DOWNLOAD PDF WORKING ACROSS THE HEALTH AND SOCIAL CARE BOUNDARY

Chapter 1 : How to Maintain Professional Boundaries in Social Work: 15 Steps

Author Information. Head of Knowledge Services at the UK's Social Care Institute for Excellence, a national body established to identify and disseminate good practice in UK social care, Amanda writes here in a personal capacity.

We then present the findings of a review of empirical studies carried out in the health-care sector see A review of the empirical literature , which establishes that the existing evidence base mainly relates to the characteristics of individual boundary spanners and that there is a lack of studies of how boundary-spanning processes enable knowledge exchange and creation. We then identify and describe a framework for conceptualising knowledge creation and exchange processes across boundaries, which we will later use to analyse our primary research findings see Conceptualising knowledge creation and exchange processes across boundaries: The chapter ends with an introduction to the particular boundary-spanning intervention under study and the setting for our evaluation see The boundary-spanning intervention under study: The contemporary NHS policy context In the health-care sector it has been recognised since the s that high-quality services, particularly for patients with complex needs, cannot be provided by one health-care discipline alone or by a single sector. Today, patients in most health-care settings typically interact with a variety of health-care professionals representing many different disciplines but do not necessarily experience patient-centred care or co-ordinated teamwork. Not all multidisciplinary teams function effectively as a unit; interprofessional work groups face additional barriers to reach the level of high-functioning teams, particularly those working in a complex health-care environment. Consequently, patients commonly receive services in several settings from professionals representing a variety of disciplines and amidst a fragmented set of professional silos, all of which create barriers to truly effective multidisciplinary care. At the same time, all health-care systems face the twin challenges of improving quality while increasing efficiency. In the contemporary challenging economic climate there is an even greater imperative for health-care systems to find ways to improve both the efficiency and the quality of service provision. A recent review has highlighted that quality improvement can in some cases lead to lower costs 1 and, as Crump and Adli 2 have pointed out, the work of key pioneers of quality, such as Deming, Juran and Kano, has shown the scope for improving quality and reducing cost in many sectors. Consequently, there have been a variety of initiatives to promote intersectoral and interprofessional working; collaborative multiprofessional teamworking has become a major policy objective of successive governments and an international trend. These initiatives have included: In the health-care context, as well as boundaries between different professional groups e. More recently, many policy recommendations and deliberations in health-care policy-making have also been reliant, to a significant extent, on successful working across such boundaries. One major policy response has been to advocate both the horizontal and the vertical integration of health-care services. Peer-based groups working across organisational boundaries or taking part in cross-sectoral work would also be examples of horizontal integration. Unfortunately, there is a lack of clear empirical evidence demonstrating how integration can improve service delivery and, until recently, there has been no universal definition of integration as a concept, or as a model. Furthermore, a systematic review found that there is also a lack of standardised and validated tools for evaluating outcomes of integration. Newly formed clinical commissioning groups CCGs are expected to play a crucial role in determining how health care will be delivered by overseeing the design of local health-care services. For the ambitions of policy-makers to be realised, processes of knowledge exchange have to improve across sectoral, organisational and professional boundaries, which can present significant barriers 15 and thereby undermine attempts to integrate health-care systems, and ultimately efforts to improve quality and efficiency. However, a systematic review of the diffusion of innovations in health-care literature covering the period up to early found that empirical studies exploring the role of boundary spanners were sparse. Boundary spanning as an act was not conceived to be serving in an easy position, and the implication is that managers may not be able to fully direct workers in such bridging positions. Difficulty working in the potentially

undefined area between units was explored further in research by Michael Tushman in , 24 who first examined the notion of complexity and integration efforts in the industrial setting. This study 20 explored how high-performing projects might intentionally develop boundary roles to mediate external information, especially in response to high levels of work-related uncertainty. However, the processes through which they can produce improved co-ordination and knowledge sharing between different professions, organisations and sectors have not been determined. This section reviews the application of the boundary-spanning concept in the field of health-care organisations, exploring how it has been operationalised as part of increasing efforts to improve the vertical and horizontal integration of health-care services. Although a small number of studies of boundary spanning in the health-care setting have been carried out, few have utilised rigorous empirical methods or have focused on the detailed processes by which such interventions have helped improve the vertical and horizontal integration of health-care services, and the quality of patient care. Only a study by Byng and colleagues 43 utilised an evaluation framework to identify the role of link workers in efforts to improve care. Furthermore, most studies have rarely taken the time to construct theories or explanations for what they observe or find in their analyses see Grol and colleagues 44 for a critique of the atheoretical nature of the vast majority of quality research in health care and a call to researchers to make more systematic use of theories in evaluating interventions. Clearly more studies are needed that can connect boundary-spanning activity to quality improvement efforts that have a real impact on patient care outcomes. Although contemporary policy initiatives aim for combined vertical and horizontal integration, dominant ways of thinking about how to achieve this, coupled with inadequate training of clinicians and health-care managers and the existence of sectoral, organisational and professional boundaries, are nonetheless likely to emphasise the vertical dimension. More generally, the ability of collaboration and other network forms to achieve higher quality at lower cost is seriously questioned by the substantive literature not least because there has not been an easy transition to collaborating across traditional sectoral, organisational and professional boundaries. However, there is recent evidence that more effective, nuanced forms of collaboration may be emerging, not through explicit partnerships, but from interacting networks of committed and deeply engaged participants, 54 and health-care reforms in Europe now commonly emphasise community participation, interprofessional learning and collaboration across the public and independent sectors. A review of the empirical literature Before undertaking our fieldwork and designing our research tools we undertook a focused literature review to develop a clearer understanding of the findings from relevant empirical research studies. The methods we used to undertake the review are detailed in Appendix 1. TABLE 1 Direction of integration and boundaries spanned in the 38 empirical studies Overall, we found that the 14 studies of vertical boundary-spanning provide clear descriptions of how people at different levels of a health-care system relate to each other but are weak on process and evidence-based patient outcomes. Top-down policy initiatives for collaboration were not found to have led to better co-ordinated services. Predefined roles for clinical boundary spanners appeared to be challenging to accomplish in reality and social personal and political factors played a greater than anticipated role in this. Political awareness and facilitation skills seemed important for inter- and intraprofessional working, particularly in this vertical dimension. For individuals in high-status positions, successful boundary spanning requires a willingness to work outside professional identity groups; for those in lower-status positions, gaining and communicating professional competency may be more important. In summary, although interdisciplinary and interorganisational boundary spanning is a well-described challenge, there is little research to demonstrate how effective vertical integration is accomplished by implementing boundary-spanning interventions. Studies of horizontal integration appear to provide rather more positive support for boundary-spanning interventions than studies of vertical integration. More of the studies of horizontal integration examined the crossing of sectoral boundaries â€” 13 57 , 59 , 60 , 66 , 67 , 69 , 71 , 73 , 82 , 85 , 87 , 88 , 90 compared with only three 62 , 65 , 76 in the vertical integration articles â€” reflecting how non-health-care sectors experience horizontal relationships with clinical services. Efforts in the horizontal integration of primary care services are commonly implemented to improve access for patients seeking

particular medical services. Boundary-spanning interventions in the form of online discussion forums, published resource guidelines and complex pathway guidelines have the potential to improve joined-up working, particularly in community settings. However, sustaining integrated solutions relies on the flexibility, adaptability and continued reflection and insight of those who are facilitating the intended change, and the receptiveness to this change in the wider environment. For individual staff, achieving boundary status is associated with accomplishment, but also ambiguity. Professionals with enhanced expertise but in new boundary-spanning posts, such as clinical nurse specialists, general practitioners GPs with special interests or dual specialists, may not be readily accepted either socially or politically, making system-wide integration sluggish. The 38 empirical studies that met our inclusion criteria were then analysed using the seven iterative steps of meta-ethnography for evidence synthesis see Appendix 1. The resulting important themes were: A wide range of communication skills Martin and Tipton 55 compiled a typology of communication roles from a purposive sample of non-clinical, salaried patient advocates who, as boundary spanners, might review medical charts, facilitate selection of doctors for second opinions or socialise with waiting family members. Although this research suggested, theoretically, that as boundary spanners these advocates may serve as system change agents â€" particularly when responding to patient complaints â€" the descriptive nature of the research did not build empirical evidence for vertical integration. Similarly, Abbott 56 found that to be effective, nurse consultants needed to be credible leaders, be familiar with relevant policies and organisational structures, build and maintain effective relationships and apply communication skills including facilitation of conflict. In another mixed-methods study, 57 three structural variables team informational diversity, team boundedness and extra team links were used to understand how to increase interorganisational boundary spanning in health promotion teams. Three types of boundary spanning were reported as being associated with team effectiveness: The author suggests that the most effective teams should maintain an open team configuration, invite experts and change team composition over time including part- and full-time members. In this way, increased scouting implied greater informational diversity, and greater interorganisational team effectiveness, even in less bounded teams with more part-time members. Tools, and processes, can serve as boundary-spanning entities as well. Three studies 58 â€" 60 examined how knowledge sharing was accomplished through boundary-spanning methods. Hara and Hew 58 observed an online community of practice for advanced practice nurses, finding that the non-competitive and asynchronous nature of online communication facilitated the improvement of current knowledge and validated best practice. A study of health behaviour change explored the use of referral guides along with support people external to the organisation to implement linkages in the community. However, hurdles were discovered in both resource availability and accessibility to patients, and affordable infrastructure to support boundary-spanning activities was needed. Often boundary-spanning individuals were needed to fill in the gaps, and marshal the use of technology, when paradigm shifts in practices had not yet occurred. As translators and diplomats, boundary spanners may serve to communicate new ideas across a divide. How that knowledge is shared, and whether or not it is adopted, is a sign of its impact. In a study of health planning staff and board members it was found that effective performance as boundary spanners improved collaboration. Open communication appeared to enable the ability to act on shared objectives. Knowing the staff views and agency routines increased the perception of board effectiveness. Formal and informal role negotiation The development of new professional roles to bridge treatment areas is a relatively recent innovation in the UK. With the development of these roles comes ambiguity in task definition and efforts to build professional credibility. Examining pilots that sought to train GPs in specialist genetics and cancer roles, it was found that recruiting for such hybrid roles was difficult because of the day-to-day work of GPs; sustainability of the project was a major concern. Consensual divisions of labour may be backed by institutional goals, but, at the micro level, how roles were negotiated was not entirely clear. For example, a mutually agreeable role for the boundary-spanner clinician was delimited by the specialist to be less clinical and oriented towards a more educational role similarly, nurse consultants are described as struggling to negotiate their role as either autonomous expert or process supporter,

with a common experience of having difficulty identifying priorities Short-term economic incentives were difficult to address with long-term preventative cost-saving calculations. In this way, politics was identified as an important aspect of role definition for boundary spanners. In these examples, beneficial evidence from putting a clinician in a boundary-spanner role was difficult to collect, and the role was constantly renegotiated within the context. When considering intentional efforts to vertically integrate services, the authors noted that colocated specialists and practitioners in hospitals had not only a supervisory relationship but also a more dialogical and informal relationship. Practitioners not located in the tertiary setting but working in primary care appeared to have more clinicalâ€"governance relationships with the hospital-based specialists. Negotiating disciplinary boundaries between specialists and generalists may be mediated by disciplinary values which may be semantic, historical, practical and unrelated to patient need or disease trajectory. In a role study in palliative care â€" and despite policy guidelines to share care â€" covert and overt tensions between services were noted, particularly in the practice of referrals. In these ways, boundary-spanning managers and newly appointed link workers who were perceived to have less clinical knowledge had less ability to influence others in the vertical dimension, even if supported by policy initiatives, newly funded posts or intentional clinical or managerial placement. Vertical integration may be suggested by policy, but professionals make individual decisions to collaborate, or move patients across boundaries, based on many other factors. French 64 describes four contextual factors physical, social, political and economic that influence how work group participants use evidence to make policy decisions. Doctors, managers and nurses working in different settings may have varying perspectives of what is needed for patient care. For example, in the social context of care, respondents reported using independent action, involvement in teaching and direct challenge to influence the care decisions by medical staff. Subterfuge and adaptation were also described as covert strategies used to influence care patterns. Finding time to engage in vertical integration activities was also a challenge for clinicians. Nurse consultants working in boundary-spanning positions were described as needing additional time to negotiate priorities and relationships, which limited the time that they were available for patient care, 56 whereas cardiac surgeons reported that time constraints may contribute to inaccurate medical stories that are reported to newspapers. For example, expanding the roles of mental health workers to bridge the hand-offs between the courts and components of the mental health system was a solution explored in one case. An assessment to gauge interagency co-ordination was mentioned but not reported in detail. For mental health link workers it was found that, although there was potential for these liaisons to improve communications between secondary education services and child and adolescent mental health services, staff were concerned that some increase in workload might result in the short term. Juggling the conversations between constituencies required a chain of conversations, which was framed as a creative process central to organising; the tension was positive and necessary for seeking change. In this case study the tenuous space between collaborators is described as a source of potential energy. Attempts to map out a mental health safety care pathway also met challenges, because of complex assumptions about work arrangements, and attempts to connect the expectations of clinicians, managers and service users. To co-ordinate services, and accommodate to variation, the pathway needed to become more abstract in its scope. As a boundary object the author describes the imprecision and looseness of the resulting pathway as an effective alignment and compromise between stakeholders. Creative solutions can resolve such tensions, while balancing the needs of standardisation with diversity of purpose. Substance abuse programme directors, who were also treatment counsellors, were found to spend more time making community presentations and liaising with monitoring organisations, which the authors assume but did not measure may have improved treatment practices and political leverage. The leadership activities that characterise boundary spanning appear to mediate contextual pressures, but further studies would need to explore this issue more fully.

DOWNLOAD PDF WORKING ACROSS THE HEALTH AND SOCIAL CARE BOUNDARY

Chapter 2 : Professional boundaries - Wikipedia

Working across the Health and Social Care Boundary Chapter Â· November with 3 Reads DOI: /ch6 In book: International Perspectives on Health and Social Care: Partnership.

Surely there is a responsibility to let clients know where the SWs boundaries are. This may sound self-evident but if SWs have difficulties around boundaries then it stands to reason that clients will â€" if these are not made clear surely that is a form of respect? Amanda June 19, at 1: A confident professional does not need to hold on to power to do the job. Managing boundaries and supporting another person to improve their welfare and wellbeing may be part of the job -it is not a reason to hold power over that person Jackie June 19, at 7: But it has to be carefully considered. I have been caught out and learnt the hard way. Herschell June 20, at 3: Initially, past history were interred and I made the fatal mistake of disclosing information about myself that impacted on the client and their extended family. It was a painful lesson in how to be a friendly social worker as opposed to a befriending social worker. David June 20, at 1: I recently had the misfortune to report a manager, who not only supervised the case of a client who lacked capacity , but did so against her best friends clients partner express wishes. Said best friend of my manager, also held court appointed deputy over health and welfare. My managers views also differed from her friends wishes â€" and clients wishes when able to express these. This was in terms of future care needs, and how these could be met. The carer herself â€" and family, were able to recognise and state the potential conflict of interest. In my view the above was a breach of everything I believed in, and left me â€" as a very experienced practitioner, considering whether social work is now for me? I question whether clients â€" or workers, are adequately protected by their professional bodies, managers, or those agencies meant to protect vulnerable adults and children. The dog meant the world to this young person, and he did it to save the dog being taken away. Where is the justice in that? If you start empathising with an abusive parent that is very bad. If you are working with a lonely older person at the end of their life then perhaps you could be a little less rigorous about personal boundaries. Perhaps you could adapt your social work to the prevailing situation using professional judgement.!! I think that my hero Bob Holman probably crossed a few boundaries by actually living amongst the people he cared for. HCPC would probably have suspended him or worse. Nick Andrews July 17, at 4: Donald Forrester has done some interesting research in this area. From my experience of working with people over many years I do believe that most people are more hurt than hurtful. Nick Andrews June 25, at 7: I have recently co-ordinated a Joseph Rowntree Foundation funded project under their programme A Better Life, which illustrated how poorly designed and simplistic professional boundary guidance undermines wise and humane practice, which always takes into account the specific context, rather than set rules. As for the statement: I would be happy to share further information on our work and the work of other erudite and wise people who have explored this subject in more depth. Katy Smith July 17, at There is a guy in Scotland called Phil Coady who has been doing similar work. I am hoping to talk with him this week. Regards, Nick With hope in our hearts June 26, at 3: John Smith June 27, at 7: The names are freely available on the regulatory websites. What have you got to hide by concealing the names of those whose practise has been found to be wanting? I fully expect this comment will not be published, in which case I will be sharing my concerns more widely. Job of the week.

Chapter 3 : Top tips on managing professional boundaries in social work

Understanding and maintaining professional boundaries in social care work - An interview with Frank Cooper by JKP Posted on January 6, Frank Cooper is a freelance trainer specialising in professional boundaries in social care, and has over 16 years' experience as a social care professional.

Working In Partnership In Health Care Social Work Essay Introduction about Working in Partnership In Health and Social Care Health and social care is a term that is being used all around the world and is associated with a set of integrated services that are being made available from various health and social care providers. The numerous departments of health care offer great assistance to patients by giving them safety as well as ensure their safety in every aspect of the care organization and services. Here, it can be stated that philosophy of health care organizations is to provide agreed care plan to patients that states the needs of individual with a people centered approach. In the present report different philosophies of health and concepts related to working in partnership in the sector has been discussed Davies, Since a last decade medical awareness has startled people to believe that health and care services are made for the benefit of every class of people and doctors are much concerned to offer prominent services. In the current situation on transforming health and social care Jeremy Hunt gave an inspiring speech to enhance the health system and also integrated a work plan to exist between local councils and NHS. Here, the focus is being given to assess and examine the diverse health care organizations and the way quality of health services are delivered on regular basis in different health organizations like Healthalkonline, UK Clinical Research Collaboration UKCRC in order to achieve a unified outcome. Moreover, the study also includes in an assessment of partnership between experts in diverse medical areas and diverse agencies working with them. Explain various philosophies and concepts of working in partnership in health and social care Health and social care professionals have an essential role among the partnership workers as each level and different professional group depends on some kind of activity that is related with performance of a group. Partnership is defined as a shared commitment among partners that have a right to participate and will be influenced in with benefits and disadvantages arising from the partnership. The secretary of State for Health in UK has made an impressive development in health care revolution for eco-friendly creation of social cares in the country by partnering with clients and communities to develop and enhance health care services in the country. The Healthalkonline have been developing services since more than 5 years with events and avenue for people to work and participate in different health and social care activities in UK. The program mainly involves in development of charity organization, involvement of expert medical researchers with the best technique to be enforced for the benefit of people VanVactor, The developments led by group researcher has framed different policies have raised awareness, assessed opportunities, management and way to utilize available resources for most beneficial outcome. Similarly, UKCRC has also developed policies to seek donation and bring in the idea to partner with diverse clients and achieve in similar interest. In working with partnership there are certain philosophies that strengthen the work, philosophies like empowerment, humanity, independence, trust, equity, and respect Balloch and Taylor, The empowerment philosophy focuses on process through which people can acquire increased amount of control over different decisions and actions that will impact on their health. It is given much of significance because they are essential for foundation and development of an effective relationship between professional and client. Independence philosophy in this sector present the ability to make decisions that will probably impact on the life of a person without control of others and family members. It is a situation in which a person is not under the power of others and has control over their affairs. Here, in patients are given autonomy to select the way of treatment and can easily self regulate with their necessities Davies, The philosophy of equity guides in distribution of opportunities for well being and every client is provided the accessibility to health services. However, respect in partnership is also an essential factor because partners working together possess in common goals and this relation is ultimately based in mutual understanding and

respect for each other competency and skills to attain beneficial results. Review current legislation and organizational practices and policies for partnership working in health and social care Legislation is the law that has been transmitted by governing body or the process through which acts are endorsed by a legislative body that is being established and empowered. Whereas, organizational policies are statement with an agreed intent that specifically sets a corporations views with respect to a given situation Zakariasen and et. It is a set of policies and principles that gives a definite direction to a company, a procedure is a sequential method to implement an organizational policy and it defines a legal series of activities that is being undertaken to accomplish a task in a consistent manner. There are several legislative and organizational policies that impacts on partnerships in health and social care of UK, the Equality Act , Disability Discrimination Act and Care Standard Act Haworth and et. In this respect the Equality Act states in that measures to safeguard the various ways of discrimination like victimization, discrimination and harassment in health sector. However, the Care Standards Act is an act of UK parliament that is designed in for administration of a range of social care institutions that includes in children homes, hospitals and residential care homes Lloyd, The Disability Discrimination Act includes in provisions that makes unlawful to discrimination against a disabled person with respect to employment, provision of goods and diverse services. The recent enhancement in health care facilities has emphasized on facilities to improve the services and the legislative policies of Healthalkonline and NHS have gone further encouragement towards deployment of staff and joint education in health care systems. Explain how differences in working practices and policies affect collaborative working Before the word collaboration entered into medical system, the health and social care sector was experiencing a common issue which acted as a barrier in its smooth functioning. The main attribute of working together includes in factors like, respect, trust, mutual working, team work and focuses to eradicate any kind of boundary Walsh, Collaboration is defined as the act of two or more companies which are working together for a specific purpose and undertakes the work jointly and effectively. In this respect Clinical Commissioning Group CCG was established in that focuses to empower professionals of NHS and Healthalkonline to enhance their existing services and ultimately community can acquire in benefits. The main attention given here is to reduce inequality, promote the involvement of patients with innovation and research. Similarly one of the governing bodies Care Quality Commission CQC was established in the year it basically regulates in health care services and is accountable for assessment of services and publish in results that assists in companies to make effectual devices to enhance their existing services. Analyze models of partnerships working across the health and social care sector The model of partnership states an order, which is beyond the single identity it may result into unnecessary disagreement between the two working parties. There are mainly four types of models available for partnership in health and social care i. In this context, the unified models reflect principles where a practice is entirely integrated with management and leadership that involves in delivery of services through various agencies Barnard, The corporations using this model are not permitted for government funding as they possess their own financial systems but undertakes with work to offer a suitable care for service users. Whereas, the coordinated model seeks in for cooperative working in which unit are liable for functions that is associated with area of skill under separate management and there is no single incorporated system within this model. Coalition models occurs when various companies aligns together to achieve a particular goal and it facilitates them to undertake effectively so that clients can be satisfied with the services they acquire. On other hand hybrid model states information where in organization that functions with a mixture of diverse models in order to acquire a full range of services without any of the model dominating each other. In recent years it has been found in that Healthalkonline has focused on shared decision making approach as it reduces the health issues and plays an important role in decision making practices Keating and et. This approach mainly comprises all the three models, hence it can be concluded in that these models primarily helps in different companies to plan themselves and conveniently focuses on a particular model. Evaluate partnerships relationships within health and social care services Partnership in health and social care is associated with chief successful relationship between doctor and clients, in working with partnership the main benefit that is

being acquired is that workload between practitioners are distributed equally according to one with own expertise Liddell, In general working in partnership is an effective approach to manage issues efficiently and it can be a difficult issue if not managed adequately and could not deliver prominent outcomes if aims and objectives are not clear. In this context it has been observed that UKCRC aims to assess in better ways to look after patients and keeping its patients healthy through effectual partnerships. The management uses in approach for messages to professionals and hence, in order to assess in partnership relationships within the health and social care services is its perfect emphasis that both should focus on the available work as well as certain tips need to be managed like focus should be use more knowledge, expertise and responsibility than roles must be given Glasby and et. Organizations can also enforce in sharing of work practice and better networking potential with joint venture and working in team. Conclusion From the above report it can be concluded in that different health and social care professionals needs to design and develop optimum skills, as working in partnership in health and social care is effective to all services. Through partnership organizations attains interpersonal working environment and it offers numerous benefits like social exclusion can be managed more efficiently, activities by different agencies will be less diluted with a range of agencies. Partnership working in health and social care. Results from a Pilot Study. Journal of Integrated Care. Childhood abuse, limited intervention and homelessness: Pathways to the mental health and justice systems. International Journal of Prisoner Health.

Chapter 4 : The Sample of Working In Partnership In Health Care Social Work Essay

The health and social care system has recognised a need to change considerably to respond to changing needs and demands, and workforce development is a central part of this process.

The text explores key topics and approaches to partnership working. Readers will find the following chapters: Partnership working and organisational culture; 2. Key elements in effective partnership working; 5. Working across the health and social care boundary; 7. Partnerships in the digital age; 8. The economics of integrated care; 9. Self-directed support as a framework for partnership working; The outcomes of health and social care partnerships. In their introduction, the editors of this volume state that they have brought together a large diversity of opinions and concepts regarding cooperation in health and social care. They claim that, notwithstanding the diversity in approaches of the authors, the underlying bottlenecks turn out to be the same almost everywhere. The many different ways to interpret the concept of cooperation provide an example of this diversity. I personally find the definition given by Glasby the most recognizable from a practical point of view. On two axes, he connects the various forms contributing to the intensity of a particular cooperative relation, such as sharing information, consulting each other, joint management, etc, with the scope of this cooperation. It could be limited, for instance, to the health care sector, or the scope could be widened to the social care sector, or to collaboration with municipal authorities, etc. Thus, the book provides a rich source of knowledge for everyone actively involved in setting up and elaborating on partnerships in health and social care from an organizational perspective. Culture plays a vital role in setting up effective partnerships. A forced integration of the cultures of several organizations does not work; it will merely result in tensions and distrust. Is it possible to steer clear of such pitfalls? A merger between two organizations with a more or less similar culture cannot lead to a positive result, while two culturally different organizations will be able to create an innovative entity. The majority of the other articles deal with different aspects of the organizational dimension of cooperation in health and social care. Reading these articles left me with the impression that a great amount of knowledge has been gathered, but that the connecting thread is missing. The reader is confronted with the results of an impressive diversity of studies on collaborating, but risks losing sight of the purpose of all this knowledge along the way. The author argues the necessity of an approach in which clients get control over the provisions they need. The perspective of users on the quality of provisions and services is mentioned occasionally in several other articles. One author states, for instance, that the competence of staff members and the continuity of both the provided care and the presence of staff members are important to clients. It is difficult to award this book an unequivocal rating. People who are at work dealing with organizational issues with regard to innovative constructions of cooperation, will find a wealth of concepts, ideas, and suggestions in this book about a more effective structuralization of their collaboration. For them, it offers a rich source of knowledge about the possibilities and bottlenecks of cooperation. Yet, for those people who regard innovation as striking a good match between the supply of services and provisions of health care and social care organizations on the one hand, and the need for care and support of the clients of these provisions and services on the other, this compilation can be disappointing. Thus, it all depends on the take the reader has on what innovation is about. What I miss in this compilation, however, is the question of what space is cleared in cooperative relations for the input of the users. After all, working more effectively will only become possible when the experiential knowledge of users is incorporated in the design of a more integral approach. Only then can there be any improvement in health and social care.

DOWNLOAD PDF WORKING ACROSS THE HEALTH AND SOCIAL CARE BOUNDARY

Chapter 5 : Kingâ€™s Fund evidence says we must share skills across health and social care - NHS Empl

Edwards, A. () Working across the Health and Social Care Boundary, in International Perspectives on Health and Social Care: Partnership Working in Action (eds J. Glasby and H. Dickinson), Wiley-Blackwell, Oxford, UK. doi: /ch6 If you are a society or association member and.

Michael West In addition to improving patient care, the aim of integrated care â€" and of the proposals set out in the NHS five year forward view â€" is for health care organisations to work more effectively across boundaries. Intellectually this idea makes good sense and is attractive and persuasive, but in practice it is not just difficult to achieve â€" it requires us to confront possibly our greatest flaw as a species. In other research children quickly learnt to be profoundly prejudiced simply on the basis of eye colour. And we can see how inter-group prejudice condemns mergers and acquisitions to limited success or outright failure. This approach makes it difficult to build cross-organisational co-operation, supportiveness and shared identity in the short or medium term, attractive though the idea might be, because of all the work that has been done to build pride in our existing organisations. Successful integration requires leaders to find ways of blurring boundaries between pre-existing organisations by emphasising the benefits of the larger grouping as will be the challenge for Manchester with its new mandate to manage a combined health and social care budget. But inter-group bias will ensure that integration will not always be easy. People working in health care organisations will inevitably resist the kinds of organisational transformations that NHS leaders are proposing, unless they believe that these changes are for the long term and will not be abandoned, and that they will make a powerful, positive difference to patient care. People also have to be reassured that change will help them do their jobs better and maintain their key working relationships. What then are the solutions? The first is establishing and promoting an overarching shared vision across newly merged organisations or across health and social care divides. From the perspective of health care staff, this vision must relate to improving the delivery of high-quality and compassionate care. It also means continually identifying, communicating and valuing progress towards achieving shared goals with outcomes particularly focused on patient care, rather than on less inspiring outcomes such as productivity, cost effectiveness and efficiency. Second, it is vital that there is frequent and sustained contact between key individuals and groups from the merging organisations. Cross-boundary relationships often spawn conflict because of clashes of values, working methods, identities, territories and inter-group prejudice. The issues need to be identified and resolved quickly, transparently and creatively in the best interests of patient care and all those involved. Cross organisational trust is built through authenticity, openness, fairness and commitment in the process of conflict resolution. Third, the different organisations that come together or that seek to work collaboratively must build an approach of mutual altruism, mutual concern, unselfishness and an eagerness to work tirelessly at developing cross-organisational or cross-boundary relationships that are characterised by a strong sense of mutual support, belonging, appreciation and trust. We understand much about inter-group relations; how they affect our ability to work together to solve shared problems think of the difficulty of nations working together to deal with climate change , and how pervasive this fundamental human tendency is. If we are to be effective in creating the organisational forms and processes needed to meet the health and social care needs of our communities, we have to recognise the problems that will confront us. Good ideas on paper are one thing; the realities of human behaviour are quite another and we can and must adapt our good ideas to take account of this.

Chapter 6 : Setting the boundaries in social work | Social Care Network | The Guardian

practice in social work and social care, and the mismanagement of these boundaries can lead to unprofessional conduct and negative consequences for both worker and client.

He previously also taught in the fields of volunteer training and drugs awareness, and has developed accredited courses in his chosen fields of specialty. Tell us a bit about yourself and how you come to write this book. I have always delivered training, firstly for my employers and then freelance. As time went on I came to realise the importance of boundaries and noticed the lack of training available. Having delivered the training for a while, the book seemed like the natural next phase. Why are professional boundaries important in social work and social care? Professional boundaries are vital in social care work because we are working on a deep level with vulnerable people. This means that we have a responsibility to them to do things to the best of our ability and to ensure that our help and support does not damage or disenfranchise them. Working with difficult issues can also be very stressful and draining work, and professional boundaries help us to manage ourselves and our emotions. How do they differ to professional boundaries in any other sector? Whilst the basic boundaries within this book are similar to many other sectors, the application, understanding and maintenance of the boundaries is more complex. The relationship that social care workers hold with their clients, the amount of time they spend with their clients, and the nature of the subjects they deal with all complicate things. The most complex area of professional boundaries is managing the relationship between client and worker, and social care workers often have the most complex relationships with their clients. Who have you written this book for? However, given the lack of detailed training in the sector generally, it is suitable for people at all stages of their career. Boundaries is an area that is always worth reflecting on in order to improve your practice, and going over the materials in the book should provide food for thought for anyone involved in social work or social care. You are an experienced trainer in this area. What do you tend to find trainees struggle with the most in relation to professional boundaries and confidentiality? Most of the training work that I have done is with professionals who have already been trained and are experienced. In terms of confidentiality, the area that they seem to find difficult is managing the complex boundaries when working jointly with other social care professionals supporting a single client. Once you are working with other professionals you feel part of the same team and it can be difficult to withhold information. The other area that people often find difficult is dealing with concerned family members. Can you give some examples of the negative consequences of failing to maintain boundaries? At its most extreme, failing to maintain boundaries can lead to issues of serious neglect and abuse with clients, either through the failure to offer necessary support or by the relationship slipping into deeply inappropriate areas. If you then move jobs or have to refer them on, any positive work that you have done could fall apart as a result of the difficulty they have in separating from you. As a worker it is very easy to slip over the line without noticing that you have done so, particularly if the client you are working with brings up strong feelings or memories for you. Being self-aware and keeping a check on yourself is essential. The book contains signs to watch out for in both worker and client behaviour, and also some insights into issues such as co-dependency that can be both a cause and effect of boundary issues. Have you ever experienced conflicts relating to your own professional role? I have had many situations involving boundary crossings and issues, I think that anyone working in the social care field will have had many similar experiences. I was a new, locum worker. I went to a senior member of staff and asked for support in dealing with the situation. In the end I stopped working at the unit and made a complaint about the member of staff. This situation was much more complex to resolve and involved working closely with my manager and other members of staff to support her. One really useful feature of the book is a self-assessment questionnaire for the reader to fill in. Tell us how it was devised and what kind of feedback you have had on it to date. What I wanted was a format to engage people in the subject. I have always enjoyed filling in those questionnaires and it is a format that people are familiar with. It has been incredibly popular

and I get feedback all the time on it. I use a version of it in all my training sessions and a version has been published in Community Care Magazine. Finally, the book is full of very practical and hands-on advice. Can you give us a few examples of the kind of tips that feature in the book to take away? The aim of the book is to be practical and hands on reference guide. It includes signs that you or a client are crossing boundaries and that the relationship may be heading in an inappropriate direction. There are tips about assertive communication, which is essential to enforcing boundaries successfully; a list so high risk situations; and guidance on how to react to boundary crossings and high-risk situations.

Chapter 7 : Book review: International perspectives on health and social care. Partnership working in actio

The main aim of this project is to develop a sustainable, practical framework to help staff share knowledge across health and social care boundaries.

Share via Email Robin Currie. General Social Care Council Professional boundary issues are a concern for many social workers and their managers, because building relationships forms an important part of their work. The vast majority of social workers manage their relationships in line with professional values and use such professional relationships as a vehicle to improve the quality of life of service users. But of the small number of social workers taken through conduct proceedings by the General Social Care Council GSCC , many have been due to breaches of professional boundaries. The few who flout these values can bring untold harm and distress to service users. Furthermore, their actions can undermine the credibility and public trust in social work itself, significantly reducing the capacity of social workers to work effectively with future service users. There are certain actions that clearly breach professional boundaries, such as if a social worker has a sexual relationship with a service user. However, there are other areas of social work practice where what constitutes acceptable behaviour will depend on the particular situation. Sometimes to hug a service user would be quite appropriate, in other circumstances it could be considered predatory. Due to the complexity of social work practice the new GSCC guidance on professional boundaries is important. This fits with my own experience as a social worker and manager. For example a community social worker might need to develop relationships in a way that would be unacceptable for a formal caseworker. How then do social workers know what is and what is not proper? The answer is that this happens as we go through a socialisation process into the social work profession. Social workers are subjected to a range of influences as they move through their career. This model of professional practice puts a major responsibility for developing professional identity on individual social workers. The new GSCC guidance emphasises the importance of social workers recording, as well as raising, boundary issues in supervision and using these opportunities to reflect on the proper way of dealing with the many grey areas in the development of relationships. However, we know that many social workers receive poor supervision. When I was a member of the GSCC Conduct Panels, hearing allegations of professional boundary violations, it was frequently claimed by registrants that they received little or no supervision. Line managers have a vital role in providing effective supervision through which they are able to support social workers to engage in critical reflection on their practice. At times managers do need to go further and set boundaries in the way social workers interact with service users and others. These are demanding and challenging roles. Line managers need time as well as support and training if they are to undertake their roles effectively. Whilst the GSCC guidelines have clear implications for both social workers and their managers, perhaps the biggest challenge they pose is for employers who in an era of budget cutbacks have a responsibility to create the conditions in which safe and effective social work practice can prevail. The new GSCC guidance is available here.

DOWNLOAD PDF WORKING ACROSS THE HEALTH AND SOCIAL CARE BOUNDARY

Chapter 8 : Institute for Apprenticeships / Advanced clinical practitioner (degree)

In addition to improving patient care, the aim of integrated care - and of the proposals set out in the NHS five year forward view - is for health care organisations to work more effectively across boundaries. Intellectually this idea makes good sense and is attractive and persuasive, but in.

Professional Communication Skills for Nurses sixth edition. Foundations for clinical mental health counseling: An introduction to the profession 2nd ed. Upper Saddle River, NJ: Nursing further reading[edit] Anewalt P Fired up or burned out? Understanding the importance of professional boundaries in home healthcare and hospice - Home Healthcare Nurse Nov-Dec;27 10 Pages Beardwood B The loosening of professional boundaries and restructuring: A matter of therapeutic integrity. Sexual Misconduct Task Force - Standard for therapeutic relationships and professional boundaries Nurses Board of South Australia - Professional boundaries guidelines for registered nurses in Victoria Nurses Board of Victoria - Professional boundaries: Working Together in Health and Developing collaborative European â€¦ - Cameron A Impermeable boundaries? Developments in professional and inter-professional practice - Journal of Interprofessional Care, Chavkin W, Breitbart V Reproductive health and blurred professional boundaries. Exploring professional hierarchies and boundaries in focus groups - Qualitative Health Research, Crowden A Professional boundaries and the ethics of dual and multiple overlapping relationships in psychotherapy. Infrastructures to support integrated care: Galletly CA Crossing professional boundaries in medicine: Reactions of Students and Implications for Teachers - S. Internal coalitions and crossprofessional boundaries - American Journal of Sociology, Hamre GA, Berntsen KE integration across professional and organisational boundaries in health care: Boundaries and Stalking Issues: Working across Professional Boundaries: Working Across Professional Boundaries: The interdependence of behavioral and â€¦[â€¦ - â€¦ Journal of Integrated â€¦, Lane K The plasticity of professional boundaries: Generalist and specialist knowledge in the modernization of genetics provision in England, Knowledge and Capabilities; 28 April Martin GP, Currie G, Finn R Reconfiguring or reproducing intra-professional boundaries? Inter-organisational communication Plaut SM Sexual and nonsexual boundaries in professional relationships: A Multi- â€¦, Pugh R Dual relationships: Personal and professional boundaries in rural social work - British Journal of Social Work, Ravotas D, Berkenkotter C Genre as tool in the transmission of practice over time and across professional boundaries, - Mind, culture, and activity, Reynolds TS Defining Professional Boundaries: Chemical Engineering in the Early 20th Century - Technology and Culture, Richmond PA Perspectives of professional boundaries from adolescent females in a residential treatment facility: Forum - Physiotherapy, Stone J Respecting professional boundaries: Contesting Professional Boundaries at the Margins - Vamos M The concept of appropriate professional boundaries in psychiatric practice:

Chapter 9 : How social workers can better manage professional boundaries | Social Care Network | The Gu

in breaking down and working across organisational boundaries. Working towards achieving this goal will require full engagement of all staff - people from the frontline.