become less pronounced when the GP models only in Pioneer 2 is compared with Pioneer 1.

Many of the differences between areas/models are likely to be explained by the different contexts, caseloads and purposes of the MDTs, for example the wider range of professions who attend MDT meetings in Pioneer 2. The largest difference in views between areas on the impact of the MDT on work experience was to do with increasing the understanding of available local services; respondents in Pioneer 1 were much more likely to agree with this statement, perhaps because they are part of a more complex system within a dense inner city locality compared with the three MDTs in Pioneer 2. By contrast, the apparently larger impact on patient care reported by respondents in Pioneer 2 may be due to their individual caseloads being more homogeneous and/or having a more narrow focus.

Differences between GPs and other professions involved with MDTs

GPs tended to have more positive views than respondents from other professions with respect to the operation of MDT meetings, perhaps suggesting that the meetings are organised to suit their interests over other attendees.

GPs were more likely than respondents in other professions to identify financial constraints and insufficient local resources as barriers to the successful operation of the MDT. Those from other professions were more likely than GPs to mention incompatible IT systems and difficult IG regulations as barriers. GPs and other professions both felt that MDT meeting attendance positively affected their work experience, although with slightly different emphases. However, respondents from other professions were more likely than GPs to say the MDT had a positive impact on patient care/treatment.

Placing our MDT staff survey findings in the context of the MDT economic and impact evaluation

As noted earlier, this survey constitutes just one component of our economic evaluation of the impact of MDT care on patient outcomes and experiences, and informal carer and staff experiences. The survey findings shed light in particular on those components and processes in our conceptual model of MDT functioning related to collaboration (through information exchange, communication, and shared decision-making), and to outputs and outcomes, especially staff satisfaction. The topics covered in the survey have also been explored, along with those pertaining to other parts of our conceptual model, including the contexts in which the participating MDTs operate, and the resources available to them, in our qualitative interviews with strategic level managers and

operational and frontline MDT staff. Our analyses of the qualitative interview data, currently underway, are allowing us to describe and interpret, in greater depth than possible with a survey, staff perceptions of the processes and outcomes of care delivery through community-based MDTs, and in different contexts. As noted above, the survey findings resonate with those of our observations of MDT meetings. Findings from the staff survey, interviews and observations will be triangulated, and compared and contrasted with those related to patient and informal carer experiences, and patient outcomes, and framed in the context of the literature on community-based MDTs.

Conclusions

Our survey of staff connected with MDTs in two areas in England was part of a wider economic and impact evaluation looking at the operation and benefits of MDTs. The range of views obtained suggested that the MDTs in these two areas were broadly successful in facilitating information exchange between professionals working in different organisations and sharing decision-making with respect to patients on their caseloads. Attendees at MDT meetings increased their awareness of local services available, and felt the MDT improved their own work experience and job satisfaction. MDT staff also thought that the MDT led to improved patient-centred care and provided benefits for patients over and above those they would receive if they were not on the MDT caseload.

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Appendix A: MDT staff survey questionnaire

Q1.2 Health and Care Staff Survey 2019

The Policy Innovation & Evaluation Research Unit (PIRU) at the London School of Hygiene & Tropical Medicine (LSHTM) is undertaking this survey as part of its evaluation of health and social care integration activities in $\{e://Field/Area\}$.

The survey asks about your experiences of working together with professionals from your own and other organisations to provide services to **men and women aged 55 and over who need health and social care**. The survey asks questions about the multi-disciplinary team (MDT) in $\{e://Field/Area\}$, known as the $\{e://Field/MDTname\}$, and about how well the team is working.

The survey should take about **15 minutes** to complete. If you cannot complete it in one sitting, it will save your answers so you can return to it at another time.

Responses to the survey are **strictly confidential**. No-one outside the research team will be able to see your completed questionnaire or to identify your individual responses. No individual, service, organisation or MDT will be identified when we report on the survey results.

If you have any questions or comments about the survey, please contact Mustafa Al-Haboubi on 020 7299 4815 (mustafa.al-haboubi@lshtm.ac.uk) or Bob Erens on 020 7927 2784 (bob.eren@lshtm.ac.uk) between 9.30am and 5.30pm.

Completing the survey is entirely voluntary and you may withdraw at any stage. We would very much appreciate your help with this important survey.

To continue with the survey, please click 'I agree to take part in the survey' below.

- I agree to take part in the survey (1)

Q1.3 What is your profession/discipline/role? *Tick one only*

- GP (1)
- Hospital/specialist doctor (2)
- Practice nurse (3)
- Community nurse/matron (4)
- Nurse practitioner (5)
- Other nurse (please type in) (6) _____
- Occupational therapist (7)
- Physiotherapist (8)
- Mental health professional/worker (9)
- Social work manager/social worker (10)
- Care navigator/coordinator (11)
- Voluntary/community services representative (12)
- MDT administrator/coordinator (13)
- Health coach (14)
- Other (please type in) (15) _____

Q1.4 Your MDT

In $\{e://Field/Area\}$ there is a health and social care multi-disciplinary team (MDT) referred to as the $\{e://Field/MDTname\}$. Do you consider yourself to be part of this MDT?

- Yes (1)
- No (2)

Display This Question:

If Area != P1

Q1.5 **In the last 6 months**, have you attended any of the regular meetings held by this MDT? We are referring to the regular meeting that meets $\{e://Field/Frequency\}$.

- Yes (1)
- No (2)

Display This Question:

If Area = P1

Q1.6 **In the last 6 months**, have you attended any of the regular meetings held by this MDT?

- Yes (1)
- No (2)

Display This Question:

If In the last 6 months, have you attended any of the regular meetings held by this MDT? We are refe... = Yes

Or In the last 6 months, have you attended any of the regular meetings held by this MDT? = Yes

Q1.7 In the last 6 months, how often did you attend these regular MDT meetings?

- More than one MDT meeting per week (1)
 - One MDT meeting per week (2)
 - About one MDT meeting per fortnight (3)
 - About one MDT meeting per month (4)
 - Less than one MDT meeting per month / I attend only very occasionally (5)
 - Other frequency (please type in) (6)
-
- (I have not attended the regular MDT meetings in the last 6 months) (7)

Q1.8 In the last 6 months, have you referred any patients/service users aged 55 years or older to the $\{e://Field/MDT\}$?

- Yes (1)
- No (2)

Display This Question:

If In the last 6 months, have you referred any patients/service users aged 55 years or older to the ... = Yes

Q1.9 What is the most important consideration(s) in your deciding to refer a patient/service user (aged 55+) to the $\{e://Field/MDT\}$? Please type in

Display This Question:

If In the last 6 months, have you referred any patients/service users aged 55 years or older to the ... = No

Q1.10 What is the main reason you have not referred any patients/service users (aged 55+) to the $\{e://Field/MDT\}$? Please type in

Q1.11 In the last 6 months, have you provided any care or treatment to a patient/service user (aged 55+) referred to you by the $\{e://Field/MDT\}$?

- Yes (1)
 - No (2)
 - Don't know (3)
-

Display This Question:

If Area = P1

And In the last 6 months, how often did you attend these regular MDT meetings? != (I have not attended the regular MDT meetings in the last 6 months)

And In the last 6 months, have you attended any of the regular meetings held by this MDT? = Yes

Q1.12 You said you have attended regular MDT meetings. Which MDT meetings have you attended in the last 6 months? Tick **all that apply**

Display This Question:

If Area = P1

And And You said you have attended regular MDT meetings. Which MDT meetings have you attended in the last... q://QID88/SelectedChoicesCount Is Greater Than or Equal to 1

Carry Forward Selected Choices from "You said you have attended regular MDT meetings. Which MDT meetings have you attended in the last 6 months? Tick all that apply"

Q1.13 The next few questions are about the operation of the MDT meetings you have attended in the last 6 months. If you said at the previous question that you have attended meetings of more than one MDT in the last 6 months, we have selected one MDT at random. Please answer the questions in this survey thinking of the MDT meeting shown below. Please tick the right arrow key to continue.

Display This Question:

If Area = P1

And In the last 6 months, how often did you attend these regular MDT meetings? != (I have not attended the regular MDT meetings in the last 6 months)

And In the last 6 months, have you attended any of the regular meetings held by this MDT? = Yes

Q2.1

The next few questions are about the operation of the $\{Q1.13/ChoiceGroup/DisplayedChoices\}$ meetings you have attended in the last 6 months. First, which of the following professionals/disciplines regularly attend the $\{Q1.13/ChoiceGroup/DisplayedChoices\}$ meetings? Include your own discipline.

Please tick ALL that apply

- GP (1)
 - Hospital/specialist doctor (2)
 - Practice nurse (3)
 - District/community nurse/matron (4)
 - Nurse practitioner (5)
 - Other type of nurse (please type in) (6)
-
- Occupational therapist (7)
 - Physiotherapist (8)
 - Mental health professional/worker (9)
 - Social work manager/social worker (10)
 - Care navigator/coordinator (11)
 - Voluntary/community services representative (12)
 - MDT administrator/coordinator (13)
 - Health coach (14)
 - Other (please type in) (15) _____
- Don't know (16)

Display This Question:

If Area != P1

And In the last 6 months, how often did you attend these regular MDT meetings? != (I have not attended the regular MDT meetings in the last 6 months)

And In the last 6 months, have you attended any of the regular meetings held by this MDT? We are refe...
= Yes

Q2.2 The next few questions are about the operation of the $\{e://Field/MDT\}$ meetings you have attended in the last 6 months.

First, which of the following professionals/disciplines regularly attend $\{e://Field/MDT\}$ meetings? Include your own discipline. Please tick ALL that apply

- GP (1)
- Hospital/specialist doctor (2)
- Practice nurse (3)
- District/community nurse/matron (4)
- Nurse practitioner (5)
- Other type of nurse (please type in) (6)

-
- Occupational therapist (7)
 - Physiotherapist (8)
 - Mental health professional/worker (9)
 - Social work manager/social worker (10)
 - Care navigator/coordinator (11)
 - Voluntary/community services representative (12)
 - MDT administrator/coordinator (13)
 - Health coach (14)
 - Other (please type in) (15) _____

- Don't know (16)

Display This Question:

If Area = P1

And In the last 6 months, how often did you attend these regular MDT meetings? != (I have not attended the regular MDT meetings in the last 6 months)

And In the last 6 months, have you attended any of the regular meetings held by this MDT? = Yes

Q2.3 We would now like your views on how the regular **Q1.13/ChoiceGroup/DisplayedChoices** meetings operate.

- Tick the right arrow button to continue (1)

Display This Question:

If Area != P1

And In the last 6 months, how often did you attend these regular MDT meetings? != (I have not attended the regular MDT meetings in the last 6 months)

And In the last 6 months, have you attended any of the regular meetings held by this MDT? We are refe...
= Yes

Q2.4 We would now like your views on how the **regular $\{e://Field/MDT\}$ meetings** operate.

- Tick the right arrow button to continue (1)

Display This Question:

If In the last 6 months, how often did you attend these regular MDT meetings? != (I have not attended the regular MDT meetings in the last 6 months)

And If

In the last 6 months, have you attended any of the regular meetings held by this MDT? = Yes

Or In the last 6 months, have you attended any of the regular meetings held by this MDT? We are refe... = Yes

Q2.5 Do you agree or disagree with each of the following statements in relation to the regular MDT meetings you have attended in the last 6 months?

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
MDT meeting rooms are able to comfortably accommodate everyone attending. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MDT meetings are well planned and orderly. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MDT meetings usually include the appropriate mix of skills and professionals. (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MDT meetings facilitate the exchange of information among professionals. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The atmosphere of the MDT meeting is comfortable and relaxed. (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Professionals attending MDT meetings are consulted on matters pertaining to them. (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MDT meetings provide opportunities to resolve differences in views and opinions on care options for patients/service users. (7)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MDT meetings are effective at reaching decisions. (9)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Everyone in MDT meetings can participate as fully as they need to. (10)

Enough information is provided at MDT meetings to enable appropriate decisions to be made about patients/service users. (12)

MDT meetings are chaired effectively. (14)

There is enough time at MDT meetings to adequately discuss all the patients referred to each meeting. (13)

Display This Question:

If In the last 6 months, how often did you attend these regular MDT meetings? != (I have not attended the regular MDT meetings in the last 6 months)

And If

In the last 6 months, have you attended any of the regular meetings held by this MDT? = Yes

Or In the last 6 months, have you attended any of the regular meetings held by this MDT? We are refe... = Yes

Q2.6 Are there any professionals/disciplines/organisations that do not regularly attend MDT meetings, but whose regular presence would benefit those attending or the patients they discuss?

- No/Can't say (1)
- Yes (please type in below) (2) _____

Display This Question:

If Area = P1

And And You said you have attended regular MDT meetings. Which MDT meetings have you attended in the last... q://QID88/SelectedChoicesCount Is Not Equal to 1

And In the last 6 months, have you attended any of the regular meetings held by this MDT? = Yes

And In the last 6 months, how often did you attend these regular MDT meetings? != (I have not attended the regular MDT meetings in the last 6 months)

Q2.7 You answered the previous questions in relation to $\{Q1.13/ChoiceGroup/DisplayedChoices\}$ meetings. Would you give similar responses in relation to the other MDT meetings you have attended in the last 6 months?

- Yes (1)
- No (2)
- Can't say / depends / varies (4)

Display This Question:

If You answered the previous questions in relation to $\{q://QID96/ChoiceGroup/DisplayedChoices\}$ meet... = No

Q2.8 Why not? Can you briefly say how the other MDT meetings differ? *Please type in*

Display This Question:

If In the last 6 months, how often did you attend these regular MDT meetings? != (I have not attended the regular MDT meetings in the last 6 months)

And If

In the last 6 months, have you attended any of the regular meetings held by this MDT? = Yes

Or In the last 6 months, have you attended any of the regular meetings held by this MDT? We are refe... = Yes

Q3.1 The following questions ask about how the MDT meetings affect your work experience and satisfaction. Would you agree or disagree that the $\{e://Field/MDT\}$ meeting...

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
Makes you feel part of a team in supporting and caring for patients/service users? (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increases your understanding of the role of others involved in planning and providing care? (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increases your understanding about the services and resources that are available locally? (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increases your trust in the other professionals/disciplines who attend the meetings? (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Helps you do your job better? (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gives you the opportunity to go the extra mile in providing patients/service users with the care they really need? (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Enables you to use your professional knowledge and skills in a way that is of greater benefit to patients/service users? (7)

Increases your satisfaction in the role that you play in providing more person-centred care? (8)

Increases your satisfaction in the role that you play in providing more joined-up/coordinated care? (9)

Q4.1 The [\\${e://Field/MDT}](#) aims to coordinate the provision of health and social care services for patients/service users. The following questions are about barriers or challenges which may affect the working of the MDT.

To what extent do you think the following are barriers to the successful working of the [\\${e://Field/MDT}](#)...

	Very significant barrier (1)	Fairly significant barrier (2)	Not very significant barrier (3)	Not a barrier at all (4)	Don't know (5)
The different cultures of the professionals who participate in the MDT. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Financial constraints in the NHS. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Financial constraints in local social services. (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lack of protected time to attend MDT meetings. (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Incompatible IT systems making it difficult to share patient/ service user information/ records. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Information governance regulations making it difficult to share patient/ service user information/ records. (10)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lack of appropriate local services and support for patients/service users to be referred to. (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Insufficient local health and social care resources to deal with the number of patients/ service users referred on by the MDT.
(7)



Q4.2 Are there any other services and support to which the $\{e://Field/MDT\}$ should have access to enable it to provide more comprehensive and integrated care? *Please type in*

Q4.3 Are there any types of patients who are not currently discussed by or referred to the $\{e://Field/MDT\}$ who you think should be?

- Yes (1)
- No (2)
- Don't know (3)

Display This Question:

If Are there any types of patients who are not currently discussed by or referred to the ... = Yes

Q4.4 What other types of patients do you think should be discussed by or referred to the $\{e://Field/MDT\}$? *Please type in*

Q5.1 We would now like to ask about the difference you think the $\{e://Field/MDT\}$ makes to the care and outcomes of patients/service users. For the next few questions, we would like you to think about **whether the $\{e://Field/MDT\}$ brings additional benefits** to patients/service users aged 55+ who are receiving care and support from the MDT compared with similar patients/service users who

are **not** receiving MDT care. Compared with similar patients/service users who are **not** in the care of the MDT, does the [e://Field/MDT](#) ...

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
Facilitate more innovative or creative solutions in caring for patients/service users? (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increase the involvement of local voluntary or community organisations in the care of patients/service users? (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Facilitate data sharing about patients/service users with other participating MDT professionals/disciplines/organisations? (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reduces duplication of assessments of patients/service users? (14)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increase awareness among MDT participants of the different options available for providing care to patients/service users? (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Enable more patient-centred care and support to patients/service users? (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Make it more likely that patients/service users will receive services that are joined-up and without gaps? (6)

Make it more likely that patients will receive services that meet their needs? (7)

Make it more likely patients/service users receive services at the time they need them? (8)

Better enable patients/service users to live independently? (9)

Make it more likely that unmet need among its patients/service users is recognised and addressed? (10)

Result in fewer unplanned hospital admissions among patients/service users? (11)

Result in fewer delayed discharges among patients/service users? (12)

Result in more efficient use of health and social care resources? (13)

-

Q5.2 Overall, would you say that the [\\${e://Field/MDT}](#) meets the care needs in an appropriate way for...

- All of its patients/service users (1)
- Most of its patients/service users (2)
- Some of its patients/service users (3)
- Only a few of its patients/service users (4)
- Very few or none of its patients/service users (5)
- Don't know (6)

Q6.1 **Background Information** We would like to know a bit more about you and your work experience. Are you male or female?

- Male (1)
- Female (2)
- Do not identify with either / prefer not to say (3)

Q6.2 To what age group do you belong?

- 16-29 (1)
- 30-44 (2)
- 45-64 (3)
- 65 + (4)

Q6.3 What type of organisation do you currently work for or represent? *Tick one only*

- Clinical Commissioning Group (CCG) (1)
- Local authority (2)
- NHS acute trust (3)
- General practice (4)
- Other primary care provider (5)
- NHS Mental health trust (6)
- NHS Community health services trust (7)
- Voluntary or community organisation (8)
- Patient/service user/carer/citizen (9)
- Other (please type in) (10) _____

Q6.4 For how many years have you worked for this organisation?

- Less than 1 year (1)
- 1 year, less than 2 years (2)
- 2 years, less than 5 years (3)
- 5 years, less than 10 years (4)
- 10 years, less than 15 years (5)
- 15 years or more (6)

Q6.5 Lastly, if you have any other comments you would like to make about providing coordinated health and social care in this area, *please type them in here.*
