Multidisciplinary team working in primary care: Q&A document

This webinar was run as part of Healthcare Improvement Scotland's work on the primary care phased investment programme (PCPIP). Learning events, such as this webinar, are key to PCPIP's national learning system to facilitate sharing of insights and learning to support ongoing improvement in the design, delivery and assurance of high-quality health and care services. .

This document provides answers to questions posed by webinar participants that were not addressed during the live Q&A. We are not able to give full answers to some questions but have signposted to other organisations or sources of information where we can.

The following questions were submitted during the Primary Care Phased Investment Programme (PCPIP) Learning System Webinar on 31 October 2024, we have organised them into the following categories:

NOTE: The answers given in the final section of this document are the views of Professor Stewart Mercer, one of our guest speakers. Prof. Mercer is an independent academic and as such his answers reflect his views alone and do not reflect the opinions of Healthcare Improvement Scotland.

Pre-submitted questions

Communication

Q. Public perception and understanding of MDT working. What messaging/promotion of the benefits to patients and service users has been done/ is planned?

A. There has been a variety of different messaging to patients about the wider Primary Care MDT. This has been led by Scottish Government, Public Health Scotland and Health Boards. One example is here General Practice Receptionists | NHS inform

Q. What previous communication has General Practice had on why it matters?

A. There has been a variety of different messaging about the importance of the Primary Care MDT led by Scottish Government, Public Health Scotland and Health Boards. The 2018 GMS contract itself explains how an enhanced primary care multidisciplinary team can relieve some of the pressure on GPs and allow how this in turn can enable GPs to work as expert medical generalists. Healthcare Improvement Scotland also promotes its value in its improvement work including earlier webinars such as the Primary Care Resilience Webinar.

Finance – The Scottish Government's Responses to the Following Questions

Q. Will the PCIP funds continued to be ringfenced for GP delivery when baselined?

A. Following agreement at the GMS National Oversight Group, the Scottish Government is exploring the potential to baseline the Primary Care Improvement Fund (PCIF) from 2026/27 financial year, aligning to reporting timescales attached to the Primary Care Phased Investment Programme.

The Scottish Government is establishing a short life working group to consider the opportunities and risks associated with baselining the fund and the arrangements required to mitigate the risks identified, including how to ensure funding continues to be used to support intended aims.

Q. Can any assurance be given that additional funding will come to other boards following the learning from the demonstrator sites? We regularly have feedback that PCIP is working well in FV, but there's insufficient resource to meet GMS contract requirement.

A. A key aim of the PCPIP is to build evidence to understand the national context for the implementation of the multidisciplinary team (MDT) component of the 2018 GMS Contract in Scotland, including the long-term Scottish Government investment required for all areas across Scotland. The findings from the national evaluation, as well as the interim evidence reports, and the recommendations from the expert group will be critical in informing decisions on investment and policy development.

To support development of the business case for the investment required, the Scottish Government is establishing a sub-group of the national GMS Oversight Group in early 2025, ahead of the PCPIP final report in December 2025.

Q. Can Scottish Government afford to ignore the private contractor model of General Practice in order to achieve the most cost-effective modernisation of primary care in Scotland?

A. The Scottish Government supports the independent contractor model. It has increased funding for GPs, most of whom are independent contractors, by £73.5 million this financial year.

Other

Q. Our Physio Advanced practitioners have an allocation of hours in MSK outpatient departments. What they do for this period is not yet decided. I would be interested in your thoughts about how an APP could be best utilised in an MSK outpatient setting. What is the input of pharmacotherapy team in this?

A. Healthcare Improvement Scotland (HIS) advises on quality improvement and cannot comment on specific local operational decisions. HIS Primary Care Phased Investment Programme focusses on pharmacotherapy and CTAC services within General Practice and does not include outpatients.

Questions during the webinar

Q. How can practices and MDT teams communicate to ensure they feel there is some collaboration on the service they receive- not just in terms of practicalities such as finish times, but also clinical priorities as we don't have enough resource to deliver it all.

A. As the question notes, effective MDT working depends on good communication so that there is a shared understanding both of ways of working and local priorities. Local arrangements need to be developed and agreed including a mechanism for GPs and MDT services to discuss and agree where the clinical priorities lie.

Q. How do we address the tension that arises due to protected learning time for PCIP staff but no national PLT for GPs and their staff?

A. Time to meet, communicate and learn together is an important part of MDT working. Varying terms and conditions within the MDT do pose challenges for teamworking in primary care. Although there is no national programme for PLT, many practices have prioritised dedicated time to meet and learn within their team, with an 'on-call' person available for any urgent calls.

Q. how does this relate to hub/central models? we are finding that this is increasingly an issue as there is not enough staff or space for MDT in GP practices, so we very rarely get the privilege of having staff in our practice.

A. Good MDT working is more challenging when staff are not co-located. It generally involves more effort and might include for instance, Teams meetings, in-person meetings where practical, social event planning etc. As part of the evaluation of PCPIP we will be looking at the context for implementation which will consider models and approaches to MDT working.

Q. We really value our MDT staff, they do great work, and we really enjoy having them with us and work hard to make them feel welcome and involved in everything - there are intrinsic difficulties in having staff who are employed, line managed and paid elsewhere. NHS staff sitting alongside practice staff usually have better terms and conditions which can be difficult (getting development time/protected workload/better pay etc). When there are shortages in practice (as inevitably happen) we cannot ask MDT staff to "chip in" to help as we don't have the ability to approve extra hours. This feeling of all working together to manage demand on difficult days is the kind of thing which can help teamwork (and conversely cause ill feeling) **- How do we solve this?**

A. Varying terms and conditions within the MDT do pose challenges for teamworking in primary care. However, the same principles of shared objectives, working interdependently and good communication all still apply. One small element of good communication is ensuring staff understand the reasons for these differences.

Q. When is Scotland going to have a training programme for Physio/MSK. We are far behind NHSE in what is available.

A. At the current time, individual boards have a responsibility to develop and support education and training and a few boards, for example NHS Lothian, have established pathways for MSK physios. . As part of the AHP Transforming roles programme there is a longer-term aim to have greater consistency around levels of practice, job titles and knowledge, skills and behaviours for roles, and consistent education pathways for AHPs as set out in the Scottish Government's AHP education and workforce review recommendations.

Questions addressed to Prof. Mercer

NOTE: Professor Stewart Mercer is an independent academic, and as such, the answers he has provided below **reflect his views alone** and do not necessarily reflect the opinions of Healthcare Improvement Scotland.

Q. Does SIMD or rurality make any difference as well?

A. We only have the qualitative data, but the people who most want to see their GP are those with multimorbidity. So yes, patients with complex problems in deprived areas want to see their GP. Rurality – more of these patients are older and will thus have multimorbidity.

Q. Do you plan to do a national survey of MDT staff as well? 19 is a very small number (although appreciate qualitative)

A. No as explained, PHS did one so we didn't see the need to duplicate and there is no available national accurate list of all MDT staff and addresses, so we would not have been able to do a national survey of all MDT staff. Their findings were similar to ours. This is their report: https://publichealthscotland.scot/media/24974/main-report-primary-care-reforms-multidisciplinary-team-feedback-survey.pdf

Q. It is difficult to evidence 'time saved' in General Practice. I feel the focus should be more on where would general practice be if we didn't have all these MDT teams and support complementing GP care?

A. Yes, but not easy to answer that question.

Q. Will your work look at the appropriateness (right place, right care) of the activity in Primary Care, similar to what has been reviewed in A&E.

A. No, our funding is now finished.

Q. Is reduction in workload achievable with the ageing population?

A. Well, need and thus demand will continue to rise…so we need more GPs and MDT staff, working together effectively.

Q. How can GPs, as expert medical generalists, be expected to lead, support and develop teams with no allocated time or funding to carry out such a role?

A. In my view, no.

HIS Comment: It may be of interest that a central concern of the PCPIP evaluation is understanding the role of the expert medical generalist in the context of multi-disciplinary team working.

Q. hub based mdts are likely to further destroy any gains over the last few years as MDT staff move out into hubs, away from practices. Unless the MDT are managing to take patients with them by having changed cultural dependence on 'my GP', likely to simply fragment care in my view.

A. GPs are essential to provide holistic expert medical generalist care – MDT staff can't do that, so they are not a replacement for GPs.

HIS Comment: As there are concerns around fragmentation of services, HIS is working with sites to consider how existing local management arrangements addressing inequalities, continuity of care and patient perspective can help inform their PCPIP work.

Q. Have you looked at what has been common findings in teams that are working well?

A. The other main speakers covered this during the webinar

HIS Comment: In summary the key factors associated with good MDT working discussed by the speakers were summarised by Dr Paul Baughan as: clear shared objectives, working interdependently and good (formal and informal) communication. There was particular agreement around the importance of making all staff feel welcome and the power of small gestures in supporting that.

Q. re objectives, it is vital that the objectives of the GP practice (i.e. primary care approach) and the objectives of the workstreams are the same.

A. Well, they should all be about improving the care of the patient in an integrated way that doesn't increase treatment burden, duplication, fragmentation etc.

Q. Is there a fast-track development programme to help MDT staff get up to the pace of general practice as it has been well described today that the pace of general practice is a challenge for them?

A. I don't know but it's something young doctors have to learn too, and typically after a year full time in a practice as trainees they are only really beginning to get the hang of it. So, I don't think there is a quick fix.

HIS Comment: Local areas have their own approaches and need to adapt to local circumstances. Examples HIS is aware of include from Ayrshire and Arran, a newly developed structured induction for new pharmacists. New pharmacists will be supported to put their theoretical knowledge into everyday practice whilst they gain confidence in a fast-paced general practice setting. For CTAC, there is an induction process which includes orientation, systems and processes, shadowing, education, supervised practice and restorative supervision. Practice profiles help staff understand local variation.

Published January 2025

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