**Listen to THIS - Episode three: Relationship building in interdisciplinary working and teams**

Tara Lamont: Welcome to Listen to THIS, where we have conversations with all sorts of people examining how we can improve the quality and safety of healthcare.

In this series, we'll dive into both current and long-standing healthcare challenges and shine a light on some of the work that's being done to address them.

I'm Tara Lamont, Fellowship advisor at The Healthcare Improvement Studies Institute. Do we know enough about what makes teams work well across services organisations and the relational work that goes into that?

In this episode we'll focus on an important area of building relationships across interdisciplinary teams. Increasingly, staff are working in teams with many different professionals across different settings, but they may not been trained to do this. What makes such teams work well or better?

COVID was a big shock which changed the way we work, and remote working has become the norm for many. How does that affect the way that staff bond, newer staff learn and the shared understanding of work and care?

Joining me today are three THIS Institute Fellows.

Jenelle Clarke: Hi, I'm Jenelle Clarke, I'm from the University of Kent. My THIS Fellowship project is looking at the rituals of integrated working, specifically how everyday practices shape how people work together within and across services.

Justin Waring: I'm Justin Waring from the University of Birmingham. My THIS Fellowship project looked at the development of interprofessional working in the provision of surgical care for older people.

Sarah Yardley: Hi, my name's Sarah Yardley, I'm a clinical academic, so a doctor and researcher at University College London. And my THIS Institute Fellowship project is about the role of relationships in healthcare, thinking about the social and cultural.

Tara: Thanks. So it'd be great to hear a bit more about what are you puzzling out or working through in your research around teams and the relationship building that goes on. And perhaps I can start with you, Sarah.

Sarah: My fellowship work focused on two areas of healthcare practice, where relationships of all sorts between multiple different people in different roles, different contexts are really important.

The first of those, people living with potentially life-limiting, progressive serious physical illness, in particular in need of palliative care, whether that's from specialist services or elsewhere in the healthcare system.

And the second, people living with severe and enduring mental illness. So that covers many different diagnoses, but loosely the kinds of mental illness where people's function is really impacted on an ongoing basis. I guess the essence of what I'm trying to look at is a number of different gaps between the rhetoric and the reality of healthcare systems, between policy and practice, and particularly taking the perspective of the people healthcare should be helping.

The gap between expectations and experience and bringing to light the hidden work and hidden workarounds that go on to try and address what matters most. Often these are very much relationally mediated.

Tara: Thanks, Sarah. I think you came up with this lovely phrase, ‘*relational glue’*.

Sarah: Yes. So I've got three working catchphrases, if you like, ‘collective social safety’, ‘relational glue’ and ‘relational reach’.

So collective social safety is actually a phrase that was developed with my patient-carer, professional research participants to try and describe something more than physical safety, which everybody gets.

Psychological safety, which people will have often heard of but is often still thought about in quite an individualised way “Do I feel safe?” And there was something that they wanted to describe that went beyond that was about being safe together. Me feeling safe with you feeling safe with me. It goes both ways and it incorporates understanding of things such as trust and forgiveness, which are obviously more than just, “do I feel safe in myself?”   
  
Relational glue was the phrase that we came up with to describe the essence of what that connection is. It's being in relationship, it's the in betweens that glue things together within a system. And then relational reach describes how you can multiply that up.

We began to talk in my research workshops about chains of people knowing each other and people having fair access to those chains of knowing. Because obviously it's not realistic in an entire healthcare system for every individual to know every other individual.

But if I know you and you know Jenelle and Jenelle knows Justin…that's a chain of knowing that if everybody has fair access to those chains of knowing, we can make relationships beneficial for everybody.

Tara: That's really interesting and I think that probably resonates, Jenelle, with some of your work about the kind of rituals and practices which helps to make those relationships happen.

Jenelle: It does resonate very much. So it probably would first be helpful if I explained what I mean by a ritual. So I'm based within sociology. I take a very sociological approach to understanding what a ritual is. And a ritual can be something big, it can be something ceremonial outside of healthcare, things like weddings, football games, football tournaments. Or it can be something very small, very every day, which is like…take a greeting, for example. You know, “hi, how are you? Yes, I'm fine”.

A ritual will be a practice that's done with other people, so at least one other person. It has shared attention, shared emotion between either two people or a group of people. And it produces feelings of confidence and wanting to repeat that ritual again.

These everyday practices are really setting the tone, they're setting the expectation for how people work together and how they relate. So if in the main, let's say you take a clinical healthcare team, if in the main, most of those interactions – so whether they be meetings, they be daily greetings, they might be getting a cup of coffee together, lunches, those kind of things – if those interactions are more or less positive, as in they leave people feeling good about themselves, good about their place, their role, their fit within their team, good about their contribution to that and what they get back from the group, that's what we would call a successful ritual.

And if you have enough successful rituals, if that's your baseline, you're going to want to repeat those rituals.

So when the meeting invite comes up, it says ‘team meeting’, if most of your team meetings go fairly well, and you know what's expected and you're getting something from that, it doesn't mean you never disagree, it doesn't mean there aren't tensions or things that are uncomfortable or awkward, but those things are worked through to the point where you feel good about those things…

So when that meeting invite comes through, you're not thinking, “oh, Lord, how can I get out of this?!” It's, “oh, yeah, of course, a team meeting”. That's what I mean by a ritual. So what my project is looking at…is working in an integrated way is difficult.

It's challenging because you're working often across different specialties if you're in integrated care (and the way I'm interpreting integrated care can be something within the NHS). So it could be one team working with another NHS team, or it could be inter-organisational working. So the NHS working with, say, local authorities working with the private sector, third sector organisations or other stakeholder groups, each of those different teams’ organisations can have different ways of working, different expectations for their own organisations.

So different priorities, different values, different funding streams, different IT systems. The challenges of integrated working are well known. And what makes successful integration is also well known. So things like good communication, you need to have a culture of trust, a culture of belonging. Exactly what Sarah was referencing, and I suppose what I'm looking at through these rituals is how do teams work towards having these cultures and this sense of trust, this sense of belonging, this sense of connection - exactly that glue that Sarah's referencing, how do they do this through their everyday practices?

Because in my experience in working with teams is when things go wrong, it doesn't usually come out of the blue as such. It can do. But a lot of times there's things in place that people aren't entirely happy with. They're aware of some of the problems and things then start to slip.

You have some problems and you can often pinpoint some of these daily practices where things just aren't quite clicking, they're not quite gelling for everybody that actually aren't being addressed and worked through.

But when they're working really well, people don't notice because they're working so well and it's just, it's so supportive, it's so underpinning. So I'm really interested in those everyday, I call them rituals, those everyday ritual practices of how people interact and relate. Because for me, it is so fundamental to establishing what Sarah's describing of good relational working.

Tara: And that's really interesting, isn't it? Because what you're saying about almost the unknowing practices of good teams, because we all know when it's very forced, the kind of team bonding exercises on an away day, but I think you're saying that there are some organic and helpful everyday small activities which happen.

If I can turn to you now, Justin, because you're very much exploring new pathways and people who perhaps haven't worked together before. Could you tell us a bit more about your work?

Justin: So the fellowship project is looking at changes in the perioperative pathway for older people undergoing surgery.

What this is looking at in particular is the changing and the expanding role of geriatricians, clinicians who look after older people and how they are building new relationships with surgeons and anaesthetists and a whole range of other health and care professionals to support older people through this surgical pathway.

And in the first part of the pathway, it's often thinking about what are their holistic needs, what are their complex care problems? There are multiple care problems in multiple conditions and then how could these better understood, diagnosed and addressed?

Can people be optimised is the word often used, before they go to surgery, so that they're fitter and healthier when they undergo the surgical procedure and then afterwards, how can the geriatrician work with the surgical team, the anaesthetic team, to support recovery and rehabilitation and longer term discharge and there's been a long history of geriatricians having this role in the pathway, but what the move is to make it more integrated.

 So there's a real sense of a team and shared decision making. And obviously this can be challenging because healthcare professionals tend to work in quite siloed ways, with their distinct identities, areas of practice, their distinct cultural norms.

And so what the project has been looking at is the specific work and it's something that Sarah alluded to around this hidden work…what is the work that people are doing to build these relationships in particular, often geriatricians we spoke to talked about some sense of opposition or anxiety or pushback from other professional groups.

And so what did they have to do to try and build these relationships and build these new bridges? And in many ways there was no simple answer. It took time and it took time to build that mutual understanding and respect and trust.

It also took the importance of demonstrating the value that transdisciplinary working can have to say. Actually, there are things that you, as a brilliant synergy, don't quite understand about persons wider health issues or their wider kind of circumstances that actually, we as geriatricians can really help support. And then in other ways it's just being present, being there, being a part of the team.

And this goes back to some of the things that Jenelle talked about in terms of building those relationships and making them feel positive and valued.

But it also involves mediating conflict, because there's often conflict in teams and in professional relationships. And actually it's about accepting that conflict can be okay, you know, we're allowed to disagree, but how do we move through disagreement into a more positive a solution or settlement?

And I think this sense of mediating conflict, or what I often talk about in terms of diplomacy, is really important in healthcare settings to help think about moving towards these much more positive outcomes that people think, okay, I might not have won in this situation, but actually the greater good is being served.

Tara: It's interesting too what you're saying about being present, because I think in some of your earlier research you were highlighting the importance of actually physically co locating teams. Do you want to say a bit more about that?

Justin: So in a past study, which actually very much set some of the foundations for the Fellowship project, looked at some of the problems with organising and planning for people's hospital discharge and this is a real tricky time at someone's care pathway. They've often had intensive acute hospital care and now they're almost being transferred out back into their home or community setting and there's a handover period.

But actually people still have lots of complex things going on in their lives. They might have lots of complex social issues, personal issues, as well as over and above their physical health issues. And actually what you also need at this point is the combination of occupational therapists, physiotherapists, the other clinical team, but also social workers, social care, family members, friends. It's a real big constellation of people involved.

But often these people are all separate and they're all in different places and locations. And so one of the big things was about finding the time and the place where you can start to connect these people together.

And one of the things we found is this concept to be called ‘functional proximity’, that if you can find times and places for people to actually connect and have that face-to-face time, have that opportunity to discuss issues with each other, it's much more easy to work through the problems.

But then over time that supports familiarity, it supports trust, it supports that mutual learning that are the foundations for good relational working. And I think probably that support some of those relational glue that Sarah's work talks about.

Tara: And I guess there's a challenge then when we move to remote working and you've all been talking about these very complex teams, but Sarah, did you want to come in on this?

Sarah: Well, it links to the thing about remote working in a way Tara. As Justin was talking and building on some of the things Jenelle said too, there were three things coming to mind.

My fellowship research was conducted in pandemic times. And I think that provided me with unexpected insights on actually, sometimes I wonder whether thinking has been a bit too focused on the mode of closeness or the mode of connecting, by which I mean the sort of practicality. So are you literally in the same location physically or are you using a telephone or are you using a video call?

Because I think the pandemic taught us some of the assumptions we made, and from my clinical practice I know this very well, that although mode--I'm not saying it doesn't matter-- it's not the be all and end all. And actually there were other things. Again, people talked about closeness, I guess a more everyday language way of saying proximity in my research, but they describe closeness in moral or value based terms. So I know I'm on the same side of this person. I know, I think we're working towards the same values. We've got the same goal.

And actually, quite rapidly, people from disparate parts of the healthcare system and different roles would be talking about, “oh, yes, we're all on the same side”, but it's the system. So the othering of them and us and who was close was about how people were thinking about things and also having shared language and understanding of the meaning of that language, not just having shared words.

So that was really interesting to see those different dimensions of proximity.

But I think the other thing that was really important that came up as Justin was talking is they're often positioned in this slightly ambiguous advisory or liaison role, but from the person receiving care, the patient or service user's perspective, they're not really interested in any of that, about how the system's organised.

They just want somebody who's going to help meet their needs. They're not even interested in the service offer per se, they just have this set of needs and would like people to be working in a way that allows those to be met. And moving between systems or having dual needs within a system really brings that to light.

So whether that's in and out of hospital, whether it's needing geriatric care alongside surgery, whether it's needing mental health care alongside physical healthcare, these points, I think, really highlight how proximity is a more complex thing than simply location. But we should be paying more attention to closeness as a relational thing.

Tara: I mean, one of the things I'm wondering across all your work is whether the system and individual organisations afford the time that is needed. Is it recognised and understood the relationship work that you're all describing? I don't know, Jenelle, if you've seen in your research where that's more or less achieved?

Jenelle: It really varies by team. I think it's really difficult to say. I think there have been in some teams where it is recognised, sometimes as difficult as it is, from what I've seen, sometimes it can come down to the leadership structure and what's valued specifically within that team, or down to the organisational structure of what's valued within that organisation. And that's where you can see some of the variability, I suppose.

But I think some teams, they really get it and they understand that. We all have meetings and there's meetings all throughout the day. They serve different purposes, but it's how you use that meeting and what you're doing within that meeting to build that relational work. It's how you ask questions, it's how you listen, it's how things are discussed.

And that's all contributing towards what I was mentioning earlier, about do people know what their role is – like really basic things. But you'd be surprised at how often these basic things go wrong, where people don't actually know why they're there or what their purpose is or what so and so's purpose is, because they've just parachuted into this group and who are they?

What do they do? When there's uncertainty around things like that of how things begin to fit? I think that's where you see some of the erosion of relational working or it just not getting that momentum and getting that traction to have that fitting together. I think it's dependent upon not just…I liked what Sarah said just a minute ago…it's not just about the proximity, it's that closeness, but it's how you're doing that and I think can make a difference into better team working, better team dynamics.

But there are certainly some teams, organisations, what have you, that could benefit, I think, from a further understanding that as Justin said earlier, this type of work, it takes time, it doesn't just happen.

And I think a lot of times we think that things like communication, trust, these things will just naturally happen. If you just do your job, you're good at your pocket of what you do and it will just somehow magically fit together. A lot of times it doesn't work that way. You do need to be doing a little bit more in addition to that in order to make that all fit together, it doesn't just happen by itself.

Tara: And I could see you nodding there, Justin. You've had the experience of working with very good and inspirational teams, so you can see how it happens.

Justin: I think one of the things that sprung to mind as Jenelle and Sarah were talking is around scale as well. What are we talking about in terms of the care system? And obviously what we're dealing with is people relating to people. Often we're thinking about teams on the, let's call it the shop floor.

But one of the things I've been really interested in recently is how these relationships work at not just organisational, but the inter-organisational level. So with the introduction of integrated care boards or before those sustainability transformation partnerships, where you're trying to make different organisations and sectors work together in a different way to provide better health and social care, but it's still depending upon relationships because you're getting all these people and you're sticking them in the room and going, “oh, you're now an integrated care board”.

And actually, one of the interesting things that we've been looking at over this kind of process is actually how they're not afforded the time, they're not afforded the opportunities to build those relationships. And one of the interesting things is around how we often substitute all those soft things, the glue, for procedure and governance and policy, and I think those can actually work in the opposite direction.

So I think one of the things that we...again, thinking about this at a different scale, whether it's at the shop floor or the organisation or the wider care system, what we're often seeing is change in roles, relationships, the allocation of responsibilities and resources and often we don't afford the people doing this the time to actually build those connections, to build the understanding, to find the ways of working, to build their glue.

And we just assume that we can, I don't know, using the analogy, pop down the DIY shop and slap some glue over it in the form of a good set of policies. And this glue is going to work and actually it doesn't.

And I think that's where we see so many problems, is that we don't allow and recognise the time that it takes to build relationships at these different levels. And at different levels, it has even more complications because the level of people involved grows and the diversity of those people grows. So I think in many ways it's so important to foreground and acknowledge the importance of all this soft stuff and the hidden stuff and the glue. And I like the glue analogy.

Sarah: Thank you. Maybe I should make it my mission! We'll all just start talking about stuff and glue and not use any academic words at all.

But time is something that I really think is an area for further research in all of this, because I have, you know, you asked us at the beginning, Tara, about what's bothering us, what are we thinking about at the moment.  And I have really conflicting thoughts about how we think about time. I don't want people to go away with the idea that working relationally always takes more time. There are some things you can do to build closeness that take fractions of milliseconds. Like when I'm walking around the hospital as a doctor, everyone is wearing a name badge. Using their name does not take a measurable amount of more time, but it does make a real difference.

But on the other hand, I don't want to say I wouldn't want people to go away without the idea that time, as Justin just described isn't important.

I think the problem is often the system we work in healthcare doesn't allow us to think collectively about time management. And so we end up with the incentives in the system are all about part system efficiency: how quickly can my bit of the system do its bit, not about whole system effectiveness.

And there were two good examples of this in my research. One is some things that I would loosely call weaponising referrals. So making referral systems as difficult as possible, rejecting referrals without every last thing, you know, ticked, crossed, dotted on the right form, et cetera.

When I asked people about what was going on there, what they actually talked about was not so much time initially, but about how they felt if they accepted a referral, they became responsible and they were concerned that they would be criticised if they didn't work according to the rules.

And what they meant by that was they felt that they were being asked by their organisations to spend their time demonstrating they'd done everything they can to stop things going wrong, rather than being creative when creativity was needed in non-standard situations to do the best for a patient.

So, for example, should a district nurse go out to somebody's home and do their dressing in an unorthodox way because that's all that the patient will allow them to do, but they're worried, no one's going to back me up when I explain why I made that choice, but when I unpicked it a bit more, it was about time because they didn't have time to spend with that patient to build trust and rapport and negotiate to get to the best way of doing that dressing.

So there's this sort of…yes, it's about time…no, it isn't about time. The other example was, I spoke to and observed some people working in complex care hubs or groups that were related to integrated care systems, and what they told me was we're very willing to work in this way.

This is why I've taken this job from wherever they'd come from before, but we're only allowed to do it with the people who are causing a lot of noise in the system. So if you're a patient who turns up at six different emergency departments, phones your GP 10 times a day, calls social services, doesn't answer the door when your palliative care team comes out, et cetera, the system starts going, oh, this is using up lots of resource, so let's pull these people together, work relationally, invest in this meeting.

And other people said to me, these are really expensive meetings, but we're biased in what it costs not to have the meeting. And I feel that the bar well, first of all, I think it's disappointing that we're talking about noise in the system, not patient need.

And secondly, I feel the bar is set too high. And if people could invest earlier on and that was seen as a positive thing to do, we would have better whole system effectiveness. And I would love somebody to come up with a way to research whether actually any of this does take more time or not, because I think we just don't know.

Tara: Well, that's on the subject of time, that's a great note to end. We could carry on talking for hours, I think, but thank you all so much. It's so interesting to hear about the work that you're doing, so thank you. Jenelle Clark, Sarah Yardley, Justin Waring. I've been your host, Tara Lamont, and I hope you've enjoyed listening to Listen to THIS.

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