Academy of Medical Royal Colleges

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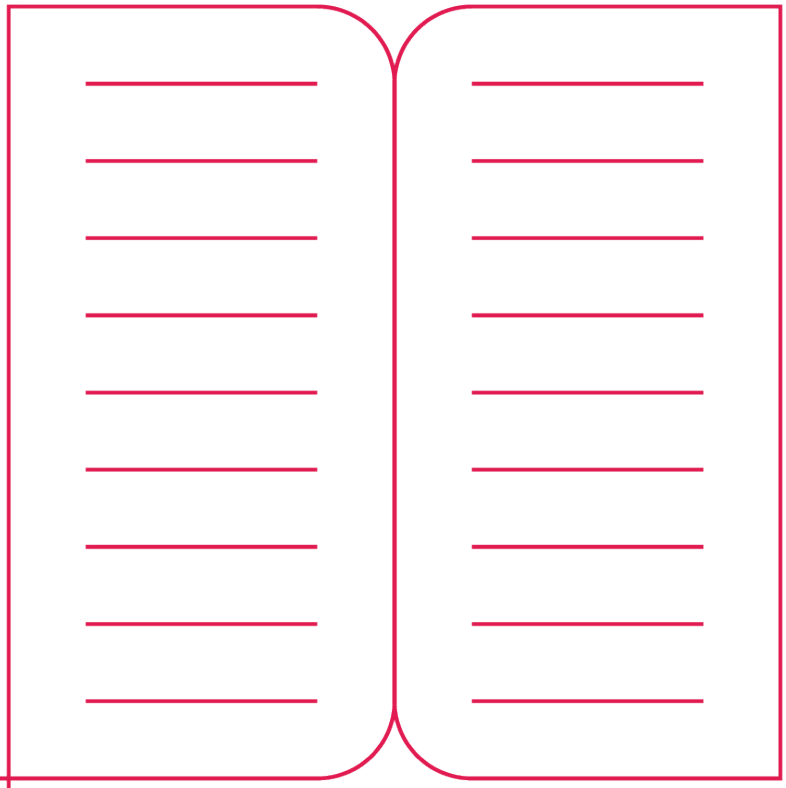
Developing professional identity in multi-professional teams



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Foreword

Delivery of healthcare has been transformed over the past few years in order to meet increasing demand and to improve patient care and experience. This has largely been achieved through better use of the entire workforce which has been enabled through broader training and a more flexible approach. In essence, traditional professional boundaries have been stretched so that patients can benefit from a broader, more diffuse, skilled team. However, it is not simply doing more to achieve more — this approach has improved job satisfaction, stimulated career development, allowed everyone to work to their maximum potential, promoted interpersonal relationships and enhanced retention of staff. The total benefits amount to considerably more than the sum of the individual parts.

The advantages of being a member of a specific profession are also tangible, however; the sense of belonging and professional identity this brings must not be lost within the multidisciplinary team. Each member contributes their own particular skill set which commonly has been optimised and enhanced to deliver within specific clinical settings. Individual professional development is exciting and rewarding.
The opposite side of that coin is professional protectionism — others delivering activities considered within the domain of a specific professional group may be seen as threatening and can cause conflict if not recognised and addressed properly. The balance between identity and protectionism can be fine, but what is vital for success is that each member is encouraged and enabled to contribute as part of a group that fully respects each other's roles and abilities. This is happening at pace across all healthcare professions at all levels.

The value of multi-professional work has been fully exemplified in the rapid advances that have occurred during the COVID-19 pandemic — and this document will be invaluable in developing this further in the future world of endemic COVID-19.

Professor Carrie MacEwen
Chair, Academy of Medical Royal Colleges

Executive summary

In health and care settings, a strong and confident professional identity has been linked to staff wellbeing, clinical practice and patient care. To maintain these benefits, however, one's professional identity must be flexible and able to withstand changes in the professional environment — it must be able to adapt to new ways of working.

This guidance offers advice on how professional identities can flourish in multi-professional teams, looking at both individual and team identities. We set out how professional identities are formed and why they are important for health and care staff. We then consider how individuals work in different models of teams and the varying ways in which they interact with staff from other occupational and professional groups. The guidance recognises the importance of individual professional affinity while acknowledging the risks of protectionism.

We have identified five key themes which are explored in this guidance:

- How **changing roles and responsibilities** should be communicated and understood
- The principles that underpin **effective team-working**, which enable individuals and teams to thrive and deliver the best care for patients
- The importance of **celebrating diversity and difference** and **resisting protectionism and silo-working**, which involves creating a supportive culture, promoting respect for the contribution of others, and resolving conflict effectively
- How **interprofessional education and training** can enhance professional identity formation and team-working skills at the outset of medical and healthcare careers
- The ongoing role of **CPD, supervision, mentoring and appraisal** in stimulating a culture of shared learning and a supportive and self-reflective environment.

Throughout the guidance we include case studies of multi-professional team-working taken from different health and care settings. They provide examples of initiatives and schemes that enhance the development of individual and team identities, that readers may wish to replicate in their own workplaces. These case studies also reflect on some of the challenges that need to be overcome to embed new ways of working and highlight successful strategies and approaches.

The guidance then identifies ten key principles for promoting identity development in multi-professional teams that can be used across different health and care contexts. The purpose of this guidance is to help individuals build pride and confidence in their own professional identity — including the values, skills, and attributes they bring to a team — while developing shared identities with colleagues from across different professional groups.

Introduction

Effective team-working is essential for the delivery of patient-centred care. With an ageing population, a rise in comorbidities and increased specialisation of healthcare, patients need a holistic, team-based approach. This requires practitioners from different clinical professional backgrounds working together and adapting to new models of care.

The NHS and social care workforces are already multi-professional in character, comprising groups ranging from doctors to nurses, pharmacists to psychologists and social workers to optometrists. The 14 different allied health professions — a diverse group ranging from music therapists to paramedics — make up the third largest workforce in the NHS and there are over 50 separate specialisms amongst healthcare scientists. Of course, the healthcare workforce also comprises crucial non-clinical staff who contribute to the successful delivery of healthcare.

Over time, tasks that were traditionally the preserve of one clinical group, often doctors, have become the responsibility of other members of the team. Non-medical prescribing — the extension of prescribing rights to some other healthcare professionals — is a well-established part of multi-professional working which has helped to share clinical responsibility. More recently, the Medical Associate Professions (MAPs) — comprising physician associates (PAs), surgical care practitioners, and anaesthesia associates — have grown rapidly. In 2018 there were around 600 qualified PAs in the UK;[1] the *Interim NHS People Plan* anticipates that there will be over 2,800 PA graduates by the end of 2020.

Multi-professional teams are at the centre of health policy across the UK. NHS England's GP five-year contract framework (launched in 2019) supports Primary Care Networks to recruit up to 20,000 additional staff, including clinical pharmacists, PAs, physiotherapists, community paramedics, and social prescribing link workers. The Interim People Plan, meanwhile, was developed on the basis that *'multi-professional clinical teams will be the foundation of the future workforce'*, a conscious shift away from *'treating the workforce as a group of separate professions'*. NHS Scotland's 2020 workforce vision *Everyone Matters* sets out the importance of *'putting new and extended roles into practice'*, while multidisciplinary primary care teams are central to the *Health and Wellbeing 2026 — Delivering Together* roadmap in Northern Ireland.

The COVID-19 outbreak and response have demonstrated the importance of multi-professional working amid unparalleled service pressures. *"There are no more surgeons, urologists, orthopaedists — we are only doctors who suddenly become part of a single team to face this tsunami that has overwhelmed us,"* pronounced Italian doctor Daniele Macchini. These words resonated with health teams internationally and were used as a strapline across workforce deployment plans and briefings in the NHS. The Academy of Medical Royal Colleges (Academy) *Principles for reintroducting healthcare services – COVID-19* highlights, amongst other things, the need for updated ways of working that rely heavily on the developed, team-based workforce.

The Academy previously set out in a joint statement with other professions that the diversification and expansion of roles is essential for the delivery of twenty-first-century care and that new ways of working are dependent on the highest standards of professional education and training being maintained. Effective multi-professional team-working requires mutual respect and collaboration, without protectionism of specific practices or roles leading to the associated perpetuation of silos. We need a culture change that ensures all members of the multi-professional team are utilised flexibly and effectively and are supported in their practice and in their professional development. All health and care professionals should be enabled to work to their full potential.

There is a wealth of literature on and resources to support effective multi-professional team-working (see Resources). Building on this, the Academy has developed this guidance to support those working in health and social care to consider how they can nurture and develop their own professional identities and those of their colleagues, while working within and across multi-professional teams.

To compile this guidance, we conducted a literature review of material on professional identity formation, team-working and multi-professional working. We held phone interviews with experts in academia, policy and practice and organised focus groups with participants from across the health sector. The resulting guidance brings together practical advice and case studies designed to help a range of clinical professional groups in their practice. While it may not be plausible to integrate some of the initiatives outlined amid the COVID-19 response, the principles we set out will be crucial to the effective restoration of services and patient care in the wake of the pandemic.

What is professional identity and why is it important?

In forming their professional identity, individuals internalise the values, norms, skills and behaviours of their occupational group. This results in them *'thinking, acting, and feeling'* like a member of that group[2] — whether that be a doctor, nurse, pharmacist, midwife, or advanced level clinical practitioner, or indeed a lawyer or engineer, for example. A professional identity enables them to attach meaning to their work as well as to develop a sense of self and perception of belonging.

For health and care professionals, identities are formed in different settings and through various interactions — from formal education and training through to clinical practice and patient care, as well as mentoring and supervision. The transition from studying to practising is a key milestone, but professional and occupational identities are not simply acquired — they continue to develop over time. Individuals shape their professional identity in relation to the perceptions and expectations of those around them, including colleagues, patients, employers, and regulators, as well as those outside of their working life and wider society. Encounters may reinforce or challenge someone's professional identity.

All individuals hold multiple identities. As well as having their own sense of self (both personal and professional), a health or care worker is likely to identify as being part of a team, as an employee of an organisation and as a member of a professional body, such as a Royal College. Identities are shaped through an individual's participation in, or engagement with, these different 'communities of practice', i.e. they learn through their interactions with different groups.[3] People manage their multiple identities in different ways, learning to navigate and reconcile the many layers. 'Identity dissonance' describes situations where an individual struggles to reconcile their different identities.[4]

Research suggests that a strong professional identity has both positive and negative consequences for individuals and their colleagues.[5] It has been linked to autonomy and resilience;[6] wellbeing and the ability to mitigate burnout;[7] ethical decision-making in difficult situations[8] and patient care (e.g. adherence to standards and interpersonal communication). A study commissioned by the Professional Standards Authority found that it was *'the commitment of individuals to practise in line with the standards that follow from their own professional identities that drives good patient care'*.[9]

If an individual has an overly rigid professional identity, however, this may lead to poor team-working and resistance to change. Distinguishing dogmatically between their in-group and out-group can lead an individual to display favouritism towards those they consider their peers and even bullying behaviours towards those they consider different.[10] A rigid identity might also fail to equip the individual for changes in their working patterns, practices, or professional environment.

The introduction of new roles or new ways of working can be perceived as a challenge or threat to pre-existing professional identities. For example, if a doctor regards carrying out an endoscopy as a core part of their professional role, then ceding this task to another professional group may be seen as resulting in a loss of status, authority, responsibility or experience.

To shore up a professional identity that they believe to be under threat, an individual may resist change and become protectionist. Individuals should be able to express concerns about changing practices, particularly where these relate to patient safety, but an open-minded and collaborative

approach is crucial to professionalism and patient care. For many health and care staff, new ways of working will be perceived more positively, since changing roles and responsibilities can help to highlight the core aspects of one's own identity.

In 2018, the General Medical Council (GMC) and research consultancy ComRes undertook research on 'What It Means to be a Doctor', which showed how team-working can be crucial to professional identity and wellbeing. Doctors were asked the extent to which different factors, relating to working with colleagues, were linked to day-to-day satisfaction. Ninety-one per cent of respondents cited *'sharing expertise and ideas'* while 89% cited working in a team to *'cure or improve patient health issues, sharing ideas on solutions for a patient's diagnosis and treatment'.* Feeling as though other colleagues *'respect[ed]'* them was cited by 88%. When respondents were asked about changes over time, 58% of those who had been practising as a doctor for more than three years said that the introduction of multi-professional teams had had a positive impact on their work as a doctor. Sixteen per cent said the introduction of such teams had had both a positive and negative impact. This suggests that some of the opportunities and challenges around multi-professional team-working still need to be negotiated.[11]

A key challenge that has been identified is how to foster multi-professional collaboration without *'homogenizing the distinctiveness'* of different health and care workers.[12] This guidance recognises the importance of colleagues retaining a sense of their unique qualities and contributions, their own professional identity, while working closely with others from different occupational groups. This is important, because research suggests that *'secure professional identity within multidisciplinary teams is associated with higher levels of perceived integration'*.[13]

This guidance focuses on how professional identities can be maintained, nurtured, and developed, to reflect that the process of identity formation is ongoing. As the professional landscape changes, identities will be shaped and reshaped. While some core values and characteristics will remain consistent, others will change over time.

Definitions and models of team-working

Across different specialties and settings, the use of multidisciplinary or multi-professional teams has been shown to limit adverse events, improve patient outcomes, and enhance patient and staff satisfaction.[14]

In health and social care, teams take different forms, constitute different professional groups and work together in a variety of ways. Terms such as multidisciplinary, interdisciplinary and transdisciplinary are used to describe groups of individuals who belong to separate professional groups, or different disciplines within a professional group, working together. While sometimes used interchangeably, these terms refer to distinct conceptual models of team-working, as outlined below.

DEFINITIONS OF CONCEPTUAL MODELS OF TEAM-WORKING

Multidisciplinary teams
The patient is assessed individually by several professionals (such as nursing, social work, psychiatry, medical, etc.). Participants may have separate but interrelated roles and maintain their own disciplinary boundaries. The process might be described as additive, not integrative.

Interdisciplinary teams
Members come together as a whole to discuss their individual assessments and develop a joint service plan for the patient. Practitioners may blur some disciplinary boundaries but still maintain a discipline-specific base (for instance, aspects of functional assessment may be shared across disciplines). Teams integrate closer to complete a shared goal.

Transdisciplinary teams
Team members share roles as well as goals. This requires specialist practitioners to share their skills (allowing others to learn and take on skills) as well as acquire new skills in other areas from other practitioners. The result is a more blended team that shares objectives and many core skill sets required to achieve the overall goal.

— Taken from: Graham Ellis and Nick Sevdalis (2019) Understanding and improving multidisciplinary team working in geriatric medicine. *Age and Ageing;* vol. 48: 498–505 doi: 10.1093/ageing/afz021.[15]

Effective healthcare teams can take the form of any of these different models and some structures or configurations will be more suitable in certain situations. It is important that team members are aware of the model that they are working within, since this determines what is expected of them and drives their goals and objectives.

Across these different models, the patient, their family, friends and carers are increasingly being recognised as integral members of the team, contributing their own expertise to decision-making processes, as well as to other areas such as service design and development.

EXAMPLE OF MULTIDISCIPLINARY WORKING WITHIN A BREAST CANCER TEAM

Multidisciplinary team (MDT) working and decision making is common within cancer care. Across the UK it is standard practice for all patients with cancer to have their treatment plan discussed at an MDT meeting.

The MDT is often made up of professionals from a range of backgrounds including nurse specialists, pathologists, GPs, geneticists, radiologists, nuclear medicine specialists, psychologists, surgeons, oncologists, physiotherapists, and occupational therapists.

Each individual team member contributes to the decision-making process from their area of clinical expertise. Disagreements about the best course of action are openly shared and a consensus reached. The patient and their relatives and carers are integral MDT members and their views are represented within the meeting. Research suggests MDT working can improve cancer staging accuracy,[16] patient satisfaction and time to treatment.[17]

EXAMPLE OF INTERDISCIPLINARY WORKING WITHIN AN ACUTE HOSPITAL SETTING

The acute care team — made up of medical doctors, advanced practitioners, nurses, operating department practitioners, physiotherapists and radiographers — responds to all cardio-respiratory and medical emergency calls within the hospital. The members take on different roles according to their professional training, skills and competency.

The team works on a shift basis and members change from shift to shift. The team is therefore transient, with members coming together to deliver care during an incident. A team briefing or 'check in' at the start of the shift and debrief after each response and at the end of the shift help the team to form shared goals and objectives.

CASE STUDY 1
TRANSDISCIPLINARY TEAM-WORKING WITHIN THE NHS LANARKSHIRE HOSPITAL @ HOME SERVICE

The NHS Lanarkshire Hospital @ Home service provides care in the community for patients aged over 65 who would otherwise be admitted to hospital. Patients are referred to the team by GPs, community services, or A&E (or other emergency receiving departments).

The clinical team consists of medical doctors specialising in care of the elderly, advanced nurse practitioners, community psychiatric nurses, physiotherapists, occupational therapists and healthcare assistants who are also trained in providing specific therapeutic interventions. The team also includes a service manager, a senior nurse and administrative support staff.

During the first clinical review, a patient can be seen by any practitioner from any discipline, followed by a clinical review from the Consultant Geriatrician. They undergo a full care needs assessment including medical, nursing and therapy needs. The proposed care plan is discussed with all team members and agreed with each staff discipline carrying out treatments and reviews as appropriate. All nursing and allied health professionals are trained to deliver a range of nursing and therapeutic interventions.

The team liaises with colleagues across many different departments and service providers including day hospitals, community services, district nurses, palliative care teams, homecare providers, social work and acute services as well as with the patient's family and carers. The administrative support team are vital in coordinating referrals and organising transfers of care. Virtual ward rounds are conducted every day for care plan review until the patient is well enough to be discharged from the service.

Source:
NHS Lanarkshire Hospital @ Home service, c/o North Health & Social Care Partnership, Kirklands Hospital, Fallside Road, Bothwell, G71 8BB.

In this guidance, we use 'multi-professional' as an overarching term to describe teams where individuals from more than one professional group work together to deliver agreed objectives. We encourage readers from different types of teams to apply the learning in ways which are most appropriate to them.

Changing roles and responsibilities

As the professional landscape changes over time, new roles appear and may take on tasks and responsibilities traditionally held by others. These changes may be perceived as a threat by existing groups. Professional protectionism or resistance can inhibit the development of new models of care and prevent those working in new roles from forming their own professional identities. To deliver the best care for patients, multi-professional teams must overcome traditional boundaries to work together more collaboratively; understanding the contribution of each member of the group and appreciating that this is not rigid, but based on their training and abilities.

Flexibility is needed to ensure all practitioners can work at the top of their licence and expertise. Clinicians should be encouraged to focus their time on what they alone are trained to do, while tasks that other professionals are skilled and trained to do should be undertaken by them — understanding that this is not dependent on professional labels. In this way, effective workforce planning releases time for care. With more health and care interventions being delivered by non-medical professionals, it is likely that doctors' remit will increasingly shift towards providing leadership, giving support on difficult clinical matters, and delivering care to patients with the most complex needs.

Communication is key to new ways of working. Clearly defining roles and responsibilities is important for patient safety, identity formation and effective team-working. Organisations should think carefully about their change management processes, ensuring that there is effective communication about new roles or models of care. Team members must understand their role, the roles of others in the team and appreciate how their skill sets complement one another. There should be a shared understanding of an individual's scope of practice, their competences and lines of accountability and governance. These issues must also be well understood by those working in administration. Such clarity can be challenging in more fluid or transitory teams, or where professional boundaries are blurred. In this guidance, we suggest ways in which teams can find the time and space to build these relationships and nurture both individual and group identities.

As roles expand and diversify, patients and healthcare professionals need support to navigate the changing landscape. Roles and responsibilities should reflect recognised training and where possible, qualifications. They should also be communicated in clear and accessible language. Some titles have changed over time and some continue to be used variably, which can create confusion. A range of initiatives have been used to raise awareness of new roles, including videos in waiting rooms, special editions of (or articles in) patient newsletters, information pamphlets for staff and Q&A sessions for colleagues. Some of these methods are described in the case studies. Organisations can also involve patients from the outset, by engaging them in the development of new models of care and the use of new roles.

Health and care professionals must consider how they explain their role to patients and colleagues. This is particularly important for those working in new or less familiar roles. For instance, when introducing themselves, they may refer to their background and training, their role in the team and the tasks they can perform. Those in more established roles should introduce

new colleagues positively, focusing on the skills that they bring and the care they can provide. Research suggests that role recognition is important for professional identity formation, but some people working in non-traditional roles report being mislabelled or introduced incorrectly.[18] Team members should not be defined by restrictions on their practice, though it may be important for patients to understand the limits of a role in certain contexts (e.g. not being able to prescribe). For example, research shows that patients largely have a positive experience of physician associates but that they describe problems when the limits of the role are reached. Greater patient understanding about the role helps to manage and inform expectations.[19]

CASE STUDY 2
PHYSICIAN ASSOCIATE IN PRIMARY CARE

Aimee Ehrenzeller is a physician associate (PA) working in primary care in Wales. After taking a psychology degree and volunteering for St John's Ambulance, she decided to train as a PA. She was attracted by the opportunity to work across different areas of medicine and the geographical stability the post provides.

Now working in general practice, Aimee offers on-the-day appointments, telephone consultations, and runs the practice's baby clinic. The practice receptionists are trained in care navigating to direct patients to the most appropriate health professional and patients can request to see Aimee directly.

Aimee has helped raise awareness of the PA role within her practice and across her Health Board. One edition of the practice's patient newsletter was dedicated to the allied health professions, and Aimee has delivered talks at hospitals about the role of PAs, which has given colleagues the opportunity to ask questions and enhance their understanding.

Aimee wanted to develop her practical skill set. Her GP supervisor supported her to undertake training to fit intrauterine devices (IUDs). Through the Faculty of Sexual and Reproductive Healthcare (FSRH), Aimee has obtained a Letter of Competence Intrauterine Techniques. Previously open to doctors and nurses only, the FSRH intends for this qualification to be made available to other professional groups, including PAs, midwives, pharmacists and other healthcare professionals registered in the UK and Ireland.

One challenge Aimee has faced is that the insertion of the Mirena coil is designated as medication administration and the local health board's (LHB) existing policies do not cover PAs to perform this. This is because PAs are new to the area, having only been employed there since 2018. Aimee's LHB and the Faculty of Physician Associates are supporting her to develop local protocols which will enable her to insert Mirena coils without direct supervision from a doctor.

Source:
Aimee Ehrenzeller, Physician Associate, Aneurin Bevan University Health Board.
Contact: @aimeeehren (Twitter).

Further information:
Blogpost — My first year as a GP Physician Associate.

CASE STUDY 3
PARAMEDIC IN PRIMARY CARE

While still working in the ambulance service, Georgette Eaton's introduction to primary care came as part of a six-month placement during her studies to become a 'Paramedic Practitioner'. She developed her clinical skills under direct clinical supervision within the surgery and following the placement, worked in the same surgery one day a week. She recalls a warm reception from team members, and the supervision and guidance from her mentor (the practice partner) developed her clinical competence in primary care.

Since this initial experience, Georgette has worked across other primary care settings, including other general practices, home visiting services and out-of-hours services. Across all these settings she has worked autonomously, with indirect supervision as required, largely undertaking assessment and treating patients, or creating treatment plans. However, a recurrent challenge Georgette has encountered across each environment is the lack of awareness colleagues (both clinical and non-clinical) have regarding her skill set and scope of practice, and how her experience as a paramedic lends itself well to working in primary care.

Georgette recalls that, initially, some patients were suspicious of paramedics working in general practice: *"They would say to me; 'Where is your ambulance? Why am I seeing you, a paramedic, and not my Doctor?' It was necessary to explain my role to patients and set their expectations. I would reassure them, 'Yes I'm here to see you, no I haven't got my ambulance today, but it's okay, I am meant to be working here, so, how can I help you?'"*. Information leaflets explaining her role within the practice helped, as well as her being an active part of the patient participation group. Georgette found that after such engagements patients became more accepting and would often request to see her instead of the GP when appropriate.

Georgette advises others starting out in similar roles to spend time engaging with colleagues and patients, helping them to understand the role and its contribution to primary care.

Source:
Georgette Eaton, Advanced Paramedic within Primary and Urgent Care, Member of the Primary and Urgent Care Special Interest Group for the College of Paramedics.
Contact: georgette.eaton@CollegeofParamedics.co.uk.

A shared understanding of new roles helps facilitate their integration. Health Education England (HEE), in partnership with NHS England and NHS Improvement, has developed a multi-professional framework for advanced clinical practice in England. This includes a national definition and standards that underpin the multi-professional advanced level of practice. It formalises that health and care professionals working at this level *'exercise autonomy and decision making in a context of complexity, uncertainty and varying levels of risk, holding accountability for decisions made'.*

The principles can be applied to different settings and roles and this flexibility is crucial for ensuring that the framework remains relevant. Those working in advanced or extended roles have their responsibilities circumscribed by regulatory frameworks, competence, training and local circumstances, but will also have opportunities to upskill. As our case studies of advanced practitioners in primary care show, an individual professional's skill set and the tasks they can perform will develop over time, particularly as the policy context changes. For example, if the statutory regulation of physician associates is introduced and they acquire prescribing rights, their role and responsibilities would shift. Professional identities are not static but undergo revision, particularly with the acquisition of new skills and areas of expertise.

CASE STUDY 4
PHYSIOTHERAPY FIRST CONTACT PRACTITIONERS WITHIN PRIMARY CARE MUSCULOSKELETAL SERVICES — FROM PILOT TO NATIONAL PROGRAMME

In 2014 Neil Langridge became one of the first advanced clinical practitioner physiotherapists to work within primary care as a First Contact Practitioner (FCP) in the musculoskeletal pathway (MSK). In this pioneering role, he worked autonomously to provide a first point of contact MSK service (without a medical referral required) within a GP setting. The service included assessment, diagnosis, treatment and discharge.

Reflecting on his experience, Neil comments, *"you have to be a bit of a chameleon, it's important to be adaptable as you rely on a wide range of skills from assessment and diagnosis to providing treatments like injections and rehab. It's also important to make time to discuss patients with colleagues and get support when required. Working within a multi-professional team provided opportunities to extend my knowledge as I could learn from colleagues in other disciplines. Maintaining contact with physiotherapy colleagues ensured I maintained core competency skills".*

In 2018/19 NHS England supported other pilots across the country as part of a programme to address waiting lists and declining performance in elective care against the Referral to Treatment (RTT) standard. Evaluation of these pilots has consistently demonstrated positive outcomes. Over 70% of patients received specific self-management advice, patient satisfaction rates were between 90-99%, and 97% of users were likely or very likely to recommend the service to friends or family. Where available, MSK triage services reduce the demand for secondary care services by 10%. First Contact Practitioner services are also reported to deliver a return on investment of £0.81-£2.37 for every £1 spent on implementation.

NHS England has developed a national mobilisation plan for local systems to roll out this service for patients across the country as part of the NHS Long Term Plan. The ambition is for the whole NHS England patient population to have direct access to MSK FCPs by 2023/24, across all Primary Care Networks. It is hoped that further roll-out of the FCP MSK service will improve patient access to appropriate care, reduce the existing GP workload burden, and assist with GP staff recruitment and retention efforts.

Source:
Dr Neil Langridge, Consultant Physiotherapist, Musculoskeletal Services, Southern Health NHS Foundation Trust.

CASE STUDY 5
MULTI-PROFESSIONAL RADIOTHERAPY LATE EFFECTS SERVICE

The Macmillan Radiotherapy Late Effects (RTLE) service based at Nottingham City Hospital supports patients who have been cured of cancer but who are experiencing late effects and poor quality of life following radiotherapy treatment. The service recognises that the complex symptoms of late effects require a holistic, multi-professional approach. Designed to fill a gap in current provision for patients, it is one of few such services nationally, though it seeks to provide a model of care that can be adopted by other leading Cancer Centres.

The service was developed in 2013 by Emma Hallam (Macmillan Consultant Radiographer), Liz Stones (Macmillan Advanced Practice Radiographer) and Dr Judy Christian (Clinical Oncologist), with Emma and Liz delivering the weekly patient clinics. In setting up the service, they drew on the learning from a range of other departments and colleagues. Emma describes how they went *"knocking on doors asking for help"*, enhancing their skill set to include elements of physiotherapy, nutrition and fatigue. The knowledge exchange was reciprocal, with the RTLE team sharing their own expertise about the late effects of radiotherapy.

The RTLE team did not wish to be seen as encroaching upon the work done by others, so sought to be sensitive in making these approaches. They visited teams individually to ensure that they were tailoring the new service to the needs of specific patient groups. They also used patient stories to demonstrate how they could complement existing services and enhance the support available to patients. The team has also built links with primary healthcare and other community cancer services to help ensure as many patients as possible can access the service.

Referrals have increased significantly since the service was introduced and patients have indicated that they appreciate the RTLE team's in-depth understanding of radiotherapy late effects. The RTLE service has been recognised nationally through a Macmillan Innovation Excellence Award 2016 and the long-term care category in the Quality in Care Oncology Awards 2016.

Source:
Emma Hallam, Macmillan Consultant Radiographer, Nottingham Radiotherapy Centre, Nottingham University Hospitals NHS Trust. Contact: emma.hallam@nuh.nhs.uk.

Effective team-working

There are many different structures and models of teamwork in health and social care, as we have seen. Michael West and Stephen Woods define a team as:

> *'...a relatively small group of people working on a clearly defined, challenging task that is most efficiently completed by a group working together rather than individuals working alone or in parallel; who have clear, shared, challenging, team level objectives derived directly from the task; who have to work closely and interdependently to achieve these objectives; whose members work in distinct roles within the team and who have the necessary authority, autonomy and resources to enable them to meet the team's objectives'.*[20]

West and Woods distinguish between 'real' teams and 'pseudo' teams. The latter lack a shared goal and do not communicate clearly or work together interdependently. A number of healthcare professionals appear to work in such 'pseudo' teams. In the 2019 NHS Staff Survey, only 72.4% of respondents indicated that the team they worked in had a set of shared objectives, while only 60.4% said their teams meet often to discuss the team's effectiveness.

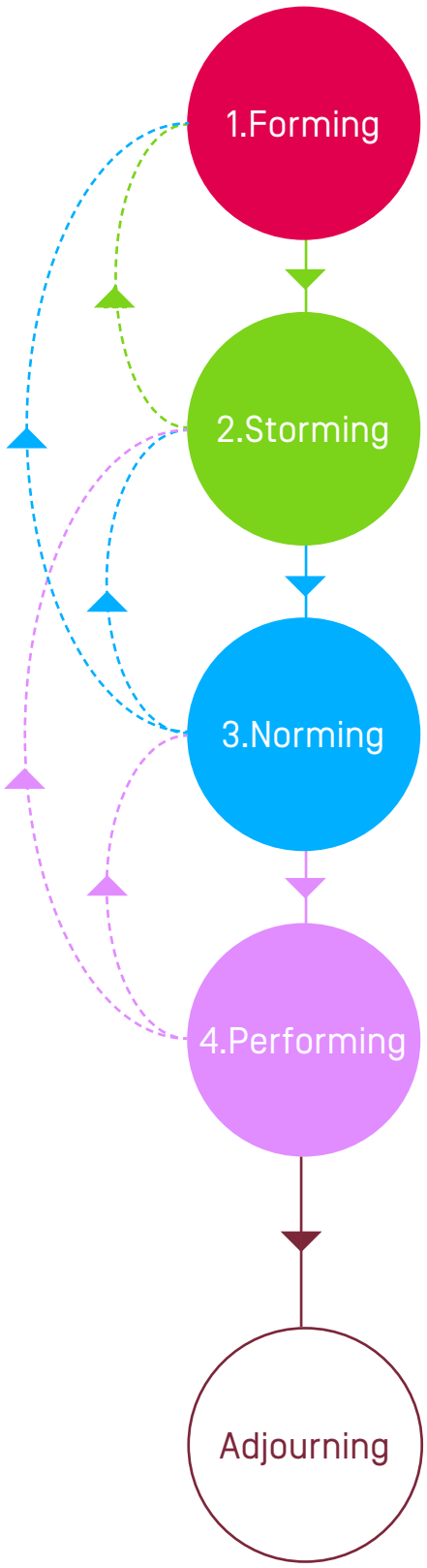
Effective teams have several common characteristics or qualities. They:

- Share goals and objectives, which all team members are aware of and subscribe to or engage with. Case Study 6 provides an example of how local organisations came together around a shared approach to patient care
- Regularly meet to reflect upon and monitor their performance. This might take place in the form of team briefings, huddles or 'check-ins' at the start of the shift, or debriefings after a significant event, such as responding to a cardiac arrest call. Reflective practice sessions are more formal ways in which teams can meet to reflect on their functioning, while Schwartz Rounds provide a forum for staff from all disciplines to come together to discuss the social and emotional aspects of healthcare[21]
- Are flexible and share a sense of reciprocity when working with different professional groups. They are willing to help each other and take up tasks within their competence but not normally within their expected role (see Case Study 1)
- Evaluate performance data together to assess how well they function as a team and make improvements or changes based on this (see Case Study 7).

To encourage teams to reflect, leaders may wish to consider applying models of group development, such as that devised by psychologist Bruce Tuckman and developed with Mary Ann Jensen (1977). Tuckman and Jensen's model recognises five stages of team development: forming, storming, norming, performing and adjourning (see Fig. 1). Each stage entails specific interpersonal issues and tasks that team members must navigate.[22] The role of a team leader is to support team members to navigate these stages, ensuring that the group's objective is clear, that

conflicts are acknowledged and dealt with, that positive norms are established and that there is an effective team structure that results in successful outcomes. Not all teams will go through the final 'adjourning' stage as a group, though rituals such as a team outing to acknowledge members who are leaving at the end of specific projects form an important part of team development.

Figure 1. Stages of team development (Himmelfarb Health Sciences Library)



Forming is characterised by dependent personal relationships where team members:

- Get to know each other and learn to function as a team
- Are well-mannered, tentative and compliant
- May feel confused, inhibited, uncomfortable and uncertain
- Focus on defining goals, and planning tasks

Storming is characterised by competition, conflict, and organisation of tasks:

- Team members may have different opinions on how to accomplish goals
- Conflicts may promote deeper understanding of others' perspectives
- The team works through issues to determine how to pursue goals
- Successful teams manage relationships and task-orientated issues

Norming is characterised by cohesive interpersonal relationships:

- Ground rules and norms are established
- Conflict is reduced as team members organise to work on tasks
- Team members' cohesiveness and confidence increases
- Social relations develop to create a team identity
- Team interactions are based on trust and support
- Team members discuss and negotiate differences constructively

Performing is characterised by team members' interdependence:

- The team is dedicated to sucessfully completing tasks
- Successful development of norms allows teams to handle stressful deadlines
- Cooperation and collective decision making enables the team to focus on performance

Adjourning is characterised by termination of relationships:

- Teams end when tasks are completed
- Team members may experience various emotions as relationships end
- Teams may focus on performance evaluations, processes, and procedures
- Team members may celebrate success or learn from experiences

It is also important for teams to recognise that members possess multiple layered 'identities', including their own individual identity as a healthcare professional and their shared identities as part of a team, an organisation and a professional group, as we have explored. Practitioners may have a pre-existing identity from a previous clinical role (e.g. as a nurse or pharmacist) and then develop an additional identity in their new (advanced) role. Some will move between these identities, reconciling and integrating them to create a blended or hybrid identity, but others may struggle to combine them.[18] The ability to hold multiple identities — without conflict — may help individuals integrate better into multi-professional teams and settings.

CASE STUDY 6
POPULATION HEALTH AND JOINED-UP DATA IN TOWER HAMLETS

Tower Hamlets Together (THT) is a partnership of local health and social care organisations, which grew out of one of NHS England's Multi-specialty Community Provider Vanguard sites. The Vanguard programme provided the stimulus for new projects, but over time partners realised the need to concentrate their efforts through developing a clear, shared goal.

The THT collaboration is underpinned by a population health approach and supported by joined-up datasets. Tower Hamlets was atypical in that there was already a degree of integrated data across general practices, thanks to the work of the Clinical Effectiveness Group. This data was further utilised with the set-up of multidisciplinary networks, which began in 2009 with the delivery of diabetes care packages. The data usage was also developed and extended through a Pioneer Integrated Care Programme (2012-16). Since then, the momentum for using joined-up data has increased, with the East London Health & Care Partnership now driving more integrated data across acute and general practice settings.

THT Clinical Lead Dr Isabel Hodkinson explains that joined-up data enabled them to identify where patients had poor experiences or outcomes and where money was being spent. In some instances, expenditure was high where outcomes needed improvement. One of the key areas targeted for improvement was women's reproductive healthcare, as discussed in FSRH's report on new models of care.

Isabel reflects that clinical leadership and a shared understanding of population health have been crucial to driving more joined-up datasets. The main challenge was the fear of 'blame culture' – the concern that sharing data might lead to being judged negatively. Drawing on quality improvement (QI) methods, THT cultivated an atmosphere of shared learning and curiosity and placed the patient experience at the forefront. Isabel describes how bringing in the voices of patients and their families to QI projects can help flatten professional hierarchies, re-orienting conversations around patient care and health outcomes.

THT is now leading an ambitious Whole Systems Data Set Project to link NHS and local authority data to help them better understand health inequalities and how these relate to service use.

Source:
Dr Isabel Hodkinson, Principal Clinical Lead for Integration, Tower Hamlets Together.
Contact: Tower Hamlets Together contact.

CASE STUDY 7
THE HAXBY GROUP — USING DATA AND QI TO IMPROVE MULTI-PROFESSIONAL TEAM-WORKING

The Haxby Group is a leading provider of community-based healthcare in Hull and York, working across 11 GP surgeries and serving over 60,000 patients. The practice has a thriving multi-professional team including doctors, nurses, nurse associates, pharmacists, as well as nurse practitioners, paramedics, and physician associates, some of whom work at an advanced level.

The group has seen many benefits to a multi-professional team approach to care delivery. Advanced clinical practitioners play a significant role in both seeing and triaging urgent care patients resulting in release of GP time to provide care for other patient groups including those with more complex needs. Consequently, the standard length of routine appointments increased to 15 minutes.

When the group started to introduce advanced clinical practitioners and other healthcare professionals to the practice, there were initially some concerns about safety and efficacy.

The group has used QI methodologies to evaluate their approach as well as to help refine and drive improvements to their new way of working. They employed team members who were able to capture and analyse data. Monthly team meetings were held, including all members as well as administrative staff.

During the one-year pilot, they measured the number of patients seen by different types of healthcare professionals and various patient outcomes, including how many times the patients would require a GP review, A&E attendance rates and rates of accessing the NHS 111 service. Using Plan-Do-Study-Act (PDSA) cycles every month, changes were made to the system in response to the data as well as staff and patient feedback. During the pilot phase, the number of patients seen by non-GP healthcare professionals rose with no increase in negative patient outcomes. Team members reported that the QI approach helped to increase confidence in the new system across the group. The new multi-professional team structure was subsequently rolled out across the other two sites.

Further information:
Haxby Group

Source:
Professor Michael Holmes, Partner, Haxby Group York/Hull and Vice-Chair, Royal College of General Practitioners (Membership & International).
Contact: Haxbygroup.york@nhs.net (FAO Michael Holmes).

Celebrating diversity and difference

Effective teams incorporate a range of skills and expertise. For individuals in the team to thrive, there must be mutual trust and respect and their contributions must be recognised and valued.

Multi-professional teams should be designed around patient need. The deployment of advanced or extended roles is part of strategic workforce planning and these roles should not be used or perceived as medical substitution where there is an undersupply. Those working in these roles must be appreciated for the unique attributes and skills they bring. There needs to be a shared understanding of the ways in which they complement and enhance the wider team's performance and contribute to the care of patients. For example, while junior doctors move to gain experience, advanced level clinical practitioners tend to be more geographically rooted, and this can help provide stability for teams and continuity of care for patients.

Professional protectionism and resistance to new roles may emerge if those in more established roles fear that their domain and expertise are being eroded or undermined and that they might lose a sense of what makes them 'distinctive'. They may fear a loss of status, a decline in opportunities, job losses, or be reluctant to cede tasks that they feel competent to perform and enjoy undertaking. Tensions between those in occupational groups may also arise from differing perspectives, particularly if there are differences in their cultures of care or philosophies of practice.[13] These differences can affect how those from different professional groups perceive one another.

Within the multi-professional team, all members must feel empowered to express opinions and raise concerns, particularly where these relate to patient safety. This may be especially difficult in teams which are strongly hierarchical in nature or tribalist in behaviour and in transitory teams where members are unfamiliar to each other. Leaders must help promote an inclusive and supportive culture by role modelling effective multi-professional team-working. The language used to describe colleagues and the behaviour shown towards them can have an impact on how others perceive the role.

Professional bodies have an important role to play in role modelling collaborative working and challenging silo working. The Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Faculty of Sexual and Reproductive Healthcare share a building and work together to, for example, release joint statements. The Royal College of Anaesthetists has set up the Centre for Perioperative Care to facilitate cross-specialty and cross-organisational working on perioperative care to benefit patients. These multi-professional initiatives demonstrate the value of collaboration to members, the media and the public.

A further way in which Colleges and Faculties can role model multi-professional working is through extending membership opportunities to related groups. The Royal College of Surgeons of Edinburgh, for instance, established the Faculty of Perioperative Care to recognise the important role played by surgical care practitioners and surgical first assistants as part of the wider surgical team and it provides them with support and career development opportunities. The Royal College of Surgeons of England offers associate membership to surgical care practitioners, surgical first assistants, physician associates, advanced nurse practitioners and advanced clinical practitioners. The Faculty of Physician Associates, which launched in 2015, is a faculty of the Royal College of Physicians of London. Multi-professional membership schemes can break down boundaries between traditional and new professional groups and enable both to shape and enhance their professional identities.

Teams and organisations must cultivate a climate of *'psychological safety'*. Amy Edmondson coined this term to describe *'a shared belief that the team is safe for interpersonal risk taking'*. This entails a '*climate characterised by interpersonal trust and mutual respect in which people are comfortable being themselves'*. In other words, an environment where people are confident in their own professional (and personal) identities and those of their colleagues.[23] Teams need to foster a supportive environment, where hierarchies are flattened and feedback is encouraged.

To facilitate this inclusive culture, it is essential that teams develop strategies to manage and resolve conflict. Potential conflict may include concerns about or resistance to changes in the constitution of the team. Clearly communicating different roles and responsibilities helps to tackle uncertainty. Team members may be less likely to feel anxious about changes if they have a forum to express concerns and if their concerns are adequately addressed. Members are also less likely to feel threatened if they have a confident sense of their own professional identity and are reassured about the opportunities available to them. Hostility or negativity towards team members must be confronted, with clear pathways for tackling bullying,undermining and harassment.

Case studies 8 and 9 describe initiatives which have helped to promote greater understanding and shared values either within teams or across professional groups. The former has helped to demystify the work of other colleagues, while the latter brings multi-professional teams together around a common goal. Both initiatives incorporate celebratory events, which recognise and reward good multi-professional working. They also illustrate how time and space away from everyday practice can facilitate relationship-building.

CASE STUDY 8
THE WESSEX MODEL

The Wessex Model is a GP-consultant exchange programme designed to improve communication and understanding across primary and secondary care settings. It was created by Dr Sally Ross in Portsmouth in 2015, with subsequent schemes run by Dr Pritti Aggarwal in Southampton in 2017 and others elsewhere.

Under this programme, GPs and consultants volunteer to spend half a day in each other's workplace. At the end there is an evening event to celebrate shared learning with an emphasis on local solutions that could remove barriers to more integrated care.

Some participating pairs have been surveyed about their experience of the exchange. Analysing these findings, Drs Aggarwal, Ross and Adam Fraser suggest that observing colleagues from another specialty helps to improve morale, rekindle compassion, and generate mutual respect. Participants learned more about their counterpart's workload and interactions with patients, as well as the IT systems and administrative processes they used. One respondent commented on *'the value of knowing our colleagues personally; realising we're in it together'.*

The exchange model has been adopted by NHS England for dissemination nationwide. While the initial programme paired GPs and consultants, other professional groups have since been matched. A similar scheme at Birmingham Children's Hospital brought together junior doctors and managers to promote joint leadership development.[24]

Source:
Dr Pritti Aggarwal, GP Principal, Living Well Partnership and Dr Sally Ross, GP, Partnering for Health Ltd.
Contact: prittiaggarwal@nhs.net and sally.ross1@nhs.net.

CASE STUDY 9
ROYAL COLLEGE OF PAEDIATRICS AND CHILD HEALTH QI COLLABORATIVES

The Royal College of Paediatrics and Child Health (RCPCH)'s Quality Improvement (QI) Collaborative programmes support multidisciplinary teams to undertake structured training in QI to develop new models of care and improve health outcomes together. Facilitated by an expert external trainer, the nine-month programmes comprise weekend residentials, one-day events, teleconferences, an online platform, and a final celebration. The first Collaborative (now in its ninth wave) was for teams working in paediatric diabetes. A second Collaborative in paediatric epilepsy was launched in Summer 2019.

Initially, there were reservations that whole teams would not have time to participate and that practitioners were more used to training in their own professional groups. The QI Collaborative requires applicants to sign-up as teams (rather than as individuals), ensuring collective buy-in. The multidisciplinary team is interpreted in its broadest sense, to include doctors, allied health professionals, nurses, managers and administrators.

The strength of the scheme lies in the fact teams are brought together around a shared challenge or purpose. Since QI methodologies are new to most participants, there is no 'expert' within the team and so traditional hierarchies are erased. All members are empowered to share ideas, and participants learn more about the skills and attributes their colleagues bring. Any conflicts that arise are resolved through democratic decision-making. These values are underpinned by the celebratory ethos of the final event.

Following the Collaboratives, teams have not only implemented specific QI initiatives but also new ways of working together more effectively in day-to-day practice. For instance, some have recognised that they need designated time for developmental meetings, not just clinical handovers. One solution has been introducing a 30-minute QI-specific team meeting before the usual MDT meeting on a weekly basis. To maintain a sense of unified purpose, teams have also established shared areas to exchange ideas, whether that be a WhatsApp thread or a team wall in the office.

The scheme has received positive feedback from participants. A consultant paediatrician described how they *'all felt part of a bigger team over the weekend'*, while a paediatric diabetes dietician suggested that QI had given them *'a sound platform to build upon in optimising team working and improving patient care'.*

Further information:
RCPCH - Quality Improvement and patient safety.

Source:
Dr Megan Peng, Quality Improvement Manager, Royal College of Paediatrics and Child Health.
Contact: megan.peng@rcpch.ac.uk or for general enquiries: qips@rcpch.ac.uk.

Education and training

Interprofessional learning at undergraduate and postgraduate level provides an opportunity for professionals from different groups to better understand the roles of others and to identify areas of overlap, as well as where competency strengths and boundaries lie. It also helps learners develop the skills to enable them to work within multi-professional teams. Opportunities for joint learning and training should be encouraged — there are many successful, established models of this within healthcare.

CASE STUDY 10
THE LEICESTER MODEL OF INTERPROFESSIONAL EDUCATION AT UNDERGRADUATE LEVEL

The Leicester Model involves 20-1000 pre- or post-qualified students per programme. Most students are from medical, nursing, therapy (AHP) and social work backgrounds, with increasing numbers of pharmacy, psychology and health science students. Students are grouped into cohorts of 24-32 per teaching venue and divided into interprofessional groups of three to five students for the four-phase programme.

During phase one, students interview a patient in their home or a care setting to understand medical and social care issues impacting on their physical, psychological and social functioning. They also meet with representatives of the community in which their patient lives, to gain a wider understanding of the context of service provision. For example, they might meet with the police, a tenants' association, or managers from NHS Trusts.

Facilitated by experienced clinical and academic tutors, phase two involves the student group reflecting on each interview, relating service and theoretical perspectives with health and social care policies. They then interpret their findings and prioritise the issues identified. The student group analyses the interdependence of different statutory and voluntary providers and critiques their team-working during phase three. The group identifies practical multi-agency solutions to improve the patient's quality of service delivery. In phase four, student solutions are formally presented to the agency workers and their managers in an interactive presentation session. Students also provide written feedback to the individual service providers.

The intended learning outcomes (set out on p. 53 of the Leicester Model) include the ability to: explore the importance of effective communication within and between multidisciplinary teams, analyse where differing professional responsibilities and roles may overlap or be in conflict along the patient/service user pathway and assess mechanisms for overcoming team-working problems.

Further information:
AdvanceHE — The Leicester Model of Interprofessional Education.

At postgraduate level, interprofessional training provides opportunities for collaborative practice and team building and can help build mutual understanding, trust and respect. Multidisciplinary training courses, including postgraduate courses in advanced clinical practice, bring together team members from different professional groups allowing them to interact and develop cross-cutting knowledge, skills, competencies, and interpersonal skills alongside colleagues from other professional groups. The Ophthalmic Common Clinical Competency Framework described in Case Study 11 provides a good example of a common postgraduate qualification available to a range of related professional groups. Professional organisations have a role to play in creating shared learning opportunities for different professionals (see also Case Study 2 on FSRH qualifications).

CASE STUDY 11
THE OPHTHALMIC COMMON CLINICAL COMPETENCY FRAMEWORK (OCCCF)

The OCCCF provides standards and guidance for the knowledge and skills required by non-medical eye healthcare professionals delivering patient care in multidisciplinary team settings. It was developed in 2016 by the Royal College of Ophthalmologists, the Royal College of Nursing, the College of Optometrists, the British and Irish Orthoptic Society and the Association of Health Professions in Ophthalmology.

The framework recognises that traditional eye healthcare teams in hospitals are changing to meet patient demand. This is due to the increase in successful, but recurrent, treatments and the rise in chronic disease management linked to the UK's ageing population. Aspects of clinical work that were previously undertaken by medically qualified ophthalmologists are now being delivered by a broader multi-professional team. Qualified optometrists, orthoptists, ophthalmic nurses and ophthalmic clinical scientists have taken on expanded roles, and this releases ophthalmologists to deal with the more complex cases and decision-making.

In conjunction with Health Education England, the framework was developed into a curriculum in 2019 with workplace-based assessments and resources, covering four high-volume clinical areas — acute and emergency eye care, cataract assessment, glaucoma and medical retina. The delivery of the curriculum is carried out locally, as with postgraduate medical training.

The curriculum seeks to support patient-centred care and upskill the non-medical healthcare professional workforce within a hospital setting. It enables them to continue taking on expanded roles to help manage demand and to deliver safe, efficient care for patients. By providing competencies that are transparent, transferable and based on standardised training, the OCCCF also offers valuable recognition and career development opportunities for this part of the workforce.

CASE STUDY 12
MAUDSLEY SIMULATION'S 'STUDENT INTERPROFESSIONAL MENTAL HEALTH SIMULATION' (SIMHS)

Simulation is an increasingly used modality for delivering training to healthcare professionals at undergraduate and postgraduate level. Maudsley Simulation, part of South London and Maudsley NHS Foundation Trust, is the UK's first simulation training centre focusing on mental health with the aim of improving services for all who are affected or impacted by mental health issues.

Their one-day interprofessional mental health simulation course brings together nursing, clinical psychology and medical students, in a true-to-life learning environment, to help develop the students' clinical knowledge and skills in the psychological and physical care of psychiatric patients within a multi-professional team setting.

Research into the effectiveness of SIMHS has indicated that it helps participants to understand and appreciate the skill sets of other professional groups and fosters collaboration. After taking part in the training, students recognised the need to consult other colleagues to achieve the best possible outcome for patients and suggested that working with other disciplines encouraged them to be more open-minded. [25]

CPD, supervision, mentoring and appraisal

Continuing professional development (CPD)

Access to CPD opportunities is key for the development of all professional groups. It is particularly important that appropriate opportunities are available for all team members to prevent resentments forming and to encourage ongoing learning and skills development across teams. This requires all professional groups to have fair and equitable access to CPD. HEE has developed guidance for the trained and qualified Medical Associate Professional workforce, setting out common standards for ongoing CPD, assessment and appraisal.

Multi-professional learning is not only important in undergraduate and postgraduate education but throughout one's career. Bringing together professionals from different disciplines for training on cross-cutting topics like domestic violence, safeguarding, or quality improvement also provides an opportunity for team development. Multi-professional teams need resources to ensure that they can develop effectively as a group and as individuals.

CASE STUDY 13
SAFE - OR: BUILDING SUCCESSFUL OPERATING TEAMS

'SAFE - OR' is a full-day multidisciplinary workshop run by the Royal College of Surgeons of England for members of the surgical team including surgeons, anaesthetists, nurses and operating department practitioners.

The course is based on the WHO Guidelines for Safe Surgery and the implementation of the WHO Surgical Safety Checklist. Working in small groups, participants complete a series of exercises, critical clinical scenarios and role-plays designed to improve their skills in communication, teamwork, handovers, issue identification and problem-solving. Participants also engage in QI projects.

The SAFE - OR programme has been developed through a collaboration between the Royal College of Surgeons of England, the Association of Anaesthetists, the Royal College of Obstetricians and Gynaecologists, Lifebox, the Association for Perioperative Practice and the World Federation of Societies of Anaesthesiologists.

Supervision and mentoring

Multi-professional team-working relies upon appropriate and supportive supervision. Healthcare professionals should be supervised by the most appropriate colleague, which may be someone from the same or a different professional group (see Case Study 14). For example, a nurse prescriber may supervise a trainee doctor writing a controlled drug prescription, a GP might supervise a first contact practitioner physiotherapist in general practice, or an Emergency Nurse Practitioner might supervise a nursing associate performing an arterial blood gas. It is crucial that supervisors understand the role and responsibilities of those working under their supervision. They must also recognise that different professional groups have different approaches to and cultures of supervision.

In addition, many professionals benefit from being supervised or mentored by an individual from within their own professional group, which helps them develop core values and a clearer sense of their identity and their unique contribution to the team. Some members of multi-professional teams, especially those who are the only individual from their professional group, describe feeling isolated from others within their discipline. Opportunities for profession-specific mentoring and peer support networks should be made available (see Case Study 15). This can help prevent individuals feeling misunderstood, marginalised or undermined within a multi-professional team. Exposure to role models is also an important part of identity formation and career development.

CASE STUDY 14
INTERPROFESSIONAL TRAINING IN GENERAL PRACTICE

Julia Taylor is an Advanced Clinical Practitioner (Primary Care Nurse), GP Trainer, and GP Training Programme Director (PD) in the East Midlands. Nationally there are only a few programme directors who are not GPs, and Julia believes she is the only one in another clinical role. Originally trained as a nurse, Julia has worked in acute care and the voluntary sector and started working in primary care 18 years ago. She completed an MSc in advanced practice in 2007. She still undertakes regular clinical work in primary care.

When in 2017 the local primary care school sought a new GP Programme Director, the job advert sought a registered health professional (but was not GP-specific). Julia met the essential and desirable criteria and a colleague encouraged her to apply.
Julia reflects that, as an ACP, she brings a different set of experiences to GP Training and the PD role. Many of the trainees assume she is a GP and she has encountered no resistance when they discover her non-traditional background. Instead, the trainees appreciate the different perspective and expertise she offers. *"I hope that it comes across that I enjoy the role"*, she reflects.

With the commitment to developing multi-professional teams to enhance quality care for the population, Julia hopes that there will be more opportunities for nurses and allied health professionals to take up roles alongside their medical colleagues.

Source:
Julia Taylor, ACP (Primary Care Nurse), Lister House Surgery, Derby.

CASE STUDY 15
ROYAL COLLEGE OF OCCUPATIONAL THERAPISTS CLINICAL FORUM FOR OCCUPATIONAL THERAPISTS WORKING IN NEW ROLES IN PERINATAL MENTAL HEALTH SERVICES

Due to the recent increase in perinatal mental health services, a large number of occupational therapists have taken on new roles within these teams. Some occupational therapists reported challenges such as finding it difficult to adjust to new ways of working, defining their role and specific skill set within the multi-professional team, and other team members not understanding their roles.

In 2019, the Royal College of Occupational Therapists (RCOT) ran a series of workshops, funded by HEE, for occupational therapists working within perinatal mental health teams. Workshops have focused on supporting occupational therapists to develop a clear understanding of their roles, responsibilities, competencies and scope of practice, as well as how to communicate these to colleagues and patients. Case-based discussions and reflective practice sessions around complex case presentations have helped clinicians develop their clinical skills and expertise.

Supervision by senior experienced occupational therapists and networking events as part of a newly established Clinical Forum have helped clinicians to feel grounded in their professional philosophy and more confident in their skills within this new clinical setting. To date, over 100 perinatal mental health occupational therapists have engaged in the programme.

Reflecting on the support provided, one participant commented, *"I feel refreshed and more focused in my role, excited about how I will develop".* Another remarked that the workshop was *"a springboard into putting the occupational therapy into the perinatal mental health team that I work in".*

Source:
Dr Sally Payne, Professional Adviser — Children, Young People and Families, Royal College of Occupational Therapists.

Appraisal

Appraisal is an annual requirement for all NHS staff, with processes and formats varying across different professional groups and workplaces. An effective appraisal should ensure individuals have a clear understanding of their role and the part they play within their team and their organisation. It should also identify personal and professional development needs, with the purpose of improving performance and patient care.

Appraisals could include an assessment of the individual's ability to work within a multi-professional team. For example, this can be done through 360-degree anonymous feedback (from colleagues and patients). Supportive appraisals can help create a culture of learning and self-reflection, where teams learn and develop together. A constructive approach to the appraisal process can therefore contribute to a climate of 'psychological safety' and group identity formation.[26]

Conclusion

In multi-professional teams, members should be supported to develop their own individual professional identity as well as a collective team identity, if they are to flourish in practice. A shared team identity recognises and values the unique attributes of all members without blurring the boundaries between different professional groups. Teams should appreciate how each individual member contributes to the care of the patient and how they can work together effectively.

Individuals need to develop and nurture their own sense of identity, but identities are not formed in a vacuum — they depend on the support of colleagues, managers, system leaders, and professional bodies. Identity development is both an individual and collective responsibility.

Changing ways of working can entail anxieties, resentments and hostilities. These conflicts must be tackled openly to create a supportive environment in which all team members can thrive. All health and care professionals must be enabled to develop confidence and pride in their work, to ensure that they can fulfil their potential and work at the top of their scope of practice. Interprofessional education and training pave the way for effective team-working, but this must be continually supported and reinforced through effective supervision and access to mentors and role models. Professional identity and career progression are interlinked and all health and care staff must feel reassured about the opportunities for further development available to them. A culture of curiosity and learning that values reflection and improvement can enhance individual and group identities.

The development of professional and team identities is an ongoing process and this guidance recognises the need for identities to adapt to changes over time. A professional identity should be strong and self-assured but not so rigid as to lead to protectionism, silo-working, or the inability to acclimatise to new ways of working.

We have identified 10 key principles for promoting identity development in multi-professional teams. These principles have implications for individual health and care professionals, team leaders, managers, and professional bodies, all of whom must come together to create a positive culture for collaborative working.

Principles for promoting identity development in multi-professional teams

1. Teams should meet regularly, reflect on their performance, cultivate shared goals and objectives and provide emotional and social support. While transitory teams may find it difficult to replicate all these qualities, they should seek to emulate them where possible (e.g. through briefs and de-briefs).

2. An individual needs to have a strong sense of what they bring to the team. They should understand the unique skills, attributes and expertise they provide.

3. Roles and responsibilities of team members must be clearly communicated to colleagues and patients through different mechanisms (e.g. patient information leaflets, Q&A sessions).

4. Teams need clear accountability structures and lines of responsibility to ensure people work within their competence and that others are aware of their remit. This facilitates effective team-working and improves patient safety.

5. Teams should use data and quality improvement methods to strengthen their ways of working. They should create a culture of continuous improvement and review whether the team is serving its purpose and fulfilling its objectives.

6. Team, service and organisational leaders should embrace multi-professional working, value all team members, and create a climate of 'psychological safety'.

7. Focusing discussions on patient experience and outcomes and bringing in the voices of patients and their families can help teams to overcome protectionism and break down professional hierarchies.

8. Professional organisations should help break down barriers by providing support for multi-professional teams. They should role model collaborative working at the highest level.

9. Effective, supportive supervision must be delivered by the most appropriately trained person, but individuals should have access to mentoring within their own professional group (where possible) to help develop their identity and values.

10. Opportunities for interprofessional education and training should be provided throughout an individual's career, from first qualification through to CPD, with equitable access for all professional groups.

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Expert interviews

Ms Camila Azevedo	External Affairs Manager, Faculty of Sexual and Reproductive Healthcare
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Dr Susannah Brockbank	Royal College of Physicians of London Trainees' Committee
Ms Yinglen Butt	Associate Director of Nursing (Clinical Standards & Supporting Practice), Royal College of Nursing
Professor Katherine Checkland	Professor of Health Policy and Primary Care, University of Manchester
Mr Kerrin Clapton	Research Policy Manager, General Medical Council
Ms Laura Coveney	Policy Researcher, Royal College of Ophthalmologists
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