LEADERSHIP IN HEALTH CARE

JILL BARR
LESLEY DOWDING

6TH EDITION

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About the Authors

Jill Barr is a lecturer at Coventry University, teaching student nurses and MBA/MSc students in health care. She has worked as a principal lecturer at the University of Wolverhampton and at De Montfort University, Leicester, with a number of awards from pre-registration nursing to community specialist nursing programmes, non-medical prescribing, physician assistant/associate, advanced practitioner and public health Masters. Her own professional career has been exciting, varied and totally integrated with personal development, including writing with Lesley Dowding for over 20 years. Jill qualified as a nurse, midwife and health visitor, working in all these areas in practice as well as gaining her nurse licence in Michigan, USA. With a breadth of practice experiences in acute, community and industry, the patients, women, families and communities that have been served have been an important tapestry in her personal development.

Lesley Dowding's career has encompassed many different experiences since qualification, as a nurse and midwife, within general theatres, midwifery and gynaecology, a nanny in Michigan, USA, a veterinary assistant (Michigan, USA), an anaesthetics and recovery sister (UK), and as nurse tutor within schools of nursing and universities (UK). Lesley has taught a variety of subjects for pre- and post-registration nursing students, but now focusing on Leadership. She has a passion for effective management techniques, endeavouring to make what might be considered dry theory applicable to clinical practice. To do this, Lesley and Jill have written two books related to management theory and practice in health care: *Managing in Health Care: A Guide for Nurses, Midwives and Health Visitors* (2002, Pearson Education) and *Leadership in Health Care* (Sage, first edition 2008).

Sue Pye (the illustrator) has known Lesley since their early training days in Birmingham. She then went on to have her family but was always painting and drawing as a hobby. Her lifelong love of Art prompted her to undertake an Illustration degree course at The University of Plymouth, leaving with a BA (Hons) in 2007. The opportunity to lighten the text via fishy cartoons exhibits her quirky sense of humour.

6

Interdisciplinary and Interprofessional Working

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Learning Outcomes

Figure 6.1 Chapter 6 learning outcomes

By the end of this chapter, you will have had the opportunity to:

- Critically discuss the importance of interdisciplinary and interprofessional working in health for effective patient care and safety.
- Critically explore the opportunities and challenges of interprofessional working in the contemporary context.
- Identify issues of practice communities, tribalism and professional identities, and the importance of interprofessional education.

Introduction

In Chapter 5, we explored the nature of team life and the importance of leadership in relation to team behaviour and management of demanding situations. We also explored the importance of teamworking in relation to improving patient/client outcomes. This chapter aims to explore another facet of the notion of teams within the context of working across boundaries with people from diverse backgrounds.

The importance of effective interdisciplinary, multidisciplinary and interprofessional teamworking for quality health care has long been underpinned by research, inquiries and policy (Reeves et al., 2010). Lord Darzi (Department of Health and Social Care, 2024a) undertook an investigation for the new Labour government to identify the state of the NHS. This 163-page document identified that the NHS was in serious trouble, with performance being compromised by a deteriorating healthy life expectancy of the nation, an aging population, a rise in long-term conditions, and a deterioration in mental well-being (particularly in children and young people). It is therefore vital that interdisciplinary, multidisciplinary and interprofessional working has leadership skills at its tenet for success. A new NHS ten-year plan will be formulated using this data.

Failings in the NHS have become more evident in the last few years, especially concerning the quality of patient care. There is an emphasis on interprofessional teamworking across several NHS agencies and partnerships. In his independent inquiry into care provided by a Midlands NHS Foundation Trust, Francis (2013) noted that 'patients were seen intermittently by various members of the multidisciplinary team but there was little evidence that there was a planned multidisciplinary approach to their care'.

Similarly, Keogh (2013) also signalled the importance of healthcare leadership and proposed the following improvement issues:

- **Patient experience**: understanding how the views of patients and related patient experience data are used and acted upon (such as how effectively complaints are dealt with, and the 'visibility' of feedback themes reviewed at board level).
- **Safety**: understanding issues around the Trust's safety record and its ability to manage these (such as compliance with safety procedures or Trust policies that enhance trust, training to improve safety performance, the effectiveness of reporting issues of safety compliance or use of equipment that enhances safety).
- **Workforce**: understanding issues around the Trust's workforce and its strategy to deal with issues within the workforce (e.g. staffing ratios, sickness rates, use of agency staff, appraisal rates and current vacancies) as well as listening to the views of staff.
- **Clinical and operational effectiveness**: understanding issues around the Trust's clinical and operational performance (such as the management of capacity and the quality – or presence – of Trust-wide policies, how the Trust addresses clinical and operational performance) and in particular how Trusts use mortality data to analyse and improve quality of care.
- **Governance and leadership**: understanding the Trust's leadership and governance of quality (such as how the board is assured of the performance of the Trust to ensure that it is safe and how it uses information to drive quality improvements).

The Ockenden Report (2022: 11–13), which examined maternity services at Shrewsbury and Telford Hospitals, noted the high maternal and neonatal deaths causing concern also indicated issues related to governance, leadership and patterns of repeated poor care.

The National Nursing Research Unit (NNRU) (2013) and NHS England (2023) identified that research and surveys show a close correlation between staff experience and patient care and satisfaction. Patients receive better care by staff working in teams that are well led, have clear objectives and have the time and resources to provide that care. The Coalition for Collaborative Care (C4CC) was set up in November 2014 to help improve person-centred care for people with long-term conditions. The C4CC brings together like-minded organisations, including NHS England, who want to bring about change; they work in co-production with people who have lived experience of long-term conditions. This innovative partnership of more than 45 national organisations across the health, social care, voluntary and community sectors, is focused on changing the relationship between people with long-term health conditions and the professionals supporting them. From 2024 the NHS has developed a Comprehensive Personalised Care Model (see Figure 6.2) which allows the expertise of both patients, their relatives and NHS staff to be used most effectively to help people manage their condition and maximise their well-being during their treatment and care whenever that is required.

Activity 6.1

Defining Key Terms

Jot down what you understand by the terms 'interdisciplinary', 'interprofessional' and 'multidisciplinary' working.

There are several similar terms – such as interdisciplinary and interprofessional – which are often used interchangeably.

The term *interdisciplinary*, as an adjective, relates to two or more disciplines collaborating towards a shared goal. In health care, this may be a care activity which involves various disciplines within one profession. One example is that of the disciplines of a children's nurse and an adult nurse working in accident and emergency (A&E), collaborating on addressing the needs of children requiring emergency care in that hospital. Another example is a local district nurse and a General Practice nurse collaborating to work on tissue viability treatments offered in the home and at the surgery for consistency. Interdisciplinary communication will also be required when patients cross boundaries from the community into hospital, or on discharge from hospital to home. A breadth of international, national and regional interdisciplinary networks and forums have been set up around certain conditions or concerns such as cardiac/coronary care, child health, learning disabilities and mental health.

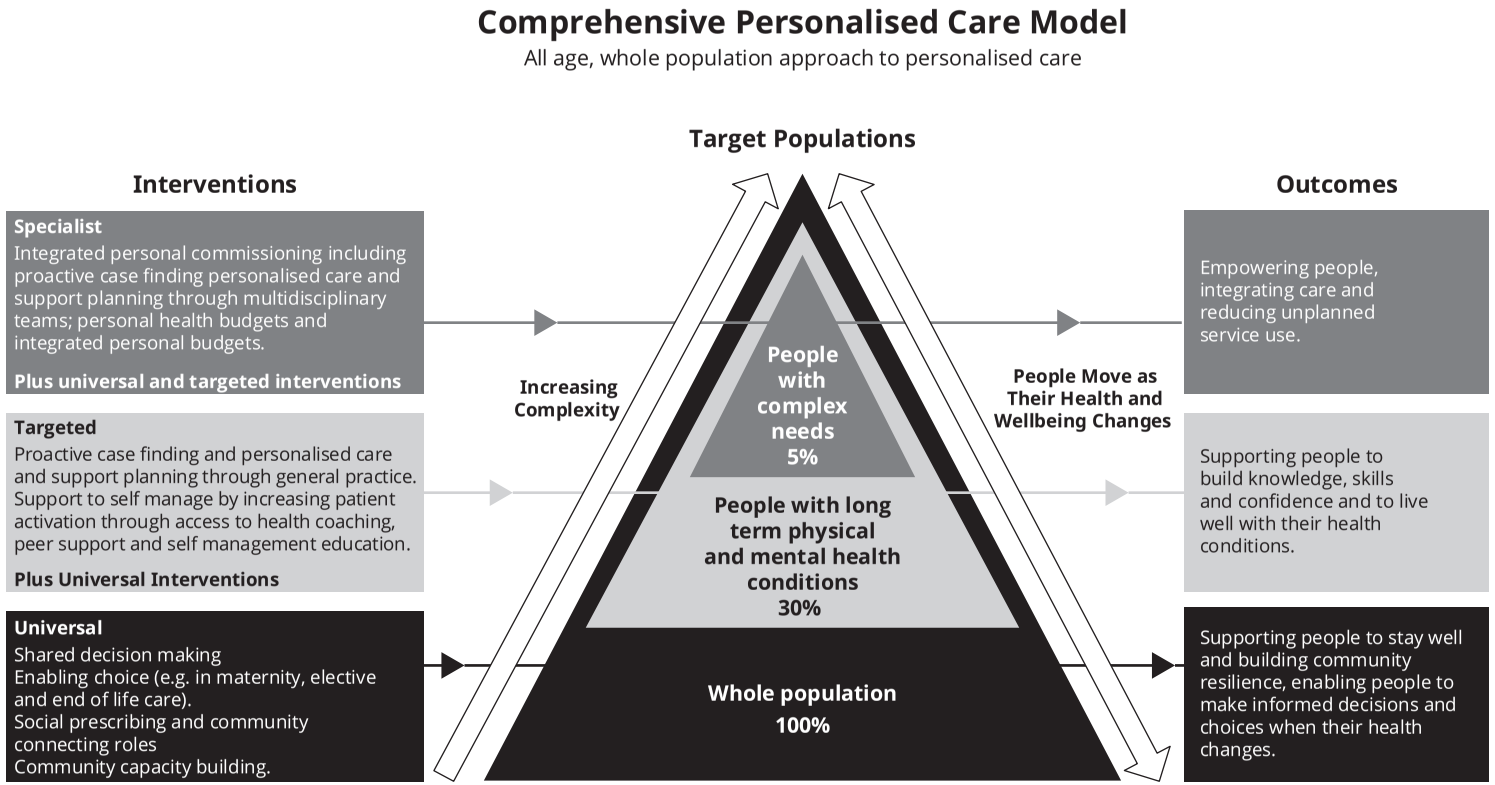

Figure 6.2 Comprehensive Personalised Care Model

Source: NHS England, 2024a

Interprofessional as a term relates to two or more professionals collaborating towards a shared goal. In health care, this could involve nurses, doctors, allied health professionals (e.g. occupational therapist, speech therapist, podiatrist, physiotherapist), therapists and social workers collaborating in working out a management plan to discharge an older person with complex needs, following a cerebral haemorrhage.

The term *multidisciplinary* implies that healthcare providers from different professions work together to provide diagnoses, assessments and treatment, within their scope of practice and areas of competence. However, this term is somewhat less used as it is now felt that it does not demonstrate an interactive relationship but is, rather, probably how healthcare practice usually manifests itself.

The term *collaboration* has also been defined by Goldman and Kahnweiller (2000: 435) as a 'mutually beneficial and well-defined relationship entered by two or more organisations to achieve common goals'. Petri (2010) undertook a concept analysis of *interdisciplinary collaboration* in the context of health care and developed a definition of it as follows:

> … an interpersonal process characterised by healthcare professionals from multiple disciplines with shared objectives, decision-making, responsibility and power working together to solve patient care problems; the process is best attained through an interprofessional education that promotes an atmosphere of mutual trust and respect, effective and open communication and awareness and acceptance of the roles, skills and responsibilities of the participating disciplines. (Petri, 2010: 79)

Historical and Contemporary Context of Interprofessional Working

From the 1500s, the development from craft guilds to professions has been documented by Reeves et al. (2010). They note the separate development of professions rather than an integrated development, and thus healthcare tension arose. From a sociological perspective, different health and social care workers developed their own 'closed' organisation through professional training and indeed cultural values which can be linked to Freidson's (1970) theory of professional closure. The early professionalisation of medicine resulted in a hierarchical dominance over other disciplines.

For this chapter, it is important to note that some areas of multi-professional and multi-agency care have resulted in having more attention given to them than others, and thus have attracted more developed national policy, regional and local policies and procedures. This has resulted in more mature attention being paid to vulnerability, risk assessment and multi-professional and interagency care management and safeguarding. We need to be mindful of vulnerable children, which has been seen to lead the way in safeguarding, and then vulnerable adults, which may reflect the elderly, as well as those

at risk of domestic and institutional abuse from a broad range of categories, and the challenge of global human trafficking. The challenges of this range of 'social problems' have placed considerable stress and strain on all healthcare practitioners, multi-professional and interagency working, and healthcare leadership over the last few years. It must be said that, despite these developments, children and vulnerable adults sadly still get hurt and die.

Child vulnerability set the way for working collaboratively. It was only in the mid-1970s that the UK started to collect data on child abuse and set up interdisciplinary child protection management systems. Several child deaths, such as that of 7-year-old Maria Colwell, who died in 1973, led to the Fisher review which concluded that there was a lack of communication between the agencies that were aware of her vulnerable situation. Eventually, child abuse registers were set up in the 1980s; since the late 1980s, health policy has advocated for effective interagency collaboration. This is in the context of several serious child deaths where reviews note the breakdown of interprofessional communication, influencing effective child protection. The death of 4-year-old Jasmine Beckford in 1984 also triggered changes in child protection services; and as other children continued to be abused and died, the services and the government attempted to address policy and interagency practice. The rise in recognition of this social problem influenced another high-profile case, the 1988 'Cleveland child abuse' scandal, which emerged with what the media felt were overzealous medical and social professionals removing over a hundred children from their families, most of whom were found to be wrongly diagnosed as abused. However, this posed issues of tension for interagency protection working to focus on the needs of children and the needs of families.

Ongoing policy documentation influenced the Children Acts of 1989 and 2004. Following the first Laming Inquiry, prompted by the death of Victoria Climbié, further child deaths such as those of Baby P and, in 2013, another child, 4-year-old Daniel Pelka, who suffered at the hands of his parents, the lack of poor interagency working together was again identified. More interagency legislation has developed over the last few years:

- Female Genital Mutilation Act 2003 (www.legislation.gov.uk/ukpga/2003/31/pdfs/ukpga_20030031_en.pdf)
- Safeguarding Vulnerable Groups Act 2006 (www.legislation.gov.uk/ukpga/2006/47/pdfs/ukpga_20060047_en.pdf)
- Children and Young Persons Act 2008 (www.legislation.gov.uk/ukpga/2008/23/pdfs/ukpga_20080023_en.pdf)
- Children and Families Act 2014 (www.legislation.gov.uk/ukpga/2014/6/pdfs/ukpga_20140006_en.pdf)
- Children and Social Work Act 2017 (www.legislation.gov.uk/ukpga/2017/16/pdfs/ukpga_20170016_en.pdf)

This reflects the breadth of interagency policy which is there to address the social problem of safeguarding children. HM Government (2018b) has updated the

Working Together to Safeguard Children statutory guidance. All relevant professionals should read and follow the guidance, so that they can respond to individual children's needs appropriately. Policies in themselves do not prevent abuse – it is the commitment and best safeguarding practice of all those who work with children that do this. The Lucy Letby case illustrates this when a nurse was convicted of several neonatal deaths in 2018 (the case continues under appeal).

Activity 6.2

Safeguarding

Discuss with a colleague the role you both play in safeguarding children.

As a member of the public or as a healthcare professional, it is important to recognise that we all have a role to play in safeguarding children. Vigilance is imperative in society today, whether you encounter children in your care or within your home or holiday community.

In terms of the vulnerable adult (anyone over the age of 18 years who may be unable to protect themselves from abuse, harm or exploitation, which may be by reason of illness, age, mental illness, disability or other types of physical or mental impairment), they are now living longer and relatives are often faced with caring for older and more dependent parents and family members. The extended family in the UK tends to be horizontal in that it can include members of the same generation, such as siblings, aunts and uncles, family living together or very close to each other. Historically, the extended family or interprofessional community care provision was more accessible and available. Domestic challenges prove to be a social issue as more people look after their relatives in their own homes and the cost of professional care becomes too high. Along with this, the growth of the independent sector in care and nursing homes has meant that often older people without families become more vulnerable in institutional care. The White Paper (DH, 2015) *No Secrets* sets out a code of practice for the protection of vulnerable adults in care, with strong recommendations for an interagency framework and policy to manage potential and actual elder abuse. The Care Act (2014) attempted to address the care of vulnerable adults.

This Act explained how commissioners and providers of health and social care services should work together to produce and implement local policies and procedures. They should collaborate with the public, voluntary and private sectors, and they should also consult service users, their carers and representative groups. Local authority social services departments should coordinate the development of policies and procedures. The importance of protection of vulnerable adults (POVA) has since been developed to note the 'safeguarding of vulnerable adults (SOVA)'. Policy and legislation have now been underpinned by this 2014 Act.

Activity 6.3

Reflecting on Government Policy

Explore this document on government policy and reflect on how it may affect your healthcare role: www.gov.uk/government/publications/safeguarding-policy-protecting-vulnerable-adults/sd8-opgs-safeguarding-policy.

The Care Act (2014) principles appear to fit well with all codes of professional practice:

- empowerment
- prevention
- proportionality
- protection
- partnership
- accountability.

However, often those dealing with vulnerable groups on a day-to-day basis may well feel disempowered themselves and thus not have the knowledge, power and skills to signpost to those who can take action. As an adult example, domestic abuse is possibly an issue not only for older people but also younger people across both men and women. Many people also suffer physical, mental and sexual abuse from their partners, family or carers. Healthcare professionals tend to deal with the resulting medical or psychological issues and rarely have time to address the deeper safeguarding adult issues.

Hague et al. (1996) undertook a two-year research study into multi-agency work which was supported by the Joseph Rowntree Foundation. They noted the variation in domestic abuse services across the country. There was concern as to whether the interagency collaborative approach was pioneering work or just a 'smokescreen'. They concluded that there was a need for a national commitment to resourcing interagency work in a structured, coordinated way. There is now more political pressure for health visitors and other health and social care professionals to screen families for domestic violence (Early Intervention Foundation (EIF), 2014). The authors link domestic abuse to what is termed the 'toxic trio' of domestic abuse, mental health issues and substance misuse, and note the impact of economic pressures affecting families and thus the need for early intervention (EIF, 2021).

Activity 6.4

Domestic Violence

- Have you considered domestic violence as another possible risk factor when you have cared for a patient with a mental health issue and/or substance abuse?
- Check out whether you are aware of any domestic violence screening assessment tools.
- Has this section raised your awareness of the health issues related to child abuse, elder abuse and domestic violence?

Screening for domestic violence has been developed in the USA. NICE guidelines (PH50) (2018) recommend a needs-based assessment, frontline staff training and a breadth of tailored services. A 'domestic abuse' research evidence review in 2020 highlighted a broader view of domestic violence but focused on more psychological and coercive abuse evidence, and hence it is also worth exploring in the context of intimate terrorism, mutual violent control, situational couple violence and violent resistance. You may think these issues are not related to your role but perhaps feel you want to raise awareness of this social problem in your own working team or the wider multidisciplinary team, if seen as relevant. Population screening is not advocated but raising awareness of needs and services is important.

Another key emerging public health issue requiring multi-professional working is that of global human trafficking. This has been identified as the trading of humans for the purpose of forced labour, sexual slavery or commercial sexual exploitation for the trafficker or others, and organ donation. The crime of human trafficking is complex and dynamic, taking place in a wide variety of contexts and difficult to detect. One of the greatest challenges in developing targeted counter-trafficking responses and measuring their impact is the lack of reliable, high-quality data related to the scale of human trafficking and the profile of victims (Migration Data Portal, 2024). It can involve vulnerable grooming and forced marriage and is linked with organised crime, coercion, exploitation and population geography (Aronowitz, 2009; Kampadoo et al., 2016; Smith, 2018). Ronda-Pérez and La Parra (2016) commented that the health sector has a key role to play in this public health and social problem which makes victims invisible immigrants. They note that collaboration by 'actors' in health, social services, law enforcement, justice systems and non-governmental organisations in each global society is necessary to provide child and adult protection. However, Foot (2016) explores the complexity and multifaceted challenges, conflict and human challenges in collaboration in the context of gender, race, poverty and power. Healthcare leaders have a responsibility for raising awareness in their teams of human trafficking and of the 2014 Jay Report and 2022 Crowther Report which highlighted the recent shocking violations in Rotherham and Telford. As healthcare professionals ourselves, we need to now be more vigilant about organised crime and abuse in general.

Experience of Interprofessional Working

There may be positive or negative perceptions of interprofessional experiences in healthcare staff. In their Canadian research into perceived interprofessional collaboration, Regan et al. (2016) concluded that empowerment and authentic leadership promote professional practice environments and enhanced interprofessional working. What are your perceived experiences? Chapter 2 identified several reflective models, including Driscoll's (2007) simple model which is a useful tool for exploring interprofessional working events and their impact – it asked What, So What, and Now What?

Activity 6.5

Interprofessionalism

Using Driscoll's reflective model reflect on a recent interprofessional experience.

Worksheet 6.1 may be useful for realising the complexity of working in an interdisciplinary way while caring for patients and clients, and links to improving your healthcare leadership skills. It is also a useful way to focus as you complete your portfolio of experiences/learning as supporting on-going evidence prior to re-registration.

Worksheet 6.1 Your reflection

Features	Underpinning ideas	Your practice reflections
What?	**Describe event**	
What happened? *Knowledge and comprehension*	Describe the situation: achievements, consequences, responses, feelings and problems	
So What?	**Debate, compare and contrast**	
Analysis/Evaluation	Discuss what has been learnt: learning about self, relationships, models, attitudes, cultures, actions, thoughts, understanding and improvements	
Now What?	**Demonstrate, construct, predict**	
Application and synthesis	Identify what needs to be done in order to improve future outcomes and develop learning	
	What did you learn professionally and what skills do you need to learn for the future?	
Now write three personal SMART goals relating to improving your interprofessional working skills	1 2 3	

Contemporary Healthcare Practice Across Acute and Community Sectors

The NHS as an organisation is an important and governmentally scrutinised public service element of what is known as the health industry in the UK. However, there are a great many health and social care industries that organisationally impact on the health of the nation – or even on global health.

Generally, the local arrangements for health care in the UK have a three-part structure:

- primary care (community care/walk-in centres)
- secondary care (acute/hospital care)
- tertiary care (residential nursing/care facilities).

Primary care usually involves the services that patients and clients can access directly from their home locality and does not require referral to specialist services. NHS England (2020) notes that primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes General Practice, community pharmacy, dental and optometry (eye health) services. The NHS is a complicated concept in the UK (NHS England, 2024b). The World Health Organization (WHO) is also now less specific about a definition but notes that the goal of primary health care is better health for all. There are five key elements identified to achieving that goal:

- Reducing exclusion and social disparities in health (universal coverage reforms).
- Organising health services around people's needs and expectations (service delivery reforms).
- Integrating health into all sectors (public policy reforms).
- Pursuing collaborative models of policy dialogue (leadership reforms).
- Increasing stakeholder participation.

Secondary care usually requires referral from a primary care service for more specialist services in an outpatient service, or more directly via the hospital inpatient system. Interestingly, district nurses were formerly perceived as a primary care service, but in today's context an external referral is usually required, and patients cannot always self-refer. Tertiary care usually means a service referred from secondary or even primary care, such as a specialised rehabilitation service, a nursing home or a hospice. The notion of quaternary health care is also emerging as a concept of highly specialised or even experimental treatment, but this is not yet clearly defined. The boundaries between these care services are sometimes very blurred – for patients as well as professionals. Professional groups have in the past either seen themselves as working in community services or within institutionalised acute hospitals or specialist treatment centres. This has sometimes caused challenges for patient care when the patient moves from the community to hospital, or when being discharged from hospital to community services. Globally, primary, secondary and tertiary care are dependent on each country's health service structure.

There have been several other models that aim to ensure that the patient journey from primary and community care into secondary or tertiary care, or secondary care back to primary care, is well planned and seamless. Services set up as 'in-reach' community provision bring staff from across the community into hospital services, a residential home or even prison services. Nelson et al. (2009) conducted evaluative

research into an innovative in-reach nursing and physiotherapy service in a residential home. They noted the challenges of cultural differences between the various services but concluded there was successful up-skilling by the staff in the home. Outreach specialised services are about bringing specialised hospital services out into the home territory. There are also differences between skills, even within the same discipline. In community nursing, there is a tendency for nurses to develop generalist skills covering a wide range of skills around a variety of medical conditions, in a comparable way to the practice of General Practitioners. In contrast, those nurses who work in the acute sector tend to specialise in certain conditions in line with the medical direction of the clinical area. Generalist skills and specialisms in midwifery, mental health and learning disability are also evident. Interdisciplinary conflict may manifest itself when either a generalist or a specialist professional feels threatened. However, the generalist and specialist model of care offers the best of both worlds for patient journeys, even while the challenge may be about the transition from primary to secondary to tertiary care. A further challenge for patients may be the transition from one acute Trust to another, where complex needs demand a variety of specialist referrals.

Policy, Leadership and Working Together

The government's structural framework for the National Health Service continues to stress the importance of interprofessional working for the needs of patients and children. Integrated Care Boards (ICBs) were created in 2022 to allocate the NHS budget and commission services for their local population. It takes over the functions previously held by CCGs. They are clinically led, statutory NHS bodies responsible for the planning and commissioning of healthcare services and have four key aims:

1 Improving outcomes in population health and health care.
2 Tackling inequalities in outcomes, experience and access.
3 Enhancing productivity and value for money.
4 Helping the NHS to support broader social and economic development

(The Kings Fund, 2022)

NHS England has the responsibility of developing ICBs, ensuring they are fit for purpose, and commissioning highly specialised services. ICBs work closely with NHS England, and as co-commissioners they work with NHS England's regional teams to ensure joined-up care. As local authorities are responsible for public health, ICBs work closely with them through *health and well-being boards*. They work together to achieve the best possible outcomes for the local community by developing a joint needs assessment and strategy for improving public health. However, in 2025 the Labour government announced plans to abolish NHS England to cut bureaucracy and now await major structuring and reorganisation plans to emerge alongside the planned NHS Constitution Review 2025.

Teamworking, with various professions involved, requires skills and competencies in interdisciplinary collaborative working. All professional-based pre-registration education identifies multidisciplinary teamworking skills. Leadership in collaborative practice for patient care is recognised as an advancement competency.

The NHS Leadership Model has developed now within the remit of NHS England. The nine dimensions of the model are:

- inspiring shared purpose
- leading with care
- evaluating information
- connecting our service
- sharing the vision
- engaging the team
- holding to account
- developing capability
- influencing for results.

(NHS Leadership Academy, 2014)

You will find the framework a useful improvement tool to review your own SWOT analysis.

Activity 6.6

NHS Healthcare Leadership Model

Explore how your own SWOT analysis aligns with the NHS Healthcare Leadership Model. Can this model provide any ideas for your own future career planning?

Rationale for Collaborative Working Practices

It is generally seen as important that we work together across the disciplines and professions to address the following:

- Population health needs and demographical changes which reflect complex issues that cannot be addressed by a unilateral approach.
- Public protection where healthcare staff support each other but are also charged with public protection in their codes of conduct and standards of practice.
- Consumerism/public confidence.
- Governmental targets.
- Resource management.

- Budget control.
- Complexity of work.
- Role expansion/extension.
- Specialism versus generalist skills.

However, from some patient/public perspectives, the notion of interprofessional working has presented challenges. The public often have a much simpler perspective on the NHS and perceive it as made up of doctors and nurses. Depending on their experience of their care/treatment, however, patients/the public come to realise that several other professional groups are involved – though they do not always understand the differing expertise or skills. The patient experience does not always receive consideration by interprofessional services and patients do not always feel at the centre of decision making, which is influenced by power, context and patient autonomy (Ocloo et al., 2020; Howarth and Haigh, 2007).

In terms of the perspectives of the patient, interprofessional working has therefore provided some challenges. Some older people have found the complexity of the various personnel roles, uniforms and badges they have met during a hospital stay somewhat confusing. If they need a home service, they may be confused by the number of professionals who ask to assess their needs. A patient once stated that she had just experienced a 'circus' of visits from healthcare professionals which was traumatic, troublesome and extremely tiring – particularly as they often asked the same questions, sometimes within an hour of each other. Often, professionals fail to introduce themselves in a hospital and there is no overall record of who has seen the patient, and this further adds to the confusion for patients, their families and also ward staff.

Activity 6.7

Multidisciplinary Scenarios

See if you can identify the disciplines/professional groups that might be involved in the scenarios in Worksheet 6.2:

Worksheet 6.2 Interprofessional scenarios

Health event	Professionals and support staff involved
Having a baby	
Bringing up a child until age 18	
Screening events: • Cervical • Breast • CVD • Prostate • Bowel	

(Continued)

Worksheet 6.2 (Continued)

Health event	Professionals and support staff involved
Mental health episode	
Surgical intervention	
Eye issue	
Foot issue	
Stroke	
Problems with getting pregnant	
Children with a diagnosed learning difficulty or developmental delay	
A challenge where an older person in a family is told they are terminally ill	

Effective Collaborative Teams

Activity 6.8

Reflecting on Good Practice

Write down what you think makes a good interdisciplinary or interprofessional team.

You may have had experience of interprofessional teamworking that provided satisfaction for you on a few personal and professional levels. The factors you may have thought about would relate to any kind of team effectiveness:

- patient-centred goals
- openness
- collaborative decision making
- clear communication channels
- good conflict management
- good leadership.

One aspect of effective interdisciplinary or interprofessional teams is how well the members of each team collaborate with each other. McCrae (2011) noted that the multidisciplinary context of care has provided challenges for nursing models, and thus the nursing-based theory that was taught in the 1970s and 1980s tended to be unilateral in focus. Sommerfeldt (2013: 519) concurred and noted that practice, assumptions, stereotypes, power differentials and miscommunication can complicate the interactions of healthcare professions where there is a lack of clarity of knowledge, skills and roles in nursing.

Professional power is a complex concept, especially in its relationship to patient empowerment. The work of Foucault (1995) noted that power in the modern world is

spread throughout society and power is used to control knowledge. Gilbert (1995) suggests that you need to understand power to realise the real meaning of empowerment. Bradbury-Jones et al. (2007) note that power is a contested concept:

- It has a diversity of interpretation.
- Everyone has an opinion on what it means.
- Power has a value (nebulous).
- Power is perception.
- The concept of power is interwoven with empowerment.

Activity 6.9

Power and Health Care

Jot down four ideas linked to the notion of power in healthcare practice.

You may have thought about the various power issues linked to different professions such as doctor, social worker and pharmacist. You may also have thought about the types of knowledge they use or their skills in health and social care. Wilkinson and Miers (1999) highlight the work of Freidson (1970), a medical sociologist who saw the profession as an occupation that had succeeded in controlling its own work and been granted legitimate autonomy, usually through the state. This is a form of hierarchical occupational power in society. Some occupations are considered professions and others semi-professions. Social work and nursing may have been consigned to the category of 'semi-profession' on account of the perceived limitations of their knowledge base, training and autonomy (Etzioni, 1969). Democratic accountability and bureaucratic hierarchies are presumed to imply a degree of lay interference in professional activity which does not correspond with the traditional ideal of professionalism.

Orchard (2010) notes the importance of interprofessional patient-centred collaborative practice. However, the relative importance of the healthcare team, the patient/family and their choices, however, are often seen as being in competing spheres. Patients may 'move' into the sick role and not realise or even desire a role in major decisions relating to their care within the context of the interprofessional team. The patient needs to be helped to retain control over their own care within the context of having access to the knowledge and skills of the interprofessional team. For instance, patients often feel confused when facing complex symptoms relating to the involvement of more than one medical specialty and dealing with various hospital and GP appointments. Bergman (2014) highlights that the healthcare world has a good deal of conflict among caregivers, patients and their families. He notes that medicine's scientific, psychological and language complexities, high stakes, fragmentation of care, multiplicity of players, time constraints, institutional

politics, cultural differences, competing philosophies and economic dimensions can all hinder patient/family understanding. For those requiring acute secondary care, hospital life in itself also compounds the situation. Odero et al. (2020) explored the values that influenced the power dynamics between patients and healthcare professionals to understand the patient-as-partner approach. The value of patient input into all healthcare education was seen as key to addressing past authoritarian healthcare perspectives.

Public involvement in shaping health care is fraught with difficulties in engaging with ill patients or the multi-interest factors, but as the health service moves away from a paternalistic culture, public involvement is now a key principle for policy, research, delivery and medical education (Coulter, 2011). Pollard et al. (2010: 186) identify that policy has helped in the shifting of power, though they note the ongoing challenges of the role of 'lead professional' and that of information sharing. Snape et al. (2014) identify the various values involved with public engagement and question whether this agenda addresses the power imbalance. Laverack (2005) argues, however, that in professional practice someone can only possess a certain amount of power if another person loses an equivalent amount of the same. Do you think this is true?

Foucault (1995) noted in his work on the deconstruction of power that:

- It is 'exercised rather than possessed'.
- It is not a thing, it cannot be relinquished.
- It is embedded in everyday practice and interaction.

In exercising power, this can be seen in:

- control
- politics
- wealth
- hierarchy
- a reaffirmation of the social order.

Cooke (2006) noted that those 'without power' are marginalised. Disempowerment, then, can reaffirm one's own identity with others in the same issues, leading to a solidarity movement embracing loyalty and conformity for those within the marginalised group. The issues of power present within each professional group are an interdisciplinary challenge as well as an interprofessional one. Some groups of nurses feel less powerful and marginalised than other groups of nurses. Similarly, this is true for allied health professionals, social workers and doctors. Urisman et al. (2018) researched the introduction of the interdisciplinary ward round process in a surgical intensive care environment in San Francisco in the USA, using a mixed qualitative and quantitative approach. They concluded that this model of ward round improved collaboration and had a positive impact on the quality of patient care delivery.

Other Challenges to Effective Interprofessional Working

Issues of power obviously pose a challenge in working with different teams but there are specific issues relating to interprofessional working.

Activity 6.10

Challenges to Good Teamworking

Note down what you think are the main barriers to good interprofessional teamworking.

When doing the above activity, you may have thought of the following challenges or barriers:

- Differing professional philosophies, priorities, funding and status rewards.
- Differing professional education and training.
- Different professional uncertainties.
- Gender/class differences.
- Staff vacancies.
- Agendas – personal and professional.
- Structural barriers within health care.

Stereotyping how we perceive different professions and even disciplines can hinder how well we communicate with each other. If we perceive the doctor as sitting at the top of the hierarchy, then upward communication may be more of a challenge. Nurses may either be seen as angels, battle axes, handmaidens or sex objects. Doctors are an admired group in society but often perceived as male. Physiotherapists are linked with fitness and activity. Social workers have been described as wearing sandals and tank tops, and health visitors linked with twinsets and pearls. Of course, these are all inaccuracies but it's a way of identifying the pigeon-holing and stereotyping of the range of professions. In her research, Rushmer (2005) identified blurred boundaries between professional groups. She noted that, informally, staff are encouraged to blur the boundaries, to reduce protectionist and rigid demarcations which adversely affect service provision. Pollard et al. (2010) highlight the difference between the 'old' models of professionalism, stressing autonomy and specialist expertise which may inhibit healthcare transformation, and 'new' models of professionalism that emphasise the importance of teamwork and reflective practice. Tang et al. (2018) explored the collaborative experiences of 11 junior physicians and eight nurses in Singapore via themed analysis of interviews. Although a small sample, it was concluded that heavy clinical workloads, organisational constraints and differing power relationships affected interprofessional collaboration, and managers should encourage ward round

participation and active contribution in the decision-making process of patient care. It appears that interdisciplinary and interprofessional working is an idea that requires commitment and experience to accomplish positive outcomes.

It is therefore seen to be necessary for professionals to be more flexible in their approach to working with other professional groups. Tang et al. (2018) question what blurring of the boundaries may involve and whether it offers a way forward in resolving the difficulties experienced by differing health professionals in working together. Some of the challenges here concern what is termed 'professional tribalism', which is discussed in the following section.

Communities of Practice, Tribalism, Power and Professional Identities

Wenger-Trayner and Wenger-Trayner (2021) argue that many professional groups behave in similar ways to tribes, and suggest the notion of communities of practice:

> Communities of practice are formed by people who engage in a process of collective learning in a shared domain of human endeavour: a tribe learning to survive, a band of artists seeking new forms of expression, a group of engineers working on similar problems, a clique of pupils defining their identity in the school, a network of surgeons exploring novel techniques, a gathering of first-time managers helping each other cope. In a nutshell: Communities of practice are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly.

Walmsley et al. (1997) suggest that individuals belonging to the same professional group exhibit many attitudes in common, especially at the ideological level. Individuals working in common circumstances, in similar positions, hold certain views in common, and this has implications for professional boundaries. More recently, Wagner et al. (2019) explored some in-depth philosophical ideas around communities of practice and used examples of families of children with Autism Spectrum Disorder (ASD), who collaborate to work together to share coping strategies as well as support from governmental organisations.

Activity 6.11

Impact of Attitudes on Care Delivery

Write down some suggestions for a variety of attitudes concerning care delivery in your present practice.

As a paediatric link health visitor in an outpatient clinic, one of us was mainly concerned with child development progress, nutrition and growth as well as home support via the health visiting service across the city. The liaison social worker was mainly concerned with supporting parents – with benefit and charity advice as well as social work and housing support in their district – but also focused on child protection social work liaison across the city. The paediatrician had requested the liaison roles in the clinic but her main role concerned the medical condition of each child and their medical treatment. Interestingly, as a team, this was seen as a holistic approach to care. The downside was that these morning clinics often overran into the afternoon as the needs of each child/family were considered from our triple perspectives.

Child protection issues remain a political challenge to interprofessional working and often in the media limelight, reflecting the dilemmas of safeguarding vulnerable children and supporting parents. Errors of judgement have been seen in too many cases over the years, but as the health and social care context of our society becomes more complex – with the mobility of families, complex family structures and the diversity of health and social care services – it is envisaged that safeguarding children will now pose a major future societal challenge. However, it must also be recognised that although children are a vulnerable group, there are many other vulnerable groups, such as older people, those with learning disabilities or severe mental health difficulties, victims of domestic violence, and more recently the slavery of women involved in human trafficking. It is a sad indictment that safeguarding vulnerable adults has not garnered the same political emphasis. Many older people, the mentally ill or those with a learning disability may be abused by families, carers and even staff in the caring services. These are often seen as the forgotten groups, overlooked by the political strategists.

Activity 6.12

Adult vs Child Care

Consider the following question: Do you agree that poor interprofessional working in adult care has not been addressed with the same importance as childcare? Why is this?

You probably work with a wide range of patients and clients, but you will obviously see individuals and families who appear more vulnerable than others. Adults often find difficulty getting health and social care support, particularly if they have some mental or learning disability challenges. There are limited safeguarding laws to protect these groups, and often the individuals involved do not have the capacity to understand fully the risks to them. It is, therefore, crucial that interprofessional care encompasses a more interprofessional learning model for the future.

Learning and Working Together

Education plays an important part in collaborative working skills and knowledge. Interprofessional education (also known as IPE) refers to students from two or more professions learning together during all or part of their professional programme, with the objective of cultivating collaborative practice (CAIPE, 1997) for providing client- and/or patient-centred care. Using a triangulated method of research into interprofessional care in long-term conditions, Laurenson and Brockelhurst (2011) concluded that educational providers and professional awarding bodies need to enshrine interprofessionalism within curricula and qualification accreditation, thereby intrinsically instilling collaboration into care provision. As noted, professional pre-registration UK courses now include interprofessional education as part of their curricula based on positive outcomes. Barr (2002) conducted a systematic review of the literature concerning interprofessional education (IPE) in health care, and from the literature noted that successful IPE needed to demonstrate/include the following:

- service users at the centre of the programme
- the promotion of collaboration
- a reconciliation of competing objectives
- a reinforcement of collaborative competence
- a clear rationale for IPE, both in learning and in practice
- the incorporation of interprofessional values
- common and comparative learning
- a range of interactive learning methods being utilised
- use towards self-assessment and qualifications
- evaluation programmes
- the dissemination of findings.

Activity 6.13

Reflecting on IPE

- What are your experiences of IPE?
- Can you say whether they have been positive or negative?
- Did they fit with the recommendations of Barr (2002)?

Horsburgh et al. (2001) undertook research with a multi-professional group of health-care students in New Zealand and found that most students reported positive attitudes towards shared learning. The benefits of shared learning, including the acquisition of teamworking skills, were seen to be beneficial to patient care and likely to enhance professional working relationships. However, professional groups differed:

nursing and pharmacy students indicated strongly that an outcome of learning together would be more effective than teamworking; medical students were the least sure of their professional role and considered that they required the acquisition of more knowledge and skills than nursing or pharmacy students; research students concluded that developing effective teamworking skills is an appropriate focus for first-year health professional students. The timing of learning about the roles of different professionals may yet need to be resolved though. More recently, Bar et al. (2018) examined the attitudes of healthcare professional students in Israel towards interprofessional collaboration using a descriptive cross-sectional design, and concluded that perceptions of the role of other healthcare professionals improved relationships and patient health care, and could be enhanced by interprofessional education and practice-based learning.

Confidentiality and Ethical Issues

One of the challenges for interprofessional working relates to the ethical issue of patient confidentiality. The Nursing and Midwifery Council (2018a: 5) identifies confidentiality as a fundamental part of professional practice that protects human rights. This is identified in Article 8 (Right to respect for private and family life) of the European Convention of Human Rights which states:

- Everyone has the right to respect for his private and family life, his home and his correspondence.
- There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

The NMC (2018a) state that it is not acceptable for nurses and midwives to:

- discuss matters related to the people in their care outside the clinical setting
- discuss a case with colleagues in public where they may be overheard,
- leave records unattended where they may be read by unauthorised persons.

Discussing the care of patients across the boundaries of a single care delivery setting is less clear. The sharing of information between medical teams in the NHS and social work teams in the local authority has been a long-term challenge. The important ethical consideration is about patient choice and consent when information sharing would benefit patient outcomes. Safeguarding children is a specific area where the rights of the child are more important than those of the adults involved.

Interprofessional Working and Global Health

On an international level, the importance of interprofessional collaboration has been more recently highlighted in trying to deal with global health inequalities. As the economic downturn across the world impacts on the health industry, the need for more effective use of the skills and knowledge across the professions globally is even more imperative.

The World Health Organization (WHO) convened a WHO Study Group on Interprofessional Education and Collaborative Practice in 2007 to review inequality issues, tackle the challenges within a global health workforce and maximise human resourcing. A framework for world health interprofessional education and collaborative practice was produced in March 2010: *Framework for Action on Interprofessional Education and Collaborative Practice* (WHO, 2010). It highlights the status of interprofessional collaboration around the world, identifies the mechanisms that shape successful collaborative teamwork, and outlines a series of action items that policy makers can apply within their local health system. It also provides strategies and ideas that can help health policy makers implement the elements of interprofessional education and collaborative practice that will be most beneficial in their own jurisdiction.

Campoe (2020: 297) noted that the COVID-19 pandemic has led to clinical environments and systems changing very quickly. Interprofessional collaboration and communication are now seen as being more important than ever for patient-centred care and safety.

Summary

This chapter has briefly looked at various aspects of team life to meet the identified learning outcomes. These were:

- **Critically discuss the importance of interdisciplinary and interprofessional working in health for effective patient care and safety**. This was seen in the context of inquiries into poor health care standards but more positively in terms of working to improve patient care outcomes nationally and globally.
- **Critically explore the opportunities and challenges of interprofessional working in the contemporary context**. The issues of policy attempting to address the economic recession, stereotyping and the diversity of cultural differences between professional groups, were explored. The opportunities for leadership and effective teamworking were highlighted.
- **Identify issues of practice communities, tribalism and professional identities, and the importance of interprofessional education**. These issues were explored to raise awareness and support the need for improved interprofessional education.

Further Resources

Interdisciplinary care: In a healthcare environment, a patient may encounter dozens of professionals, from a whole range of varied disciplines, in a short space of time. In theory they should all combine together to provide the best outcome but all too often confusions and problems arise. See www.youtube.com/watch?v=Fh7tIr4Tl1o

National Society for the Protection of Cruelty to Children (NSPCC) (2024) Child Protection System in England. This website provides an overview of the child protection system in England: https://learning.nspcc.org.uk/child-protection-system/england