Teamworking & Team Approach

For the purposes of this course 'team-working' and a 'team approach' are seen as distinct and separate entities. Team-working is a simpler concept to grasp, particularly in relation to co-ordinating care… and is by far the more frequent method used in teams where care co-ordination of complex cases is practiced (e.g. CPA). ***It essentially refers to one allocated named individual taking on the role, but with a clear remit in a good functioning team of co-ordinating the specialist input of team colleagues in line with the needs that have been assessed***. The number of colleagues involved, as well as the timing and frequency of their input, is a negotiation to be made by the allocated co-ordinator. How much they are involved in co-ordinating inputs from outside of the team will depend on the nature of the team, and local policy.

The *team approach* is something that was closely associated with assertive outreach. Though, in the experience of the author, most assertive outreach teams are closer to the description of team-working than a full team approach. A team approach is the natural way of working in acute care services (in-patient units and Crisis Resolution & Home Treatment teams) that operate shift systems for 24-hour care and support, and in residential support services, because different staff will be available at different times.

The *Practice Based Evidence* consultancy has worked with many assertive outreach teams since 2001, attempting to look at what a full ***team approach*** has to offer both service users and staff in the co-ordination of complex care and support. In essence, ***it involves all staff working with all service users through flexible arrangements, permitting the allocation of a care co-ordinator to be 'nominated' for overseeing administration functions, rather than allocated with a stronger emphasis on personally delivering more of the care and support***. It has worked well in some cases and not so well in others. Anecdotally, the different degrees of success can be largely put down to the value base of different groups of individual workers, more than the perceived resistance of service users to seeing different people.

In the initiative developed with the West Suffolk Assertive Outreach Team in 2006, they outlined the following responses to what was positive and what was difficult about adopting a different way of working with a team caseload.

Benefits of the *team approach*:

- Different staff members leading each time
- Stops us becoming precious about specific service users/areas of our work
- Promotes involvement of the whole team
- Helps staff members to get updated on people we know less about
- Accommodates annual leave/sickness without the work being disrupted
- Establishes a structure and sets a deadline
- We always have the psychiatrist involved in the process (and other people/agencies relevant to the individual's needs)
- Enables a more thorough assessment
- Challenges us to think more about the review process

- Reduces the sense of resistance to case allocation
- Helps to link the process of reflection about what has been happening to any revised aims and objectives
- Highlights the problems associated with just having one person as care co-ordinator.

Challenges of the *team approach*:

- Ensuring efficient communication within the team (e.g. potential for promises by one staff member not being prioritised or honoured by others)
- The total team caseload is a lot of people for us to hold detailed knowledge of everyone… only the team Doctor has an overview of all service users
- How can we pick up on 'interim' changes between *review periods*? (More an issue of using other systems effectively i.e. electronic records/contact notes/handover/whiteboard, etc)
- Making the whole process real for people (i.e. we still have to accommodate the differences of expectation of the organisation and the service users)
- Still need to consider how and why we ask people to be signing copies of their CPA care plan/risk forms… what does signing or not actually signify in reality? It could be an institutionalised response rather than a genuine agreement or sense of involvement
- It can be a long-drawn-out process with delays set by the need to agree the care plan at the clinical meeting… this can result in an imbalance of talk and action
- 'Risk' needs more attention as to how it is presented and discussed with the service user… the *usual* formats are difficult to adapt or make more user-friendly… too much paperwork expected, yet it inadequately reflects the reality of 'working with risk'
- Service User Personal Safety Plan has a good but limited use for engaging service user's views.

As a system it has much to offer but demands the constant attention of everyone to the team processes. Therefore, it will not function effectively where this fails to be achieved.

Reflective exercises (for individuals or groups)

- How is the role of co-ordinating care enacted in your practice &/or that of your team? How much of a genuine team approach are you able to achieve?
- How are conflicts about any aspect of care co-ordination resolved within your team (who has the authority to drive these decisions forward)?