

Chapter 8

Working with Staff

For most integrated care initiatives one, or perhaps the, key resource that they will use to achieve better outcomes will be the staff working within the service. They are the main contact point that service users and their carers will have with the new arrangements, and are central to shaping people's experience of receiving support. Staff members will have unique insights regarding the current challenges faced by service users, carers and local communities, and through their experience and professional knowledge, to the potential solutions that could address any gaps or shortfalls. Taking a different perspective, as discussed in Chapter 5, they have the potential to disrupt or indeed effectively prevent new models of practice being introduced. Due to personal commitments and other connections with an area, many will work in the same locality for many years, meaning that they can outlast changes in policy or service reconfigurations, and so can provide a remaining legacy of how to work with other professions and services. They are, furthermore, key stakeholders in their own right, whose welfare and future career hopes should also be considered and responded to.

Ensuring that staff members within an integrated care initiative are able to work positively within the service and so contribute their skills and knowledge is therefore a key consideration. This is clearly not dissimilar to other services within this sector, and so the leaders of the initiative should have experiences that they can draw on. There are, though, key added challenges to overseeing an integrated care initiative. It may incorporate a range of professions and functions that are unfamiliar and different to a manager's own background and experience. Dependent on their professional and employing organisation, there may be alternative sets of performance and development frameworks. They may not be based wholly on the initiative, but spend some of their time working in other services. Finally, evidence highlights that there are additional

complexities regarding the workings of an integrated care initiative that must be considered and responded to.

We have previously explored the change process and how to positively engage staff through leadership and the management of change. In this chapter we focus on approaches that can be used to positively engage staff in the delivery of integrated care. The key questions considered are the following:

- What are the common difficulties in professions working together?
- What are the skills, knowledge and values required for inter-professional working?
- How can we understand organisational culture?
- How can we use supervision within an integrated care initiative?
- What contribution can training and development make?
- How can we develop good team working?
- Can communities of practice make a positive contribution?

What are the common difficulties in professions working together?

Healthcare services in particular are a rich tapestry of different professional groups – medics, nurses, therapists, psychologists and pharmacists, to name but a few. Furthermore, within these health professions there are often distinct specialisms related to different medical roles or conditions – surgeon, physician, geriatrician, psychiatrist and so on. Professions were created as a means to guarantee the quality of service that would be provided to a service user. This is generally achieved through requiring a minimum level of qualifications and experience, compliance with ongoing practice development and review, and registration with a recognised professional body. Therefore people who pursue such a career have to pass rigorous training lasting many years in which they become socialised into this profession's ways of thinking, communicating and values. They develop pride in their profession based on their inside knowledge of its particular skills and evidence base, and will have considerable loyalty to its status and role. Furthermore, professions can also be interpreted as a means to protect particular types of employment and therefore income to a discrete set of individuals. This could be seen to translate into professional groups wanting to maintain their own 'turf' from others in case this decreases their own ability to earn a good wage.

In social care and housing support there is a smaller range of formal professions, with social work and occupational therapy being the most common. There are, though, a number of frontline roles in these sectors and indeed in healthcare that may not meet the formal requirements to be a profession, but that must demonstrate a high level of competence and will have requirements regarding training and experience. Management is similarly not a distinct profession as such, although many such jobs now expect or at least prefer a relevant qualification. There are also 'true' professions within support functions such as accountants, lawyers and human resources (HR). All of this means that integrated care initiatives are likely to be a melting pot of professions and other groups who all believe in the importance of their role and the need for it to carry on in the future. Whilst in many ways this diversity is the strength of such a service, there are a number of issues related to 'professions' that commonly arise. Furthermore, it is also the case that bringing them together and especially co-locating them can lead to an intensification of these tensions. Key issues that can lead to such tensions are the following:

- *Skills and identity*: Professionals who are in a minority within an integrated care initiative can feel that they start to lose their particular skills and knowledge through being distant to others within their profession. This can make them feel that they are no longer as confident in being able to practise in such a role. They can also start to take on some of the ways of thinking and communicating of the professions that they are surrounded by, and even begin to express criticism of their own profession as a way of 'fitting in'.
- *Status and power*: Professional rivalries exist in most settings, as those from different groups attempt to get their ways of thinking recognised and seek to avoid domination by others. This is often a combination of believing in their perspective, not wanting their profession to be diluted, and the undoubted connection between status, salary and opportunity. Common rivalries are those between doctors and nurses, nurses and therapists, and social workers and just about everyone else! There is also a divide between the recognised professions and other roles.
- *Communication and understanding*: Professionals often find it difficult to translate what their perspective is to someone of another profession. This can be due to the different terminology and acronyms that are used, the specialist knowledge held by one but not by another, and the patterns of communication that are

normally deployed. Perhaps more fundamentally, professions can have alternative ways of seeing the world and the needs of service users and their families, which means that they can be saying the same thing but mean something very different. It is striking how little professionals who have worked together for years actually know about each other.

- *Incentives and performance:* One of the by-products of the various professions developing in parallel is that they have been able to negotiate or been subjected to alternative systems of performance and (perhaps most importantly) pay. There are also similar issues connected with professions and roles employed by different organisations or sectors – so, for example, administration staff working for the NHS or local authority, or between those undertaking support roles within the statutory or voluntary sector. These are important in relation to the issues of status, and also because staff members who are seconded into an initiative may not feel that their frameworks are recognised and understood, which would put them at a disadvantage in terms of promotion and reward.

What are the skills, knowledge and values required for inter-professional working?

Being a professional, or indeed undertaking another role successfully, requires the individual concerned having a set of competences connected with their profession and/or role. Being competent is to demonstrate the necessary skills, knowledge and values required to practise to a good standard. For all professionals and practitioners this includes *complementary competences* that are central to their own professional role and that can be delivered alongside that of others. For example, nurses are able to administer medication, physiotherapists to recommend movements to strengthen physical recovery, and psychologists to provide therapeutic interventions. There are also a set of *common competences* that have to be demonstrated by most, if not all, professionals and practitioners, such as communicating with service users, treating people with respect, and making accurate and timely recordings (Barr 1998). An integrated care initiative entails another set of competences in working with those from other professional roles, sometimes termed *inter-professionality*.

Inter-professionality: The process by which professionals reflect on and develop ways of practicing that provides an integrated and cohesive answer to the needs of the client/family/population... [I]t involves continuous interaction and knowledge sharing between professionals, organized to solve or explore a variety of education and care issues all whilst seeking to optimize the patient's participation... Inter-professionality requires a paradigm shift, since inter-professional practice has unique characteristics in terms of values, codes of conduct, and ways of working. These characteristics must be elucidated. (D'Amour and Oandasan 2005, p.9)

There has been considerable work internationally to define these core inter-professional competences. The Inter-professional Education Collaborative in the US has developed a holistic model that incorporates the main findings from research and previous models. This has four domains, as shown in Table 8.1.

Table 8.1: Core inter-professional competences

Domain	Demonstrated through...
Work with individuals from other professions to maintain a climate of mutual respect and shared values	Acting with honesty and integrity, placing service users at the centre, embracing cultural diversity, respecting other professions and roles, demonstrating high ethical standards
Use the knowledge of one's own role and those of others to respond to the needs of service users and populations served	Clearly communicating one's roles and responsibilities, recognising own limitations, engaging other professions and roles as required, clarifying each other's responsibilities, engaging in professional and inter-professional development
Communicate with service users, carers, citizens and other professionals and roles in a responsive and responsible manner that supports a team approach	Choosing communication tools and techniques that facilitate team discussions and interactions, avoiding discipline-specific jargon where possible, expressing own knowledge and opinions clearly, actively listening and encouraging opinions from other team members, giving constructive feedback and responding to that received, using respectful language
Apply relationship-building values and principles of team dynamics to perform effectively as a team to provide a quality service	Developing consensus on ethical principles, engaging relevant others in shared problem-solving, applying leadership practices that support collaboration and team effectiveness, managing constructively disagreements that arise, sharing accountability for outcomes, reflecting on team and individual performance, using evidence within improvement processes

Source: Inter-professional Education Collaborative Expert Panel (2011)

How can we understand organisational culture?

It is hard to find an enquiry or review regarding poor care or abuse of vulnerable people that does not highlight that a poor or negative culture within the services and organisations has been a contributory factor. Equally, the need to ensure a positive culture is generally included within the recommendations of such investigations. The concept is also widely included in the vision of organisations and partnerships, and within national policy and practice guidance. Despite becoming such a central part of our thinking about how services work, there continues to be uncertainty about what culture actually is, and if we can change it for the better. For example, one issue of debate is the extent to which there is a common culture across organisations, with some commentators arguing that there are, in fact, a set of sub-cultures within different services and other groupings that can act as a support or resistor to the overall organisational direction. Others do not even see this level of solidity, and instead argue that there is not settled culture but, instead, numerous dynamic and changing relationships between individuals and teams. Formal evidence of culture change and a corresponding improvement in outcomes is limited, although (in line with integration) this does not mean that ‘culture’ is not a vital factor. Leadership is thought to make an important contribution to the creation and sustainability of a desired (or not so welcome) culture.

Culture, and in particular, cultural differences and clashes between professional groups and their organisational ways of doing business, has been raised within numerous studies of integration. Two helpful models to understand the types of issues that are connected with culture are those by Schein (2010) and Johnson and Scholes (2001). Schein proposes that culture can be seen as operating on three levels – values (ideologies or charters), artefacts (physical manifestations such as dress code, company reports and environment) and assumptions (thought processes, feelings and behaviour). These levels can be further differentiated into three domains in which organisational culture is enacted – *patients* (or service users, in our terms), *people* and *place* (Gale *et al.* 2014). Table 8.2 provides an interpretation of this framework in relation to an integrated care initiative. The artefacts listed can by themselves provide practical challenges to the running of an integrated care initiative. As importantly, though, they can signify (or be interpreted as signifying) a deeper assumption about the services and professional groups that contribute to an integrated care

initiative. For example, if one professional has greater access to funding and time to undertake development, this can be seen as a symbol of how this profession is seen as more important.

Johnson and Scholes developed the ‘cultural web’ as an accessible framework to present the symbolic, political and structural aspects that influence the overall ‘paradigm’ or ways of thinking within an organisation. Such ‘deep thinking’ is key to how organisations will interpret and therefore respond to opportunities and circumstances that they encounter, and understanding the paradigm can help to explain why stakeholders can see a similar problem or solution so differently. Figure 8.1 provides an overview of key questions that can be deployed in order to explore the paradigms within an integrated care initiative.

Table 8.2: Observable artefacts commonly encountered in an integrated care initiative

Domain	Example of common artefacts within an integrated care initiative
Service users	Terminology: tenants, patients, service users or clients are but a few of the terms that are used within these sectors Relationship: service users in housing have to sign a legal tenancy agreement, whereas in health there may be no signed care plan Charging: healthcare is largely free, whereas charging applies in social care and housing
People engaged in delivering a service	Staff dress: uniform commonly worn by health staff that differentiates between them and non-health staff, and between different health disciplines Terms & Conditions: staff may be entitled to different holidays or opportunities for learning and development Payment: salary differentials lead to distinct variations in holidays, cars and housing
Place in which services are delivered	Location: are service users required to come to a discrete building or are they supported in their own home? Use of building: if a discrete building, is this shared with other services and organisations? Standard of building: is the building in a good state of repair and designed for the service in question? Facilities for staff: are there different expectations on office and desk arrangements, and facilities for refreshments?

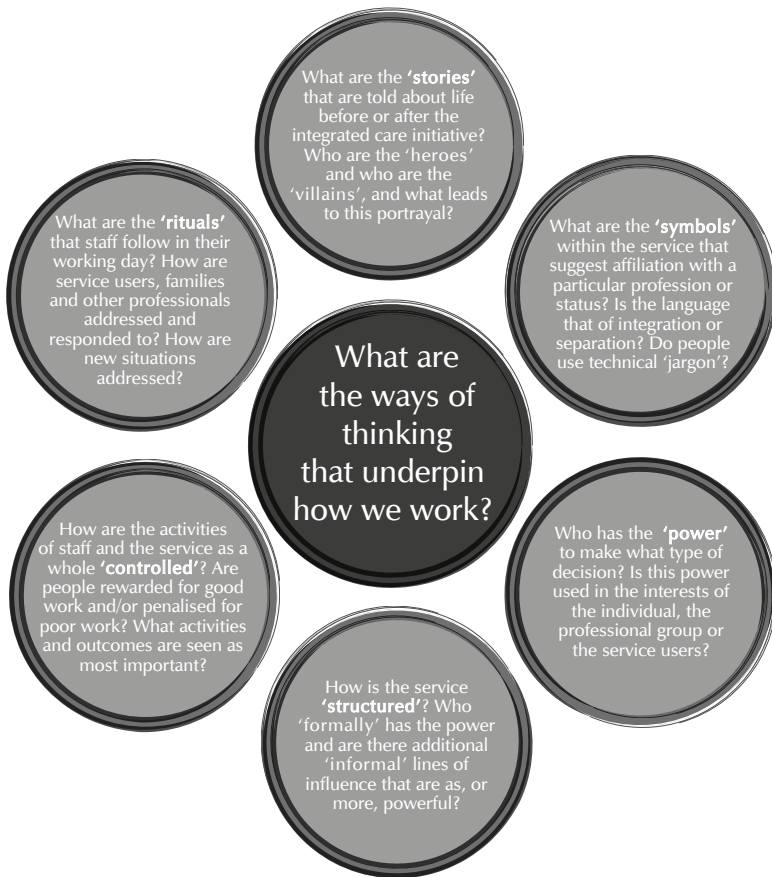


Figure 8.1: Key aspects of a cultural web within an integrated care initiative

What interventions can positively respond to these aspects?

We have presented *professions, skills and knowledge* and *culture* separately to provide clarity about what the terms refer to, and the particular issues that they have been shown to lead to within integrated care initiatives. It will be clear, though, that there is a strong connection between these aspects. For example, the extent to which professional training has incorporated working with other disciplines will partly determine skills in communicating effectively, and professional cultures influencing people's willingness to participate in joint development sessions. The interventions that can be taken therefore need to be sensitive to the three aspects, and can seek to respond to one or more of them simultaneously.

Furthermore, the interventions themselves can interact, and should be deployed on the basis of the issues identified when initially planning the integrated care initiative (see Chapter 2) and emerging evaluation findings (see Chapter 9). The four staff-based interventions we will be focusing on in the sections that follow are supervision, inter-professional learning, team working, and communities of practice (CoPs).

How can we use supervision within an integrated care initiative?

Supervision of practice is a core requirement for all health and care professions to retain their professional status. Employers should also provide it for non-professional practitioners as a means to promote good practice and to ensure good quality of care.

Supervision has been shown to provide a number of important supports to staff members (Carpenter *et al.* 2012):

- providing an opportunity to reflect on aspects of practice about which the individual feels less confident
- considering options for intervention including the opportunities presented by new treatment and support
- receiving professional advice and having informed discussions about unfamiliar and high-risk situations
- offering a forum in which they can express the emotional impact of their jobs and the impacts that their decisions may have on the lives of others
- making staff feel valued and nurtured as individual professionals and practitioners.

It has also been shown to have benefits for the service through improving job satisfaction, encouraging engagement and commitment, and helping reduce staff turnover. These benefits for individual staff and for the service are also then likely to have benefits for service users through improving the consistency and quality of the service offered.

The importance of supervision is in many ways heightened within an integrated setting as staff will be based with professionals and practitioners from different disciplines and may not have a more senior or indeed other colleague from the same background. This can reduce the opportunity for peer support (which can also help with the aspects

listed above), and contribute to the feelings of isolation and professional dilution mentioned above (see also Table 8.3).

Table 8.3: Types of supervision

Type of supervision	Usually completed by...	Purpose
Managerial	Supervisor with accountability and authority	Review their performance Set priorities/objectives in line with the organisation’s objectives and service needs Identify training and continuing development needs
Clinical	Experienced clinician/ practitioner of same background	Reflect on and review their practice Discuss individual cases in depth Change or modify their practice and identify training and continuing development needs
Professional	Experienced clinician/ practitioner of same professional background	Review professional standards Keep up to date with developments in their profession Identify professional training and continuing development needs Ensure that they are working within professional codes of conduct and boundaries
Inter-professional	No common arrangement	Reflect on the individual’s experience of working within an integrated care initiative Identify training and development needs relating to inter-professional practice Discuss opportunities to improve integrated care received by service users and their families

The terms ‘clinical’ and ‘professional supervision’ are often used interchangeably (see Table 8.3), and in many (but not all) cases will be provided through the same process. ‘Managerial supervision’ is again linked, but through its focus on organisational objectives and performance of the staff member in relation to these, it has a more distinct focus. Within an integrated care initiative there is also another aspect of practice that needs to be considered and incorporated within a supervision structure – that of inter-professional working. The key stakeholders, functions and

elements of supervision have been brought together in a 4×4×4 model of supervision (SCIE 2013) that incorporates:

- four *stakeholders* – service user, professional/practitioner, organisation and partnership
- four *functions* – management, support, mediation and development
- four *elements* – experience, reflection, analysis and action planning.

There is no single way to provide supervision within an integrated care initiative, and the key issue is that all the elements outlined in Table 8.3 are available to all professionals and practitioners. For example, if the person's line manager is of a different profession, there can be a separation between managerial and clinical/professional, with the latter being provided by an individual within the same service, from a different part of the same organisation or, indeed, from another organisation (see Case example 8.1). Group supervision is another option, and whilst developed in uni-professional settings, there is increasing evidence of the benefits of restorative supervision for both the supervisee and supervisor (see Chapter 4).

Case example 8.1: Occupational therapy supervision

Understanding the difference between professional accountability and operational line management was a breakthrough moment in Aneurin Bevan's Health Board, freeing occupational therapists (OTs) to work wherever they needed to work under the day-to-day direction of a team manager who could be from any agency or profession. The focus from within the Health Board's occupational therapy service shifted away from the protection of the existing organisational structure to the creation of a professional structure to support OTs, regardless of where they worked, to access professional supervision, annual appraisal, and training and development. Within new models of integrated service delivery, OTs remain professionally accountable to the most senior OT in their organisation, but are increasingly being deployed into teams to be managed on a day-to-day basis by an operational team manager. The creation of a very strong professional identity, which upholds a focus on occupation, is at the core of what makes OTs different from other professional groups. This was critical in enabling OTs to grow in skill and knowledge, with the confidence that they can perform their roles independently whilst completely supported by a robust governance framework.

What does this case example tell us?

- » It is possible to separate out line management and professional supervision and development so that they are delivered through different processes and people.
- » Moving away from the traditional structure led to a renewal of professional identity and purpose.

Source: Kelly (2015)

What contribution can training and development make?

Providing training and development opportunities are an obvious way to support staff members who will be working within an integrated care initiative to develop the skills, knowledge and values that have been identified through their supervision and appraisals. Within the field of integration there has been particular interest in the potential of inter-professional approaches to such training and development. Inter-professional education (or IPE as it is often shortened to) is differentiated by the expectation that participants will not only learn alongside those from other professions and functions, but also that they will actively learn through interactions with each other (see Table 8.4). Much interest and research in inter-professional learning to date has related to undergraduate training, but there is also a growing body of evidence regarding its deployment within continuing professional development. Case example 8.2 demonstrates how theories of education can be practically applied:

- Locality teams were expected to produce a real business case to respond to a local priority for integration (*experiential learning*).
- Flexibility was built within the programme to enable participants to identify additional/alternative areas of learning (*adult learning*).
- There were multiple opportunities for reflection through action learning sets, personal diaries, team reviews and individual development sessions (*reflective practice*).
- Participants were expected to work in their teams to undertake work-based tasks in between block teaching days at the university (*collaborative learning*).
- There was an emphasis on professionals within teams sharing knowledge and skills and encouragement to explore differences as well as areas of overlap (*social learning*).

Table 8.4: Different types of learning

Type of learning	Description	Scenario example
Uni-professional	Professionals learn in isolation from other professional groups	Updates for physiotherapists on the latest developments in physical therapy Attendance of an OT at a national occupational therapy conference Training for home carers on manual handling
Multi-professional	Professionals learn alongside other professional groups	Presentation on new areas of policy and legislation that could affect many professionals and practitioners in the service Briefing on new information-sharing protocols within the organisation
Inter-professional	Professionals learn with, from and about each other	Adult safeguarding training in which different professions participate in interactive sessions based around case studies People-centred care planning in which service users talk to groups about their experiences, and there is group reflection on their insights

In designing an inter-professional learning opportunity it is important to follow a mapping process similar to the one followed in Chapter 2 for the integrated care initiative as a whole, with expected outcomes clearly identified along with the learning opportunities that would enable these to be achieved. The framework outlined earlier can be a helpful structure to think through and set expected outcomes in relation to the competences of staff members. A helpful means to frame the learning objectives is that provided by Kirkpatrick and Kirkpatrick (2007), which is adapted below, in a series of related questions:

- *Experience*: Do participants report having found the learning opportunity interesting, relevant and enjoyable?
- *Learning*: Did participants gain the expected knowledge and skills, and were these retained after the development opportunity?
- *Behaviour*: Did this additional knowledge and skills lead to a change in their professional and inter-professional practice?
- *Impact*: Has any change in behaviour contributed to the achievement of the expected benefits for service users and carers, financial efficiency and improving population health?

Inter-professional learning can be provided through more formal and discrete sessions (see Case examples 8.2 and 8.3). However, there are numerous other means to provide development opportunities that can positively engage professionals and practitioners, which may not require additional resources and external facilitators. For example, opportunities for different team members to present a case study of a service user they are supporting can be an excellent structure to demonstrate the work of the different professions. If this includes time for others to contribute their thoughts regarding existing challenges faced by the service user, this can improve the integrated care that they receive. Service users may also find such sessions illuminating and constructive, and can participate directly in such reflective learning. This does, of course, need to be well structured to avoid being tokenistic or, worse, distressing for the service user. Shadowing other professionals and practitioners is another inexpensive but informative opportunity for understanding more about the work of others. Debriefing from complaint investigations and sharing compliments provides insights regarding how service users and carers are experiencing the care provided, and the potential for collaborative action planning to respond to weaknesses and to build on strengths.

Although outwith the focus of this book, it is worth noting the rich learning opportunity that an integrated care initiative can provide for undergraduates and other trainees. Providing such opportunities is vital if we are to enable the professionals of the future to be able to work together successfully, and there is evidence that students can take on negative stereotypes of other professions during their training that inhibits their willingness to then work with other disciplines. Students are also often good at challenging our ways of thinking through bringing a fresh pair of eyes and the latest thinking in practice!

Case example 8.2: The Integrated Care Development Programme (ICDP)

The ICDP was a continuing inter-professional educational programme for health and social care managers and commissioners. Multi-professional strategic teams from a single locality participated in university and workplace-based learning activities centred on the development of an integrated business plan to address a local priority for improvement. These learning activities included taught sessions exploring research and theory, group discussions and presentations, challenge events in which external stakeholders critiqued draft plans, and reflective exercises.

The evaluation used participant self-assessment, semi-structured interviews and group discussions to assess the achievement of expected impacts on the participants, their organisations and partnerships, and patient/service user outcomes. The findings indicate that whilst those employed in management and commissioning roles had considerable experience of working across professional and agency boundaries, they derived individual benefits from a workplace IPE programme. The principles of design and delivery developed in pre-registration and clinician/practitioner IPE courses also applied to those working at a more strategic level. Organisational impacts were reported, but six months post-programme, evidence was not yet available of significant improvements in patient outcomes and/or financial efficiencies. Individual motivation, team dynamics and support from line managers all affected the extent to which individual and organisational impacts were achieved.

What does this case example tell us?

- » Adult learners respond to education that is based around the real tasks and pressures that they encounter, and to flexibility in the activities provided.
- » Inter-professional issues are also present at more senior management levels, and can be positively addressed through shared learning opportunities.
- » Alongside individual commitment and ability, more contextual factors such as support from organisations influence engagement and learning.

Source: Miller et al. (2014)

Case example 8.3: 'Sliding Doors'

NHS Education for Scotland, the Scottish Social Services Council and a learning and development consultancy developed the Sliding Doors resources. These aimed to support health and social care staff in understanding a new model of care that valued older people as community assets, ensured their voices were heard, and supported them to enjoy full and positive lives in their own home or a community setting. The workshop commenced with participants considering what a 'good life' meant to them. Identifying their personal outcomes early in the session encouraged participants to have a personal connection with what followed. An actor portraying 'Maggie', an older woman with

dementia, diabetes and depression, and 'Iain', her husband, interrupted the discussion. Participants gained an insight through the unfolding drama into what was important to Iain and Maggie – what made a 'good life' for them. This made a connection between the participants and the actors. The participants then worked in groups to discuss what they had learned about Iain and Maggie, and what they needed to know and do as professionals to support Iain and Maggie's expressed 'good life'. The drama then continued. Two years passed – Maggie was less able, and Iain had to go into hospital for a minor operation. This change represented a turning point: how Iain and Maggie's lives moved forward from here would depend on the responses and actions of everyone around them.

The film 'Sliding Doors' (directed by Peter Howitt in 1998) shows two possible futures for a young woman. In one, she catches a tube train, meets a man, and finds love and fulfilment. In the other, she misses the train and her life continues as a struggle. The chance event of catching the train or not – determined by the 'sliding doors' of the tube train closing – is a turning point for the possible future she will follow. In the workshop, 'sliding doors' acts as a metaphor to describe participants' potential to positively influence people's lives. It promotes awareness of how their decisions and actions as professionals affect other people going forward, and causes them to reflect on whether they support them to 'live the life they want to live' or not. This requires understanding of what is important to individual people at specific times in their lives. The aim of this exploration of the turning points in Iain and Maggie's lives is to help participants to understand the cultural and practice shifts they need to make as professionals. Iain and Maggie directly challenge them towards the end of the workshop to make two or three key commitments as people with sufficient influence to help ensure their future stays close to what is important to them in their 'good life'.

What does this case example tell us?

- » Putting the lives of service users and carers at the heart of IPE makes the learning relevant and engaging to professionals and practitioners.
- » More creative methods such as drama can be used to illustrate alternative ways of thinking and practising.

Source: Walker and Gillies (2014)

How can we develop good team working?

Most professionals and practitioners operate as a team, and indeed, many are part of several teams at the same time. The centrality of teams to our work, and the contribution that good team working can make to achieving integrated care, has become increasingly recognised. This is also true for ‘non’-integrated teams, although in reality, most teams within the health, social care and housing sectors will contain more than one profession and/or practitioner discipline. This includes senior management teams that will often have members from a financial and human resources (HR) background as well as a management and/or clinical or other professional background. When teams work well they are thought to lead to greater efficiency and effectiveness, and to be key facilitators of ‘safe’ services through open communication and shared problem-solving. Teams are also promoted on the basis that they will provide a more enjoyable and enriching work environment for the staff concerned, and so improve motivation and retention. There is some evidence to support these positive views (see Table 8.5), and also the contrary perspective, that dysfunctional teams are often highlighted as contributing to examples of poor, or indeed abusive, care.

Table 8.5: Summary of evidence of integrated teams

Beneficiaries	Summary of evidence
Service users and families	There is evidence that multi-disciplinary teams have positive impacts for cancer patients (including better care planning, improved satisfaction and longer survival times) and within mental health services (including reductions in severity of symptoms, fewer compulsory admissions and a better social situation). There are not always positive impacts reported, though, with examples of service users reporting that integrated teams were not easy to access or respectful in their approaches
Professionals and practitioners	Positive experiences of being part of a team can lead to improved job satisfaction, lower levels of stress and reduced injuries and sickness
Organisations	Teams can contribute to a reduction in errors and near-misses, and can support more enabling models of care that are based outside of institutional settings. Evidence regarding the cost-effectiveness of such teams is mixed, though, with examples of them being assessed as leading to better outcomes and lower costs, but also higher costs with no improvement in outcomes

Source: Jelphs, Dickinson and Miller (2016)

A key issue is that simply labelling a group of individuals a ‘team’ does not automatically enable them to work together successfully as one. This is often paraphrased as the divide between ‘real’ versus ‘pseudo’ teams, with real teams being described as ‘comprised of [a] small, manageable number of members with an appropriate mix of skills and expertise, who are committed to a meaningful purpose and have collective responsibility to achieve performance objectives and outcomes’ (Harris *et al.* 2013, p.22). Much of the work on teams in the UK has been based on the pioneering work of Michael West and colleagues at Aston University on the English NHS. Their work highlighted both the benefits of ‘real’ teams but also the damage caused by ‘pseudo’ teams. From their research and others exploring this field, it is possible to highlight a number of key issues that need to be considered when introducing or strengthening teams within an integrated care initiative. Interestingly, whilst the final arrangements and logistics may differ, the principles behind them apply to teams in any setting or service (see Figure 8.2 and Case example 8.4).

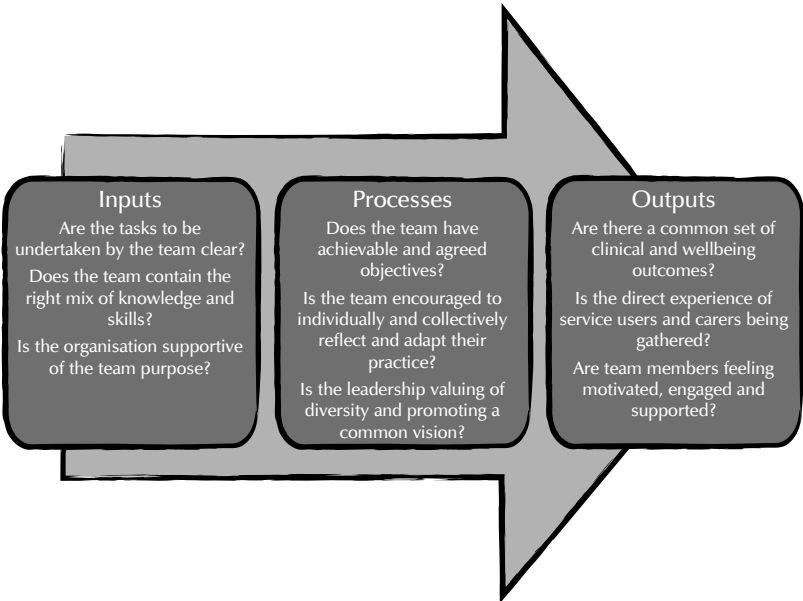


Figure 8.2: The Input–Process–Output Model of team effectiveness
Source: West and Lyubovnikova (2013)

Case example 8.4: Team working development in a fictional homeless scenario

The complex needs service undertook an evaluative review of its work that highlighted a number of key issues regarding team work in the service:

- » Due to the 24-hour nature of the work and the shift patterns that were in operation, there were few opportunities for team members to meet as a whole.
- » Whilst all staff members saw their overall purpose as being to support homeless people to improve their wellbeing and independence, there was a lack of agreement regarding the objectives that sat beneath these high-level aspirations, for example the point when the service user would be ready/expected to leave the service.
- » In addition to being part of the complex needs team, the practitioners were also members of inter-agency teams developed around individual service users. There was feedback from both staff and external stakeholders that these teams did not always function that well.

In view of the evidence regarding the importance of teams within integrated care initiatives, it was agreed to make developing their team work a key priority for the next 12 months. A simple electronic survey was developed mirroring the aspects of the Input–Process–Output Model (see earlier), and circulated to all the team members. A whole service event was arranged, with cover being provided to enable all staff members (including those who work at night) to attend. The results of the survey were shared, and a series of interactive group sessions used to jointly reflect and respond to the findings. Alongside this more internal focused activity, the service's steering committee was informed of the issues regarding the inter-agency teams. The committee contained representatives from these key agencies and decided to undertake joint work to strengthen collaboration within these temporary teams. This included bringing various professionals and practitioners together in development sessions to consider scenarios based on situations previously faced by service users.

Can communities of practice make a positive contribution?

Much of the current thinking and practice regarding communities of practice (CoPs) arises from the work of Wenger and colleagues. They originally proposed the term to describe the process through which ‘novices’ engaged in ‘situated learning’ to reflect that this involved much more than simply acquiring knowledge, but also socialisation and identity of development. They subsequently redefined it to reflect the engagement of groups of individuals in creating and sharing knowledge, and suggested that they could and should be actively developed by organisations to support improvement (see Wenger, McDermott and Snyder 2002). They suggest three key characteristics of CoPs – *mutual engagement* (interaction with each other, developing relationships and negotiating meaning), *joint enterprise* (undertaking similar tasks, common opportunities to influence and producing joint outputs) and *shared repertoire* (the stories, artefacts, words and rituals that are created). Reviews of their impacts on practice indicate that they can have positive benefits in relation to implementing new processes and technology, facilitating knowledge transfer, completing basic training, and reducing professional isolation.

There is not a recommended size or membership for CoPs to work effectively, and different methods of communication and engagement between members (e.g. workshops, seminars, social media groups) can be effective (or not) depending on the purpose and context of the CoP. It is clear, though, that simply calling a network of people a CoP will not lead to one being experienced in practice.

CoPs are often uni-professional or within a single organisation, and in such circumstances can be a barrier to inter-professional working due to the strong relationships and shared knowledge between members acting as a barrier to the inclusion of those outside of the CoP. This does not mean that they should be disbanded, or that members of an integrated care initiative should be prohibited from participating in such CoPs. Indeed, withdrawing from established CoPs could lead to members of the service losing vital updates and connections within their professions or areas of interest. It is important, though, to map out the existing CoPs, to consider the benefits of connecting their work and assessing the risks to inter-professional working of their inherent boundaries. Individuals who are members of different CoPs can act as key boundary spanners for this process (see Chapter 4). Multi-professional and multi-organisational

CoPs can also be developed (perhaps through expansion of existing ones with a narrower membership) as part of an integrated care initiative (see Case examples 8.5 and 8.6).

Case example 8.5: Communities of practice (CoPs) for those working with the multiply excluded

The Multiple Exclusion CoP programme was developed to explore if CoPs could overcome fragmentation in services and staff feeling out of their depth due to uni-professional training and experience. Five CoPs were established in different localities with a small budget for housekeeping and facilitation support. Each was expected to have between 6 and 12 members that represented the housing, criminal justice, social care and health professions working with this user group. They met monthly to discuss anonymised case studies presented by their members. There was also an online forum to share information between the CoPs, with further support from the research team to identify relevant evidence and policy documents.

The CoPs seemed effective in building collaborative networks. They provided an opportunity to discuss the challenges that they all individually faced without the pressure of having to represent, or indeed defend, the interests of their separate agencies. Key aspects to these positive impacts were the use of the case studies, the opportunity for 'face-to-face' contact, and the sharing of evidence through the researchers. They were not sure that this positive experience would lead to improved outcomes for service users in the short term due to the wider context in which the services were operating and their limited membership.

What does this case example tell us?

- » CoPs can provide a forum in which professionals and practitioners from different agencies and backgrounds can share experiences and insights.
- » The common motivation was to improve the lives of a marginalised group through better inter-professional and inter-agency working.
- » Spending time together with structured activities helps remove barriers on a micro level, but these remain on a macro level.

Source: Cornes et al. (2014)

Case example 8.6: Communities of practice (CoPs) and primary care improvement

To support the identification, management and treatment of patients with chronic kidney disease (CKD) in primary care, this project involved 19 general practices creating improvement teams. Based on the CoP principles, these included a GP, a practice manager and a practice nurse who were supported by an external facilitator from the research team. The latter included nephrologists, management academics and analysts. Team members in the practices had different motivations for participating, including an overall passion for learning and improvement, an interest in CKD in particular, and the potential to gain more income through better achievement of quality standards. It was also hoped that the practises would form a wider CoP during the project.

The multi-professional nature of the teams was seen largely as positive, and their shared commitment to their practise and patients provided a common focus. In the smaller practices there was better engagement from other practice staff who also often attended the CoP meetings, whereas in the larger practices it seemed more difficult to get other practice members on board due to a lack of identification with the team's work and other demands on their time through other initiatives. The CoP between the practices was less successful, with limited participation in teleconferences and an online community. Key factors that contributed to this were thought to be competition between the practices to be 'the best' in their area, and a tradition of uni-professional networks as the vehicles for information sharing.

What does this case example tell us?

- » CoPs worked well within smaller services as a means to bring together professionals and practitioners through face-to-face meetings around a shared interest.
- » CoPs based on virtual meetings and online forums were less successful due to rivalries and a lack of shared connection with those from different professions and services.

Source: Kislov, Walshe and Harvey (2012)