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Improving collaborative working

Contents

Introduction

This report highlights some of the barriers faced, and guidance and evidence to improve collaborative multi-agency working, including examples of multi-agency collaborative working from across the UK. This report also looks at communication in collaborative working, looking at ways to improve communication.

Multiple sources were searched including Social Care Wales, What Works Centre for Children and Families, SCIE, Google, and Scopus. The searches conducted in Scopus used the following search strategies.

multi-agency limit to: 2019-2024
communication OR communicate OR communicating AND collaborative OR collaboration OR collaborating OR collaborate OR multi-agency OR multi-agencies OR multi-disciplinary OR co-produce AND "social care" OR "social work" limit to: 2019-2024*

Disclaimer: This summary includes relevant literature that was identified from the above searches, it is not an exhaustive list, it presents key findings and not recommendations for practice.

Barriers to multi-agency collaborative working

A publication from Scottish Government and various collaborative projects highlight the barriers that can hinder effective collaboration[1]. A study looking at extra-familial harm highlights the failures in multi-agency arrangements[2]. Various articles and case studies also highlight barriers to collaboration.

Key barriers to collaboration include:

- Short-term funding – resulting in precarious working conditions, high staff turnover, and loss of knowledge / expertise [1]
- Inflexible funding – lack of flexibility to respond to need, complex and time consuming, overly bureaucratic [1]
- Reductions in funding / limited resources [1,3]
- Agencies in competition, rivalry, or misalignment of roles [2]
- Funding– restricting and intense monitoring of spending [1]
- Lack of trust – not trusting other agencies, questioning their competency [1,4]
- Unsatisfactory understanding of each other's duties and challenges [1]
- Power imbalances – not feeling like equal partners, even excluding them [1,4,5]
- Lack of open honest communication [1,6]
- Time to develop trusted relationships and to plan– staff turnover [1,3,6,7]
- Need more engagement and to empower communities and third sector [1]
- Procurement and resourcing processes [1,8]
- Different IT systems / personal records [8]
- Information governance and sharing information [8]
- Organisations are organised differently, different processes, and work styles [6]
- Difficult to get to a shared understanding / vision [4,6]
- Not including all partners in meetings and decision making [4]
- An incoherent approach, not coming to mutually agreed approach [4]

What factors make collaborative working successful?

An evidence review of 75 studies about multi-agency working with children in care from Wales Centre for Public Policy identified common factors which help to ensure effective collaborative working[5]. The UK Integrated Care Competencies Framework identified key qualities needed to work collaboratively[9]. A study looking at the extra-familial harm highlights the failures in multi-agency arrangements[2]. Many articles and case studies also provide contributions to what made collaboration successful.

Factors for successful collaborative working include:

- Having a key worker or team leader- a dedicated person who acts as a link between the different agencies and is directional when needed [5,10,11]
- Information sharing - where workers can easily access information [5,7]
- Joint training [5,12]
- Co-location – working together on a daily basis or meeting regularly, to build relationships and trust, and to share ideas / knowledge [1,3,7,9,12–15]
- Safe spaces to contribute, be heard, listen and value each other's input [15]
- Joint funding / pooled budgets [5]
- Parental / carer empowerment – involving them in discussions and decision making, with rotating chair to disrupt power imbalances [5,10]
- Clarity over goals / actions, shared purpose and vision [1–3,10–12,14,15]
- Understanding of and accountability for each person's responsibilities [5,7,9,14]
- Understanding the skills / contributions each agency / person brings [9,10,13]
- Strong leadership who are dedicated to the vision [5]
- Power-sharing between agencies, shared decision-making, and each agency team is seen as equal and has a representative [3,5,15]
- Shared language, processes, and understanding [5]
- Assessing needs and mapping support – increased confidence to refer [16]
- Strong project management to drive collaboration and momentum [7,13]
- Adaptability and flexibility to accommodate change [7]
- Embed impact evaluation using measurable outcomes [7,10]
- Creating demonstrable models of collaborative delivery which can be scaled up or replicated elsewhere [7]
- Establishes links, shares decisions, breaks down barriers and avoids duplication [9]

- Celebrate success of multi-agency care team outcomes [9]
- Dedicated time [13]
- Openness and tolerance for ‘not knowing’ [2]
- Understanding potential benefits / outcomes of their multi-agency working [2,14]
- Team reflection time, improve communication and strengthen constructive discussion between members [10]
- Manage conflicts, being open and curious [15]
- Specific methods of assessing, monitoring and evaluating progress of multi-agency plans are agreed [11]
- Clear lines of communication across partnership organisations [11]

SCIE also include links to information on various enablers to integrated care such as system leadership, asset-based approaches, and population approaches. There are also links to activities to help achieve integrated care including; joint needs assessments and care planning, community-based integrated services, etc.[10]

The Human Learning System is an approach that incorporates collaborative working and their guide explains how to implement this way of working, detailing each step needed and things that need to be considered at each stage. The stages in brief are:

- Stage I: Understanding the system – clarify purpose, actors in the system, building trust, identifying factors involved, building knowledge, and shared understanding.
- Stage II: Co-designing explorations – types of explorations, establishing inquiry questions, designing actions in response, designing methods for data collection / analysis, and creating enabling environments.
- Stage III: Running experiments – protecting experiment from ‘business as usual’, learning from system, iterating, and learning.
- Stage IV: Embedding / influencing – embed changes, influencing other cycles, and continue learning cycles.
- Stage V: System stewardship – managing and governing the learning cycle.[17]

Examples of multi-agency collaborative working

A study looking at a multi-agency approach to reducing rates of emotionally based school non-attendance, using the Research and Development in Organisations model to structure the action research process, which consisted of cycles of action and reflection.[3]

A qualitative study investigated the experiences of police and social workers, across Scotland, who worked closely with Looked-after Children and each other in an inter-agency capacity.[4]

An NHS and third sector collaboration to enhance crisis mental health service provision for young people in Greater Manchester explored the benefits and challenges of the collaboration, and suggests how the collaboration between the NHS and third sector may be improved for future projects.[6]

There are a collection of collaborative case studies from the Welsh post-16 sector.[7]

A multi-agency pilot project in London with young people transitioning from CAHMS to adult services, it set out to design and deliver a DBT-informed group for young people aged 16–24 who presented with emotion regulation difficulties and do not fit or meet criteria for generic mental health services. They set out service level agreements and expectations at the start, meeting in different locations, and identified shared values.[8]

Wirral built a multi-agency training programme and improved partnership working to help professionals confidently support parents in distressed relationships. They held a multi-agency awareness-raising workshop event for senior leaders and managers from across the children and families sector, to galvanise commitment to workforce development and training. They delivered classroom-based training to professionals from the voluntary and community sector, local authority children's services, education, and health, and to early help-appointed police community support officers. They appointed a Children's Services Partnership Manager, and established a reducing parental conflict (RPC) steering group.[11]

Hartlepool built a local partnership to increase the early help practitioner workforce capacity to attend to the quality of parental relationships.[12]

East Midlands Reducing Parental Conflict Working Group case study, the project involved three main activities; needs assessment, intervention and support mapping,

and the creation of a theory of change. This group already had a strong working relationship, regularly working on collaborative projects.[13]

Birmingham Children's Trust worked with local partners to gather data, complete a population needs assessment, and to map current services. They used the information to identify gaps in their current provision.[16]

'Andy's story' was a case study about a man who was homeless, was a victim of financial abuse, and was in poor health. A team of people from various organisations worked to support Andy, they identified his needs and his likes / dislikes, to help to meet his needs, which was regularly reviewed.[18]

Collaborative multi-agency working supported development and delivery of the programme, Gwên am Byth to support oral hygiene and mouth care for older people living in care homes. However, they provide limited detail on how they work collaboratively.[19]

A digital mental health and neurodevelopmental service claims that working online helped to facilitate multi-agency collaboration in this study.[20]

Sefton engaged with stakeholders to develop a local outcomes framework for reducing parental conflict, holding workshops to discuss, develop and agree the outcomes for the framework.[21]

Walsall mapped the local workforce involved in reducing parental conflict to assess workforce skill levels and the impact of the current training offer, as phase one of a four-phase reducing parental conflict evaluation project.[22]

There are numerous case studies using the Human Learning Systems approach available on their website. The Human Learning System focuses on forming effective human relationships, working together, and continuously learning and evolving.[23]

Communication in collaborative working

A scoping review identified effective professional collaboration relies on frequent, efficient, and continuing communication. Communication should:

- Use positive, strength-based language
- Avoid discipline-specific jargon
- Mutual respect and open-mindedness
- Share information
- Virtual networks / telehealth resources can enhance collaboration [24]

A case study around improving an existing integrated care initiative in the Netherlands, using a participatory approach to further improve collaboration between health and social care professionals. Improvement activities included interprofessional meetings focussing on reflection and mutual learning and workplace visits. According to participating professionals, the improvement activities improved their communication and collaboration by establishing mutual understanding and trust. Enabling factors included the safe and informal setting in which the meetings took place and the personal relationships they developed during the project. Different organisational cultures and interests and a lack of ownership and accountability among managers hindered the improvement process, whereas issues such as staff shortages, time constraints and privacy regulations made it difficult to implement improvements on a larger scale.[25]

One study highlighted the positive aspects social workers bring to the collaborative team, one of these was active communication. Active communication was described as consisting of three distinct qualities:

- Building relationships – being trusted, reliable, accessible, and visible
- Holding information – not just a physical record also informal communication
- Filling care gaps – shifting tasks / roles to fill gaps, knowing team roles / skills

These qualities highlight aspects of communication useful for collaboration.[26]

A scoping review identified communication as a priority area when implementing integrated care systems. The review cited common communication barriers including systemic factors (fragmented structure of care pathways and fragmented relationships within care pathways) and technological issues (inadequate, or inaccessible IT communication resources). Facilitators of communication include

conscious efforts to build strong and trusting relationships between stakeholders, encouraging service user involvement in designing care models and self-care, greater staff involvement with service users' communities, and highly available and efficient IT resources dedicated to service user consultation, safe service user transfer and general care team activities.[27]

A primary care team in Canada, looked at the implementation of the Interprofessional Collaborative Relationship-building Model (a tool for understanding the stages of development of the interprofessional team's relationship-building). The results describe how the team developed interprofessional relationships in three of the four stages of the model: looking for help, fitting-in and growing reciprocity. However, they identified co-location was not a stage but the context where collaborative relationship-building took place.[28]

Another study using the interprofessional collaboration model, looked at interprofessional collaboration between social work, financial and employment service organisations in The Netherlands. Aspects identified as beneficial to communication were, having open communication, getting to know each other, and joint meetings. Having a co-ordinator was also noted as beneficial to collaboration.[29]

A study from Sweden explored psychiatric outpatient clinicians' experiences of interprofessional communication and identified important elements to good communication. Elements to good communication included:

- Formulating a message and gaining feedback to confirm understanding
- Variety of communication methods (conversations, team meetings, conferences, digital platforms)
- Adjusting communication depending on the recipient, for example streamlined for those with time constraints
- Setting reminders to share information at appropriate points
- Understanding the purpose of the communication and being well prepared for the interaction
- Valuing opportunities for communication (open doors)
- Having a work community with mutual trust, openness to asking questions, sharing insights, and offering support
- A sense of community and shared responsibility for patient-centered care
- Everyone's communication was considered equally important
- Physical proximity in the workplace [30]

Social Care Wales - Collaborative communication skills programme

The training programme develops the skills and capabilities of the workforce to deliver outcomes focused strengths-based practice. The training also considers the wider organisational implications and practicalities of embedding this way of working as a whole system approach is required.[31]

The training includes:

- Theories of human behaviour that inform effective responses
- Principles that underpin our professional responses
- Skills and strategies practitioners can use to engage with people at times of challenge and stress
- How organisational systems can support effective practice [31]

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