IFIC FORUM DISCUSSION MARCH 2026

Teamwork as a Pillar of Integrated Care

The Nine Pillars of Integrated Care – Pillar Discussion Series

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Introduction

The International Foundation for Integrated Care (IFIC) hosted the third in IFIC's series on the Nine Pillars of Integrated Care forum discussions in March 2026, bringing together an international panel, spanning academic research, clinical practice, health systems, and lived experience, to examine the state of integrated teamwork: what is working, what is not, what needs to change, and what a genuinely people-centred vision of teamwork might look like. The panel discussion was chaired by IFIC's Chief Executive, Niamh Lennox-Chhugani.

Integrated teamwork is the engine of integrated care. It is the point at which care integration is most tangibly experienced by people at the centre of care and by the professionals delivering it. Without functional teamwork as its operational foundation, integrated care remains a policy aspiration rather than a lived reality.

This paper synthesises the discussion and audience contributions from the Forum under three themes: the current situation, the changes required, and a utopian vision for the future of integrated teamwork.

1. The current situation: what is working and what is not

1.1 The promise of integrated teamwork

The Forum affirmed that where integrated teamwork functions well, it produces outcomes that siloed care cannot replicate. Panellists and participants identified several areas of genuine progress.

There is growing recognition that integrated care requires diverse professionals working collaboratively, sharing responsibility for care planning and delivery. The Forum heard examples of interdisciplinary teams that have developed high levels of trust, shared language, and mutual respect — particularly in contexts such as mental health, children's services, and older people's care, where resource constraints and complexity of need have driven professionals to find new ways of working together. As Niamh observed, these sectors have often worked better in an integrated way precisely because resource pressures and the complexity of the populations they serve have made collaboration a practical necessity rather than an optional aspiration.

The lived experience perspective brought a powerful reminder of what integration looks like when it works. Mick shared his own lived experience describing an example of person-centred integrated care he had encountered. The simplicity of this example was instructive: a team of two, operating with compassion, clinical skill, and respect for the person's own support network. As Mick put it, a team does not have to be complicated; it just has to be compassionate, caring, and the right team for the right time.

Deirdre highlighted the joy that many health and care professionals find in working as part of integrated teams. The opportunity to work at the top of one's licence, to learn from colleagues in other disciplines, and to grow professionally through exposure to different perspectives was identified as a significant motivating factor. The ECLECTIC Framework and Toolkit[1], developed at University College Dublin through co-design with older people, family carers, and 13 different professions, was offered as a practical example of how teams can be supported to build their own capability for interprofessional working.

There was also a sense that understanding of integrated care has matured considerably over the past five years. Niamh reflected on the marked change in participants joining IFIC's education programmes, noting that by 2026, students arrive with a much deeper understanding of integrated care than was the case in 2021, suggesting that the concept is moving beyond the committed few into broader system consciousness.

1.2 The persistent challenges

Despite these areas of progress, the Forum surfaced a range of deep-seated challenges that continue to undermine integrated teamwork in practice.

[1] ECLECTIC Project Resource Pack - UCD School of Nursing, Midwifery and Health Systems

The problem of team identity

One of the most striking findings shared was the fundamental lack of clarity about what a team actually is. Deirdre described how, in her research on integrated care pathways for older people in Ireland, professionals were often unable to identify which team they belonged to, let alone articulate how their team related to other teams in the system. Professionals reported belonging to multiple teams simultaneously, their professional team, their interdisciplinary team, and various reporting lines, and experienced confusion, tension, and what Deirdre described as an identity crisis around team membership. The assumption that professionals understand what a team is and can identify their place within it turned out to be far less reliable than expected.

Professional hierarchies and power dynamics

The Forum grappled extensively with the role of hierarchies in integrated teamwork. Robin was candid about the reality that most health and care cultures are dominated by doctors, noting that this is not always driven by doctors themselves. Many would welcome constructive challenge, but this is embedded in institutional norms and societal expectations. The consequence is that some professions, and particularly non-professional roles such as domiciliary care workers and voluntary peer support workers, see themselves as having less important perspectives. Robin argued that without consciously naming and addressing these power dynamics, they will inevitably shape how teams function.

Edelweiss took a deliberately different angle, stating that she had "absolutely no problems with hierarchy and disciplines," and pushed back against the assumption that hierarchy itself is the problem. Her argument was that hierarchy is task-dependent: in an emergency, a clear hierarchy and clearly defined roles are necessary and work well, but the ways of working that suit emergency care cannot simply be transposed to chronic conditions or long-term trajectories, where different tasks draw on the knowledge of different people involved and the hierarchy required for one task is not the hierarchy required for the next. She drew a sharp distinction between clinical hierarchy, team leadership and clinical decision-making, arguing that these are commonly conflated but are in fact different things. The only constant factor across the trajectory, she observed, is the person, and where relevant their family or support network. Everything else changes. The unresolved problem, in her view, is therefore not the existence of hierarchy but the fact that systems have not worked out how accountability shifts as roles and responsibilities shift across a trajectory.

She made a connected point about professional identity. Professionals are often pushed to select a single identity, when in practice everyone holds many identities at once without contradiction. The same logic applies to roles within teams: roles are not fixed, and treating them as fixed is part of what makes integrated working harder than it needs to be.

Trust: necessary but not sufficient

Trust emerged as a central theme, but the Forum moved beyond the familiar assertion that trust is important to examine why it is so difficult to build and sustain.

Edelweiss returned throughout the discussion to a recurring analytical question: is the enabler of integrated working culture, or structure? And to her answer: one does not work without the

other. To illustrate, she described an intra-hospital interdisciplinary team with high trust and stable membership that treated two conditions, one well-resourced and the other not. For the well-resourced condition, interdisciplinary working flowed easily. For the under-resourced condition, the same trusted professionals had to beg colleagues for their time. Trust, individual relationships and team history matter, but they require organisational mechanisms and sustainable resources to hold over time. She cited examples of partnerships sustained for several years that, once the supporting resources ended, left teams wanting to continue working in the same way but unable to find how to do so. Trust, on this account, is necessary but not sufficient, and analysing it in isolation from the structures around it is part of what has prevented the field from making more progress.

The Forum also heard that trust-building is particularly challenging when working with populations who have previously been failed by services. Edelweiss noted that the populations who may benefit most from integrated care may also be those for whom trust is hardest to build, particularly where previous experiences of services have reinforced the expectation that systems will fail them again. Her conclusion was structural: trust requires time, consistency, and attention to the conditions that make relationships possible, including the diversity of experience within teams and the ability to bridge gaps between professional and community perspectives. Robin framed trust as requiring professional curiosity, a genuine, ongoing effort to understand what colleagues do, what motivates them, and what pressures they face, and noted that even senior professionals often have a surprisingly vague understanding of their colleagues' professional responsibilities. In many ways, it can be harder to ask about the basics of others' professions and responsibilities the more advanced one is in their career, but the necessity of doing so remains, as it is very difficult to collaborate if you do not understand the pressures and expectations that others grapple with in their day-to-day work.

System conditions working against integration

A recurring theme was the extent to which the conditions created by health and care systems actively work against integrated teamwork. Several specific system-level barriers were identified. The relentless focus on productivity in health and care systems leaves little space for the relational care that integration requires. As Niamh noted, meaningful engagement in integrated teamwork takes more time and may reduce short-term efficiency, even though it generates long-term gains in value and quality of care.

The tendency to create new teams to solve fragmentation problems, rather than building the capacity of existing infrastructure, was identified as a significant contributor to further fragmentation. New teams are layered onto the system, often without adequate integration into existing primary and community care structures. Deirdre's research in Ireland found this to be a persistent pattern.

Accountability structures remain tethered to individual professions and clinical hierarchies, making it difficult to implement shared or distributed models of team leadership and decision-making. The question of who signs off on a clinical decision continues to default to the highest-status profession present, regardless of whether that arrangement serves the person at the centre of care.

Mick provided a powerful illustration of how macro-level policy shifts can devastate team functioning, describing how the Ontario provincial government's decision to curtail harm reduction programmes demoralised teams, drove professionals out of the field, and

undermined years of relationship-based, evidence-informed practice. The experience highlighted the vulnerability of integrated teamwork to political and ideological forces beyond the control of those delivering care.

Deirdre raised the issue of professional trust in the system itself, observing that health and care professionals bring with them a long history of working in systems that have breached their trust. She described examples from her research where nurses were pushed into social work roles to compensate for gaps in team composition, feeling unsafe and used by the system. Professional supervision structures sometimes actively blocked development opportunities because integrated roles did not fit within traditional scope definitions. This systemic breach of trust, she argued, is a critical barrier that precedes any attempt to build trust within teams.

2. What needs to change

The Forum identified a series of interconnected changes required across education, system design, leadership, measurement, and culture to make integrated teamwork, with the person genuinely at the centre, a reality rather than an aspiration.

2.1 Transform professional education

Both Deirdre and Edelweiss were emphatic that current models of professional education are failing to prepare the workforce for integrated practice. Deirdre argued that universities are letting the future health workforce down by not building in meaningful opportunities for interprofessional working, team-based problem solving, and exposure to a wide range of disciplines, including non-traditional partners such as the voluntary and community sector, home care workers, and people with lived experience.

Edelweiss offered a striking example from IFIC's education programmes. Professionals leading integrated care teams in countries undergoing system reform told her that, after completing the course, they finally understood the purpose of the work they had been doing. Her point was clear: from a system perspective, this reveals a serious gap between reform expectations and professional preparation. Reforms cannot proceed coherently if the people leading them only understand the purpose of their work retrospectively. Education has to come first, or at minimum move alongside reform from the outset. Professionals cannot be expected to navigate transformational change without the conceptual frameworks and practical skills to make sense of their new roles, new relationships, and the system within which they now work. She also issued a caution to the integrated care movement itself: it still tends to preach to the convinced. Once the conversation moves beyond the integrated care community, people bring different values and perspectives, and the movement does not always recognise how difficult it is to bridge that gap.

2.2 Redesign system conditions

The Forum was clear that integrated teamwork cannot be achieved through exhortation alone. The system conditions in which teams operate need fundamental redesign. Robin argued that systems need to help teams establish a clear shared purpose, identify the outcomes that matter for their collaboration, provide access to both quantitative data and qualitative feedback from people and families, and, critically, create protected time for reflection and learning. Without these foundational conditions, teams are set up to struggle regardless of the goodwill and commitment of their members.

Accountability structures need to evolve beyond single-profession models. The Forum acknowledged this as a particularly thorny issue, but one that must be confronted if shared and distributed models of team leadership are to become viable. Edelweiss drew a clear analytical distinction that the Forum returned to several times: clinical hierarchy, clinical decision-making and team leadership are commonly treated as a single thing but are in fact three different things, requiring different skills. She noted that many professionals take on clinical decision-making authority comfortably but do not feel comfortable with team leadership, which is a

distinct role that someone else in the team may be better placed to hold. Recognising this distinction is a precondition for redesigning accountability to reflect the realities of integrated working, and for taking shared and distributed models of team leadership seriously.

Resource allocation models must reflect the reality that integrated teamwork takes more time, particularly in its formative stages. The Forum heard that the investment of time in building relationships, understanding roles, and developing shared language yields long-term gains in care quality and staff experience, but that current funding and performance frameworks rarely accommodate this temporal dimension. Edelweiss argued that this reflects a structural mismatch: systems are still designed around episodes, while the lived reality of most people who depend on integrated care is a long trajectory. Until the design of systems is better aligned with care trajectories, teams will continue to absorb this mismatch as additional complexity in their day-to-day work.

The system must also become trustworthy for its own workforce. Deirdre's argument that health professionals need to trust the system before they can fully invest in integrated teamwork has significant implications for how systems manage workforce development, professional supervision, scope of practice, and career progression within integrated models of care.

Role blurring driven by resource gaps rather than genuine skill development, and the blocking of professional development opportunities within integrated roles all erode the trust that systems need from their workforce.

2.3 Invest in team leadership

Integrated team leadership emerged as a critically undervalued competency. Robin described the complex skill set required: the ability to be involving, encouraging, and challenging simultaneously; to encourage diversity of viewpoint while enabling conflict to be resolved positively; and to hold the team's purpose and the person's needs at the centre of decision-making. Very few professionals come equipped with these skills, and very few systems invest in developing them. The default of assigning team leadership to the highest-status profession — often a doctor who may neither want nor be suited to the role — was identified as a persistent and damaging pattern.

2.4 Rethink what we measure

The Forum challenged the assumption that current system-level metrics capture the value of integrated teamwork. Deirdre argued that the evidence base for team-level outcomes is poor partly because we are collecting the wrong metrics. System metrics can be counterproductive for teamwork, failing to capture the micro-processes that teams undertake to build relationships, coordinate care across boundaries, and create impact at the level of the individual person. The Impact Canvas Framework, developed as part of the ECLECTIC Toolkit, was offered as a practical tool for making these micro-processes visible, both within the team and to the wider system.

Robin's observation that team members may feel a team is very effective while the people accessing support do not experience that effectiveness was a salutary reminder that person-reported experience must be central to how we evaluate teamwork. The Forum also heard that

high-performing, emotionally cohesive teams can become exclusive and inward-looking, potentially reducing their inclusivity of the people they exist to serve.

2.5 Place people and communities genuinely at the centre

The Forum was unequivocal that people at the centre of care, their family carers, and their communities are not variables in the teamwork equation but its most constant factor.

As Edelweiss had put it earlier, the person is the only witness to the whole trajectory, and in that sense the most continuous member of any team built around them. This framing reorients the question of who belongs to the team: not those defined by the system, but those who are present across the journey.

Mick broadened this further by arguing for a concept of community of care rather than simply teamwork, recognising that for some populations, including Indigenous communities in Canada, decisions about health, social care, and wellbeing are community-based, not purely individual. The Western emphasis on the individual as the unit of care, he suggested, needs to be challenged if integrated care is to be genuinely people-centred in diverse cultural contexts.

The language of compliance and adherence, still commonplace in health and care, was challenged as fundamentally incompatible with genuine partnership. A shift from seeing people as recipients of care to recognising them as partners and co-producers of their own health and wellbeing outcomes is essential, but this requires more than a change of language — it requires a redistribution of power within the team.

2.6 Create cultures of honesty and learning

The Forum heard a call for greater honesty about what is and is not working in integrated teamwork. Edelweiss described IFIC's experience of trying to identify international examples of effective primary–secondary–specialist teamwork: the team originally aimed to find the best examples, then downgraded the search to good examples, and downgraded again because the exemplars themselves repeatedly asked not to be held up as best practice, acknowledging that they were trying but were struggling with significant challenges. This transparency about difficulty and failure, she argued, is essential for shared learning but remains rare. There is a threshold of honesty that the integrated care movement has not yet crossed, and without it, the opportunities for learning from each other remain limited.

3. A utopian vision: the future of integrated teamwork

Drawing together the threads of the Forum discussion, a vision emerges of what integrated teamwork could look like if the barriers identified were genuinely addressed and the changes called for were realised.

In this future, the person at the centre of care is recognised as the most continuous member of any team built around them, alongside their family or support network, where relevant. They are the witnesses to their own trajectory, the experts in their own experience, and the primary agents in decisions about their health and wellbeing. Their family, carers, and community are not peripheral to the team but integral to it, contributing knowledge, continuity, and care that no professional can replicate. For populations where health and wellbeing are understood as collective rather than individual, including Indigenous communities and other culturally distinct groups, the concept of team expands into a community of care, honouring different ways of knowing and deciding.

Professionals in this future hold strong, confident identities rooted in their disciplines, but they wear these identities lightly enough to be genuinely curious about what others bring. Multiple identities coexist without contradiction: one can be a doctor and a team member, a specialist and a learner, a leader in one moment and a follower in the next. This means that professional identity should be understood as multiple and context-dependent, rather than fixed or singular.

Professional boundaries are clear but permeable, serving as the basis for complementary contribution rather than as barriers to collaboration. Hierarchies exist where they are needed, for example in emergency care or in moments requiring specific clinical authority, but they should not be fixed or assumed across all contexts. In integrated care, authority may need to shift with the task, the context, and the person's needs. The hierarchy that governs a clinical decision is not necessarily the same as the leadership required to support the team. The contribution of team members who do not come from 'registered professions' is recognised with time for team development and reflection built in to build understanding and improve joint working.

Team leadership is recognised as a distinct and skilled practice, not an automatic consequence of professional status. Leaders of integrated teams are developed, supported, and valued for their ability to hold diversity, navigate conflict, create psychological safety, and keep the person's needs at the centre of every decision. Leadership itself is shared and distributed, with different team members stepping forward as the situation demands.

The system in which these teams operate is designed around care trajectories rather than discrete episodes, enabling integration rather than obstructing it. Culture and structure have to move together: a strong culture of collaboration cannot survive without structures that resource it, and the best-designed structures will fail without a culture that values relational care. Education prepares professionals from the outset for interdisciplinary, person-centred practice, with shared learning across professions, exposure to the voluntary and community sector, and engagement with people with lived experience as standard elements of training. Continuing professional development and supervision structures support growth within integrated roles, rather than penalising professionals for working beyond traditional scope boundaries.

Accountability models recognise shared responsibility and distinguish clearly between clinical decision-making authority and team leadership.

Resource allocation reflects the reality that relationships take time and that the investment in building trust, shared language, and mutual understanding yields long-term returns in care quality, staff wellbeing, and system sustainability. The metrics by which teams are evaluated capture what actually matters: the experience of the person at the centre, the quality of coordination across boundaries, the strength of relationships within and beyond the team, the micro-processes of care that create real impact, rather than proxy measures of productivity that incentivise fragmentation.

Trust permeates the system at every level: trust between professionals who understand and respect each other's contributions; trust between people at the centre of care and the teams around them, built through consistent, compassionate, responsive engagement; and trust between the workforce and the system that employs them, earned through genuine investment in their development, wellbeing, and professional integrity. The system itself becomes trustworthy.

The integrated care movement operates with radical honesty about what is working and what is not. Learning is drawn not from idealised exemplars but from the frank sharing of struggle, failure, and adaptation. The language of the movement reflects its values: people rather than patients, community of care rather than caseload, partnership rather than compliance, trajectory rather than episode.

And at the heart of it all is genuine care, for the people at the centre, for each other, and for the work itself. As Mick put it, teams do not need to be complicated; they need to be compassionate. The most powerful acts of integration are often the simplest: a doctor who asks a person what kind of support they have at home; a team that makes space for humour, for disagreement, for learning together; a system that trusts its workforce enough to let them do what they came into the profession to do.

This vision is utopian, but it is not unreachable. The Forum demonstrated that across countries and contexts, the building blocks are present: the knowledge, the commitment, the lived experience, the practical tools, and the growing understanding that integrated teamwork is the mechanism through which integrated care becomes a reality for people. The challenge is not one of imagination but of implementation, and of the collective will to redesign the systems, structures, and cultures that currently stand between where we are and where we need to be.