July 2021

Qualitative evaluation of South Warwickshire Place Based Teams

Final report

SQW

Contents

Contact:
Sarah Brown
Tel: 0161 475 2102
email: sbrown@sqw.co.uk

Approved by:
Graham Thom
Managing Director
Date: 30/07/2021

1. Introduction

1.1 In December 2019 SQW was appointed to undertake a qualitative evaluation of South Warwickshire's place-based teams (PBTs). The twelve teams were established as part of South Warwickshire Foundation Trust's (SWFT) Out of Hospital programme and were intended to support people with non-clinical needs to reduce or prevent inappropriate use of primary care. The rollout of the teams was staggered with the first teams going live in 2018 and the most recent in early 2020. The evaluation was intended to develop understanding of how the model was being implemented and working, including exploration of issues arising and identification of emerging good practice.

1.2 Initial scoping work was undertaken by SQW at the start of 2020 and a research protocol submitted in March 2020. However, due to Covid-19 the research was put on hold. The research resumed in September 2020 and refocused on the operation of the multi-disciplinary team (MDT) that sit within each PBT. The MDTs were deemed to be a more specific and identifiable intervention.

1.3 The MDTs bring together healthcare professionals and representatives from other statutory and voluntary and community sector (VCS) organisations within the local area. Patients are referred to the MDT if they are considered to have a social need that is affecting or may affect their health. The varied professional expertise and networks of the MDT can be utilised to identify appropriate solutions for the patient.

1.4 Each MDT has a clinical and a professional lead, both of whom are part of the local district nursing team. The teams meet weekly for one hour to discuss referrals, ongoing cases and those ready to be discharged. Some teams reduced the frequency and duration of their meetings in response to low levels of referrals during the Covid-19 pandemic and currently meet fortnightly for half an hour. The patient's holistic needs are discussed, with all attendees able to contribute their knowledge of the patient, ask questions, and add reflections on the appropriate course of action.

1.5 The study aimed to explore the following aspects of the MDTs:

- The rationale for intervention in the form of MDT meetings
- The aim and intended outcomes
- Operation of the MDT meetings (and any changes to delivery), looking at the referral process, operation of the meetings, and onward referrals/follow up
- Facilitators and barriers affecting implementation
- Learning arising from delivery experience
- Experiences of MDT attendees

- Potential improvements to the model.

1.6 The study also examined changes driven by the Covid-19 pandemic, including effects on referral numbers and sources, attendance at MDT meetings and new ways of working and their effectiveness.

1.7 The evaluation approach was based on observations of MDT meetings and interviews with meeting attendees, referrers to MDTs and recipients of referrals from MDTs, contextualised by analysis of available data relating to referrals and attendance.

1.8 The research was split into two phases:

- Phase 1 involved observations of six MDT meetings and interviews with several attendees at each meeting, amounting to 30 interviews in total. The observed meetings were proposed by SWFT and interviewees were proposed by the MDT leads. Data on referrals and attendees was collected where possible from MDTs and this was analysed to contextualise the qualitative outputs
- Phase 2 collected the perspectives of those stakeholders who refer, or who might be expected to refer but do not, into the MDT, and those involved in progressing actions identified through the meetings. A total of 14 interviews were conducted in this phase across six MDTs. Interviewees were proposed by the MDT leads.

1.9 Fewer interviews were conducted in Phase 2 than originally planned. This reflected a lower level of engagement and involvement in the MDTs from wider stakeholders than anticipated. Interviewees were primarily social prescribers, third sector organisations, for example Citizens Advice Bureau, and district nurses.

1.10 This report presents findings based on both phases of research. The following sections of the report cover:

- Section 2 – findings on the operation of the MDTs
- Section 3 – findings on outcomes
- Section 4 – findings on enablers, barriers and challenges
- Section 5 - reflections on findings.

2. Operation of MDTs

2.1 This section presents findings from the two research phases on the operation of the MDTs, covering evidence collected from: observations of six MDT meetings; interviews with the clinical and professional leads of those meetings plus several other attendees; interviews with stakeholders who are, or who might be expected to but are not, referring into the MDT; and interviews with those involved in progressing actions identified through the meetings. It is supplemented by a small amount of data regarding referrals into and attendees at MDT meetings.

Rationale and purpose

2.2 Interviewees across the six MDTs shared a similar understanding of the rationale behind the introduction of PBTs and the purpose of the MDT meetings. Two core aims were identified:

- To reduce pressure on primary and (perhaps to a lesser extent) acute services by identifying and supporting people with social needs, and perhaps medical needs if these were not already being addressed. Addressing these social needs was expected to avoid medical needs escalating, resulting in reduced use of primary care and fewer admissions to hospital. For example, loneliness, debt and unsafe living conditions could be tackled to avoid poor mental health, accidents and injuries, and the exacerbation of long-term conditions.
- To improve outcomes for patients by increasing and improving multidisciplinary working, bringing a range of professionals together to identify and address people's needs more quickly and more effectively. The combination of professionals with the expertise to address medical and social needs was seen to be valuable in supporting patients with a complicated or complex mix of problems.

> **"Everybody working collaboratively to get the best outcomes for that patient"**
>
> **MDT attendee**

2.3 There was a strong belief among interviewees that health issues are often closely linked with social issues, indeed that social problems can be at the root of health issues. This belief is central to the aim of using an MDT meeting to address patients' social needs in order to reduce pressure on upstream health services.

2.4 A small number of interviewees referenced the historical role of district nurses in providing holistic care (that is, addressing social issues alongside providing health care) compared to current service provision that does not have enough capacity to identify or address such issues. The identification of social issues by healthcare professionals was perceived to be a service gap that the MDTs were able to fill.

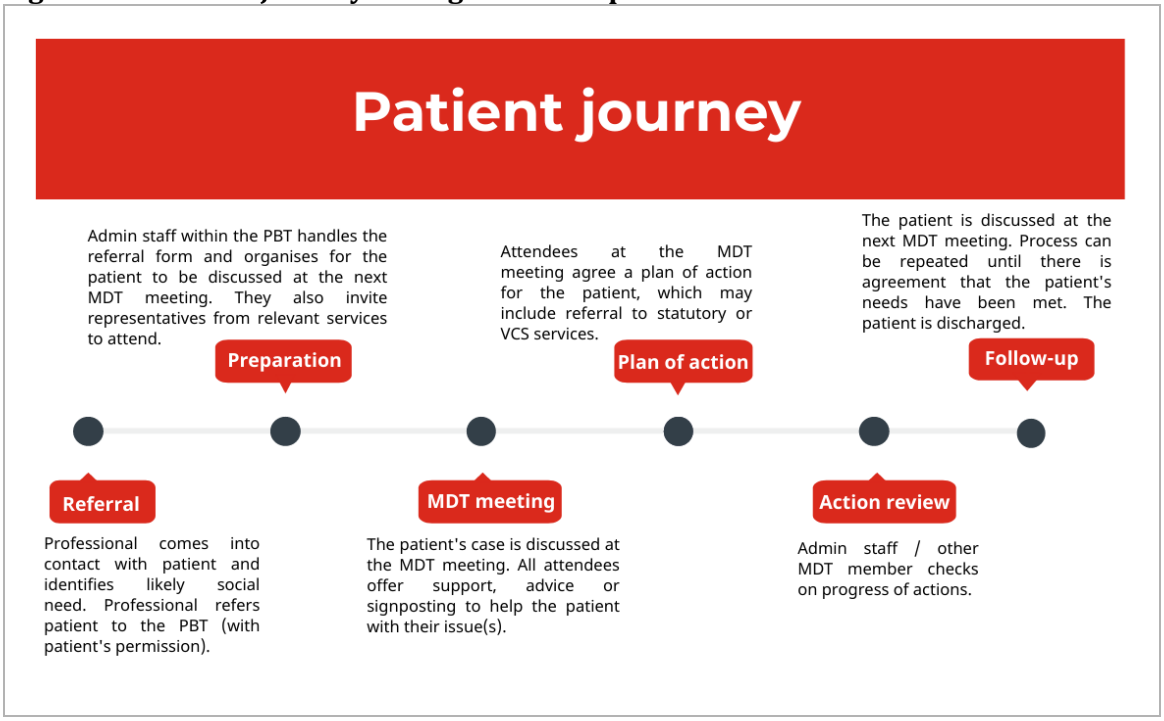
2.5 Interviewees from one MDT offered a more positive perspective on the purpose of the MDT meetings, namely that there was the opportunity to provide multi-disciplinary support and access support from a range of services and across the local community to help people "*live the life they want*" and support their families.

Operation of the MDTs

Patient journey

2.6 The graphic below (Figure 2-1) describes the patient journey through the MDT process. In terms of eligibility criteria, a patient only needs to be resident in Warwickshire with a social need that could affect their healthcare needs.

Figure 2-1: Patient journey through the MDT process



Source: SQW

Attendees

2.7 Four types of attendees are common to nearly all the MDTs. These were present during the observations, which were reported to be typical of MDT meetings (see Table 2-1):

- Each MDT has a **clinical lead** that always attends the meetings to provide clinical input. The inclusion of clinical expertise at the MDT meeting reassures referrers and attendees about the team's capacity to handle the risk associated with medical needs. Most clinical leads are from a district nursing background and are Band 7 (mid-seniority). They might have around one day per week allocated to MDT work.

- All teams also have a **professional lead** although this person does not always attend the meeting. In two of the six meetings observed, the professional lead did not participate in the meeting. Feedback in interviews indicated that their role was seen to be more about organisation and convening. The professional leads were from operational roles and of a similar level of seniority to clinical leads (Band 7).
- Five of the six teams had **administrative support**. The team without administrative support identified this as a problem in terms of placing a burden on a clinical member of staff who had to perform the administrative role.
- Five MDTs also had a **social prescriber from a VCS organisation** present, which was generally seen to be helpful in terms of the individual being able to bring good knowledge of local community support to the meeting.

2.8 There were variations across the teams in the other individuals present during the observations. For example, only one team had a dietician present and another was the only one with representation from the Department of Work & Pensions. A few of these other individuals were regular attendees in addition to those in the list above, including Fire & Rescue, local authority housing, and some of the SWFT representatives. Other attendees joined periodically depending on capacity and the case mix to be presented at the meeting. Three teams had recently brought in a care navigator to support the signposting and referral process, while one administrative role was also held by a care navigator. It is possible to distinguish between the core membership who undertook key roles (as described above), regular members who would be copied into all relevant correspondence and attend most meetings; and irregular attendees who would be approached to attend specific meetings.

Table 2-1: MDT attendees present during observations

Organisation	MDT 1	MDT 2	MDT 3	MDT 4	MDT 5	MDT 6
District nursing	• Clinical Lead • Professional lead • Care Navigator • Administrator	• Clinical Lead • Professional lead • Care Navigator • Administrator	• Clinical Lead	• Clinical Lead • Professional lead • Administrator	• Clinical Lead • Administrator x2	• Clinical Lead • Professional lead • Care Navigator • Administrator
Social prescribers	• Citizens Advice	• Health Exchange (VCS)	• Carers Trust		• Brunswick Healthy Living Centre (VCS)	• ConnectWELL(VCS)
Other	• Registered social landlord • Citizens Advice • Act on Energy (VCS organisation) • Carers Trust • Medical researcher	• SWFT (quality matron) • Coventry and Warwickshire NHS FT (mental health nurse) • Department of Work & Pensions • Local authority independent living service	• SWFT (assistant practitioner) • Citizens Advice • Act on Energy (VCS organisation)	• SWFT (dietician, assistant practitioner) • Housing department, local authority • Mental health, local authority	• Fire & Rescue	• SWFT (physiotherapist)

Source: SQW

2.9 Interviewees reported that, since launch, the following other organisations/roles had attended MDTs with varying degrees of frequency:

- Healthcare professionals such as home first nurses (offering out of hospital care), practice nurses, clinical practitioners, GPs and specialists e.g. dieticians, occupational therapists, physiotherapists, dementia care workers, hospice workers, mental health nurses
- Community services such as housing (both council and social), social services, fire and rescue service, environmental health, JobCentre Plus and police
- VCS organisations such as Age UK, Citizens Advice, Carers Trust, Alzheimer's UK, homeless charities.

2.10 Data show that the average number of attendees per meeting was seven, with most MDTs having a similar number of attendees, ranging from five to seven, with one MDT as an outlier with an average of 12 attendees (Table 2-2). However, it is not known how many attendees were at each meeting to understand any patterns in attendance. Interviewees indicated that attendance was determined by the number of referrals made and the needs reflected in those referrals.

Table 2-2: Average number of attendees for MDT meetings

PBT	Go live date	Average attendees per meeting
Atherstone	May 2018	4.8
Rugby South and Rugby North (joint MDT)	Oct 2018	7.3
Bedworth	Nov 2018	7.1
South Leamington and North Leamington (joint MDT)	Feb 2019	7.0
Camphill	Jul 2019	5.0
The Manor		5.0
Kenilworth and Warwick	Oct 2019	7.2
Stratford	Dec 2019	11.7
Southam	Jan 2020	5.6
Overall		6.7

Source: SWFT
Note: two PBTs did not provide information, so were excluded from the analysis (PBT10 – Alcester and PBT11 - Shipston)

2.11 Interviewees discussed how attendance was generally at its highest soon after launch and then dipped as people found it dropped down their list of priorities. This trajectory was exacerbated by the Covid-19 pandemic, when staff had to focus on core responsibilities and adapt to new ways of working, or were even redeployed.

2.12 Yet, for some interviewees, small core teams, with skilled, experienced, well-networked people, were seen to be effective and efficient: they viewed the commitment of these core staff

to MDT meetings as key to sustainability. The virtual MDT meetings introduced as a necessity because of Covid-19 restrictions have therefore been beneficial in both allowing core MDT team members to increase the frequency of their attendance due to the reduced travel time and supporting a slightly wider membership by improving access for staff who only need to attend on an ad hoc basis. Given the MDT funding only covered the clinical lead, professional lead and, in some cases, admin staff, attendance by other professionals was dependent on the goodwill of their manager and service. Making the MDT accessible and relatively low input was therefore important in supporting attendance from wider organisations.

2.13 However, some drawbacks to virtual meetings were noted:

- Clunky communication because of technical difficulties, accidentally speaking over one another, and no possibility of 'side chats'
- Greater challenges in building relationships with new attendees
- Limited access to private space for confidential discussions for some staff.

2.14 A significant number of interviewees expressed disappointment that attendance from GPs, mental health and social services had been extremely limited. They attributed this to limited capacity and/or a preference for referring patients with social needs elsewhere, for example to social prescribers employed by primary care. The introduction of primary care social prescribers may compensate for low attendance by GPs by providing a different link between MDTs and primary care, allowing GP referrals to come in via that route rather than directly and offering a route back to the GP where necessary. The low engagement from social care has remained source of frustration because of the belief that patients may need social care, or indeed already be in receipt of social care, and coordination with other agencies could improve outcomes.

Referrals

Numbers of referrals

2.15 SWFT shared data showing the total number of referrals received by each MDT. Since the first two teams went live in May 2018, there had been 589 referrals to October 2020 (for 10 teams and to February 2021 for the other two). Broadly, the teams that started earlier had the highest numbers of referrals. By dividing the total number of referrals by the number of months since a team went live, it was possible to calculate the average number of referrals per month for each team (see Table 2-3). This ranged from 0.6 referrals per month for Southam to 4.5 for Rugby South and Rugby North. The former was one of the newest MDTs, and the latter one of the oldest, as well as being a joint MDT, that is a single MDT meeting bringing together two PBTs. Most of the teams ranged from 2 to 4 referrals per month, with Southam and Shipston the outliers. The significantly lower number of referrals for these two newest teams is likely to be influenced by the Covid-19 pandemic, which caused most teams to pause activities and a lot of referrers to reduce activity.

2.16 The data did not show actual referrals by month so it was not possible to track referrals over time and draw inferences about performance of MDTs. SWFT was unable to provide these data due to local data recording by each MDT (collecting referrals by month would require manual data collection from each PBT).

2.17 There were no specific targets set for the MDTs but feedback from SWFT and the MDT members indicated that the referral numbers were below expectations (although no indication was given regarding expected numbers). Qualitative evidence from interviews suggested that teams took time to build up referrals and that referrals had never quite reached initial expectations before the Covid pandemic disrupted progress, as noted above. However, feedback from a small number of interviewees indicated that the MDTs were able to flex according to the number of referrals, reducing meeting duration and frequency to match lower numbers of referrals during Covid and stepping it back up when referrals began to rise. One interviewee reported that a small number of referrals was desirable given the relatively small scale of the MDTs and that the current rate meant each referral could be given sufficient time for thorough consideration. The small-scale of the MDTs was seen as advantageous as it facilitated the development of strong, trusting professional relationships and a good base of local knowledge. Even so, given the eligibility criteria are relatively broad, it is interesting that referrals were relatively low across all the MDTs even before Covid. This is explored further below.

Table 2-3: Referral data for MDT meetings

PBT	Go live date	Number of referrals	Average referrals per month
Atherstone	May 2018	83	2.8
Alcester		92	3.1
Rugby South and Rugby North (joint MDT)	Oct 2018	112	4.5
Bedworth	Nov 2018	88	3.7
South Leamington and North Leamington (joint MDT)	Feb 2019	70	3.3
Camphill	Jul 2019	32	2.0
The Manor		33	2.1
Kenilworth and Warwick	Oct 2019	36	2.8
Stratford	Dec 2019	28	2.5
Southam	Jan 2020	6	0.6
Shipston	Feb 2020	9	1.0
Total	-	589	2.6

Source: SWFT
Note: data covered the period from go-live to October 2020

Source of referrals

2.18 SWFT data for all teams showed that a range of healthcare professionals referred into MDTs. In those teams that provided the number of referrals from each source (some only indicated which organisations/roles referred in), district nurses were the most common source of referrals but it is not known how other sources of referral compared. This finding was also supported by evidence from the interviews with MDT members. Interviewees gave two reasons for the high proportion of district nurse referrals:

- The MDT meetings are led by the district nursing teams, with the clinical and professional leads being employed within district nursing, meaning district nurses are more likely to be aware of the MDT and the process for referring, as well as perhaps feeling responsibility to generate referrals.
- District nurses often visit patients in their homes which affords the opportunity to observe social needs such as cleanliness and temperature of the home, evidence of food purchase and consumption, hoarding, fire risks, and loneliness.

2.19 According to the data, other healthcare professionals making referrals included GPs, nurse practitioners, social prescribers/care navigators, occupational therapists and specialists, for example dieticians, psychiatric nurses and physiotherapists. Non-medical sources of referrals included housing teams, the fire service, police and social services. Interviewees suggested that there were very small numbers of referrals coming from these sources, even GPs, who were expected to be important sources of referrals. However, there were variations between teams, with some having made some progress in GP referrals prior to the pandemic.

2.20 Interviewees attributed the low referrals from sources other than district nursing in part to the existence of other services that can support these patients. For example:

- In 2019 NHSE funded one social prescriber for each Primary Care Network meaning most GP can refer patients with social needs directly to a social prescriber employed by primary care
- In January 2020 SWFT commissioned Age UK Warwickshire to deliver a social prescribing service for the South Warwickshire PBTs
- There are social prescribing schemes within the area such as ConnectWELL, which covers the Rugby local authority area
- Other local organisations also offer health and wellbeing support, for instance the Carer's Trust has Wellbeing Advice Workers.

2.21 Interviewees had mixed views on the range of options for supporting patients with social needs. About half considered that there were advantages to having multiple different professionals performing a similar role. First, different services and roles, such as care navigators and social prescribers, have different knowledge and experience so they can support rather than replace each other. Second, the risk of duplication was perceived to be

small while demand was high. The other half of the interviewees considered low referrals to be a consequence of the new hospital-based social prescribers and were frustrated that the investment in establishing the MDT and training care navigators was being wasted.

2.22 Interviewees also attributed low referrals to a lack of clarity regarding referral criteria. A couple of interviewees spoke about referrals that were returned as 'inappropriate'. While there was a general understanding that MDTs were intended to address cases of mixed social and medical needs, much of the confusion seemed to relate to the level of complexity that MDTs could deal with and differing understanding as to what constituted 'complex'. Stakeholders explained the local definitions of simple, complicated and complex cases:

- Simple – patients with only a single issue that can be addressed by one agency
- Complicated – patients with multiple issues that can be predicted and addressed in a planned and coordinated way between agencies
- Complex – a patient has multiple issues that interact with each other in unpredictable ways and where multiple solutions may be tried before it becomes clear what approach will work to resolve the case.

2.23 It appeared that MDTs were being used for all three types of case, although the rationale for the MDTs was that their multidisciplinary strength would be an efficient way to deal with complex cases that were harder to resolve by single agencies. In future, setting clearer criteria and definitions for cases would help stakeholders refer the most appropriate cases and prevent referrals being refused, which may avoid discouraging referrers.

The range of cases

Simple: *Male patient who is cared for by his wife (as a sole carer). The man requested a befriender and the district nurse made a referral to Age UK, although action was delayed due to COVID-19. Details on the Carers Trust and local hospice were also shared with the man and his wife.*

Complicated: *Middle aged woman, grieving for mum with a recent diagnosis of diverticulitis. The woman identified weight-loss as key issue to improve her self-image. Two referral routes were undertaken: to Cruse and Myton services for bereavement support and counselling; and registration with a dietician for diet clinics at the GP surgery.*

Complex: *One lady hadn't left her house in five years, which was affecting her physical and mental health. The MDT assessed her needs. Different options were considered, including befriending. Observation at a home visit identified that she could not access her garden. The MDT arranged to get a ramp fitted to her property so she could go into the garden to improve her physical and mental health. The support was delivered by the housing association in partnership with Citizen's Advice.*

2.24 Some potential referrers were also reportedly discouraged from referring due to the additional administrative burden involved in referring to an MDT instead of community nursing, PCN social prescribing or similar (an MDT referral required an email rather than an EMIS referral within the primary care system). **MDTs have taken action to improve referrals**, mainly through frequent communication with potential referrers. For instance, the administrator in one team sent a weekly email to the district nursing team reminding them of issues to consider when visiting patients, including: 'Are they lonely?' 'Are they struggling for food?' 'Are they struggling to pay their bills?' The administrator also sent a weekly email to the MDT attendees with the agenda and minutes, the patient leaflet, and the referral form. This prompted attendees to make referrals. Teams also spent time trying to engage GPs, for example by presenting at learning sessions and talking to practice staff. However, one interviewee indicated that positive relationships had not translated into referrals and felt somewhat frustrated by this.

2.25 **The Covid-19 pandemic reduced referrals significantly**. At the time fieldwork was conducted (April 2021), they remained low but with some signs of an increase. The drop-off was attributed mainly to services reducing or entirely halting face to face interactions with patients, limiting opportunities to identify patients with social needs. Due to the lack of service options available, some interviewees also chose not to refer cases in as they could not be addressed at that time. A small number of interviewees suggested that as services became busier with their core work, they were less able to maintain awareness of wider services such as the MDTs, to which they might only refer intermittently.

2.26 The reduction in referrals led to some teams changing their weekly meetings to fortnightly. Some teams paused meetings for a few months after lockdown restrictions were introduced and re-started during the summer as restrictions eased.

Reason for referrals

2.27 According to data provided by SWFT, referrals broadly fell into three main categories: social isolation and loneliness, which was the most frequent reason for referral; living conditions and housing, the second most common reason; and mental health issues such as anxiety, depression, and bereavement. Other reasons for referral included substance abuse, financial problems and debt, hospital admittance, carers support, disability support e.g. mobility aids and daily support (e.g. support with shopping).

2.28 Interviewees reported similar types of reasons for referral. When reflecting on the range of needs identified, several interviewees characterised the MDT as a kind of safety net that can catch concerns that do not fit neatly into a health or medical category and hence can be overlooked by busy healthcare professionals. In some cases interviewees suggested that the MDTs were unique in offering this inclusive service, although sometimes this followed contradictory claims regarding duplication with other services and interventions.

2.29 For some MDTs, the Covid pandemic has not affected the type of referrals, even where it has reduced the overall volume. However, most MDTs experienced some changes to the nature of

referrals for following the introduction of Covid-19 restrictions at the end of March 2020, including:

- New needs for delivery of food parcels and grocery shopping
- An increase in people suffering from social isolation and loneliness.

2.30 An interviewee from one team specifically mentioned an increase in issues with hoarding as people were confined to their home.

Destination of onward referrals

2.31 After the initial referral is brought to the meeting and the patient's needs discussed, an action plan is agreed. Actions include referral or signposting to appropriate sources of support to meet identified needs. Reflecting the range of referral needs, data showed patients were signposted/referred on to a range of support, including (but not in order of frequency as data were not available):

- Healthcare professionals such as district nurses and specialist services (mental health, drug and alcohol, wheelchairs, Parkinson's etc.)
- Social prescribers
- Community services such as finance officers, police, fire service, environmental health, and social services
- Charities such as Age UK, Mind, HEART, and Carers Trust.

2.32 Many of the destinations for onward referrals were the same organisations as those referring in and attending the meetings (though a particular patient would not be referred on to the same organisation that had referred them into the MDT). Evidence from interviewees indicated that MDTs help practitioners deal with patients that they cannot support within their own service by allowing them to refer the patient to a group of professionals with a range of expertise and networks, thereby increasing the possibility that suitable support can be identified for the patient. Prior to the MDTs, practitioners may have accessed different forms of support for patients through personal knowledge and experience. Interviewees stated that the advantage of the MDT is that newer practitioners without local knowledge and contacts can refer patients in to access a wide range of professional expertise. Even for better networked practitioners, it can be more efficient to bring a case to the MDT so multiple professionals can discuss a patient in a single meeting rather than contacting individual services to see if they can help the patient.

2.33 There were some differences in emphasis between teams, perhaps reflecting different knowledge: for example some MDTs reported referring more regularly to housing officers than other MDTs. These MDTs had regular representation from housing services.

2.34 Interviewees reported that a patient might have several needs and so might be directed to a number of services to ensure that all needs were met. For instance, an elderly lady might need a mobility aid and be suffering from social isolation so the mobility aid would be organised first, followed by signposting to a local coffee morning or lunch club. In general, interviewees indicated that most needs could be met through local provision, whether statutory or VCS.

2.35 Covid was reported to have made it more challenging to offer certain kinds of support, for example befriending to address social isolation. Other services reduced or stopped home visits which restricted some service delivery, for example the Fire & Rescue service temporarily could not provide 'Safe and Well' checks. However, there has been innovation and more befriending is offered by telephone and smaller coffee mornings have been arranged by one social prescribing service to fit within Covid restrictions. The limitations on service provision generated by Covid was reported to have slowed down the progress of some patients because they have outstanding needs that cannot currently be addressed.

3. Outcomes

3.1 This section presents findings on outcomes from the MDTs, utilising evidence collected from observations of MDT meetings and interviews with MDT attendees and other stakeholders.

Outcomes for patients

3.2 After the initial referral is brought to the meeting and discussed, the case is reviewed at the subsequent meeting(s) and the plan is updated as required. Reviews are continued until attendees agree the patient's needs have been met. The process generally takes from a couple of weeks to two months from referral to discharge. There is no time limit for a referral to stay with the MDT, and those patients who don't feel ready to access support or need support which is not available at present, will remain with the MDT. Interviewees reported that agreed plans of support are nearly always implemented although sometimes patients decline to engage and occasionally a patient passes away.

3.3 Interviewees offered examples to illustrate the varied nature of cases, as set out below.

Patient stories

District nurses were going to a home to dress wounds after a surgery. They learned that, aside from the daughter being unwell, the family had experienced a lot of bereavement and there were issues with money and depression. The MDT arranged for the family, who hadn't had a holiday in ten years, to get a grant from the Carers Trust to go away together. This was something to look forward to during the daughter's illness. The family also had help to decorate their house and were given some food parcels.

A patient with mobility issues and dependent children bought a farm. The MDT liaised with the local education authority to arrange transport so the children could attend school. A housing grant was organised to help pay for new heating and an occupational therapist and physiotherapist went in to help with the mobility issues.

An elderly female patient was moved from her home to a care home. She had mobility issues so was essentially stuck in her room and felt socially isolated. She was referred to the MDT who contacted a befriending service. They arranged for a volunteer to pay her visits. The patient was reported to be enjoying the experience and looking forward to the visits.

3.4 However, there is no formal method for following up on discharged cases to gain an understanding of longer-term outcomes for patients, that is, whether the support provided addresses the patient's needs in the medium to long-term and is likely to have helped them to

avoid ill-health or escalation of existing health conditions. The example below reveals the type of anecdotal evidence collected from the research which shows how longer-term outcomes could be anticipated through MDT involvement but which are not yet quantifiable.

Patient experience

An elderly lady received a below-knee amputation in hospital. She was discharged from hospital and taken home by paramedics to the first-floor maisonette where she lived with her husband. The wheelchair she was given as part of the hospital discharge was too wide for the doorways of her home so she couldn't move from room to room. Moreover, even with a smaller wheelchair, she had no way to travel up or down the stairs. She was referred to the MDT by the district nurse who visited her at home. Following the referral, a supportive GP organised a smaller wheelchair, the Carers Trust organised support for the husband, and a Housing Support Officer completed applications for more appropriate housing. Another MDT member arranged a benefits audit to ensure the couple were receiving the benefits to which they were entitled. As described by one MDT member;

"It's been a multi-faceted support package."

3.5 There was consensus among interviewees that for the patients, without the MDT referral route, their situation would likely remain unaddressed given the complexity needs requiring a multidisciplinary approach.

Outcomes for staff

3.6 Many interviewees reported job satisfaction from being able to support patients that they perceived would not get support easily from elsewhere.

> **"I didn't realise there were so many voluntary organisations out there"**
>
> **Clinical lead**

3.7 Some interviewees were positive about the increased knowledge of and contacts within other services gained through attending the MDT and the potential impact this would have on patients and service users outside the MDT process. For example, a representative from a housing service met a member of staff from an addiction service at an MDT. This helped the housing officer to offer better advice and access better support for those of his residents with substance abuse issues. One interviewee said of their colleagues, "It's changed their lives completely," because it had given those staff a different route to supporting residents that were previously very difficult to help. This improved staff confidence and job satisfaction. Interviewees also recognised that improvements in

relationships and connections had helped speed up administrative and logistical processes creating time efficiencies for staff and patients.

3.8 Several interviewees described time within MDT meetings being reserved for service updates from social prescribers and other organisations. One social prescriber interviewed spoke about delivering a service information session using MS Teams which was open to everyone to attend and promoted to the district nurses in their area. MDT attendees valued the opportunity to learn about the local service offer.

3.9 Some of the district nurse interviewees noted that increased knowledge of local services allowed them to make referrals to these services directly when necessary. This was particularly relevant for patients with simple or complicated needs where the MDT multiagency approach was not necessary. Knowledge of the local offer also became more valuable during Covid as it enabled the district nurses to act more quickly in response to new needs. Finally, in some cases, district nurses found that the additional knowledge enabled them to refer on patients with non-clinical needs to a more appropriate service, saving them time in their caseload.

Outcomes for the system

3.10 Interviewees considered that MDT activity should reduce pressure on all healthcare services through providing people with appropriate, timely support that would avoid or reduce the need for healthcare in the future. Qualitative feedback indicated that some MDT attendees perceive that the support provided is preventing declining health and thus reducing the burden on local healthcare services. For example, one hospital liaison officer stated that: *"They have certainly helped to prevent readmission to hospital for a lot of people".* Fire and rescue, and police interviewees who had referred to, and received cases, from MDTs, also reported reductions in pressure on emergency services. Interviewees reported that routine attendance to properties of vulnerable people identified by MDTs to conduct Safe and Well checks reduced the likelihood of emergency call outs later on. These visits were also able to pick up other health and social needs that could be referred onto other services before escalation. One interviewee stated that the MDT had resolved cases that their own service would have taken longer to address or not been able to address.

Reduced pressure on the emergency services

An elderly man was calling 999 over 30 times a day. Initially, the calls were to the ambulance service until they were compelled to blacklist his number. These calls were then transferred to the police, who had to attend the man daily at his property. The police also received several complaints from the neighbours due to the state of the property.

Once the case was referred to the MDT, the police and local authority worked together to move the man into supported housing. When he was in new accommodation, the calls reduced, resulting in time savings for the emergency services.

3.11 One interviewee saw the value of MDT meetings in legitimising holistic approaches to care, *"giving [him] the green light to spend more time looking at and helping with the holistic needs of people."*

4. Enablers, barriers and challenges

4.1 This section presents findings on the enablers, barriers and challenges facing MDTs, utilising evidence collected from observations of MDT meetings and interviews with MDT attendees and other stakeholders.

Enablers

4.2 The multidisciplinary approach was widely cited as a key strength. Simply, having an assortment of professionals from different organisations in the meeting was seen to provide a better chance to identify the correct solution at the outset, particularly for more complicated and complex cases. Yet, some interviewees also thought it was important to have the *right* mix of professionals with the expertise to progress cases. Specifically, one interview reported "The only issue is quite often the partners that you want there, to take some of this work, to provide solutions, are not there." At that point, attendees with the right profile/contacts/relationship need to invest time in engaging other partners in the case.

> **"Because it is multi-disciplinary, somebody always comes up with an idea."**
>
> **MDT attendee**

4.3 Positive leadership was identified as a key enabler in generating the right atmosphere to encourage people to work effectively together and continue to attend. The leadership was also seen by a few interviewees to be important in ensuring the team has the most appropriate representation from across the healthcare system, whether on a regular or ad hoc basis to meet case needs. Active leadership was also cited as a key factor in whether MDTs had restarted meetings following the drop in referrals due to Covid-19.

4.4 Maintaining good connections with the district nursing team to elicit steady referrals was seen as important in sustaining the MDT and picking up cases which may otherwise fall through the gap. One MDT was in the process of ensuring all their district nurses had attended at least one meeting to help them understand the purpose of the team and the types of cases they could refer. District nurses were also encouraged to attend meetings to handover their referral 'in person' to ensure sufficient understanding of both the clinical and social needs in the case.

4.5 Some interviewees welcomed attendance of social prescribers at MDTs, seeing this as an important source of referrals and a key support service for patients. Where social prescribers weren't involved in an MDT, this was reported to be a problem which was being addressed. The social prescribers were generally considered to bring knowledge about local services and support options for people, including the quality and availability of local services. This was seen as a helpful way to reduce demand on care navigators where needed. New members of

MDTs also reported that the knowledge of social prescribers was very helpful in bringing them up to speed with local assets, which not only helped their engagement with the MDT, but also their wider work. Rather than viewed as competitors, social prescribers were seen as allies who brought complementary knowledge, expertise and networks that were important to identifying and securing the right support for patients.

4.6 The shift to virtual meetings instead of face to face was welcomed by many interviewees in terms of making meetings more accessible and hence facilitating wider, more consistent attendance. A minority of interviewees discussed the advantages found in using a range of locations for meetings (when Covid restrictions were not in force), for example hospitals and assisted living buildings. It was reported that staff would combine the MDT meeting with visits they were making to patients.

4.7 Good administrative support was reported to be crucial in ensuring the smooth running of MDTs, stimulating referrals, effectively sharing information and checking up on progress. One team without a dedicated admin resource connected it to low attendance and referrals.

4.8 More broadly, MDTs were seen to rely on the commitment of key staff who buy into the model of holistic care and engage fully.

Barriers and challenges

Multiple support options

4.9 The potential for overlap among MDTs, primary care social prescribers, social prescribing services, and other roles and initiatives was acknowledged by a significant number of interviewees. These interviewees identified a need to clarify the purpose of MDTs, referral criteria and pathways to minimize duplication, inefficiency and confusion among potential referrers, particularly GPs who have limited capacity to stay abreast of the continually changing support landscape.

4.10 Some interviewees did not perceive significant risk of overlap. They viewed the MDT as a useful way to bring together representatives from different initiatives so patients could benefit from their case being discussed by multiple professionals and more support options being considered. They saw the potential for complementarity between teams and services, shared learning and efficiency in updating knowledge of support options, particularly across the VCS landscape. Interviewees also viewed the patients referred to MDTs as potentially less likely to be picked up by some support options (e.g. primary care social prescribers in GP practices) during Covid-19 given the move to phone consultations and limited in-person appointments.

4.11 Overall, the perception from most MDTs, with one notable exception, was that there was sufficient demand for services, and so multiple avenues for patients to receive support was not negatively affecting referrals into MDTs. That said, it would be beneficial for MDTs (and similar initiatives) to have the security of long-term commissioning to allow it to become

familiar to referrers and other wider services, for relationships to develop and any inefficiencies to be resolved.

Low engagement from health and care system partners

4.12 A key challenge identified by most teams was low engagement from other parts of the health and care system:

- **GPs** – most teams reported struggling to engage GPs, despite GPs being a key target of engagement efforts. Some GPs attended introductory sessions on the PBTs but did not engage further. A couple of teams reported that a GP had once or twice attended or dialed into an MDT. Two teams also reported that a practice-based social prescriber attends their MDT. Where GPs do make referrals, the information is typically insufficient to develop a plan of action without a visit to the patient by a member of the MDT. Other interviewees believed that GPs find it easier to refer to their own social prescribers.
- **Social care** – interviewees reported finding social care more difficult to engage than GPs. They expressed a desire to involve social care because of their experience and knowledge but recognized that capacity may be a barrier. Interviewees from two teams felt capacity was not the only barrier and that different working culture might play a role. One interviewee reported that their MDT had used a PCSO (Police Community Support Officer) to elicit engagement with social care because a 'uniform holds weight'.
- **Other key services** – interviewees identified other services that had not engaged by attending meetings but had received referrals. It was felt that it would be advantageous for representatives from these services, such as bereavement specialists and community mental health, to attend MDT meetings.

4.13 Covid-19 was identified as a barrier to greater engagement from some parts of the system due to increased pressures on staff. Mental health service engagement was identified as being particularly constrained due to increased demand yet reduced service capacity.

Sustainability of VCS organisations

4.14 Interviewees commonly cited the lack of sustainability of VCS organisations that could offer support to patients as a challenge. Maintaining up to date knowledge of the shifting VCS landscape, as services are recommissioned, changing provider, staff and often the service name, was seen to require considerable investment of time. For this reason, one team particularly valued regular attendance by the local social prescribing service, who had better networks within the local VCS. Covid-19 has further affected the sustainability of VCS organisations: interviewees reported that some of their usual support options were either no longer available or were experiencing high demand and had long waiting list times. For example, befriending services were on hold for a considerable period due to social distancing measures.

Patient uptake

4.15 Interviewees from half of the MDTs included in the fieldwork referenced patient reluctance to accept help and so they declined of services. In some cases patients gave their consent to be discussed at the MDT meeting but then declined the support offered. Various reasons were given for this, such as pride and addiction. It was considered important that staff approached people sensitively to ensure their engagement.

Resource intensity of MDT involvement

4.16 Another challenge identified by a few interviewees was the demanding nature of the work. For the clinical lead, the care navigator and the administrator (or those performing these roles), there is a significant workload in monitoring referrals, organising and facilitating meetings, checking on progress, and encouraging attendance. One interviewee observed that the original model was intended to be a cooperative endeavor among all parts of the healthcare system (nursing, primary care, secondary care) but that much of the responsibility and workload now falls solely on the district nurses.

4.17 While some MDT members only need to attend hour long weekly meetings, make referrals, and perhaps follow up on cases, a few interviewees were also clear that their involvement in the MDT was not strictly considered part of their role and they contributed to this work because they saw the value in it. They could not guarantee that their organisation's involvement would continue if they moved roles or if management challenged their involvement.

Information sharing

4.18 Challenges relating to information sharing within the health and care system are not specific to MDTs. Communication between different systems, e.g. between primary and community care, remains a significant issue. Prior to the pandemic, most MDTs did not have access to primary care systems and thus emailed updates to GPs rather than updating records directly. The shift to greater virtual working during the pandemic has improved information sharing in some cases. Primary and community care systems have been aligned to allow GP surgeries to access community notes and vice versa. MDT teams that use community care systems can now update records directly, allowing the GP easier access to relevant information.

5. Reflections

5.1 This section presents reflections on the findings in the preceding sections.

5.2 In some ways, it appears that **the MDTs are functioning as intended**. They are led by district nurses and bring together professionals from other organisations to ensure a range of expertise is brought to bear on the referred cases. Interviewees were consistent in describing the purpose of the MDTs, namely improved outcomes for patients and reduced pressures on the healthcare system through addressing social needs and prevention of ill health. The MDT meetings have been adapted to working under Covid restrictions and there are positive reports of outcomes for patients.

5.3 However, a number of issues require examination. First, **referrals were lower than expected even before Covid and have got lower since**. There are a range of possible reasons for the low referral rates: lack of capacity to engage by referrers; lack of awareness on the part of potential referrers; preference among referrers to use other services; lack of demand for the service among patients.

5.4 Of these, the first (lack of capacity among referrers) was evident during the pandemic, when existing levels of referrals reportedly declined sharply. The second (lack of awareness among referrers) may also be true to some extent: while teams have undertaken awareness raising, competition for the attention of potential referrers is high given the multiplicity of services and organisations that exist. However, given some of the teams have been in operation since May 2018, and referrals remain low among regularly contacted professionals, it cannot be the most important reason.

5.5 The third reason (preference among referrers to use other services) may be significant, based on the evidence from interviews. There has been a growing recognition over the past decade or more that demands on healthcare are deeply intertwined with social issues. This has driven efforts to find ways to identify and address social needs among populations to reduce pressures on health services increasingly burdened with an ageing, sicker population. In 2019 NHS England's Long Term Plan and the Comprehensive Model for Personalised Care laid the foundations for delivery on this agenda over the next few years, which included funding for a social prescriber for each Primary Care Network. The landscape includes a myriad other related initiatives aimed at tackling social needs to improve outcomes and reduce pressures on the healthcare system. Warwickshire exemplifies this complexity with a variety of personalised and holistic care initiatives. Complexity may be a strength in terms of ensuring there are different options are available for different circumstances. However, as noted earlier, complexity may also result in confusion for referrers who stick to preferred services.

5.6 The final reason (lack of demand among patients) may also be critical to levels of referrals. **If demand is low, willingness of referrers will make limited difference**. It is challenging to measure unmet demand. When the MDT was designed, there was no specific demand assessment but there was a general perception that there would be significant demand for

the service. There were mixed opinions among interviewees about the level of demand but overall there was a sense that there was plenty of need and that need was likely to have increased due to the pandemic.

5.7 This leads on to the second key issue: **what is the most effective and efficient model for meeting need?** While interviewees were broadly positive about the ability of MDTs to address issues for patients, there are several aspects to reflect on:

- **How to communicate the purpose of the MDT as clearly as possible for referrers** to ensure they know which patients they can refer and which patients are most appropriate for the MDT approach, namely those with complex or complicated needs above those with simple needs. The MDT that ensured all their district nurses attended at least one MDT meeting to help them understand the purpose may be an instructive example.
- **How the teams maintain an up-to-date knowledge of the support landscape**, particularly given the fragility of the VCS, and the challenge of delivering support in a context of pandemic restrictions. While district nurses have some knowledge, the inclusion of a social prescriber in the core team appears to be one effective option. One advantage of social prescribers, particularly those from the VCS, is their continually refreshed knowledge of local services
- **Who should attend regularly and who should attend on a case-by-case basis** – a small, core of committed team members appears to have been working well in many areas, with the inclusion of senior clinical input to manage risk, but there is a question of how to manage inputs from less frequent attendees when required, perhaps including GPs and social care.
- **The extent to which virtual working should be maintained** when the pandemic eases, and whether this could maintain engagement from regular members and support efforts to increase engagement and attendance from ad hoc members. The evidence suggests that virtual working has been successful in securing increased attendance from both regular and infrequent attendees because of the absence of travel time.
- **The extent to which the current geographical model could be adapted to support attendance and/or referrals –** MDTs have already adapted to local circumstances: two MDTs already bring together two PBTs each (Rugby North and Rugby South, Leamington North and Leamington South) and have the first and third highest rates of referrals, which suggests that some merging of teams has been sensible. However, mergers may not be appropriate for all teams: in some cases the small-scale nature of the MDTs appears to create efficiencies by supporting the development of effective professional relationships and good knowledge of the local service offer. This is likely to be even more important when addressing complex/complicated cases where patients may be involved with or require involvement from multiple services.

5.8 The extent to which the MDT meetings are addressing their intended aims is difficult to ascertain without more detailed data on outcomes. While there were many stories and

examples of outcomes, with no follow up on patients after their discharge from the MDT process, **actual outcomes are presumed rather than evidenced**. SWFT and the MDTs should consider how more evidence could be collected or accessed. A clearer picture on outcomes would likely be helpful in increasing engagement from other services (presuming it is positive). It is worth noting that as patients are being referred to healthcare and other statutory services as well as VCS services, it may be that MDT intervention does not always reduce pressure on the healthcare system in the short-term. This is a fundamental challenge in quantifying the benefits of preventative interventions. The other issue is the scale at which the MDTs are operating. While they may be fulfilling a purpose and offering valuable support to patients, at the current scale the impact on the healthcare system will be minimal.

5.9 There are evidently benefits to staff from participating in the MDT, such as increased knowledge of and contacts across services as well as job satisfaction from supporting patients, and greater understanding of how to apply a holistic approach to caring for patients could have benefits beyond their direct involvement in the MDT.

5.10 The **value of the MDT might in fact lie in its small scale**. As an in-house model rather than an externally commissioned service, with staff able to shift time between the MDT and other responsibilities, as during the Covid-pandemic, the **MDTs could function as a safety net or backstop**, covering patients that have been overlooked by other services, particularly patients with complex needs, and re-directing them to the appropriate place. Although this may describe a smaller-scale model than initially envisaged, it would allow the MDT to have a clear function and clearly differentiate itself from similar social prescribing initiatives.

5.11 Ultimately there cannot be a single model for an MDT. The most efficient and effective way to meet need will be for MDTs to adapt to local circumstances based on: the nature and scale of unmet need locally; capacity and willingness among local services to be involved and/or support the MDT; fit with other similar initiatives; options to support ongoing attendance, for example use of virtual working; and routes to efficiently maintain knowledge of the support landscape.

Qualitative evaluation of South Warwickshire Place Based Teams was supported by the Health Foundation, an independent charity committed to bringing about better health and health care for people in the UK.

Contact

Graham Thom
Director, SQW
T: +44 (0)7766 916897
E: gthom@sqw.co.uk

48 Melville Street
Edinburgh
EH3 7HF

About us

SQW Group

SQW and Oxford Innovation are part of SQW Group.
www.sqwgroup.com

SQW

SQW is a leading provider of research, analysis and advice on sustainable economic and social development for public, private and voluntary sector organisations across the UK and internationally. Core services include appraisal, economic impact assessment, and evaluation; demand assessment, feasibility and business planning; economic, social and environmental research and analysis; organisation and partnership development; policy development, strategy, and action planning. In 2019, BBP Regeneration became part of SQW, bringing to the business a RICS-accredited land and property team.
www.sqw.co.uk

Oxford Innovation

Oxford Innovation is a leading operator of business and innovation centres that provide office and laboratory space to companies throughout the UK. The company also provides innovation services to entrepreneurs, including business planning advice, coaching and mentoring. Oxford Innovation also manages investment networks that link investors with entrepreneurs seeking funding from £20,000 to £2m.
www.oxin.co.uk