



## COLLABORATIVE WORKING IN PALLIATIVE CARE: RECENT RESEARCH AT THE UNIVERSITY OF HUDDERSFIELD

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## WHY WORKING TOGETHER MATTERS

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

## ○ Especially true for Palliative and Supportive Care:

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

## DEFINITION OF COLLABORATIVE WORKING

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

## HUDDERSFIELD/MACMILLAN STUDIES

- Nursing roles in community palliative care
- Evaluation of Midhurst Specialist Community Palliative Care service
- Unpicking the Threads: Specialist and Generalist Nurses' roles and relationships in supportive care

## NURSING ROLES IN COMMUNITY PALLIATIVE CARE

- Research question: *What is the relationship between community nursing roles and the delivery of primary palliative care?*
- Carried out in three diverse geographical areas
- Main focus on District Nurses and Community Matrons
- Also interviewed a range of other professional stakeholders (GPs, managers, social services etc)
- Total N. of interviews = 46
  - DNs = 24
  - CMs = 15
  - Others = 7

## EVALUATION OF MIDHURST SPECIALIST COMMUNITY PALLIATIVE CARE SERVICE

- Midhurst service provides specialist palliative care in large rural area of West Sussex, Hampshire and Surrey
- Set up when local in-patient service closed
- Aimed to provide as near as possible same range of services in community
- Most of population do not live within easy reach of a conventional hospice
- Multi-disciplinary team, with CNSs, Community Support Team (staff nurses + HCAs), Consultants, therapy professions, counselling

- Evaluation by Sheffield and Hudds Uni's, plus Monitor Group (economic)
- Huddersfield focus: *the role of the Midhurst team and the nature of its relationships with patients, carers, and other health and social care professionals*
- Total of 69 interviews
  - MH team = 30
  - Patients = 11
  - Carers = 10
  - Other professionals = 18

### UNPICKING THE THREADS

- Research question: *how do generalist and specialist nurses work with each other, with other professionals and with patients and carers to support cancer patients?*
- Also interested in comparisons between services for cancer and long-term condition (LTC) patients
  - Asked clinician ptps where possible to describe one cancer case & one LTC case
- Focus not just on EoL: also addressed support for cancer survivorship

- Set in one metropolitan borough
  - Mainly urban, with some suburban and rural areas
  - High deprivation and high health inequalities
  - Boundaries of PCT, Acute Trust and Local Authority social care co-terminous
  - Adjacent to other densely populated areas (and some more rural areas)
- Total of 78 ptps:
  - 15 DNs, 11 CMs, 7 community spec nurses (LTCs)
  - 13 acute specialist nurses (7 LTC, 4 cancer, 2PCSN)
  - 6 patients, 6 carers
  - 20 others

### KEY THEMES ACROSS ALL THREE STUDIES

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

### ROLE PERCEPTIONS AND UNDERSTANDING

- Collaboration is made difficult where there is:
  - Lack of knowledge/misunderstanding of others' roles
  - Uncertainty re own role
- E.g. Community Matrons' role in EoLC
  - In Nursing Roles study, DNs and CMs themselves varied considerably re whether and how they saw CMs as having role in community palliative care
  - In UTT, CMs (and others) had differing views re their involvement with cancer patients, at EoL and before

### VIEWS ON CM ROLE IN EoLC (NURSING ROLES STUDY)

- NO ROLE FOR CMs IN EoLC

“We don’t really need to involve them at all; I’ve been working at Goldborough for coming up for a year now and I’ve never needed to involve a community matron in any palliative care.”

(District Nurse, Goldborough)

- None of the CMs took this view

DNs have lead role, but CMs usefully involved

“It (Community Matron role) may stop perhaps crises happening [...] She sees it coming and then we’ll talk about it and maybe we’ll go in before it happens, so it’s probably a lot better for patients.”

(Community Staff Nurse, Woolbeck)

- This view also shared by many CMs

### CMs should lead in case management of (some) palliative patients

“I think the future for the Community Matron role in palliative care is to proactively identify patients that are mainly a year or just before that of potentially dying so that we can get in there and effectively plan the care that’s needed...”

(Community Matron, Goldborough)

- A few CMs argued for leading case management role even for cancer pts - View not shared by DNs

- Leaving aside what CM role *should* be, clearly potential for mismatched views that may impact on collaboration

- CMs may feel excluded by DNs who see no role for them
- DNs may feel their role is being stolen by CMs who want to “take control”

- In the 3 areas, different organisational histories and arrangements impacted on opportunities to address such issues

## ROLE FLEXIBILITY

- In all 3 studies, role flexibility was seen as assisting collaboration
  - Doing what you can (within competence) rather than what is strictly defined by your role
  - Enables negotiation of roles between professionals, around needs of patient
- Flexibility can be inhibited by:
  - Sense of threat to professional roles and identities
  - Organisational constraints – e.g. workloads, information systems

## EXAMPLE: MIDHURST TEAM

- TEAM ETHOS OF FLEXIBILITY
 

“We try to stay flexible because that’s the uniqueness of the service...it shouldn’t be task-oriented”  
(Clinical Support Team)

“...it’s a very flexible workforce, people don’t get too entrenched in what their role is”  
(Service manager)

“...as far as OT and Physio are concerned our roles are very interlinked – I do quite a lot of breathlessness and she does quite a lot of equipment”  
(Midhurst OT)

## Minimising of hierarchical relationships

“I don’t feel there’s any hierarchy as such, which I mean that in a positive way, you know: the Consultants, the CNSs, the Clinical Support Team, we all try and work as one, and there’s no fear of asking questions if you don’t know anything”  
(Clinical Support Team)

## CONTEXT OF CHANGE AND UNCERTAINTY

- These studies were carried out over period of considerable change and uncertainty about the future (even by NHS standards!)
- Generally seen as unhelpful for collaborative working
  - Changes to roles
  - Changes in management
  - Financial restraint
  - Fears about own jobs
- Midhurst team somewhat insulated from worst of this by relative independence

#### RELATIONSHIPS AS CENTRAL

- Overall, quality of relationships amongst professionals is crucial
  - Accessibility and availability
  - Longevity of relationships and shared job history
  - Respect
  - Making an effort
- Examples from UTT project

#### Accessibility and Availability

“Working here in this building has been a real bonus because I’m working alongside, you know, physically working next to other specialists: dermatologists and heart failure nurses, COPD”  
(Lymphoedema CNS)

“I think sometimes when you phone somebody – over the phone, it depends on your communication skills, often things are forgotten. But face-to-face they’re brought to mind a little bit better”  
(District Nurse)

#### Longevity of Relationships /Shared Job History

“Because I’ve known [name] who’s the manager for so long we have a very close relationship, so that if I ever have any problems that I can’t manage I can refer to the Acute Trust for specialist care with the Consultants [...] We have close links with all the services really, and I think because a lot of us have worked together over the years we know names and faces”

(Diabetes Community Nurse Specialist)

#### Respect

“Very, very accessible [i.e. *Consultants*], even out of hours when they shouldn’t be, you know, they leave their phones on. And I think that’s because we don’t mither them with silly things, so when we do ring them they know it’s a problem that we can’t sort out, so it’s like respect really, isn’t it?”

(COPD Acute Nurse Specialist)

### Making an Effort

“Going and seeing ‘em. Lurk outside a Doctor’s room. I’m always lurking down here. Go in and see the Doctor. Nip over and see the District Nurses. Go to the Hospice – I know the girls at the Hospice now. Go to Intermediate Care. You can’t go all the time, I don’t mean that, but go make your face known”

(Community Matron)

### Change and Development – Through a Relational Lens

- People best able to collaborate where they have strong networks of personal relationships with colleagues in other professions and/or organisations
  - Builds trust to enable flexibility
  - Aids mutual role understanding
- NHS changes (at all levels) can inhibit collaboration because they disrupt professional networks of relationships
- Often neglected in organisational change and service development at all levels

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

(Manager)

### SELECTED PUBLICATIONS

- King, N., Bravington, A., Brooks, J., Hardy, B., Melvin, J. and Wilde, D. (in press) The Pictor Technique: a method for exploring the experience of collaborative working. *Qualitative Health Research*.
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- King, N., Thomas, K., Martin, N., Bell, D. and Farrell, S. (2005) “Now nobody falls through the net”: practitioners’ perspectives on the Gold Standards Framework for community palliative care. *Palliative Medicine*, 19(8): 619-627.

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