A shift to multidisciplinary teams in general practice: What this means for people experiencing health inequalities and frequent users of primary care services

June 2023

Background

Primary care services are the front door to the NHS –they are the first port of call when we feel unwell and the main coordinator of care when we are living with ill health.

The model of general practice is changing and, at the core of this, general practice is moving away from a model of 'seeing a GP' to a model that is 'consulting with the multi-disciplinary team'.

The shift to multidisciplinary teams has arisen, in part, in response to the emerging pressures within primary care teams –who are serving greater numbers of people requiring a greater complexity of care because of the aging demographic of our population and growing number of people living with multiple conditions.

Understandably, professionals in primary care see the need to draw on the diversity of skills and experience of a wide range of health professionals within the primary care team. There is also an opportunity to connect people to the specialists they need faster.

Primary care teams now include over 15 skilled roles, yet for many people accessing care, 'going to the GP' (the place) is synonymous with 'seeing a GP' (a doctor who is a general practitioner).

Project aims

At National Voices, we believe that changes in health and care should be driven and underpinned by what matters most to people who use and need it the most. Through this insight and learning project we worked with people who frequently use primary care, people from groups who experience health inequalities and voluntary sector organisations to understand:

- The levels of awareness of the shift to multidisciplinary teams in General Practice.
- How people who frequently use primary care and those who are from groups who experience health inequalities view the changes and if they have experienced any unintentional consequences.
- How primary care teams can build trust with these groups as part of the shift from a single GP to a multidisciplinary team.

- How primary care teams can assure people who frequently use primary care and people from groups who experience health inequalities that general practice has oversight of their care.
- How these insights can inform communications and make early recommendations around changes to the model of general practice.

Project scope

To achieve this, we:

- Conducted a rapid evidence review of what is already known and understood about what the shift to multi-disciplinary teams has meant for people experiencing health inequalities and frequent users of primary care services. We also looked at how these changes should be communicated to these groups.
- Ran 3 insight and learning focus groups with:
    - 15 people who were from groups that experience health inequalities and/or frequent users of primary care.
    - Representatives from 14 voluntary sector organisations who work with groups that experience health inequalities and/or frequent users of primary care.
- Lived experience and voluntary sector participants in this project including people from racial and ethnic minorities, the LGBT+ community, people living with a wide range of physical health conditions, people living with mental illness, those who have been in touch with the criminal justice system, as well as those with experience of other health inequalities.

Strategic context

Fuller Stocktake

This insight report responds to and builds on the aspirations set out within the Fuller Stocktake in May 2022, which recommended:

- Streamlining access to care and advice for people who get ill but only use health services infrequently, providing them with much more choice about how they access care and ensuring care is always available in their community when they need it.
- Providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions.
- Helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention.

Primary Care Recovery Plan

This insight report also responds to and builds on relevant information set out within the NHS England Primary Care Recovery Plan in May 2023, which committed to:

- Implement 'Modern General Practice Access' which;
    - Expands the role of receptionists who will become more skilled and empowered care navigators,
    - Includes investment in a new National Care Navigation Training programme and funding for higher quality digital tools to support the whole practice team to contribute to rapid assessment and response.
- Build capacity through larger multidisciplinary teams, by targeting a further £385 million of funding in 2023/24 for roles within the multidisciplinary team such as link workers, dieticians, mental health practitioners and more.
- Launch a major communications campaign to explain the evolving nature of primary care to the public, as well as communication toolkits for ICBs to develop local messages.

Key themes and summary

We found that…

- There was a low level of awareness of multidisciplinary teams, including amongst people who frequently use primary care.
- In the current context of pressures in primary care, people often felt that multidisciplinary teams were a cost reduction measure, rather than a initiative designed to improve their care. This was the case, even though most people reported positive experiences with individual members of the multidisciplinary team.
- For some groups, particularly those who have experienced inequalities and barriers to primary care, the shift to multidisciplinary teams can be experienced as a further barrier to participation in health and care.
- The major themes that emerged were the importance of embedding practice within multidisciplinary teams which build trust, valuing the time and energy of patients and setting clear and reasonable expectations of what primary care users can expect.

Key barriers to good experiences of multidisciplinary teams

- There was a low level of awareness of multidisciplinary teams, including amongst people who Often people reported that they have to repeat themselves to multidisciplinary teams.
- Some people reported that they didn't feel involved in the decision making around their care in multidisciplinary teams.
- Some people reported that they felt a loss of continuity of care as a result of the shift to multidisciplinary teams.
- Some people reported not always knowing who the right person was to speak to, or what the role was of the person they were speaking to.
- Some people reported that they weren't sure what to expect from appointments (e.g.how long they would be).
- Many people were concerned that the increased complexity of multidisciplinary teams may mean they need to invest more time and energy into navigating primary care and advocating for themselves.

Insights from our rapid evidence review

Patient perspectives on multidisciplinary teams

Our rapid evidence review found that:

- There was very little evidence on how widely service users understood the move towards multidisciplinary teams in primary care services. We found no published research on how best to explain these changes, either generally or for specific groups.
- There was some evidence that multidisciplinary teams can improve quality of care. More was found on improved patient satisfaction, trust, and relationships with health professionals. This was particularly true for people with more complex care needs. How well multi-disciplinary teams operate was a variable in these factors. (Kerrisseyet al 2023, Ndoro2014, Smith et al 2021).
- Evidence on how multidisciplinary teams affect the wider health system was inconclusive. Some studies showed that improved care from multidisciplinary teams reduced healthcare use and associated costs in the longer term. Other studies found no impact. (Goldzahlet al 2022, Dale et al 2016).

What is important for multidisciplinary teams to function well?

Our rapid evidence review found that:

- Multidisciplinary teams need a wide range of skills to have the biggest impact, but GPs maintain an important role. Co-producing the shape of multidisciplinary team meetings and involving patients in them can bring benefits. (Lammila-Escaleraet al 2022). It is important for one individual to hold responsibility for coordinating the work of a multidisciplinary team.
- Multiple studies showed the value of non-clinical roles on multidisciplinary teams. Roles such as disabilities experts, social workers, and behavioural therapists can promote a broader understanding of the individual, their condition, and wider services in the area. This helps address complications that are not solely clinical. (Leach et al 2017, Tyler et al 2021).
- Organisational support for multidisciplinary teams is key. Without it team members can feel barriers are outside their control. Sufficient time needs to be invested in multidisciplinary teams and strong management is needed to make sure any plans developed for patients are followed through. (Simpson et al 2021, Leach et al 2017).

What are the common shortfalls of multidisciplinary teams?

Our rapid evidence review found that:

- Perceptions among professionals of where a multidisciplinary team beginsand ends can vary. GPs can have a narrower view of this. Familiarity between team members and knowledge sharing are both key. (Doekhieet al 2017).
- Some research shows that while multidisciplinary team approaches are often used to manage patients when they are in decline, opportunities for proactive care planning can be missed. (Doekhieet al 2017).

Wider context of evidence on multidisciplinary teams

While our rapid evidence review focussed primarily on the experiences of frequent users of primary care and people experiencing inequalities in primary care, we also noted:

- Evidence on how multidisciplinary teams affect the wider health system is inconclusive.
- That general practices felt that barriers to ideal multidisciplinary working were outside their control. Internal organisation was found to be the biggest facilitator of multidisciplinary teams (Leach et al, 2017).
- According to one study, multidisciplinary meetings reduced the probability of visiting a primary care nurse by three percentage points and decreased length of stay by one day following emergency care admission (Goldzahlet al, 2022).

Insights from our focus groups

Awareness of multidisciplinary teams

In our focus groups, we found that awareness of the term 'multidisciplinary teams' was low. Those that did tended to be involved in the system at some level or had only found out after seeing a professional other than a GP. However, the majority of participants in the focus groups spoke about direct experience of seeking care with members of the wider multidisciplinary team at their local GP practice.

"I've never heard of MDTs. It's hard to imagine practically what that would look like. How is it different to a referral being made by my GP?"

Lived Experience Participant

"If I wasn't part of a Patient Participation Group and didn't look at the website every week, I don't think you would know these changes are happening"

Lived Experience Participant

"If you're involved in community transformation, you're aware. Otherwise it's just when you call to see a GP and see someone else. I speak to other patients and there is a lot of confusion. People don't know when to see a GP, someone else, or if the practice even offers what they want"

Lived Experience Participant

Perspectives on the shift to multidisciplinary working

Within the focus groups, there were mixed responses to the shift to multidisciplinary teams. Some participants could see the direct benefits from them and felt it made their care easier.

"I've seen big changes in primary care. I have a good surgery that signposts quickly and can review my medication without speaking to a doctor. I'm a member of a Patient Participation Group but there can be so much going on that you don't know where to put your first step."

Lived Experience Participant

Some voluntary sector participants highlighted their concerns that they felt people they support are not well served by general practice as a whole and that it was hard to distinguish this from the shift to multidisciplinary teams.

"Our members don't understand the shift. They just know they can't see their own doctor for 6 weeks. They don't believe anyone understands, them, their child, or condition"

Voluntary Sector Participant

Concerns about a rationing of care

Many participants in our focus groups reported they felt that multidisciplinary teams were part of a wider rationing of care, rather than an initiative designed to improve their care. There was a perception from many people in the focus groups that people were being asked to speak to a different healthcare professional because there weren't enough GPs available, rather than because it was the best professional for them to speak to.

"It is significantly harder to get a GP appointment. They used to run a triage system. Last time I called it was already full at 8:30am. I was told to go to a walk-in centre or call 111"

Lived Experience Participant

"There are still thresholds for care within these teams. We need that clarity"

Voluntary Sector Participant

"It is becoming more difficult to book timely follow-up appointments with GPs, which means I have to book those appointments much further in advance"

Lived Experience Participant

It's important to note that when people engaged with another member of the team e.g. a nurse or paramedic, they were mainly pleased with the services offered by individual. It was not the individuals or roles that were seen to be as lower quality or not meeting a need, but the way they are positioned.

Concerns about deepening inequalities within primary care

In our focus groups, we identified that for some people who have experienced exclusion from primary care previously, the shift to multidisciplinary teams was experienced as a further barrier to their participation in health and care. Focus group participants also reported that they had to explain an element of their identity or address an issue related to stigma repeatedly as a result of the shift to multidisciplinary teams.

"One problem with health care teams is repeatedly asking them to use my chosen name as opposed to my legal name as they often don't communicate well with each other."

Lived Experience Participant

"It can be more complicated if you need an interpreter or someone to advocate on your behalf and there isn't one available"

Lived Experience Participant

"With my symptoms, before I was on medication, it can be mistaken for drug addiction. I was looked at like a drug seeker. Doctors can be wary to give it. This makes it difficult to be open. It's important to enable this openness. I just want a normal life without pain"

Lived Experience Participant

Duplication in work and communications

Many of the participants in our focus groups highlighted that they often needed to repeat themselves. This eroded trust and affected the quality of experience amongst primary care users, who didn't feel like anyone had oversight of their care. The frequent need for repetition eroded confidence in care. The reliance on repeating information also indicated that members of the multidisciplinary team can struggle to trust the information gathered by their colleagues, or find time to review information previously captured.

"I often find myself having to go over things with my doctor because things haven't been reported properly by other professionals"

Lived Experience Participant

"I did not have a good experience with this team as there was a lot of miscommunication about what my needs were and how they could be met,

and I already find it difficult to trust one person let alone several who don't have experience working with trans people. The result was me avoiding seeking treatment at all and relying on my community instead"

Lived Experience Participant

One Lived Experience Participant flagged the risk of 'death by assessment'.

Being 'part of the team'

Some people in the focus groups reported that they didn't feel involved in the decision making around their care in multidisciplinary teams. They were keen to be kept in the loop and involved in decision making where appropriate, but felt that this often wasn't the case.

"MDTs provide care but that doesn't involve you"

Lived Experience Participant

"Patients and parents would appreciate being told that an MDT meeting had taken place and who was involved. They need a summary of the discussion"

Voluntary Sector Participant

"There's good work going on in primary care but a communication gap in that getting back to the patients. There needs to be someone in primary care following through"

Voluntary Sector Participant

Continuity of care

Some people reported that they felt a loss of continuity of care as a result of the shift to multidisciplinary teams. This was often the GP:

"I've had my GP all my life. I've benefitted from that. My GP knows me on a personal basis and I really appreciate it"

Lived Experience Participant

"Trust is easy. See the same doctor every time. Repeating yourself makes you think nobody is listening"

Lived Experience Participant

For other participants, it was important to have one central point of contact within an MDT, whether this was a GP or another member of the team.

"You need a central person. It should be the first person you deal with."

Lived Experience Participant

"I've one child with ADHD and another who is trans. Things get lost in translation and I don't know what professionals are talking about. You need a central person to help families."

Lived Experience Participant

Confusion about roles and who to speak to

Some people reported not always knowing who the right person was to speak to, or what the role was of the person they were speaking to. Having this clarity was of critical importance to many of our focus group participants.

"There is a lack of clarity on professional roles in an MDT approach. People are pleased to speak to someone quicker, but don't know what their role is"

Voluntary Sector Participant

"What will I see? Can I phone other people up? Who are they? Should I say I have different needs, can I have an MDT? Who do I have the initial conversation with? What will happen next? What should my expectations be? Maybe we should think about the patient journey."

Voluntary Sector Participant

"You need a central person. It should be the first person you deal with. Sometimes you have MDTs working with other MDTs in different services. It's complex and needs managing"

Lived Experience Participant

Expectations and follow through

Some people reported that they weren't sure what to expect from appointments, and so weren't prepared for them or able to get the most value out of them. Following through with agreements made at appointments and being transparent about that process was also key.

"The first time I was aware was when I was put on for triage in the afternoon when I called for an appointment. I had no idea what that meant. A paramedic called me."

Lived Experience Participant

"Getting a longer time with professionals than you would with a GP is good, but patients need to know that beforehand"

Lived Experience Participant

"People need autonomy and visibility about what is being done. If you're used to inaction, it's an issue. In the past people haven't followed through with promises"

Lived Experience Participant

"One of the main ways MDTs can build trust is through transparency in actions"

Lived Experience Participant

Concerns about extra bureaucracy

Many participants highlighted concerns that the increased complexity of multidisciplinary teams may mean they need to invest more time and energy into navigating primary care and advocating for themselves. Others highlighted that they can feel lost and as if they are going around in circles.

"I've hit brick walls that last for several months, just to get bloods done. We get lost because people don't hear people or follow up. I've been back to receptionist many times"

Lived Experience Participant

"I'm a member of a PPG [Patient Participation Group] but there can be so much going on that you don't know where to put your first step"

Lived Experience Participant

"Some MDT members are part of teams across different primary care networks. It can be another layer of bureaucracy, particularly for people with long term conditions"

Lived Experience Participant

What does good communication look like?

What is working well

Focus group participants highlighted some of the benefits they had experienced of multidisciplinary teams.

> *"I've seen big changes in primary care. I have a good surgery that signposts quickly and can review my medication without speaking to a doctor"*

Lived Experience Participant

> *"Referrals to secondary care have improved via an MDT approach. MDTs can unpick complexity that may not be obvious. They help look at wider determinants and the huge amount of risk that is held in primary care"*

Voluntary Sector Participant

> *"Sometimes external services have suggested treatment I didn't want but my GP and nurse helped me make a cohesive argument against it"*

Voluntary Sector Participant

We heard that when multidisciplinary teams work well, they can lead to more streamlined and efficient care, though many individuals were initially unaware this was due to a multidisciplinary team approach.

What does good communication look like?

The key themes emerging from our engagement showed that multidisciplinary teams that work well in general practice:

- Are co-designed with frequent users of primary care and people experiencing inequalities to meet their needs, and to ensure a smooth patient journey.
- Make people feel welcome and understood.
- Have strong processes in places for listening to people and remembering what they have said.
- Are designed in ways that build trust, create a sense of continuity and which value the time and energy of patients.
- Proactively communicate in a consistent way so people know what to expect and understand the role of various members of the team.
- Involve and include people in decision making around their care.

- Follow through with promises and are transparent throughout their engagement with patients.

There are many parallels with National Voices' earlier work on 'I Statements' –which are simple expressions of how people hope to be treated in health and care settings. The eight 'I Statements' are as follows:

1. I am listened to and what I say is acted on.
2. I make decisions that are respected, and I have rights that are protected.
3. I am given information that is relevant to me, in a way I understand.
4. I am supported to understand risks and uncertainties in my life.
5. I know how to talk to the person or team in charge of my care when I need to.
6. I know what to expect and that I am safe when I have treatment and care.
7. I am supported and kept informed while I wait for treatment and care.
8. I am not forgotten.

What would make a difference?

Proposed actions

Based on the insights we gathered, we have identified a series of proposed actions for those who design and deliver primary care. We propose that:

1. The success of a multidisciplinary approach should be measured against a team's ability to deliver care in a way that matters most to people who use their service.

   The point of a multidisciplinary team isn't and shouldn't be about managing the number of appointments in general practice, or the demand on the system. The aim of a multidisciplinary team should be on delivering the joined up, equitable vision of care set out in our 'I Statements'. This should prioritise what matters to the person using general practice. The success of a multidisciplinary team should be measured accordingly.

   We propose that offers available through NHS England's upcoming National General Practice Improvement Programme should support general practice teams to deliver change centred around the 'I Statements' and what matters most to people, and explore greater use of technology to support this.

   However, it is important to note that these changes will not be enough on their own –there will need to be investment in developing trust and a collaborative culture within teams that enables them to shift to a person centred approach to multidisciplinary working. There will need to be an investment in leadership, co-design and communication. This needs to be supported and resourced by Integrated Care Systems, who can free up time and headspace to support this important work.

2. NHS England should better equip general practice teams to deliver consistent messages explaining how they can support people, using lay explanations to share what changes in general practice mean for them.

   Most people find out about multidisciplinary teams by experiencing them first hand and this is likely to continue to be the case. While the shift to multidisciplinary teams may be an exciting one within the system, it's unlikely to radically change how people expect to access and navigate primary care overnight.

   The term 'multidisciplinary teams' has stuck because it means something from a system perspective, but it would be good to explore different options for labelling this in a way that means something for patients.

The priority for communications about the changes in general practice should be about sharing consistent messages outlining a clearly defined and nationally available offer within general practice, in layman's terms and in a way that highlights what matters to patients. We propose that this should be reflected in the activities that form NHS England's upcoming campaign on the changes to primary care, including in toolkits developed for ICBs.

3. NHS England should develop a programme of work to explore how continuity of care can be achieved through multidisciplinary teams, taking advantage of technology and the evolving role of care navigators.

   While continuity of care –in terms of the clinician a person sees –is often important to frequent users of primary care and to groups who experience health exclusion or inequalities, it is not needed for everybody in the general population. However, there is more that could be done to achieve continuity of care within a system or service.

   The changing role of receptionists set out in the Primary Care Recovery Plan and the launch of the new National Care Navigation Training Programme create an opportunity to reimagine the role of the front-of-house team in supporting continuity of care.

   We also welcome the commitment within the Primary Care Recovery Plan to funding for higher quality digital tools to support the whole practice team to contribute to rapid assessment and response. There are also unexploited opportunities in the role that technology can play in underpinning a smooth patient journey that builds trust –reducing the need for repetition and assessments, capturing key needs during triage and communicating these well throughout a patient's journey.

4. Integrated Care Systems should work with general practice teams to involve frequent users of primary care and people who experience inequalities in the co-design of their services.

   Too often, decisions about how to design and deliver work within a multidisciplinary team don't take into account the needs of diverse groups of people –diverse communication needs, the stigma that some communities face, the challenge of living with particular health conditions and much more.

   Many of the issues identified in this report could be resolved by bringing diverse lived experience voices to the centre of service design and transformation in GPs across England. Involving Primary Care Network and Practice Patient Participation Groups is a good start, but this will need to go deeper and wider to encompass the

diversity of individuals who make up our population. In particular, this will require general practice teams to go beyond traditional boundaries and involve people from populations who experience significant inequalities in service design.

We propose that offers available through NHS England's upcoming National General Practice Improvement Programme should encourage and support general practice teams to be more ambitious about how they involve frequent users of primary care and people who experience inequalities in the co-design of their services. Integrated Care Systems will play an important role in leading and resourcing general practice teams to strengthen co-design and co-production.

5. General practice teams should aim to actively involve patients in discussions and decisions about their care.

   If people using services are truly at the centre of care, they should feel 'part of the team'. General practice teams should aim to actively involve patients in discussions and decisions about their care. This should include patients receiving a summary of discussion when they are discussed at a multidisciplinary team, as well as information about how they can discuss any decisions made. This could include transparency about the thresholds and waiting times for care, as well as choice for patients about how and when they can get care.

Acknowledgements

This work has been funded through the VCSE Health and Wellbeing Alliance, jointly managed and funded by Department of Health and Social Care, NHS England and UK Health Security Agency. For more information, please visit: https://www.england.nhs.uk/hwalliance/

We would like to particularly thank National Voices' Associate Jonathan Moore for his significant contributions on this project.

We would also like to thank voluntary sector organisations and people with lived experience for their advice and input on this work, including Turning Point, Women in Prison, Ectodermal Dysplasia Society, Rethink Mental Illness, Faith Action, Salvation Army Housing Association, Hounslow Borough Respiratory Support Group, Cyclic Vomiting Syndrome Association, Hospice UK, LGBT+ Consortium, Caribbean and African Health Foundation, Pregnancy Sickness Support, Arthritis and Musculoskeletal Society, and the MS Society.

We would also like to thank Jean Ledger, Rosie Francis, James Raymond and Dr Minal Bakhai from NHS England for their input and advice on this independent report.

National Voices

National Voices is the leading coalition of health and social care charities in England. We have more than 200 members covering a diverse range of health conditions and communities, connecting us with the experiences of millions of people. We work together to strengthen the voice of patients, service users, carers, their families, and the voluntary organisations that work for them.

We make what matters to people matter in health and care.

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