Principles for improving multi-professional team-working in light of the experiences of COVID-19

The 10 principles below are taken from the full report Multi-professional team working: The experiences and lessons from COVID-19.

1. Effective training opportunities for all staff groups must be ensured to support new ways of working. Digitally enabled care requires new skills, previous opportunities for learning should not disappear without adequate substitute, and those who lost training time should be supported to recover. Creative training solutions should be encouraged and tested, such as clinical simulation for non-technical skills.

2. Developing generalist medical skill sets is crucial for potential future acute surges in healthcare demand and to meet changing patient needs. It will allow for a flexible workforce that can be deployed across clinical areas and manage increasingly complex cases including patients with multiple co-morbidities.

3. Continuing to value and nurture upskilling across occupational groups, including new roles, will help empower staff to expand the scope of their practice and will create a more agile and fulfilled workforce.

4. Increasing visibility of all multi-professional team members across healthcare settings will help dissolve professional silos and embed new or unfamiliar roles. Working alongside other occupational groups improves understanding of other's capabilities and potential utilisation in the team, and enhances collaboration.

5. Healthcare professionals and organisations must strive to counter silos between specialties. Strong clinical leadership with effective communication facilitated between both senior and junior members of specialty teams is required to maintain the cooperation seen during the pandemic and create a sense of shared purpose.

6. Maintaining accurate, reliable communication between and within specialty teams across care settings will enhance the quality of patient care. Ease of access to prompt specialty advice and input is crucial for professionals in community, primary, and acute healthcare settings, reducing unnecessary or delayed referrals for further medical care.

7. The use of hybrid models combining virtual and face-to-face options is likely to become standard for patient and colleague interactions. Attention is required to how these models can reduce health inequalities, meet clinical demands, and satisfy both patients and practitioners. There must be rigorous evaluation of new methods and the suitability of different platforms.

8. Hybrid working requires buildings and equipment geared towards both virtual and face-to-face interactions. Physical spaces for rest and relaxation and for teams to come together should be provided, and staff should be furnished with and trained to use equipment for video calls.

9. The pace of change during the pandemic sometimes meant that patients and the public were not involved in service redesign, but their input should be sought as new ways of working and new roles are embedded. Routinely co-producing services with patients can enhance experiences of care and reduce health inequalities.

10. Positive changes during the pandemic typically required supportive working relationships at all levels and across different occupational groups, from managers and commissioners, to collaboration with colleagues in non-clinical roles (e.g. administration, estates, security, and IT). Opportunities for networking and service design across these groups should be enshrined.