Leading Interprofessional Teams in Health and Social Care

Vivien Martin and Anita Rogers

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LEADING INTERPROFESSIONAL TEAMS IN HEALTH AND SOCIAL CARE

This book presents compelling narrative case studies of a variety of interprofessional teams and explores how teams work in three key and interrelated areas: creating and implementing change, team working and leadership. Each case study is followed by an analysis in which creative approaches to interprofessional working and examples of best practice are identified. This book shows that there are many different new forms of leadership and demonstrates tensions between traditional models and emerging models. It also looks at how theory and policy are translated into practice and how service change may benefit service users.

The wide range of examples of practice in complex settings make this book essential reading for all students in health, nursing and social care, at undergraduate, postgraduate and professional levels.

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Health and Social Care

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PREFACE: OVERVIEW OF THE BOOK

This book is organised in three parts. Part 1 offers an introduction to the context, Part 2 presents the case studies and Part 3 reviews the extent to which the practice described in the case studies reflects or challenges theoretical perspectives on change, leadership and team-working.

PART 1— INTRODUCTION

This gives an overview of the health and care context from which the issues raised in the book have emerged.

PART 2— CASE STUDIES

Part 2 of this book presents five case studies that illustrate the issues of leading and teamworking in the interprofessional, interdisciplinary and interagency environments that are emerging in health and social care.

Each case study presents an account from some team members describing their work and their views. This is followed by a number of examples drawn from these interviews but presented as perspectives offered by the team on change in health and social care, team-working and leadership. These examples are not attributed to particular members of the team but used to indicate the issues that have arisen in that particular context.

Each case study concludes with a short section suggesting some ways in which readers might learn from the case studies to improve their own understanding of emerging issues in these complex interprofessional, multidisciplinary and interagency environments. The case studies are as follows.

Virtual Multidisciplinary Team

This team includes members of cancer service teams in a number of geographically remote settings who meet regularly through use of a video conference. Issues raised include difficulties in changing perspectives from former hierarchical relationships, formal and informal teamworking, introduction of new technology and frustrations over lack of funding.

Assertive Outreach Mental Health Team

This team includes staff from health and social care and focuses on working in the community with people who have serious mental health problems. Issues raised include tensions between this innovative service and traditional hospital services, inclusive teamworking with qualified and non-qualified staff, and difficulties in working within a regulatory framework that was developed for traditional provision.

Outpatients Referral Team

This is a widely dispersed team represented by a hospital manager, a service user representative and a General Practitioner. Issues raised include political and service user involvement in service development, tensions over funding priorities and the extent to which centres of excellence develop around expert staff rather than in response to local planning priorities.

Cancer Collaborative Network

This team are all members of this local collaborative arrangement but also of different service delivery teams. They are all working within a framework for improvement developed nationally by the Modernisation Agency within the Department of Health. Issues raised include use of facilitation, tools and techniques for effective continuous improvement within service provision, transition from traditional structures to partnership working and development of new flexible roles.

Reablement for Homecare Team

This team includes both social care and health staff and works in the community to support people who have been discharged from hospital, often with a reduction in ability, to care for themselves at home. Issues raised include strong views on the dangers of disempowering service users, practical difficulties in providing assistance when it is needed and tensions arising from balance of work in using expert and generic skills.

PART 3— THEORY AND PRACTICE

Part 3 takes a wider view of the issues raised in the case studies and considers the extent to which existing theory can be applied to help us to understand change, leadership and teamworking in these complex settings. It concludes with some suggestions of areas in which it would be helpful to focus new research.

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This book would not have been possible without the generosity of all the people who took part in the discussions and interviews reported. Although we cannot name people or organisations we thank all those who helped to produce this book. We hope that the book contributes to improvement of health and care services to benefit service users and the dedicated staff whose voices we hear in these case studies.

PART 1
INTRODUCTION

CHAPTER 1
LEADING INTERPROFESSIONAL TEAMS IN HEALTH AND SOCIAL CARE

Health and care services in the United Kingdom are delivered through a range of organisations, each of which operates with a degree of interdependence within a local healthcare economy. Service users want timely and effective services that improve their quality of life, organised in ways that make them easy to use. When these services are delivered by a number of different providers, people find themselves having to go to a series of different organisations and individuals, explaining their needs to each one and giving a range of personal information time after time. The focus of change in public services is on 'joining up' services to enable smooth pathways for service users. Barriers to working across agencies, across disciplines and across professions must be overcome. Leadership and team-working are essential in order to design and develop new service configurations and new ways of working.

The goodwill and co-operation of the staff who work directly with patients and service users at a local level have reduced some of the barriers to seamless care. The best efforts of patient-focused staff, however, are frustrated by the hierarchical structures and bureaucratic processes that have contributed historically to the organisation and control of statutory public bodies in the United Kingdom. Attempts to improve public services seek to address this problem by encouraging the integration of previously separated services. The 'joining up' of public services is part of the political drive to modernise service provision.

The overriding aim of modernisation of public services is to reduce deprivation and social inequality in order to improve the health of individuals and of society as a whole. Instead of aiming to treat problems when they become apparent, a preventative approach seeks to improve the conditions in which people live so that ill-health and social need are reduced and, as far as possible, prevented.

If services are examined from the perspective of service users, the need for more seamless service provision becomes all too apparent. Both health and social care services have traditionally been provided by a variety of different public, private and voluntary agencies. The providing organisations differ considerably in size, capability, funding arrangements and the extent to which they are subject to public accountability. Whilst a number of these agencies operate under the overall umbrella of local government, many lie outside their jurisdiction, including National Health Service provision and the wide range of voluntary organisations. As a result, the allocation and disposition of resources to each of the contributory areas of service provision is subject to the accountability frameworks, funding regimes and operating practices of each of the 'providing' organisations. These features may be very different. It may require a great deal of

leadership and teamwork to bring systems and processes together sufficiently closely to enable joint or partnership working to produce real benefits for the service user.

Demand for more coherence has been fuelled by highly publicised service failures, particularly incidents involving abuse of children or elderly people. In many of these cases, investigation revealed a need to cope with problems that exceeded the capacity of any one organisation or profession. Policy changes have contributed to increasing the need for care in the community through closure of the old-fashioned mental health institutional hospitals.

Health and care services are now required to consult more widely with citizens and to be more inclusive in involving local people in development of local services. This increasing involvement in decision-making has raised expectations of wider choice for service users. Alongside these developments, however, the increase in demand on resources threatens spiralling costs. Attempts to control costs inevitably include consideration of different approaches to managing service provision.

Modernising Social Services (Department of Health, 1998) detailed service failings in social care and set out an agenda that was intended to bring services up to the standards required. The paper emphasised the need to improve protection and services for children alongside improvement of workforce standards, partnership working and improvement of delivery and efficiency of service. The NHS Plan (Department of Health, 2000) detailed the government's plan for investment and reform that was intended to lead to staff working differently with more decision-making located in local health and care communities. It acknowledged that structural and cultural change would be required to align responsibilities at the local level and to enable resources to be devolved. The Health Act (Department of Health, 1999) took away legal obstacles for joint working across health and care public services by pooling budgets, supporting commissioning arrangements for partnership agencies and merging some services to provide a 'one-stop package of care'. Development of Primary Care Trusts provided for closer working at the most usual first point of contact for service users. Funding was targeted at improvement of quality and efficiency of care through development of services including rapid-response teams, intensive rehabilitation services, recuperation services, one-stop services for older people and integrated home care teams. Joint commissioning for mental health and services for older people was introduced to bring those services closer together.

The drive to modernise these services has placed particular emphasis on changing the ways in which services are configured. Reconfiguration involves linking service areas and different organisations to create easier access and smoother pathways for service users. When care provision crosses these traditional boundaries there are often difficulties in establishing new systems. These can result from a wide range of factors, including differences in pay scales, overhead charges, methods of calculating workloads and formal agreements over work practice. Different performance indicators may be in use leading partners to value (or have valued for them) different measures of what might be considered successful outcomes. In addition, professions in the health and care environment have different approaches to provision of care. There are often differences in cultures, values or in focus of service provision that make it difficult to make progress in partnership until enough common understanding and agreement has been established.

Social workers expect to engage in interagency working as a normal activity when they collaborate with others to achieve objectives for service users. Health professionals

often focus on direct personal care or on delivery of a high-quality specialist service, even if this will only address one area of a service user's needs. There is, however, always a tension between maintaining the specialisms and developing a more holistic approach by accommodating the strengths brought by other professions.

Development of interprofessional education has attempted to address changing expectations:

> Interprofessional education has developed over the years… It has worked to restore equilibrium as working relationships have been destabilised, the unquestioned authority once enjoyed by the established professions challenged, hierarchies flattened and demarcations blurred, as new professions have grown in influence, consumers have gained power and a better informed public has expected more.
>
> (Barr, 2002, pp. 13–14)

Unfortunately, there is often a gap between the aspirations of a holistic and interprofessional approach to care developed in educational environments and the reality experienced by students in work placements. The workplace experience is often of a service under extreme pressure to deliver and without time or energy to be able to work in anything other than familiar and well-understood ways.

Ultimately, it is people, not organisations, that work together. People make partnerships work. Organisational leaders set the direction within which organisational partnerships can be formed. Leaders and staff at all levels develop the interpersonal relationships that enable collaborative working. If people are to think and work in different ways they need to learn to do things differently. Government policies have acknowledged the need for learning throughout working lives (*Working Together, Learning Together,* Department of Health, 2001). This approach to lifelong learning was also supported by a Human Resource programme (Department of Health, 2002) which focused upon improving workforce planning, modernisation of training and education, modernisation of services and enhancement of staff skills to enable them to work differently. In order to achieve so much change, leadership is crucial:

> Leaders work with others to visualise how change could make an improvement, they create a climate in which the plans for change are developed and widely accepted and they stimulate action to achieve the change. Leaders who can work with others to achieve improvements are needed at all levels of health and care services. Leaders are needed to make the small day-to-day changes that ensure services continue to meet the changing needs of the communities they serve. Leaders are also needed to achieve the more dramatic step changes that have to be accomplished to change the direction or focus of services when new approaches are introduced.
>
> (Martin, 2003, p. 5)

Leaders are required to set a proactive agenda. They have a key role in developing a shared and compelling vision of better services and then aligning this vision with the

direction and objectives of the organisation to clarify purpose and to enable strategies to be developed so that the desired change can be achieved. Leaders can develop the capacity of organisations to change and to work in partnership by negotiating to find ways of working across barriers.

Nothing now stands still for very long. Both theory and practice are constantly changing. Theory becomes out of date as new ideas and discoveries replace older theories. Practice also changes as new procedures and processes replace older ones in response to development in knowledge about the impact of people's actions. Individuals also have to change and develop practice to accommodate new technology and processes. The knowledge that informed actions five years ago might no longer be a sound basis for decisions today. In health and social care, professionals, clinicians and others, whose work is informed by traditional bodies of knowledge, are increasingly aware of the need for continuous personal development. High-quality services cannot be sustained unless health and care staff are consistently engaged in learning, individually and together.

PART 2
CASE STUDIES

CHAPTER 2
VIRTUAL MULTIDISCIPLINARY TEAM

INTRODUCTION

The Virtual Multidisciplinary Team has been established for about three years. It began as a project looking at the feasibility of using new technology to connect rural Trusts with other Trusts to overcome clinical and physical isolation.

This team was developed to conform with new guidelines for multidisciplinary teams for each type of cancer. The team uses video links to connect them to other organisations and to specialist centres. As the Trust deals with a wide range of referrals for cancer, other teams have developed in a similar fashion, often including some of the same staff but each with a lead clinician.

The use of this technology as a way of developing a multidisciplinary team has also provided the opportunity for the Trust to engage at a distance in conferences. Some of the team members comment on the potential they see for wider use of similar technology to improve services in future.

How the team works

The team has developed ways of working that facilitate decision-making in the meetings and have invested time in improving their practice. Most of the team members' activities take place in their normal practice teams and setting. Members of the virtual team are selected because of their roles and the view that this enables them to bring to the discussions.

Meetings are scheduled and the participating individuals prepare to ensure that time is not wasted. Sometimes quite a large number of people are involved. In this small rural Trust, the team usually meets in a room that is large enough to accommodate everybody physically but not large enough to allow the video camera to relay all of the participants visually. This results in the lead consultants appearing to communicate directly with other consultants and other members of the team claiming a presence only as voices if they contribute at all.

Many of the members of this team acknowledge that the use of video has brought advantages in various ways. There are, however, many frustrations and concerns amongst the participants. These are rarely connected with the use of technology, but almost always about how the ways of working within the Trust enable the specialist teams and this multidisciplinary team to provide a high quality of service. Many of the participants have experience in other settings and comment on the difficulties of moving from traditional service delivery into any new ways of working.

PERSPECTIVES FROM THE TEAM

Strategic planner

When I first came here the Trust was new and we had to develop a mission statement, a vision for the Trust and write our first strategic plan. So I was involved in all of that and became strategic planner so that included projects and funding.

My first involvement was as the project manager looking at the feasibility of using new technology in rural Trusts like ours to reach out to other Trusts in the UK to overcome geographic and clinical isolation. At the same time a new way of working was being introduced for cancer care. For every type of cancer, and they identified ten types, you had to have a multidisciplinary team within each Trust to collectively review every new patient referred to it. That was new for us because our teams don't just concentrate on one type of cancer. We link into specialist centres but to get people from those different sites to come together was virtually impossible. But it was a requirement, so we had to find a way to overcome it. The use of video conferencing was ideal for a place like this. We had commitment from the clinicians at both sites because they could see it was a practical solution to their problems. So my main involvement was finalising the local study, but then, at the end of it, there was no funding to implement all these wonderful ideas that we had.

Everybody began to feel quite let down, so we decided that we would write business cases and that was where I came in, writing them. We identified possible sources of funding and eventually caught the attention of a cancer and scanner appeal. They funded our equipment and somewhere to connect to. So that's how it started.

There was a set of minimum standards we had to follow and the first one was to set up a multidisciplinary team and to identify a lead clinician for that particular cancer type. So they became the nominated leader of each team but we also have an overall clinician responsible for cancer. We decided that we had the most referrals for three types of cancer, which were lung, colon/rectal and breast. So we established those teams first. The meetings just took off really. We went live, didn't test it. My involvement was making sure that the equipment was set up, that it worked on the day and that people knew how to use it. Also I had to work with members of the teams to sort of set up the etiquette of the meetings to make sure that people didn't interrupt each other, that the room was set out correctly and that everybody had a say on the day.

In a meeting like that certain people always dominate and often people interrupt each other. Because of the very slight delay in the video link, so fractional it's almost imperceptible, but if someone butts in they do take over. So we had to talk through where people were going wrong. The senior consultant was good too as he told members of the team off if they weren't acting correctly. Like a coaching session.

We have these sessions every so often because people tend to lapse into their old ways of working like everyone does, so have to be reminded of how to conduct the meeting. Often it is when we have an outsider watching or observing—like today when we had a link with a conference in London. There'll be hundreds of people there watching us and the senior clinician wants to make a good impression so he'll be there today to make sure. Straight afterwards we'll stay in the same room and we'll talk through how we thought we did.

Lots of the etiquette, as I call it, is about how the equipment is used. We now have a format. The lead clinicans should prepare a case history of each patient. Everybody has a list of the patients so we follow them through in the same order, everyone knows exactly who we're discussing so there should be no controversy. It follows a pattern where the lead clinician describes the patient's condition and the background. Then the pathologist talks about the histology and the radiologist talks about the X-rays and their findings. Then the members of the team will add what they've found. It's facilitated really by the members of the team. People just jump in usually. The camera should be a lot further away so they can see the whole team. It's often the specialist nurses who have a lot to say. It depends on personality. There's one nurse who's very confident and self-assured and always speaks up on behalf of the patient. Often she contradicts what the consultant said. She's very direct but he values her opinion—that's one of the benefits of this type of working.

One of the downsides is the time meetings take. They're booked through the year but if there aren't many patients referred they can cancel a meeting because they are frequent. Preparing for the meeting takes time. Often referrals come in a day or two before, so somebody, usually a medical secretary, formulates the list to give to a consultant the day before summarising the case histories, which puts pressure on the secretary. Then they have to make sure that the histology reports are ready. The pathologist tends to do this himself, going through all the slides to make reports and so do the radiologists.

Some people might feel it's not worth the time it takes because before a consultant would just have picked the phone up and spoken to someone in another hospital. But frequently the patient used to have to travel between the two sites. They'd go to a consultant there, who'd write a letter, then our consultant would review that and write a letter. So the patient suffered really because in a period of their life when they were quite ill they had to travel. They don't have to now as all the information can be transferred electronically, unless they need treatments we don't do here.

The composition of the teams has changed. With changing technology you get different people becoming important in the team. We have just introduced a new system here for radiology, digital imaging, and we have someone who started as a secretary who is now the manager. She can operate the computer and video conferencing equipment herself, so doesn't need a radiologist there. She draws the images from the network and displays them and can talk through what the report says.

We'll end up with more teams. There are more types of cancer that we're not covering at the moment. We have general practitioners coming into the hospital to provide those services. They need to have links with specialist centres as well, and they work in their surgeries, so that's another extension of this technology.

I like this work, new technology, setting up projects and new ways of working. On technical stuff they always come to me. They seem to depend on me but they know what to do. I find they communicate very well with me, they always make sure that I'm made aware of everything. Not just their problems, but what's going well. They know they can always call on me. People come to me because I can often get them the funding to expand their service. I've just managed to secure about eight thousand pounds for a new microscope and another camera for our postgraduate centre.

Radiologist

The team started before I came. The senior consultant inspired it—he went to America and saw this happening. I got interested because of applications of telemedicine in radiology—that will happen in a big way in a year or two.

Video conferencing could always be done better. You shouldn't meet people for the first time on video—you should eyeball people first, it's not ideal on a television screen. You get to know them by seeing them every week on the square box but it would be better to travel down there to meet the first time. It works reasonably well. Improves the quality of the meeting because you have folks there you wouldn't normally have. All the people in the room probably meet every day in the coffee room or we would see them in the corridor, talk about cases—you know those people well.

If I was talking about an investigation I might say all the evidence is here, we know what to do, or I might say shouldn't we be doing this or that. It's not my role to make any decisions. These meetings are to make decisions about patient management. The person with responsibility should make the decisions.

I think video conferencing is a good thing—though people say that it doesn't really alter very much about what they're going to do because the next course is fairly obvious. So why are we doing this politically correct thing, sitting round consulting with everybody when we know what we're going to do anyway? I think the patients would probably be reassured if they knew. The decisions are taken seriously and thought about. On the whole, although people groan about it, it is a good thing. Part of it is playing the game but partly also because they know it's quite a good thing. A few technical things would make it snappier and smoother. More time to prepare, more dynamic in some way.

I worry about patients who don't want to be fitted into this system. The people managing the health service want to be in charge. To take over from medical people and control them more. They think it can be better managed, more value for money. The people who are most resistant will retire, so these ideas will have to gain more purchase as new people come in. I think a lot of things are quite positive. We treat patients much better than we used to but because of the costs, the whole system is not being pushed in the right direction. Change is constant, change is accelerating. In the NHS you can't assume that everyone will agree with your ideas or assume good will—or it will almost always all end in tears—you somehow have to be prepared for that change.

I once sat for ages on a committee that looked at medical complaints and the most striking thing about it, so constant it was unbelievable—it was to redress a sense of grievance. Always about not being told, not knowing to expect something. Most people did not want money. Most said that if it could possibly be avoided, I don't want this repeated. Staff are not daft, they know things are changing and things will be different. They accept that. What they don't accept is that no-one will talk to them about it. It's easy to say but not easy to do.

Chemotherapy nurse

I haven't got a degree but don't have burning issues about it being needed. In clinical work, how you perform is how you learn and improve on yourself. Working as a team you get a chance to learn from colleagues on a clinical basis.

When I worked in London it was very much more relaxed, we were seen as equals, were seen as a team, introduced ourselves as a team, nurses, doctors, occupational therapists, physiotherapists. Patients would be with us for twelve months or so. They would get to know us as nurses, as doctors, the whole team. We had a family environment and carers wanted to be seen as part of that family. Doctors were called by their first names, nurses were all called by their first names. It was the first time I came across a consultant who said, 'I'm Jack', not Doctor something. It was a multidisciplinary team where we'd have an afternoon each week and talk about individual people. Our plans, our fears, how we were going to deal with it ourselves, how the families were going to deal with it, where we'd go from there, who else we'd need to involve, whatever.

I came here and we've tried to have multidisciplinary meetings but it hasn't been successful due to time constraints, lack of resources. I wondered whether it was because we're a small unit, only the one consultant. However, with the video link it has taken off. People are making more of an effort. Consultants are there and find it quite comforting, reassuring, to have a colleague on the other side of the link that they can talk to.

For me personally, it's made people aware of me and who I am, the chemo nurse. I know that people know who to phone. Before I don't think people were aware. I like the fact that I know all the consultants and can phone them up myself. I know deep down that if I were to phone one and say we have a problem with one of the patients, they'd take me seriously and deal with it. I phoned one this morning and he came immediately. He knows me, he trusts my judgement and we're more on the same level. The barriers that have been built up over the years between nurses and doctors are going. The older I get there will be consultants the same age as me, that helps. You feel more like a contemporary, remember the same things, schools, holidays.

In the multidisciplinary team the consultant knows that if he's not there I'm there and will pick up the referrals and plan. It's very helpful when it works well. What doesn't work is that sometimes we discuss people when we're not ready to discuss them—but they're just administration problems really. We can be a bit too keen to decide treatments—treatments that haven't been discussed with the patient.

What I do find a bit annoying is that with one group I go to we discuss the patients with one hospital but they get referred to another. So I get no benefit because I don't know what treatment that person's going to have, so we waste time and discuss things that aren't appropriate. The consultant writes and says this is what I advise, the next one discusses it with another, so we're going round and round in circles. Once the referrals are made we don't need to discuss it all again in the multidisciplinary team.

The consultants quite like to chat, it's like going to a conference for them. But for me it's valuable time, time that I'm taken off giving treatments. I haven't got anybody to fill my shoes in, I can't cancel clinics. I have to build this into my daily work. We're a nurse led unit. The consultant is here as support but when he's away he doesn't have someone

to deputise for him. We have to be confident in what we do, knowledgeable in what we do. We have to give patients support and for them to have faith in us.

But innovations, there's lots of them, it's nice to see people that are still innovative. It's nice to go to conferences, see people. There's lots of ideas but it's finding the time, the energy to do it. You come in and do more than your paid hours each day, then it's difficult to build new things up. We like to be seen as a happening kind of place. We do our bit. One of the nurses does aromatherapy and she and the art therapist have set up a group that look at alternative therapies and how they can be of help and benefit to people in the community. Hoping to get any patient, or carers, who might benefit to try. Things have been a bit slow getting off the ground but that would be an innovation.

Sometimes I find the multidisciplinary team meetings quite useless because we don't come to a decision. If I give two hours every fortnight I want a decision—not all that wasted chit chat. I'd rather be back on the shop floor doing some good. You can't waste time in meetings all day, sounding boards for people to talk, talk, talk. Life's not like that any more. The NHS has changed. It's hard. We haven't got this time, we are pushed for beds, patients coming in all the time, out of our ears…

Consultant surgeon

I lead a team in cancer management. The thing that I find, certainly in terms of the multidisciplinary side of things, is that you generally divide the decision-making, almost as though there is strength in numbers. I think that's not necessarily a good thing—at some point, someone's got to say, thanks for this, thanks for that, what we're going to do is that.

There might be a patient who is not of sufficient performance status to have a particular form of chemotherapy. That decision might have been made, but alternatively, that decision might have been made in the referral clinic. So the team makes a collective decision. But I would have referred this patient for their opinions before treatment. It is checks and balances, but against that you have to put the time involved in doing it. The patient care I've no objection to at all, but I find complying with the administration absolutely irritating. For example, all patients have to be considered—that's not a problem. All multidisciplinary team decisions have to be written in the notes, but then when you have to audit it to find your evidence there's a problem. There's a tail to all the lists that's extremely annoying. If you then base your hospital comparitors essentially on the administrative criteria, there's no clinical outcome measure, which I find extraordinary. There are administrative outcome measures, but no clinical outcome measures. I'd be looking for survival and quality of life—but these seem to be purely administrative standards.

This multidisciplinary team really just puts into a managerial context what I've been doing for a long time. This way of working is fine as long as you've got everybody believing in it, everybody participating. I have no-one to discuss things with surgically, no histolo-gists, but we use protocols so that everybody with these particular conditions gets these things. It would be nice to have colleagues to say think about this or look at this. Whether it's a good interchange of ideas I'm not absolutely sure. Whether it's putting patients on a production line. But the resource cost of having a proper meeting would be enormous. If you take the hospital as a hub and the various spokes there would

be a lot of meetings. I think that it is wrong to discuss every patient, I think you should discuss exceptions. I think that these standards should be looked at again from what's happening. This presupposes that in the old days we didn't have meetings—we did. This undercuts and standardises. How would I do it better? The first thing I would do is discuss patients by exception. Many are routine. There are one or two a month perhaps where there would be benefit. If I led the team I'd say there's no need to discuss the others. We should look much more at the technical priorities. Breast-screening, for example. Most people who look critically at the literature say that it's a complete waste of money. But women vote, no politician is going to stop it. You should screen for bowel cancer to find pre-cancerous conditions.

I can just battle on until someone takes notice. I think that the command model of the army works much better than NHS. My personal satisfaction is in the clinical side—I should be left to get on with it. It would be good if someone came and said you had a problem in theatre yesterday, how can I help? This won't happen. It's resources. They're so terrified of the possible waste of resources that they won't allow people to make decisions. Multidisciplinary teams spread the decision collectively so they can't be wrong. It would be difficult to sue the whole team. It's a comfort zone—everyone shares the blame.

A while ago our audio-visual system was awful. I decided to get it upgraded—I just did it. We got half the money from the postgraduate dean then the Trust paid for the other half. They didn't like it but it got done. I also made the decision to get operating lights here and went out and raised money—the Trust agreed to pay to have them fitted if I paid for them. It just wasn't a priority for them.

The boundaries are very blurry. I always get the impression that the management is an obstacle, albeit not for their own fault. To me it is a complete anachronism that there are not enough nurses. We don't pay enough. I said, 'Get a crèche.' They said, There's nowhere to put it and you'd have to get someone in qualified to manage it.' I gave up on that—choose your battle! Be prepared to make yourself such a nuisance that it's easier to agree with you than not to.

Macmillan nurse

When we first started as Macmillan nurses they saw us as able to do anything. The difference I found was the community side. The multidisciplinary meetings have brought the team much closer, helped to build relationships. Prior to those meetings we didn't have any regular contact.

It meant the consultant having to shift his work schedule round to come earlier to fit in this meeting so that he could do his clinic and then have the meeting. Those meetings were good, we all got to talk a lot more because with the technology the background noise means you can hear what's going on so you have to be very quiet. A lot of the early video ones people would say they couldn't hear. We've had lots of feedback with people going and sitting in at the other end. It's bad enough just with the traffic. In both cases, they have delivery lorries and on many occasions we've heard lorries backing. Also it has to be very rapid, you have to get through a large number of people at a time, so it had to be honed as much as possible. I don't feel as though I should be giving any sort of opinion—it feels like information-gathering.

The team leaders are each of the lead clinicians from each cancer type. They set the agenda. It's about direction rather than day to day or a particular meeting. A sort of agreed agenda, taking you along. On the team there are the chemo nurses and consultant, the surgical team, consultant and the stoma nurse. She gets us involved very much earlier because she feels she hasn't got the counselling skills for social problems, how they'll get home, etc. We lack direction at the moment—everyone's doing their own little bit, no-one's pulling it together. We've got to keep reminding people that we're here. I like to think that I can get certain things sorted out for patients, make things better for them.

Clinical trials nurse

I'm a research nurse, but because I'm the only one here and they wanted to develop the clinical trials area here, I was given this title. I've been here seven months. I used to work for a charity with general practice research. Coming back to hospitals was quite a shock. Leadership had changed. The multidisciplinary team—I had no idea what it was until I came here. In the loose sense of the word, we all work in multidisciplinary teams, with different grades of staff and different disciplines, we learn to do that anyway, but to have a set multidisciplinary team that meets regularly and communicates with other hospitals was new. I think it's better, because you know who everybody is and what their roles are, much more organised.

The purpose of video conferencing is for the consultants to discuss cases. It's the way it's always been. Consultants have a case load of patients and take responsibility for them. Sometimes people feel that we meet as a matter of keeping up targets and keeping up figures. We have multidisciplinary team meetings with the main regional hospital every week, then with others every other Friday and Tuesday. Some people feel that it's doing it for the sake of doing it, to keep the powers that be happy. I find it quite useful because I work on my own and don't have anybody to talk things through with. You also get a sense of what happens to the patients that you'd miss if you didn't have the meeting. I am a little bit out from the rest of the team, although I liaise with them. The rest of the team treat the patient, I don't. But if I get to hear, in the multidisciplinary team, of a patient receiving treatment who might be suitable for a trial, I approach them.

I like talking to patients, doing paperwork and mixing with others in the hospital. I miss working as part of a research team. I read but if you can talk it through with someone you understand it better. I learn about new treatments from journals—but you can't buy a journal every week.

PERSPECTIVES ON CHANGE IN HEALTH AND SOCIAL CARE

We have extracted from the individual interviews some of the team's views on change in health and care, teamworking and leadership to discuss in this and the following sections.

This team came together through use of new communications technology that enabled video conferencing. This team see themselves as pioneering use of this technology and are particularly aware of changes that new technology might bring to service delivery. They are also very much aware of the difficulties of introducing such change. In this range of perspectives about change in health and social care they raise a wide range of

issues, few of which are related to learning how to use new technology. Although recognising advantages that new technology might bring, this team has a strong sense of historical tradition and its potential to smother change.

In Example 2.1 some of the vision for use of technology in service improvement is expressed, together with disappointment that adequate funding is not necessarily provided to enable such innovations to be introduced.

Example 2.1 **How new technology can enable change in service delivery**

The use of new technology has been recognised now so appears in every policy document. With a small amount of money we could restructure to change the way the A&E department works. The equipment we need costs about forty thousand pounds, which really isn't a huge amount. That would mean we could take calls from all the peripheral community hospitals with minor injury units, to review cases before they're transferred here to see if we can provide advice and guidance instead of transferring patients here physically. They may not need to be admitted here then. Likewise we could then link with our specialist centre for head injuries before we transfer patients. Video technology again.

I have this vision about how we could change the whole way in which the hospital works. We'd have to have enough input financially and then a change in attitude, particularly in some of the older consultants. We're moving towards it anyway because we have this new digital imaging system being installed this month that means that people will be able to view X-rays on their desk-top. So if we convince all consultants that it's worthwhile in their consulting rooms, they wouldn't have to wait for a written report about an X-ray. They'd be able to have it on their screen with the report alongside and show the patient. Involve the patient in discussion about their treatment options instead of telling them what they've decided. That's a big change.

It takes time and focused attention to develop a workforce able to make effective use of new technology. Although there is so much potential for use of new technology to enable improvement in service delivery, some staff only see it as a personal tool that they might choose not to use. In Example 2.2 we are reminded that many senior professionals have not necessarily learnt to be comfortable and confident in using computers.

Example 2.2 **Attitudes and skills in using technology**

The technology offers the opportunity for instant results and to include the patient. That's the key, otherwise we're just using technology to speed things up for staff, for their convenience. For example, the radiologist accesses things from home. But some of the consultants don't want these computers. They still dictate letters and give them to their secretary and write a list of points for a secretary to deal with. They don't take any responsibility to do these things themselves.

There is also a fear that in rapid change, some of the good practice that has built up over years will be lost. There is a perceived tension between the need to provide cost-effective services without forcing service users into predetermined slots through stereotyping. This is discussed in Example 2.3.

Example 2.3 **Everyone is different**

I think that we're losing the element of wise counsel really, part of treating people in the right way. Each person is absolutely unique, so they don't fit well into systems. Everyone is different. What is appropriate treatment for one person might be completely wrong for the next person. Medicine run by ever stricter protocols has its limitations. We've made huge strides in treating people, but don't start stereotyping.

Attempts to standardise services so that service users can expect similar treatments wherever they happen to live may make it more difficult to respond to the essentially personal and individual nature of heath and illness. This theme emerges in various accounts, but Example 2.4 comments on the nature of change but also raises issues about the relationship between education and practice. The suggestion is that if a new generation of practitioners are developed with expectations of new types of roles, these will quickly become the norm in practice settings. Professional education is only partially provided in academic settings and practice is developed within contemporary practice settings. If the philosophies, values and attitudes do not align, student professionals will be very much aware of that through their reflection on experience. It is unlikely that significant change can be achieved without the full engagement of those working in the service workplace.

Example 2.4 **Change of power structure**

The power structure that was totally outrageous in the past is being dismantled slowly in the NHS, so that doctors are being taken right off the top of the pyramid. They are becoming more specialised. Increasingly patients are slotted into a particular straitjacket—if you have a stroke, this is the way that strokes are managed. It's not a case of individual medical opinion which could be capricious at the best of times. Everything is done more to protocol. There's much more involvement of nurses. Probably doctors will be far less highly trained, nurses better trained—all changes hugely resisted by medical people, but people who train in that new system won't know anything else.

Roles in health and social care have frequently changed. Many new professions and specialisms have been developed. Although expertise is important, service users often need to use a sequence of service provision and expect much of that provision to be geographically close to their homes. Even in densely populated urban areas it is not easy to appoint staff with an appropriate mix of specialised and generic skills. Recent initiatives to introduce more flexible roles and workers with more flexible skills have raised a number of issues, some of which are discussed in Example 2.5.

Example 2.5 **Change in roles**

The role of nursing staff is developing and in all of the other professions you're having changes. For example, radiography are now taking on an enhanced role. There are fewer radiologists because they're so specialised. So the radiographer's role is changing as a result. They're taking on a lot of things because there's no radiologist. And below that we're having new levels of staff coming in with different supporting skills and often with interdisciplinary skills as well. Usually support workers support

more than one area—radiography assistants don't only have to just work in radiography, they can work across different disciplines. Therapies too—ccupational therapy helpers can also do physiotherapy and speech therapy, a bit of everything. A good interdisciplinary worker needs initiative, and an 'OK' attitude. Sometimes people hide behind their profession as though it's their whole identity—I'm a radiographer, I'm a nurse—but it's starting to blur.

There is a possibility that in developing more flexible roles for health professionals they become less involved in using their expert skills. In Example 2.6 a nurse comments on how the nursing role has changed and how she thinks this has impacted on the quality of patient care. She is particularly concerned that nurses are not in close enough contact with patients to use their specialist skills. This example raises questions about the extent to which we want nurses to have generic and flexible skills and which expert skills they should have.

Example 2.6 **What do we want nurses to do?**

When I trained as a nurse, we were trained to take care of people. Nowadays, nurses go to university and learn how to write about how to look after people, not the hands-on stuff about how to do it. You look around here and the trained nurses don't do any of the physical care. They're running around with drugs lists and care plans but you don't see one doing a bed bath. The care assistants do the caring now. I'm not saying they don't give good care, they do. But they're not trained to notice certain things, like a bit of facial droop.

In Example 2.7 another nurse is concerned about the impact that changes in both nurse education and practice have had on aspects of the service. She suggests that the wider education necessary for nurses to be able to take more specialised roles has created a gap in the practical activity of giving care to patients when they are unable to care for themselves.

Example 2.7 **Quality of care**

I think patients are probably getting less care than they did. I had a private operation a few years ago and the care was fantastic. When I trained that was the care that everyone was entitled to. When you've had an op you want to get out of the gown that has blood on it—in the NHS you don't get that now. You have to wait for a relative to come in and change you. A friend I trained with did a return to nursing course. We assumed you'd update skills and and treatments, but all she did was learn about hospital policies. Then people get on the wards, find they can't do it and leave.

When new roles are introduced, there may be difficulties in using new specialist skills to work differently if the ways in which work is organised are not reviewed. Example 2.8 comments on the strength of old traditions in describing how an exclusive team could be built around an individual consultant.

Example 2.8 **Who do nurses 'belong' to?**

There was a feeling that you're a specialist nurse with that consultant, his handmaiden. So you go and work with his patients and don't have anything to do with other patients even if they desperately needed our skills. We needed to break down those old taboos. Macmillan nurses were always intended to be available for any palliative condition throughout the Trust. We belonged as much to the General Practitioners as to any consultant.

Some new roles have been developed with the intention of contributing specialist skills wherever they are needed. An example of this type of role is the Macmillan nurse, whose skills are in palliative care and intended to support any individuals with a terminal illness and their carers. It is not always easy to introduce this type of service into existing frameworks where each service area feels ownership of its own patients. Example 2.9 gives an account of one type of problem encountered.

Example 2.9 **Making new services available to service users**

We've had problems getting patients referred to us early enough. The ward and chemo nurses felt that they didn't need us earlier, that there was nothing of value we could put in. We felt that we were picking up pieces too far down the line. That wasn't good for the patient themselves but was particularly hard when you were supporting a bereaved person afterwards because they felt that there were so many unresolved issues, lots of things that hadn't been discussed.

Some members of staff thought that we should be involved earlier, but one senior person was vetoing them. She couldn't justify why she was keeping ownership of her patients and not handing them on and eventually backed down. She said that the patients didn't ask for the service, so there wasn't any need. But we should be offering the service, not waiting for them to ask for a service they probably don't know exists. When

that was put to her she suddenly realised that she had got a role in referring patients to us. We still have the odd hiccup but most of the time now, it's fine.

Many of the new specialist roles that nurses are taking are proving very successful, but there is still often difficulty in finding appro-priate funding to resource different types of staff. Example 2.10 describes how specialist nurses can provide effective leadership and management to take on a very senior role.

Example 2.10 **New types of nurses**

We're constantly fighting for resources for new types of nurses, so they can take on these specialised roles. We have hospital practitioners who really run things at night. They're really more skilled than junior doctors. They work with all disciplines within the hospital and liaise with GPs and the ambulance service too. They have a huge role and they are leaders in their own right. Their authority must come from the respect they command. We work long shifts and then hand over to them. I can go home and don't have to worry at all. I used to take lots of calls from junior staff because they had no-one else to refer to. Hospital practitioners feel that they are in command. They are the most senior operational manager on site and if they have a problem they go straight to the executive team.

Nurses may also find themselves directly involved with trying to secure resources to support their area of service. In Example 2.11 a nurse explains her involvement in fund-raising. We might be concerned about how much of a nurse's time should be spent in securing the funding to provide premises and equipment.

Example 2.11 **A nurse-led improvement**

We've put in a bid for some money to have the two portacabins out in the car park knocked down and have our own palliative care building there. We went to a session where people from the Opportunities Fund were describing what this money was and what it could be used for. We kept thinking we can't apply for this—we don't fulfil their criteria. It was all about refurbishing things that you'd already got—but our portacabin wasn't fit to be refurbished. It leaks and you can't get a wheelchair in there, so it just wasn't feasible.

We set up a meeting. We've got an art therapist and an occupational therapist and invited one of the chemo girls and the ward sister, so brought them on board and the consultant. We talked about what we actually want, what is feasible and whether we could apply. One of the managers knew how to set about tackling the bid, how to put it in the right language and set it out. The head of works in the Trust also came to a session. We heard last week that we've got the money! And just through a chance phone call the local Rotary Club are raising money to equip that building. A lot of our work now is going out and promoting this.

In Example 2.12 there is a discussion about how change can be carried out. It is acknowledged that change can be enforced, but it is suggested that if people understand the need for change they will cooperate much more readily.

Example 2.12 **It works because people want it to**

This team works because everyone, by and large, wants it to. Things either work because they're enforced through totalitarian structures or because people want them to. Consultants have traditionally been totally independent. Traditionally you couldn't push them into any straitjacket, you could only coax and lead and get their assent to do things. It is less so now. The coaxing and encouraging is still necessary—particularly about the need to consult. The structures are all worked out but it still relies on people seeing the need and wanting to do it.

When a number of specialists are involved in contributing to decisions about treatment, as in a multidisciplinary team, the decision is no longer made by one consultant in isolation. Different or conflicting views may be expressed and opinions are potentially open to challenge. This is a very different environment for those used to taking decisions without wider discussion. Example 2.13 comments that it is helpful to review each case on the basis of the evidence that is presented because different views can be shared in reaching a decision.

Example 2.13 **Evidence as a basis for decision-making**

It's becoming less common now, but someone from the old school type wouldn't want to hear any other opinion. They would just make the decisions whatever anyone else said or whatever the circumstances. But it's a much tougher world out there now and people are wanting to share the burden more, to receive ideas and other people's opinions as well as their own to make decisions. Although there are different opinions, it seems to gel fairly quickly and having seen the evidence people almost always agree.

An evidence-based approach to decision-making facilitates consideration of more than one perspective. In Example 2.14 there is agreement that the multidisciplinary approach can improve the experience of service users but a suggestion that the benefits may only provide an improvement in the experience of treatment but not in the outcomes. When there is a strong policy drive to change practice in order to achieve proposed benefits, it is important to ensure that appropriate measures are in place to confirm whether or not the new ways of working are bringing the anticipated benefits.

Example 2.14 **Process and outcomes**

We're more aware of what we each do in the clinical management of these patients, so it does improve standards. My general impression is that it does improve quality of life

Patients may feel a hell of a lot better, but may not survive longer. This is something that we want to look at, but there's no way of doing this at the moment within the multidisciplinary team system. Clinical outcome is very difficult to measure—it is easier to look at how many times, etc. We should be making the important things measurable, not just measuring what is easy.

When staff are working in multidisciplinary teams it is difficult for them to contribute if they feel subordinate to others who they believe, or are expected to believe, have a greater right to voice an opinion. In Example 2.15 a nurse explains how she has experienced changes that have brought her greater respect.

Example 2.15 **Hierarchies and equality**

Years ago when I first started nursing, nurses were here, doctors, even junior doctors, were above. The ethos was very much nurses would run around after a doctor, set trolley, do everything for them, even wipe their noses. Throughout my training I thought, OK, this is how life is going to be. But as I became older, more confident, knew more, I thought this isn't how I want to be treated, or to treat them. They were predominantly men. There were a few of us at the time, young nurses who were qualifying and getting sisters' posts. Things changed. We fought to be seen as an equal.

Changes of attitude do not necessarily happen quickly or involve everyone at the same time in any particular context. Not everyone believes that multidisciplinary team approaches have made a difference. One of the nurses commented, 'The buck does stop with the consultant. At the end of the day, the consultant will say that's what I want and he'll find someone else to do it if necessary.' So that even if a nurse challenges a consultant the concern might be ignored or overridden.

We have heard about the increasing range of roles that some staff are encouraged to take. We have also heard about the increase in monitoring, recording and other administrative systems. Many staff experience an increasing workload and sometimes feel overwhelmed by pressure of work. Some staff feel exhausted and have no energy to innovate or engage in change. In Example 2.16 one of this team explains how she feels.

Example 2.16 **No energy to be innovative**

I always used to think I was innovative, but the unfortunate thing now is pressure of work seems to have sucked out every spare bit of energy I have. I feel so demoralised, and I think a lot of my colleagues feel the same. I want more staff, a better unit. We're dealing with a hundred people a month in that small room and trying to give a good service to people who are suffering terribly That's my experience. We do work very hard but we're expected to work with such constraints that it's unfair. And you know that there aren't going to be any changes however loud you shout or stamp your feet, so you do sometimes lose a bit of hope, faith, whatever.

PERSPECTIVES ON TEAMWORKING

In Example 2.17 one of the key benefits of working in a multidisciplinary team is described as the potential to take a holistic view of the patient. To consider an individual with a personality and a lifestyle rather than treating a condition as though bodies are all the same.

Example 2.17 **Building the holistic approach**

It works well when each patient being discussed is known. Consultants need to know their age, diagnosis, past history, the scan, histology results. We also need to know how the person feels. That's where the nurse comes in. The doctors might steam ahead and say that's surgery, or agree, yes that's a chemotherapy regime. We might say, hold on a bit here, she's not quite ready, there are family problems, or he's elderly, they're weak or cannot cope. That's the part we contribute to, so we have a whole picture, see it holistically.

Over the years we haven't been seeing people as a whole, especially doctors. They have seen people in beds. They haven't been thinking of the family, their social or financial background, their networks, that kind of thing. We are starting to see the person as a whole and thinkinq, chemo, radiotherapy, surgery? Is that the best? As specialist nurses you know that if you speak out you're going to have some support from somewhere. With doctors you do get some who're gung-ho but you'll have someone who'll say let's slow things down a bit, consider this type of treatment. So you get the best.

Those who are used to making decisions alone, however, may find it frustrating to be asked to consider other opinions. In Example 2.18 we hear from a team member who thinks that taking time to consider a range of opinions has the potential to cause damage by delaying treatment.

Example 2.18 **Decision-making in a multidisciplinary team**

One problem with multidiscipline is that although it contributes a lot of different opinions it will still take someone to make the required decision. This may dilute the surgeon's role, which has, by necessity, to be relatively decisive. This is one of the drawbacks because although you have the reassurance of a multidisciplinary team it takes the decision-making out of your hands. If you use the multidisciplinary team as a decision-making forum, then you can, by definition, delay treatment.

If the multidisciplinary team does not have the ability to make decisions together it is difficult to see what benefits could be gained. In Example 2.19 a team member explains how the process challenges decisions that might have been made by a consultant who is prejudiced against or favours particular types of intervention.

Example 2.19

Consideration of a wider range of options
One advantage of the multidisciplinary team is that the safety net is much bigger. There's less chance that you might forget to refer patients on and it gives you protocols and guidelines to work to. So it would stop a surgeon who would never refer patients to chemotherapy or radiotherapy because they didn't believe it was beneficial or effective. Within the multidisciplinary team that's less likely to occur.

We might hope that evidence of successful clinical outcomes also influences judgements about treatment. This raises issues about how staff in isolated settings can keep up to date. The interdisciplinary team meetings offer an opportunity for peer review that is not usually possible in smaller, isolated organisations. As we see in Example 2.20 the review of each case does raise the question of which treatment is currently considered to be most effective. As there are different costs involved in different treatments, this discussion may also raise difficult issues regarding what is valued when we use the term 'value for money'.

Example 2.20 **The benefits of peer review**

They may cast doubts about what each other should or should not have done. It's very rare to hear doctors challenging in front of other people. One of our consultants was criticised for choosing a low-cost treatment option. They were horrified that we would consider cost as a factor. Our consultants said it was value for money as the treatment's well tried and tested. They said that there are far better treatment options, although at a cost. The patient's outcome is of paramount importance so they

changed the treatment. The consultant is usually very pleased. He'll change his practice because of that. It's like peer review really—it would never have happened before.

One of the nurses confirmed in Example 2.21 that she saw a particular benefit for consultants in the peer review aspects of the team because nurses tend to already have those benefits in teamworking in their everyday areas of practice.

Example 2.21 **Working in peer groups**

Sometimes consultants feel quite isolated here. For nurses it's different. We've got a huge team, we're used to that kind of camaraderie, support, saying I'm out on a limb here, I don't know what I'm doing, can you help? I think consultants don't like to say hey, I don't know what to do. However, they've got a compatriot down there and they find it useful. Doctors find it more useful than I do personally.

Another nurse talked in Example 2.22 about how she constantly learnt through teamworking—but in her professional groups rather than in the multidisciplinary team. It is also interesting in this example that she mentions including the patient in discussing treatment options. Although there is an increasing emphasis in national policy on including service users in decision-making about their own use of services and development of services, this has rarely been mentioned in connection with this multidisciplinary team's activities.

Example 2.22 **Learning in practice**

Sharing experience, that is how we learn, that is how we improve. If something's not happening, I stop and I do it another way. If there's something I don't know I read up, I discuss it with colleagues, I phone colleagues. Having meetings is important, discussing with contemporaries is important, keeping updated is important. If somebody is having a treatment and I thought it wasn't doing them any favours, we'd discuss it with the other nurses and then we'd go to the consultant and he'd come along and we'd make a decision with the patient being involved.

The virtual meeting arrangements involve a number of people sitting around a table with their video connection to one or more other Trusts. The equipment and lay-out only allow, however, for a small number of people to be visible on the video link. The people who are always visible are the consultants. The nurses are never visible although their voices can be heard if they speak. In Example 2.23 one of the nurses commented that she felt this was disempowering.

Example 2.23 **The power of visibility**

Nurses don't count you see. I didn't say that. Historically consultants have always been god, have taken the lead. It's our fault in a way. Nurses don't sit in front of the camera in the multidisciplinary team. The three chairs that are for the surgeons, the consultants who sit at the top of the table, so the rest of us don't get seen. What is there to say? The kinds of thing that we as nurses would say about a patient would not be very interesting to the consultant on the other end of the video. He's not going to want to know if the patient is happy with their treatment or if the patient's got problems at home, or things like that. They just want to treat people, don't they? They're not interested in the whole person like nurses are.

In Example 2.24 one of the nurses comments that they do contribute to the team meetings, but only when the discussion touches either on their specialist areas or concerns a patient with whom they are working.

Example 2.24 **When we contribute to the team**

There are times when we feel like we're probably closer to the patients. Things will crop up that are particularly about palliative care and we can take a lead in those. The chemo girls will put in their bit about chemo. When it impinges on us or the patients we're seeing then we will say.

The extent to which visibility empowers or disempowers individuals may be less important than attitude. In Example 2.25 a medical secretary, who might in a hierarchical setting be considered as having less of a voice than a health professional, is able to make challenging contributions whilst others disengage themselves from the proceedings.

Example 2.25 **Choosing to be involved**

The medical secretaries are always invited to the meetings. There's one medical secretary who will always speak out. She'll say, 'l spoke to that lady on the phone and she didn't tell me that,' so she'll certainly contradict people. Another secretary says she falls asleep, it's so boring for her.

One aspect of developing a team involves sharing humour. In Example 2.26 a problem is presented as a joke. In services that focus on delivering one particular type of treatment there is a danger that everything will be seen from that single perspective. This might lead to the possibility of other causes or other conditions being overlooked.

Example 2.26 **Some truth in an old joke**

There's an old joke that the worst place to get appendicitis is in a hospital, on the wrong ward, because nobody will think of it. They'll go off on the condition they're focused on because it's getting much more specialised and concentrating more on the specifics of an illness, without the causes of illness. The mental and spiritual, the cultural causes; there's a massive number of things related to why people get sick or are perceived to be sick.

Jokes of this type can be a difficult issue in a multidisciplinary setting as each contributing discipline or professional group may have different attitudes towards what they consider to be humorous. In very stressful work, which includes many areas of work in health and social care, teams sometimes use 'black' humour to find a funny side to tragic conditions that might otherwise overwhelm them. This sort of humour is often tolerated within a team because its therapeutic purpose is understood and shared, but it can be considered offensive to anyone whose work area is different. In Example 2.27 this type of humour is cited as a reason for not involving patients in the meetings when they are being discussed.

Example 2.27 **Talking about patients**

We still haven't involved patients directly in the meetings. It wouldn't really be right because they're being discussed in detail. Each of the teams has its own individual character and they all operate in slightly different ways. Sometimes they become quite light hearted which I find quite offensive really, when they could be joking about patients with cancer—but it's part of the way that they deal with things.

With increasing emphasis on involvement of service users in decisions about their treatment and about service development, we might expect consideration to be given to use of this type of technology to include individual patients in a conference at appropriate times, even if that does mean that black humour has to be avoided.

Some practical suggestions to consider if virtual multidisciplinary teamworking is to be effective are outlined in Example 2.28.

Example 2.28 **Factors that facilitate virtual multidisciplinary teamworking**

You definitely need a focal point. For clinical teams you need a clinical champion who will support the whole process and not let go, always be there. To motivate people, bring them together, co-ordinate and control the whole clinical side of things. You don't need IT support because it's just communications and anybody can learn how to use it. You need a trainer and troubleshooter. But you need someone to be a catalyst. To make sure that it, and the equipment, is up and running. You also need someone with the authority to get people into the room.

PERSPECTIVES ON LEADERSHIP

Several members of this team commented on both leadership and management, implying different types of activity. In Example 2.29, leading is seen as being senior amongst professional colleagues rather than engaging with the systems of the organisation as a manager would be expected to do.

Example 2.29 **Leading and managing**

They all say, 'I'm a nurse, I'm not a manager.' There is resistance to becoming managers. They seem to like the concept of leading rather than managing. They're leading their colleagues rather than managing resources. They don't want to manage money and budgets. They want to treat patients and use their nursing skills.

More perspectives on the differences between what leaders do and what managers do are given in Example 2.30. The control, monitoring and co-ordination roles usually associated with management are mentioned as examples of leadership along with giving support and direction.

Example 2.30 **Aspects of leadership**

I think any area or any place that you work there has to be an element of leadership. When I work on the ward I give directions, but not in this role. In this unit I take the leadership role because I'm the one that's here full-time, I go to the multidisciplinary team, I see the patient through their journey. However, as far as telling my colleagues what to do, that's not necessary because we're all practitioners in our own right, we know what to do and how to do it. I don't give instructions and tell them this is what you're meant to do today. We know what's to be done and we just do it. But you do need someone to take overall charge, leadership, control, coordination. How everything fits together.

Leadership means someone to take control, to co-ordinate and support. Not somebody who is yes, follow me, gung-ho, that sort of type. Somebody who can give direction, give a solid basis to your daily work. I give direction to myself. I know what I'm doing, when I walk to work I work it out, what I'm going to do that day, when I go home I set it up for the next day. I've always done it for myself. I tend to look to myself for leadership and so give that as well.

In Example 2.31, professional leadership is aligned with the management roles of allocating work and delegating. Clarity about how work is allocated is valued.

Example 2.31 **Leading in a managerial way**

A good leader in a managerial way was one of the ward sisters. We knew what we had to do on a daily basis. She would allocate and delegate. She wasn't democratic though, she was quite autocratic and a lot of people didn't like that, but it suited me. At least she got things done and they were done well. She'd look to me clinically to look at people and see if there were any improvements needed. She didn't lead well that way because her clinical skills weren't that good. Things like looking after a patient, dealing with them psychologically, she'd look to me. We ran a tight ship, but it was a good one.

A view of leadership that is more differentiated from management is offered in Example 2.32. In this example the ability to build on strengths is valued.

Example 2.32 **Working with strengths**

She was a good leader on all sorts of levels. She was very dynamic but was good at using people's strengths. She was very perceptive about what people's strengths and

weaknesses were.

Example 2.33 gives an account of the discomfort of working with a manager who tried to control and enforce through criticism. Although this manager worked very long hours, this was not considered to be beneficial and there is an implication that this put an expectation on others to work unpaid overtime.

Example 2.33 **Not a leader**

I'd had quite a rough time with a male charge nurse whose first ward it was, who didn't know how to run a ward, couldn't let go. He was very hands-on. Instead of arriving at half past seven he'd be there for six o'clock. Instead of going home at three thirty he'd go home at eight in the evening. He'd come in on his holidays. We used to joke amongst ourselves because we had to be strong, but he had to find ten things wrong with you or with your performance before you could get on with your work. He just didn't know how to handle people.

The difference between use of force and use of support and encouragement is discussed in Example 2.34. It suggests that it can be very powerful if people realise the need for change sufficiently to wonder why they hadn't already thought about it for themselves.

Example 2.34 **Push and pull of leadership**

Leadership should be persuading people to follow you. It's the baddies that push people into straitjackets. If people think, maybe I should have been doing this for myself, then they'll follow. People are pushed into things by massive interests outside themselves, like corporate interests, that might seem glittery and seductive and the right way to go. But people who resist that only bring out in us what was there already, perhaps explain to us why it's not right, why we should resist. Articulate it.

Another aspect of leadership is described in Example 2.35 where it is associated with offering guidance without taking over control. It is suggested that authority is gained through being knowledgeable.

Example 2.35 **Leader as guide**

Leadership to me means guidance. It would be someone to steer the ship through stormy waters, not necessarily to take control but to steer. In my last job my leader was a medic as well, most of the time they have been. Everybody's expected to be a leader which is alright in one way, to lead yourself and to lead colleagues who work for you—but I think it's gone a bit far. You have to be quite strong minded because there are some difficult people, including consultants. If you're going to lead nurses you have to be strong

minded, knowledgeable and know what you're talking about.

In Example 2.36 the term 'covert' leadership is used to describe how a leader can encourage and steer, sometimes push, in the desired direction.

Example 2.36 **Covert leadership**

In these meetings someone's pushing the thing and running it and keeping it up to scratch, but you don't know that because everyone else is tacitly happy with that situation. They've put their own bit of effort into it and it's working well. If it doesn't work, someone stands up and says so. Allowing the players to play. Command and control—forget it, everyone would get cross.

Another aspect of leadership in this team (Example 2.37) seemed to be a rather parental role in keeping order. Several members of the team mentioned that there are often 'difficult' people and it seems that leaders are associated with the authority to settle differences. We might expect team members to want to develop skills that enable them to find resolutions for themselves in these circumstances instead of looking for a senior figure to intervene.

Example 2.37 **Leadership and keeping order**

The senior consultant would ensure we all had our say and actually come up with some sort of agreement about how we would work after that. Because we're all nurses and he's a doctor—we all sort of think of ourselves as being three equal groups and unless he gets on board things are difficult to resolve. He doesn't stand any nonsense if he feels that things are getting too emotional or tied up in little things that we shouldn't be worrying about. We've got some very strong personalities that clash badly at times so it gets very personal.

One of the nurses commented in Example 2.38 on the parental role that the leader sometimes took in the multidisciplinary team meetings. She seems conscious of the parent/child relationships that seem to have developed, but although she is willing to offer support to the leader, she seems unable to influence the meeting to ensure that it makes good use of her time.

Example 2.38 **Frustrations in meetings**

If there is a leader there things run a bit better. If there is any dilly-dallying he'll say let's get back on track. But sometimes it depends how he feels. Sometimes he gets exasperated. He must get tired of doing it too. I know how I'd feel if I had to say it at a meeting with nurses. I'd wonder what they'd think of me. Sometimes we'll come out and

say well, that was a waste of time. Or well come out and laugh and say how awful it was. Sometimes I'll try and catch his eye so he'll think he's got a bit of support when it's awful and say something.

In Example 2.39 one of the team members is aware of her strengths but thought her need to think things through before voicing an opinion made her unsuitable as a candidate for leadership.

Example 2.39 **I don't sound like a leader**

I'm not a natural leader. I think they'd be more able to voice their opinion. I wish I could think more quickly and come up with pat remarks. I'm one of these people who like to take things back and mull them over. I'm more analytical, not quick. My skills are useful though, because I'm a bit of a perfectionist, dotting all the 'i's and crossing all the 't's.

Another team member mentioned that there seemed to be an expectation in the Trust of a particular type of person as a leader. This was not necessarily the same sort of person as patients might choose: 'The Trust is looking for a figurehead—the patients are looking for someone who can get things done on an individual basis.' Another mentioned 'getting things done by fluttering your eyelashes', which is probably not how the Trust intends decisions to be made.

One particular aspect of leadership was suggested as important in the context of rapid change in health services. This is the ability to understand the potential impact of change on all of those who work in the context. Example 2.40 outlines this idea of the leader's role in anticipating and planning for impact of change.

Example 2.40 **Anticipating the effect on others**

The easiest thing to miss is how much the folks around you are being affected, particularly the non-medical staff. Things are changing around them rapidly all the time. If you're not careful, no-one considers them until there's a big outbreak of anger or something. We've all got to look out for each other more. The old patterns and relationships are changing and some are breaking down. Not necessarily a good or bad thing, but it affects everyone. The leaders will be those who anticipate that, the effect on other people. Most of us rush around dealing with problems that have got out of hand. The really clever thing would be to anticipate the effects on other people.

There are also some examples of shared leadership in this team. In Examples 2.36 and 2.38 we heard accounts of how the person chairing the meeting was frustrated by the behaviour of team members. Interestingly, it was one of the team members who took the lead in finding a way to address the issues (Example 2.41).

Example 2.41 **Shared leadership**

If something went drastically wrong or seemed to be not up to standard, he'd get angry. Though he didn't show his anger, you could sense his frustration. He'd say to me after, That was not how we should conduct these meetings.' So I'd make a list of all the things I'd noticed that we could correct and we'd go through those points with the members of the team. Not particular people, but behaviours. Though some people would jump to conclusions and defend themselves strongly even if they weren't at fault!

LEARNING FROM THIS CASE STUDY

This multidisciplinary team was formed to comply with policy guidelines intended to shape improvements in cancer services. Team members give a range of perspectives on change, leadership and the value of formalised teamworking through interprofessional meetings.

The subject of meeting etiquette flags up a number of important issues about ways of working, models of service, losses and gains within the transition and change process. The change that has enabled them to work in a virtual conference has itself opened wider potential for use of computer and communications technology to improve services.

Implicit throughout the case study is a question—what does it mean to be a professional? Professionalism has traditionally been associated with expertise. There is concern now that being a professional is much more diffuse. For example, you might think about what would happen if all of the participants were visible on screen in a video conference and whether this would have implications for expertise and power.

Consider the processes of developing a 'meeting etiquette' and the impact on ways of working. You might find it helpful to refer back to the strategic planner narrative who refers specifically to meeting etiquette. Examples 2.21 to 2.26 are particularly relevant. You may find it useful too, to consult the earlier examples in Perspectives on Teamworking and the discussion about teamworking in Part 3. Reflect on the following questions:

- How might an evolving meeting etiquette impact service provision?
- How might it impact ways of thinking, leadership and team-working?
- What advice might you give this group about effective team-working?
- How might a member of this team lead development of a service improvement that made use of the experience the team has in use of new technology?

What insights have you gained from considering the case study and how might you apply them to your own situation?

CHAPTER 3
ASSERTIVE OUTREACH MENTAL HEALTH TEAM

INTRODUCTION

The Assertive Outreach Mental Health Team was established to improve the service offered to those in the community with identified long-term serious mental health problems, including schizophrenia, bi-polar disorder and psychosis. In particular, the outreach approach is intended to extend the service to people who, for whatever reason, do not use the more traditional services that are delivered in health and care organisations.

The Assertive Outreach Mental Health Team was the first to be established in the area and started eighteen months ago when the team leader was appointed. The government set the National Service Framework for Mental Health Care and a Policy Implementation Guide which provided criteria for the composition of the team. While there is flexibility to adapt the team to local need, the guidance is prescriptive about essential personnel. These include a consultant psychiatrist, a certain number of nurses and social workers per population, a psychologist, community psychiatric nurses, an occupational therapist and support workers. It is a fully multidisciplinary and interprofessional team.

The government policy states that all patients with a mental health problem should have a care plan approach. Most teams work with individual clients and patients on a one-to-one basis, each qualified professional having a personal case load. This team is different in that although it uses care co-ordination it does so through a team approach. The theory is that all the people in the team will have working knowledge and a day-to-day relationship with each client.

The team was initially jointly funded by the National Health Service Trust, the Social Services Department and the Drug Action Team. These management structures have now merged with one direct manager and one source of funding.

How the team works

The team works from nine to five Monday to Friday but also, due to locality needs and constraints on numbers, the team members work flexibly to cover evenings and weekends. The team operates in deprived areas and tries to address social inclusion because people with mental health problems are often isolated and less likely to go out and have a social life. For example, on Bonfire Night team members went with clients and patients to a local pub for a meal and then held a party to help to enmesh participants into the local community. The team differs from other teams in the informality of its approach, trying to work on people’s strengths to increase their independence and coping skills.

Each qualified member of staff is expected to have approximately ten clients. Every morning staff have a risk and allocation meeting, mentioning every patient by name.

Certain work is ongoing but some work is more therapy oriented. For example, occupational therapists might meet to work on independence and self-care. Nurses might have fixed time to work on voices or delusional symptoms. The team also, however, have to respond to day-to-day crises.

PERSPECTIVES FROM THE TEAM

Team leader

I'm a nurse by profession and have done a variety of nursing jobs. This is the first time I've managed a multidisciplinary team. I'm from a health and social care perspective and the two, through government and politics, have been very much separate entities. I've got very frustrated over the years at how people have to go through lots and lots of paperwork and assessments to get holistic care. This post is certainly a leadership challenge, with lots of issues of diversity and rights and personal differences.

The team was the first to be established in this area. This is probably why it has had a lot of profile and people were aware of us. Our general manager was very passionate about leadership and developing staff, saw this job as evolution and was successful in getting the drivers along with her, of which I'm one. This is what I've always wanted to do.

I think that teams evolve and have had a lot of freedom in how they evolve. It's very positive in that we have looked at what was missing in this locality. We knew that there were less community staff per population in this area and nobody worked weekends or evenings, so nothing for people in crisis, people who were very needy. It was very easy for me to appoint, because I had new monies, new offices, people who wanted to work here chose to come here—nobody's been reconfigured. People are here because they want to be here. So leadershipwise, a doddle. Very challenging, lots of ideas, not always easy to manage, but easy stuff to lead.

I'd worked in the locality for fourteen years. So I had strong beliefs about what the needs were and I wanted to fill that gap. I thought I knew a lot about social care until I worked with social workers and realised that my knowledge is very limited. I think learning in the team takes a lot of time. This team has a smaller case load than in the rest of the service. We have a lot more time for the clients. We have a lot more time to learn with each other and with the clients.

We try to approach people who wouldn't go out without us, some people would get out anyway. So we focus on people who would be sat at home alone and try to get them out and to mingle in society. So we do quite a lot of things, go to the pictures, go bowling, play pool, whatever they are interested in—go horse-riding, do some quite interesting things with some people. So that's why we are different from other teams. We don't sit in a room. We don't work on people's problems but try to work on people's strengths to increase their independence and their coping. If they were to come to us it would be different. We had three people come to us this morning and for assertive outreach that's brilliant because normally they don't want to see us. We're a year in now and have developed quite good relationships, but they're difficult to engage. We do structured work with them in our interview room, but a lot of our work is informal and

done in informal settings. We go to them. Which a lot of community teams do, but I guess we have more flexibility.

As they know more about us some of the clients know who can solve their problems quickest. A guy came in with debt problems and asked for a social worker because they know the phone numbers, who to ask and they're quicker. One of the ways of addressing the issue was to get the unqualified workers. It's been the biggest success of the team. They are, perhaps, the most important members of the team, including running errands and leaving qualified people free, but that's brought about a challenge in itself. Of the two support workers we've got, one's going away to do his training next month, so we've developed him. Training is quite important to me. Learning and being flexible. We've had three 'away days' in the year and we've changed our policies each time, to adapt. Our clients are always changing as well, of course; their needs are changing.

We have quite a few informal team-building days—and nights, drinking nights—as well. There is an acceptance that we're all very different in how we carry our personal lives, but there is respect. There are times when I get it wrong. For example, I've felt very removed from the team recently, there's been so much demand from above. This week's been better. I realised that I've got to look after them. The top's got to wait for a while. There are times when I don't perform but there are times when I've got to let them see how it goes without me. We do have a delegation model.

It's the best job I've ever had in my career. I would have left a while ago. What worries me is that there's been so much research done about this service saying that retention of staff is very difficult. Burn out is very high and team leaders often work for two or three years and then move on. I think, for me, that needs to be addressed. It needs to be looked at day to day. I've got a youngish team, pregnancies, babies, marriages and that's quite important. You need to look at where people are in their lives. Your biggest resource is your staff.

Community psychiatric nurse

I'm qualified as a mental health nurse and have been in the team for eighteen months. I've worked in acute wards and I feel quite privileged to have got a job in the team. In teams I've worked in before it's been just nurses. I've carried quite a large case load of about thirty clients on my own and had sole responsibility for those clients. Whereas in this team we have smaller case loads so we have the flexibility to see the patients more often and everybody sees all the patients.

We work with quite a challenging client group. The clients I was seeing before were primarily primary care clients with anxiety and depressive disorders whereas this is the other end of the spectrum and it's a much more intense kind of job. So although I've got a smaller case load it's actually a much more stressful job.

We're all fairly senior clinicians really. We've all reached a certain level and all got a lot of experience and all paid a similar amount of money and all on similar terms and conditions. Everybody's committed to this type of work and everybody respects everybody else. I think the team leader's quite skilled at picking people who are able to get on with each other but, more importantly, able to get on with the clients.

There were high expectations placed on the service at the beginning, before things were in place. We're expected to see a certain number of patients per month and in

reality, we just can't do that safely. There's pressure on us to take on certain patients that are maybe not appropriate. Maybe that's about numbers. Boxes have got to be ticked and patients have got to be seen regardless of how effective that is. Time is the biggest constraint because we just don't have the time to do the job we're expected to do. We are doing positive work but then people say you're only seeing forty patients and it should be ninety patients. There is quite a lot of criticism of the team. Then they'll say, 'Oh, which pub are you going to today?' We're seen as the team that takes people out and does all these nice things, but they don't see the hard work that we do.

I really think that we could put this passion that we've got over to other staff, because I've seen all the other staff on the wards and they're really burnt out. If we could say that the patients are real people and educate about what we do, it would be really nice. People still don't know what Assertive Outreach is. They've got certain perceptions and it's up to us to put those perceptions right. It's about having time to do it—you still have all these other things to do. Patients have got to be the priority. Maybe we have to prioritise that now though because it's affecting the way the patients are being treated when they have to go on the wards.

There have been hard, hard times when we have really struggled. We've done remarkably well to put up with the criticism that we've had and to put up with the pressure we've had from other services to take people off them. We need to look at saying no to things. Staffing is the big thing. We're nearly up to full strength now. We've been so keen to prove ourselves that we've taken on more than we should have done. It only takes a couple of people to be off sick or on holiday and you really notice it.

It's been really tough because it's not only this pressure but we're seeing a very demanding client group. Often it's a thankless task. You feel so deskilled. But you can say I don't know what to do and maybe someone will take some of the work off you. If it wasn't for other members of the team I'd have walked off ages ago. You need that with this client group. They're just so demanding. We had a client who died unexpectedly. That was very traumatic. We've had violent incidents against staff. These sorts of things you need to pull together.

We've all learnt to be realistic. Not expecting clients to be going to work or living a wonderful lifestyle, but looking at the small changes that you've helped them achieve. If someone's just managed to reduce their drug intake by a small amount each day. Seeing changes and realising this is a real bonus. We were talking about a patient today who is really poorly at the moment but instead of just going off and wandering into the fields to walk as he used to, he came in here and said, 'Can you help me?' We've not stopped him becoming ill but we've managed to get him to come here and say he's ill. Others are still being admitted, but maybe it's only for a few days now and not for weeks. We try to say something positive about what we've done at each team meeting.

The team is an exemplar in some ways—we need to hear that more. The team leader is very good at selling what we do. She is so passionate about it. Having a positive leader makes such a difference.

Health care assistant

My role is as a support worker. We work alongside the trained staff, sort of like the buffer between the trained staff and the clients. We're more friendly, they can relate to us

a lot better. We look more towards engagement, social inclusion, medication and benefits issues. So we're more like friends. Possibly because they find that we're not judging. They're not talking to us about reducing medication, side effects. We do talk to them about that, but not to such an extent.

A lot of people we deal with have no social network, they don't have many friends to talk to. They're coming in just to talk to you because they've got nobody else. Just about everyday mundane things. Someone to say yes, that's a good idea, or no. You find that you get a lot of one-word answers and you're digging around to try and find some common ground to work your way in.

You often find with your dinner break that when you're having your dinner you're having it with clients or that's the time to get your notes written up. Everyone's so passionate. It's not a case of everything stops because we've got to have a dinner, we've got to start at this time or got to finish at this time. We're willing to be flexible because we're so passionate. If someone comes in at five o'clock we can be ten o'clock at night just because they want you there.

Before, in a traditional in-service team, if you needed to see someone you had to wait and book them up. We're all accessible and we've all got a voice. If we don't particularly agree with somebody else's diagnosis or somebody else's thoughts on a particular person, it's healthy that we can all have a discussion. You can see why, for example, an occupational therapist wants to go down this particular way of thinking. So you've got social workers talking about the social aspects, the occupational therapist talking about the home environment, your community psychiatric nurses and medication issues, the support workers on social inclusion issues, so we've all got a say. But if you've got someone who's got a drugs- or drink-related problem it's no good sending them to a social worker or an occupational therapist. We've got a dual diagnosis specialist, it's their speciality. Overall the team leader has to take the call and say yes or no and take the consequences. The total package, I think, is very good. It's the best service I've ever worked in.

I feel as valued as the consultant, because my point of view is taken on board. I feel that in the team I'm not lower down the ladder but equivalent. For me it's a plus because before it was, 'What do you know, you're only a support worker'. Now it's a good point because support workers get more contact with the client.

For me the downside is that you've got different disciplines on different pay and different hours. For me it's not an issue because we chose to come here. Social workers get more money and they get more holidays and community psychiatric nurses don't, they get less. But there's no animosity, no malice—we all accept it. It would be nice to be under one umbrella, but a lot of the time you're rewarded for passing particular courses but the course doesn't necessarily make you any better. For a nurse or social worker, it's experience, hands on, that makes you better so there's no particular way to assess you on that.

With any new service, there are people looking to see if it's ready for a fall. People who want to knock because they don't understand. We actively encourage anybody and everybody, from the wards, from different disciplines, from upstairs—the rehab service, the generic services, the elderly services, to spend a day with us to see how we work. Because we're a new service and we're teamworking, people are unsure. They don't

know what to expect, they don't know what our expectations are. With any new service it's got to be established and, I suppose, show a success that people can measure.

Because it's a new service and there have been no other ones on line, we've been certified, forensic, elderly, crisis treatment—we've been all treatments. These services are coming on line now, but we were getting everything. We were thinking, until these services come on line should we step in and help? We could offer a little bit more than other services could at the time, but we weren't ideal.

Dual diagnosis nurse

I used to work in a high-security hospital with sex offender treatment of personality disordered patients. I'd always been interested in drugs and alcohol, professionally I mean! I've only for the last six to nine months actually felt that I've been doing the job I applied for. When I first started there were very few members of the team. We all had to muck in with anything and everything. We didn't have support workers to do some of the more practical day-to-day tasks. It's since the team expanded and we've got more staff that I've been able to move into my role, which is dual diagnosis: individuals with severe and enduring mental health problems including substance misuse, drugs and alcohol.

Research shows that a large proportion of psychiatric patients, up to fifty per cent, at some point in their lives have a substance misuse problem. So it's a big problem. Although it's a specialist role, it's quite a wide population, really. The process is to identify the folk that have those two problems (although they have a hundred and two generally), assess the needs of those patients and then advise the rest of the team as to what, from a dual diagnosis point of view, I think should happen. So that might include detoxing people from various substances. It might include health education, minimising harm that people do to themselves through using substances. These are often chaotic, transient kinds of people living on the streets. It's quite an achievement to track someone down and talk to them.

I think the team are doing extremely well. Although I'm on my own in the sense that there's only me in the team doing my sort of job, the rest of the team are very supportive. I couldn't do all the interventions myself because there wouldn't be the time and I'm just not qualified in certain areas. My role is more advisory. If you're involved by yourself for a long time with patients of this sort you can very easily become disillusioned, burnt out, burdened with it all. It's very useful to have the rest of the team to give bits of that person's care too.

The multidisciplinary element in the team is a big help in enabling that to happen. The occupational therapist, for example in the team, can speak very knowledgeably about her subject and the other people in the team probably don't have a great understanding of that but are prepared to listen and learn. So we're always educating one another about what we do and how we do it. I think this openness of opinion has evolved from that. You need to know that people are up to speed with what's happening, know what the potential prob-lems are and know what the plan is if something were to go wrong or a certain situation were to develop. With the client group that we work with, you definitely need people you can trust.

It comes back to people's opinions being valued, the honesty. People are passionate about things and that comes over in the way they communicate about things—I'm going

to tell you what I think and I'll tell you in the way I think you need to be told. In some instances, in some teams, that can cause a problem because people are viewed as aggressive or over-opinionated or whatever, but I don't think that's happened in this team.

We have a meeting every morning to discuss every patient. Even if you're not directly involved with that patient, for that particular part of their care, if something happened later on that day that you had to deal with, you'd have a broad outline of what was going on in that person's care. You could comment on it knowledgeably, you could give an opinion about that because you would have a broad overview. There would be people that you'd be very definitely involved with and you'd pass that information on to other people so that they could do the same if you weren't around. I think communication is the most important part of what we do. At every level, between ourselves, us and our clients, us and other professionals, it's the key to keeping people safe.

In my particular role, I'm given a certain amount of autonomy purely due to my experience, knowledge, the specialism that I'm in. Which is a good thing because there are times when you need to make decisions there and then and you can't refer back to someone else.

Personally, I would like to be given more responsibility for developing that area of work but there are constraints. But day to day, I don't feel constrained at all. If I needed to go and do something and I was confident to do that, there wouldn't be any constraints placed on me.

PERSPECTIVES ON CHANGE IN HEALTH AND SOCIAL CARE

The examples in this and the following sections are drawn from the interviews with team members and illustrate issues related to change, teamworking and leadership.

This team frequently compared their way of working with traditional models to indicate how much had been changed to enable this different way of working. In Example 3.1 a comparison is made with the traditional hierarchy in which all other disciplines defer to consultants and in which senior staff do not expect their actions or judgement to be questioned by those junior to them.

Example 3.1 **Traditional hierarchy and teamworking**

Before I worked in a team where the staff nurses, and especially the consultants, wouldn't want to be questioned. What they said went. People do act differently if there's a medic about, if they think they're being watched, being judged. In past cultures they knew best, which isn't always the case. In this team, from the student observing support workers to the occupational therapists, we all see things differently, like a big jigsaw. Everybody's thoughts are taken on board, whether they're right or wrong. You're not condemned for speaking out of turn because something relevant may not have been picked up.

Everyone in health and social care services has experience of change but not everyone finds it easy to adapt. In Example 3.2 one of the team described how staff in one area of

work were openly hostile to change. She suggested that this resistance was partly because people were not aware of the potential benefits of delivering services in different ways and partly because they resisted being forced to change.

Example 3.2 **People don't want change**

When there was talk about the Assertive Outreach team being set up some staff said, 'Why the hell do we need that? Things are OK. What do we need that for? Here we go again. Change for change's sake.' That attitude really does pervade through. I think that's why we need to be selling the positive result of that change. There is an attitude, 'We'll stay as we are, thank you very much.' People don't like to think that change is being forced upon them.

Resistance to change is also often associated with not recognising the need for change. If people believe that change is necessary they are less likely to resist it. Several members of the team mention that they think it is important to convince staff in other services that the approach used in Assertive Outreach is more successful for some clients than traditional service delivery. Institutionally based mental health services changed dramatically when many of the institutions were closed and replaced by care in the community. The community-based approaches used by this team may not have been appropriate before these policy changes.

The flow of funding for mental health services has also changed to focus on resourcing service delivery in the community. Many health and care staff are very aware of resource constraints although budgets are usually only held by managers and team leaders. In Example 3.3 a nurse explains why she thinks it is difficult for nurses and other professionals to be successful in gaining funding for innovation. The traditions that helped nursing to develop into a profession may also be holding the profession back from engaging fully in service development.

Example 3.3 **We're supposed to be humble**

Historically we nurses are very bad at singing our own praises because we're supposed to be humble. In nursing, particularly in this country, we're still being Florence Nightingale. It's still the female occupation. What we haven't realised is that if we do sing our praises, we'll get more resources. The Trust is being inspected in January—it would be so simple to stomp around and criticise. But if we succeed, we get increased funding. And if we could spend that on service users, job done! There's a lot of cynicism about change and nurses are no different. I think we've been our own worst enemies.

There have also been long-standing tensions between different professional roles. Members of the team described tensions between social workers and psychiatric nurses related to overlapping roles and different priorities in approaches taken in different areas of practice. These differences also caused tensions between services delivered within

institutions and this new service delivered in the community, particularly as described in Example 3.4 when a patient might need to be admitted temporarily to a ward.

Example 3.4 **Tensions between services**

Sometimes patients are admitted to an inpatient ward and we get quite a lot of hostility from the ward staff. It was affecting the way I deal with clients and the way I deal with other staff. There's a lot of bad feeling about this team because it's new and needs to prove itself, two hundred per cent perhaps. We're completely different. It's a whole new, creative and flexible way of working. Until we can see real positive results people aren't going to believe in it, but these results aren't going to come up overnight. They've got to be a little patient with us really.

Much of the tension in this case seemed to arise because of different models of care. Services that develop with a philosophy that differs from the traditional hierarchical, institutionally based services often need to develop new ways of working. This is where leadership is usually considered important, as the ability to set a new direction rather than the management role of monitoring and controlling an existing area of work. In Example 3.5 the distinction between leadership and management is discussed but it is proposed that this is not an easy distinction to make in health and care because change for improvement is a constant feature.

Example 3.5 **Leadership as keeping a balance**

I consider myself a leader and not a manager. When you manage something it doesn't move easily or grow easily, you're usually managing something so that it is contained. Health and social care cannot be contained—it's growing every day as we learn and progress, so it is a bit different. Some things have to be managed to be kept safe, risk issues and problem-solving. Also fifteen people with very different ideas. Unless you manage that you've got chaos. How do I do that? Balancing, lots of good supervision and stepping out. Good training for myself and learning. Most important for me has been to learn and to listen.

In Example 3.6 the team leader comments on how her experience helped to pave the way for development of a new service area.

Example 3.6 **Leading in health and care**

The vision at the top is that health and social care will have to work together. Although I'm a nurse, I'm passionate also about change and truly working together. I think they thought that I'd bring people together and do that. There is passion there and determination. I've been given the freedom of having budgets. Also, I've been around a long time and know people and I think that helps. When something has worked they trust

you next time. But even if things have gone wrong, we've owned up to it and said next time we'd do it differently, so it's being genuine and honest.

PERSPECTIVES ON TEAMWORKING

The approach of this team is based on a philosophy that is significantly different from the underlying philosophy of traditional service provision for mental health. Example 3.7 outlines the difference between the traditional 'medical model' and the new and more holistic 'bio-psychosocial model'.

Example 3.7 **Conflicting philosophies of care and treatment**

The philosophy of the team is to try and maintain people in their own homes, in their own environment. Basically to improve their standard of living and quality of life, rather than to treat them medically. Before, I worked to the medical model, just nurse led and consultant led. Whereas in this team the consultant is part of the team and we work to the bio-psychosocial model, so it's not just about medication and jabbing people.

So when you say what do we actually do, sometimes it can feel like it's just about medicine but we also visit people in their own homes and it's

much more of a supportive role than in my previous jobs. It's much more on the same level as the patients, it sounds a bit corny, but being a friend. Actually looking at what they want, their needs and their strengths. Trying to see patients grow and develop rather than just going and treating their illness.

This new service model demands that professionals relate to service users in a different way. Developing this new type of relationship is not always easy for people who developed their practice in traditional services. As a nurse commented: 'Before, I was almost a therapist type. Now one of the patients said you're my friend, you're my family. I think a lot of traditional services would be a bit edgy about this but it works for her and that's what patients want.' This change of attitude towards patient-centred services is unlikely to develop unless services themselves change. Service delivery that involves patients and clients may need to look and feel very different from services delivered by experts to treat conditions rather than people. In Example 3.8 one of the team explains the importance of sharing a vision of how the service should work.

Example 3.8 **Sharing a vision**

Certain things are a base line. A foundation of what we're trying to achieve. A common vision that we want to see anybody who walks through this door in control of their care. Being able to articulate what they do and don't want. Able to minimise their distress and maximise their potential. It's our core philosophy and every discipline has got that.

The vision describes the aspiration for this new service approach but different ways of working are necessary in order to achieve these outcomes. Example 3.9 explains the difference between how this team works and how staff usually work in more traditional services.

Example 3.9 **Working as a team**

The difference between this team and others you compare it with is that this one works as a team. The government policy is that all patients with a mental health problem should have a care plan approach. Other services work with one qualified professional with a case load. So if the professional is off sick, someone else in the team will have to open their case files and read them. In our team we do still use care co-ordination, but it's a team approach. The theory is that all the people in the team will have a working knowledge and a day-to-day relationship with the client.

This team put considerable emphasis on bringing their various strengths to bear on meeting the needs of their clients. Example 3.10 describes the benefits to be gained from this approach.

Example 3.10 **Meeting clients' needs**

The team works together well because we're all passionate and we're all client orientated. We're all looking for what clients need. From the lowest-paid support worker or student up to the highest-paid consultant, we've all got a voice, we've all got a say in this person's care. We can all see things from a different perspective and we are all client focused. We've all got strengths in certain areas and we've all got weaknesses in certain areas so we all compensate for each other and we all look after each other.

Although this way of working together brings benefits that the team value, people sometimes feel that their professional contribution is less visible than in traditional services. In Example 3.11 a nurse discusses some of her feelings and the importance of developing a shared evidence base to underpin practice in these new settings.

Example 3.11 **Roles in the team**

The other nurse and I have had this ongoing conversation about how other members of the team have quite specific roles. The occupational therapist does the occupational therapy and the social workers will deal with sections and benefits but what does the psychiatric nurse do? Sometimes it feels like we're just mopping up what other people don't do. Like medication. Like being the injection nurse—everybody else does the nice psychological therapies and things like that and we give the injections. It means that your relationship with a client is basically different because you're seen as the person who gives them the nasty injection. It's sounding very negative really, but that's the reality

We've had to do some self-analysis to forge our roles in the team as specialist workers like everybody else. I'd like to do some of the psychological work. I'm on a course at the moment on psychosocial interventions for people with psychosis. Theoretically, at the end of that I'll be able to look at things like cognitive behavioural therapy for people with psychosis and do much more in-depth assessments. It's really about having an evidence base for what you do, being able to say what you do in a structured way.

Many professionals in health and care have a strong personal identity with their profession. When their role is wider than the normal professional one, particularly if their activities seem sometimes not to include a professional contribution, people can feel a loss of identity. This is discussed in Example 3.12.

Example 3.12 **Personal and professional identity**

One of the challenges of the team is because it's more mixed, with a lot of evidence and research to build on. In the eighties they tried this, made what we called a community mental health team. You ended up with groups of staff quite concerned about their profession and where their profession sat in a multidisciplinary team if they became generic workers. They lost their professional identity and their skills and their ability to be confident in their profession and where it sat. A lot of hostility and anxiety was caused.

I think the challenge is to ensure that people are able to take up what they wanted to do when they became a social worker or a nurse or whatever, but at the same time, to meet the needs of the team. And that is a day-today challenge, especially if you have less staff. If you're short, people start feeling very deskilled. One of my nurses said, 'I'm just an injection nurse', and she's much more than that, but that's what she'd become that day. So that is a challenge as a team and it's how it differs from other teams. It is because we're multidisciplinary.

In a team that consists of professionals and trainees from many different disciplines the differences in education and experience can create difficulties for individuals in learning to work with the team. The team leader is not always the most senior member of staff but usually takes responsibility for developing teamwork. In Example 3.13 this team leader discusses some of the issues she faced.

Example 3.13 **Developing teamworking**

It's a challenge to manage people who are more academically qualified than myself and who get paid more. The psychologist very much wants to be part of the team and his core values are about teamwork. He's come from a similar environment and is quite passionate about it. He's certainly a genuine team player but has clear beliefs as a psychologist of what his role will be. That's brilliant, because he's there for the team but very much a team player.

The consultant to the team has been around for many years and probably had (by his own admission) the least idea of what teamworking's about, but he's really been sold the team model. It works and he feels valued. He has learnt to accept the support workers—they may not have all the qualifications but they see the world more through the client's eyes than any of us. He's started to value that.

A good team player feels able to do their bit and understands their role within that team, but, at the same time, values every other player. It's like a game of football. The striker can never score goals on his own and the goalkeeper can't stop them without all those people in the middle. It's vitally important that those people communicate and respect each other. If one person in that team's ignored, then you've got a weak link.

Although the professional roles in the team are important in bringing the necessary knowledge and skills to deliver the service, the personalities in the team are important in enabling staff to work together. In Example 3.14 the importance of humour is mentioned as one way of helping individuals to deal with stress and occasional traumatic events.

Example 3.14 **Personalities in the team**

We're all fairly good at recognising when somebody gets stressed and saying, hang on a minute, calm down. We share a similar sense of humour. You have to have quite a sick sense of humour. These things matter. You have to be able to laugh. Some of the things you see are quite traumatic and we've had some quite difficult times lately with patients. So to be able to go off and have a laugh and debrief informally. There's a good mix of personalities too. There's a couple of people who are quite loud and a couple who are fairly quiet and the whole thing seems to meld together quite well. We've all got quite strong personalities too, all quite assertive. That comes from passion for the job, I think.

In this team the approach to service delivery makes it essential to be close to the patient as an individual. This close relationship necessarily involves the emotions of staff in responding to individual patients. The nature of the service means that many of the service users are very distressed and this can sometimes be overwhelming for members of the team. In Example 3.15 one of the team's rituals is mentioned as one way in which the team try to give themselves a supportive environment.

Example 3.15 **Team rituals that help**

We have a little handover each morning, a little team meeting and whoever's in first makes everyone else a cup of tea. These little rituals—you need a bit of grounding in these sorts of things really. If you think about the job you do, sometimes it can blow your mind, so many really troubled and distressed people that you see. We're very good at supporting each other.

Emotional support is not the only type of support team members need from each other. Some of the team's patients and clients are dangerous to themselves and to others. Example 3.16 describes an occasion when the team made a decision to refuse to accept the transfer of a patient from an inpatient service to their community-based service.

Example 3.16 **Staying safe as a team**

Historically there's been a quick burn out because of demands made on staff. For example, we had somebody referred to us because they can't be managed on the ward. It's taking seven or eight staff to control this person on the ward. What good is it sending them home and asking us to visit them as lone workers or pairs? What good could two people do in one person's home when they're struggling with seven or eight people on the ward? We did have to take a team decision. Although we're all passionate about it and we like the job and do want to be here, it is just a job and we all want to go home safe.

The degree of risk faced by the team demands that the team members have considerable trust in each other. In Example 3.17 one of the support workers discusses how this degree of trust has to extend to all members of the team, regardless of their role or qualifications.

Example 3.17 **Trust in the team**

The foundation of trust was built by the people who were here at the beginning and that has sort of rubbed off on the people who've come since. With the type of clients we are dealing with you have to trust the people you are working with and you have to trust their opinion, regardless of your role or qualification. The support workers are often viewed as the unqualified staff, but in lots of situations their opinion is often the most important because they have the most day-to-day contact with someone. Therefore I would trust their opinion implicitly, not over anyone else's, but due to the amount of contact they would have with someone. So I think trust is a very big part because you've got to feel that you can say what you want without being made to feel inferior or inexperienced or that your opinion isn't valued.

As a new team, it was inevitable that their practice as a team would be shaped, to some extent, by their experience. Sometimes useful learning came from making mistakes. Example 3.18 describes how the team learnt to build more careful planning into their routines.

Example 3.18 **The need for planning**

When we first opened, we saw clients who were all new to us. They all carry an element of risk in terms of their health and injury to themselves or others. We'd decided who could go and visit people but there wasn't

a particular structure. Then people visited a client on Monday and two different people went on Tuesday. There was no continuity. This caused an incident that was quite risky because we hadn't had feedback from the people who visited on Monday. On Tuesday the client was quite frustrated and said he'd told our colleagues these things yesterday, so we found ourselves quite at risk. We had quite a heated debate about that as there was no plan before we went to see that client of what we would do as a pair. There was no planning basically. It was very early on in the team's development.

After that we met as a team and changed our procedure for visiting clients to make sure there is continuity with all our clients. We listened to clients too and made them more in control of who they see. We did that initially by problem-solving, evaluating what happened, learning from it. Then identifying areas for training and certain people are on a course now because of it. We've adapted our behaviour as a team.

Openness to learning seems to be an important feature of this team. The trust that they have in each other enables individuals to admit errors and to accept that they need to learn. In Example 3.19 we are offered an insight into how one of the senior professionals in the team felt when being open about mistakes.

Example 3.19 **Developing together**

I can think of things I've done that weren't the wisest things. I would like to think that the staff in there would tell me. I certainly think they would and that they feel able to and that I could tell them. There have been a couple of times when the risk was quite high, times when it was quite dangerous and we've all had to learn from that. I think that the fact that I can hold my hand up and say that I've got a lot to learn here has enabled others to say, 'OK, if she can say it, I can say I did that wrong.' It's a learning philosophy and it's OK as we evolve and grow to keep refining that.

In Example 3.20 one of the team proposes that turbulent relationships are only symptoms of the commitment that the team feel to the service delivery model. The team have respect for each other that transcends day-to-day difficulties.

Example 3.20 **Tensions and the glue that holds the team together**

There've been lots and lots of battles. Traditionally there's always been this thing about social workers versus psychiatric nurses. This all goes on in our office but it's light hearted. I think the fact that we've got lots of people who are quite dedicated to the model that we use helps. This team is fantastic because of personalities in it. But it has the potential to be

blown apart if one person were to come in and not be committed to the model. We find that because everyone's passionate about what they're doing means that we all have respect for each other.

The importance of the model of service delivery is frequently mentioned by team members. The team leader expanded on this in Example 3.21, explaining why she thought it important that team members and service users should know something about the origins of the philosophy guiding the team and the evidence base that supports their practice. This example is interesting in demonstrating how local service delivery can be directly informed by initiatives in other countries. It gives an example of the growing importance of considering models of health and care in an international context.

Example 3.21 **Learning from other countries**

It's very important when you get a new member of the team to say that the biggest change in mental health is the closure of institutions. So rather than just saying this new team's developing here, let them know the model's developing nationally. Say it's an American model, it's a Canadian model and it's a New Zealand model.

A patient came to a bring and share session and said, 'Do you know, the first team was from America?' The boost I got from one of my clients telling me and the group that this came from America was fantastic and her excitement at knowing this. It made us all look at what happened. Why was it set up in America? Why have we adopted it in England? What's different? The latest thing wasn't working in England and why was that? In England we've made it national policy but in America it still isn't national policy.

So it's not just about giving information, it's about getting them to think about it, asking them questions and then personalising it to here. What's working here, what isn't. My job is, when something's going well, to tell them, they need to know that.

In a team where learning and development are important it is interesting to hear in Example 3.22 of the experience one of the team had in a previous area of health services and in this team. There are both practical and personal aspects to learning and the attitude of workplace colleagues can help or hinder.

Example 3.22 **What helped and hindered my learning**

When I joined the health service my qualifications weren't very good and I opted for an access course. There were some obstacles put in my way. For example, the course was on one particular night every week and I was often on the wrong shift. It would have been easy to work out for me but I had to do a lot of swapping and shifting myself although I was after getting on nurse training.

In this job, I told my manager that that's what I was after ultimately and she actively encourages me. Which is nice if I need extra time off for studying. I'm being seconded which means I'll get paid to train and have a job waiting for me. I'm on the student rate so it's the light at the end of the tunnel and I'll be getting paid.

For the interview for nurse training at college I was advised about what to say, what not to say, what to show and what not to show. I'd started at college before and when I came for this job I asked if our hours meant that I'd have to miss college work because you don't want to miss. I was told that if I needed the time I could have the time.

I was constantly asked how I'm doing. When I passed there were congratulations, everybody was pleased for me. It's helpful. Help with any assignments, anything. Even now if I'm struggling or want a chat about the way I'm working with particular clients—if I think it's working or if it's good or bad—I can ask any member of the team and they'll give me advice. It is also nice to be asked for advice as well—it's not just a one-way street where you're constantly asking and no-one's asking you.

This team are not alone in being established to develop new ways of working. As more new teams are established to develop new services, new mechanisms will be needed to link these teams together and to provide links into the other services provided by the host organisation or the local health economy. In Example 3.23 the team leader comments on the need to share information and experience openly rather than allow replacement 'silos' of practice to develop. There is a danger that the strength of passion and vision that fuels development of new services may lead to reluctance to consider other, possibly potential alternative, ways of working. She suggests that host organisations may have a role to play in helping to develop opportunities for discourse related to service development.

Example 3.23 **Linking teams within the organisation**

I think it is important that we have the connection of threads, of all these teams. People became very proud to say they were part of this team and we had a lot of conflict from other services. It was very easy for some of us to do the 'them and us'. But that was just repeating what we've always had, just new silos. I think what we need to do is to genuinely look out of the box. There's another new team just started this week, equally as passionate as we were. They all want to come for induction. We will listen to what they want and their beliefs and let them tell us what they think is good and what's bad. We have a lot of vision ourselves and we need to think about their vision and how we fit in that vision.

PERSPECTIVES ON LEADERSHIP

Some of the team members had very definite ideas about what makes a good leader. In Example 3.24 we have a description of a leader whose priority is to work in and with the team, acting as a personal example.

Example 3.24 **A team leader**

Someone who is a team player, enthusiastic, accessible. Not someone who's shut away in an ivory tower so you never see them. If you know that your team leader is ready to put the same hours in as you or more, you have nothing but respect because it rubs off.

For another team member, the leader's role is described in Example 3.25 as about developing direction in a way that involves the team and shares responsibility.

Example 3.25 **Leading by developing direction**

To me a good leader would be someone who offers direction. Somebody who will make decisions, who looks after their staff and their needs, but also who is willing to enable their staff to develop and to take on part of that leadership role. Leadership to me is about direction but not in a prescriptive way. Guiding people towards a vision. The leaders I've not respected in the past have said you will do this or that. The ones I respect are more ready to allow people to come to their own decisions.

It is not surprising in this team that the vision and direction are closely aligned with their practice. The team leader sets out her approach to leadership in Example 3.26, reflecting their model of practice.

Example 3.26 **A psychosocial model of leadership**

There's a theory of psychosocial intervention and I'd like to adapt that to management and leadership. It's no different—working on people's strengths, minimising their weaknesses, giving them independence, giving them control—you can adapt all of that to staff. That's my philosophy in leadership. The best day in my office will be when I'm redundant because they're doing it all.

People do not always want to have to be independent and responsible in a fully democratic environment. There are occasions when the leader's role is seen as being the decision maker and taking the ultimate responsibility on behalf of the team. Some of the tensions between a democratic and autocratic leadership style are discussed in Example 3.27.

Example 3.27 **Democratic and autocratic leadership styles**

I think the effective leader is in the main democratic but sometimes autocratic. Certainly in times of emergency a leader needs to make those tough decisions, stick by them and rationalise why they've made them. If everything is democratic, there's an implied sense of shared leadership. But a team like ours, with the client group we deal with, needs a strong leader. It needs someone who is prepared to fight the corner of the team if necessary, and to be fairly secure in their own convictions. It would be patronising to be told everything you had to do. I don't think that would make an effective leader.

There is also some personal frustration if individuals hope that their leader will take up an issue on their behalf rather than support them to solve the problem themselves. The

comment in Example 3.28 links this frustration with difficulty in managing personal emotions about the situation.

Example 3.28 **Try to solve it yourself**

I found it frustrating. She said, try to solve it yourself. A big part of me would like her to say, 'l will do that for you as your manager.' She always says she's a leader, not a manager, so I can see where she's coming from on that, but it was very frustrating at the time. I was aware that if I was to go and address this issue my own feelings could have come to the fore. It was something that was really grinding me down. I could see her rationale for doing it, but it was quite frustrating.

This discussion about personal responsibility and decision-making appears to have been an open one within the team as the team leader makes a point of explaining, in Example 3.29, why, on one particular occasion, she made and enforced a decision.

Example 3.29 **It has to be my decision**

Sometimes you have to make decisions and to own it, the decision. Risk is a good example. There's a gentleman that a note says on no circumstances is anyone to visit this person. There was a query about whether he'd got a gun. One of the staff said she was quite happy to go in there, but I said no, end of story, because if anything were to happen I'd be carrying that to the end of my professional career. So I've made the decision

that nobody visits until that's sorted. There are times now when I'll say no, that's not going to happen.

Leaders also have expectations of those who lead and inspire them. In Example 3.30 the team leader comments on how inspiration can come from both senior and junior staff.

Example 3.30 **Sources of inspiration**

For me as a leader it's vitally important that I have somebody to inspire me, to give me vision. I can think of who those people are straight away. You need people who you believe mean what they say at the top but you also need equals and people below you who will inspire you. There's one of the unqualified staff here now whose core beliefs, values and passion to learn has reinvested me.

Inspiration can also come from people who are able to demonstrate effective models of practice and share their enthusiasm with others. In Example 3.31 we hear more about how one clinician's enthusiasm prompted development of the Assertive Outreach model in England.

Example 3.31 **Inspiration for service development**

Assertive Outreach is an American model and we've got very strong. The Americans come to us and we go to them. I was inspired by the passion of a clinician who set up the National Forum. She passionately believes that this benefits clients. So it was her own vision, her own style of leading Assertive Outreach into this country. She met with two or three who were trying to do similar things here and it's now a national organisation. For me it's the best network, grass roots, led from the bottom up, with very small funding but led by clinicians for clinicians and with the people we care for. So she really inspired me, the whole philosophy.

In this country, if you've got a psychosis it's the end of your life. You're on benefits for ever, you'll never work again and your family will desert you. If you go to America, it's very different. You don't automatically get benefits or lose your family. Clients over there seem to have this belief, the American way, to think things can get better and I've got to be strong and fight this. That's what gets it going here. As we've seen clients grow and get better, that's what inspires us.

There are also some practical aspects to leadership that the team have noted. In Example 3.32 the team's practice of taking it in turn to chair meetings demonstrates how this has enabled individuals to develop leadership skills and recognise these strengths in others.

Example 3.32 **Chairing a meeting**

In our meetings we always have a roving chair, a different person each week. I'm not the best. What makes him the best? His style I think. He's quite boxlike, quite structured, but keeps things moving. He'll say enough and move on, but everyone has a chance to speak.

In Example 3.33 we see how one team member took a leadership role in offering a development opportunity to another.

Example 3.33 **Leading the development of others**

He's a support worker and came along with very little experience of mental health and he had one client who was acting quite dangerously with bi-polar disorder. So the qualified nurse sent him off to read all about manic depression and low arousal techniques. So the qualified nurse was able to use her skills in setting the care plan but also got a lot of reward after teaching this unqualified person how to deal with that client.

This team frequently mention their need to explain and demonstrate their work within their organisation to gain wider understanding of what they do and why they believe it is a good service. In this context, the role of the leader in influencing opinion is important.

Example 3.34 offers an example of how this leader used her influence and sought to involve senior staff in the work of the team.

Example 3.34 **Influencing up the organisation**

The chair of the Trust came here for a day. He's a very busy man but he spent the whole morning here. The team said that if he's coming here, he wants to see what we do. No pomp and circumstance—we sent him an email telling him to dress down. Then he met patients, real patients. He met someone who was stuck on heroin, someone who was injecting. Sadly, one of the people he met that day has died. I next saw the chair at a conference and I wanted him to know that this client had died and I wanted him to know how that had affected the team. And I wanted the team to know that he knew that.

What can he, as the chair of the Trust, do to stop that happening again? It's about linking the hierarchy together. From the bottom up. I'd like to believe, for once in my life, that support workers can inform the chief executive.

There is an emphasis in this team on developing leadership at all levels. In Example 3.35 the team leader explains how she offered the opportunity for someone else in the team to deputise in her role while she was on holiday. This appears to have been done in full knowledge that his preferred style was different and in the expectation that this would be helpful rather than something that might undermine her authority.

Example 3.35 **Delegating the lead**

When I took my holiday I invited someone to develop their leadership and management skills by acting up in my absence. His style of leadership is quite different to mine but there's something quite challenging about that. He's quite autocratic. He's from Social Services and used to be a manager, quite clear about direction. More likely to say, 'That's your role, get on with it and if it goes wrong come and see me.' He's taught me things about management and decision-making—at times I can sit on the fence. Whereas he's very quick to make decisions. We complement each other.

This team also appear to feel free to challenge each other, including the formally appointed team leader. In Example 3.36 style of leadership is important as both the issue that provoked the challenge and the means of addressing the problem.

Example 3.36 **Challenge to leadership**

I was challenged about my behaviour with the client by one of the team. I think that was quite interesting as there were quite a lot of challenges then about style of leadership. He challenged me somewhat harshly and publicly. I dealt with it by speaking to him in private and saying it wasn't appropriate and don't do it again. He came back and apologised and said he was quite passionate about it because it was his client's care. Then

I said some of the things he'd said had been quite right, just not how he'd delivered them.

The notion of leadership at all levels is essentially concerned with how people find themselves able to take the lead. Flexibility is often important in enabling people to take the initiative. As the team leader commented, the degree of financial flexibility varies: 'Social Services are a lot more flexible—you have a pot of money called "service user monies", and they're much more flexible, less dominant. So I have a pot of money so that if I want to take the clients out for a day, I can. If I see an urgent thing that I think needs doing, I can get it done. I'm more able to respond to crisis and I love that because that's what this team's about.'

In other cases, flexibility is required in the interpretation of regulations, particularly if they were designed for a significantly different working context. In Example 3.37 a number of issues are raised relating to interpretation of what constitutes health and safety risk and who might have the authority to approve activities that might appear to flout the regulations. In this example, there are two reasons given for paying service users to do decoration and repairs to rooms used by the service. The team member argues that it is beneficial to clients to pay them for the work if they need the money, implying that some clients would be grateful to be employed in this capacity and that it would enhance their self-images. There is a budget aspect in that she implies that it is cheaper to pay for casual labour than to bring in the Trust's estates department. A further dimension is that the team member felt that the chair informally supported the idea of involving patients in decorating the team premises.

Example 3.37 **Flexibility in context**

Some of the decorating and odd jobs here have been done by clients. The chair of the Trust said to me, 'We get so heated up about health and safety policy, but if you're telling me we can get patients to paint the rooms'. It's a lot cheaper to give clients money for food and debts than to get the estates department. Lots of middle managers were saying you can't do that because of policies, but because the top had told me I could, I scrapped the middle bit. And it worked.

In this case, this approach worked, but what would have happened if there had been an accident? Risk assessment would have considered the extent to which involving patients in carrying out improvements to buildings would bring unnecessary risks. Risk, however, is always a matter of judgement about balancing potential benefits against the potential risks. Risks can often be minimised without reducing the potential benefits. In this case, advice might have been sought about how to carry out this work as a community activity supported by the team. In a team where activities include supporting clients to carry out normal domestic and social activities, are odd jobs and decorating very different?

Perhaps there is risk to the team, however, if they are perceived to ignore the organisation's regulations and the managers who have to ensure compliance. The team members often mention their concern about gaining support and understanding for their innovative approach. Innovation usually involves challenge to the existing ways of doing

things and this may include challenge to individuals whose roles involve maintaining order, often through use of rules and regulations. There is always a tension between the urge to disregard the established system in order to take swift action and the benefits of working with the system to create the changes that would enable different ways of working to fit within the regulations.

Example 3.38 explains how risk-taking is encouraged but within the boundaries of policies and procedures.

Example 3.38 **Boundaries to risk**

Our chief executive says make decisions, try something out. Take a risk. If it goes wrong, own it, look at it. If something does go wrong and you're honest about it and can justify it, that's OK. Certainly a rule's in place that if you can't justify it you're out on your ear. That's fine by me. I get excited about that ability to bring about change. The boundaries are the policies and procedures.

There are several features of this team that facilitated shared leadership. Although it is a big team it operates without a pyramid hierarchy and individuals take substantial personal responsibility for the overall operation of the service. The degree of respect that team members hold for each other is frequently mentioned, along with the importance of listening to each other. One of the team members explains in Example 3.39 how each member of the team takes a leadership role over particular issues.

Example 3.39 **Clinical leadership in the team**

I'm taking a clinical leadership role as opposed to a managerial one. There are several levels of leadership in this team. There's the kind of organisational leadership which is above us. Then there's the managerial and micro-organisational role that the team leader holds. Then individual team members from myself through the other nurses, support workers, occupational therapist, all have leadership roles clinically. In the team leader's absence, if she's not here to deal with certain things, there are some things we'd feel competent enough to deal with. Some of that leadership would be passed on. One person stays in the office and deals with any crisis calls, emergency calls or unplanned visits. The role of that person is to co-ordinate the rest of the team. Finding out where people are physically, allocating whoever to that particular job. That's another element of leadership. So I don't think there's one type of leadership in the team, I think there's numerous different types.

One type of leadership identified by a team member was leadership in discussions. In Example 3.40 this is discussed in the context of the value that the team places on the contribution of each member.

Example 3.40 **Leadership in discussions**

Different situations need different styles of leadership. We all participate in leadership in team discussions. No-one's opinion is less valuable than

anyone else's, regardless of role, qualifications, experience. The strength of that is that the team is able to communicate more effectively if everyone feels valued. A good leader would step back from that and allow it to happen as opposed to imposing it. It's almost evolved naturally in this team that everybody does have a say and that what they say is valid and will be taken into account. We're able to give opinions and have that recognised.

I think leadership is fairly evenly distributed within the team. Staff initiate debates about the way we work. We're all capable of saying this is how we think things should be done. We all feel responsible enough to do that and accountable for the care that we're giving. The team leader has fostered this atmosphere of respect, said that we're all responsible for our own actions. Others in the team, particularly the support workers, have said, 'I'm not used to being asked my opinion.' I just take it for granted that we would ask.

People coming in now remind me of the fact that this is unusual.

Example 3.41 explains how the way in which the team works and the emphasis they place on discussing their work together enables them to develop a bigger picture for themselves and their clients.

Example 3.41 **The team develops a bigger picture**

Obviously there are certain clients that you deal with more than others. When you spend time with clients they'll discuss and open up different avenues. So you could possibly be able to pick up on the issues and bring them to the attention of everybody else, particularly if it's not been discussed before or it's not been thought of as an issue. In one way, the more people who are involved in seeing the client, the expanded social networks, they're not just seeing a worker—the team is thought of as a whole. You just get a bigger picture.

In spite of the apparent openness of the team there are sometimes difficulties that they do not find easy to resolve. In Example 3.42 the team leader explains how she helped the team to resolve an issue that had been developing into a problem.

Example 3.42 **Dealing with problems in the team**

There is high emotion at times. Of course we all have our professional conduct, but the team has to set standards as well about what's acceptable to the team. Individuals will tell me about things that are annoying them and ask me not to do anything about it, but I'll say, how can I not do now that you've told me. So what I try to do then is to pass if back to them about how can they solve it, because it would be much better if they

can sort it out. I try to make them feel empowered enough to do it themselves. If two or three of them come to me with similar problems then I'll resolve that in terms of a staff meeting.

Two or three people mentioned to me that it was really annoying that one person was always late. For me as the team leader, that person gives me a hundred and fifty per cent when she's there. She gets here late and she lives a long way away. But I look at what she does in the team—she's the one that was here until three o'clock one morning. She stays late, always has, until a thing's done, and she works hard. So for me as the leader, how can I resolve this? Without offending her too much, but addressing the needs of the team. Eventually, I said at the team meeting that there are issues about everyone getting here at nine and shall we change the team meeting to quarter past? I said that some of us aren't great at mornings, me being one of them.

Afterwards, one of those who'd complained said, 'l really liked how you dealt with that because you owned it too. You were one of those who was sometimes late but I didn't tell you.' Well, it's true because I like to see my boys off to school. This has worked for a while and if there is a problem again with any member of the team they know that I'll deal with it.

Much has been said by this team about the problems faced in their work and how long it takes to achieve successful outcomes for most of their clients. In Example 3.43 we are reminded that it is very important for individuals and for the team as a collective to have their work recognised.

Example 3.43 **Sharing success**

It used to be if you've done a bad job you get told about it but if you've done a good job it's just taken as read. Here the leader's so enthusiastic that a pat on the back works wonders for anybody. If you've done a good job, you're told you've done a good job and it's shared with everybody else. So it does make you feel great. Because we're a team, if someone's done a good job it's shared, we've all contributed something to it.

LEARNING FROM THIS CASE STUDY

A number of themes emerged in the narrative accounts. The team has a high profile because it was the first to be established in the area. It is a large team, but flat in regard to qualifications and structure and members describe it as a respectful environment where everyone has a voice. They attribute this working environment to two factors, the person in the lead and the strong personalities of the team members. The team is united by a common vision and philosophy and shares a passionate belief in the model of service offered. There is a shared sense of humour but open conflict is not unusual and is often resolved by the camaraderie established through various processes and shared rituals built over their time together. There is an ethos of learning, a willingness to take responsibility and to share leadership.

Like some other teams we have encountered in the case studies, this team sees itself taking a lead in new ways of working, new approaches to service. Members of the team experience both struggle and pride as they uphold their shared vision. They refer to the 'high emotion' of dealing with a high risk client group. Their internal group relationships and communication sometimes mirror that high emotion and the team has developed ways and means to handle this.

The case study highlights too a number of other significant issues, the boundaries between leadership and management, the role of learning and development and the influence of leadership approaches in the larger organisational context.

Consider Example 3.37. Do you think this was an example of effective leadership within the team? Within the Trust? How might the team have worked with the middle managers instead of apparently ignoring their concerns? How do we move from people using their energy to 'fight' the system to involving them in developing a better system? Can you apply these ideas to your own situation?

In reading and reflecting upon the case studies and the range of examples you may find it useful to consider the following questions:

- How does the team handle emotional encounters?
- In what ways does a learning and development ethos relate to leadership approaches described here?
- How do the varying demands of leadership and management get reconciled?
- What aspects of the case study are relevant to your own experiences of working in teams?
- What would you consider changing in your own situation as a result of working with this case study?
- List the three most significant things you have learned from this case study and why they are significant to you.

You may find certain sections of Part 3 helpful, including the section on emotional intelligence. Can the various models of leadership help you to identify what 'leadership frameworks' the team uses to implement its unique service?

CHAPTER 4
OUTPATIENTS REFERRAL TEAM

INTRODUCTION

Members of this team contribute to provision of an Outpatients Referral system in a rural area. The only full-time member of this team is the manager of the service, who co-ordinates referrals. There are a number of other people who might be considered part of the team. Here we include perspectives brought by a service user repre-sentative and a general practitioner.

How the team works

Their general practitioner refers patients who need specialist services to an appropriate consultant, usually in their local hospital Trust. Once the referral is received, the Trust contacts the patient to arrange an appointment with the specialist. Patients remain as outpatients unless, during their treatment, it is necessary for them to stay in a ward as inpatients. Although the general practitioner refers the patient to a consultant, they continue to communicate with each other until the patient no longer needs the specialist services.

In this area there is a Community Health Council which represents the interests of health service users (these have been replaced by other mechanisms in many areas of the UK). In this case study, the chief officer of the Community Health Council explains how she contributes to the Outpatients Referral service to ensure that service users' concerns are considered.

The full team meet infrequently but much of the collaboration is carried out through informal processes. Although there have been improvements in the services provided by the Trust, the system for referrals can be affected by many factors that are not within the immediate control of the Trust, including the availability of specialist staff.

PERSPECTIVES FROM THE TEAM

Outpatients manager

I don't see myself as a leader—it's more of a co-ordinating role. I receive information, decide what to do with it and put in place the actions to do it. There's very little delegation.

The problem of having a little Outpatients User Group is that there's a danger of diluting things, of having too many grass roots people involved to make decisions. Within limited funding the Outpatients User Group can make decisions on the funding we've been allocated. But to make more fundamental change it's quite a lengthy process to get executive support plus the Trust Board, to go upward to get support for major change that needs more funding.

The Innovations in Care Board are a partnership chaired by an executive member of the Trust and including local authority and community representation. I think it needs to be at a high level, chief executive level, then you can drive it forward. You're then looking at professional managers running the show rather than health professions—but if you want to make change you have to have appropriate means.

At the moment I sort of lead the process, but have to input the process as well, which isn't very helpful at times. You know what needs to be done at the basic level, but no-one volunteers to do the work. Some people seem to want to meet about everything but I think that's a waste of time. I'll get on and do the work and if there are any problems I'll ask people. I consult as I go through the process. If I need to talk to a colleague, I'll talk to a colleague. If I need to talk to the boss, I'll talk to the boss. If I need to talk to files, I'll talk to files. If I need to talk to a nurse, I'll talk to a nurse. That to me is good. In terms of chairing and leading the process forward, if you can have that sort of dialogue and process, that's fine.

I have tried to get executive-level managers on the group. The impact has a monetary risk if you're looking at the cost of risks. There's nothing that this project doesn't touch on. That's where you have problems. It started with just the Outpatients but we need to change the Information Department and other departments. We focus on achieving targets but we don't focus on strategic improvement.

Some people work with just determination and guts. Certain people on the Board can move things on. Fortunately things that I ask for tend to get through. You need allies, powerful people.

Chief officer of the Community Health Council

I have a patient watchdog type of role. I got into it totally by accident. I'm a biochemist by profession, always having worked in a lab. I took a career break and then when the children started school looked around for some part-time work, but I was constrained by living in a rural area. I was using skills that I'd picked up doing voluntary work and then this job. I've been ten years now. The job has evolved as my situation has evolved—now it's full time.

Most of the job is to service the Council. Basic administration, organising the meetings and taking minutes and taking forward whatever the members want me to take. Writing letters. Lobbying Parliament or whatever. Trying to take the members' vision forward. If there is a lack of dentistry or whatever, perhaps ambulance problems, I forward this to other domains. That's a very main part of the Community Health Council role. Another very significant part of my role is helping people who have complaints about the NHS. This takes about a third of my time and it can be quite stressful. There's an awful lot of pain out there. A lot of counselling as well as going with people to reviews and consultants, holding their hands through things and on to the ombudsman.

There are also visits, making sure the reports go to the right people and that the reports are followed up. I also train staff and members, in the wider region. It is like a leadership role without being the power behind the throne. It's the chairman who is the face of the Community Health Council, but I like to think I support him very strongly.

At first you do what has been done before, but you soon put your own stamp on it, have a view of how things should be developing. You get to know how things work. Working with politicians and Members of Parliament you get to know their thinking. In my position I've got to speak up for the lay person. I am a lay person. I'm a patient. My Mum is elderly. I've got kids. I just try to be honest and say this is the type of service I'd like us to have here and play it with a straight bat.

We meet for a couple of hours at lunchtime when there is something for us all to discuss and meanwhile the manager is beavering away. He brings us up to speed and asks for opinions. Everyone comes from a different position and represents a particular viewpoint. Our sphere of influence is very, very wide. Everyone wants to get into public consultation, public involvement, which is not an easy nut to crack. It does put pressure because you can never get it right. You're often faced in public meetings with stony silence. You meet a lot of people and a lot of different public bodies.

I'm very good at switching off. I think it's very important. I take a lot of work home, do a lot of reading, but I switch off in that if I've had a particularly difficult day or difficult complainant, I try not to take baggage home. You have to be flexible over timing though.

General Practitioner

The referral process depends largely upon the expectations and beliefs of the patient. They may or may not be expecting to be referred. Or might expect referral to a specific doctor or site. There are huge differences in referral patterns for very complicated reasons. You can have somebody doing more referrals to a specialist because that person knows more about the condition. For example, an expert in attention deficit disorder may do more referrals onto a tertiary centre. On the other hand someone may do more referrals because they know very little about it and don't have the skills to deal with the problem. Our practice very rarely do any paediatric referrals because we are all quite experienced and qualified paediatric general practioners, so we deal with most of it in house. A person may have a special interest in an area therefore keep the patient to deal with themselves. The analysis of referral patterns is a complicated issue because there are at least four or five variables. Referral patterns are very interesting and complicated, with what the patient brings to the process and what the practitioner adds to the process. Complicated as in where you refer and why.

Referrals fall into several categories in my head. I've got one that's 'urgent and important'. It has to be important before it ever becomes urgent. That's why you set up 'safe havens' for referrals like suspected cancers or incredibly serious things that need to be acted upon swiftly. There is a time scale that has to be met for the welfare of the patient. So for suspected breast cancer, suspected bowel cancer, things that need urgent action, it is crucial to set up a place where referrals are genuinely important.

Change is usually clinically driven. Obviously it's a clinical drive to improve and to standardise quality. You really want a standardised quality of referral letter and a

standardised response. You want people seen appropriately to their need. Unfortunately it still probably relies an awful lot on the old boys' or girls' club. Over periods of time, decades, surgeons will have got to know various general practitioners personally, not as friends but in terms of their clinical functions. If a paediatrician I know gets a referral letter off me they wake up because they will know it is something unusual. Alternatively, we could have a situation where a particular surgeon gets a lot of referral letters off me but through postgraduate education and personal contact knows that every letter he gets off me will need surgical input because we still have access to imaging at our surgery. Therefore, a lot of our knee referrals, we know they're broke. The orthopaedic surgeons love getting those referral letters because they know what they are going to do.

On top of that you have your managerial drives. You have waiting lists and the Patient Charter. It's alleged that waiting lists are being closed for political reasons or financial reasons. So there is a managerial and financial impact on referral patterns. Some hospitals have been known to shut their waiting lists altogether so that they don't breach the charter. Paradox. It is interesting when you listen to people speaking who have an overview from above, a complicated understanding of a very large institution. Often people forget that something is the way it is usually for very good reasons.

How complicated it does become. I might refer a patient to a new team because of their clinical skills. Sometimes people don't need more surgery. Maybe I'll save someone from having another operation, because that clinician will say whether someone does or does not need an operation with confidence and ability. You are aware, though, that making that decision has a ramification on your local provider unit because you're not using it. Referral can change the pattern of provision. The service quality in the local provider unit has to be good enough to continue to refer people to it. With additional specialists, interest and commitment, it could change completely.

Speaking about the NHS on a grand scale, it affects referral patterns. If someone said my patients' hips could be done in the south of France, go for six weeks and come back fixed, but these options are not available. If they do become available we would have quite an iconoclastic population base. They'll travel. There are practical advantages to having a local provider unit, but I think there is a rapidly changing perception that it is not necessary for routine surgery. It's totally different when you are ill. When you are acutely ill you want to be where your family is. It has a real knock-on effect to your recovery chances. Again, standards have got to be adequate.

PERSPECTIVES ON CHANGE IN HEALTH AND SOCIAL CARE

In this and the following sections we consider some of the issues raised by individuals in the team. We have grouped these into perspectives on change, on teamworking and on leadership.

This team are very conscious of the political drive for change. As discussed in Example 4.1, the nature of political power tends to encourage support for initiatives that can be expected to show improvements in a short time. This approach to change is not always in the interests of service users.

Example 4.1 **Political and patient agendas**

I think it would be nice to have a period of stability. Whenever we have new structures they say it will be cost effective and save money, but I've yet to see that. A patient isn't interested in administration and structures, they just want a hospital and a service when they need it. So I do feel that there's perhaps a bit more reorganisation than is really wanted. A politician's agenda wants to be able to say, 'I've set up this', when 'this' probably didn't need to be set up. They set up projects that run for two years then want to set up new ones, not give money to the ones that have just started working and could do with another two years. The pot is only for new projects. I think, oh dear! We can see this, most people can, but we can't influence it. Politicians don't want to hear 'just keep it the same', particularly if it was set up by a previous administration. Democracy has a price, but maybe it isn't as democratic as we think it is. Patients don't want all this change. They want a service.

Funding is often a fundamental problem for those trying to improve the connections between services, particularly in health and social care where the funding systems are significantly different. In Example 4.2 some of these difficulties are discussed, together with implications of political involvement.

Example 4.2 **Barriers to joint working**

It's been going on for years, wanting the divide between health and social care more seamless, but it never works. Social care is often means tested and health isn't. There's been talk about putting social care into health, but it is difficult. There's a vision to work together but local councils say they haven't got the money and they'd have to increase the rates—no politician wants to do that. So even if they want to do good work, they can't capitulate over this one because they wouldn't get in again to do the good work.

Some initiatives gain funding to pilot a scheme but not enough to achieve sustainable change. In Example 4.3 this problem is described, but in this case the change was sustained by funding from a different source.

Example 4.3 **Need for sustainable development**

There was a scheme set up initially with money from Social Services, an intensive care at home package for people who had been discharged from hospital but who needed a bit of nursing input. It worked really well. Was able to unblock beds, helped patients, but then was threatened because the money ran out. Health put some money into it then, because they realised there were such advantages, but it was limping along, trying to find enough money. Another initiative has come up now that does much the same but it went through

another pot of money and can now carry on the same sort of work.

Example 4.4 discusses a particular frustration over lack of investment in the infrastructure that supports service delivery and mentions some of the areas that would benefit from being able to make use of computers.

Example 4.4 **Long-term gains**

There's a whole range of things that without investment won't be possible. People are used not to having these things. They think that we've done it this way for ages and don't see a saving to be made. They see it as a drain on resources. They don't see the gain over a long time. If we actually put whizz-bang new computers in every room, complete with bar-code scanner, that's a cost of about fifty thousand pounds. But they don't then see the saving over five or six years in admin time, time in clerical costs, in the way in which we manage our case notes. Savings in all of the systematic changes that support the whole process of improving services.

Example 4.5 outlines another potential improvement that has been delayed by lack of funding for computers.

Example 4.5 **Need to plan investment**

There is a joint assessment plan between Social Services and Health. Joint assessments of need. That's being held up because none of the district nurses have direct access to a computer terminal. The Trust can't afford to buy them. There is talk about using charitable funds to support the system. We're strapped for cash.

Example 4.6 comments on how increasing use of computers has brought the possibility of changing the system of referrals to offer more direct access to consultants' lists by general practitioners. This type of change, however, is also easily disrupted if staff do not have sufficient access to equipment.

Example 4.6 **Potential improvements in referrals**

The mechanics have changed with the computerisation of the practice. The paper is disappearing. We are looking forward, possibly, to direct access to waiting lists. That would mean instead of seeing the surgeon, a simple hernia might go straight to the operating waiting list. So a general practitioner would be able to refer directly to the waiting list. You would need to have a great deal of trust between the clinicians involved. You'd obviously have to have occasional meetings and agree protocols and pathways.

There was an attempt to have a computerised referral for prostate problems recently. Including the referral form. But it didn't work. It was almost comical. The computer that

was on the Trust site wasn't in the Outpatients department so they couldn't use it often. There are technical things like that. It doesn't all happen immediately. It needs a critical mass of change and then it will happen.

Increasing use of computers has streamlined referral systems to some extent, as described in Example 4.7, but wider access to information has also led to a better-informed public with some knowledge about which centres have the best records of success in treatments. As this team member explains, comparisons are not always made from similar base lines. As records of this nature become more available, they will not be meaningful unless the assumptions underlying the data are made clear and those using such data are helped to understand how to interpret the information.

Example 4.7 **Informed patients influencing the referral process**

Breast lumps are a relatively simple referral pattern. With a breast lump you'll get a secondary referral to a Breast Centre, hopefully a dedicated treatment assessment centre. You need, as a practitioner, to have confidence in the clinical ability of your referral centre. So more and more of our breast referrals are going now to another county. Patients don't even go to, the local hospital. The time when people accepted a referral to the local hospital purely because it was the local hospital is fading. Publicity about the difference in outcome, depending on the ability of the unit you go to, makes people more aware, particularly at the higher socioeconomic level, of differences in quality. Between doctors and between hospitals. Ten years ago, people saw a doctor as a doctor and didn't perceive differences.

Patients have every right to influence where they are referred to. I think the government league tables, albeit crude, in terms of waiting times and outcomes has influenced this. Outcomes have been criticised. This has not gone down well with the profession because of the very complicated nature of outcome. If you look at a tertiary liver referral unit the outcomes are appalling because you get people who are usually going to die. So the outcomes actually may be remarkably good. If you are a super specialist, you take on the more difficult cases. It's the same thing for cardiac surgeons. The best surgeons do the most difficult cases. It would be very easy for a good surgeon to have an almost perfect record if they always picked easy valve replacements. So league tables are complicated. It should be possible to grade people going in and grade them coming out.

Example 4.8 suggests that decision-making power has shifted from consultants to politicians because of increasing public demand for information and high-quality services.

Example 4.8 **Who has the power?**

I used to think that consultants thought they had the power. But times have changed and

they're realising that their little domain is not as powerful as they might want. I think the power actually comes from the politicians because Trusts have to dance to the politicians' tunes, have to return var

ious returns every month, have to deliver to the politicians' agendas. The politicians are listening to the people and saying what they want.

Political interventions have set targets as an attempt to improve services and to ensure a more even quality across geographical areas. This is not always successful when resource limitations also have to be overcome. Example 4.9 comments on how the political attempts to reduce waiting lists to improve the quality of services may sometimes reduce quality for individuals by taking decisions about allocation of scarce resources away from the clinical staff.

Example 4.9 **Attempts to force improvements don't always work**

You've got the 'need to be done soon' conditions. Like hernia and hips. The problem with hips is that they go to a waiting list. The waiting list initiatives and the time initiatives are detrimental to patient care. Someone who goes onto a waiting list to have their hip replaced may still be walking around, perfectly well, managing. But you may have someone else crash onto the waiting list with a very rapidly deteriorating hip who within a month can't walk. You can't skip the person who can walk on this list to treat the more serious one first. There is a managerial force pushing the clinical need down, and the waiting list up in terms of importance. Time is now being given a more important status than the quality of a person's life. You have a new factor in the referral pathway that never existed before.

Standards and targets can cause other difficulties when funding is not available to meet new requirements. In Example 4.10 some of the issues that may arise when organisations attempt to meet new standards are discussed. There are not only funding problems but also muddles over estimating changes in staffing needs.

Example 4.10 **Muddles and manipulation**

One of the standards is that everyone who has a heart attack should see a cardiologist within twenty-four hours. There's a very weak clinical evidence base for that. It's weak research. No real evidence behind it whatsoever. It's a political statement but it's deemed a good standard of care.

So you try to find a coronary specialist to meet that standard locally. You obviously need the infrastructure around that person to allow them to function. A dedicated coronary care area is a standard of practice. And you ain't got it. So, in a political arena, the money is found to build one. Then you've got nobody to run it.

Then you get involved in this very complicated area that I think needs to be sorted out behind closed doors. At the moment, say you have ten peo

ple in a day who have had a heart attack. There are nurses looking after them, they are in beds and they have monitors. It's disingenuous of an organisation then to make a business plan that staffs the unit from scratch. Which clearly doesn't take into account that the drugs are already paid for, the nursing staff are there, the beds are already there, the monitoring is already being done. There is an upgrading cost undoubtedly. But it's not a staffing from scratch cost.

There are also often difficulties in finding highly qualified staff to lead areas of clinical expertise. As we see in Example 4.11 the arrival of a specialist in a particular locality may lead a Trust to take a rather opportunistic approach to establishment of a specialist centre.

Example 4.11 **Who should the funding follow?**

Let's say a well-known consultant married a girl from this area and moved here. The hospital would say, 'Yes, come and work here.' The people who are already working here on the surgical wards would be enthralled, enthused and committed (which they probably already are). Suddenly it's all turn around. Now a General Practitioner has the advantage of a surgeon you want your people to see, with the abilities to do the level of scanning that needs to be done and with a chemotherapy team on site, on the patient's doorstep. One man could make the difference. There is knock-on effect to the management structure. You have to resource the surgery. Then you need to look at where the money goes. That money needs to follow the patient. Which it doesn't at the moment.

From this account, some people might think that money seems to follow the personal location choices of specialists. We might consider how the situation described in Example 4.12 would change if resourcing decisions were made with due consideration of both the evidence base and the existing local infrastructures.

Example 4.12 **One way of creating centres of clinical expertise**

It's very interesting that when you have a clinician with a special interest land somewhere, they will create a clinical team and go out and canvass referrals. Most hospital consultants when they arrive will go around and introduce themselves to clinicians and even have postgraduate evenings so that we know what is happening. Even Trusts will send out flyers—it's routine practice. The new consultants come around and tell you what their interests are: 'Hello I'm Joe Bloggs. I'm interested in stomachs.' I say, 'OK, I'll refer stomachs to you then.' So if somebody gives very good care in gastroenterology, suddenly, gastroenterology referrals go through the roof.

The autonomy of consultants has often been presented as one of the barriers to change in healthcare. Example 4.13 suggests that more recently trained and appointed consultants may be more ready to engage in wider service improvement.

Example 4.13 **They take their toys away**

There are certain consultants who want to do things their own way. They have their own lists and they want to do them as they've always done them and they're not going to change for any politician. So they take their soldiers and just don't play. So getting them onto the system tends to be done behind the scenes, not actually in this group. So there's a lot of smoothing. Change is hard and some feel that they don't want appointments to go centrally. They think, 'I want them to go through my secretary,' so they have control and don't want the control to go. But I think we now have most of them on board. As the older ones leave and the new ones come in there is a new ethos, I feel.

The increasing emphasis on consultation and involvement of service users in co-development of services is also contributing to improvement. A local initiative is described in Example 4.14.

Example 4.14 **Local improvements**

We did an initiative about food in hospitals. We were getting a lot of grumbles, food was cold, etc. So we went to the hospitals, asked if we could we do a little survey on this and they agreed. So we compiled a questionnaire. Volunteers went up and had meals in the hospitals. That resulted in a slight change in meal times to allow later suppers and more variation in menus, so a few changes. Also things like heated trolley and covers on plates—some little things that we managed to get on board. The patients are the people we want information from but the hospital has to be involved as well. We needed the catering department and the Chief Executive to be willing.

As organisations gain more experience of consultation with service users it often becomes apparent that special efforts have to be made if all potential service users are to be included. Example 4.15 explains how an approach was made to young people.

Example 4.15 **Wider consultation**

It worried me for a while that when we consult people we tend to go to middle-aged, white and middle-class people. Where are the children? So we went out to a primary school with a school governor and talked to the children about what was important to them in the health service and

took that back to the hospital. One issue was sexual health, for example, having a little clinic for the teenagers so that they don't have to see their own family General Practitioner.

PERSPECTIVES ON TEAMWORKING

Much of this team's work is carried out in large meetings. Example 4.16 outlines some of the issues that arise in these meetings.

Example 4.16 **Herding cattle**

Clinical networks are groups of consultants—ophthamology, general surgery, radiology, dental, all sorts, and lay members. Their purpose is to co-work across these areas to cover each other, perhaps to specify. Perhaps they can do more hips in one place than another. Clinical governance is another topic. They need to train together, so instead of saying this is my domain, they have to work together. The chair is a very good co-ordinator. He doesn't lead strongly but gets everybody inputting and does lots of smoothing and pouring oil on troubled waters, getting them all to work together—a bit like a sheepdog, like herding cattle. Everybody is equal but the person who actually leads has to have a lot of social skills and credibility because it needs a lot of people skills to draw people together.

In large meetings the behaviour of participants can create difficulties for others present. Example 4.17 describes some of the feelings raised for one participant when others seem not to share an understanding about protocols of behaviour in meetings.

Example 4.17 **Behaviour in meetings**

An example was in a Primary Care Board. We got the General Practitioners on the Board and went through a big organisational development plan. We got them functioning as a Board. You don't all butt in, you address through the chair. Basic common sense about meetings. Then there's the responsibilities of Board members, because General Practitioners can, of course, go out and say whatever they want as individuals, but as members of the Board they can't, they have to toe the Board line.

That basic stuff about how to behave in meetings isn't known very well and it becomes very important, for example, when you're discussing with professionals. Especially nurses, because nurses don't really know how to behave in meetings. They're butting in, they're talking. The idea is that you pick up on body language, so you know when people are pausing naturally or when people have stopped and finished what they're saying.

Example 4.18 describes a situation in which it is possible to disagree but still to maintain a good working relationship.

Example 4.18 **Maintaining good relationships**

You have to build up relationships with people. It can be difficult. There are times when

you have to criticise the Trust and sometimes you are not going to see eye to eye and that's the end of it—you have to agree to disagree. But you've got to be careful about the relationship. Sometimes things have gone terribly wrong and you have to say this is something different and we actually want to do that…there's an interplay…give and take.

Example 4.19 describes some improvements that this team has made and some of the ways that they overcame difficulties.

Example 4.19 **Service improvement**

The team is about innovations and care. Waiting lists are always a big issue. You have to think how can we make it easy for people who don't intend to cancel and that type of thing. So from the patient's point of view, you go to your doctor and you're told yes, I'll refer you to so and so, but then you're left at home and you have no idea how long this is going to take, a month or six months—you're left in limbo. So it occurred to us that if a patient had more information, they'd be able to plan. So if you're told it will be so many months you'd be able to think, well yes, I can go on holiday, I needn't think about this yet. We thought that there are lots more things that could be made more patient friendly.

So now when people go to their General Practitioner they will say 'I'm referring you to so and so', and they can flick it up on the screen and see that the waiting list is about five months. Then they'll say, 'You'll get a letter from the hospital to say that I've referred you. What will happen then is that a month before the appointment is due the hospital will get in touch and make an appointment.' So people have more choice, can make the appointment that suits them. More people turn up because they won't be at work or moved away. The 'do not attend' rate has gone right down and more people can be fitted into clinics. Some 'do not attend' rates are horrendous, run at about twenty-five per cent. Such a waste.

I'm on the team from the patient's point of view, so I look at specimen letters and draft letters, think whether I'd like to get a letter like that. Would I understand it? Is it confusing? How best to contact the patient? Then other people from Outpatients look at it from their point of view. And people from the Records department from their point of view—how awkward is it going to be to send out letters, make appointments, etc. There are some consultants there who have their own lists and who might say, 'l don't like the fact that they can make appointments. What do we do with

urgent cases? If we have routines how do we fit those in?' So everybody brings how it will affect them and we can look at where there are hiccups. The manager co-ordinates and chairs the meetings and draws it all together. So no-one has a real lead, more of a co-ordinator with everyone having a strong voice.

Example 4.20 suggests that not only is local change best made by those in the particular area of work, but also that helpful change can often be made without additional resources if people share the existing resources more effectively.

Example 4.20 **Encouraging teamworking to manage local change**

They might not co-operate as a team. It's a threat. They'll have to share offices. Each consultant wants a named personal assistant—you have almost a cultural thing about one doctor, one secretary. No-one wants to share. This is silly. We're producing review after review after review, which isn't getting anywhere. Writing lengthy documents and doing desk workload exercises—how many people have long letters to write, how many have short letters to write, how many are filing…it ain't working. You can have piles of work one week, different others.

If there is a limited resource, left to themselves people will help each other out and get it done. I'm not going to tell them how I think it should operate. Part of the change process is not to help them necessarily in the way they want to be helped. We're going to start changing teams but not because we've had a review or produced a document for consultation. Well work on changing things naturally. I delegated and got them to set up groups to look at their work. They'll look at their working practices and things and they'll come out with the best system that will be sharing what they do and sharing resources.

In an area where staff turnover is slow, with frequent changes in the ways in which services are organised, people often move from one role to another. In Example 4.21 this is presented as an advantage because staff gain wider experience of taking different perspectives in different roles. This may enable people to have better understanding of the variety of views about an issue and to be more flexible about negotiating solutions.

Example 4.21 **Same people, new roles**

In a place like this, the players stay the same but the structures change. You have the same faces but they're in slightly different roles. You see people with different hats on. In many ways it is an advantage because they can understand from someone else's point of view, might say, I used to feel like that too—how can we get round it?

PERSPECTIVES ON LEADERSHIP

Example 4.22 discusses how leadership in health and care in the political environment is setting helpful frameworks and direction for local service improvement.

Example 4.22 **Political leadership and clinical needs**

Leadership and the political environment are tied together. If you have your heart attack here today, the standard of care you will receive from the local hospital is actually relatively rather good. It would stand up to the standard of care you would receive anywhere else. The National Service Frameworks are excellent in that they set down a

standard of care that should be uniform across the country. In other words you try as a national political leader to say to the clinicians, and I think it's a rather brave thing to do, you tell me what the standards should be and well try to reach the standards uniformly across the country. Which is brave. Which is good.

At local level, the issues for leaders are more about balancing service development within available resources. Example 4.23 describes some of the tensions involved when making choices about service development when there are competing priorities.

Example 4.23 **Managing resources and expectations**

I think the two leaders, the chief executive of the Trust and the chief executive of the Local Health Board, had an understanding. I think they said, we could do this now, and then in a couple of months when more money comes on stream perhaps we can do that. We can't do it all now. This is the understanding we'll work on. Everybody will be happy and calm, all the politicians. The newspapers will be cool.

But then you get a clinician firing off in a meeting, wanting it all on day one, for all the right reasons, but politically naive. Either more money will come or it will backfire and you'll have people wandering around wondering what is the future of that hospital. It's a very dangerous ploy. Leadership is a balancing act, between clinical need and the realisation that rationing really does exist. A balanced distribution of resource is necessary for the benefit of all the patients. It's no good having a clinician firing off in his own particular area when the outcome might cripple several other very important areas.

Example 4.24 comments on the need for an overview of service provision and commitment to provision of a complete local service from all those that contribute.

Example 4.24 **Need for overarching vision**

When you have crossover you've got to have some form of leadership otherwise things fall between two stools—that's their responsibility…no that's their responsibility. I think you have to have overarching vision, perhaps even more than leadership if people are coming from two different perspectives and don't want to lose power. Overarching and with some sort of commitment to taking one service forward coming from both sides.

Example 4.25 describes a leadership role in structuring meetings to enable wider participation in discussion about change.

Example 4.25 **Developing a structured process**

This is a partnership process, so everyone has a right to have their view, everyone has a right to be heard, but everyone has the right to have their views listened to, discussed and

debated. Just because you want your thing to go ahead doesn't mean that it will be accepted and implemented. So it's how you manage that process.

That's a particular challenge we have. If you're involving people in meetings in ways they haven't been involved before, asking them to make a contribution, particularly when it's something that they're impassioned about, there has to be a way of educating them, showing them, demonstrating, how best to participate in the process. You could ask whether the group is the right mix, right people. You have to have structure and order.

Example 4.26 describes leadership as encouraging and shaping developments in ways that support the agendas of influential participants.

Example 4.26 **Pulling the strands**

With leadership you've got to have charisma so that you draw people along with you. I don't think it would work at all if I made decisions and said we're going to go this way or that way. I like to think I pull all the strands, the important ideas other people have got, and try and translate them to some sort of positive action. I can decide this is a good idea or yes, we should be doing that. It's very intuitive in many ways. You have to be quite well read as you get tomes and tomes of reports from everywhere. You need to know what the current thinking is because thinking goes in trends—what's flavour of the month one month might not be another month. What's attractive to the politicians, especially when there's an election in May. Anything that gets them in the headlines will be good. So you have to know in a sort of underhand way how to fit in your messages to best effect.

Another example of leading through influence rather than by having power is given in Example 4.27.

Example 4.27 **Leading by influence**

I try to analyse. Dealing with members and politicians, they obviously have a vision, but say, 'We want that.' When they want something to happen and can only see the pros, I try to see the cons, see the bigger picture, to steer a way through it. Otherwise, we'd be caught out. Often we know far more about what's going on than people who come from one service area, particularly if they don't get on. Sometimes I could bang their heads together. Like you do with kids when they're quarrelling, try to make them see each other's point of view. Sometimes someone from outside can take the heat out of a situation. Sometimes I just say, 'Can I just clarify? You say your problems are so and so, you say your problems are so and so.' Just articulating it for them. Move away from the confrontation. Then I might say, 'What if?' Make some suggestions. Some might be completely silly and they'll say, 'That won't work', but then things evolve and they become less antagonistic towards each other.

Leadership in a public forum can bring personal conflict. Example 4.28 describes having to act on a decision that seemed wrong.

Example 4.28 **The power of the people**

Once a decision was made that I totally disagreed with. In hindsight I think it was made for a political end. Nobody could see where this decision had come from. In the end, we had to take the decision through because so many people wanted it, but it hadn't been carefully thought through.

I had to do a radio interview following the decision and I'd written it out for the other decision that I'd expected. I had to cancel the interview because I didn't have any idea what to say. No idea how to say 'support this decision', why they voted in this way, what were the reasons. I had to do a lot of thinking about this afterwards and it took a lot of smoothing over. We were among many making this decision and although I think that it would actually have gone this way in the end, I still don't support the decision.

It taught me a salutary lesson. I learnt that it's not just leadership, there are so many other things at play. Politically where votes are and who's trying to support who for what reason. What seems eminently sensible to me might for some other reason just not get through. I hold the cards but there still might be a joker in the pack that I'm not seeing. So I know now that I do have to be careful. To be aware that until the decision is actually taken, it's not taken. Until we know, I've learnt not to sound confident, to hedge my bets, not go around assuming it. It completely turned pear

shaped on me and I realised that this is what democracy really is. That actually you can't say, 'This is how we're going to go', even as a leader. It is the power of the people.

Example 4.29 describes leadership in public service more as a type of 'servant leadership'.

Example 4.29 **Servant leadership**

In many ways, one would query whether I am a leader—really I serve the members. It's the members and the chair who actually should lead—ask the members and they'd say, 'She's the dogsbody, she does what we tell her.' But I suppose I lead by perhaps suggestions, by ways of bringing knowledge too. I help the members and guide them.

Example 4.30 comments on some of the skills that a leader needs in such a public environment.

Example 4.30 **Some necessary leadership skills**

Personality is very important, people skills, in this type of job. You've got to be able to get on with members of the public. You've got to have empathy, compassion with people

who have complaints. You've got to be able to speak in a public meeting, when you're saying something that perhaps people don't like, so you've got to be able to take the flak, to be able to take quite a bit of stress. You've got to be confident enough to deal with people at Board level, with Chief Execs and to be able to say your piece. Be able to speak articulately and sensibly. So a good education is quite useful as well. People skills are the most important, and intuition.

Another member of this team explains in Example 4.31 how agreement is obtained to progress a plan. This person also commented on a lack of project management skills within the service.

Example 4.31 **Agree the plan**

My role is to lead the process and also to do it, which is an incredibly time-consuming role. You get the guidance, you get the information, you think of the changes. The one thing that it's worth getting people's approval for is a plan. That's certainly where you need partnership working. You say, here's a plan, comments please, let me know what's right, what's wrong, agree the plan, from that point get an action plan. Fine. Settle on that plan. That's the point at which everyone's happy to buy into the vision.

LEARNING FROM THIS CASE STUDY

The case study says much about leadership as a political process, one that involves influence, relationships and knowledge of the most effective channels to work through. Leadership takes place within a democratic political environment that is inherently 'messy'. It is unpredictable, changeable, and characterised by tension, conflict and competition for scarce resources. The price of democracy and winning votes means that change is sometimes conflated with service improvement, where shifting funding patterns can be an advantage, but sustainability of established services can suffer.

Team members talk about leadership as a political process at both a macro or large-scale level, and at a micro or teamworking level. The large-scale, political environment is one where clinical and political/management drivers for change can and do clash. Reconciliation requires an overriding vision. Political leaders provide that vision by articulating the needs and wants of an increasingly well-informed public. One of the difficulties is the degree to which the political players ought to determine the way in which services are delivered.

At a more local level, the team gives many examples of how any change influences the complex patterns of interrelationships. Change in one department inevitably requires change in others. Making a referral decision has implications for the individual patient, the local provider in the near environment and the specialist centre in the far environment. Leadership at a local level involves effective team-working and a meeting 'etiquette' to facilitate participation. Leadership requires building alliances with those who have power and influence.

Example 4.23 talks about leadership as a balancing act between clinical need and the realisation that rationing really does exist. A balanced distribution of resource is necessary for the benefit of all the patients. Do you agree that this is a key focus of leadership? Where would you place this view in the management/leadership continuum? This seems to be a statement that respects the status quo. Where might challenging the status quo come in? What alternative views of leadership might you consider?

In reading through the case study and examples consider the following questions:

- How might various and alternative views of leadership such as those discussed in Part 3 make a difference to the examples in the case study?
- What role does leadership have in considering the ripple effects of change?

What leadership approaches are used in your own current team or organisation? What could you do differently given that you have the power and influence to make a difference? What can you do now?

CHAPTER 5
CANCER COLLABORATIVE NETWORK

INTRODUCTION

This Cancer Services Collaborative Network is supported by the National Health Service Modernisation Agency and was set up specifically to bring about practical improvements in cancer services. Cancer services in the UK have lagged behind North America and Europe particularly around survival rates for people who have had cancer. This appears to be not because the treatment or specific services were poor but because people have accessed services much later in cancer, making curative treatment more difficult. Once this became apparent, it was clear that more emphasis had to be placed on providing early access to services and providing better integration of services.

There are many similar local networks in the UK supported by this modernisation programme. The scheme uses an American approach called Health Improvement Methodology. This focuses on introducing continuous incremental change as opposed to large-scale planning and implementation. Both local government and Strategic Health Authorities provide strategic co-ordination but many other public, private and voluntary organisations have become involved.

How the team works

This local collaboration involves several teams. There is a small team of facilitators who work with teams from health organisations, Social Services and social care voluntary agencies to improve access to services and the patient's journey through sequential services. Areas of improvement that the teams are working on include waiting times, appointments, communication between primary and secondary care, patient information pathways and meeting targets for urgent treatment. They are also beginning to address palliative care services.

Improvement of services is part of everyday work although this often runs alongside maintaining the existing services until they can be replaced by more integrated ones. The improvements are designed and developed by staff already involved in service delivery. This is core to the philosophy underlying the approach, which places importance on application of local knowledge and skills to address local problems. The locally employed facilitators are trained and supported by the Modernisation Agency and are also supplied with a range of tools and techniques that they can use and share to support staff making local developments.

PERSPECTIVES FROM THE TEAM

Network service improvement lead

This network is made up of two acute Trusts and six Primary Care Trusts. My role is to lead service improvement for cancer patients, to enhance their experiences and to enable them to have a better outcome at the end. It's not about the clinical aspects, it's about the processes that go along the patient pathway. I lead a team of service improvement facilitators and I am talking about facilitating and not doing. So they go into a clinical team when invited in and they use their tools and techniques to enable that team to move that work along.

We learn specific tools and techniques for modernisation methodology, which is mapping a patient journey, capacity and demand, and out of that comes an action plan for the team. The team take ownership of that plan and take it away, but we are there with the skills to help if a facilitation day is needed or some input. For example, how do we do this, what sort of numbers do we collect here, how do we collect the numbers? It's about supporting and facilitating rather than doing. The initiative has been going three years but has gone through some changes of identity and role. This facilitation phase has only been going a few months and we changed the title and looked at the role of facilitators.

Within your mandate you are working with different organisations. That's where you have the different challenges and the human dimensions. The Network Board is made up of membership from the acute Trusts and the Primary Care Trusts. So if we say service improvement is on the agenda this year, this is how we are going to do it, there is a process. It is up to the lead to work out which is the best way of working to gain the most. I have one of the smallest networks in the country but the issues and challenges are exactly the same.

Our team changed from being project managers to facilitators. I was told to do it, but now my thought processes have changed. I have had to think about facilitation and support compared to pro-ject management. I also had to get my team to think that way. Before they got an action plan and implemented it. Their job now is to go in and facilitate to get an action plan, but the action plan has other names on it, not theirs, because it has to have the ownership of the clinical team. That team has to take the work forward but they can ring us anytime to say, 'We are stuck here, what are we doing and where do we go? We need some help on this or we need training on this.' So it's a different way of working.

It wasn't difficult to bring the team on board. I started gently saying things about how we'll have to change the way we work. So the team worked out how we would take this forward. We modelled in our own team what we hoped we would do in the settings. There are five on the team from a range of backgrounds. They can be anything. A radiographer, a nurse, etc. It's about learning the skills. It's good to have insider knowledge, but it's also good for the dynamics of the team to have outsider knowledge. The current team have all worked in health but one of the members comes from Australia. Another person works two jobs, one in the public health sector. One worked in information and audit.

I feel my team are together. If any of us have a problem it comes to the team and we try to work it through. As a leader, I can bring some things to the team, but there are other

things I need to sort out outside of the team. It can be very difficult but I have made sure there is a system in place for my team and I did that in the very beginning. You have to take all the old processes, put them to one side and think in a different way.

My resources come down from a national pot and I have another pot for new service improvement. That pot of money is about a service improvement where we've identified what we have to put in place but haven't got resources. For example, this will let us fund a nurse for twelve months, see what the outcome is and evaluate. If we find that's what's needed, then it's up to the Trust to pay for it in future because my pot of money runs out. Often they want it, but they don't want to fund it next year. One guy was very sceptical about the team's work but he's gone outside and seen what value he has here and has changed his mind. I'm glad that I will be able to relay that to my team, because he gave them problems. I am proud of all of us.

Lead facilitator

I'm a service improvement facilitator with the Cancer Services Collaborative that was established to bring about practical changes. It has made some great inroads into breast cancer. One in three people will get cancer at some time in their lives and one in four will die from cancer. It is very much a disease of the elderly. Not exclusively, but as the population grows older more people will get cancer. The NHS Cancer Plan aimed to reduce the risk of cancer, to improve cancer services in the community, to improve and give faster access to treatment, improve the lives of cancer sufferers and also to improve research.

Cancer Collaborative people are employed by local health organisations to assist with these improvements. We have a team leader who is the service improvement lead. I am employed by a Primary Care Trust and work across the five in this region that form the Cancer Network. Cancer Networks are loose organisations that bring good practice together.

I helped to facilitate a baseline assessment of General Practitioners' cancer services in the community. There was a questionnaire that asked things like, 'What information do you have in the surgery on cancer? Do you keep a list of cancer patients? Do you keep a list of palliative care patients? Do you use the fax referral system for the hospital?' At the moment I'm following that baseline assessment up. I might go to a Primary Care Trust Executive Committee and give a presentation on the results of the assessment, which says things like only one in five practices keep a list of palliative care patients. The question is, if they don't know who they are looking after how can they develop a service? Last week I presented a 'Time to learn' session, which was when all the general practitioners come together.

My frustrations are about having influence but no power. The baseline assessment had been sitting in the doldrums, so I spurred it into action. Now, I am trying to spur the Primary Care Trusts to do something about the results. But, the report sits on people's desks, among the priorities. To push the cancer corner is an uphill struggle because the new contract does not emphasise cancer as a primary care issue. It is seen as an acute issue. People want to move in the same direction but their own agendas can get in the way.

Social service lead

I've been involved since phase three of the Collaborative. Before this I was managing the community Macmillan nurses. So it was all palliative care. Getting to grips with what's going on in the acute Trusts has been quite a steep learning curve.

I've had to learn about using the Modernisation Agency's redesign methodology—process mapping, capacity and demand. It was something I hadn't come across before—the techniques and things. Cancer Collaborative is changing in the third phase, becoming more about sustainability. People who were programme managers have become facilitators, so staff are changing their own service. Being the lead means working with them, making sure that it's fitting in with national and local priorities, feeding that information back to the national team and also taking a strategic view.

We meet up very regularly and have a service improvement steering group. We get together with the cancer services managers in the acute Trusts and the network team. We also have a clinical lead for service improvement who works one day a week with us. I take a linking role and get the overall view and try to move it forward in a strategic direction, making sure that we are actually achieving what we set out to do. It's basically about improving the patient's journey through various methods. We are looking at things like waiting times, patients being seen, urgent referrals from their general practitioners to the target of first (definitive) treatment within sixty-two days. Also improving communication between primary and secondary care and looking at patient information pathways. Palliative care is a big issue for us as well.

One of my biggest challenges is engaging with clinical teams and getting them on board, because a lot of them have worked very hard on their services and have already done a lot to improve things. What works well is getting together with them and talking it through. Getting them to come up with some of the areas they can improve, working with them on those ideas. To be a good lead you have to be able to communicate well and listen to some of the problems they have. Have a strategic view. Have a vision of where you want them to be and be able to demonstrate it. Trying to get people out of some kind of silo.

My personal strategic view is keeping the patient at the heart of the journey on whichever pathway their care is taking, be it acute, primary or palliative. How you improve that patient experience. We get lots of information back from clinical teams about what the patient experience is. Also from mixing with the national team and the other networks and what's going on in their area. Now we have a reporting system where we put everything on to a database and look at what other teams are doing. A lot of work is available on line. We also get an update on key implemented changes. This gives us something to discuss with clinical teams about whether there is anything they think can be done here. That is the idea of the team going in to help the clinical team look at their service and any redesign needs so that if there is an improvement it can be sustained.

The service improvement leads meet up together and with our associate director from the national team, who is very supportive. The clinical lead is a palliative care consultant. She helps us to engage with the clinicians. It's about credibility. Even in this day and age sometimes peer to peer is more effective. If we are trying to engage general practitioners we would write joint letters. People are doing joint training now. When I trained it wasn't like that. You were very much doing a nursing course.

Service manager for Older People's Services

My role is multifaceted. I'm employed by the local authority in a joint-funded post with the Primary Care Trust. I have management responsibility for all Older People's Services in the locality provided through the county council but I also now have responsibility for instigating and overseeing partnership schemes. It's a fairly new con-cept. We were asked to move into a locality base for social work for provider services as well as external commissioning. It aligns far more with health colleagues and it really went in the right direction with regard to the NHS Plan and as a way forward for partnership schemes.

My background is in social work though mainly in health. This new approach is key to the merging of services in the locality. I am working so closely with primary care colleagues and acute Trust colleagues that it gives a much more partnership approach. It doesn't contradict or conflict with your own professional identity. It's about seeing how together you can work to provide a service.

I am very fortunate that in this part of the county there is a very open communication. In that people have been very willing to talk and explore different options. Primarily I am here to manage county council services and to move forward with commissioning that affects local authority money. But I also have a direct link through to the director of Integrated Care Services within the Primary Care Trust. My line manager is within the county council but I also have an indirect route through to the director and the chief executive within the Primary Care Trust. If there is any confusion, the way forward is to talk it through to find a solution to the problem. We deal with each situation as it comes up. We have to value people's professional identity and their interest base that has brought them into a particular role.

The palliative care pilot that we are looking at initially started with conversations and individuals just networking. The facilitators came in a little bit later but have been extremely helpful and bring a different perspective. The initial group was a 'hospice at home' service, including myself and my social work staff within the hospital who have a particular interest in palliative care, my home care staff and our Primary Care Trust colleagues.

What we wanted to achieve is a seamless service so that patients and their families could come in one door and they didn't have to open six others. Our prime action was about a more integrated way of working. Not everybody being based together but a far more integrated way of working and knowing who to network with if somebody needs to pull in another service. As part of that, it was about a certain number of home care workers developing their skills to work alongside the 'hospice at home' service so that they could do the same job. At times you want to run before you can walk and you make mistakes that way. You must plan it and work with people on what needs to happen. We have to be clear on what needs to be offered before we take it out to general practitioners because they will want to grab it and run with it.

I've asked the home care manager to work with the manager of the hospice and the Macmillan nurses and with other colleagues to talk through what the roles are and what we need to achieve because that has implications for costs. For them to have ownership of what's going on they need to identify what it is that's required. If they're not involved from the word 'go' they can't see where this is going and they can't own what's going on. There are some quite painful changes to be made to the way things work across both health and social care and they have supported us in doing that. But that has to come from

them owning the service that they're involved in and wanting to see it achieve. So they are prepared to work with us even if we have to make difficult changes.

We will eventually end up with groups of people who are offering a common service. Not a 'one-stop shop', but a streamlined service. So that someone might go out and see a patient but say that a bit more involvement is needed. So we might offer respite care for the carer, or something like that. The hospital home service had been the initial port of call but they'd found it very difficult to access other services along the way because it wasn't being seen as a high priority. This way we're hoping that they will be able to access services because we'll have put in the network to do that. You need to identify what the issue is and what the gap is, then look at how that can be remedied. Sometimes you can put in place what other people have done. But sometimes it is a case of having to look at it and saying, 'What do we have to do to achieve this?'

I think it has been right for my post to be based here because people have been able to get to know me. They've also got to know social care a lot, lot better. For health colleagues understanding the local authority system has been a steep learning curve. At times social care is seen to drag its feet, but there is a political process that has to be followed because we are led by elected members of the county council who are responsive to the public. So there is a clear route that things have to take. Because I've been based here people can see it working day by day—the constraints that I have to work to as well as the advantages.

There are formal and informal structures. My colleague is community nursing manager for adults and we're directly opposite, office to office, so we spend quite a lot of our time working things through together. Up until two weeks ago we shared the same office but because of the noise have been given our own offices, so now we're next to each other. It has been a real relief but you do lose some of that daily contact. You'd take a phone call and they'd hear what it was, I'd take a call, ask their advice, whatever. A two-way street really.

I think what motivates it here is the strong staff base, an extremely committed force of people. They are quite practical people and so am I, sometimes too practical and not strategic thinking, but we can talk things through and that's what makes it work. I have an optimistic view but not unrealistic. If I can get district nurses and social workers talking better together they'll have a better understanding and feel more at ease and comfortable with each other. Then the next time a district nurse phones up and says, 'I've just been to see Mrs Smith and she really isn't that well and doesn't look too comfortable. She could probably do with a bit more care packaging, more than twice daily calls for a couple of weeks just to get her through this.' If the social worker accepts that without going out to see for herself, it is a big step forward. I think we're getting there and it isn't a pie in the sky dream.

PERSPECTIVES ON CHANGE IN HEALTH AND SOCIAL CARE

The issues raised in this case study have focused on continuous improvement in the context of cancer services. Everyone we interviewed gave a range of examples, many of which we have drawn out of their individual stories to discuss below.

This team are unusual in sharing an approach to their work that has been developed through a national initiative by the NHS Modernisation Agency. This is explained in Example 5.1.

Example 5.1 **Health Improvement Methodology**

Health Improvement Methodology aims to take a good idea, try it out to see how it goes and study it. If it works out well, do it again, and do it more, and keep doing that. Look for constant little change and build up evidence that these changes are good. If things don't work out you've done small changes and you haven't done a lot of damage.

So you might work with one patient, or one practice, or one consultant and their list of patients. It might include something like introducing a new form with a space to put a mobile telephone number on. It's only a small change, but part of the problem in making an appointment is that you only have a home phone number. Try it out, see if it works. If it does, you might put it on all of the forms.

Although that example is of an improvement that could be easily introduced, most of the change discussed by this team involves working across organisational boundaries. Services that have been provided for many years have particular characteristics. The policy drive to modernise service provision usually requires closer integration of these services in order to provide a quicker and smoother journey for service users. Some of the issues are outlined in Example 5.2.

Example 5.2 **Reconfiguring local services**

We're trying to work across different systems, different management styles, different organisations. We're working across a Primary Care Trust

then a county council. Some of the work in this local sub-economy around our acute Trust is with a different unitary authority. It does at times prove extremely complicated and frustrating because you can't always move things on in the way you want or as quickly as you want. But because we work closely together we can usually find a way through without it becoming too bureaucratic.

The formalities of different funding systems and different areas of responsibility represent boundaries that have to be overcome in joint working. Another set of issues arise from the nature of the work and the attitudes and experience of staff. In Example 5.3 some of the problems of working differently are outlined.

Example 5.3 **Changing people's mind sets**

The issues and challenges are about change management, human dimensions of change, vision. Sometimes we think people have the same vision but they don't. We are trying to

bring a national programme to fit into local priorities and it's how you do that. Also there is the historical aspect of how people have always done things and you are trying to get them to think and work in a different way. It's about changing people's mind sets. The Modernisation Agency have given us the tools, the techniques, the technology, to do this, but what they had not concentrated on was the human dimension within it so not done enough work on that.

So provision of techniques and tools is not enough—time must be spent on working with staff to ensure that everyone understands how the new approach will work. Service users can't wait until new services are tried and tested, therefore existing services have to be continued until improvements can be introduced without too much disruption. This team has developed an approach to incremental change that accommodates the necessity of keeping existing services running while introducing improvements. This process is discussed in Example 5.4 where an interagency collaboration is proposed.

Example 5.4 **Incremental change**

We've had to take it very, very slowly because we are asking people who have been established in roles for a very long time to make some quite fundamental changes. The team has been running for eighteen months but there are still changes that need to happen, so you have to take it at a steady pace. At a pace that the service can be provided, because that's why we're there—to provide the service. But it's also about bringing your staff along and not making them feel displaced or unsafe with what's going on around them.

We try to target certain areas at certain times. What we're beginning to do came out of some initial discussion with the independent sector. Service users are used to having a home care worker from Social Services going in, but at a certain point, because of the deterioration of their condition, they may feel that that a nurse or somebody else needs to come in. It often leads to a disjointed approach with the best intentions in the world. So that's where the discussions first started.

From there we've been able to highlight that there are a small group of people within the home care sector who would be really interested in extending their skills to work alongside other agencies, both in the independent sector and health. To develop their skills so that we could have a more streamlined service. And that's where it started. The group are looking at an operational policy—how could this work and what do we need to do. They're also looking at the training needs of individual staff. So it's been a fairly slow process but we need to put those bits in place before we start asking staff to make changes or take this development on board.

One of the reasons for the emphasis on incremental change rather than large-scale change is the opportunity it gives to try new approaches without the risk of damage if the new ideas do not work satisfactorily. Example 5.5 explains a little more about the potential benefits of incremental change.

Example 5.5 **Small steps to significant results**

I'm not sure how the initiative will work out. The initial aim is purely and simply to hone the skills of home care workers within social care to become able to work alongside colleagues in health and the voluntary sector. To provide a more seamless route through for patients at an extremely difficult time in their lives. The pilot is really just to tease out how that might work. We're building it with a facilitator's help against the 'gold standard' framework and trying to look at how that models out in this particular field and how it could fit in and enhance that. A pilot to me is a really good way of just teasing something out, to see if it's viable, how it will work, what are the teething problems and what do we need to consider for the future. They are often quite small changes but can produce big changes.

Many professionals fear loss of identity if they work in multiple skills areas. The training, experience and commitment to a Code of Practice that denotes professional status represents a considerable investment to the individual. There is often a fear that interprofessional working will demand significant blurring of professional boundaries, to the point where the expertise that a professional has developed may seem not to be valued. Example 5.6 presents joint working as a potential advantage, providing a way of working in which different expertises can be complementary and enhance the experience of the service user. It is clear, however, that for this approach to succeed, professionals from different backgrounds would have to both respect and trust each other.

Example 5.6 **Benefits of integrated services**

A couple of years ago we were a bit panicky about all having to integrate. But integrating doesn't mean that you're going to lose your identity. For me, it's meant that I can still bring my social work identity to what I'm doing and I can enhance what they're doing and they can enhance what I'm doing. What it primarily does is cut down bureaucracy. Achievement will be the day when no matter who goes in to make an assessment, we will all be able to look at their information and respect their professional credibility in making a judgement of what's required. We won't then expect to go in and make our own assessment, do it all over again. That would be a real achievement.

Perhaps we can do it with the palliative care pilot. We're looking at using the single assessment process. It means that the services can be provided quicker and can be more appropriate for the person who requires it. It doesn't matter whether it is a nurse, social worker or who is going in, the service user will be confident in knowing that the information will be passed on and the right person will come to see them.

We're starting to see changes coming into place that are beginning to make a difference to delays in hospital and to the types of care that are given in the community. If you can do that you've still got job satisfaction.

If real benefits from change can be demonstrated it can help staff to overcome some of the more trivial issues that hinder improvement. In Example 5.7 we hear how attitudes can change once staff see improvement and understand how it can be achieved.

Example 5.7 **Motivation from service improvement**

It's important to develop followership for the vision so that they start to want the vision as much as I want it. No one wants to work in a rubbish organisation. The staff know what's needed. But there isn't necessarily someone there to point out a possible solution. A lot of my work is about linking and saying why don't we bring those two things together because that might help what you want to achieve.

Everybody gets bogged down by the day-to-day routines and their own badges and stuff. They don't realise that all the badges are interlinked somehow and if you start to make those links work for you, you can make the job and the service better. And that's what most people are in it for. They want to see an improvement in the service for the people they are working for.

If most staff want to improve services for the benefit of service users we might expect that collaboration to identify and implement improvements would be easy to secure. This is not necessarily so. In Example 5.8 we are given an outline of how improvements can be identified collaboratively.

Example 5.8 **Identifying opportunities for improvement**

Recently we did a networkwide processing session. We mapped the patient's journey, right from primary care through being referred to the hospital, being discussed in the multidisciplinary team, having treatment and then the follow up. We got all the team together from both sites and we tracked the patient's journey. We had booking people there, clerks, so that everyone could have a say. We looked to see if there were any areas of duplication or any areas where the patient had to come up to the hospital and it wasn't actually of benefit to them. Sometimes you can cut it right down in terms of days. Also sometimes visits to hospital can be cut down if they can come up and have more than one test done in one go.

Other mechanisms are needed to ensure that service developments are planned and co-ordinated. Example 5.9 comments on some mechanisms that are being introduced to enable better planning so that the service can be proactive rather than always reactive. It also mentions the impact of using different ways of measuring performance.

Example 5.9 **From reactive to proactive**

When the patient is dying everyone pulls the stops out to achieve a reasonable service. What I am trying to do is to turn a reactive service into a proactive service so that people

are planning and co-ordinating and thinking ahead. For example, so that a palliative care patient can die in their own home if they would like to. A survey in 2002 suggested that of 65,000 people three-quarters would like to die at home. Yet three-quarters die in hospital. My biggest satisfaction is knowing that the local team of general practitioners and district nurses are working to achieve that choice. It's satisfying personally for me, when I am talking about the 'gold standards' framework, when general practitioners say, 'Yes, we are interested in that.' Because it means I've presented it in a way which answers 'What's in it for me?'.

General practitioners are having a new contract next year and for the first time they will be measured on quality. There's still some number-counting. It's made up of 1,000 points and for every point they get money. They will get six points for listing their cancer patients. If they see them within six months of diagnosis they will get points. A firefighting reactive service will be turned into a well-planned, well-co-ordinated and well-communicated service. There are quality points for organisation, and for

having proper summary information on patients. So with the 'gold standards' framework I am able to introduce it and say, 'What's in it for you is a tool to help you achieve not only what's good for your patients but also points for your quality pot.'

There are, however, reasons why some people are not immediately ready to co-operate. In Example 5.10 the General Practitioner contracts are mentioned again as mechanisms that do not always encourage participation in innovative projects.

Example 5.10 **Will they co-operate?**

How open are practices to the kind of work we are doing? They are not. It comes down to the leadership thing. In terms of actually getting people to buy into any of these things one's got to find out what interests them. General Practitioners are self-employed business people who happen to be doctors. They are paid for what they do. They are interested in what's in it for them in terms of money. So, for instance, when we did the baseline assessment, the Primary Care Trusts paid them to return the completed forms. Which ensured they were completed. It's as basic as that. People become very cynical about this. For example, people say General Practitioners won't do anything unless you pay them. The basic facts are that that's how they earn their money.

There are also reasons why individuals do not co-operate as we see in Example 5.11, even if they seem to have agreed to be involved. In some cases the team might be able to overcome resistance but the key people have to be committed if they are part of achieving change.

Example 5.11 **You must have the key people on board**

We wanted to change the direction of a clinic because when people come in they need certain diagnostic tests. What the clinician was trying to do was change the actual

dynamics of the clinic, so that the patient wasn't waiting every step of the way. We co-ordinated the clinic so that they would go in and have a test at a certain time and they would come out and know where they were going next, whether it was to see the surgeon or whatever. Before they would sit and wait until they were called and then would go back and wait. So it was to try to manoeuvre that so they knew more or less exactly where they were going.

Everyone was on board with it. It was a small 'plan-do-study-act' cycle. But on the day that we trialled it, put it into action, it didn't work. The reason it didn't work, unbeknownst to us, was that the clinician involved decided on that day that her patients needed a lot more tests than would normally have been needed. So that threw the whole thing out.

When we got talking afterwards, nobody challenged that. But was there something else going on? Something about thinking that everybody was on board although there was scepticism. So next time we did it, we worked very closely with that person. We got all her issues and challenges out and asked her what she thought should happen. In the regular meetings, she hadn't said anything, but maybe she felt the environment wasn't right.

We run the 'plan-do-study-act' cycle. Although it seems simplistic, it isn't easy and it isn't easy to say we failed. But it's alright to fail, because a failure is a learning now. In a lot of organisations, including the National Health Service, we are not allowed to make mistakes, but what they are trying to be now is a learning organisation.

When people feel that they are likely to be blamed and penalised for failure it is very difficult to innovate. Innovation always involves some degree of risk of failure. There is risk in doing anything differently. There are ways of overcoming this type of 'blame culture'. As mentioned in Example 5.11, one way is to see failure as an opportunity to learn. In health and care services people are often risk averse because so many service users are vulnerable and staff would not want to put them at risk. The incremental approach to change used by this team (and many other similar teams) makes small, sequential changes that can be evaluated quickly and developed further only if they are successful. There are techniques that can help to assess potential risks and contingency plans can be made to limit any potential damage.

Another approach that can build confidence in change is the use of standard-setting, so that standards are identified as targets for good practice that can provide direction for those planning improvement. Example 5.12 discusses the use of a new framework of standards for palliative care.

Example 5.12 **A framework for change**

A major part of my work is around palliative care and the introduction of the 'gold standards' framework for community palliative care. It's a framework which has been developed by a General Practitioner working with the Macmillan cancer relief organisation, a charity that has been established for 100 years and works very closely with the government around cancer services. The Macmillan sponsors General

Practitioners to spend some of their time focusing on cancer and educating other General Practitioners on cancer. The one who developed the framework is a General Practitioner Macmillan facilitator. She spent some time looking at palliative care in the community and came up with this framework of best practice. Basically there are seven steps in the framework. The first one is listing your palliative care patients and the seventh one is around care of the dying in the community. So the framework aims to co-ordinate good practice in the community.

It's been tried out the past two or three years in dozens of practices in the community, and it has been firmly established as a good way to go, so I am rolling it out in my area. I send out leaflets to practices, saying, 'Here is the "gold standards" framework. Let me come and give you a presentation on it and encourage you to adopt the framework.' Already several practices are adopting it and I meet up with them every three weeks.

These new initiatives are focused on improving the patient's journey through whatever services they need, but if they are to be successful in the long term they will need to be resourced. The incremental approach to change takes place alongside existing provision and often has to compete for funding with the current well-established and familiar services. In Example 5.13 this conflict is illustrated in a discussion about how new initiatives might influence the commissioning process.

Example 5.13 **Commissioning to meet needs**

In the commissioning process it is up to the Primary Care Trust to decide how money is being spent. It isn't always specific pots for this and specific pots for that but a decision about where you want to spend for your patients. So that decision-making process is part of the commissioning process.

That has been a hodge-podge in the past. Everybody has done it differently. How do you get to this decision? What makes you do this and leave that out? How do we commission and what makes us consider that is right? Should we be looking at this in a different way and turning it on its head? Have we looked closely at what we need? How did we do that? What were the processes we went through and what were the outcomes of that process to get us there?

That is about service improvement. That's about what we look at in mapping the patient pathway. Where the gaps are. What it is that we have to influence to make it better. If there is anything we can make better that doesn't cost more but is about doing something differently. And then looking at the demand for this particular thing and whether the capacity meets that demand and if it doesn't, in what ways it doesn't. Then taking that whole equation to the commissioning process and saying what we've done and that this is here to inform commissioning. It's a new way of informing commissioning. It's a very reflective process and time consuming. It might not happen next year but the next year.

Commissioning processes can only be informed by these new initiatives if information about the impact of the service improvements is produced and understood. Incremental

change produces gradual improvements rather than dramatic ones that might gain greater publicity, but where there are networks of groups able to share expe-rience and information there is a potential to develop an evidence base to inform future investment in improvement. Example 5.14 discusses the extent to which learning in other groups can inform planning and development elsewhere.

Example 5.14 **Learning from other initiatives**

Quite a bit can be learnt from other groups. With collaborative care we did look at other schemes. We went to visit other schemes in the country, just to look at how things could be developed. For example, I was asked to visit, with two county councillors, a home care scheme in another county. This was about three years ago and we were just at the beginning of looking at ours. One of the things that came out was that they hadn't been able to involve the home care aspect from Social Services, as much as they would have liked to.

So from that visit I was able to come back and think to myself, well, if we are going to do this, we really do need to bring social care and health in together. Although I took from them some really good ideas I also think that we've sorted some things in a different way. It helps you to balance out what you're doing yourself and also to get other ideas. So we try to look at other schemes when appropriate, as and when we can. To look at other examples.

Leaders who are developing new initiatives often want and need personal support. Example 5.15 comments on the possible need to look wider than one's own organisation to find appropriate mentorship.

Example 5.15 **The need for development skills at all levels**

I am looking for mentorship now with the Strategic Health Authority. My line manager is a clinician. And they are not the best to be your line manager as far as a personal development path. The director of modernisation is the person I should be looking to. But the way things are in the NHS the people with that hat on in the acute and Primary Care Trusts are not necessarily skilled in the skills that I have. If I went to them, they would not necessarily understand what I am doing and what I need.

There is a need not only for senior staff who can mentor change agents but also for staff who have appropriate experience of change and understanding of the complexity of interprofessional and interagency working. In Example 5.16 we hear more about the issues that arise in developing staff in more flexible collaborative services.

Example 5.16 **Developing staff in collaborative services**

We are going to be doing some work with the General Practitioner about a proper referral

route. So that if they have a patient requiring a certain service there is a single access point. Refer them through and then from there it would be looked at from a multidisiciplinary perspective—who can best meet the needs of that person, rather than, 'Oh this is social care. We can only deal with this bit'. It's to try to take some of those barriers down that often stop the service getting to the person in time when they actually require it. It's about an understanding of everybody's role. The pilot has shown that from an auxiliary nurse to a social care point of view they didn't really understand what each other did. It's about breaking down some of that.

In addition to providing standards and frameworks to support change and appropriate staff development, Example 5.17 demonstrates that the structural and physical arrangements within organisations can be significant in enabling change.

Example 5.17 **Physical signals**

My role was welcomed within the Primary Care Trust, whereas in some other areas there was a little bit of suspicion of what the job was about and why this social care person needs to be here. But this Primary Care Trust have actively made me part of their management structure. I am based with them. I am in their office space, not in Social Services. Therefore it was automatically seen that I was part of their structure as much as within the local authority.

PERSPECTIVES ON TEAMWORKING

In this case study, one of the issues was difficulty in bringing people together to form teams, as discussed in Example 5.18.

Example 5.18 **Taking the first step**

I just can't get people together to talk and meet, can't do it by phone, we have to get people physically together to spend a few minutes to actually make a decision. This idea of a multidisciplinary team meeting is a fundamental aspect of the cancer plan. That you get together in the same room. It's about making quality decisions. In the past, you had individuals making decisions because they worked on their own. These days the aim is to get them to be part of a team and for the team to produce a good-quality decision. This can happen in smaller ways and bigger ways,

though. With teleconferencing and showing slides on TV screens they can have joint decision-making without being in the same room.

Trying to make change is the first step. What are the first three things you are going to do when you leave this room? What tiny thing can you do to start this process moving? This thing about getting people together is a stumbling block. The rest won't happen if

this doesn't happen. I see it as the handle to grab hold of the whole thing, because sometimes you don't know where to start, you don't know how to get people moving. If there is a clear, almost physical aspect, you can almost physically grab hold of it.

So if I can find some tick to put on some little step it will have consequences all the way down. Systemic management. You can't get change in one area without impact in another. It's difficult to know where to start but they can see things differently when you get people together.

Once the potential participants have been identified, it often needs the intervention of senior managers to enable a team to work together across organisational boundaries, as in Example 5.19.

Example 5.19 **Starting a collaborative team**

It's a bringing together of home care staff, auxiliary nursing staff, qualified nursing, social workers and therapists. All together in one team that provides rehabilitation and a focus to facilitate people coming out of the hospital but also preventing them from having to go in the first place.

It's not an easy process because you are trying to work with people who have come from very different persuasions. Yes, they have a common theme but they have a very different outlook and focus because of their training and where they come from. Asking them to work together and to start to take down the professional boundaries and some of the preciousness around the job.

That needed to happen first of all at my level. They needed to see that people like myself and my counterparts at the Primary Care Trust could put that aside and say, how is the best way to move this service forward? So we've worked it very, very much together. Even if there have been some specific issues for staff that are employed by the county council and staff that have been employed by the Trust, we've still worked it together. So that as far as the staff are concerned it's a joint focus and a joint voice that is speaking.

When a team are brought together from different backgrounds, they need to learn to work together. Example 5.20 explains how a common concern with the patient's pathway can provide a focus.

Example 5.20 **How does this team work together?**

Maybe that's about the team working differently. A team is made up of people with different skills. It's the skills that you bring together and the intuition and the vision that makes a whole team. The strength is within that team. Now when we do something we move it forward as a team. If we were mapping a patient pathway, which is the first thing you do to look at what's happening in the system, you can get people into different groups to bring key themes back, and the themes with the map end up as the work plan or

the action plan.

The role of a facilitator is to help teams to work together, particularly in planning how they can identify and address service improvement. Example 5.21 explains how a facilitator can help a team to find solutions for themselves whereas bringing in a new manager to make improvements is less likely to work.

Example 5.21 **The facilitator's role with the team**

The facilitator's role is to help them. To lead them on thinking where the gaps are, what objectives to make and how we can move that forward.

When we brought the services together, the rotas were completely different. The nursing service kept their rotas in a completely different way to home care. But it took several months with a facilitator to work with their managers and the team to look at having one rota and one way of working for the whole team.

If we'd had a new manager to come in to take over from everybody else it would have put everybody's backs up. The facilitator came in to work with the team rather than to manage the team. To work with them to find a solution. It's not to say that we mightn't need a manager in the future, but if we'd tried that at the beginning it would have set us up to fail.

In Example 5.22 another member of the team commented on the way in which the facilitators had changed their roles from being the project manager responsible for carrying out a change to facilitating teams to make their own changes.

Example 5.22 **Changing roles in teams**

Project management to me is doing. It's a different role. A couple of years ago the team started out as project managers. They actually did the work. Now it's about using our skills to facilitate and also to train the people to do it themselves, to take ownership of it rather than giving it to us to do. The ownership is when they do it and we support and facilitate them doing it.

The facilitator is an outsider as far as the service delivery work of the team is concerned and Example 5.23 explains why the presence of an outsider can be helpful.

Example 5.23 **Acting as a link**

Although I felt completely involved in the hospice I was always slightly on the outside, which itself has an advantage. Although I was a social worker to that hospice we discussed everything and I could go to any of them, They always knew that I was just that little bit apart so I could give an objective overview. I feel the same here really. Although

I'm very much part of it, my professional credibility is still within social care. So I can help them if they want to talk to anyone in Social Services. I can act as a link for them. So it acts on a formal and informal way.

The facilitators are not the only ones who have faced considerable change in roles. As the interprofessional service development teams are formed, all the team members need to develop new skills. Some of the practical issues are discussed in Example 5.24.

Example 5.24 **Developing new roles**

It's a question of working with them and their needs. If they want to extend their skills and looking at how to do that. It's trying to understand where people are coming from in the first place. We've had social care staff that have been employed by Social Services and we've had auxiliary nurses that have been employed by the Primary Care Trust. What we've said is that the ideal, eventually, would be to have a role that was generically across the two. So you didn't have this barrier of 'l am a home carer so I can't do this', or 'l am an auxiliary nurse so I am not supposed to do that'.

We looked at the job descriptions of both the home carers and the auxiliary nurses and we have produced a generic care worker. New people that have been taken on have come into that role so they are not one or the other. But they are working with the established staff. You need to give people time to make the adjustments.

Not only time is needed to create change across organisational boundaries. Staff also need the ability to reconfigure systems. This needs an understanding of the complexity of budgets and policies. In Example 5.25 some of these systems issues are discussed.

Example 5.25 **Issues in reconfiguration of services**

The auxiliary nursing staff and the generic care workers were on different contracts to the home carers that were employed by the county council. We agreed to look at pooled budgets or integrated services, whatever we wanted to call them, to get everybody on the same contract. We had consultation meetings with unions, human resources, finance colleagues to advise us on how that could happen. It was not as straightforward as we thought. But what we could do is to work with the staff who were on social care contracts and actually offer them the opportunity to move across onto a health contract in a generic care role, working on the same team. This then placed them on exactly the same contract as other people. We put that option to five people and four opted for it. So they moved across, feeling much safer than they would have a year ago. This allowed me to extend their hours. I could give them more stabilised hours to work, which is what they wanted. It freed up other money to work with and we could extend staffing numbers. We had to do it stage by stage. They needed to see that we'd followed it through, consulted on it, and put suggestions to them.

Once teams have formed and are working to deliver local improvements, they can develop very close working relationships. Example 5.26 describes some of the changes in team dynamics when one strong member of the team was away from work for a period of time.

Example 5.26 **Managing loss in the team**

One very strong personality who was absolutely fantastic and very driven has left the team recently. That person would see something and do it whereas other members of the team think differently. They will not necessarily do the job in the same way as that person either, but they relied a lot on them to move things forward quickly. So when the person left, there was a very down side to this team. I got them together then, and said, 'What is missing out of the team, what has gone away, what do we need to understand about that and how will that make a difference? Will it make a difference? What do we need to put into place so that it doesn't cause a great void that prevents us from moving forward.'

So we had that discussion. They decided we will have to do it ourselves. They were so delighted with themselves. They've organised this and that and found it was not so difficult. When the person comes back, the team will be different. They have taken on some challenges they were a bit worried about because somebody else had done them but they're not so difficult. The team will change again when the person comes back. They won't rely on one person so much and that may be good but may also be a challenge.

We faced it squarely and openly, confronted the anxiety, and helped people to take ownership of their own strengths. They had to accept that you are as good as the person who has gone away for a bit, and you can also do what that person does with a bit of support and help from everybody else.

Ultimately, respect is central to teamworking. Example 5.27 shows how mutual respect can help to overcome the different approaches that people bring in a team with such diverse backgrounds. The common focus on the patient experience is the key for their joint work.

Example 5.27 **Respecting others**

It's about respecting people's professional identity and professional judgement. We both know the objective, but we might have slightly different ways of getting there. You have to respect that. You can't cut it off and say you're not going to be that way. I know what my skills as a social worker and as a social work manager are, just the same as my colleagues do with nursing. That doesn't mean to say that you haven't got a partnership approach, because you have. You're both able to bring a philosophy to it that can enhance what's happening to the individual you're working with.

PERSPECTIVES ON LEADERSHIP

Leaders of teams in this case study have had to be able to take an overview of service delivery in a locality, linking closely with other organisations and agencies that contribute to service provision. In Example 5.28 some of these links are mentioned, along with the need for leaders to set a broad direction for change in the area.

Example 5.28 **Linking with local and national developments**

She provides leadership in terms of change management. She directs me and my hospital colleagues to focus on particular areas of change. The agenda gets developed partly by national initiatives and partly by local discussion with various clinical groups.

In such a complex environment, leaders have to be able to operate with people from different backgrounds and with different views about practice in health and care. Example 5.29 gives a description of this multifaceted role.

Example 5.29 **A multifaceted role**

What we now have is an intermediate care interprofessional lead who works across social care and the Primary Care Trust. She doesn't manage the service but she leads the service and therefore, she acts as the consultant for all the different facets. That has proven its weight in gold because she was able to give the time to it that neither I nor my colleagues could do. Our role is more about strategic planning and management

rather than the day to day of how the team needs to work. She doesn't manage. She leads. If we had brought in a health person to purely manage the whole service it would have put some barriers up. Social care people might feel that a health person might not understand their role.

One of the key concerns for everyone in this context is how to work effectively across organisational and agency boundaries. In Example 5.30 the importance of respecting different views is emphasised again.

Example 5.30 **Working across boundaries**

Leading is about being able to see across the boundaries. I think that's what's held people back in the past really, the more traditional type of boundaries. See the other point of view and a bit of give and take.

Working across traditional boundaries raises problems in other ways for members of the team. Example 5.31 discusses the issues that were raised when staff were asked to change from their traditional uniforms to one that identified them as members of the new team.

Example 5.31 **Working with change in identity**

We were asking people to make some changes to what they've been wearing, been identifying with, for a very long time. To get them to work as one team we needed them to wear the same. They agreed that it needed to be a uniform. But then we had to make it a separate uniform from one you would normally wear as an auxiliary nurse in Health and what you wear as a home care worker within Social Services. So that was quite a major thing to ask them to do. It's such a visible identifier of who you are.

We talked to them about the reasons behind having this new uniform. We let them choose it once we had a decision about everybody doing the same. One afternoon we had all the swatches of material for dresses and tabards and we let them choose the colour, the pattern and the style. People still went away and had some misgivings about giving up their identity—there are probably still some people feeling like that. But they are wearing the uniform today. They were from the day that collaborative care started. So they have taken that on board and have done it. Some of the things they were saying were things like, 'How are we going to identify between us?' How are people going to know the difference between auxiliary nurses and those who are home care trained? Our argument back was that you don't need to because you're one team and you're going in there to work with a person on specific aspects of their rehab programme that you have been asked to do. So it doesn't matter what background you come from.

Even when the physical issue of uniform has been agreed, it is not easy for people to think from a more generic perspective. One team member explained in Example 5.32 that from time to time it is as though people temporarily put their original badges back on.

Example 5.32 **Changing badges**

Modernisation is doing things in a different way. It means having to get people to take off their own badges for a few minutes and become part of this virtual group or this virtual organisation that is in place. But when there is a crunch or a difficulty and when the discussions dry up and when the vision on the flip chart comes close to being the reality, people start putting their badges back on.

My role, and part of leadership, is not to fight that, but to appreciate it. To say, 'Let's look at some things we can handle in reality, let's look at some small thing we can do.' It's me trying to convince you that if we can get some little change there, maybe we can do other little changes and we can get an overall improvement.

am in a position where I am required to push the vision, but I constant-turn to reality when people put their badges back on and I've got to fin ind out where they are sitting, where they are thinking from and bring them back to the vision again. So there is this constant to-ing and fro-ing.

Other leaders in this team mention vision. In Example 5.33 the importance of sharing vision is stated.

Example 5.33 **Leading to make the team effective**

I think leadership makes it effective. I am not sure if they were left on their own that would have happened. So it was a bit about my vision and trying to see where their vision was and meeting in the middle somehow. They hadn't had a full-time leader before. When I came I explained how I see a team working together. Valuing the differences within the team so that the team always remains strong.

Development is also highly valued as noted in Example 5.34.

Example 5.34 **Growth and development**

I have put my time into my team, because if I don't have a strong team and they don't get their development, I am going to lose my team. They are the life blood of what we need to do. If you don't give them an approach that can be developed they will walk. They need a pathway. It's about growth and development and that is eternal.

In Example 5.35 some frustration is expressed about the ability of senior budget holders to consider alternative ways of delivering services.

Example 5.35 **Thinking differently**

They say we won't have the money. And that's about thinking differently. If we thought differently, maybe we wouldn't need that money somewhere else. It is about a massive thought process. I get very frustrated about the leadership gap at that level and above.

Frustrations can, however, turn into achievements as explained in Example 5.36.

Example 5.36 **Highs and lows**

Last week, I was going home and never coming back again. Then somebody says something to you and it makes it all worthwhile. One consultant was very sceptical but he's rung me today and asked if I can come and help him. He will become champion for what he needs to do. I don't think he knows that yet but I know. He will become a champion of change.

Frustration can lead to motivation once the obstacles are overcome, but leaders have to find motivation for themselves if they are to inspire others. In Example 5.37 this motivation is described as passion, a very emotional experience and one that might be

considered to be a failing as well as a strength. In this example we are also offered an insight into how such passion can inspire a career pathway.

Example 5.37 **Driven by passion**

My failing is my passion. But it's my strength. It gets me up in the morning. I strongly want to make it right for the team and ultimately for the patients.

I came into health as an auxiliary nurse. No qualifications. Now in my fifties I have a Master's. It's all from passion. I started my career because people wouldn't let me do the next step because they didn't think I could do it. I have fought all the way.

Reflection on a role model can also help to motivate leaders as described in Example 5.38. In this case, the role model was also able to offer encouragement and an opportunity to gain experience in a leading role.

Example 5.38 **Learning from a role model**

Leadership is about oneself having a leader, a role model. I had a role model. A director of nursing came into post, and she became my line manager and she saw something in me that I didn't see. She said, 'l have a vision that other people don't and sometimes they have to catch up with you. That's why I know you'll do this job well because before you start in the morning you know what it should look like at the end of the day.' I know what I am supposed to be doing and why I am doing it. I have a vision and a sense of direction. She set me on my path. She saw something else in me.

They wanted to have a surgical unit and they wanted it commissioned and opened in three months. She gave me a file with letters and costings and she said get on with it and I did it. I did it for the first month alongside my bed management job. The bed management job is operational. So I knew what was happening in the whole hospital at any one time. I used my bed management skills, my skills and background as a nurse and my co-ordination skills. She allowed me to do what I needed to.

A significant aspect of leadership in this case study is the ability of those in leading roles to provide conditions in which staff can learn and work together. In Example 5.39 a leader explains how a team was identified and developed.

Example 5.39 **Providing conditions for team-building**

I identified a particular home care manager in this area who is interested in developing this side of work and a small number of home care assistants and co-ordinators to work with her on developing this pilot. They have identified that there are training needs and linked in to the hospice and other training via the acute Trust to build their skills and understanding so that they feel safer in what we are asking them to do. The Macmillan service and the occupational therapy service are interested to work collaboratively with

the pilot to see how it could be developed in the future.

Facilitators also play a leading role in developing vision, direction and motivation for change as described in Example 5.40. This is linked with an ability to develop ideas by tracking, summarising and synthesising.

Example 5.40 **Leading by facilitating**

My job is about facilitating, about bringing change, about making things happen, but I have no power to do that. I have influence. I have got to get in there and make it happen because that's what I am paid to do. And there is a leadership quality needed. I have to present myself as upbeat, someone with vision, someone who can turn concerns into opportunities, someone who can pick up on contributions which others have overlooked. I often use a flip chart to bring things together which people have lost in the discussion and don't realise they've said. It's also a leadership job to draw people out from their own agendas.

LEARNING FROM THIS CASE STUDY

Members of the Cancer Collaborative Network discuss a number of stakeholders with multiple agendas in an environment where roles, structures and processes are changing rapidly. The broad vision focuses on improving access for cancer patients and the patient's journey and this requires cross-agency, cross-boundary working. Members of the Cancer Collaborative Network talk about the need to be proactive rather than reactive in bringing about small incremental change. Everyone is working with situations of considerable complexity and Example 5.2 gives a snapshot of some of these complexities. There are costs and benefits to integrated working and Example 5.5 highlights the benefits of a single assessment process. However, several examples identify potential 'trouble spots' in the change process.

To bring some coherence and understanding to the change process it can be helpful to ask questions such as why, who, what and how.

- What is changing? There are a number of comments about change on many fronts. What kinds of changes are happening?
- Who is implementing change? Who is receiving the impact of change and what are the consequences? Who is leading change?
- How is change being handled? How are individuals leading change? How is teamworking supporting change?
- Where does learning come in and how does it occur?
- Why are certain areas targeted for change?

What insights have you gained from considering the case study and how might you apply them to your own situation?

CHAPTER 6
REABLEMENT FOR HOMECARE TEAM

INTRODUCTION

The Reablement for Homecare Team was created by a locality manager and funded as a joint Health and Social Services project. The remit was to put together a joint rehabilitation team in the community, an area of a city. The purpose of the team is to assist people to be able to live in their own homes after disabling health incidents. For example, if someone had a stroke the team would help them to be able to function at home afterwards.

It was originally made up of an occupational therapist, a physiotherapist, a nurse and a social worker, all as twenty-hour posts, and an administration post. After the first year a full-time manager's post was funded by Social Services. Some additional jointly funded professional posts were added together with a number of care assistants. Most of the funding came from Social Services because the team were able to provide evidence of financial savings in avoiding frequent referrals to other services and, in terms of users' and carers' quality of life, could show year-on-year continued independence. The team work with approximately 2,000 clients.

How the team works

Referrals are made to the team from hospitals, social workers and General Practitioners. Occasionally a client refers themselves, usually because they've been a client before and wants a little more help, in which case funding is arranged through the appropriate social worker or general practitioner. A reviewer goes to visit the client in their home to discuss what the client wants to achieve and what they may be physically capable of. The team then plan a programme of tasks and/or exercises and the reablement assistants go out and supervise the tasks and work with the clients to try and achieve their goals. It could be a very simple task like being able to get up and go to the kitchen to make a cup of tea, being able to go to the toilet, or preparing a meal. Anything that the client feels that they need help with to enable them to gain similar independence to that which they had before they became unable to do these things.

Reviews are held with each client to make sure that the care package is working well and to arrange any necessary increase or decrease to the care package. Sometimes people need to be rehoused or need to have social worker input. The reviewer can put referrals into the reablement team to ask them to work with someone's mobility in the house or outdoors, or their social tasks, for example, cooking and meal preparation. The reviewer

monitors, makes sure records are up to date and after about twelve weeks, checks if the package is still needed.

Team meetings are held every six to eight weeks, staggered to avoid always falling at the same times in shift patterns. People often come in for meetings even if it is their day off. Two team members work on each patch with one peripatetic worker. Handovers are carried out at the end of each shift to discuss any changes or problems.

PERSPECTIVES FROM THE TEAM

Team leader

When I am being the leader, I think about getting the best from the people that work with me. I say 'with' me, as opposed to 'for' me, because it really is about being with me. It's about giving them the space to think creatively and the encouragement to take calculated risks. For me, what's really important is to support those people and make them feel secure. What helps is like-minded people and without a doubt if I hadn't had people with the same beliefs as me, I doubt if we could have made it work.

I manage occupational therapists, physiotherapists and social care staff and getting them to think outside the box takes quite a lot of time. Often, if one person manages to get the service user's confidence, gets somebody believing in them, I don't feel it's necessary to bring another person in. For example, to look at finances or at how the carers or relatives are managing the situation. Physiotherapists and occupational therapists have come to me in the past to look at somebody's mobility. What I encourage them to do is to look at what motivates that user, what is it that is important to them. We have spent time taking people to the bookies, because that actually is what they want to do. They want to be able to walk or get the bus to go and do that—that's important to them.

I took on this job because I was a social worker in an acute care setting and so often I would hear consultants and nurses make a decision about somebody that would write off their life. A classic example, the turning point for me, was an elderly lady who had a stroke. She had been the main carer for her sister who had had polio as a child and had quite profound disabilities. Her stroke meant that she couldn't transfer from hospital to her home independently, and that was enough to stop her from going home. That she couldn't transfer independently meant that she had to go to the toilet without a home care assistant coming in three times a day. But the doctors in the hospitals wouldn't even consider catheterisation or other methods to manage that because it might mean then that she couldn't control her bladder. I have to say that in talking to clients, they would rather lose the control of their bladders and be catheretised but go home than have to go into a nursing home.

At that time there were no alternatives. It was a risk to open your mouth. Even today there is still a lot of pressure. It's about people not being prepared to take risks, going for the safe option and what they think is kind to users—although in reality it will often shorten their lifespan.

I was told, just put together a team. I had the freedom to go outside the box. In the whole of the six or seven months (and you still get it today) our in-house home care provider would say the right things but actually never really provide the service that was

asked for because their carers would not stop ‘doing for’. That makes a huge, huge difference. I took the money out of two nursing home beds. We took a risk. I went to a private agency and said, this is what I want, these are the hours I want. There was too much inflexibility with an in house. There were lots of risks. It was scary because the project only had two years’ funding.

Certainly in the last six to nine months frustrations are beginning to get to me but I am hoping the tide will turn again. I put my staff first and try to keep them motivated. Structurally there is obviously a hierarchy. But all the reablement assistants are told from day one, and I reinforce it in front of the therapists, that when they come in and have a discussion they are all equals. Their input is of more importance than the therapists because they are the people seeing the clients seven days a week. Their ideas, their thoughts, their opinions are valued and will be taken on board because, they may be paid slightly less per hour, but the knowledge that they give us allows us to do a good job. I would hope that everybody is treated and valued as an individual regardless of the level, regardless of what their pay or title is.

The one thing I am probably most proud of is that if you look at sickness levels in home care staff, in residential care or in social work staff, the team as a whole have an incredibly low sickness level, because they feel responsible to each other. In particular, I’m thinking of the reablement assistants because they have a partner but are a group of seven, they come together very frequently to train and have workshops and away days. They have loyalty to each other. So they know if I go sick today, my partner’s probably going to pick that up.

I will always put what I believe is the right of the service user first and if that means standing up to my staff I will do that. I will always put my staff next. I will always protect them against the outside world. I think that’s why my staff will take risks and I hope why they respect me, because they know I will always support them.

Team administrator

Staff meetings are an update on anything that’s happening. Our leader goes to team management meetings and updates us on what’s happening, any information that might affect us or our work. Staff changes, procedural changes, anything really, any changes. She’s very upfront. I think the idea is that if she tells us, we won’t hear the gossip and start scaremongering between ourselves. For example, there was a rumour some time ago that one of the departments that we work with was going into the private sector, which might mean that our jobs would change or stop. She went to the team managers’ meeting and was able to tell us the truth and what is probably going to happen. She started the team. Fought many a battle to maintain it. If Reablement hadn’t been started, I think there’d be a lot more people in care, not in their own homes. This area is densely populated with elderly people so there’s always someone who needs this. It’s what service users want.

It can be tricky working with other agencies. It was difficult two or three years ago to get referrals from people. Social workers weren’t making them because, well, perhaps it’s a mental thing. You’ve got a client that you really, really care about and you want the best possible for them. It’s like looking after a child, I think, you want to do everything for them.

If you've got a client who's just got out of hospital you'd probably see them several times a day. Then you'd report to the physio and very, very gradually cut down and concentrate on the programme of exercises and tasks rather than oversee the simple things. Once they can do the basic things we can say, alright, we've done this, let's do something on mobility now, like how about getting on a bus and doing some shopping? It's staged, according to what reports we give back. The physios will amend the programme according to what state the client is in. If it's running normally, we see the client contact sheet every week and send it back to the therapists unless it's a bit more pressing, or not clear, or we don't understand. When we start with a client they give us a pen picture; what caused their problem, what they'd like to be able to do, what their current restrictions are and, as a result of that, what work we need to be doing with them. So if any of that changes we need to tell the therapists and we report back.

In April we had an away day where we talked about the business plan for the team, for what Reablement were doing and where we thought we were going. The team leader outlined what sort of thing needed to go into a business plan and we brainstormed strengths and weaknesses of our team. Then we broke up into groups where we talked under the headings of the business plan about what it meant for us and came up with a series of statements. We needed to have training and support, to know where we are and what we're doing. We need to be able to satisfy our clients. We're all committed to restoring people to as much independence as they would like.

We have an emergency mobile phone to whoever is on duty, so if we need direct action we can phone. If there's a problem we would probably ask the person we work most closely with or the most experienced one here. We're not allowed to administer medicine—we're allowed to give them the packet and tell them what it says, but one gentleman got really confused with his medication. The chemist hadn't done what he should have done. So the reablement assistant phoned the OT who was on duty to come and sort it out. He was on a drug which changes, and he had his day's medicine in his box. On Friday the chemist turned up on his doorstep with another box of medication and said, your dose changed. He was taking fours but the chemist said, 'Now you take threes one day and fours the next and these are the threes.' In my opinion, he should have taken the current dose out and changed the dose in the box. He added to the confusion. The gentleman not only had the doses he had been taking in the box, he had part of the dose he should now take in another box. But there's always someone you can call in a case like that.

The same gentleman, I went one night and he wasn't there. Should I break the door down? Basically, I walked around the property to ascertain that no-one was there, then checked with the neighbours and nobody knew where he was. I rang the emergency line and they gave me advice. I went home and found the pen picture and found his daughter's phone number and it turned out he was at the pub—she knew exactly where he was. But it was my responsibility to make sure that wherever he was he was safe.

The manager is the leader. Even though we don't see her very much, she makes sure that we're alright, she's where the buck stops. She gets herself very much involved—if the therapists can't man the phone line, she does. Her door is always open.

Social care assistant

I mainly deal with people who've been discharged from the hospital. They may need some help from the reablement team when they go home, so they have a slow discharge and the reablement team link in. If I see something and think they would benefit from reablement, then I will put the referral in. One of us would then go out and assess them and they may feel there isn't anything more we can do for that person, then I would look at the picture as a whole.

The leader is the manager of the whole team. She's the one that supervises all the staff. Because they're jointly funded, obviously they have their manager that they go to, but she oversees the whole team.

I value my own supervision sessions because it's a time and a place where I can air my views and my feelings to somebody, and they can do the same to you, and it's all done above board, professionally. You feel comfortable about that. I feel comfortable talking about anything to do with work, or personal. If you've got that type of relationship that's good. It's all about confidentiality, you've got to be able to trust your manager. Others will say they can only talk about work, but that's fine, that's up to the individual. A good manager listens, is good at hearing what you say.

We have meetings on a regular basis. The therapist has regular meetings with our team leader about the clients and we meet every fortnight. The team leader always feeds back the information she's been given. The admin staff type up the notes so everyone has a copy. Supervision as well, it's relevant to your post and to you. If I ask her a question she'll find out for me, give me the information. She might give me some graphs about my work and I'll do the same for her, it's a two-way thing.

In the end, you're all working towards one thing, to make sure the client stays at home and that they've got the support that they need. We probably need to employ more people. You look at the whole system and think, are you wasting money in one area, could it be saved in another? But they're looking at it from a high point of view, not from our point of view. We're mixing with people, going to see them in their own homes. People do shout and say what about this and that, but I don't think it's being heard.

Occupational therapist

As occupational therapists we're ideally placed to influence policy, but nobody at a high enough level asks us. I keep saying we must get together and talk it through and if we come up with a plan we can say this is how we think this little area should work. But everybody's got different agendas and we're all at the same level so there's not somebody to say, you might think that but this is what we're going to do.

The structure is very piecemeal. It's very flat, across clinical abilities and everybody owns different little bits. Within this whole structural change we sit here in the Reablement team and it's difficult to see where it would go. We get on well and there's not a lot of point in changing something that works quite well unless it's going to make something else work better. There's no point in us breaking ourselves up if it's just going to add a bit to other teams—it does work quite well.

PERSPECTIVES ON CHANGE IN HEALTH AND SOCIAL CARE

One of the most important policy directions in public services is bringing the focus on the experience and involvement of the service user rather than on the convenient organisation of service provision. There is always a balance to be sought between efficient and effective use of resources, but the emphasis is now on providing what service users need, where and when they need it. Often, a range of different services are needed and this can cause difficulties when they have traditionally been provided by different organisations and agencies. There are many similarities in how services are organised that should facilitate closer working, but Example 6.1 demonstrates that it is not easy to bring services together.

Example 6.1 **Issues in merging services**

I think health and social care merging is a good idea because we're all aiming for the same results. We all have to do health and safety checks. They only do certain moving and handling, we only do certain moving and handling. Why can't they amalgamate the two? We're all working side by side at the moment and we need to get working together. It needs the hierarchy to realise that and to do something about it. It has to come from the top. We do it this way, they do it that way. Maybe culture needs to be changed slightly. It might be 'My way's best' kind of scenario. It may be that it's people like us that need to bring them together, say why don't you try this, this and this? We're the ones actually doing it, seeing it every day, hands on.

One barrier to collaboration between service areas is the difficulty organisations often encounter when they attempt to engage in interagency working, particularly when changes in practice are perceived to have implications for jobs and contracts. These issues are described in Example 6.2.

Example 6.2 **Barriers to interagency working**

It's been a tough battle because it's a threat to some departments. People's perception of the Reablement and Reviewing team is that 'They're going to go in, make people totally independent and then they're not going to need my service any more'. This happens if you've got an agency that's being paid to go in and get someone out of bed, put their breakfast in front of them, wash them. Then, all of a sudden, we go in and teach people how to do this with aids, so we seem a threat. We're not a threat. If we're working with someone who won't be able to be totally independ

ent we'll involve other agencies. It works both ways, we can help them find clients too.

Even when things are working well and a team is able to demonstrate that it has developed good practice, it is not easy to share these ideas in ways that make it possible to reproduce this success elsewhere. As one of the team pointed out, They might say this

works well in this county, maybe we should do exactly the same in this county. But people's cultures might be very different, staffwise. Their views, knowledge and experiences may be very different to the staff in that county. So the system that works very well in one place might not work here.' She went on to suggest that more standardised or national approaches to training might be helpful in enabling the spread of good practice (Example 6.3).

Example 6.3 **Modernising services through staff development**

Could everybody have the same kind of input everywhere, have the same training, same knowledge base? I'm a social care assistant and I've been one for twelve months. There are others that have been social care assistants for twenty years and they may not have had any training for ten of those twenty years. Whereas I've been having training for this twelve months and new systems have been coming in, so I'm quite fresh. They might not have had the training because they don't want to do it—it's not all mandatory, so they may stay at the level they were at ten years ago whereas maybe we should all be moving.

If you're in that position, no matter how old you are, you should be having the same training as everybody else at the same level. You may have had training twenty years ago but standards have changed, the world's changed. People's attitudes towards things have changed. You may think you don't want to know anything else and there are people out there who don't want to train, they just want to do their job. You do need to have some sort of training, though, and you should be made to do it to keep up with legislation and modern times.

This team had strong feelings about the potential for service users to be damaged by some of the approaches taken in traditional health care. This perception is potentially a very strong barrier to collaboration between health and care and is not one that is often openly discussed. The issues are complex because they involve challenges to behaviour and attitudes that people have often thought are humane. At the heart of this issue is the potential conflict between the focus on social empowerment, which is typically one that would be prevalent in social care, and a focus on treating illness, which is typical of traditional health care. For one of this team, the issue was illustrated starkly in different approaches in services for older people (Example 6.4).

Example 6.4 **Writing off older people**

I continually talk about integration with health, although I am not sure I believe in it because of the culture. I saw injustice, selling out, particularly with older people. I felt like we were selling them short. As we do so often, we fit our users into the service, rather than fit the service around our users. I would say that most people would rather go home and take the risk of having a fall, and maybe of dying in six months, than go into a nursing home for six years. It will take away dignity, kill them with kindness. And the user doesn't realise, doesn't make the connection that as long as they sit in the chair and have the nice lady make the tea, soon they won't be able to do it.

I can't bear bullying. I can't bear individuals being so trusting in the professional when the professional really doesn't lay open all the options. Older people are so vulnerable, so believing that what they are told is gospel. I saw the pattern of bullying over time. Watched how their lives can just become nothing. Even those who started off being resistant would often accept eventually that their children want them to be safe. So it was the easy route, the doctors saying there's nothing more for you. But I was able to prove, over a period of time of doing the job, that people who had been written off, sometimes two or three years before, still had something to come back.

Uncomfortable assertions are made in this example. The suggestion that it is commonplace to fit service users into inflexible services rather than ensuring that services are designed to meet the needs of service users. The suggestion that professionals do not always either offer a full range of options to service users or ensure that the users are fully involved in making decisions about their own care. The suggestion that older people may be deprived of quality of life.

Particular issues arise for older people when it appears that they will not be able to be fully independent. The potential for people to learn how to live with less than their former capability is not always fully considered and there is often a tendency to seek the apparent safety of care that provides for physical needs but removes meaningful day-to-day activity. In Example 6.5 members of this team talk about taking risks as something that is part of their practice but not easy to do in services that are publicly accountable.

Example 6.5 **Looking after people**

Although there are now government guidelines saying that we must try to keep people at home, the culture has not changed within many health and care organisations. You still have the culture of 'caring for' within home care context, and you have a huge proportion of social workers and care assessors who still want to look after' and not take risks. I think

our county has one of the highest admission rates to residential care. So you have staff saying they are doing the right thing, and maybe believing they are doing the right thing.

One practical way to determine the best option is to involve service users in considering the options open to them and the potential consequences of choices. Not all service users expect to be involved in decisions about their care. Many have confidence that professionals know best. If service users are feeling worried about how they will be able to continue to live at home with less ability than before, there may be a tendency to opt for the 'safe' option.

There are obligations on professionals to ensure that service users are helped to understand the implications of decisions about treatment and care. In Example 6.6 these ideas are demonstrated in the team's practice.

Example 6.6 **Training service users**

Periodically the therapists will drop in on a client to see how things are going. We need to communicate with them, not just by looking at them, but if they think they're making progress. We have training sessions with them. They might discuss the effects of a stroke, different ways in which people might be affected, their reception might change, organisational skills might go. There are different ways in which they might use the equipment, of course.

There is a wider issue in society about how better understanding of the implications of choices about care can be developed. Service users are increasingly involved in developing services that are responsive to their needs.

PERSPECTIVES ON TEAMWORKING

Team members felt that there were some things about how they worked as a team that helped them to be successful. The processes and procedures that they had developed helped each member to work independently but also kept coherence in the team's approach. Their reporting and record-keeping, with use of client contact sheets, helped them to contribute to provision of individual programmes for each client. Several team members also mentioned the importance of good communications. The day-to-day work was reviewed through regular team meetings, arranged so that people who worked different shifts had opportunities to attend within their working hours. Away days were used for developing longer-term plans, with the whole team involved in considering the team's strengths and weak-nesses and what they might do to improve. There were also arrangements for supervision within the team and for consultation between team members. One team member describes in Example 6.7 how much more quickly individual needs could be met within the team's resources through their good communications and approach to joint working.

Example 6.7 **A team approach to improving service**

I think it's good working in this environment because you've got physiotherapists, you've got the occupational therapist and you've got the care staff. You've got reviewing officers that go out and see people every day and you can ask them for advice, what they've seen, etc. You've got the admin staff there to support you and to find out information if you can't find it for yourself.

So you can pick people's brains. For example, you can say, 'So and so's got a bath board but doesn't know how to use it', and they can go out and help. It saves time. If you're working in different organisations it might take six weeks to get someone to go and show someone how to use a bath board. A lady doesn't want to wait six weeks to learn to use a bath board and it only takes ten minutes to go and show them, but because everyone has their workloads you can't always do it.

Staff in this team each have a specialist role but they also all take responsibility for considering the impact of the team's contribution to the care of an individual. This holistic approach to care can cause tensions for professionals whose training and experience has focused on developing expertise within a particular discipline. The team leader describes in Example 6.8 how she develops her team to be able to take this broader view.

Example 6.8 **Holistic teamworking**

It's about not just looking at their own discipline, but often taking risks with what might be somebody else's discipline. For example, when the occupational therapists or physiotherapists go out to visit somebody, what I expect of their assessment and work is not just about the physical and the practical things specific to their job. It's about not just looking at your specialism. It's leading on your specialism, but it's also about looking at the family dynamics, and how that might impact on what you are doing.

The team leader also felt that one of the most energy-draining aspects of her job was keeping the team's confidence in this interdisciplinary approach, particularly when there were disagreements about ways of working. As she points out in Example 6.9, if these disagreements are not addressed and resolved as interdisciplinary issues, the team would be working collaboratively, to some extent, but not in a fully interdisciplinary way.

Example 6.9 **Keeping an interdisciplinary focus**

That's the bit that takes the most emotional energy, trying to keep them up there believing in what they do while all the politics around them are going on. Keeping them a coherent team. It would be very easy to walk away from a team member who wants to do things differently and say, 'You just get on with it your way and I'll get on with it in mine.' Then, immediately, what you've got is a multidisciplinary team sitting together but working independently. And I would say there's certainly a lot of examples of that around.

Although much of the work went well, there were frustrations in the team. Low staffing levels were perceived to be a problem: 'If you've got low staffing levels, things get missed. Not with the clients, I don't think any of us would do anything with a client if we didn't feel safe doing it. When t's don't get crossed and i's don't get dotted, there's a very grey area.' There is always a risk that controlling and regulating practice will stifle innovation, but in health and care some degree of regulation is important to ensure that service provision conforms to safety guidelines. This team were aware of the need for staff to have back up when they were faced with a situation that they did not feel equipped to deal with adequately. The use of mobile phones and duty staff often provided the necessary cover. There was also mention of working with other community agencies, including pharmacists.

As this team became better established and more experienced Example 6.10 describes how policies and procedures increasingly provided a framework for decision-making and reduced the need for staff to call on the team leader for decisions.

Example 6.10 **Routines and exceptions**

The team leader's split into a million pieces. We all need pieces of her, various bits and bobs—she works very, very hard. She has an open-door policy—we don't have to wait for our meeting with her to raise anything that we're worried about or concerned about. But most of the time now, because we're well established, we can get on with it. Most things have happened before and we have procedures and can just get on with them.

The hard work of the team leader is also seen as an example for other staff to follow. The routine work is shared but she also encourages team members to take responsibility for areas of development. As she explains in Example 6.11, it is important to ensure that train-ing, information and possibly other resources are provided to enable individuals to develop new projects.

Example 6.11 **Individual development responsibilities**

In their review and development I try and give each team member a responsibility and an ownership of something that they want. When they come to me with an idea I will try and encourage them to expand on it and, if appropriate, to actually be responsible for it. It's the same as I hope we do for our users. I try to motivate and enable people to take responsibility and do it themselves. I will give them whatever tools they need, be it formal training, be it time, be it information.

Information-sharing is one of the concerns in the team. Team members mention that the team leader shares information about the wider environment in which the team operate. In Example 6.12, however, a team member expresses frustration at not having easy access to updating in professional issues. In an interdisciplinary team individuals may feel that they have less access through shared practice to knowledge development in their own area of expertise. Some team members mentioned that there is a danger of feeling deskilled. Perhaps this is one of the issues to consider in developing staff within an interdisciplinary environment, particularly once an understanding of holistic ways of working has been established. There is, of course, also a personal responsibility in maintaining an up-to-date knowledge about one's area of practice. In a multidisciplinary team environment it is unlikely that specialist journals would be bought for each disciplinary area but different arrangements might be made for access to libraries and personal subscriptions where appropriate.

Example 6.12 **Updating professional knowledge**

I once had a manager who would go and find out about things. She was busy getting all the information. We had all the journals, British and American occupational therapy journals. She was always well up with what worked, the outcomes. It's about having your finger on the pulse, having the interest and the drive and the information you need because you can't change anything unless you have the information.

Performance management in interdisciplinary teams can also be an issue if staff are used to being supervised by someone with a similar professional background. In Example 6.13 the focus of performance reviews seems to be on the role of the individual and their contribution to teamworking. There appears also to be an opportunity for individuals to identify areas of personal development.

Example 6.13 **Performance reviews**

We have our performance reviews, she's always very supportive, very positive. I would imagine that unless we were really awful at our jobs she would emphasise the good. Then focus on the weak bits and look at what to work on. She asks what do we find negative and how do we want to work on it. Then at the next performance review will ask how we're getting on with so and so.

The team leader's view of how she supports the team puts emphasis on how she reduces the pressures on them. But there is a danger, which she acknowledges in Example 6.14, that this approach has the potential to increase pressure on herself.

Example 6.14 **Who carries the baggage?**

I am not sure whether it would be seen as a good management tool, but I actually make time for everybody, both to do with their profession but also to do with them as individuals and their personal issues. I listen to them. I listen to them when they want to come in and offload, because by offloading they can then go on and do a good job, because they are not carrying baggage around. That often doesn't bode well for me, but that's how I think they've kept together for seven years.

PERSPECTIVES ON LEADERSHIP

Several of the team associated leadership with appointment to a post, but commented that there was more involved. Several mentioned the importance of interpersonal skills and showing respect for others. There were comments about how differences in the team were addressed and how a leader might get the best out of the team. In Example 6.15 there is a description of a leadership approach that maintains a warm atmosphere but does not avoid confronting problem areas when improvement is needed.

Example 6.15 **The best example of leadership I've seen**

My last boss had very good leadership skills, very professional. She's very down to earth, doesn't think that she's something that she isn't. She is very warming. You could say that people might take advantage of that, but she has spoken to people and asks, 'Why are you doing it like this?' She looks at all aspects, doesn't just take on board what one person says, looks at it as a whole. I think that probably comes from her social work training. As a social worker you have to look at everything as a whole picture.

One of the team described these skills as 'personal skills rather than about the professional ones we learn or gain'.

Another important issue for this team was that a leader should give protection. Support was frequently mentioned and this team leader was noted as being approachable and having an open door. One said that 'the buck stops' with the team leader, who said herself, 'What's really important is to support those people and make them feel secure.' The need for a sense of security is often most necessary in times of change. In health and care services frequent change can be very disruptive. Example 6.16 outlines some of the dangers and how this leader created conditions that enabled staff to make a positive contribution.

Example 6.16 **Leading culture change**

She has put things in place. At one time she felt there was a lack of communication—she said she didn't want people to be talking about something that, if she knew about it too, she could help to put right. So the two longest-serving assistants started coming to the weekly team meetings and drew up a list of what needed looking at. It was very responsive. It was a time of upheaval and everyone was feeling a bit funny. We'd had a major change and people don't like change. It could have very easily have descended into a sniping session. She said that she realised that people are apprehensive but if you have anything personal to say about anyone or anything, say it to me. She was firm that she wouldn't allow any negative input, not voiced in a public meeting. It made a safe framework to work in. She's quite emphatic that if someone asks someone else a question it should be honoured and answered properly.

A good leader was seen as being able to involve staff in thinking creatively about the ways in which the team worked. This involved both making time to meet and discuss work together but also the 'safe framework' that enabled individuals to take decisions themselves and sometimes to take calculated risks.

If staff are to feel confident in making decisions that might contain an element of risk, the way in which these staff are supervised and given feedback has to contribute to their development. In Example 6.17 one of the team explains how she felt in performance reviews carried out by two different supervisors with very different styles.

Example 6.17 **Leading performance improvement**

We have our performance reviews, she's always very supportive, very positive. I would imagine that unless we were really awful at our jobs she would emphasise the good. Then focus on the weak bits and look at what to work on. She asks what do we find negative and how do we want to work on it. Then at the next performance review will ask how we're getting on with so and so.

I have worked in an environment in a residential setting where the manager wasn't a very good leader. Not very professional. Confidence in that leader was zilch. When you had a supervision session you knew that the supervision would be talked about to other members of staff, which obviously caused animosity between staff groups. You don't feel confidence in managing your own workload or leadership of staff groups because that leader might not be giving you the right vibes or encouragement because they can't lead other people. Even if you've done something yourself and think, 'Gosh, I shouldn't have done that', a good leader points out all of the positive things that you did do if you're in that situation and then says, 'Well let's have a look at where you felt you did go wrong.' Whereas a bad leader says, 'You shouldn't have done it like that and now I'm going to have to put it right.'

Another aspect of leadership is to make sure that people are given the opportunity to learn skills to carry out new aspects of work, as in Example 6.18.

Example 6.18 **A good leader**

It was somebody I worked with when I was younger. We were setting up a new department and they got this whizz kid from outside and he was excellent. He was dynamic, he set us up but at the same time he wasn't heavy handed. He set the system up then let us do the job ourselves. When you consider that none of us had ever done that, used these computers, he was there but he wasn't standing over your shoulder. He had a sense of humour, invaluable.

When considering what makes a good leader, one of the team said that 'it's about what they do, what they stand for'. In this team, the team leader explained why she took the lead in establishing the service. She spoke with passion about decisions and actions that she felt not only ignored the views of elderly people but which brought pressure on them to comply with choices that were not in their best interests. This team face complex options that involve making choices between risk and safety all the time. The emphasis that they place on having the support of the team leader reflects the context of this type of work. There are, however, dangers for the leader who invests so much in supporting others if this drains their own personal resources. These dangers are magnified when the leader's emotional commitment to the area of work encourages them to overwork.

Someone who was leading professionals in an innovative service that worked with vulnerable people explained what happened to him in Example 6.19.

Example 6.19 **Emotional drain: management and leadership conflict**

Three years ago I reached the point of working to live rather than living to work. I did have a breakdown. The management recognised its role in that and I have had really good therapy support since that time. I think it's because they've forgotten. They said take the time it needs. I have the most superb therapist. It's one of the best things that happened because it stopped me dead in my tracks.

I found I could not control what emotion I was in at any one time. I was starting to show inappropriate emotion. Not anger, but I found it difficult to sit in a meeting. From having been a fairly outgoing person I started finding it hard standing in front of people. And that's about management not protecting us.

When I broke, I said enough's enough. There was restructure. I'm not sure you will ever get support from management because management has a different agenda. Yet I straddle that myself, the role between leader and manager. It's such a tough act. You still have to come up with whatever management want, and the price is high sometimes. The crucial thing is having support. Being able to pick the phone up and offload so you can go home and have a normal life.

This team raises issues about what professionalism means in health and care. One of the team said of a health professional, 'she would probably have difficulty in respect, because I suspect she would see it as a threat allowing people to be equal.' These services need expertise and professionalism but the modernisation agenda challenges professional attitudes that might claim to know best because of their expertise and insists on involvement of service users in making decisions. The emphasis on interprofessional and interdisciplinary working also challenges the notion that any one profession has a sufficiently complete view of a situation to be able to make well enough informed recommendations. In services that are intended to promote social inclusion, leaders must be able to embrace inclusiveness and equality of people, whatever their roles in health and care settings.

Motivation was another common theme in this team. Most spoke enthusiastically about their work and one commented that staff turnover was very low. Public services and, in particular, health and care services, attract staff who have a 'service ethic'. Example 6.20 explains what that meant to some staff who worked in an environment that they had joined thinking it to be a service but which became driven by productivity targets.

Example 6.20 **Motivation for working in a service**

I worked once in a bank and the girl who managed there had read all the books, believed it all, but it was gobbledegook. She couldn't understand that we didn't want pay rises and

promotion, we just wanted to go in and do the business. But they had targets, you've got to serve so many people per hour, you've got to sell so many products per number of hours in the week. None of us did any of that, because we just couldn't be bothered. Our age group thought that banking should be a service but they saw it as selling products.

There were some features of this team that encouraged people to take a lead. One person commented that leaders needed personal confidence and skills and a sufficient knowledge base and experience. She considered this to be a mix of personal make up and things that could be learnt. Another considered that having appropriate knowledge was a duty: 'I think knowledge is very important. You've got to know what you're talking about and if you're not sure you need to find out. It's your role to find out and to support staff accordingly.' Training and development was seen as having a role in leadership development.

There were also features that facilitated shared leadership and enabled those not in an appointed leading role to take the lead over some areas of work. Everyone in the team was seen as needing to have an equal input into the decision-making arrangements. Individuals took the lead frequently because of the way that the team worked within predetermined agreements and frameworks for decision-making. Example 6.21 describes how different people took the lead for different things.

Example 6.21 **Shared leadership**

I think we're all leaders in our own departments. One is the leader of the rotas, the cover for the week for reablement staff. Another is a physiotherapist, a locum. The reviewing officers have their own workload on appointments and organising the work. I have my own workload, make appointments and go out and do visits. The team leader is aware that people are out and about but she expects us to take on our own workload and manage that, but if there is an issue or there are problems or concerns, or if we need advice, then she's there for that. So we have to take leadership. But we talk to each other if there are any concerns, ask each other about progress, how it's going—everyone interlinks.

In this team, the barriers that were experienced in taking a lead were closely related to the nature of the work. Several mentioned the strength of belief in the work of the team as being both motivating and, potentially, problematic if there were different views about either what should be done or how it should be done. Much of the work involved negotiation and sharing of information to ensure that service users and carers were well enough informed to make choices and engage fully in decision-making. In some cases, the focus that members of the team had on working with the service users could raise difficulties at the organisational level if it challenged the ways in which partner service providers contributed to the same area of work.

In discussing what was expected of leaders, members of this team were very aware of the political and interagency dynamics in which this service operates. Although government policies encourage increasing provision of care in the community, the practices of many of the collaborating agencies, including voluntary or private sector

bodies, has not necessarily changed to reflect what is currently regarded as good practice in public services. In a team with this diversity it would be difficult for a leader to develop a sense of community of practice in which processes and practices could be openly reviewed and revised. The contracting processes that are required to operate in multiagency environments tend to set out agreements about levels and processes of service provision that are difficult to change. The most difficult issues, however, would usually arise if individuals felt that their practice was being criticised or challenged.

Example 6.22 suggests that a leader needs to have vision and give direction for developments and to be able to explain clearly why the team works in ways that may be unfamiliar or unconventional.

Example 6.22 **Leading vision and direction**

She has to be all-sighted. To see that this team is working alright now, in the confines of what is happening everywhere else in England. In general, looking at where this team is going to be in twelve months' time. She is actively seeking to promote us. We've always been slightly experimental and she is deeply committed to what we do. She's also deeply committed to the people she works with and wants to move us forward into what social services and healthcare will be doing in future. She gets herself actively involved in that in order for people to see what we do.

In a team in which individuals have so much autonomy we might expect there to be difficulties over balancing personal responsibility with sharing and mutuality. The team leader said that she always supports and protects staff. For members of her staff, the frameworks within which they operate usually provide guidance. For another, the social life of the team played an important part as described in Example 6.23.

Example 6.23 **Making shared leadership work**

How do we manage all leading? You need a good sense of humour, patience, a good knowledge of everybody's role—you've got to understand what an admin assistant needs to do, what a care assistant is supposed to do, what a reviewing officer does. You need to have a good understanding of people's positions, a good understanding of people's experiences. I might have weaknesses in one area and others might pick that up, but we need good humour and support. We gain that understanding through communication, through supervision, general chit-chat and spending time with each other in various ways.

Leadership is the person responsible for co-ordinating. Leadership is about the personal skills rather than about the professional ones we learn or gain. It's about the individual. We are so reliant on good will, on nurturing creativity, so that if you stunt somebody by being overpowering, dictatorial, you just stunt their creativity.

LEARNING FROM THIS CASE STUDY

Members of the Reablement team share a philosophy of holistic care and service user involvement. These approaches are aligned with legislation and policy developments. The team, however, describe a range of barriers involved to more integrated ways of working with other agencies and organisations. They see themselves as trail blazers and describe the difficulties of sustaining and promoting their views and ways of working across these.

Implementing a more shared approach to service provision relies on effective interprofessional working The team works at maintaining an interdisciplinary focus amongst themselves. Balancing mutuality and individual responsibility, shared leadership and individual leadership is key to this kind of working. Examples 6.8 and 6.9 discuss some issues related to keeping this balance.

Read the descriptions by each team member about how the team works and discuss with examples:

- Who took the lead, when, why, and over which issues?
- How did the team do it and how did this link to their 'expert' background and role in the team?
- How did leadership work in this teamworking context?
- Can you apply any of the comments in these accounts to your own situation?

What are the strengths of this team? How do they differ from those in your own team? Are there any in this team that you might develop in your own team? What are the weaknesses of this team? How could they overcome them? How might these ways of improving effectiveness work in your own team?

In considering your responses to these questions, you may find it helpful to refer to Part 3, especially the sections on new forms of leadership and maintaining a team.

PART 3
THEORY AND PRACTICE

You have heard multiple voices giving perspectives on leadership, teamworking and change in the context of interprofessional teams. In applying a range of theoretical models to the case studies, this section draws together themes, key learning points, and potential applications that have emerged from practice.

The current climate is one that challenges each person involved in health and social care to develop a more inclusive and sustainable culture in which service users have ready access to seamless service and a coherent package of care. This challenge involves change, both large and small scale, in asking each person to take increased leadership responsibility and to work more effectively interprofessionally. Change is, in many ways, both the backdrop to and a focus of current practice.

CHAPTER 7
THEORY AND PRACTICE IN EXPERIENCE OF CHANGE

Studies of change initiatives in organisations have resulted in a number of models that attempt to answer the following questions:

- How can we understand complexity, interdependence and fragmentation?
- Why do we need to change?
- Who and what can change?
- How can we make change happen?

(Adapted from Iles and Sutherland, 2001, p. 22)

These questions can help practitioners to organise their thinking and action. We will follow them through in this chapter, focusing on complexity, interdependence and fragmentation.

The teams we interviewed were both producers and products of change. Many teams were created in response to top-down change, their formation directed by legislation and policy. At the same time, the teams also initiated change from the bottom up, change that had impact on their internal functioning and the external environment of colleagues and service users. Whether change comes from the bottom up or from the top down will have implications on how it is accepted. Team members operated on several levels at the same time. Reminiscent of Russian stacking dolls, they were members of teams within teams. They identified with their professional groups, and they had allegiances to their teams. There were time and resource constraints, tensions and controversy about models of care. Change efforts often spotlight traditional organisational dilemmas such as autonomy versus control, innovation versus 'no surprises', participation and ownership versus timely delivery and job security versus role changes. Juggling these complexities can be exhausting, frustrating and problematic. Some teams described the use of process-mapping techniques to help them to identify potential improvements in services. These techniques can demonstrate where tensions or limited capacity cause blockages in the flow of activities and can help teams to sort out dilemmas and find a way through the dynamic relationships. (If you would like to find out more about these mapping processes, consult Martin, 2003, pp. 112–119.)

WHY CHANGE?

The impetus for change often comes because the people involved have a vision. They can see how things could be improved and are committed to making things happen. Change is a process and involves:

- becoming aware;
- developing a vision;
- developing direction;
- inspiring action;
- reviewing, revising and reflection.

Handling change takes thought, emotional energy and practical action. Change often requires people to think about things in a different way as well as to do things in a different way. Learning is at the heart of change.

While all of us have experiences of learning, not everyone thinks or feels about learning in the same way. Learning involves letting go of the familiar and stepping into the unknown. For some, the journey into the unknown is an opportunity, an invitation to an exciting journey of discovery. In some of the case studies change was seen as opportunity, a reflective learning approach, which in many ways mirrors the change process itself and seemed to offer an important key to effective functioning. It was apparent that individuals and teams were using a process resembling Kolb and Fry's (1975) experiential learning cycle. Figure 7.1 demonstrates how learning moves through five stages.

The Assertive Outreach Team leader described how the team used just such a process in the early stages of developing their service when they were faced with situations of considerable risk and the need to develop new procedures. The Virtual Multidisciplinary Team had to consider a new 'etiquette' of meetings for video conferencing. Many staff in the case studies treated change as opportunity by:

- *Becoming aware of experience.* For example, when a nurse describes becoming aware that they 'were supposed to be humble' and their dissatisfaction with that realisation. This awareness in itself was a different way of seeing, a learning that opened the doors to new ways of doing.
- *Finding out more* by gaining experience, talking, reading and observing role models. Nurses talked about how they gained in confidence as a result of gaining experience and that experience

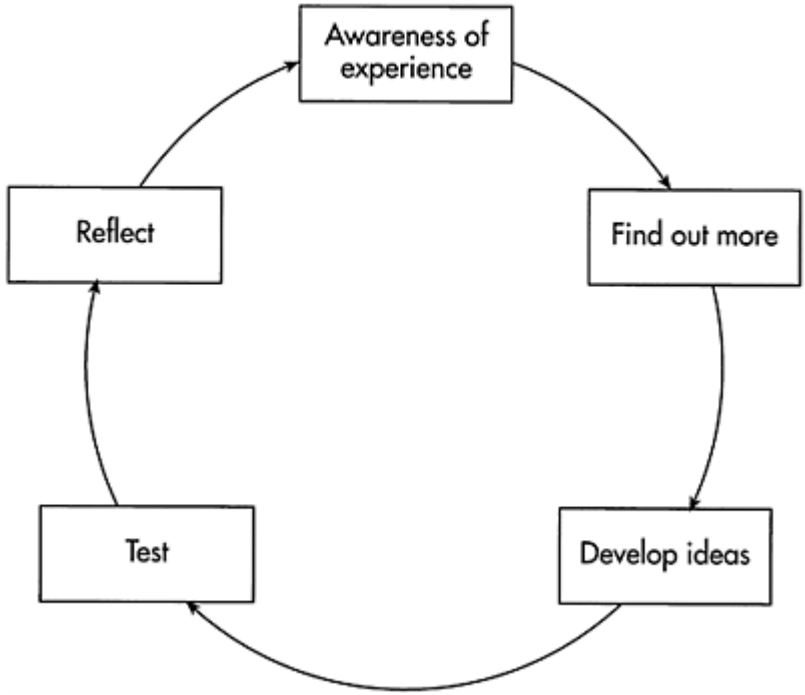

Figure 7.1. An experiential learning cycle.

often included discussion with peers, widening their circle of contacts and information.

- *Developing ideas* about the need for innovation in services and facilities, as well as new ideas about how they could participate and, indeed, catalyse innovation, as the Macmillan nurse on the Virtual Team described.
- *Testing.* In the Macmillan nurse's account, testing included drawing up a business plan and seeking resources to implement ideas.
- *Reflecting* on what went well and what they might have done differently as the members of the Assertive Outreach team describe.

The reflective learning process is not only an important tool in moving through a change process, but it also signifies a fundamental mind set, one of experimentation and hope. One Trust chief executive encouraged this experimentation and learning mindset when he said, 'Don't come to me for permission. Come to me for forgiveness.' The learning cycle approach encouraged team members to be on the look out for why change might be needed, while, at the same time, providing a framework for how change can happen.

WHO AND WHAT IS CHANGING?

The variety and the extent of change facing interprofessional teams magnifies the complexity of an already complex environment.

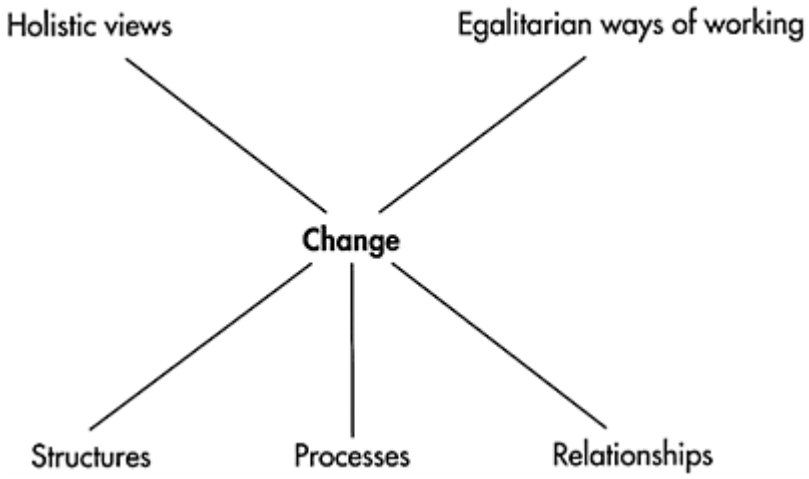

Figure 7.2. What is changing?

Clustering these changes, forming patterns, can bring an increased sense of control and meaning as the diagram in Figure 7.2 illustrates.

Two philosophical changes seem to be taking hold. The first of these is a move toward an increasingly holistic view of the service user and the need to adapt services to accommodate this view. The second change, which is separate but inevitably related, is the move from traditional, hierarchical ways of working to more egalitarian approaches. These philosophical 'shifts' have implications for structures, processes and relationships.

The formalising of interprofessional teamworking is a response to a servicewide commitment to a more holistic view of the service user. More egalitarian ways of working require that all voices be heard. These shifts have implications for decision-making processes, chains of accountability, access to and use of resources, roles and tasks expected from team members. Team leaders manage budgets as in the Assertive Outreach Team, consultants share decision-making as in the Virtual Multidisciplinary Team, and project managers become facilitators as in the Cancer Collaborative Network.

A systems model of change (see Figure 7.3) helps in understanding the dynamics of continuous and wide-ranging service change. Services are essentially processes that involve some sort of transformation. Once people have received a service they are, in some way, different. The systems model helps us to consider what resources and conditions contribute to enabling the transformation to take place, what activities and processes actually take place to cause the transformation and what outputs result. (For further reading, consult Martin, 2003, pp. 106–109.)

With so much change, it can be difficult to recognise the terrain. But many features of the terrain remain the same, serving as points of orientation. They are markers for taking stock of what remains

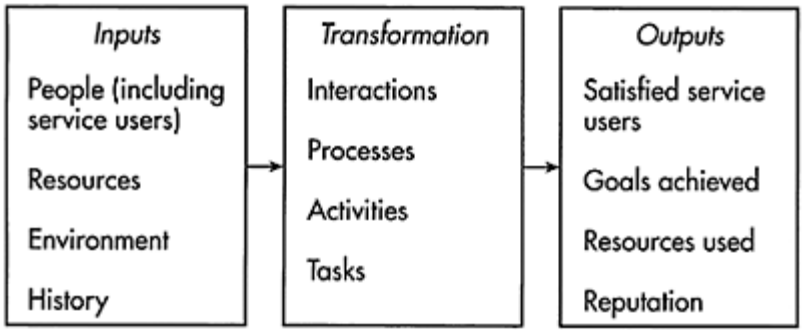

Figure 7.3. A systems model of service change.

the same and what is in the process of changing. In many of these case studies there are examples of change being introduced alongside existing services rather than as an immediate replacement for these services. Peter Senge *et al.* (1999) used the term 'balancing processes' and pointed out that these can sometimes look like resistance to change. Balancing processes play a role in conservation and it is important to pay attention to what is being conserved. Processes that conserve financial cash balances, adequate service capacity or technological know how are good examples. He suggests that many change strategies for developing learning organisations also rely on conservation of personal purpose, honesty and quality of relationships.

The Virtual Multidisciplinary Team offers an example not only of who and what is changing but *how change happens*. In Figure 7.4 this is set out as a systems model.

Systems, processes, tasks, roles and responsibilities are all subject to change. People, however, and the people involved in the change process, remain the pivot around which change efforts will succeed or fail. Not everyone will be fully committed to change, but a critical mass should be enough for a change to succeed (Senge, 1990). Some people will be more significant than others in influencing attitudes. It may be important to determine what level of support is actually needed from individuals and groups to develop a critical mass. Making connections between key people often creates a contagious excitement which can also increase commitment to innovation and change (Smale, 1996). Those who are fully committed or who readily comply with what is asked will take action whereas those who are not prepared to comply will actively oppose change. There may also be people who are apathetic about the proposed change but will comply sufficiently to retain their position in the setting.

Gleicher (1986) developed a pseudo-mathematical equation that sets out the

conditions for successful change. The model begins to address the importance of considering the individual costs and

INPUTS	
■ People—includes service users and various staff involved in service provision with varying attitudes, needs and abilities.	
■ Resources—includes access to various new technologies such as video conferencing with tertiary centres. Other resources include grants to support the development of technology, space and time.	
■ Environment—includes the particular features of the local community such as its rural nature, its isolation and its prominence as the only acute care provider in the region. Consideration of the wider environment includes the technical, economic and political climate.	
■ History—many of the team members have worked together for several years. This is a small community and providers are also service users.	
TRANSFORMATION	
Interactions Processes Activities Tasks	At the simplest level, the formalised process insists that all team members meet every two weeks to consider treatment of every patient. While views vary about the meetings, most agree that it is a time-consuming process, requiring preparation and development of a new etiquette. The process has encouraged shared decision-making, challenged practice and increased visibility of team members to each other.
OUTPUTS	
Satisfied service users Goals achieved Resources used Reputation	The transformation that has taken place has created a new way of working. A somewhat simplified view is that treatment of the individual patient is more widely informed. A greater range of treatment options may be considered. The outcome is increased quality of life for service users.

Figure 7.4 A systems model of the service provided by the Virtual Multidisciplinary Team

benefits in any change that are key to understanding the levels of enrolment, commitment and compliance to the first step of any change effort:

if A=the individual's or group's level of dissatisfaction with things as they are now;
and B=the individual's or group's shared vision of a better future;
and C=the existence of an acceptable first step;
and D=the costs to the individual or group;
then change is unlikely unless A+B+C is greater than D.

This proposal signals again the importance of ensuring that enough of the people involved see how they might achieve an improvement.

THE EMOTIONAL SIDE OF CHANGE

People in the case studies gave a range of responses to change. The leaders in both the Assertive Outreach team and the Reablement team talked about the dissatisfaction they had experienced personally with the way services had been provided prior to the formation of their teams. Taking advantage of changes 'in the air', including new policies and new funding arrangements, they created and led their teams, motivated by their dissatisfaction with the status quo and in accordance with a vision for a better future. Significantly, they recruited like-minded people to these teams, making a shared vision and collective action more likely. These teams deal with change in a coherent, cohesive manner.

In contrast, the Virtual team appears less cohesive, possibly because there has been less emphasis on developing a shared vision. Most significantly, membership on the team and the costs to some members of the team in status, power, command of resources and decision-making is greater than for others.

Bridges (1988) makes a helpful distinction between change and transition. Change is situational and external such as in a restructuring or a merge of services. Transition is an internal, psychological process that people go through to come to terms with a new situation. He developed a three-staged model that accounts for the often surprising, difficult and paradoxical emotions that many people experience while going through change. Transition always begins with the first stage, 'endings', a time of loss as well as opportunity. No matter how welcome a change might be, it will be necessary to let go of important aspects of the past. Transitions do not leap from endings to new beginnings but move through a 'neutral zone', an inbetween time of confusion and disorientation, a disconnection from both the past and the present, sometimes without a clear and concrete vision or plan for the future. An example is moving house to a new neighbourhood. There may be a lot of excitement about being in a new place, closer to work perhaps or family. But a visit to the new supermarket may suddenly bring about a sense of disorientation, confusion, possibly sadness and a few tears. There is a sudden desire to 'go back'. The final phase brings new beginnings and means establishing new priorities, new activities, new ways of doing things.

Because of the links between change and loss, change involves bereavement. People involved in transition and change can feel over-whelmed. They may be mourning loss of belonging, loss of power, loss of familiar service models and loss of long-lived philosophies of care. We often identify with the circumstances of our lives, roles and responsibilities, those we like and those we do not. In the work of health and social care, many bring a profound sense of vocation, investing a lifelong passion and commitment. Change can threaten a sense of meaning and purpose and the very core of identity. Interprofessional teams are caught in a vortex of change and some members suffer in the face of paradox—there is both loss and gain to most change. Helping people to articulate their sense of loss and confusion, and to make explicit their personal and organisational gains, can encourage a movement toward exploration and commitment.

In practice, there are a number of actions that can assist the transition process.

Effective endings

Expressing open appreciation, celebrating past accomplishments, bringing people together to acknowledge loss, fear and anticipation of the future can help negotiate effective endings.

Handling the neutral zone

The visibility of leaders and managers, who provide empathy and reassurance is especially important during this time. Providing updated information gathering views from multiple sources can decrease the sense of disconnection characteristic of this stage.

Supporting new beginnings

New beginnings can be fragile and champions who provide encouragement, resources, support and linkages to information, networks and the wider context will help strengthen and consolidate new beginnings. In exploring perspectives on leadership with the teams in the case studies, leaders were reported to have nurtured the change process in the following ways:

- Attended to staff needs and the philosophy of the service early in the process. Consulted with staff involved to ensure that goals were shared and targets realistic.
- Placed staff support and supervision high on the agenda. Set priorities and stuck to them.
- Created ongoing mechanisms, such as formal and informal monitoring systems, to ensure continuous dialogue.
- Continually clarified roles and responsibilities and offered suitable rewards and a range of options.
- Provided clear information about new career structures, future career prospects and access to training and development.
- Took time during change to acknowledge personal reactions.
- Focused on progress that had been made and celebrated achievements.

Many of the leaders also commented on the need for personal support themselves.

LEADERSHIP, MANAGEMENT AND CHANGE

Leadership and change exist in a dynamic relationship with each other. Change is one of the cornerstones of leadership, and often it is the role of achieving change that distinguishes management from leadership. A number of people in the case studies describe the differences between management and leadership. While some preferred to see themselves as leaders rather than managers, they acknowledged the need to do both. Zaleznik (1993) suggested that managers and leaders are fundamentally different in personality. He proposed that leaders tolerate, indeed create, chaos, foster disruption, can live with a lack of structure and closure, and are actually on the look out for change. In his view, managers seek order and control through established processes, procedures and

routines. They are interested in achieving closure on problems as quickly as possible. Leadership is characterised by change, while management is characterised by stability.

How leaders handle change will determine its success or failure. In the day-to-day reality of work in health and social care, it is important to discern when to lead and when to manage and to be able to balance the two. In the Assertive Outreach team and the Virtual Multidisciplinary team we saw leaders facing pressure from team members to 'take decisions', to act as a manager in attending to the process and procedural details. This suggests that balancing leadership and management is an important challenge.

The commitment to improving services requires large- and smaller-scale change, and a distribution of leadership to all levels. Systemwide change requires a strategic view of leadership, while change at a team level might require more operational leadership, with small, incremental clinical and service changes. The need to develop awareness of the context seems to be common to all forms and levels of leadership. Many external factors will drive service change, include policy and legislation, social and technological change. An important aspect of leadership is the ability to look ahead, 'scan' the environment and forecast issues and influences your team will face.

The Outpatient Referral team offered keen perspectives on the context of their particular service change. A STEEP analysis is a useful tool for organising the complex information that this team presented about external influences driving change. STEEP stands for the different types of influence:

S	Sociological
T	Technological
E	Economic
E	Environmental
P	Political

To carry out a STEEP analysis, you consider the current and anticipated influences in each of these categories, and note the potential impact on your organisation or service. Figure 7.5 sets out how a STEEP analysis might look for the Outpatient Referral team.

Figure 7.5 STEEP analysis of the context of the Outpatient Referral team.

Sociological factors

Demographic, lifestyle factors, changes in patterns of work and consumption, have a profound influence upon the needs of the community and the expectations of individuals for service provision. With increased availability of medical information and an emphasis on patient choice, the outpatient referral group identified changing expectations, particularly in higher socio-economic levels of the population about access to referrals and levels of care. The area has a rapidly increasing population of older people and an exodus of younger people.

Technological factors

Technology is transforming referral patterns. With greater access to information, patients can participate knowledgeably in selecting their care. In addition, technology is enabling GPs to access wait lists directly and in some cases to refer directly. This can streamline things for the patient, decrease the uncertainty, allowing more control over planning their lives. On the other hand, some consultants are unhappy with the move to central wait lists and the perceived loss of control.

Greater access and skilful use of innovative technologies may mean alternative treatments to surgery are possible. This means that referrals may move from a local provider to one a considerable distance away.

Economic factors

Broad economic factors include prosperity of the country and the local area, levels of poverty, inflation, and relationships with other countries including exchange rates that influence import, export and travel possibilities.

This is a very poor region of the country, qualifying for European Union Objective One status. It is an agricultural region and there is little industry. Unemployment is low and so are salaries. The region has difficulty recruiting highly skilled service providers. This has an impact not only on direct service but on the infrastructures and the ability to work in partnership with other agencies. Although one of the group referred to the population as ‘iconoclastic’, willing to move where the service is located, it is most unlikely that members of this population could take advantage of hip replacement surgery in France or other parts of Europe.

Environmental factors

Remoteness and poor transportation is the most significant feature of this environment. While the population is one of the healthiest in the country, possibly due to a pristine natural environment, distances make access to services, when necessary,

very problematic.

Political factors

Many of the changes occurring in health and social care are the result of legislation.

Legislation is translated into improved service quality through systems that set standards, regulate staff, professions, health and safety.

Government has introduced league tables, in terms of wait times and outcomes. Although the interpretation of outcomes is complicated, these league tables can influence patient expectations. Acute care centres have to meet standards regarding the scope and level of service offered and the proposed cardiology unit in the local acute care centre is response to the standard requirement.

The STEEP framework is a useful structure for building an awareness of context and the factors that may have an impact on your service. Leaders synthesise and make meaning of the information, sowing the seeds of a vision for the future.

CHAPTER 8
A FRAMEWORK FOR UNDERSTANDING LEADERSHIP

Leadership is also about developing an awareness of oneself in context and how one might actively participate in moving the vision forward. While the interprofessional teams in the case studies offered multiple perspectives on leadership, there are some common themes. The work of Hartley and Allison (2000), who looked at the role of leadership in modernisation and improvement of public service, helps to identify those themes or elements of leadership, persons, positions and processes. Studies and observations of leadership have often focused on the characteristics, behaviours, skills and styles of leaders as *persons*. Individuals play key roles in shaping circumstances. The *position* of the leader may be important in giving authority. Equally, a person without a formal position of authority may be a leader because others perceive them as influential. Leadership also involves a set of *processes* that occurs among and between individuals, groups and organisations. These processes provide vehicles for motivating and influencing others in partnership working, working across organisational boundaries to find solutions together. We add a fourth P to this set of themes—*purpose*. Purpose is the reason for doing things and involves underlying values. Setting a vision and determining a strategy contribute to actualising these values. Purpose is related to the primary task of individual organisations. However, when groups, teams or agencies collaborate, the purpose of the joint programme is more encompassing (adapted from Rogers and Reynolds, 2003, p. 58).

BEING AND DOING AND BECOMING A LEADER

The Leadership Qualities Framework developed by the NHS Leadership Centre and their various leadership development programmes place a great deal of emphasis on developing the person. However, they go much further. They seek to develop an awareness of the larger context and ways and means of working with trans-boundary processes. Leadership development involves developing the capacity to articulate important values and to align leadership with them. The increasing emphasis on teamwork requires flexibility as we expect people to play a variety of roles in a team including, from time to time, a leading role. Health and social care recruits well qualified, competent staff and it makes sense to enable staff to work to their full potential. This includes the opportunity to make judgements and participate in decision-making at local levels. Although many staff are well informed within their professional area of work, working on interprofessional teams and across boundaries requires a greater understanding of the larger context and the capacity to listen and learn from each other.

Team members in the case studies talked about their experiences of good leaders and identified some of the characteristics and competencies they particularly value in leaders. These included qualities such as enthusiasm, availability, support and respect. This sort of emphasis fits into traditional models of leadership as outlined in Figure 8.1.

Figure 8.1 Traditional models of leadership.

Trait theories

Historical perspectives on leadership took the view that leaders were born into the role. This 'great man' theory assumed people to be leaders because of lineage, or heroic deeds. Early in the twentieth century, studies attempted to discover what 'traits' successful leaders had in common and although there was no consensus on a range of attributes, emphasis was placed on the selection of leaders rather than on development. Adair discussed trait theory as including a need to have a distinct personality and proposed that an important aspect of this would be integrity. He described integrity as 'wholeness', 'the type of person who adheres to some code of moral, artistic or other values' (Adair, 1983, p. 12). Studies found that the situation in which a leader was operating was also very important and that successful leaders often needed to balance one trait against another to accommodate the issues in the situation (van Maurik, 2001, pp. 4–6). Although people became sceptical about a pure trait approach, because of implications about innate superiority, the focus on characteristics and qualities remains a part of contemporary perceptions of leadership.

Behavioural theories

Later in the twentieth century, behavioural theory, which includes some learning theory, influenced our approach to leadership. Studies attempted to identify the behaviours of successful leaders in order then to teach and develop these behaviours in potential leaders. Behavioural theories are based on the idea that leadership is largely a matter of learning to display appropriate behaviour. Tannenbaum and Schmidt (1958) suggested that a person could choose a leadership style from a continuum that ranged from 'manager-centred' leadership through to 'subordinate-centred' leadership. This continuum demonstrates the tension between use of authority by a manager and the freedom of action allowed to subordinates.

Contingency theories

Contingency theories are variations on behavioural theories and suggest that leaders can and should adjust their behaviours or 'style' to the circumstances. These were developed in response to the failure of behavioural theories to acknowledge important differences in situations.

Fiedler (1967) suggested that a leader's style, whether task oriented or people oriented, should be 'contingent' upon the situation. He found that a situation is

very favourable to the leader if:

- The leader is liked and trusted by group members.
- The task is clearly defined and well structured.
- The leader has the power to reward and punish.

Furthermore, he suggested that it was easier for the leader to change the situation rather than to change his or her style. Blanchard *et al.* (1986) disagreed and proposed that effective leaders change their styles in accordance with situational demands. The Situational Approach developed by Blanchard *et al.* (1986) is still one of the most widely used approaches in training and development of leaders today.

Most of us are more comfortable with some styles than others. Figure 8.2 draws upon an application for organisational settings of the Myers-Briggs Type Indicator of personality preferences. The full version lists sixteen types of personality preferences. The list in

Figure 8.2 Raising awareness of different personal styles.

- You are most comfortable **conforming** to established policies, rules and schedules and you take pride in your patient, thorough, reliable style.
- You are most comfortable **responding** immediately to problems and you take pride in your open and flexible style.
- You are most comfortable when **communicating** organisational norms, values and making decisions by participation and you take pride in your personal, insightful style.
- You are most comfortable **building** new systems, frameworks and pilots, and you take pride in your ingenuity and logical, analytical style.

(*Source:* Adapted from Hirsch and Kummerow, 1987)

Figure 8.2 is therefore not a comprehensive summary, but one you can use as a tool to focus your awareness on the particular strengths you bring to your leadership roles.

The checklist in Figure 8.2 moves from a more ‘managerial’ style, through an adaptable and communicative style, to one that favours visionary, creative and analytical styles. While they are not mutually exclusive, you may find it useful to apply the checklist to your reading and analysis of the case studies to ‘detect’ various leadership styles team members described and to make your own decisions about how adaptable leadership style may be.

Often people achieve positions of ‘formal’ authority because they have developed competencies and capacities to lead and to manage. However, many people without formal position exercise ‘informal’ authority through these same qualities and competencies.

THE ROLE OF EMOTIONAL INTELLIGENCE

We have already heard described in the case studies the high emotion that often accompanies work in health and social care. Martin noted the need for leaders to be able to deal effectively with our own emotions and those of others:

> …as leadership often involves being passionate and demonstrating both anger and frustration about making a difference, leaders are in particular need of this range of competencies.
>
> (Martin, 2003, p. 64)

Goleman (1996) highlights the key role of emotion in all human interaction. His concept 'Emotional Intelligence' is a type of social intelligence that involves the ability to monitor one's own and others' emotions and to make use of the information to guide actions. Emotional Intelligence means developing competence in:

- Self-awareness—insight into our own thoughts and feelings, how they interact with our communication and behaviours and how these impact others.
- Self-management—involves the appropriate handling of our feelings and impact on others.
- Self-control—includes the capacity to channel emotions in the service of a goal.
- Empathy—means sensitivity to the feelings of others, the ability and the willingness to take their perspective and an appreciation of differences in how people feel about things.
- Handling relationships—includes listening, negotiation and conflict resolution.

In a more recent work, Goleman *et al.* (2002) discuss how at a basic, physiological level we are connected to others for emotional stability. We participate in 'emotional contagion'. Other people are significantly influenced by the emotions displayed by those in leadership positions. This makes the emotional task of leadership a primal, priority task. The more open leaders are with their enthusiasm, humour and passion, the more open team members are to each other and the more talent and potential is unleashed.

These insights open the door to an understanding of transformational leadership and leadership as a social process, where mutual influence, shared vision and collective action can transform all those involved in the process and the services to which they are dedicated.

LEADING TRANSFORMATION

Traditional models of leadership are all about actions and transactions. Rost (1991) went so far as to say they were really about management, and psychological approaches to get people to 'mind the shop'. Burns' (1978) seminal work introduced the notion of transformational leadership, currently receiving widespread attention in health and social care. Referring to Maslow's hierarchy of needs, Burns observed that some leaders are able to inspire, to raise the expectations and the performance of followers beyond

everyday needs for survival, safety, security and companionship to expectations that are concerned with, and can lead to, the greater good.

Transformational leaders can often articulate the unspoken but important values and vision of followers. A member of one of the interprofessional teams commented that leadership is about being led towards something that we realise we should have been doing for ourselves. Charismatic leadership is a form of transformational leadership, and charismatic leaders often display qualities of inspiration, enthusiasm, intensity and willingness to risk. They often emerge in times of change or crisis, but equally they are capable of creating the conditions of change. It is based on a heightened emotional relationship between leaders and followers and relies on a mutual sensitivity. You may recall times when you have worked with someone charismatic and you felt a sense of excitement, hope and purpose. You may have had a clearer sense of where things were going and how you fitted in. You may have felt more intensely involved with your own work as it took on a sense of greater meaning and importance. This may also have led you to understand yourself more:

> You got to get inside of people. That's where it all is. You can't get inside them unless you open yourself to be got inside of. Follow what I am saying? The key to other people's hearts is finding the key to your own.
>
> (Jesse Jackson, in Frady, 1992, p. 51)

Team members in some of the case studies describe just this sort of experience.

Beverly Alimo-Metcalfe and Robert Alban Metcalfe (2002) carried out large-scale research in the NHS and other public service organisations to understand how people perceive leadership and what they value in leaders. They identified the following qualities which form a 'transformational construct' or composite of leadership qualities.

- *Genuine concern for others*—They have a genuine interest in their team members as individuals.
- *Inspirational communicator, networker and achiever*—This is about being able to communicate the vision with passion and commitment.
- *Empowering others to lead*—They trust staff to take decisions and initiatives in important matters.
- *Transparency*—This quality relates to honesty and openness.
- *Accessibility, approachability and flexibility*—They are accessible to all levels of staff.
- *Decisive determination and a readiness to take risks*—They are decisive when required and can clarify shared values.
- *Ability to draw people together with a shared vision*—The leader engages internal and external colleagues, departments, agencies to draw together a shared vision.
- *Charisma*—This involves the ability to be in close contact with people and to encourage their contribution.
- *Encouraging challenge to the status quo*—They encourage challenge to traditions and assumptions about how things are done.
- *Supporting a development culture*—They empower others to take risks.
- *Ability to analyse and think creatively*—This quality is about being able to understand complex issues and to solve problems creatively.

- *Managing change sensitively and skilfully*—This quality is about being sensitive to the impact and the effects of external and internal change and being able to balance change with some stability.

Many team leaders describe themselves and were described by team members in just such a way. Not every team leader possessed all of these qualities but there are notable examples of team members contributing many of these attributes to their teams.

Alimo-Metcalfe and Metcalfe emphasise co-creation of a vision. Leadership does not so much involve the vision of one charismatic person, but the vision comes from the exchange among people in an environment of innovation. Senge (1990) identifies 'shared vision' as one of five essential disciplines that people and organisations need to develop to transform themselves. Transformational leadership is driven by values, in that leadership is not just about getting things done, but getting the right things done in the right ways.

The emphasis on *social process* distinguishes transformational leadership and newer models such as learning leadership and servant leadership from the more traditional approaches:

> Leadership is an influence relationship among leaders and followers who intend real changes that reflect their mutual purposes.
>
> (Rost, 1991, p. 102)

The notion of leadership as a social process underpins the ideas of distributed leadership and leadership at all levels.

LEADING SOCIAL PROGRESS

Purpose holds together the social process of leadership. This view of leadership relies on a collective view of the need for change and the direction of change. New ideas of leadership move from individual leaders to mobilising others and challenging all team members to reflect upon their influence in the achievement of mutual purposes. New ideas about leadership emphasise *leadership as negotiation*.

Leadership is a process that different people engage with at different times. Groups and teams do not have straightforward common purposes. There are always multiple issues, interests and agendas. Effective leadership in these complex situations requires negotiation to reconcile different interests in order to work towards common goals. Ferlie and Pettigrew (1996) have noted that broker roles may develop in *leadership across boundaries*. The case studies showed many of these emerging forms of leadership. Most dramatically, the case studies exemplified *leadership as learning and servant leadership*. The 'learning leader' unlocks human potential, and nurtures people's commitment to and capacity for learning at all levels. Greenleaf (1977) defined leaders as those who serve others, whose ethic is a responsibility to guide and support the work of others. Foster also emphasises the individual's role in contributing to community development:

> Leadership is and must be socially critical. It does not reside in an individual but in the relationship between individuals and is oriented toward social vision and change, not simply or only organisational goals.
>
> (Foster, 1989, p. 46)

Foster, in the above quotation, takes a critical social process view of leadership. This process has three key elements: shared vision, collective action and social change, as can be seen in Figure 8.3.

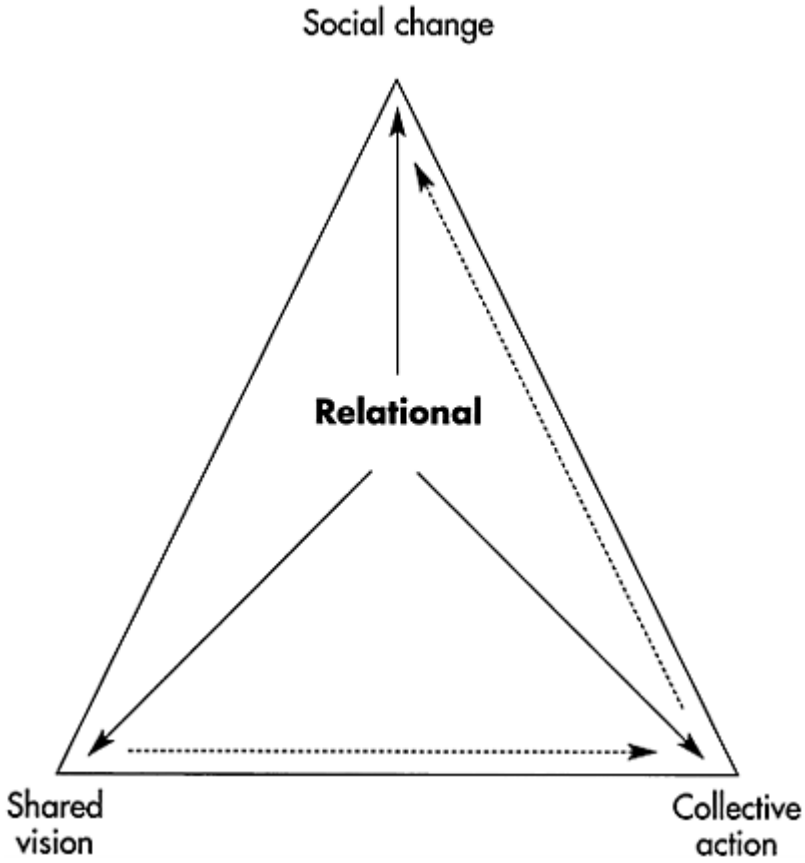

Figure 8.3 Leadership as a social process.

The shared vision that can be seen throughout the case studies, for example, is service improvement. Collective action means all of those committed to that vision working together to move closer to fulfilment of the vision. Social change, in this view, is the ultimate purpose, and it is hoped, the result, of collective action. Collective action brings changes in organisational and social structures and processes that result in a more fair,

equitable service. Relationship is the pivot to this type of leadership, as it is to most forms of leadership. Relationship supports the development of the three elements identified above, hence the solid lines. The dotted lines show the direction of the process, from shared vision to social change, and represent the fluidity and flexibility needed in this process.

These newer, process views of leadership mirror the core value systems of health and social care that include an emphasis on:

- An egalitarian culture, one of openness and inclusiveness, where information, power and resources are shared;
- Individual and collective attitudes and behaviours such as empathy, respect, flexibility, accountability and good communication;
- Mechanisms and structures that both develop and support these, such as modernisation teams and efforts;
- Capacities that include both disciplinary expertise and the capacity to understand and change structures and processes.

This approach, however, is not easy to develop within strongly hierarchical structures and cultures.

The current Royal College of Nursing's Clinical Leadership programme draws upon the Kouzes and Posner (1987) approach, which sums up well key elements that characterise the newer models of leadership discussed here:

- Challenging the status quo
- Inspiring a shared vision
- Enabling others to act
- Modelling the way
- Encouraging the heart.

In these case studies we have seen the challenge and the inspiration of transformational leadership, the shared vision of leadership as a social process, the role modelling of learning leadership, the empowerment of servant leadership and the emotional engagement required by all.

Leaders influence how people think about issues but do not necessarily have formal power in the organisation. All members of a group or team can make leadership contributions. Different leadership capacities are required to develop strategy, develop team commitment and morale and progress detailed tasks. If everyone is committed to change, everyone needs to know something about the impact of forces in the wider environment and to understand why and how change is a response to these forces.

Team effectiveness is dependent upon the capacity of its members to draw from a whole range of leadership perspectives.

CHAPTER 9
THEORY AND PRACTICE IN TEAMWORKING

The belief that interprofessional teams, with multiple skills and expertise, will be able to deliver more effective, holistic and seamless patient care accounts for the growing emphasis on teams. Almost everyone will find themselves part of a team during their work in health and social care. Interprofessional teamworking is not new. But the context and expectations have changed. There is increasing formalisation of teams and accountability mechanisms and more distributed forms of leadership.

Interprofessional teamworking offers its own challenges and opportunities. The interaction of identity and diversity represents both a key challenge and opportunity. An interprofessional team is a type of multicultural environment, in which the unique cultures of professions, departments, agencies and disciplines come together for common purposes.

Our search for a range of interprofessional teams proved more complex than we had anticipated initially. As we heard more about current interprofessional teamworking we realised that teams and team members define themselves in a range of ways and identify with a variety of teams.

GROUPS AND TEAMS

All teams are groups and most organisations have formal and informal groups. Martin (2003) describes some important aspects of groups:

- Size—It is difficult to involve everyone if a group is larger than about ten people because participation becomes more difficult. But the more people, the greater the diversity.
- Work—Some groups exist for a long time working on fairly routine tasks and some are formed to work on a particular issue.
- Status—A group that is recognised by the organisation will often have established channels of reporting to the organisation whereas informal groups may have to establish mechanisms in a more ad hoc way. Similarly, formal groups will probably have resources available whereas informal groups may have to negotiate these.

(Adapted from Martin, 2003, pp. 66–67)

The status of group or team has important implications for negotiating boundaries in multilayered, multifaceted contexts, and for the notion of leadership as ‘networking’ and ‘brokering’.

Groups may rely less upon close collaboration and consensus than a team might. They can be useful when tasks are relatively simple and fast, innovative decisions are needed. Groups become teams when there is a joint product or goal upon which its members are focused. Katzenbach and Smith (1993) point out that in teams there is a shared

understanding of the goals, and members of the team are mutually accountable for both their purpose and approaches. Teams are needed when tasks or problems are complex, consensus decisions are essential, there is a high level of choice and uncertainty and a mix of different competencies are needed.

DEFINING INTERPROFESSIONAL TEAMS AND THE CONTEXT

Interprofessional teams are a unique form of team which involves significant collaboration and the breaking down of boundaries, although these teams can be formed within the same department or organisation. The Virtual Multidisciplinary team, the Assertive Outreach team and the Reablement team are examples of teams working within the same organisation. Interprofessional team working can also involve cross-agency working, such as we saw in the Outpatient Referral team, whose membership included the head of a local agency, a General Practitioner and a hospital administrator. Teams can be *tight knit,* working in close tandem and sharing the same locale. The Assertive Outreach and the Reablement teams are good examples. Interprofessional teams do not have to involve everyone all the time, or be in the same location, but can be a *network* team, as in the Cancer Collaborative Network.

In many early stages of interprofessional teamwork it would be more accurate to use the term 'multiprofessional' to describe the degree of interaction. There is a distinction to be made between people who come together and, perhaps, agree to exchange some information or to collaborate over some issue of mutual interest, and a team that share vision and overcome boundaries to work collectively to achieve common goals. These terms tend to be used to indicate a difference between teams where individuals are defensive in protecting and preserving their professional boundaries and those where individuals agree to blur or to work across those boundaries, accepting some loss alongside the gains.

Hudson *et al.* (1998) suggested that collaborations move through different stages. Although he was referring especially to cross-organisation, cross-agency collaboration, these stages have some application to many interprofessional endeavours:

1. Isolation (no joint working);
2. Encounter (informal and ad hoc contact);
3. Communication (involving formal joint working, frequent interaction, sharing of information);
4. Collaboration (high level of trust, common interests, joint planning and service delivery);
5. Integration (organisations integrate teams or even merge with loss of individual identity).

(Adapted from Charlesworth, 2003, p. 145)

Interprofessional working involves joint working and joint working has three levels. Members of the Cancer Collaborative Network case study talk about the complexities and overlaps involved in working across these levels.

- *Strategic planning:* Agencies need to plan jointly for the medium term and share information about how they intend to use their resources towards the achievement of

common goals. In most of the case studies we heard about ways in which people had succeeded in working with other agencies and organisations within a local health economy to plan together and to initiate collaborative local improvements.

- *Service commissioning:* When securing services for their local populations, agencies need to have a common understanding of the needs that they are jointly meeting and the kind of provision likely to be most effective. In the context of the Cancer Services Collaborative, a lead facilitator works for a Primary Care Trust. The money comes from government to the Primary Care Trusts, who decide what's needed for the patients and they then buy secondary services from the hospital. The Strategic Health Authority will ask pertinent questions about how the money is spent.
- *Service provision:* Regardless of how services are purchased or funded, the key objective is that the user receives a coherent package of care, with the greatest of ease. We saw in the Cancer Collaborative Network that priorities included waiting times, appointments, urgent referrals, communication between primary and acute care and patient information pathways.

The context within which teams work is one of shifting structures, alliances and processes. Each context too has its own unique, idiosyncratic features. There are, however, some common themes with regard to what makes teams effective within an uncertain and ambiguous environment. Approaches to joint working:

- Need clarity about roles, powers, accountability requirements and differing expectations of stakeholders at all levels.
- Must be set in the context of the wider political agenda of modernisation.

(Adapted from Charlesworth, 2003)

The teams in the case studies are all very conscious of the extent to which their initiatives contribute to the modernisation agenda and there were many examples of role negotiation.

DEVELOPING EFFECTIVE TEAMS

Tuckman and Jensen (1977) identified five stages to team development which provide a useful framework for considering the factors that make a team effective in sharing responsibility during times of change. Although the original model implied that performance was delayed until several stages had been successfully negotiated, a more contemporary approach would suggest a dynamic relationship among the stages that would help account for the requirements on many teams to achieve early results.

Forming

This stage in the original model is one in which team membership is established, in which individual and team purposes are clarified and in which interpersonal relationships and processes begin to take shape. Michael West (2003) has identified how important it is to the team's future effectiveness to decide proactively on team membership and roles and the boundaries of the team with regard to the organisation and to other teams. The

Assertive Outreach team and the Reablement team spoke explicitly about the power of recruiting 'like-minded' people to the team. West, using a needs-based approach, suggested that team members look to their membership of the team for belonging, growth and control.

Storming

Storming is the stage where conflict emerges and, if unresolved, can inhibit progress and derail the team. Interprofessional teams will inevitably have conflict and there were examples of overt and covert conflict in many of the teams. One team member spoke about shouting and 'getting the conflict out in the open'. A team leader spoke about how she encourages team members to resolve their interpersonal difficulties without her intervention. The Virtual Multidisciplinary team talked about 'breaches' of etiquette. A mem-ber of the Outpatient Referral team talked about conflicting priorities and processes for negotiating scarce resources.

There are psychological explanations that account for conflict and derailment too. Bion (1961) suggested that team development involved two parallel processes, a conscious one and an unconscious one. When teams have a clear 'primary task' and agree to work to the task at hand, their members will act constructively and consciously. However, there can be unconscious processes occurring at the same time, almost as if a parallel team is operating. This parallel 'unconscious' team makes sure that anxiety is handled by using a number of defensive manoeuvres to dispense with strong emotion. One defensive mechanism involves 'disowning' strong emotions and placing them in the team. The team comes to represent a mother figure, for example, that can contain or handle strong emotion. This kind of defence manoeuvre happens when the team task is especially anxiety provoking. Teams may use any one of the three following basic assumptions to avoid the primary task.

1 *Dependency:* Team members expect the leader to protect them from anxiety about the primary task. Members will rely on the leader to have all the answers. Individuals will not use their own capacity to make choices, but the leader will carry the eventual responsibility for the outcomes.
2 *Fight-Flight:* If the team becomes too intense emotionally, an individual might take flight or might fight. One form of flight might be the use of humour and jokes to diffuse the levels of anxiety or tension. This is not to suggest that all uses of humour are inappropriate, but the uses of humour that divert from attending to the primary task. Alternatively, an individual might not attend team meetings, or might not participate fully. Scapegoating is another manoeuvre of a fight or flight group. Management might be blamed for all that is wrong or other teams and departments may not understand the service the team is providing.
3 *Pairing:* The group believes that some future event will bring resolution to their anxiety. A 'selected pair' who are in conflict or who are allied in some way may carry the hope of the group for resolution either by resolving the group's problems in their alliance or acting them out in conflict.

It often helps a team to consider its basic values and principles. Reviewing difficulties is not a one-off event, but must be a continuous one. A robust process needs to be

developed and maintained by the team to ensure continuing development of team awareness about their own interactions. In addition, if the team agree to value and respect diverse views, disagreement becomes a way of reviewing perspectives. In any change situation the views of all of those involved are important in determining whether progress will be made and to ensure that wide consultation accompanies its progress in parallel with achievement of the team's tasks.

Norming

At this stage the team settles into agreed routine ways of working. These routines must serve the needs of the team members as well as the task and purpose around which the team was initially formed. West (2003) has identified three needs that members bring to the team initially and the team must establish norms and processes to fulfil these needs for: belonging, growth and control.

- *Belonging:* Leaders and team members find ways to show interest in each other's well being. To fulfil the belonging need, the team should establish processes that build confidence, and ensure equality and consistent treatment.
- *Growth:* Personal development, planning, appraisals and objective-setting are most important. There needs to be follow through to ensure that these processes have helped the person to do his or her job better.
- *Control:* Norms and processes to keep motivation up and ensuring participation are some effective ways of giving all team members a greater sense of control.

There is a correlation between sophistication of appraisal and mortality after hip fracture. The more sophisticated the appraisal, the less mortality (West, 2003, Conference presentation).

In progressing change, however, the processes that have been agreed for the early stages of an initiative may not be the best as time moves on and situations change. It can be a constraint for a team to develop norms that inhibit change within the team and its ways of working. The balance of the team dynamics and progress towards achievement of the purpose may need to be revisited frequently to ensure that the team is not putting too much attention into maintaining itself at the cost of progressing the task.

The case studies provided many examples of 'norming in progress'. The members of the Assertive Outreach team, the Reablement team and the Virtual Multidisciplinary team talked about the various mechanisms, rituals and regular feedback processes that they had developed together to ensure their continuing effectiveness.

Performing

This is the stage at which the team is working efficiently towards its goals. As in the previous stages, nothing stands still and the situation constantly changes. The only way to be sure of effective performance is to monitor and review regularly against targets. The Assertive Outreach team described a constant process of review embedded in mechanisms that the team had developed together. The processes that are needed here are detailed management routines and these are not always the approaches that people oriented towards achieving change welcome. Everyone needs to be engaged in the

routine mon-itoring activities if the reviews of progress are to be meaningful. The Reablement team described the value of having decision-making frameworks in place to handle routine situations and enable each member to make decisions autonomously.

Adjourning

One of the characteristics of a team is that it has a limited life that completes with the achievement of its purpose. If members of the team have enjoyed working together and found the work satisfying there is often some reluctance to break up the team. However, with people who are interested in change there will also be an attraction in moving on to the next challenge. It is helpful if some attention is paid to closure by ensuring that team members have all given each other feedback where appropriate. Achievements can be recorded in appraisals and other documentation. It is important that learning as a team and as individuals is discussed and noted, so that people are able to use the experience gained from this team when they move into new roles.

While the teams we interviewed were still teams very much in process, the Cancer Collaborative Network described quite major changes in roles and activities from project manager to facilitator that took place in the move from phase two to phase three. Collaborative team members talked about how these changes had emerged from systematic review of their interventions with collaborating agencies and about the importance of learning from small change efforts.

MAINTAINING THE TEAM

Each team member brings strengths and perspectives grounded in their discipline and experience. Coupled with personality and behaviour preferences, this combination of attributes has an impact on the sorts of roles team members will choose to play. Belbin's work (1981) identified a number of significant roles in teams. These roles each offer positive contributions to teamworking, but each also has what Belbin called 'allowable weaknesses'. Each role could be linked with taking a lead on an area of the team's work:

- *innovator:* original ideas, imagination, creativity (but may be weak in communication skills and reluctant to abandon or build on ideas);
- *implementer:* turns ideas and decisions into tasks and actions (but may be inflexible and reluctant to change plans);
- *completer:* sees tasks through to completion, good on detail (but can be inclined to worry and dislike casual attitudes in others);
- *evaluator:* offers critical analysis, takes a strategic view, considers options and makes judgements (but can lack drive, warmth and imagination and can dampen morale);
- *investigator:* explores opportunities and resources from many sources, enthusiastic communicator (but can jump from one task to another and lose interest);
- *shaper:* drives the team to address the task, dynamic and challenging (but can be impatient and intolerant);
- *team maintainer:* focuses on harmony, developing ideas, listening, reducing conflict (but can be indecisive and avoid confrontation);

- *co-ordinator:* clarifies goals, promotes decision-making, communicates effectively (but can be seen as manipulative and not fully contributing to the work of the team);
- *expert:* provides specialist skills or knowledge (but can be narrowly focused on their own area of work and fail to see the big picture).

Many people are strong in one or two of the roles and could also contribute in others. It can be helpful for a team to discuss who will take on each of the roles and whether they have sufficient resources or need to add members. The discussion might also consider how the team will accommodate the potential difficulties that can arise from the associated characteristics of each role. Belbin's research (1981) suggested that consistently successful teams contained a mix of these roles.

Features of the current context introduce the need for some modification and expansion to these roles, and of the treatment of allowable weaknesses:

- *Change:* Teams that are engaged in change might need rather broader interpretations of some of these roles or other roles added in order to address some of the wider issues. Any change has the potential to affect people outside the team and often outside the area of work or organisation. The 'network' leader and the 'broker' leader are examples.
- *Joint working:* The team will need someone taking a lead on consultation and negotiation with all potential stakeholders. This might fall within the co-ordinator role or might be a more broadly ambassadorial role.
- *Technology:* Availability and expectations about the use of information technology have changed since Belbin identified these roles. There will be considerable information in the internal systems of many organisations and also information about bench-marking and best practice that can be important to consider before making significant changes. The person in the role of resource investigator now needs computer skills and ability to make appropriate and competent judgements about what information will be helpful for the team.
- *Distributed leadership:* We now expect team members to take a more holistic view of their work and their team involvement. We expect all team members to have a grasp on the context, the reasons for change, to lead some work and to share responsibili-ty in work led by others. It is no longer enough for someone to confine themselves to their own area of expertise. You may find as you review the case studies and your own work that the 'allowable weaknesses' suggested by Belbin still have a place in the current context of interprofessional teamworking.

(Adapted from Martin, 2003, pp. 74–75)

Another way to consider team maintenance is to think about the kinds of behaviours the team needs to keep a balance between the task and relationships. An effective team requires a balance of *task* and *maintenance* behaviours. Task behaviours concern themselves with the primary tasks and purpose of the team, while maintenance behaviours are concerned with the team's interpersonal process and environment (see Figure 9.1).

Figure 9.1 Team task and maintenance behaviours.

Task progression	**Maintenance**
Proposing ideas to progress the task	Involving contributions to discussion
Building on ideas	Creating a friendly and welcoming atmosphere
Challenging ideas	Compromising and accommodating
Providing data, information, opinions	Emphasising positive feedback for individual
Summarising, noting action points	Recognising personal feelings

CHAPTER 10
REFLECTIONS AND CONCLUSIONS

We have referred to interprofessional teamworking as a multicultural experience. A study (Rogers, 1994) on effective multicultural working suggested an integrative framework that synthesises a number of attitudes, characteristics and behaviours that team members in the case studies revealed. Working across cultures requires:

- *Personal integration:* The capacity to self-reflect, to accept feedback, to develop self-awareness, leading to a real desire to change and grow.
- *Experiential agility:* Flexibility in thinking and action, leading to crossing boundaries, willingness to engage, asking questions, listening, trying to understand, working through conflict and toleration of uncertainties and ambiguities.
- *Power-sharing:* Inviting participation from others, encouraging growth and development in others, delegating, mentoring and creating systems and structures that support distributed forms of leadership.
- *Transcendence:* Having a sense of things beyond oneself to live for, a belief in service and inclusiveness, sharing commitment to an overriding purpose.

These elements exist in dynamic relationship to each other and reflect a holistic perspective that seems to be at the heart of change in health and social care today.

The case studies open the door to many different possibilities for future research. Areas we have identified include:

1 Ways of supporting small incremental change so that it contributes to significant organisational change.
2 Identification of processes that enable development of successful small change efforts into larger-scale initiatives.
3 Identification of features and processes that facilitate cross-boundary working.
4 Identification of features and processes that facilitate interprofessional working.
5 Gender and response to change.
6 Career trajectories and their contribution to innovation in health and care.
7 Service user involvement in co-development of services.

Service user involvement, not surprisingly, emerges as a significant theme in many of the case studies, and one which reflects broader legislation and policy development. Research might build on work already in the literature, continuing to explore the range and boundaries of service user input into shared ownership of individual health and well being and the co-creation of services. Investigation might explore more fully the effectiveness of education and training interventions in shifting attitudes and expectations for service users and for health and social care staff. The public service emphasis on

inclusion and choice raises broader issues about the expectations and demands of citizenship and how these sit alongside capitalism and private sector provision. There is growing evidence that effective teamwork leads to significant increase in well being for team members, for the organisation and for service users. Many of the teams in the case studies are using a number of the tools, techniques, philosophies and theories explored here in an integrated, organic way.

Most importantly, effective interprofessional teams are driven by a collective passion, held together by deep and abiding commitment to service and to service users, consolidated by courage and a willingness to face down adversity, and sustained by a quest for learning and change.

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