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Professional relationships and how they relate to families

Professor Nigel King
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Definition of Collaborative Working

- When two or more professionals from different professional groups are required to interact to ensure that appropriate care is delivered
- Need not be members of a formally constituted team
- Level of collaboration can vary from the transient and superficial to close, long-term working relationships.

WHY WORKING TOGETHER MATTERS

- Need for different professionals, patients and carers to work effectively together is key to contemporary health and social care
- Failure to do so has major implications for:
 - Delivery of patient-centred care
 - Patient safety
 - Staff morale
 - Health service costs

- Especially true for Palliative and Supportive Care:
 - Complex cases involving many professionals
 - Often requires collaboration across sectors: primary/secondary/tertiary; health/social care
 - Sheer number of professionals coming into the home can be confusing and/or frustrating for patients and carers

What for you is the most significant barrier to good collaborative working?

1. Unhelpful organisational structures
2. Poor team leadership
3. Not knowing those with whom you need to collaborate
4. Conflict over role boundaries
5. Poor personal relationships
6. Poorly integrated systems and procedures

Evidence from the literature

- Definitional challenges re 'collaboration' and its relationship with similar concepts
(e.g. Zwarenstein et al, 2009)
- Clear that poor collaboration can have negative impact on quality of care and/or patient safety
(e.g. Lingard et al, 2006 re intensive care)
- Full understanding requires multi-level analysis: systemic, organisational and interactional levels
(San Martin-Rodriguez et al, 2005)
- Emphasis tends to be on collaboration within inter-prof teams
 - BUT also need to look at it across teams/services

HUDDERSFIELD/MACMILLAN STUDIES

- Nursing roles in community palliative care
(King et al, 2010)
- Multi-agency working from the perspective of patients and carers
(Hardy et al, 2012)
- Evaluation of Midhurst Specialist Community Palliative Care service
(Noble et al, in press)
- Unpicking the Threads: Specialist and Generalist Nurses' roles and relationships in supportive care
(King et al, 2013)

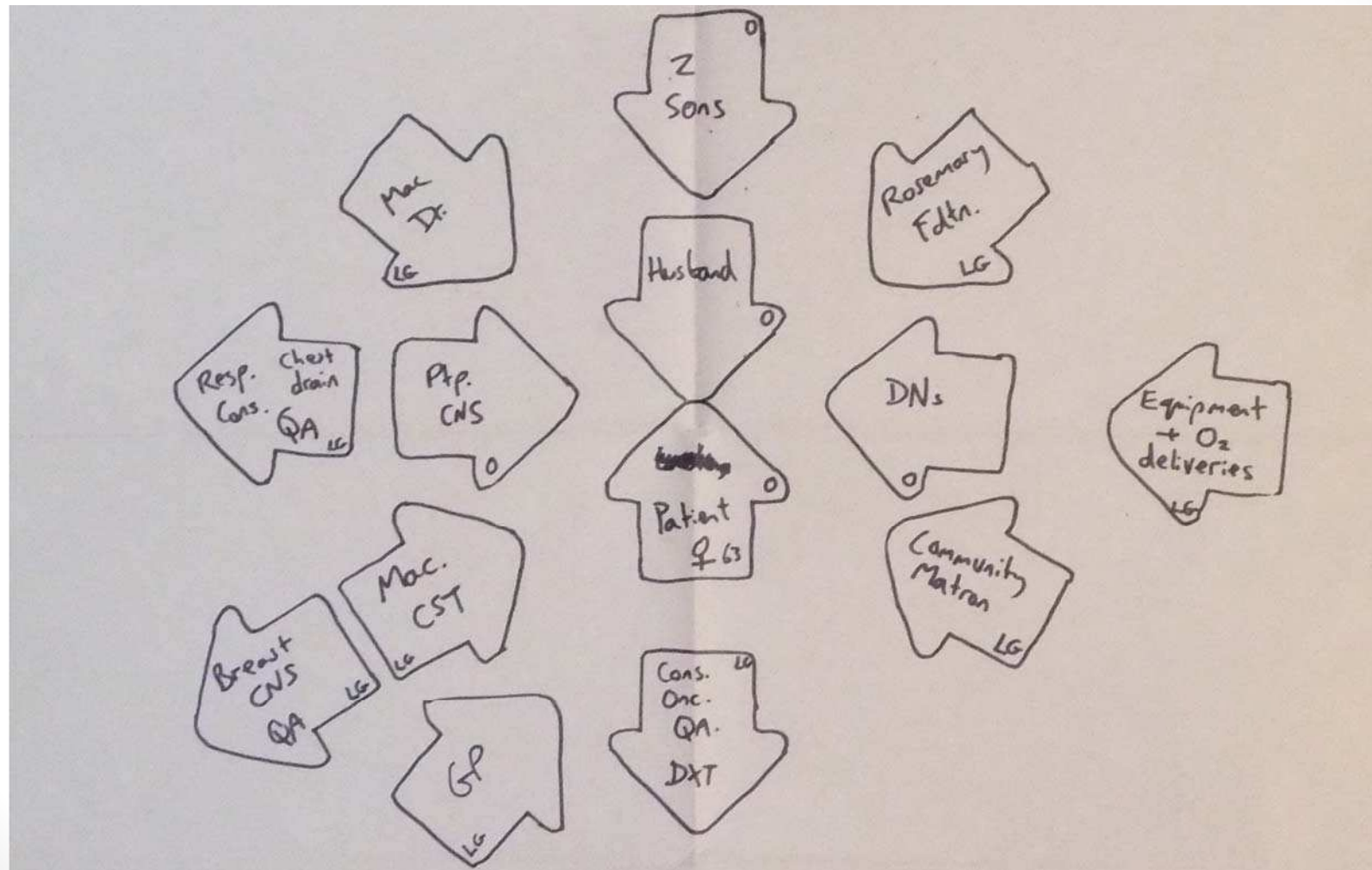
A METHODOLOGICAL CHALLENGE

- Needed participants to reflect on involvement in a complex case
 - Hard to keep it all in mind
 - Easy to slip into 'official' version of role and identity
- We wanted to get at the perspective from direct lived experience

OUR SOLUTION: THE 'PICTOR' TECHNIQUE

- Participants choose one memorable case
- Produce graphical representation of case, placing arrow-shaped 'Post-Its' on large sheet of paper
- Served as basis for reflection on, and discussion about, case with interviewer
- Draws on method used in family therapy (Hargreaves, 1979)

Example: 'Naomi' - Clinical Nurse Specialist, Midhurst team



Naomi's case

- Patient, 'Yvette', 63, recurrent breast cancer with lung secondaries, fungating wound on chest
- GP referred to MH, because of pain control issues, as well as concerns re dressing wound
- District nurses heavily involved – but struggling
- Community Matron brought in by DNs – upset patient and Husband ('Lawrence') by manner

- Naomi liaised with acute hospital Consultant and Breast Cancer specialist nurses
- Helped bring in support, inc. night sitters, from Rosemary Foundation (local charitable organisation)
- Brought in MH Community Support Team to help DNs when stretched
- Naomi concerned not to be seen as “taking over” from DNs
- Had strong personal relationship with Yvette and Lawrence

Main Themes Across Our Studies

- Role perceptions and understanding
- Role flexibility
- Context of change and uncertainty
- Centrality of relationships

Key facets of relationships in collaborative working

- Accessibility
 - Including value of face-to-face contact
- Building over time
 - Making an effort, earning respect
- Diplomacy
 - Avoiding “stepping on toes”

Accessibility

- Ability to access collaborating professionals in easy and timely fashion very important:
- *“We use both [Midhurst Consultant] and the other [first name] who’s name I can’t remember, both of those are really good and accessible especially for advice for us and for the GPs regarding medication, so that’s really useful.”*
 - Community Hospital staff member (Midhurst)
- *“Working here in this building has been a real bonus because I’m working alongside, you know, physically working next to other specialists: dermatologists and heart failure nurses, COPD.”*
 - Lymphoedema Specialist Nurse (UTT)
- Note importance of physical proximity

- Value of face-to-face contact consistently highlighted:
- *“I think sometimes when you phone somebody – over the phone, it depends on your communication skills, often things are forgotten. But face-to-face they’re brought to mind a little bit better, and if you’ve got a good relationship with somebody – another professional – then they know where you’re coming from in terms of patient referrals.”*
 - DN (UTT)

Building over time

- Building good collaborative relationships takes time and effort
- Especially important for new or changed services, as happened with Midhurst service:
 - *“Obviously the Macmillan, when they first came out here from hospital they were very hospital-oriented and to come into a community setting is quite a different setting, so that took quite a bit of time to bed down – but it worked well.”*
 - (DN)
 - *“...and to be honest here, the relationships [between Midhurst and DNs] are getting a lot stronger, you know, it’s like any new broom that comes in – people can be a little bit wary.”*
 - (Community Support Team)

- Efforts at relationship-building can earn respect and trust that has direct impact on patient care
- *“I think I’ve had to prove my worth. I’ve been here a bit longer than some of the people. I’ve had to prove me worth, and I think they can see the benefits of the service and they support me.”*
 - Community Matron (UTT)

Diplomacy

- Building relationships sometimes requires a good deal of diplomacy
 - As in Naomi's example with DNs
- *“we had to be quite diplomatic yes, because in some respects this was a situation where I would actually have liked our team to have possibly been able to take it on [...] it was quite clear to me though that the district nurses felt that they had started this and they really wanted to see it through”*
 - CNS (Midhurst)

- Issues around role overlap and boundaries (of all kinds) can be especially sensitive
- *“Then I got this call from the Hospital at Home team saying ‘Oh, we’re going in now to see this gentleman’. And I said ‘I beg your pardon?’ ‘Yeah, we’re going out to give him all the palliative care needs’. I said ‘excuse me, we’ve been going in for over a month here’, and we had a bit of a to-do, which went straight to top management [...] and they’ve never really been friendly with us since.”*
 - District Nurse (UTT)

Implications

- Quality of collaborative working is directly relevant to the quality of care experienced by patients and families
- Collaborative working is essentially relational
(though shouldn't be reduced *just* to relationship factors)
- In palliative and supportive care, relationships between teams at least as important as within teams
- Mutual understanding between professionals and role flexibility themselves influenced by relationships
- Opportunities for professionals to get to know each other should be created and supported
 - Where possible, including face-to-face contact

NHS changes (and senior managements' responses to them)

- Can have a negative effect on collaboration where they inhibit good personal collaborative relationships:

“On the ground there’s such a willingness to work together, and people will get by despite some of the senior managers and not because of them, and you know at a higher level people are getting embroiled in ownership, power and finance and things like that, but on the ground people are generally working together with a genuine commitment”

(Manager, UTT)

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