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Are interprofessional healthcare teams meeting patient expectations? An exploration of patients' and informal caregivers' perceptions

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Abstract

Poor teamwork skills in healthcare have been found to be a contributing cause of negative incidents in patient care, whilst effective teamwork has been linked to more positive patient outcomes. The aim of this research is to explore views of patients and informal caregivers on the key characteristics of effective healthcare teams and their experiences of healthcare teams using a qualitative approach. A focus group schedule was developed from existing literature to explore this. Topics included the purpose and value of teams in patient care, key attributes and their impact on patient care. Patients and informal caregivers were recruited via convenience sampling. Three focus groups were conducted. Thematic analysis identified a number of themes associated with effective teams. These themes included the perceived purpose of teams, perceptions about the structure of a team, team-based communication, the role of patients, delivery of care. Research participants noted the importance of key characteristics in effective teams, but felt that these were not always consistently present. Communication was considered to be the most important attribute in team working and also appeared to be the area in which the patient experience can be significantly improved. It is clear from the findings of this research that further improvements in teamwork skills in healthcare are needed to achieve effective collaborative practice, sustainable service delivery models and optimal patient care as outlined by the World Health Organization (2016).

Key words: interprofessional, patient, teamwork, attributes

Introduction

The use of interprofessional teams to deliver health care is a key feature of care management in the United Kingdom (Care Quality Commission, 2010; Scott Reeves, Xyrichis, & Zwarenstein, 2018).. Shorter hospital stays, caring for patients in the community and an increasing focus on prevention of illness has had major implications for both health and social care professionals, patients and the delivery of care (Boaden & Leaviss, 2000; NHS England, Care Quality Commission, Health Education England, Monitor Public Health England, 2014). Poor teamwork skills in healthcare have been found to be a contributing cause of negative incidents in patient care, while effective teamwork has been linked to more positive patient outcomes (Chesluk et al., 2015; Department for Children, Schools and Families, 2008; Francis, 2009; Scott Reeves, Lewin, Epsin, & Zwarenstein, 2010). Consequently, effective interprofessional teamwork is perceived as becoming increasingly important in ensuring patients receive quality care.

A competent healthcare team is a key enabler of integrated health services delivery (Grace et al., 2017; Langins & Borgermans, 2015; Scott Reeves, 2012) and teamwork has been identified as a key competency by the World Health Organization (Gilbert, Yan, & Hoffman, 2010). Langins & Borgermans (2015) have described teamwork as the "ability to function effectively as a member of an interprofessional team that includes providers, patients and family members in a way that reflects an understanding of team dynamics and group/team processes in building productive working relationships and is focused on health outcomes" (Langins & Borgermans, 2015)(p.16).

Furthermore, Dow et al (Dow et al., 2017) suggested that interprofessional practice encompasses both interprofessional teams and interprofessional networks. This was a view shared by Reeves at al (Scott Reeves et al., 2018) who further proposed that interprofessional collaboration and coordination were also key features of interprofessional work.

Interprofessional teamwork

A review of the literature identified a number of key attributes of effective teams in health and social care. The importance of effective communication in facilitating effective teamwork is clear. Effective communication assists in breaking down professional barriers, resolving inter-team conflict, promoting positive interpersonal relations and improving interprofessional communication (Kossaify, Hleihel, & Lahoud, 2015; Matziou et al., 2014; Nancarrow et al., 2013; Thomson, Outram, Gilligan, & Levett-Jones, 2015; Wilson, Palmer, Levett-Jones, Gilligan, & Outram, 2016). However, in recent years, there has been a significant shift in patient care designed to facilitate shorter hospital stays and caring for patients in the community. In addition, practical factors, such as the geography of the workplace and work schedule, can impact the accessibility of team members, which can hinder the teamworking process (Delva, Jamieson, & Lemieux, 2008; S Reeves, Lewin, Espin, & Zwarenstein, 2010; Sargeant et al., 2008). As face-to-face communication is not always possible, there is then a greater need for effective communication using a range of processes to support information sharing and exchange within a team; central coordinators such as secretaries are seen as central to facilitating communication because they interacted with all team members (Aungst & Belliveau, 2015; Azar et al., 2017; Bardach, Real, & Bardach, 2017; Delva et al., 2008; Kuziemsky & Reeves, 2012; Szafran, Torti, Kennett, & Bell, 2018).

Healthcare teams frequently vary in terms of their composition. This is often influenced by the needs of the patient and remit of the teams and may include doctors, nurses, pharmacists, physiotherapist, occupational therapist and social care staff such as carers. The size of the team, team composition and skills and competencies within the team are identified in the literature as key requirements for an effective team (e.g. Bainbridge et al., 2010; Delva et al., 2008; Vyt, 2008; West & Lyubovnikova, 2013; Xyrichis & Lowton, 2008). **S**hared

goals were seen to bring team members together (Institute of Medicine, 2003; Jackson & Bluteau, 2011; Mickan & Rodger, 2005; Schroder et al., 2011; Vyt, 2008; West & Lyubovnikova, 2013).

However, it is key that individuals' understanding their own roles and the role of others help team members understand scopes of practice, enhance respect for each other's roles, and importantly allowed them to understand how the roles of others are complementary to their own (Bainbridge et al., 2010; Harrod et al., 2016; Nancarrow et al., 2013). Furthermore, recognition by others as to what a team member brought to the team was also important (Institute of Medicine, 2003; Jackson & Bluteau, 2011; Youngwerth & Twaddle, 2011).

Relationships between team members including mutual trust, support and recognition, were found to improve effective team working and team relationships over time (Harrod et al., 2016; Jackson & Bluteau, 2011; Youngwerth & Twaddle, 2011). Team members should have knowledge of and respect for the competences, roles and contributions of other professionals within a team and the ability to complete the team goal (Vyt, 2008; West & Lyubovnikova, 2013). Delva et al. suggested hierarchies and power differences are seen to have a negative impact on team cohesiveness and team working (Delva et al., 2008), However, this was not a clear theme across the literature, with other research suggesting that hierarchies can provide leadership and direction for teams (Mickan & Rodger, 2005). Notwithstanding, leaders should demonstrate leadership skills rather than be based on hierarchy (Bainbridge & Wood, 2013;; Jackson & Bluteau, 2011; Macdonald et al., 2010; Nancarrow et al., 2013).

Clear leadership provides teams with well-defined team objectives, distinct direction and management, high levels of team participation, commitment to excellence and support;

moreover team members felt supported, supervised and developed (Jackson & Bluteau, 2011; Kossaify et al., 2015).

An important consideration is the environment within which different teams operate. Structural problems, for example people working across different organisations and referral of patients between team members, has historically led to gaps in service provision or duplication of services (Boaden & Leaviss, 2000). The lack of communication of organisation news and a lack of consistency in the application of policies are factors that inhibit teamworking (Delva et al., 2008). Practical issues also impact team effectiveness, for example, patient records need to be organised in a way that promotes interprofessional consultation of patient records and data files (Vyt, 2008).

Despite a wealth of literature on the views of healthcare professionals, evidence relating to the attributes that patients consider to be important in effective healthcare teams is limited.

Patient engagement with healthcare teams

Patient engagement is considered important within healthcare with an expectation that patients and family members will engage in their own health (Howe, 2006; S. Parsons, Winterbottom, Cross, & Redding, 2010). Regulatory bodies including the General Pharmaceutical Council and British Medical Association have recognised the importance of patient engagement. Recognition of the patient or the patient's representative as a key team member has been identified as a quality of a good team and impacts on patient care (Karazivan et al., 2015; Scott Reeves et al., 2015; Royal College of General Practionners, 2006).

Patient-centred care facilitates shared decision making and patients' engagement in care related decisions, in turn leads to enhanced satisfaction with care and improved

outcomes (Dunn et al., 2018; Howe, 2006; Sidani et al., 2018; Stacey et al., 2016). Whilst many healthcare professionals describe their approach as being patient centred , what this actually encompasses varies (Fox & Reeves, 2015; Gachoud, Albert, Kuper, Stroud, & Reeves, 2012). Furthermore there is the assumption patients' wants and are able to take on the responsibilities that comes with the role.

Patient involvement has the potential to increase professionals' awareness that their actions have real consequences for individuals, which moderate risk taking behaviour ((Howe, 2006). However a number of challenges have been identified that impact on patient engagement with healthcare teams and can hinder patient involvement. Also, a patient's lack of knowledge, their illness and mental state can affect their ability to be actively engaged with the healthcare team (Howe, 2006).Ethnicity and language spoken, age, education level, acute pain and mental capacity can significantly impact on a patient's ability to assume responsibility (Fox & Reeves, 2015; Stacey et al., 2016). The power dynamic between patients and healthcare professionals can be intimidating which in turn can affect negatively patient involvement (Soklaridis et al., 2017). In these situations, it is important to consider how such factors impact on accountability and liability in relation to health care decisions. Karazivan et al (Karazivan et al., 2015) build on the concept of patient engagement suggesting that patients have competencies and limitations like any other team member. They propose an approach that aims to develop patients' competency in care to overcome some of the identified challenges.

In order to facilitate patient engagement and work in partnership with patients, there needs to be trust and transparency between healthcare professionals and patients (Soklaridis et al., 2017). Healthcare professional need to be able to feel comfortable admitting when they lack knowledge without losing the patient's confidence. Whilst Soklaridis et al ((Soklaridis et al., 2017) found that there is a growing appreciation of the patient perspective in delivering

patient-centred care, it was suggested that there is a risk of "tokenising"(p124) the patient perspective since healthcare professional control healthcare provision. More recently, there is evidence that doctors do not conceptualise patients as members of the primary care team (Szafran et al., 2018) and it has been suggested that proactive discussion with patients regarding their health could have a negative psychological impact on patients (Howe, 2006). In light of this, it appears that a combination of the reluctance of healthcare professional to encourage patients to be active partners and some patient's wariness to speak up can limit patient engagement.

The aim of the research study was to explore the patients and carers perceptions of interprofessional teams in the delivery of effective patient care. This paper aims to broaden the literature on the team attributes that patients believe are key in effective team working and patient experiences of healthcare teams.

Methods

An exploratory case study involving focus groups was conducted with a convenience sample of patients drawn from staff of a North West of England Higher Education Institute (NWHEI).

Data collection

A focus group schedule was developed from existing literature to explore team attributes in healthcare. Focus groups allow the rapid identification of different people's views relating to a specific area of interest, without specifically attempting to find a consensus. Focus groups facilitate the exploration of experiences and in-depth information through the use of open-ended group discussions guided by the researcher. This approach encourages participants to consider the views and opinions of other participants, thereby

stimulating the views and opinions of all participants (Robson, 2011). In doing so, focus groups enable collection of data relating to issues that individuals may not consider and expose any shared understanding and common views.

Participants could only partake in one focus group. Topics included the purpose and value of teams in patient care, their key attributes, and their impact on patient care. Participants were asked to describe their experiences of health and social care teams and prompted to express and develop their views and opinions on attributes of teams and impact on patient care. One of the authors (SC) served as the group facilitator adhering to the standardised schedule.

Following review of the analysis of the initial focus group discussions by the research team against the research aim, no major changes were identified and the focus group schedule was deemed robust, and appropriate. Focus groups were utilised to explore the opinions of participants using the focus group schedule

Table 1: Demographic profile of participants

Demographics		**Number of participants**
Age	16-30	1
	31-44	9
	45-59	4
	60+	
Gender	Male	3
	Female	11
Education level	No qualification	
	GCSEs or equivalent	2
	A-levels or equivalent	1
	Degree	4
	Higher degree	7
	Professional qualification	

Data were collected by identifying participants from a NWHEI who had accessed care through a NHS provider for a chronic condition as either as a patient themselves, or as carer

for a family member, in the preceding 6 months (see Table 1). Participants who taught or were involved in research within a health- or social care-based programme were excluded to minimise research bias due to participant expertise in the research area. All focus groups were digitally recorded and transcribed verbatim. All data were anonymised at the transcription stage by removing participant identifiable information. Data collection continued until no new themes emerged and data saturation was achieved.

Three focus groups were conducted. The average duration of the focus groups was 68 minutes, with durations ranging from 52-74 minutes. Two groups of nine participants were of mixed gender and one group of 5 was female only (see Table 2).

Table 2: Focus groups profile

Focus group	Number of participants	Focus group reference
1	5	FG1 A-E
2	4	FG2 A-D
3	5	FG3 A-E

Data analysis

To ensure trustworthiness and robustness of the data, accuracy of the transcribing was reviewed. A grounded theory approach (Robson, 2011) was adopted to establish emerging themes using the software NVivo 10. Coding was undertaken by the researcher and all codes were subsequently subjected to peer scrutiny by two colleagues in the research team to ensure appropriateness, consistency, accuracy of codes and dependability of the findings (Gibbs, 2007). Any divergence in coding was discussed between the research team and an appropriate resolution was identified. The research team discussed the coding which were then organised in to a number of themes as detailed in the results.

Ethical considerations

The study obtained favourable ethical approval on 18th December 2014 (14/PBS/004). Written consent was obtained from all participants by the researcher prior to the commencement of each focus group. No topics were discussed that any of the participants found distressing during the focus groups. Participants were able to withdraw from the focus group at any time and could choose not to answer the questions. All data collected were treated confidentially by the researcher and any information obtained in connection with this project and which could identify participants was removed during transcribing to ensure anonymity.

Confidentiality of the focus group discussions could not be guaranteed for those participating in each focus group as other participants will know what has been said and by who. However, focus group members were asked to respect the confidentiality of other members of the group. Confidentiality was guaranteed between each focus group.

Results

Following analysis of the data, the following themes emerged: perceived purpose of teams, perceptions about the structure of a team, team-based communication, the role of patients, delivery of interprofessional care.

Whilst the primary aim was to explore perceptions of healthcare teamwork, some participants may have included their experiences of social care. The themes will now be described with illustrative verbatim quotes and because focus group data is the outcome of a discursive process, no quoted material is attributed to individuals, but the provenance from the specific group is noted.

Perceived purpose of teams

Across all focus groups participants recognised the presence of teams within healthcare and clearly described their experiences of teams within both primary and secondary care. A team approach was seen as advantageous in effective care, facilitating continuity of care and bringing together a range of healthcare professions such as medics, nurses, pharmacists and physiotherapists:

> So you can have lots of different teams that interact; involved in your care. You can have your primary care team in your GP (general practitioner) practice but you might also have links with a team in a hospital. (FG2 A)

There was a consensus that the purpose of a team was wider that just providing clinical care; participants believed that a team should provide holistic care to participants, carers and their families. Participants expected teams to work towards a common goal, with all team members having awareness of this goal and how it will be achieved. Such an approach was considered to facilitate continuity of care and quality assurance of the care provided.

> Working towards a common goal and knowing exactly what their objectives are and how they can, how they're all part of how they all achieve that goal you know, what's required of them….So there's things like socio-economic class, social welfare issues. All those. And also for their direct people, their cares and families as well. (FG1 A)

However, there was a feeling throughout discussions that they themselves were often unaware of a team approach to their own care. From their experience, healthcare professionals introduced themselves as individuals and not as part of a team. However, there was a general view that they did perceive that staff working in the same department to be part of the same team.

> You just see the random people that come into your room or that are doing these different jobs but you don't actually know who that is or that's the team. (FG3 C)

Perceptions about the structure of a team

The overall makeup of an interprofessional team was seen to be influenced by the individual patients, as each patient's needs differ. Regardless of the professions involved in team, discussions revealed participants felt that each team would be different depending upon individual personality traits, experience, strengths and weaknesses.

> So you could have a whole set of different pharmacists and a whole different set of doctors and they all interact differently, and expect different things from themselves and other people. (FG1 A)

Participants described how a mix of experience (years qualified) was important in teams. Healthcare professionals who were more recently qualified were considered to have more up-to-date clinical knowledge and skills but the practical experience of making patients better could only be achieved though through years of clinical practice and exposure to non-textbook cases. Furthermore, the overall teams' knowledge, skills and competence was considered to be more important to patients than knowledge, skills and competence of individuals

> The oldest can learn from the youngest as well. They're enthusiastic and sometimes a younger doctor or healthcare professional can know more because they've researched it, they've looked in to it, they've got the enthusiasm for it…… just because you're the most qualified, doesn't mean that you can't learn from younger people. (FG3 E)

Focus group discussions supported the presence of hierarchies in teams and this was seen as a positive factor in team working and patient care. It was perceived that hierarchies facilitated teams in understanding who was "in charge" of a team, allowing all team member to know their place and understand their role within the team. Participants described hierarchies in teams as teams in which individuals had different levels of accountability, responsibility and decision-making.

> I think it allows everyone to know their place. Everyone has a status and they know that this is what I can do with my status. (FG2 C)

> Like they're all working together but you've got one main person main person whose making the decision, instilling confidence in people. (FG3 D)

> I think people need to know….sort of who's in charge and what things there are to do and not overstep the boundaries. (FG3 E)

However, some participants did also feel that there were some disadvantages to having hierarchal structures. Hierarchies could result in patients speaking to the wrong person and not knowing who they should be "consulting" with. Furthermore, in order for a hierarchical structure to work, individuals within the structure needed to respect others in the hierarchy. If respect for others was absent, the team would not work collaboratively and may undermine decisions made in the hierarchies which could be detrimental to patient care.

> So there's all kind of things where the wrong person can get asked if you have a hierarchical structure. (FG1 B)

An area for improvement, identified in the discussion in one focus group, was the lack of willingness of individuals lower down the hierarchy to make decisions. This was perceived to result from institutional culture as opposed to an individual's skill, knowledge and competency. However participants involved in the discussions favoured being cared for by healthcare professionals who were actively involved in delivering their care on a day to day basis rather than a more senior healthcare professional e.g. consultant, who was more withdrawn from their day to day care.

> The chances are if you're on a ward you don't see the boss man. You see all the soldiers. (FG1 E)

> But they obviously have got to report back to the boss man to say……. No I'd rather see the soldiers but they've got to be, they've got to be able to make the decisions as well. (FG1 C)

A leader was perceived to enhance a team's effectiveness and discussions. Participants described how the role did not reside with one individual but moved around a

team or could be split across more than one individual. The challenges of this fluid role were also acknowledged and the need for trust and respect of others in a team were seen as key to this happening effectively.

> It's like a baton that's passed on. (FG1 A)

Team-based communication

Effective communication in teams was seen as key in ensuring that a team was functional and organised on a day-to day basis and facilitated effective transfer of patient information between team members. Focus group discussions concurred that the absence of effective communication (verbal and written) could result in confusion over the care of the patient, suboptimal care and possibly errors.

> Improve overall patient care to get the best for the patient because the communication between different healthcare professionals would help improve the overall patient care. (FG1 D)

There was a consensus, from their personal experiences, that information needed to be repeatedly given to the same and different healthcare staff. This was experienced across multiple appointments over a period of time, when they saw multiple healthcare professionals on one visit e.g. in patient stay, and across care interfaces.

> So you spend 10-15minutes of the appointment recapping. You know they have the notes in front of them, they know someone else has written, we still have to tell basically why we are here. (FG1 C)

This repetitiveness was considered particularly frustrating since, in a time limited consultation, a significant proportion of this time was allocated to repeating information from previous visits.

> So if you're going to spend that 10-15 minutes talking about something you've already delivered and has been noted somewhere, probably improperly. It's so infuriating. (FG1 A)

Access to information was thought to hinder the communication process and there was an overall consensus that IT systems were ineffective. Healthcare professionals were frequently unable to access health records and this perpetuated patients repeating information multiple times.

> Every single one of them wrote down notes, put them into their computer and then nothing happened because the next person I saw 10 minutes later didn't have access to that information. (FG1 C)
>
> I'm not actually in my office so I can't access them so do you know what those results were? (FG1 B)

The quality of communication was also highlighted in focus group discussions. There was frequently a lack of awareness at who people were, as individuals did not introduce themselves. Furthermore, the style of delivery of information was sometimes poor, with information being delivered as a matter of fact and failing to consider patient as individuals, their current knowledge and what they may need to know which often left patients feeling confused.

> My doctor looking after my mother. When he first told me that she'd got cancer. That was it. He just said that. It was very kind of blank. (FG2 D)

Discussions revealed that a lack of communication and poor communication resulted in patients feeling they were receiving poor care and *"abandoned".* The lack of effective communication was *"confusing"* and *"stressful"* for patients leading to the perception that the team was not effective and the quality of care they received was being compromised.

The role of patients

There was a mixed view in focus group discussions as to whether the patient should actually be part of the team with some participants considering this to be key to successful care. However, some participants were uncomfortable with this notion, feeling that there would be a breach of "*patient-practitioner boundaries*". Some participants felt it was

important to perceive that you were part of team even though in reality you were not, whilst others felt it was important that as patient you were an active team member.

> It's just your perception of feeling in part of the team because, this just my view obviously, but they're just the team but it's nice for you to feel involved and be included, be consulted and all the rest of it. (FG3 E)
>
> I think you should be involved. I don't think it should be a perception. I think you should. You have a right to be involved in your own care. (FG3 B)

Discussions led to the overall consensus that the importance of feeling they were part of the team could vary depending on the nature of care the patient needed and/or was receiving. In particular, it was considered important for patients who required mental health services, midwifery, physiotherapy or community services to feel part of a team. However, it was considered impractical for patients receiving acute treatment, for example emergency care, to be integrated within a team. This was due to the speed and intensity of care that may be required in such settings.

> I would think in mental health services or physiotherapy or something like that. You'd want to feel part of your own team. Like even midwifery, I can you even get your birth plan and you try and take ownership of it a little bit. A&E just so completely different because it's so fast.(FG3 B)

Delivery of interprofessional care

It was evident in discussions that participants who were from an older age group (55 years +), considered that a family approach to care was very valuable to patients. These participants reflected on the GP services prior to 2000, where many GP's were single-handedly providing their own out of hours cover. It was felt that this model allowed the GP to get to know each patient both medically and socially, understand individual family medical and social histories and were therefore more able to provide holistic care and enhance patient care. They reminisced about how a GP **"***knew every single family"* and *"knew every single person who walked in through his door" and* this was considered a strength to the overall

care provided. It enabled rapport to be built between the healthcare professionals and the patient, and they felt that the healthcare professional would bring previous knowledge relating to families to the consultation that could directly impact care treatment and prevention. Such an approach was considered a positive and enhanced overall care of families and not just individual patients.

> Also someone who can support the family. Because I think, sometimes it can just be more about the patient and …… the family as well who are actually dealing with it as well. (FG2 C)

Discussion

Participants' views and expectations on the purpose and value of teams was in line with the literature (Jackson & Bluteau, 2011; Mickan & Rodger, 2005; Vyt, 2008; Xyrichis & Lowton, 2008). There was an agreement that a teams need to consider the patient, carers and other family members. Furthermore, a holistic approach to care whereby medical and social aspects of care are considered is key. It was evident from focus group discussions that social care needs to be integrated in patient care, and patient reflections referred to this approach in mental care teams. It was felt that in other areas of care, there was no or limited social care involvement.

The value of interprofessional teams, bringing together different expertise and experience, and the overall benefit to patient care as described by participants also aligned with the literature (Jackson & Bluteau, 2011; Mickan & Rodger, 2005; Vyt, 2008; Xyrichis & Lowton, 2008). Participants however, were often unaware of the team approach and cited being unaware of which team was involved in their care. This reflects the findings of Parsons and colleagues (Parsons, Hughes, & Friedman, 2016). This implies that individuals and teams have not properly introduced themselves or have relied solely on verbal introductions, which patients may not be able to recall. This could result in patients receiving information and medical care from persons with whom they have little or no rapport. Delva et al found

that determining whether a group constituted a team and its membership challenging (Delva et al., 2008) and this could impact on whether healthcare professionals truly saw themselves as part of a team which, in turn, impacts how they present themselves to patients – as an individual or as a team. Within the literature, the manner in which a doctor greets their patient has been shown to be an influential aspect in establishing an effective and supportive rapport and provides the found the foundation of a satisfying patient experience. Such an approach would undoubtedly influence whether patients perceived them as individual healthcare professionals or as part of a team.

The national UK campaign "My name is……." in 2013 (Kmietowicz, 2015), highlighted the lack of introductions by healthcare staff to patients. Whilst the campaign has been widely endorsed by hospitals trust and NHS England (NHS England, 2015) , it appears that more work may need to be undertaken. Focus groups were held after this campaign was launched, yet participants involved in this research still described the lack of introductions by healthcare staff, however participants may be reflecting back on their experiences prior to this initiative. Providing patients with an information sheet or card that defines that defines team members name and role, and wearing a name badge in a visible location could improve patients' ability to recall names and create a greater sense of familiarity with their treating team.

Characteristics and attributes that facilitate effective teams and the function of those teams have been well documented in the literature (Grace et al., 2017; S Reeves et al., 2010; Szafran et al., 2018)(Nancarrow et al., 2013). A number of team attributes including communication, leadership and understanding the roles of others were considered key. However, it was clear from focus group discussions that participants' views on teams and the key attributes they identified was heavily linked to their experience. Attributes such as a shared goal, team and team processes did not emerge from focus group discussions, however,

these attributes would probably be invisible to patients as they occur behind the scenes and not at the practitioner-patient interface.

From participants experiences, many of the attributes identified through the literature as key for healthcare teams to be effective, were lacking in practice. The trust that participants had in their care was inherent. Participants perceived all teams to be functional and providing optimal care unless their experiences resulted in them feeling differently. Participants did however feel there was a lack of trust between different healthcare professionals. This drove the repetition of information that respondents found to be frustrating and time-wasting. Today's litigious climate may make professionals more cautious and clarifying patient stories for themselves may make them as individuals feel reassured that they are providing the best care and minimising patient harm. Furthermore, staff shortages and the increasing reliance on locum/bank staff frequently result in staff working with people where they have no knowledge of that individual's knowledge, skills or competence.

Throughout the literature, communication was identified as critical to effective interprofessional team working (Jackson & Bluteau, 2011; Macdonald et al., 2010; ; Nancarrow et al., 2013; ; Youngwerth & Twaddle, 2011) and this view was mirrored by participants. Participants felt that communication was the key feature in effective teamwork, resolving inter-team conflict, promoting positive interpersonal relations and improving interprofessional communication.

Participants recognised both the verbal and non-verbal aspects of communication e.g. writing in patient notes. It was clear from focus group discussions that the written communication between healthcare professionals significantly influenced patient care. Participants believed that the limitations they experienced in the transfer of written information was as a result of a lack of trust between team members regarding the accuracy

and completeness of the information. This resulted in the need for patient to repeat information leading to frustration and the perception of poor team working which undermined confidence in the team. Interestingly, participants focussed on delays in care and increased waiting times as an outcome of poor communication. They did not acknowledge how poor communication may influence patient concordance and medication errors. In order for regular and effective communication to happen, accessibility to the other members and the ability to use appropriate communication skills were identified as important.

In policy and the literature, the use of technology to support effective teamwork is clearly identified as a key attribute (James, Page, & Sprague, 2016; McLoughlin, Patel, O'Callaghan, & Reeves, 2018; NHS England, 2017). However, this appeared to be a source of frustration for participants. Accessing technology was a barrier and led to delays in care. Participants recounted numerous occasions where, despite technology (e.g. computers) being in place, individual healthcare professionals were unable to access the electronic patient records through lack of technological skills, or consultations occurring in a room where there was no computer. This resulted in a poor consultation for patients as healthcare professionals did not have access to relevant data or the patient having to reiterate their condition and care to date – a situation intensified as car and services are frequently delivered from different physical locations. The use of hand held technology was seen as a way of ensuring all clinicians had access to technology. However, this would not resolve problems of individuals being able to use the technology.

There is evidence within the literature that hierarchies can stifle interprofessional team working (Delva et al., 2008; Soklaridis et al., 2017). However, within the research, hierarchies were seen to be a mechanism for incorporating a range of experience within a team. Team members lower down the hierarchy were considered to have less years of service and more-up-to date knowledge, whilst those classed as being at the top of the hierarchies

would have more exposure to a range of non-text book scenarios. This resulted in participants having increased confidence in a team where hierarchies were in place possibly as result of perceiving that they would be a non-textbook case. The ability of all healthcare professionals in a hierarchy having the ability and freedom to make decisions was cited as key to hierarchies being effective and viewed hierarchies as a support mechanism for healthcare professionals. They allowed individuals to discuss treatment with more experienced staff that could result in alternative treatments being suggested, thereby developing staff knowledge and influencing patient carers found by Mahmood-Yousuf et al (Mahmood-Yousuf et al., 2008)

Participants who had traditional experiences when a single doctor (general practitioner) cared for families, visited their homes and looked after all of their health needs, perceived this as an ideal model of care in primary care compared to the diversity and associated lack of consistency of care experienced today. The move from clinicians working in isolation has been driven by the view that such an approach was heavily dependent on one individual and may put the patient at risk, and the complexity of modern healthcare (NHS England, 2017; World Health Organization, 2016, 2018) were not identified as a concern for participants. This could be because of the view that all practitioners were skilled and competent individuals until something went wrong, coupled with a lack of awareness of the complexity of current healthcare. However, healthcare services differ across geographical locations and if the research had been undertaken elsewhere in the UK, this view may have been different and further research is needed on a wider scale to explore this area. There is a recognition that one care model cannot be used across England due to the diversity in patient populations and current health services (NHS England, Care Quality Commission, Health

Education England, Monitor Public Health England, 2014) and perhaps the current model of care in this geographical location needs to be reviewed.

Mitchell et al. (2012) described the integration of the patient and /or family/care giver in to the team to establish a shared goal. Through integrating a patient into a team, the team could understand more fully the patient and family's need (Mitchell et al.,2012). Furthermore, patient safety and care and patient reports of their experiences and of their satisfaction with care could be improved through patient involvement in some form (Howe, 2006). However challenges are associated with this including the ability of patients to undertake this role due their illness e.g. dementia, acute illness, alongside professionals' wariness. Whilst there was a mixed view from participants on being members of a team, they did describe the need for care to wider than just a patient presenting complaint and consider the holistic needs of patients. Thus, whilst some participants verbalised that they did not want to be part of the team, in reality, the merits that this would achieve were welcomed and further explanation on what this actually would look like may have resulted in a different outcome. Furthermore, the challenges of integrating patients and their families into teams can be daunting. Patients may feel unprepared whilst healthcare professionals and are often ill-equipped to practice collaboratively with patients (Mitchell et al., 2012). The government's current direction of facilitating patients gaining a greater control of their own care (NHS England, Care Quality Commission, Health Education England, Monitor Public Health England, 2014) will surely require patients to be part of the team in some manner/capacity.

A key theme throughout the focus group discussions was the patient's perceptions of interprofessional teams. They believed teams to work together and comprised the appropriate professionals with the appropriate knowledge, skills and competencies to give the best care possible. It was only when patient became aware of mistakes, a breakdown in the continuity of care, that they questioned the effective of that team. This suggests that the overall patient

experience is important to patients. Such an experience is unsurprising as any team conflict should be behind the scenes and not exposed to patients. However, this may not be the case if patient were actively engaged in health care teams and as such the overall patient experience may be adversely affected.

Whist the findings of this research illustrate ways in which the perceptions of patients and carers relates to the literature on teamwork, there are a number of limitations. The analysis relies on the views of a relatively small number of patients and presents their experiences and perceptions of healthcare teams, which limits the transferability of the findings. Focus groups were heterogeneous in terms of gender, age, social status and ethnicity and this may have hindered discussions. Furthermore, age and gender may have influenced participants' exposure to different interactions with healthcare teams.

There is also likely to be a response bias in that individuals who volunteer to provide feedback through focus groups may choose to participate because they are particularly opinionated about their experiences of healthcare teams. The views shared may have also been influenced by the dynamics of being with participants who they did not know and therefore felt less comfortable to fully share their views and opinions.

Concluding comments

Key attributes that interprofessional teams should demonstrate to provide effective care have been well documented in the literature and a number of these are expected by patients in their care. Exposure to teams displaying these attributes impacts the patient experience and it is clear these attributes are not consistently present in patient care. This led to a limited understanding of the attributes especially relating to attributes that were not directly visible to them e.g. team meetings, shared goal. Communication was considered the most important attribute in team working and appears to be the area where the patient experience can be significantly improved. It is clear from the findings of this research that

further improvements in teamwork skills in healthcare are needed to achieve the international vision of the effective teamwork and collaborative practice.(NHS England, 2017; World Health Organisation, 2016)

Declarations of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the article

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